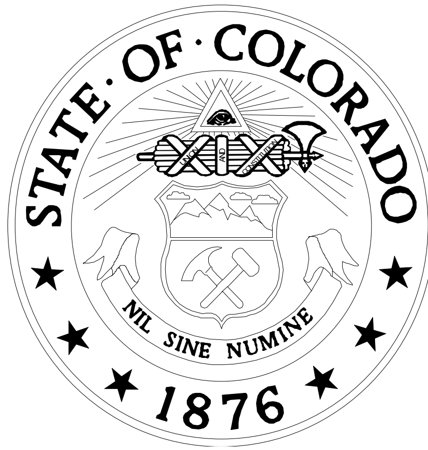


Department of Health Care Policy and Financing
Strategic Plan
FY 05-06 Budget Request

November 1, 2004

Table of Contents

I. INTRODUCTION **4**

II. STRATEGIC PLAN DIRECTION **7**

VISION 7
MISSION 7
GUIDING PRINCIPLES 7
GOALS 7

III. SCHEDULE 1 – PRIORITIZED OBJECTIVES **9**

IV. PERFORMANCE MEASURES **11**

NEW FY 04-05 PERFORMANCE MEASURES FOR THE NOVEMBER 1, 2004 BUDGET REQUEST 11
NEW FY 05-06 PERFORMANCE MEASURES FOR THE NOVEMBER 1, 2004 BUDGET REQUEST 17
FY 03-04 ACHIEVEMENTS TOWARDS PERFORMANCE MEASURES FROM LAST YEAR'S BUDGET REQUEST 22
FY 04-05 ACHIEVEMENTS TOWARDS PERFORMANCE MEASURES FROM LAST YEAR'S BUDGET REQUEST 28

V. POLICY AND PROGRAM TRENDS **30**

COLORADO BENEFITS MANAGEMENT SYSTEM IMPLEMENTATION 30
TRANSPORTATION ISSUES 31
EXTERNAL QUALITY REVIEW OF MEDICAID MANAGED CARE ORGANIZATIONS AND PREPAID INPATIENT HEALTH PLANS 32
CONSUMER ASSESSMENT OF HEALTH PLANS STUDY 32
HEALTH PLAN EMPLOYER DATA INFORMATION SET 34
ADMINISTRATIVE SERVICE ORGANIZATIONS 37
DISEASE MANAGEMENT PILOT PROGRAMS 37
TRANSITIONS IN COMMUNITY-BASED PROGRAMS 40
MENTAL ILLNESS AND NURSING FACILITY CASE-MIX REIMBURSEMENT RATES 41
SYSTEM SECURITY ISSUES 42
REPROCUREMENT OF THE MEDICAID MANAGEMENT INFORMATION SYSTEM CONTRACT 42
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, NATIONAL PROVIDER IDENTIFIER 43
HEALTH INSURANCE FLEXIBILITY AND ACCOUNTABILITY WAIVER 43
COLORADO INDIGENT CARE PROGRAM 45
OLD AGE PENSION STATE MEDICAL PROGRAM 46
STATUS OF LEGAL IMMIGRANTS 46

TOBACCO FUNDING 46
LEGISLATION SUMMARY 2004 47

VI. DEPARTMENTAL BACKGROUND 52

A. OVERVIEW 52
A1. Department Structure 52
Figure A.1 Organizational Chart 54
A2. Overview of Staffing 55
A3. Health Care Policy and Financing and its Programs 55
A4. Colorado Budget Environment 56
A5. HIPAA Information Regions 57
B. STATE BUDGET 59
B1. State Agency Budgets as a Percentage of the State Budget in General Fund 59
B2. Highest Draw of Federal Funds, by Agency 60
B3. Health Care Policy and Financing Expenditure Growth for FY 99-00 to FY 03-04 61
B4. Comparing Colorado to Other States in Federal Region 63
B5. Cost Containment Measures within the Region 64
C. DEPARTMENT BUDGET 64
C1. Department Budget Growth and Outlook for FY 04-05 and FY 05-06 64
D. CLIENTS 66
D1. 2004 Federal Poverty Levels 66
D2. Regional Demographics and Expenditures 66
D3. Children's Basic Health Plan Enrollment by Region 73
D4. Uninsured Coloradoans 74
D5. Medicaid Caseload for FYs 99-00 to 05-06 76
D6. Medicaid Caseload (without Retroactivity) by Gender for FY 03-04 78
D7. Medicaid Enrollment by Type of Managed Care Provider 79
D8. Historical Medicaid Expenditures by Eligibility Category 80
D9. Medicaid Management Information Systems – Average Cost per Client 81
D10. Medical Identification Cards – Average Cost per Client 82
D11. Percent of Medical Services Premiums Expenditures by Eligibility Category 83
D12. Medical Services Premiums Expenditures by Eligibility Category 84
D13. What Medicaid Clients Drive 75% of the Medicaid Budget? 85
D14. Children's Basic Health Plan Enrollment by Age and Family Income 93

E. SERVICES 94
E1. A 15 Year History of Medicaid *94*
E2. Paid Medicaid Claims Expenditures across Age Groups for FY 03-04 ..... *95*
E3. Utilization of Services by HIPAA Region for FY 03-04 ..... *97*
E4. Physician Services *99*
E5. Top 10 Service Categories in the Medical Services Premiums *99*
E6. Top 10 Prescribed Drugs in Medicaid *100*
E7. Top 15 Inpatient Diagnoses for FY 03-04 ..... *101*
E8. Top 15 Outpatient Diagnoses for FY 03-04 ..... *102*
E9. Top 15 Inpatient Surgical Procedures for FY 03-04 ..... *103*
E10. Top 15 Outpatient Procedures Codes for FY 03-04 ..... *104*
E11. Top 15 Inpatients Diagnosis Related Groups (DRGs) for FY 03-04 ..... *105*
E12. Top 25 Diagnosis Codes for Noninstitutional Claims for FY 03-04 ..... *106*
E13. Top 25 Procedures for Noninstitutional Claims for FY 03-04 ..... *107*
E14. Top 10 Procedures for Children's Dental for FY 03-04 ..... *108*
E15. Top 5 Lab Tests for FY 03-04 ..... *108*
E16. Top 25 Durable Medical Equipment Expenditures by Procedures for FY 03-04 ..... *109*
E17. Top 5 Radiology Procedures *110*

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
FY 05-06 STRATEGIC PLAN

I. INTRODUCTION

Each year the Department of Health Care Policy and Financing establishes strategic goals, objectives, and performance measures. Long-range planning is a systematic process for purposefully directing and controlling the Department's future activities for periods that extend beyond one year. This process is called Strategic Planning. The strategic planning process provides a focused, future-oriented direction for the Department to provide quality, cost-effective health care in accordance with the mandates of Colorado's General Assembly. The Governor, through his Office of State Planning and Budgeting, requires that the Department's Strategic Plan be included as a component of its Budget Request submission each November.

Most of the Department's programs are funded in part by the federal Centers for Medicare and Medicaid Services that provides about 50% of the Department's Medicaid budget and 65% of the Children's Basic Health Plan funding. The Centers for Medicare and Medicaid Services is responsible for overseeing the Medicare and Medicaid programs nationally and manages Medicare directly, while the states are responsible for the purchase and delivery of Medicaid services and the Children's Basic Health Plan.

In addition to the Medicaid program and the Children's Basic Health Plan, the Department manages:

- The Colorado Indigent Care Program: This is a State designed and operated program, now dominantly financed by Title XIX of the Social Security Act, through the federal disproportionate share and upper payment limit mechanisms. This program provides partial reimbursement to health care providers for providing medical care to eligible uninsured and underinsured residents.

- Old Age Pension State Medical Program: This State-only program provides limited medical care for non-Medicaid individuals receiving Old Age Pension grants. Eligible recipients for program benefits are over the age of sixty, but do not meet the Supplemental Security Income criteria, and are therefore ineligible for Medicaid. This program is funded with $10 million established in the State's constitution and $750,000 in the Colorado Revised Statutes.

- The Home Care Allowance Program: This program provides direct payment to eligible clients enabling them to purchase community-based services. The program is financed by at least 95% General Fund and up to 5% local funds.

- The Adult Foster Care Program: This program purchases non-medical residential care for eligible clients. The program is financed by at least 95% General Fund and up to 5% local funds.

This Strategic Plan provides the Department's vision, mission, guiding principles, goals, objectives, and performance measures for the upcoming year. The Department's prioritized strategic objectives are set forth in the Schedule 1. The Department has also identified how it has progressed towards the performance measures in last year's Strategic Plan.

Current issues within the Department are addressed and highlighted in the "Policy and Program Trends" section. Lastly, the Strategic Plan provides a new section with background information on the Department, programs available to serve clients, and the types of clients served.

To recap, this Strategic Plan:

- Details the Department's vision, mission, organizational values, goals, and performance measures;
- Discusses topic areas that are important and changing today; and,
- Provides descriptive overview and background information.

IMPORTANT NOTE:

In providing the extensive information in the Departmental Background section of this document, the Department accessed a number of different data sources. Different sources and different methods contain different types of information. Therefore, Medicaid caseload and Medicaid expenditures are represented as different numbers in different places.

When the Department transitioned to Cash Accounting at the end of FY 02-03, caseload reporting was changed. Caseload reporting in budget documents no longer contains retroactive eligibility adjustments. Budget caseload is held constant at its first month reported, so is pulled on a specific date. However, retroactivity is still a function of Medicaid eligibility; that is, in practice, caseload does vary over time because clients are, generally, eligible back to the date of their application. In researching new components of caseload, such as gender, the full data at the original point of time is not available and will include some retroactivity. In the gender example, the Department queried the system for the same year as previously reported, but is off by approximately 100 clients because the report ran at a different point in time. In some cases, caseload includes other programs besides Medicaid. Therefore, some caseload totals may differ within the document. At all places, the context is noted for the reader.

For budget purposes and monthly reporting to the Joint Budget Committee, the Department reports Medicaid expenditures as the amount of the Medical Services Premiums Long Bill group. Sometimes this is reported without federal financing and sometimes it is, depending on the purpose of the report. For instance, federal financing can easily skew the perception of Medicaid services. Also, in some of the descriptive information provided in this document, the Department has queried the system and reported on *all* Medicaid expenditures, even those in other Long Bill groups such as "Other Medical Services" and "Department of Human Services Medicaid-Funded Programs." As long as taken in context, this information is provided to educate the General Assembly and the public regarding various aspects of Medicaid. Some information will not correlate directly with the official Budget Request.

FY 05-06 BUDGET REQUEST
II. STRATEGIC PLAN DIRECTION

Vision

In the stewardship of the Department's programs, the Department strives to achieve a health care system that results in effective health care security for Coloradoans while being sensitive to the fiscal pressures on the State budget.

Mission

The mission of the Department of Health Care Policy and Financing is to purchase cost-effective health care for qualified low-income Coloradoans.

Guiding Principles

- The Department will treat clients with respect and consideration.
- The Department will be honest in relationships with each other, with partners, and with the public.
- The Department will be focused, accountable, and efficient.
- The Department will work to ensure access to appropriate, medically necessary health care for eligible individuals.
- The Department will purchase and finance health care in a cost-effective and responsible manner.
- The Department will evaluate success by using client input, outreach efforts, and surveys. The Department will continually search for methods to improve quality, accessibility, and cost effectiveness.

Goals

- The Department will evaluate cost control mechanisms now operating in its programs to ascertain if it is getting the maximum value and cost benefit. Alternative recommendations should assure that the care that the Department purchases is medically necessary and appropriate.
- The Department will avail itself of opportunities and resources to further the goal of improved health status of vulnerable Coloradoans while achieving cost effectiveness. To that end, the Department will learn how best to partner with contractors and other public and private sector entities to maximize the resources brought to bear on improving the health status of Coloradoans. We will improve the oversight of contracts with other State agencies, and employ more performance based contracting with private contractors.

- The Department will evaluate client health and satisfaction and will model program design and purchase of service decisions in such a way to promote improved care delivery. Clients will be furnished information about quality of care and general client satisfaction so that they may make informed choices about the care they receive.
- The Department will value its personnel through effective recruitment, hiring, and retention. Through concerted efforts, as determined appropriate and meaningful in staff development, training, and employee morale, the Department will make staff stability and technical expertise a priority. The Department will examine what motivates employees to work effectively and consider strategies to reinforce employee development. The Department will allocate its staff and resources in a way to ensure that it addresses the organization's priorities. We will focus on areas of health care risk, financial risk, and exposure as a way to prioritize the assignment of resources.

III. SCHEDULE 1 – PRIORITIZED OBJECTIVES

LEVEL 1 PRIORITIES – Essential priorities that are critically important to the core operation of the Department and are viewed as "no choice" priorities for the Department:

1.1 To maximize the opportunity to maintain health care services through the purchase of services in the most cost-effective manner possible.
1.2 To support timely and accurate client eligibility determination.
1.3 To assure payments in support of the programs are accurate and timely.
1.4 To assure delivery of appropriate, high quality care. To design programs that result in improved health status for clients served and to improve health outcomes. To ensure that the Department's programs are responsive to the service needs of enrolled clients in a cost-effective manner.
1.5 To accurately project, report, and manage budgetary requirements to effect executive and legislative intent with program and budget development and operations. To accurately record and monitor expenditures for programs managed by the Department so there may be accurate financial reporting at all times.
1.6 To work towards systemic improvement in the Department's operations to expand efficiencies, minimize waste, ensure coordination, and eliminate discrepancies.

LEVEL 2 PRIORITIES – High priorities that provide substantial support for the core business of the Department or generate substantial efficiencies:

2.1 To expand areas of potential financial recovery such as third party insurance (that should be a primary payer) and cases of fraud and abuse.
2.2 To improve management of the Department's information systems technology.
2.3 To hold accountable the Department's administrative contractors, including state and local agencies, by more outcome-based contracting and more sophisticated contract management.

LEVEL 3 PRIORITIES – Medium priorities that support a critical portion of the Department's core business and have a likelihood of generating efficiencies or improving service:

3.1 To improve customer satisfaction with programs, services, and care.
3.2 To enhance customer service, provider and eligibility personnel's understanding of program requirements, benefits, and responsibilities. To improve the usefulness of communications with clients, constituents, partners, and stakeholders.

LEVEL 4 PRIORITIES – Narrowly focused priorities as they relate to the Department's core business:

4.1 To build and maintain a high quality, customer-focused team.
4.2 To enhance program safeguards and controls.
4.3 To increase public knowledge of and involvement in the financing and delivery of health care.
4.4 To develop enhanced training and retention strategies for departmental staff.

IV. PERFORMANCE MEASURES

New FY 04-05 Performance Measures for the November 1, 2004 Budget Request

FY 04-05 OBJECTIVE: 1.1 To maximize the opportunity to maintain health care services through the purchase of services in the most cost-effective manner possible.	
Division / Section	**New FY 04-05 Performance Measure**
Children's Basic Health Plan Division	Children's Basic Health Plan Division will complete the modeling for implementation of a streamlined Medicaid and Children's Basic Health Plan by June 30, 2005 for the Health Insurance Flexibility and Accountability Waiver.
Information Technology Division, Eligibility Systems Development Section	The Colorado Benefit Management System will be implemented Statewide and the rules-based system will become stable and reliable in terms of eligibility determinations.
Health Benefits Division	The Health Benefits Division will monitor administrative service organization contracts on a quarterly basis to ensure contract compliance and cost-effectiveness.
Rates, Analysis, and Program Integrity Division	Based on identifying opportunities within the pharmacy program, the Rates, Analysis, and Program Integrity Division will implement prior authorizations, limits, and controls to effectively manage the prescription drug premiums line.
Rates, Analysis, and Program Integrity Division	The Division will effectively utilize the Drug Utilization Review Board to identify opportunities for cost savings; the Board will meet on a quarterly basis.
Safety Net Financing Section	Prior to July 1, 2005, the Safety Net Financing Section will research a benefit package for the Old Age Pension State Medical Program that can be delivered within the constraints of constitutional funding limits.
FY 04-05 OBJECTIVE: 1.2 To support timely and accurate client eligibility determination.	
Client Services Division	In coordination with Colorado Benefits Management System staff, Benefits Coordination's Medicaid Eligibility Quality Control Unit will develop a quality control process to test that eligibility is being determined by the benefits management system correctly.
Client Services Division	The majority of Medicaid eligibility policy changes will be programmed, tested, and implemented in Colorado Benefits Management System by the effective date of the change.

Division / Section	New FY 04-05 Performance Measure
Information Technology Division	The Information Technology Division will monitor and enhance the Colorado Benefits Management System eligibility determination system and the Department's decision tables to improve accuracy of the client eligibility determination.
FY 04-05 OBJECTIVE: **1.3 To assure payments in support of the programs are accurate and timely.**	
Information Technology Division	Information Technology will conduct at least one systematic system review of the Medicaid Management Information System to assure its accuracy.
Rates, Analysis, and Program Integrity Division	The Division will provide assessment of payments to the managed care organizations, Programs of All Inclusive Care to the Elderly, and administrative service organizations, to assure accurate payments for eligible clients for FY 04-05 by March 2005. The Division will assess any provider requests for offline payments within 45 days after submission.
Safety Net Financing Section	Quarterly payments to Colorado Indigent Care Program providers will be made according to a published schedule.
FY 04-05 OBJECTIVE: **1.4 To assure delivery of appropriate, high quality care. To design programs that result in improved health status for clients served and to improve health outcomes. To ensure that the Department's programs are responsive to the service needs of enrolled clients in a cost-effective manner.**	
Children's Basic Health Plan Division	Children's Basic Health Plan Division contracted with a quality improvement vendor to collect baseline data for calendar year 2004 to evaluate Health Plan Employer Data and Information Set measures. A report of the data is due by June 30, 2005.
Long Term Benefits Division, Community-Based Long Term Care Section	By May 1, 2005, Community-Based Long Term Care will develop two additional sites to provide services to long-term clients enrolled in the Brain Injury Waiver.
Long Term Benefits Division, Nursing Facilities Section	Nursing Facilities will develop a specific placement and care plan for the estimated 170 clients with mental illness living in nursing facilities.

Division / Section	New FY 04-05 Performance Measure
FY 04-05 OBJECTIVE: 1.5 To accurately project, report, and manage budgetary requirements to effect executive and legislative intent with program and budget development and operations. To accurately record and monitor expenditures for programs managed by the Department so there may be accurate financial reporting at all times.	
Budget Division	For the November 1, 2004 Budget Request, the Budget Schedules Analyst will improve the current Schedule 3 spreadsheets, creating a more automated and standardized process, including instructions and structured audits, to ensure greater accuracy in budget deliverables.
Controller and Operations Division	The Controller and Operations Division will improve the accounting and reporting of provider recoveries by developing a routine reporting mechanism for provider recoveries. A routine report will be provided to interested parties of provider recoveries collected by provider payment, by accounts receivable recoupment within the Medicaid Management Information System, and by direct payment offset within the information system.
Rates, Analysis, and Program Integrity Division	The Rates, Analysis, and Program Integrity Division will respond to requests for ad hoc reports within 10 business days, 90% of the time.
Rates, Analysis, and Program Integrity Division	Managed care organization, Programs of All Inclusive Care to the Elderly, and administrative service organization rates will be calculated in a timely manner, meeting all actuarial standards.
FY 04-05 OBJECTIVE: 1.6 To work towards systemic improvement in the Department's operations to expand efficiencies, minimize waste, ensure coordination, and eliminate discrepancies.	
Budget Division	For data requests from Joint Budget Committee staff, Legislative Council, the Office of State Planning and Budgeting, the Legislative Liaison, or the Communications Director, the Budget Division's Data Analyst will create a log, which includes the abbreviated question and response, a listing of the methodology used, and any errors identified after submission. Necessary corrections will be identified in the log. No more than three corrections will be acceptable for FY 04-05.
Controller and Operations Division	The Controller and Operations Division will fully implement a newly designed internal clearance processed for all procurement activities (requests for proposals, contracts, purchase orders). The process will be adjusted as necessary, as experience identifies flaws or additional needs. Full implementation will occur in April 2005, after one full fiscal year of using and adjusting the new process.
Information Technology Division	The Information Technology Division will obtain consultant services to assist in the reprocurement of fiscal agent services and will publish a Request for Proposals for those services.

FY 04-05 OBJECTIVE: **2.1 To expand areas of potential financial recovery such as third party insurance (that should be a primary payer) and cases of fraud and abuse.**	
Division / Section	**New FY 04-05 Performance Measure**
Client Services Division, Benefits Coordination Section	Client Services Division will maintain or increase third party recoveries over the prior year's level.
Client Services Division	Client Services Division will research methods to increase enrollment in the Health Insurance Buy-In program through the Colorado Benefits Management System.
Rates, Analysis, and Program Integrity Division	The Division will develop and conduct three new provider review types during the fiscal year to assess whether the service provided was documented, provided as outlined according to Department policy, and paid correctly. The provider types selected for review in FY 04-05 are: federally qualified health centers, dialysis centers, and orthodontic dental providers.
FY 04-05 OBJECTIVE: **2.2 Improve management of the Department's information systems technology.**	
Information Technology Division	Information Technology will provide upgrades and replacements to the Department's infrastructure to support changing business needs, as funding allows.
Information Technology Division	Health Insurance Portability and Accountability Act security regulations will be implemented and the Information Technology Division will conduct security audits to assure the safety of electronic health information on the Department's local area network. Operating system changes to Microsoft XP will be completed to allow greater security control on individual workstations from centralized administration.
FY 04-05 OBJECTIVE: **2.3 To hold accountable the Department's administrative contractors, including state and local agencies, by more outcome-based contracting and more sophisticated contract management.**	
Customer Service Section	Customer Service will establish an outcome-based contract for the Ombudsman for Medicaid Managed Care contract for FY 04-05, with a contract administrator in place by August 1, 2004. A review of the Ombudsman for Medicaid managed care contract will be completed by January 30, 2005. Integration of mental health is planned in FY 04-05
Long Term Benefits Division, Community-Based Long Term Care Section	For the FY 05-06 contract period, Long Term Benefits will develop contract deliverables directly associated with payment in order to support timely and effective service delivery, and to clearly define the areas of non-payment for non-compliance in at least two waiver programs. Development will be completed by February 15, 2005, and training of the contracted providers will occur by May 1, 2005.

<table>
<tr><td colspan="2">FY 04-05 OBJECTIVE:
3.1 To improve customer satisfaction with programs, services, and care.</td></tr>
<tr><th>Division / Section</th><th>New FY 04-05 Performance Measure</th></tr>
<tr><td>Long Term Benefits Division, Systems Change Section</td><td>By December 31, 2004, the Department will be administering three legislatively based, consumer-directed programs: Consumer Directed Attendant Support, Consumer Directed Care for Elderly, and In-Home Support Services. The programs have similar and even overlapping requirements and target populations. The Department will engage in an intense educational campaign to ensure that clients and case managers are not confused by the subtle similarities and differences. The Department will seek waiver modifications to permit serving greater numbers with greater flexibility.</td></tr>
<tr><td colspan="2">FY 04-05 OBJECTIVE:
3.2 To enhance customer service, provider, and eligibility personnel's understanding of program requirements, benefits, and responsibilities. To improve the usefulness of communications with clients, constituents, partners, and stakeholders.</td></tr>
<tr><td>Budget Division</td><td>The Budget Division will expand the availability of commonly requested information in the formulation and presentation of the Department's FY 05-06 Strategic Plan. This information will be displayed in the form of charts, tables, and graphs, as appropriate.</td></tr>
<tr><td>Budget Division</td><td>The Budget Division will conduct training sessions during FY 04-05 to Department staff to educate on budget-related activities and responsibilities. A minimum of one session in each of the following areas will be provided: the Budget Cycle, Change Requests, Fiscal Notes, and Operating Budgets. As appropriate or timely, new legislation affecting the Department will be presented.</td></tr>
<tr><td>Customer Service Section</td><td>By June 30, 2005, Customer Service will answer 90,000 incoming customer calls for FY 04-05.</td></tr>
<tr><td>Long Term Benefits Division, Systems Change Section</td><td>By December 31, 2004, the Systems Change Section will produce a resource guide of community-based programs in Medicaid for people interested in employment and will distribute it to clients and supporting agencies.</td></tr>
<tr><td>Safety Net Financing Section</td><td>Prior to July 1, 2005, the Safety Net Financing Section will research a benefit package or purchasing strategy for the Old Age Pension State Medical Program that can be delivered within the constraints of constitutional funding limits.</td></tr>
<tr><td colspan="2">FY 04-05 OBJECTIVE:
4.1 To build and maintain a high quality, customer-focused team.</td></tr>
<tr><td>Information Technology Division, Information Technology Contracts and Monitoring Section</td><td>All employees will receive Health Insurance Portability and Accountability Act Privacy and Customer Service training within 60 days of hire.</td></tr>
</table>

<table>
<tr><td colspan="2">FY 04-05 OBJECTIVE:
4.2 To enhance program safeguards and controls.</td></tr>
<tr><th>Division / Section</th><th>New FY 04-05 Performance Measure</th></tr>
<tr><td>Safety Net Financing Section</td><td>The Safety Net Financing Section will establish procedures to maximize federal revenue to sustain or increase payments to providers that conform to federal guidelines. Federal revenue will not be included in the Department’s budget until plans are approved by the Centers for Medicare and Medicaid Services.</td></tr>
<tr><td colspan="2">FY 04-05 OBJECTIVE:
4.3 To increase public knowledge of and involvement in the financing and delivery of health care.</td></tr>
<tr><td>Safety Net Financing Section</td><td>The Colorado Indigent Care Program Annual Report, which details utilization and financial trends for the indigent care programs administered by the Department, will be delivered to the General Assembly on February 1, 2005.</td></tr>
<tr><td colspan="2">FY 04-05 OBJECTIVE:
4.4 To develop enhanced training and retention strategies for departmental staff.</td></tr>
<tr><td>Budget Division</td><td>New analysts will receive training on the Long Bill, Change Requests, the Legislative Process, fiscal notes, Medical Services Premiums, and Strategic Planning within 21 days of hire in the Budget Division.</td></tr>
</table>

New FY 05-06 Performance Measures for the November 1, 2004 Budget Request

FY 05-06 OBJECTIVE: **1.1 To maximize the opportunity to maintain health care services through the purchase of services in the most cost-effective manner possible.**	
Division/ Section	**New FY 05-06 Performance Measure**
Rates, Analysis, and Program Integrity Division	The Division will continue to implement prior authorizations, limits, and controls to effectively manage the prescription drug expenditures, based on opportunities identified within the pharmacy program.
Rates, Analysis, and Program Integrity Division	Rates, Analysis, and Program Integrity Division will effectively utilize the Drug Utilization Review Board to identify opportunities for cost savings, and schedule the Board to meet on a quarterly basis.
FY 05-06 OBJECTIVE: **1.2 To support timely and accurate client eligibility determination.**	
Client Services Division	The Medicaid Eligibility Quality Control Unit will utilize Colorado Benefits Management System quality control programming in two of three pilots for FY 05-06.
Client Services Division	Ninety-eight percent of the Medicaid eligibility policy changes will be programmed, tested, and implemented in Colorado Benefits Management System by the effective date of the change.
Information Technology Division, Eligibility Systems Development Section	The Colorado Benefit Management System will be implemented Statewide and the rules-based system will become stable and reliable in terms of eligibility determinations.
Information Technology Division	The Information Technology Division will monitor and enhance the Colorado Benefits Management System eligibility determination system and Department's decision tables to improve the accuracy of the client eligibility determination.
Long Term Benefits Division, Nursing Facility Section	Patient payments for nursing facilities will be automated into the Medicaid Management Information System by June 2005. The client/patient portion of care is currently tracked manually at the county level.
FY 05-06 OBJECTIVE: **1.3 To assure payments in support of the programs are accurate and timely.**	
Children's Basic Health Plan Division	A claims audit process will be implemented in the Children's Basic Health Plan.

Division/ Section	New FY 05-06 Performance Measure
Information Technology Division	The Information Technology Division will continue the internal audit of Department transmittals to the fiscal agent to assure that complete and accurate rate changes occur, based on requests.
Long Term Benefits Division, Community-Based Long Term Care Section	Long Term Benefits will implement a process to have 90% of the prior authorization requests electronically submitted directly to the fiscal agent from providers and/or contracted utilization review agencies by December 31, 2005.
Rates, Analysis, and Program Integrity Division	The Division will provide assessment of payments to the managed care organizations, Programs of All Inclusive Care to the Elderly, and administrative service organizations, to assure accurate payments for eligible clients for FY 05-06 by March 2006. These provider requests for offline payments will be analyzed within 45 days after submission.
Safety Net Financing Section	Quarterly payments to Colorado Indigent Care Program providers will be made according to a published schedule.
FY 05-06 OBJECTIVE: **1.4 To assure delivery of appropriate, high quality care. To design programs that result in improved health status for clients served and to improve health outcomes. To ensure that the Department's programs are responsive to the service needs of enrolled clients in a cost-effective manner.**	
Health Benefits Division	The Health Benefits Division will implement at least one provider or client intervention based on the results of a quality improvement study or measurement to improve health care in the Medicaid program.
Long Term Benefits Division, Community-Based Long Term Care Section	By October 1, 2005, Community-Based Long Term Care will release a Request for Information to develop a list of specialty facilities that provide cost efficient services for long-term care brain injury waiver clients with behavioral issues.
FY 05-06 OBJECTIVE: **1.5 To accurately project, report, and manage budgetary requirements to effect executive and legislative intent with program and budget development and operations. To accurately record and monitor expenditures for programs managed by the Department so there may be accurate financial reporting at all times.**	
Budget Division	For the November 1, 2005 Budget Request, the Schedules Analyst, Premiums Analyst, and Budget Director will meet with the Office of State Planning and Budgeting's assigned analyst and the Joint Budget Committee staff to review the current status of the Budget submissions and any areas for improvement. These meetings will be accomplished before August 1, 2005. This will be after the Schedules Analyst has completed one budget cycle, the Premiums Analyst has implemented new projection methodologies, and the Office of State Planning and Budgeting analyst has completed one full cycle with this Department.

Division/ Section	New FY 05-06 Performance Measure
Information Technology Division	Information Technology will increase decision support capacity from 5 years of history data to 7 years to allow increased trending capability.
Rates, Analysis, and Program Integrity Division	The Rates, Analysis, and Program Integrity Division will respond to requests for ad hoc reports within 10 business days, 90% of the time.
Rates, Analysis, and Program Integrity Division	Rates for managed care organizations, Programs of All Inclusive Care to the Elderly, and administrative service organizations will be calculated in a timely manner, meeting all actuarial standards.
Safety Net Financing Section	Safety Net Financing Section staff will track monthly expenditures under the Colorado Indigent Care Program to ensure that the program expenditures remain within available appropriations.
Safety Net Financing Section	Safety Net Financing Section staff will track and forecast expenditures under the Old Age Pension State Medical Program to ensure that the program remains within constitutional and statutory budget boundaries.
FY 05-06 OBJECTIVE: **1.6 To work towards systemic improvement in the Department's operations to expand efficiencies, minimize waste, ensure coordination, and eliminate discrepancies.**	
Budget Division	For data requests from Joint Budget Committee staff, Legislative Council, the Office of State Planning and Budgeting, the Legislative Liaison, or the Communications Director, the Budget Division's Data Analyst will create a log, which includes the abbreviated question and response, a listing of the methodology used, and any errors identified after submission. Necessary corrections will be identified in the log. No more than two corrections will be acceptable for FY 05-06.
Children's Basic Health Plan Division	Children's Basic Health Plan will continue the process for the Centers for Medicare and Medicaid Services' approval of the streamlining of Medicaid and Children's Basic Health Plan.
Controller and Operations Division	Based on work with the State Controller's Office and the Attorney General's Office, the Controller and Operations Division will implement a new contract document for contracts with Medicaid and Children's Basic Health Plan medical providers that is different from the standard state contract, but yet meets the core needs of the State in its contracting requirements.
FY 05-06 OBJECTIVE: **2.1 To expand areas of potential financial recovery such as third party insurance (that should be a primary payer) and cases of fraud and abuse.**	
Client Services Division, Benefits Coordination Section	The Client Services Division will maintain or increase recoveries over the prior year's level.

Division/ Section	New FY 05-06 Performance Measure
Client Services Division	Client Services will implement a process to increase enrollment in the Health Insurance Buy-In program, pending Departmental approval of the project plan.
FY 05-06 OBJECTIVE: **2.2 Improve management of the Department's information systems technology.**	
Information Technology Division	The Information Technology Division will provide upgrades and replacements to Department infrastructure to support changing business needs, based upon available funding.
Information Technology Division	Information Technology will award the new fiscal agent contract and begin transition to the new contractor.
Information Technology Division	Web support and maintenance staff will be hired to build and deliver web applications for providers and clients based on program direction, depending on available funding.
FY 05-06 OBJECTIVE: **2.3 To hold accountable the Department's administrative contractors, including state and local agencies, by more outcome-based contracting and more sophisticated contract management.**	
Customer Service Section	By July 1, 2005, an outcome-based Ombudsman for Medicaid Managed Care contract (including mental health) will be in place. A review of the contract will be completed by January 30, 2006.
FY 05-06 OBJECTIVE: **3.1 To improve customer satisfaction with programs, services, and care.**	
Customer Service Section	Less than one percent of customer calls answered by the customer service staff will receive complaints at the Governor's Office.
FY 05-06 OBJECTIVE: **3.2 To enhance customer service, provider and eligibility personnel's understanding of program requirements, benefits, and responsibilities. To improve the usefulness of communications with clients, constituents, partners, and stakeholders.**	
Budget Division	The Budget Division will conduct training sessions during FY 05-06 for Department staff to educate on budget-related activities and responsibilities. At least two sessions in each of the following areas will be conducted: the budget cycle, change requests, fiscal notes, and operating budgets. As appropriate or timely, new legislation affecting the Department will be presented.
Client Services Division	Client Services will conduct semi-annual Eligibility Trainings for county and medical assistant site technicians.

Division/ Section	New FY 05-06 Performance Measure
Customer Service Section	Customer Service will increase the number of incoming customer calls answered by 10% over the total FY 04-05 calls (estimated to be 90,000 incoming calls).
Long Term Benefits Division, Systems Change Section	By December 31, 2005, the Department will have an outreach and awareness campaign underway to inform clients and collateral supporters about the opportunities and advantages of consumer direction. This campaign will achieve a 75% success rate, as measured by follow-up surveys.
FY 05-06 OBJECTIVE: **4.1 To build and maintain a high quality, customer-focused team.**	
Customer Service Section	By June 30, 2006, the Customer Service Section, with sufficient staff, will reduce the call abandonment rate by 10% over the previous year.
FY 05-06 OBJECTIVE: **4.2 To enhance program safeguards and controls.**	
Safety Net Financing Section	Safety Net Financing will establish procedures to maximize federal revenue to sustain or increase payments to providers that conform to federal guidelines. Federal revenue will not be included in the Department's budget until approved by the Centers for Medicare and Medicaid Services.
FY 05-06 OBJECTIVE: **4.3 To increase public knowledge of and involvement in the financing and delivery of health care.**	
Safety Net Financing Section	The Colorado Indigent Care Program Annual Report, which details utilization and financial trends for the indigent care programs administered by the Department, will be delivered to the General Assembly by February 1, 2006.
FY 05-06 OBJECTIVE: **4.4 To develop enhanced training and retention strategies for departmental staff.**	
Controller and Operations Division	The Controller and Operations Division will develop and implement a full-scale training for Department managers in the State Personnel Rules and processes, including hiring, reclassification, employee performance management, and employee discipline.

The following two tables delineate performance measures from the November 3, 2003 Budget Request and provide a status on the Department's progress towards these measures for both FY 03-04 and FY 04-05. This is a new section for the Strategic Plan.

FY 03-04 Achievements towards Performance Measures from Last Year's Budget Request

FY 03-04 Performance Measure:
Implement legislation as prescribed by law, including but not limited to, as applicable: proposing rules, information systems changes, developing tracking mechanisms, informing providers and clients, and reporting.

Division or Section	Achievement Towards Last Year's Measures in FY 03-04
Children's Basic Health Plan Division	A cap on enrolling new children in the Children's Basic Health Plan was implemented effective November 1, 2003 to manage to the appropriation.
Children's Basic Health Plan Division	Children's Basic Health Plan temporarily suspended the Plan's prenatal program and implemented a State-only prenatal program on November 1, 2003, consistent with legislation.
Client Services Division	Client Services proposed rules and issued agency letters to implement SB 03-176 regarding Medicaid services for legal immigrants. Implementation was stopped according to legal action. Implementation is now planned for FY 04-05.
Health Benefits Division	Health Benefits Division implemented appropriated budget reductions through the implementation of new rules regarding client co-pays, and non-emergency transportation in July 2003.
Health Benefits Division	Health Benefits contracted directly with administrative service organizations, which are able to provide cost-effective, quality managed care services to recipients. Two administrative service organizations began operations during FY 03-04: Rocky Mountain Health Plans in July and Management Team Solutions in February.
Information Technology Division	Information Technology implemented numerous cost reduction items including revising client co-pays in August and pharmacy changes throughout the year. Additionally, federal changes for Managed Care occurred in phases throughout the year, and the transaction code sets for the Health Insurance Portability and Accountability Act were completed by October 15, 2004.
Long Term Benefits Division, Nursing Facilities Section	The Nursing Facilities Section developed a process, promulgated rules, and submitted a State Plan Amendment to the Centers for Medicare and Medicaid Services responding to SB 03-266 (nursing facility fees). The Section worked with federal staff throughout the year to answer many questions and worked hand-in-hand with the providers during this time. Activity was stopped in response to enactment of HB 04-1415, which repealed SB 03-266.

Division or Section	Achievement Towards Last Year's Measures in FY 03-04
Long Term Benefits Division, Community-Based Long Term Care Section	The Community-Based Long Term Care Section proposed a revision to the private duty nursing rule to include the impact of HB 04-1422 Long Bill reductions in the maximum number of nursing hours per day/week for the June 2004 meeting of the Medical Services Board, in order to implement the new rule effective July 1, 2004.
Rates, Analysis, and Program Integrity Division	Rates, Analysis, and Program Integrity Division implemented rules, final in July 2003, and initiated data system changes for an effective date of December 2003 for SB 03-011, Generic Drug Mandate, and in February 2004 for SB 03-294, Drug Utilization Cost Control Mechanisms. In September 2003, the Division created a web site for stakeholders to inform them of the upcoming utilization cost control mechanism and to get stakeholder feedback.
Rates, Analysis, and Program Integrity Division	The Rates, Analysis, and Program Integrity Division implemented new hospital rate methodology for FY 03-04 that required rule changes in June 2003, and met with stakeholders prior to implementation.
Safety Net Financing Section	Safety Net Financing fully implemented the modified grant application for the Comprehensive Primary and Preventive Care Grant Program in January 2004, which included new rules and legislation. Necessary rules were introduced and passed. Potential applicants were provided written explanation of legislative changes in handouts, also made available on the Department's website, to provide clarification and consistent information. As a result, all applications were submitted in a timely basis and all met the minimum qualifications of the new regulations.
Safety Net Financing Section	The Section implemented a more efficient and equitable provider reimbursement methodology on July 1, 2003 for the Colorado Indigent Care Program.
Safety Net Financing Section	The Colorado Indigent Care Program Annual Report, which details utilization and financial trends for the indigent care programs administered by the Department, was delivered to the General Assembly on February 1, 2004 as required by statute.

FY 03-04 Performance Measure:
Continue successful implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) according to the timeline required by the federal Centers for Medicare and Medicaid Services through system changes, operational changes, privacy protection, and compliance with federal audits.

Division or Section	Achievement Towards Last Year's Measures in FY 03-04
Children's Basic Health Plan Division	Business Associate agreements were required of all contractors who handle protected health information for the Children's Basic Health Plan. All eight contractors submitted the signed agreements by June 30, 2004.

Division or Section	Achievement Towards Last Year's Measures in FY 03-04
Client Services Division	Client Services Division implemented new policy concerning the treatment of applicant medical records used in the determination of disability for all 64 county Departments of Human Services in September 2003.
Information Technology Division	All departmental staff received Health Insurance Portability and Accountability Act training by the federally-required April 16, 2003 deadline. Privacy protocols were implemented timely.
Information Technology Division	Health Insurance Portability and Accountability Act implementation was completed in the Medicaid Management Information System through Transaction and Code Set changes. Full implementation of the system was realized March 15, 2004, with the implementation of the final transaction for prior-authorization request submission. The timeline for implementation was in compliance with the Department's contingency plan as approved by the Centers for Medicare and Medicaid Services. The Decision Support System was upgraded to comply with the Privacy Rules.
Long Term Benefits Division, Community-Based Long Term Care Section	Business Associate agreements for the Health Insurance Portability and Accountability Act were signed by 100% of the community-based long term care providers and in place earlier than the required timeline of April 14, 2004.
Safety Net Financing Section	The Colorado Indigent Care Program implemented protocols, through the FY 03-04 provider manual, dated July 1, 2003, to clarify that providers could not transmit or discuss client specific information to Department staff without written client authorization. The Indigent Care program is not required by federal law to comply with the Health Insurance Portability and Accountability act.
FY 03-04 Performance Measure: Bring the Colorado Benefits Management System into full implementation according to the time schedule presented to the Joint Budget Committee, and implement monitoring protocols to measure accuracy and effectiveness.	
Children's Basic Health Plan Division	Children's Basic Health Plan dedicated one full time staff person to the Colorado Benefits Management System project for 12 months in order to implement program policy.
Children's Basic Health Plan Division	The Children's Basic Health Plan administrative services contractor participated as a pilot site for the Colorado Benefits Management System in March and April 2004.
Client Services Division	Client Services Division dedicated two eligibility specialists for 12 months to the development and testing of the automated rules within the Colorado Benefits Management System to ensure that eligibility for Medicaid processed according to state policy. Staff wrote the decision tables upon which eligibility is determined.

Division or Section	Achievement Towards Last Year's Measures in FY 03-04
Client Services Division	Client Services completed all system input requirements in May 2004 related to the Benefits Coordination Section, to support implementation of the Colorado Benefits Management System.
FY 03-04 Performance Measure: Implement cash accounting for medical services in FY 02-03 and FY 03-04, including building new databases of reference, developing new reliable trends and projections, changing operations to accommodate the transition, developing tracking mechanisms, and continuing to assess the impact of this significant change over time.	
Division or Section	**Achievement Towards Last Year's Measures in FY 03-04**
Budget Division	Cash accounting was fully implemented and included in the final Medical Services Premiums Budget Request submitted to the Joint Budget Committee on February 16, 2004. Final total expenditures were recalculated back to FY 95-96 using cash-based accounting principles. This new database includes cash-based final actuals for both the Colorado Financial Reporting System and the Computer Output to Laser Disk expenditure data used to forecast the budget. The new cash-based data were reviewed and tested. The current projection methodology was also tested using the new cash-based actuals. A summary of the findings can be found on pages MSP-2 through MSP-4 of the "Narrative" tab in the February 16, 2004 Medical Services Premiums Budget Request.
Budget Division	From April through June 2003, the Budget Division developed, compared, and tested four new historical databases for Medicaid caseload. From this work, a new time series was selected for officially reporting and projecting Medicaid caseload for budget purposes in the new cash-accounting environment.
Controller and Operations Division	The accounting processes to implement cash accounting for Medicaid, including programs administered by the Department of Human Services, were implemented successfully. The majority of these processes were in place on June 30, 2003 for the close of FY 02-03. Medicaid medical expenditures are now reported, including the monthly Joint Budget Committee report required by Long Bill footnote, on a purely calendar basis both within the fiscal year and for the fiscal year as a whole. The reporting mechanisms for FY 02-03 were in place in July of 2003. The reporting mechanisms for FY 03-04 were in place in August 2003.
Information Technology Division	The Information Technology Division provided necessary hardware and software for the Accounting Section and Budget Division to perform necessary activities related to cash accounting, including increasing capacity to accommodate the rebuild of expenditure history.

Division or Section	Achievement Towards Last Year's Measures in FY 03-04
Safety Net Financing Section	With the implementation of cash accounting, a new documentation and payment schedule was imposed on upper payment limit recipients beginning in FY 03-04. The annual payments made for medical services are scheduled for payment on June 1 of every fiscal year, and the associated certification of public expenditures letters to substantiate these payments are due to the Department on May 1 of each year.

FY 03-04 Performance Measure:
Respond effectively to the radically changing budget environment by coordinating closely with the Office of State Planning and Budgeting and the Joint Budget Committee to reconcile appropriations, using the budget cycle to address funding urgencies and correct conflicts, avoiding requests for luxury items or programs, continuing to assess programs for efficiencies, implementing the budget reductions in a timely manner, and developing tracking mechanisms to measure compliance with budgeted reductions.

Division or Section	Achievement Towards Last Year's Measures in FY 03-04
Budget Division	The Budget Division created a report outlining the Department's Medical Services Premiums expenditures and Medicaid Caseload pursuant to Footnote 32 of SB 03-258 Long Bill, and distributed this report to the Joint Budget Committee and the Office of State Planning and Budgeting. This was completed by the third Monday of each month in 83.4% of the months.
Budget Division	The Budget Division developed an electronic workbook for simulating financial solvency of the Children's Basic Health Plan's Trust Fund under various scenarios. This was used to aid in the development of FY 04-05 Change Requests and enabled rapid response to requests by the Joint Budget Committee staff during Figure Setting for FY 04-05.
Budget Division	Budget information was supplied regarding the Federal Medical Assistance Percentage enhancement for FY 02-03 and FY 03-04 and the impact of the "Medicare Prescription Drug Improvement and Modernization Act of 2003." The federal match enhancement was signed into federal law on May 28, 2003, temporarily increasing the federal share for Medicaid services. Adjustments were made in the November 2003 Budget Request and the January and February 2004 Supplemental Requests.
Budget Division	The Budget Division tracked the Department's third party contingency-based recovery contracts in order to report recoveries for the 4% Budget Balancing reductions.
Budget Division	The Department included data analyses on each budget reduction to medical services initiated in the last 3 years as a part of its Medical Services Premiums February 16, 2004 submission.

Division or Section	Achievement Towards Last Year's Measures in FY 03-04
Long Term Benefits Division, Systems Change Section	In October 2003, Long Term Benefits analyzed a comparison of nursing facility care costs to the costs of community-based care for individuals who had transitioned from facilities to the community through the Nursing Facilities Transitions grant. The analysis demonstrated that community-based costs were, on average, $1,200 less per month than facility-based care for individuals who had transitioned.
Long Term Benefits Division, Community-Based Long Term Care Section	The Community-Based Long Term Care Section trained 100% of Single Entry Point agencies and Children's Waiver Program providers in the use of the new Universal Long Term Care assessment instrument (ULTC 100.2). The assessment instrument was implemented by all of the Single Entry Point Agencies and Children's Waiver Program providers to assure that the most appropriate and efficient menu of services was provided for each client.
Safety Net Financing Section	Safety Net Financing tracked expenditures under the Colorado Indigent Care Program on a monthly basis to ensure that program expenditures remained within the appropriation. The program did not exceed the appropriated amount.
Safety Net Financing Section	On January 1, 2004, medical benefits to clients and payments to providers under the Old Age Pension State Medical Program were reduced in order to prevent overexpenditure of funding. Staff tracked and forecasted expenditures on a weekly basis under the Old Age Pension State Medical Program to verify that program expenditures were within Constitutional and Statutory budget boundaries.

FY 04-05 Achievements towards Performance Measures from Last Year's Budget Request

FY 04-05 Performance Measure:
Implement legislation as prescribed by law, including but not limited to, as applicable: proposing rules, information systems changes, developing tracking mechanisms, informing providers and clients, and reporting.

Division or Section	Achievement Towards Last year's Measures by November 2004
Children's Basic Health Plan Division	The cap on enrolling newly eligible children in the Children's Basic Health Plan was successfully lifted on July 1, 2004 and managed into the initial months of FY 04-05.
Children's Basic Health Plan Division	The Children's Basic Health Plan's prenatal program was re-instituted on July 1, 2004.
Client Services Division	Client Services Division prepared dual tables for the rules engine for eventual implementation of SB 03-176 regarding Medicaid services for legal immigrants.
Client Services Division	The Client Services Division passed rules and updated Colorado Benefits Management System to accommodate non-county Colorado Benefits Management System sites in determining Medicaid eligibility as authorized by HB 04-1058, Medicaid Eligibility Determinations.
Health Benefits Division	Health Benefits Division implemented the transfer of the Mental Health Managed Care and Capitation Program and nine FTE from the Department of Human Services to the Department, effective April 6, 2004, and into FY 04-05.
Health Benefits Division	Transportation as a Medicaid administrative service rather than an optional medical benefit was instituted in July 2004 by the Health Benefits Division.
Health Benefits Division	Budget reductions of approximately $737,400 were enacted on durable medical equipment through the implementation of a 1% cut in reimbursement rates, effective July 1, 2004.
Information Technology Division	The Information Technology Division completed hospital rate reductions and private duty nursing service changes in the Medicaid Management Information System, based on reductions from HB 04-1422, the FY 04-05 Long Bill.
Long Term Benefits Division, Systems Change Section	Long Term Benefits Division proposed rules regarding the operation of Consumer Directed Care for Elderly to the Medical Services Board in August 2004.
Long Term Benefits Division, Systems Change Section	By October 2004, the Systems Change Section informed stakeholders of In-Home Support Services by sending related information to 28 community disability agencies to inform their constituents.
Rates, Analysis, and Program Integrity Division	The Rates, Analysis, and Program Integrity Division implemented rules for hospital rate reductions of approximately $3.0 million, for an effective date of July 2004.

Division or Section	Achievement Towards Measure by November 2004
Rates, Analysis, and Program Integrity Division	The Division increased reimbursement rates for federally qualified health centers from the FY 03-04 fiscal year in July 2004.

FY 04-05 Performance Measure:
Respond effectively to the radically changing budget environment by coordinating closely with the Office of State Planning and Budgeting and the Joint Budget Committee to reconcile appropriations, using the budget cycle to address funding urgencies and correct conflicts, avoiding requests for luxury items or programs, continuing to assess programs for efficiencies, implementing the budget reductions in a timely manner, and developing tracking mechanisms to measure compliance with budgeted reductions.

Division or Section	Achievement Towards Measure by November 2004
Children's Basic Health Plan Division	The Division continued the process for streamlining children and families Medicaid programs and the Children's Basic Health Plan through the Health Insurance Flexibility and Accountability waiver, using grant funding, by compiling an analysis of Medicaid and Children's Basic Health Plan claims and enrollment data to assess whether or not Medicaid and Children's Basic Health Plan enrollees can be served in a combined program.
Client Services Division	Client Services implemented an improved tracking system for income and disability trusts to assure timely recovery upon the cessation of trusts. A database and queries were developed in the first quarter of FY 04-05 to select trusts on a periodic basis, to ensure trusts are reviewed each year.
Information Technology Division	The Department began security changes required by the Health Insurance Portability and Accountability Act to conform to federal security rules to be completed by April 2005. The Division also began the re-procurement process of rebidding the fiscal agent contract, due in December 2006.
Long Term Benefits Division, Nursing Facilities Section	Nursing Facilities developed a care and quality plan and a fiscal plan to ensure appropriate funding levels for mentally ill clients residing in nursing facilities by June 30, 2005.
Rates, Analysis, and Program Integrity Division	The Division assisted the Budget Division with reconciling appropriations, addressing funding urgencies, and correcting conflicts. The Division continued to assess programs for efficiencies, implemented budget reductions in a timely manner, and developed tracking mechanisms to measure compliance with budgeted reductions.

V. POLICY AND PROGRAM TRENDS

The following are key trends and hot issues that have been identified by the Department as important to the current and future fiscal years. These trends relate to new or recent changes in federal or State legislation, societal and technological changes, and new approaches in serving the Department's clients.

Colorado Benefits Management System Implementation

The Colorado Benefits Management System (CBMS) is an information technology system jointly developed by the Colorado Department of Health Care Policy and Financing and the Department of Human Services. The Colorado Benefits Management System replaces six existing systems with one unified system for data collection and eligibility:

- Client Oriented Information Network (COIN);
- Colorado Automated Food Assistance System (CAFSS);
- Colorado Automated Client Tracking Information System (CACTIS);
- Colorado Employment First (CEF);
- Colorado Adult Protection System (CAPS); and
- Child Health Plan Plus (CHP+).

The Colorado Benefits Management System has three major goals:
1. Replace antiquated, inflexible legacy systems that use outdated programming languages, are difficult to modify, and perform redundant processing in individual "stovepipe" systems.
2. Enable a universal worker who will not have to memorize rules and look through manuals to determine eligibility and will have single point of data entry for multiple programs.
3. Improve access to public assistance and medical benefits by providing one-stop shopping for clients, permitting faster eligibility determinations, and allowing for higher accuracy and consistency in eligibility determinations statewide.

The development of the Colorado Benefits Management System for eligibility determination, benefits issuance, and periodic redetermination of continued eligibility has been a collaborative project by the two Departments. The Department of Human Services manages several cash assistance and social services programs that utilize the Colorado Benefits Management System. The Department of Health Care Policy and Financing relies on the new system to determine eligibility for the following health-related programs: Medicaid, Old Age Pension State Medical Program, and the Children's Basic Health Plan. The collaborative efforts for the design and development of the system formally began in 1996.

To date, the statewide infrastructure has been rolled out in all of Colorado's 64 counties and two medical assistance sites. County workers have new personal computers with Internet and e-mail access as well as basic office software that replaced their old "dumb" terminals. The Colorado Benefits Management System was implemented on September 1, 2004.

Because the Colorado Benefits Management System replaces several legacy computer systems, historical data from these systems were transferred into the new system. Data for at least the past five years was transferred, but not all of the components currently required for all clients had been originally input into the legacy systems. Instead, some of the data was maintained on paper at the county level. County staff are now inputting the additional paper data into the Colorado Benefits Management System.

The ongoing responsibility of the Colorado Benefits Management System is eligibility determination for programs. Required data must be input before eligibility can be determined by the rules imbedded in the computer system. By ensuring all required data fields are filled, the accuracy of the benefit determination required by the system will be achieved. However, changes in laws and medical program rules will have to be incorporated into the computer program as necessary.

Transportation Issues

In FY 03-04, approximately $7.6 million was reduced from non-emergency transportation in SB 03-258, the Supplemental Bill, as part of the State's budget balancing. HB 04-1220 authorized Health Care Policy and Financing to provide non-emergency transportation services as an administrative service, allowing the State more flexibility in how it provides non-emergency transportation. As an administrative cost at $4,400,778 in FY 04-05, proper and efficient operation of the plan requires an attempt by the State to use any available free services, as well as the least costly means. Payment does not have to be made directly to a provider. States can choose the most efficient and appropriate means of transportation, including the option of volunteers, gas vouchers, bus tokens, or quasi-public/private transportation companies. States may use transportation brokers, administrative managers, and/or capitated transport services.

Colorado Medicaid implemented transportation as an administrative Medicaid expense effective July 1, 2004. The structure is still being solidified.

External Quality Review of Medicaid Managed Care Organizations and Prepaid Inpatient Health Plans

The federal Balanced Budget Act of 1997 required that state Medicaid agencies provide for an external, independent review of the quality outcomes and timeliness of, and access to, services provided by Medicaid managed care organizations and prepaid inpatient health plans on an annual basis. States determined and developed their individual protocols. A federal review of this process recently led to the establishment of a new set of protocols, three of which are mandatory and were required to be implemented in each state by March 2004. These protocols were developed to ensure national consistency with industry standards, accommodate the evolution of quality improvement processes, and allow states to utilize external quality review technical assistance. The mandatory protocols, which Colorado is currently implementing, are:

1. Determining compliance with federal Medicaid managed care regulations;
2. Validation of performance measures produced by Medicaid managed care organizations and prepaid inpatient health plans; and,
3. Validation of performance improvement projects undertaken by Medicaid managed care organizations and prepaid inpatient health plans.

Other protocols are used at the option of a state whenever information from these activities is to be used as a component of external quality review and enhanced federal financial participation in the costs of these activities.

Colorado Medicaid is implementing the three mandated protocols in all health maintenance organizations and behavioral health organizations. In addition, the Department provides technical assistance to the participants. The assessment of the protocols for the Behavioral Health Organizations is being performed and managed through a contractor.

Consumer Assessment of Health Plans Study

The Consumer Assessment of Health Plans Study (CAHPS®) is a nationally recognized survey that measures client satisfaction within a given health plan and may be used to compare satisfaction across health plans.[1] The goal of the CAHPS surveys is to effectively and efficiently obtain information that is not available from any other source—the person receiving care.

The Department requires Medicaid health plans to conduct client satisfaction surveys to ascertain differences between managed care clients, Primary Care Provider Program, and fee-for-service clients. As part of a comprehensive quality improvement effort in FY 03-04, the Department required health plans to conduct the CAHPS 3.0H Survey of Adults and 3.0H Survey of Children. Both surveys included Medicaid clients that had been continuously enrolled in a managed care plan for 12 months during 2003. The survey period

[1] CAHPS is a registered trademark of the Agency for Healthcare Research and Quality.

for this questionnaire was January 1, 2004 through May 1, 2004. Colorado Medicaid Averages are calculated by the Department to use as comparison among itself and nationally. Where available, 2003 Colorado Medicaid Averages are compared for 2004.

CAHPS 2004 Summary of Results

CAHPS Measure	**Colorado Access**	**Rocky Mountain Health Plans**	**Primary Care Physician Program**	**Unassigned Fee-For-Service**	**2004 Medicaid Average**	**2003 Medicaid Average**[2]
Overall Rating of Health Plan *"Using any number from 0 to 10 where 0 is the worst health plan possible, and 10 is the best health plan possible, what number would you use to rate your health plan?"* Percent rating an 8, 9, or 10.						
Adult	67.8%	74.0%	69.2%	70.8%	**70.5%**	**70.1%**
Child	74.2%	84.3%	73.7%	76.0%	**77.0%**	**--**
Overall Rating of Health Care *Of those respondents who reported going to a doctor's office or clinic: "Using any number from 0 to 10, where 0 is the worst health care possible, and 10 is the best, what number would you use to rate all your health care in the last 6 months?"* Percent rating an 8, 9, or 10.						
Adult	71.2%	79.5%	71.9%	76.3%	**74.7%**	**73.5%**
Child	74.2%	88.7%	80.0%	79.7%	**80.6%**	**--**
Overall Rating of Personal Doctor or Nurse *Of those respondents who saw a primary care provider: "Using any number from 0 to 10, where 0 is the worst personal doctor or nurse possible, and 10 is the best possible, what number would you use to rate your personal doctor or nurse?"* Percent rating an 8, 9, or 10.						
Adult	77.8%	82.5%	77.6%	77.0%	**78.7%**	**77.3%**
Child	80.8%	87.0%	81.4%	81.3%	**82.7**%	**--**
Getting Needed Care *Getting needed care is a composite of questions regarding the ease of finding a doctor or nurse, obtaining a referral to a specialist, getting the care the respondent or a doctor believed necessary, and delays in health care while waiting for an approval.* Percent rating "not a problem."						
Adult	67.4%	81.2%	76.4%	73.5%	**74.6%**	**72.4%**
Child	74.2%	86.2%	76.6%	80.6%	**81.1%**	**--**
Getting Care Quickly *Getting care quickly is a composite of questions regarding receiving help or advice over the telephone, obtaining routine appointments, obtaining care for an illness or injury, and waiting time in an office or clinic.* Percent rating "always and usually."						

[2] CAHPS survey of children was not performed in 2003.

CAHPS Measure	**Colorado Access**	**Rocky Mountain Health Plans**	**Primary Care Physician Program**	**Unassigned Fee-For-Service**	**2004 Medicaid Average**	**2003 Medicaid Average**[2]
Adult	67.7%	84.3%	79.0%	77%	**77.0%**	**75.9%**
Child	71.2%	87.4%	77.0%	77.8%	**78.3%**	**--**
Doctors Who Communicate Well *How well doctors communicate is a composed of questions regarding how well providers listen to and explain things, whether they show respect and whether they spend enough time with the respondent.* Percent rating "always and usually."						
Adult	86.5%	91.2%	88.4%	88%	**88.5%**	**87.1%**
Child	87.0%	94.1%	89.4%	89.8%	**90.1%**	**--**
Courteous and Helpful Office Staff *Questions regarding whether office staff at the respondent's doctor's office or clinic treated respondents with courtesy and respect and whether they were as helpful as respondents thought they should be made up the courteous and helpful office staff composite measure.* Percent rating "always and usually."						
Adult	87.3%	95.0%	93.0%	89.7%	**91.2%**	**89.0%**
Child	85.3%	95.4%	89.5%	88.3%	**89.6%**	**--**

Health Plan Employer Data Information Set

The Health Plan Employer Data Information Set (HEDIS®)[3] is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of managed health care plans. The performance measures are related to many significant public health issues such as cancer, heart disease, smoking, asthma, and diabetes that affect Medicaid populations. Each year, different HEDIS measures are selected for measurements that relate to quality improvement efforts outlined in the State Quality Improvement Work Plan.

The Department requires Medicaid health plans to conduct HEDIS measures to ascertain differences between managed care clients, Primary Care Provider Program, and fee-for-service clients. As part of a comprehensive quality improvement effort in FY 03-04, the Department required health plans to conduct ten clinical measures on both adults and children. The data collection period for each of the reported measures was January 1, 2003 through December 31, 2003.

It is important to note that rates reported in 2003 HEDIS Childhood Immunization rates were low as compared to prior year averages, national rates and national benchmarks. Rates in 2003 were for care provided in 2002 – the time of a national shortage of Diphtheria,

[3] HEDIS is a registered trademark of the National Committee for Quality Assurance.

Tetanus, Pertussus (DTP), and Measles, Mumps, Rubella (MMR) vaccine. In 2001, in response to the shortage, the Colorado Board of Health temporarily suspended the requirement that Colorado children receive the fourth and fifth doses of DTP vaccine before school entry; the measure of immunization is based on receipt of 4 doses. The ban was lifted in June 2003. Rates reported for 2004 demonstrate a strong comeback. Lower reported rates of childhood immunizations in 2003 were likely due to a result of the national immunization shortage and Board of Health ruling.

Colorado Medicaid Averages are calculated by the Department to use as comparison among itself and nationally. Where available, 2003 Colorado Medicaid Averages are compared for 2004.

HEDIS 2004 Summary of Results

HEDIS Measure	Colorado Access	Rocky Mountain Health Plans	Primary Care Physician Program	Unassigned Fee-For-Service	2004 Medicaid Average	2003 Medicaid Average[4]
Childhood Immunization Status Percent of children receiving all required immunizations by 2 years of age.						
Diphtheria, Tetanus, Pertussus (4 doses)	62.4%	76.2%	65.9%	41.6%	**61.5%**	**34.7%**
Measles, Mumps, Rubella (1 dose)	84.5%	90.8%	83.2%	56.2%	**78.7%**	**74.9%**
Polio (3 doses)	77.0%	88.1%	79.6%	56.2%	**75.2%**	**70.9%**
Haemophilus Influenzae Type b (2 doses)	69.6%	80.8%	71.8%	46.0%	**67.1%**	**62.2%**
Hepatitis B (3 doses)	73.8%	85.9%	78.1%	48.2%	**71.5%**	**66.8%**
Chicken Pox (1 dose)	81.2%	83.5%	74.9%	53.5%	**73.4%**	**69.3%**
Combo 1 Rate: 4 DTP + 1 MMR + 3 Polio + 1 Hib + 2 Hepatitis	51.0%	65.2%	55.5%	31.4%	**50.8%**	**26.4%**
Combo 2 Rate: 4 DTP + 1 MMR + 3 Polio + 1 Hib + 2 Hepatitis + 1 Pox	48.5%	61.3%	50.4%	30.4%	**47.7%**	**24.5%**

[4] HEDIS measures of Appropriate Medications for Persons with Asthma and Adult's Access to Preventive/Ambulatory Health Services were not measured in 2003.

HEDIS Measure	Colorado Access	Rocky Mountain Health Plans	Primary Care Physician Program	Unassigned Fee-For-Service	2004 Medicaid Average	2003 Medicaid Average[4]
Well Child Visits in the first 15 Months of Life						
Zero Visits—Lower is Better	22.0%	3.9%	2.2%	24.1%	**13.3%**	**18.4%**
6 or More Visits	27.5%	36.9%	51.8%	19.7%	**33.9%**	**25.7%**
Well Child Visits in the 3rd, 4th, 5th and 6th Years of Life						
	52.5%	60.4%	55.2%	39.9%	**55.4%**	**39.2%**
Adolescent Well Care Visits						
	35.0%	35.9%	34.3%	30.4%	**34.7%**	**23.1%**
Other Measures						
Breast Cancer Screening						
	55.0%	66.5%	32.2%	2.8%	**18.3%**	**42.4%**
Cervical Cancer Screening						
	56.3%	75.4%	52.6%	32.1%	**53.2%**	**25.5%**
Chlamydia Screening in Women						
Ages 16 to 20	42.0%	46.7%	21.9%	19.6%	**26.5%**	**25.2%**
Ages 21 to 26	42.8%	39.8%	24.6%	19.1%	**27.1%**	**26.7%**
Prenatal and Postpartum Care						
Timeliness of Prenatal Care	83.9%	93.5%	68.9%	59.8%	**76.4%**	**66.0%**
Postpartum Care	59.8%	70.9%	55.0%	40.7%	**56.5%**	**50.2%**
Appropriate Medications for Persons with Asthma						
Ages 5 to 9	67.2%	59.6%	71.8%	72.6%	**69.5%**	**--**
Ages 10 to 17	67.3%	71.9%	76.0%	74.0%	**72.4%**	**--**
Ages 18 to 56	69.1%	70.6%	74.5%	76.6%	**73.1%**	**--**
All Ages Combined	68.1%	68.7%	74.3%	75.2%	**72.1%**	**--**

HEDIS Measure	Colorado Access	Rocky Mountain Health Plans	Primary Care Physician Program	Unassigned Fee-For-Service	2004 Medicaid Average	2003 Medicaid Average[4]
Adult's Access to Preventive / Ambulatory Health Visits						
Ages 20 to 44	74.9%	88.3%	67.2%	48.1%	**60.9%**	**--**
Ages 45 to 64	81.4%	91.7%	68.2%	26.5%	**49.2%**	**--**
Ages 65 and Above	81.3%	93.7%	32.7%	11.5%	**22.5%**	**--**

Administrative Service Organizations

Over the past three years there has been a decline in the number of traditional health maintenance organizations participating in Medicaid programs across the country. Several states are opting to strengthen their primary care programs rather than pursue additional health maintenance organization contracts (e.g. Indiana, Oklahoma, Utah, Tennessee, Texas). In Colorado, that trend was most evident in FY 02-03, when there was a significant decrease in the number of Medicaid participating health maintenance organizations from seven to two. In response to this changing environment House Bill 03-1164 was passed, authorizing the Department to contract with any provider that can demonstrate quality and cost effectiveness.

Administrative service organizations are an increasingly popular alternative to traditional health maintenance organizations. They offer the case management and care coordination services of a health maintenance organization in a manner that is administratively less expensive. The organizations do this by not taking on the risk traditionally assumed by health maintenance organizations. Health Care Policy and Financing has begun a transition that includes using this form of organization to deliver health care to Medicaid clients. Two administrative service organizations, Rocky Mountain Health Plans and Southwest, are contracted with the Department in FY 04-05.

Disease Management Pilot Programs

A series of disease management programs began in Colorado in October 2002, with several of the programs continuing through the end of 2004. The programs included Asthma, Diabetes, Neonatal Intensive Care Unit, Schizophrenia with other medical conditions, Intensive Care Management Care, and Chronic Obstructive Pulmonary Disease. Vendors, paid through several different funding sources (hospitals, care organizations, drug and health supply organizations), identified clients, performance measures, and protocols to determine if telephonic, web-based and face-to-face education, and case management would make changes in behaviors which would translate into positive health outcomes for clients in the programs. The evaluation component is separate and independent from

the program. While these pilot programs are specific to Colorado, there is much interest nationally in the outcomes. The following table describes the programs.

Disease Management Pilot and Programs				
Program	**Funder(s)**	**Vendor**	**Performance Measure**	**Program Notes**
Asthma	• Novartis • Astra Zeneca	National Jewish Center 258 clients	• Number of hospitalizations and emergency room visits • Client functional status • Client satisfaction	• Pilot began October 2002, transitioned to support calls in May 2003, and ended December 31, 2003. • Preliminary program analysis done by National Jewish showed an 86% reduction in emergency room visits, a 55% reduction in hospitalizations, a statistically significant improvement in pediatric functional status, and that 94% of program participants were satisfied with the program. • A direct contract with National Jewish for implementation of an asthma disease management program for the time period November 2004 through June 2006 is in process.
Chronic Obstructive Pulmonary Disease (COPD)	Boehringer Ingelheim	National Jewish Center 286 clients	• Number of hospitalizations and emergency room visits • Client functional status • Client satisfaction	• Pilot began November 1, 2003 and ends December 31, 2004. • Services include telephonic education, 24-hour nurse call line, physician education, and case management of 300 clients. • National Jewish will evaluate effectiveness at the end of the Pilot.
Diabetes	Eli Lilly	McKesson 279 clients through December 31, 2003 233 clients for January 1, 2004 contract	• Number of hospitalizations and emergency room visits • Improve functional status • Reduce complications • Client satisfaction	• Phase I of the Diabetes Pilot began October 2002 and ended December 31, 2003. • Eli Lilly agreed to continue funding this Pilot through Phase II until December 31, 2004. • The University of Arizona, College of Pharmacy is conducting an evaluation of Phase I, funded by Eli Lilly. Statewide implementation is pending evaluation completion. • Services included telephonic case management of 279 clients diagnosed with diabetes, client education, care plans developed with clients, and 24-hour nurse call line.

Disease Management Pilot and Programs				
Program	**Funder(s)**	**Vendor**	**Performance Measure**	**Program Notes**
Neonatal Intensive Care Unit (NICU)	• Johnson & Johnson • Clinician Support Tech-nology	Clinician Support Technology 391 clients	• Readmissions • Lengths of stay • Parent satisfaction	• Pilot operated between October 2002 and June 30, 2004. • Services included web-based hospital specific parent and family education modules covering birth to 18 months. Program was open to all Neonatal Intensive Care Unit (NICU) patients at 4 Colorado hospitals, where 391 Medicaid and 151 non-Medicaid newborns enrolled. Denver Health and Hospitals, Children's Hospital, University Hospital and Presbyterian/St. Luke's Medical Center participated in the program. Laptop computers were provided to Medicaid parents needing Internet access. • One hospital dropped the Pilot after four months of participation, leaving three participating hospitals. This hospital cited a lack of staff to support the Pilot and lack of vendor responsiveness as the main issues for ending participation. Vendor analysis of results, performed in November 2003, indicated 81 Medicaid newborns enrolled between January and November. The primary goal of this Pilot is a reduction in the recidivism rate at three, six, and nine months after birth. The vendor analysis in November did not include recidivism rates due to the fact that adequate time for complete assessment of readmissions had not elapsed. Department support of the Pilot ended January 2004, therefore data regarding Medicaid client participation after December is not available at this time. The number of parent logins has recently dropped, from a high of 1,765 in January 2004 to 926 in May.
Schizophrenia with medical conditions	Eli Lilly	Specialty Disease Management, Inc. 255 clients	• Medication compliance • Number of hospitalizations and emergency room visits • Client functional status • Client satisfaction	• Phase I of the Schizophrenia Pilot began August 2002 and ended December 31, 2003. • Eli Lilly agreed to fund Phase II until December 31, 2004. • The University of Arizona, College of Pharmacy is conducting an evaluation of Phase I, funded by Eli Lilly. Statewide implementation is pending evaluation completion. • Services include face-to-face and telephonic case management, client education, and activities of daily living for 255 clients diagnosed with schizophrenia and at least one chronic medical condition. This program requires extensive coordination of care between mental and physical health care providers.

Disease Management Pilot and Programs				
Program	**Funder(s)**	**Vendor**	**Performance Measure**	**Program Notes**
Intensive Care Management/ Care Management Organization	• Pfizer • Astra Zeneca • Abbott • Glaxo Smith Kline	• McKesson • Health Integrated • Lexicor • American Medical Alert Company 150 clients as of December 31, 2003	• Number of hospitalizations and emergency room visits • Client functional status	• The Pilot began February 2003 and ended December 31, 2003. • The Department is not pursuing evaluation of this program due to low program enrollment. • Services included telephonic case management of 120 medically complex clients in the Home- and Community-Based Clients program. Home-based biometric and subjective monitoring (telemedicine) was also done for 30 clients under this program. • This Pilot required more coordination between all stakeholders (clients, caregivers, home care agencies, vendor, and Single Entry Points) than was originally designed in order to succeed. Additionally, use of newer technologies in an elderly/frail population requires more management and coordination than was provided for in this Pilot.

Transitions in Community-Based Programs

Community-based programs have been well received in the Colorado. The programs, designed to keep clients in alternative programs in the community, are both cost efficient and more effective than institutional settings. Over time, the programs and the communities have identified new services that would assist participants qualifying for the Home and Community Based Service waivers in Colorado's Medicaid program. New services include autism services for children, community transition services for those in nursing homes who could be in the community, as well as expansion of consumer-directed services that have been established by the General Assembly.

The Autism Waiver

SB 04-177 required the Department to submit a waiver to the Centers for Medicare and Medicaid Services to establish a Medicaid Home and Community Based Services Program for children with Autism. The waiver is intended to support children ages 6 years and younger with a diagnosis of autism to live in the community rather than in an institution by providing in-home benefits that address the following needs: behavioral therapy, occupational therapy, physical therapy, psychological and psychiatric services, and speech therapy. Each child is limited to waiver services costing up to $25,000 per year.

Community Transition Services

Twenty-seven states, including Colorado, implemented Nursing Facilities Transition grants. During Colorado's three-year grant, over 800 beneficiaries were informed of their right to choose community-based services, and 111 beneficiaries moved back into their

communities. Historically, Colorado beneficiaries remained in nursing facilities because they lacked the resources to re-establish themselves in their own homes and were unsure of how to make the move happen. Funds to purchase household items such as beds, utensils, linens, and other essential furnishings, previously unavailable through Colorado's state Medicaid plan and waiver programs, are now available. Navigators from independent living centers assist clients to identify and secure the resources necessary to establish community-based living. Not only do beneficiaries report high satisfaction with the services provided and an improved quality of life, but the combination of Medicaid State Plan, waiver, and transition services, is also less costly than the average cost in a nursing facility.

HB 04-1219 directed the Department to add community transition services to the Elderly, Blind, and Disabled waiver. As a continuation of Colorado's Nursing Facilities Transition grant that expired September 30, 2004, these services began in October of 2004 to assist Medicaid beneficiaries to move from nursing facilities into community-based settings, promoting choice, and enhancing the quality of life for beneficiaries.

Mental Illness and Nursing Facility Case-Mix Reimbursement Rates

The current nursing facility reimbursements are based on a case-mix methodology. The case-mix system adjusts reimbursement rates for Class I and Class V Medicaid nursing facilities to reflect the acuity of Medicaid nursing home residents and their utilization of nursing services. The goal is a more appropriate distribution of resources by analyzing the consumption of services based on such factors as age, health status, resource utilization, and diagnoses of the facility's Medicaid residents. For example, a bed-ridden severely ill client in need of a number of therapies may receive a significantly higher reimbursement for the facility than would an ambulatory patient with post-operative monitoring needs only. The Department of Public Health and Environment collects functional assessment data reported by the nursing facilities for all residents. The Department of Health Care Policy and Financing then utilizes the collected data to adjust nursing home reimbursement rates for Medicaid clients accordingly. While this system has been very effective for medical acuity (the parameters on which the system was developed), behavioral acuity, which can also vary significantly in the costs for each resident, has not been included in the model. The current system provides the same reimbursement for a client with several types of therapies who needs constant monitoring and a client that has mild dementia who only needs to be reminded to go to the various activities of the facility.

A case-mix approach to mental health and behavioral acuities may provide the best alternative to suitably compensate providers for expanded services and specialized care. Establishing a higher rate of reimbursement for behavioral care that requires specialized training, time, and efforts, and a lower payment rate for standard care, such as a client with minor dementia, would assure equity to providers that offer differentiated services for clients with more acute needs in nursing facilities. The Department is considering alternatives regarding case-mix variables for mental and behavioral acuity measures.

System Security Issues

Security, along with privacy, has become a very important issue for the Department. The information handled by the computer systems is regulated by the Health Insurance Portability and Accountability Act (HIPAA) of 1996, which has placed stricter requirements on the management of the Department's systems to ensure that this data is properly protected.

Overall security of the Department's network systems has become a critical issue. With each passing month, new attacks are released through the Internet in the form of both network-based worms and email-based viruses. Continual efforts are being made by outside entities (hackers) to gain access to the computer systems. It is an ongoing battle to constantly monitor for new attacks and to counter them by applying the latest fixes/patches to the systems. Upgrading the Department's infrastructure of computer hardware and software can relieve some of these issues for staff.

Reprocurement of the Medicaid Management Information System Contract

The Medicaid Management Information System fiscal agent's primary responsibility to the Department is the processing and payment of all medical provider's claims and capitation payments. The Department's fiscal agent has been Affiliated Computer Services, (ACS or Affiliated Computer Services, Inc, dba Affiliated Computer Services State Healthcare) since December 1, 1998. The last renewable contract year under the prior Request for Proposal will end November 30, 2006. The Department had worked with the federal Centers for Medicare and Medicaid Services since the summer of 2001 to secure an extension of the renewal date to December 2008.[5] On March 29, 2004, the Centers for Medicare and Medicaid Services officially denied Colorado's request for an extension. This affected the Department's ability to negotiate a more advantageous fixed price contract.

As required by the Centers for Medicare and Medicaid Services, the transition to the new Medicaid Management Information Operations vendor (or renewal with current vendor) will take place with an effective implementation date of December 1, 2006. Prior to transitioning, the Department will communicate with medical providers to disseminate information about the new vendor and the location where claims are to be sent, what processes will be used for submitting claims, and how and where to contact a help desk for assistance in working with the new vendor. Timely communications to the providers will smooth the transition and assure the providers that payments will continue without interruption.

The Department will commit staff resources to ensure completion of updates to policies, procedures, systems, and outcomes during this transition period. In recent years, the fiscal agent contract has required over $20 million per year in appropriations to operate the

---

[5] The extension was requested because of the competing priorities of Colorado Benefits Management System, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the many budget reduction Medicaid Management Information System changes.

Medicaid Management Information System. A 1331 Emergency Supplemental was submitted to the Joint Budget Committee on June 7, 2004 for FY 04-05 requesting funds to begin the reprocurement process in the current fiscal year. Although the emergency funds were not approved, the Committee did authorize the Department to proceed with contracting for a consultant, assuming that a regular supplemental would be funded.

Health Insurance Portability and Accountability Act of 1996, National Provider Identifier

The federal Centers for Medicare and Medicaid Services issues regulations for national standards to be used by all entities serving the health care industry. Previously, the Department of Health Care Policy and Financing has implemented required regulations for the privacy rule and standardized transaction codes. The security rule was implemented during FY 04-05. In FY 05-06, the Department will request the fiscal agent to assess the impacts and needs to comply with the National Provider Identifier regulations that will be implemented in 2007.

The regulations require that a federal depository be established for a single identifying code to be used by each medical service provider in the United States. Each provider who bills medical claims electronically will have his or her own unique code. The same identifying code will be used on all medical insurance claims, whether Medicare, Medicaid, or private insurance. Ultimately, the standardization of National Provider Identifiers will eliminate the need for providers to keep track of multiple codes to identify themselves in standard transaction types occurring in more than one health plan.

Regulations on other topics related to the Health Insurance Portability and Accountability Act of 1996 are still pending. At this time, the date for the release of those regulations is unknown.

Health Insurance Flexibility and Accountability Waiver

In the fall of 2001, the federal Department of Health and Human Services invited states to participate in the Health Insurance Flexibility and Accountability demonstration initiative to encourage innovative approaches to increase the number of individuals with health insurance coverage within current Medicaid and Child Health Plan Plus resources. Specifically, the current federal administration places emphasis on comprehensive statewide approaches that maximize private health insurance coverage options and target Medicaid and Child Health Plan Plus resources to populations with incomes below 200 percent of the federal poverty level. The Department is currently considering how, through more prudent purchasing, to take advantage of this potential for more flexibility in providing services to Colorado’s Medicaid and Child Health Plan Plus populations, without increasing General Fund expenditures or decreasing available benefits.

Research commissioned by the Department, through grant funds, revealed that the children served in these two programs have similar health care needs. Within the flexibility of the waiver, the Department hopes to meet the primary and preventive care “core” services for children in a more cost effective manner, and to target “core plus” benefits for those children who need additional services as a “wrap around” approach.

Currently, due to moderate fluctuations in family income, many children “bounce” between the Medicaid and Child Health Plan Plus programs. There may also be a way to ease some of the frustration and confusion among providers of which program to bill for services and the costs of paperwork associated with billing, both of which are deterrents to accepting Medicaid and Child Health Plan Plus members. Furthermore, separate programs do not allow for the purchasing power from commercial and safety net providers that one large program might. The Department believes that incorporating the lessons from private sector examples of administrative efficiencies and buying in volume will allow for better services to clients and a more effective use of tax dollars. The success of this approach could be an increase in the number of low-income children that can receive health care services. This proposed model is effective because it:

- Maximizes efficiency by limiting the number of providers and plans the Department must manage;
- Reduces the need for inter-plan coordination and referrals, promoting continuity of care, user-friendliness and administrative simplicity; and,
- Focuses on the delivery of clinically appropriate care.

The following key principles have been developed through research and substantial public input for this project:

- The streamlining project does not currently plan to include the participation of foster care, adoption, Social Security Insurance, and children’s waiver populations. These populations require much more intensive services than other Medicaid clients, and they are much less likely to move between the Medicaid and Child Health Plan Plus programs;
- There will be no increase in expenditures beyond what would have been spent under the current structure;
- There will be no reduction in eligibility criteria or benefits for either Medicaid or Child Health Plan Plus;
- The children and families Medicaid and Child Health Plan Plus programs would be combined into one program and enrollees will be able to move back and forth seamlessly depending on their respective eligibility;
- Children and families will be provided a “core” benefit package, while children who require more extensive services would be provided additional “core plus” services;
- There will be an eligibility expansion that meets federal waiver requirements; and
- Purchasing of health services will both leverage the volume of the combined Medicaid for children and families and Child Health Plan Plus programs, using best practices from the private and public sector to encourage participation from both safety net and commercial plans.

Colorado Indigent Care Program

In 1987, Congress amended the Medicaid program to require states to make enhanced payments for those "safety net" hospitals that provide services to a disproportionate share of Medicaid and low-income patients. The disproportionate share hospital payments were intended to offset the uncompensated costs of providing services to uninsured and underinsured patients. The payments assist in securing the hospitals' financial viability and preserving access to care for the Medicaid and low-income clients, while reducing cost shifting to private payers. In subsequent legislation, Congress gave states a great deal of flexibility in the design and implementation of their disproportionate share hospital plans. However, as states exercised this flexibility to finance the state share of Medicaid, the federal government became alarmed at the corresponding impact on the federal budget. Regulations were put into effect to limit states' discretion in using provider taxes and contributions for this purpose. In addition, these regulations placed limits on the amount of disproportionate share hospital payments states can make. Since January 1991, the Colorado Medicaid Program has developed and implemented several measures, using disproportionate share hospital payments to finance Medicaid program expansions and to cover the escalating costs of ongoing Medicaid programs and costs associated with the Colorado Indigent Care Program.

The Medicare upper payment limit is the maximum amount Medicaid can reimburse a provider and still receive the federal match rate. The Medicare upper payment limits are calculated by the Department such that each must be a reasonable estimate of the amount Medicare would reimburse providers for providing Medicaid services. Medicaid fee-for-service and managed care rates reimburse providers below the Medicare upper payment limits, providing an opportunity for the Department to gain a federal match on the difference between the Medicaid fee-for-service and managed care reimbursement and the Medicare upper payment limits. State and government owned and operated providers use certification of public expenditures, which generate a federal match without any General Fund expenditure for the difference. Colorado Indigent Care Program payments to publicly owned-providers are partially funded using certification of public expenditures under the Medicare upper payment limit for inpatient hospital services.

In recent years, the General Fund portion of these payments has decreased despite the fact that payments overall have increased. Covering the increasing payments has been made possible by using certification of public expenditures for provider costs related to Medicaid eligible and low-income individuals that receive a federal match. The financing methodology was also redesigned in FY 03-04. Major objectives of the restructuring were: 1) simplify the system for Department staff and providers participating in the disproportionate share hospital payments program; and, 2) minimize the General Fund and maximize federal funds while equitably distributing the pool of money available to providers who serve a disproportionate number of Medicaid and low-income clients. This includes utilizing the Medicare upper payment limit for privately-owned facilities.

The Colorado Indigent Care Program will continue to face General Fund constraints in the near-term, but with the recent restructured financing mechanism, is well positioned to find creative ways to reimburse providers for care provided to Medicaid and other low-

income individuals. The Department continues to review the distribution of available funds to these providers and explore new opportunities to maximize federal funds.

Old Age Pension State Medical Program

The Department is researching ways to restructure the Old Age Pension State Medical Program to offer a more consistent benefit package within available funding. In recent years, reimbursement rates in this program have been cut and benefits have been limited and uncertain. The Department's objective is to maximize available funding to serve these clients, permitting the consistent delivery of medically necessary benefits as well as improved correspondence and communication to clients.

Status of Legal Immigrants

SB 03-176 eliminated services for legal immigrants and reduced the FY 03-04 budget by $11 million. Due to pending litigation, the Department did not remove the funding for these clients in FY 03-04. The FY 04-05 appropriation assumes a January 1, 2005 start date for this bill, with a reduction in the Department's budget of $5,142,017 by the Joint Budget Committee. Since passage of the Long Bill, there has been further progress on the case. The trial court denied in its entirety the plaintiffs' request for an injunction. The Tenth Circuit reversed and remanded the trial court decision solely with respect to whether the State could terminate Medicaid benefits without appeal rights to recipients who failed to return two redetermination packets. Per the Tenth Circuit's order, the case is to be remanded to the district court to issue a preliminary injunction prohibiting the State from terminating Medicaid benefits for those individuals who failed to return redetermination forms unless they have been given notice of the right to request a pretermination hearing. The Tenth Circuit opinion was issued on January 12, 2004, but did not become effective until June 2, 2004, when the Tenth Circuit denied plaintiffs' Petition for Rehearing and the mandate issued. The plaintiffs have informed the Department that they will not petition for certiorari in the case. The Department has developed an implementation plan for SB 03-176 and shared that plan with counsel for the plaintiffs. The two sides are in the process of working out issues regarding the plan prior to submission to the District Court.

Tobacco Funding

Between 1994 and 1998, forty-six states were involved in ongoing litigation with the major tobacco companies in America. On November 23, 1998, a master settlement agreement was reached (City and County District Court of Denver, Case Number 97 CV 3432) wherein the tobacco companies agreed to make annual settlement payments to Colorado. During the 1999 legislative session, HB 99-1208 and SB 99-231 were enacted that defined the parameters of the settlement, and created the Tobacco Cash Fund and the Tobacco Trust Fund. As detailed in SB 99-231, the Tobacco Trust Fund is to receive 21% of the annual settlement payment and the

Tobacco Cash Fund is to receive 79%. Nine programs were originally funded from the Tobacco Cash Fund, and the Tobacco Trust Fund was designated as a reserve in the event that the Tobacco Cash Fund could not support the programs.

The Department of Health Care Policy and Financing administers three of the tobacco funded programs including: the Comprehensive Primary and Preventive Care Program, the Children's Basic Health Plan, and the Children with Autism Waiver Program. Each year the Office of State Planning and Budgeting and the Legislative Council Staff forecast how much the annual settlement payment will be, and use the statutory formula to determine how much of that payment each program is allotted. Oftentimes the actual settlement payment differs from the forecasted payment, and adjustments are made.

Since 1999, the allocation methodology for the tobacco programs has changed several times in response to fiscal conditions. For example, in FY 02-03, FY 03-04, and FY 04-05, legislation was introduced that transferred monies from the Tobacco Trust Fund to the General Fund in response to General Fund shortfalls. In addition, these bills altered the allocation formula for the programs. Currently, HB 04-1421 delineates the funding formula. The Department of Health Care Policy and Financing's tobacco funded programs receive the following amounts from the Tobacco Cash Fund:

- Comprehensive Primary and Preventive Care - 3% of the total payment, up to $5 million;
- Children's Basic Health Plan - 24% of the total payment, up to $30 million;
- Children with Autism Waiver Program - up to $1 million for all fiscal years.

For FY 04-05, the Office of State Planning and Budgeting expects that the State will receive $86,081,066 in payments.

Finally, it is important to note that tobacco funding is precarious. The total payment amount for each state depends on the aggregate sales of tobacco products and inflation. If aggregate sales fall by a significant amount, then the states' payments will subsequently decrease. Furthermore, the ability of the tobacco companies to make payments depends on their financial viability. If one or all tobacco companies declare bankruptcy for example, payments to states would be reduced or discontinued. While this may seem unlikely, several tobacco companies are currently involved in a number of lawsuits that could affect their financial stability. Taking these uncertainties into consideration, legislation (SB 03-268 and SB 04-203) was introduced in the past two legislative sessions that would securitize, or sell off, the future stream of tobacco payments. Although SB 03-268 passed, it was repealed on December 15, 2003 due to inaction. SB 04-203 was lost by vote in the Colorado House of Representatives.

Legislation Summary 2004

The 2004 legislative session launched four new programs and changed processes and procedures in every aspect of the Department. Four waiver programs, requiring approval from the Centers for Medicare and Medicaid, were added by the following legislation:

- ***HB 04-1219*** established the Community Transition Services Program effective July 1, 2004. Health Care Policy and Financing is authorized to provide community transition services for clients in the Home and Community Based Services waiver for Elderly, Blind, and Disabled clients in nursing homes. The services will include deposits for utilities and other one-time charges and start-up supplies, reducing the barriers that prevent nursing home clients from moving back into the community. Transition services providers will assist clients to live in the community and clients will receive Home and Community Based waiver services for the Elderly, Blind, and Disabled as an alternative to institutionalization.

- ***SB 04-028*** directs the Department to apply for a federal waiver to provide Substance Abuse Treatment for Native Americans beginning July 1, 2004. The costs of writing and researching the waiver are to be paid by gifts, grants and/or donations to the Native American Substance Abuse Fund, which will be matched with federal Medicaid administrative funds, and are to be received by Health Care Policy and Financing by December 31, 2004. A program, if approved by the Centers for Medicare and Medicaid, would be 100% federally funded. Historically, a waiver of this type takes approximately 3 years to be processed.

- ***SB 04-177*** adds assistance for children, from birth to 6 years of age diagnosed with autism, through a Children's Home and Community Based Services waiver program. The services include occupational therapy, speech therapy, psychological and psychiatric services, physical therapy, and behavioral therapy. The program limits services for each client to $25,000 annually. A waiver will need to be written and submitted, system changes will need to be made, and rules and processes defined for the waiver.

- ***SB 04-206****,* effective July 1, 2004, directs a waiver to be written to current Medicaid hospice services. The waiver uses gifts, grants, or donations already identified, to apply for a pediatric waiver for hospice care. The new parameters for a children's hospice program in the Home and Community Based Services waiver program will allow children to receive additional services that would prolong life that are not available with adult hospice services. The waiver seeks exemption from the mandatory do-not-resuscitate order, the physician's certification that a patient is expected to live less than 6 months, and the non-allowance of curative care therapies concurrent with palliative and hospice care. Upon approval, the budget neutral analysis is to go to the Joint Budget Committee for their recommendations for implementation of the program.

The following legislation directed changes to existing Health Care Policy and Financing programs:

- ***HB 04-1058*** concerns eligibility determination for Medicaid and was effective April 2, 2004 when the Governor signed the legislation. Health Care Policy and Financing may accept Medicaid applications and determine eligibility and may designate 1) the private service contractor for the Children's Basic Health Plan, 2) Denver Health and Hospitals, and 3) The Children's Hospital to accept applications and determine eligibility in addition to Colorado county departments of social services.

- ***HB 04-1075*** concerns the Department of Human Services administered Special Connections Program that provides substance abuse treatment for high-risk pregnant women who are Medicaid eligible. The bill extends the treatment period time limit from two months after delivery to an additional 10 months of treatment. The objective is to give new mothers a better chance at staying drug and alcohol free. A waiver from the federal Centers for Medicare and Medicaid is needed to provide these services for more than 60 days post-partum.

- ***HB 04-1220***, effective July 1, 2004, changes non-emergency medical transportation from a Medicaid benefit to an administrative service. Funding is in the Long Bill, HB 04-1422.

- ***HB 04-1264*** concerns how bills for Medicaid services received at the end of a fiscal year are paid, and was effective April 13, 2004. In FY 02-03, the Department suspended payments to providers based on cash flow forecasts and to achieve projected savings from the statutory change to cash accounting. In the future, Health Care Policy and Financing will not interrupt its normal provider payment schedule unless the Department receives a notice jointly from the Office of State Planning and Budgeting and the State Controller that there is a possibility that sufficient cash will not be available to make payments to providers and for other expenses.

- ***HB 04-1265*** transfers the administration of Community Mental Health Services to Medicaid clients from the Department of Human Services to the Department of Health Care Policy and Financing effective April 6, 2004. The appropriation in FY 03-04 was prorated for some administrative services and the budget for FY 04-05 was included in the Long Bill, HB 04-1422, for both administration and services. The Department of Human Services retains the administration of the provision of mental health services to those affected by the Arevalo versus Colorado Department of Human Services litigation and the administration of Mental Health Institutes. Health Care Policy and Financing responsibilities include, but are not limited to, the prepaid capitated single entry point system for mental health services, the fee-for-service mental health services, and alternatives to institutionalization. Health Care Policy and Financing's Administration includes program approval, program monitoring, and data collection.

- Effective September 1, 2004 ***HB 04-1284*** establishes standard procedures for a review or for audits of Medicaid providers for overpayment. New procedures include: uniform standards; single demand for repayment per audit; written notification of records to be reviewed; the offer of an on-site inspection; sampling techniques, if used, that are statistically valid and in compliance with auditing standards; and, the Department is to offer an informal reconsideration of the review/audit findings. Contingency contracts, if used to audit or review, are limited to 18% of the amounts collected and certain conditions. The costs for conducting additional on-site audits and informal reconsideration are to be absorbed within existing appropriations.

- ***HB 04-1415**,* effective July 1, 2004, repeals the Nursing Facility Provider Fee and Quality of Care Grant Program of SB 03-266. SB 03-266 provisions were not approved by the Centers for Medicare and Medicaid Services and the provider fee and grant program were not implemented. This legislation eliminated the language in statute. One aspect of the original legislation that continued was the State Nursing Facility Service Program, which, per HB 04-1415, appropriated General Fund resources to care for nursing home clients affected by SB 03-176. SB 03-176 eliminated services for legal immigrants, some of which are in nursing homes. The appropriation for FY 04-05 for that program was adjusted to begin in January 2005 when litigation concerning SB 03-176 is anticipated to be resolved and client nursing facility services would be paid from this program with General Fund.

- ***HB 04-1416*** concerns the Breast and Cervical Cancer Program, which was slated to be funded 50% from the General Fund beginning in FY 04-05. Because there is sufficient funding available in the Breast and Cervical Cancer Prevention and Treatment Fund to support the program in FY 04-05 from that fund, the provision to use 50% General Fund in FY 04-05 was suspended, saving General Fund in FY 04-05. The provisions for General Fund in future fiscal years were not amended.

- ***HB 04-1421*** reallocates Tobacco Litigation Settlement funding for FY 04-05 effective July 1, 2004. The revised funding from the Tobacco Settlement money includes the following Health Care Policy and Financing programs: Comprehensive Primary and Preventive Care Fund and Grant Program - 3%, not to exceed $5 million; Children's Basic Health Plan - 24%, not to exceed $30 million and not less than $17.5 million; and, $300,000 for the Medicaid portion of the Child Mental Health Treatment Act (see SB 04-065). Other programs receiving funding include: Dental loan repayment; Nurse Home Visitor; Fitzsimmons Trust Fund; Tobacco Education Grants; Colorado State Veterans; Read to Achieve; Tony Grampsas Youth program; senior services; and, the AIDS drug assistance program. Remaining funding is transferred to the General Fund for balancing the FY 04-05 budget.

- ***HB 04-1447*,** effective July 1, 2004, ensures a seamless transition for children no longer Medicaid-eligible due to SB 03-176 to the Children's Basic Health Plan. SB 03-176 eliminated services for legal immigrants. The children, ineligible for Medicaid per SB 03-176 but now eligible for the Children's Basic Health Plan services, are to enroll in the Children's Basic Health Plan with assistance from temporary personnel hired for that purpose. The legislation provides accelerated processing and a proactive enrollment process, as well as medical and dental services for these children.

- ***HB 04-1455*** eliminates certain appropriations in the Departments of Health Care Policy and Financing, Public Health and Environment, and Human Services for one day only, on January 1, 2005, if a tobacco tax initiative is approved through the general election. Additionally, Health Care Policy and Financing is to evaluate the merits of participation in multi-state drug-purchasing cooperatives, and report by November 1, 2004.

- ***SB 04-029*** requires, effective August 4, 2004, that service providers, when discussing care plans with clients of contingency plans, include the identification of strategies to pursue if a client's regular in-home caregiver is unavailable due to an emergency situation or unforeseen circumstances.

- ***SB 04-065,*** effective May 27, 2004, extends the Child Mental Health Treatment Act, a Department of Human Services program until July 1, 2009, and establishes funding from the Tobacco Settlement Agreement to the Child Mental Health Treatment Fund. Clients in the program are Medicaid eligible, and their health care funding flows through Health Care Policy and Financing to Human Services. Provides funding on a sliding scale basis for residential treatment room and board.

- ***SB 04-138*** repeals the provisions of SB 03-259, which established Health Care Policy and Financing 's authority to charge a monthly fee to families enrolled in either the Children's Home and Community Based Services waiver or the Children's Extensive Support waiver programs. The fees collected were to provide funding for the services from a new source, the client families, on a sliding scale. The Centers for Medicare and Medicaid Services did not approve the program waiver change to collect the fees and the legislation was eliminated through this bill. In addition to the fees and the services, administrative costs for the collecting of fees were eliminated. The change was effective April 2004.

VI. DEPARTMENTAL BACKGROUND

In providing the extensive information in the Departmental Background section of this document, the Department accessed a number of different data sources. Different sources contain different types of information. Therefore, Medicaid caseload and Medicaid expenditures are represented as different numbers in different places.

When the Department transitioned to Cash Accounting at the end of FY 02-03, caseload reporting was changed. Caseload reporting in budget documents no longer contains retroactive eligibility adjustments. Budget caseload is held constant at its first month reported, so is pulled on a specific date. However, retroactivity is still a function of Medicaid eligibility; that is, in practice, caseload does vary over time because clients are, generally, eligible back to the date of their application. In researching new components of caseload, such as gender, the full data at the original point of time is not available and will include some retroactivity. In the gender example, the Department queried the system for the same year as previously reported, but is off by approximately 100 clients because the report ran at a different point in time. In some cases, caseload includes other programs besides Medicaid. Therefore, some caseload totals may differ within the document. At all places, the context is noted for the reader.

For budget purposes and monthly reporting to the Joint Budget Committee, the Department reports Medicaid expenditures as the amount of the Medical Services Premiums Long Bill group. Sometimes this is reported without federal financing and sometimes it is, depending on the purpose of the report. For instance, federal financing can easily skew the perception of Medicaid services. Also, in some of the descriptive information provided in this document, the Department has queried the system and reported on *all* Medicaid expenditures, even those in other Long Bill groups such as "Other Medical Services" and "Department of Human Services Medicaid-Funded Programs." As long as taken in context, this information is provided to educate the General Assembly and the public regarding various aspects of Medicaid. Some information will not correlate directly with the official Budget Request.

A. OVERVIEW

A1. Department Structure

The Department of Health Care Policy and Financing was established July 1, 1994. Karen Reinertson serves as the Executive Director. The Department is split into two primary offices. The Department's Director of Operations and Finance Office is Marilyn Golden. The Director of the Medical Assistance Office is Vivianne M. Chaumont. The Medical Services Board is the entity authorized under statute to pass rules for the Department's programs, and its members are appointed by the Governor. The Medical Services Board is chaired by Julie Reiskin. With 204.5 FTEs, Health Care Policy and Financing is one of the smallest departments in terms of staff size, but, after K-12 Education, Health Care Policy and Financing is the:

- Second largest budget in State government,
- Second largest consumer of General Fund (21%), and
- First in federal funds drawn.

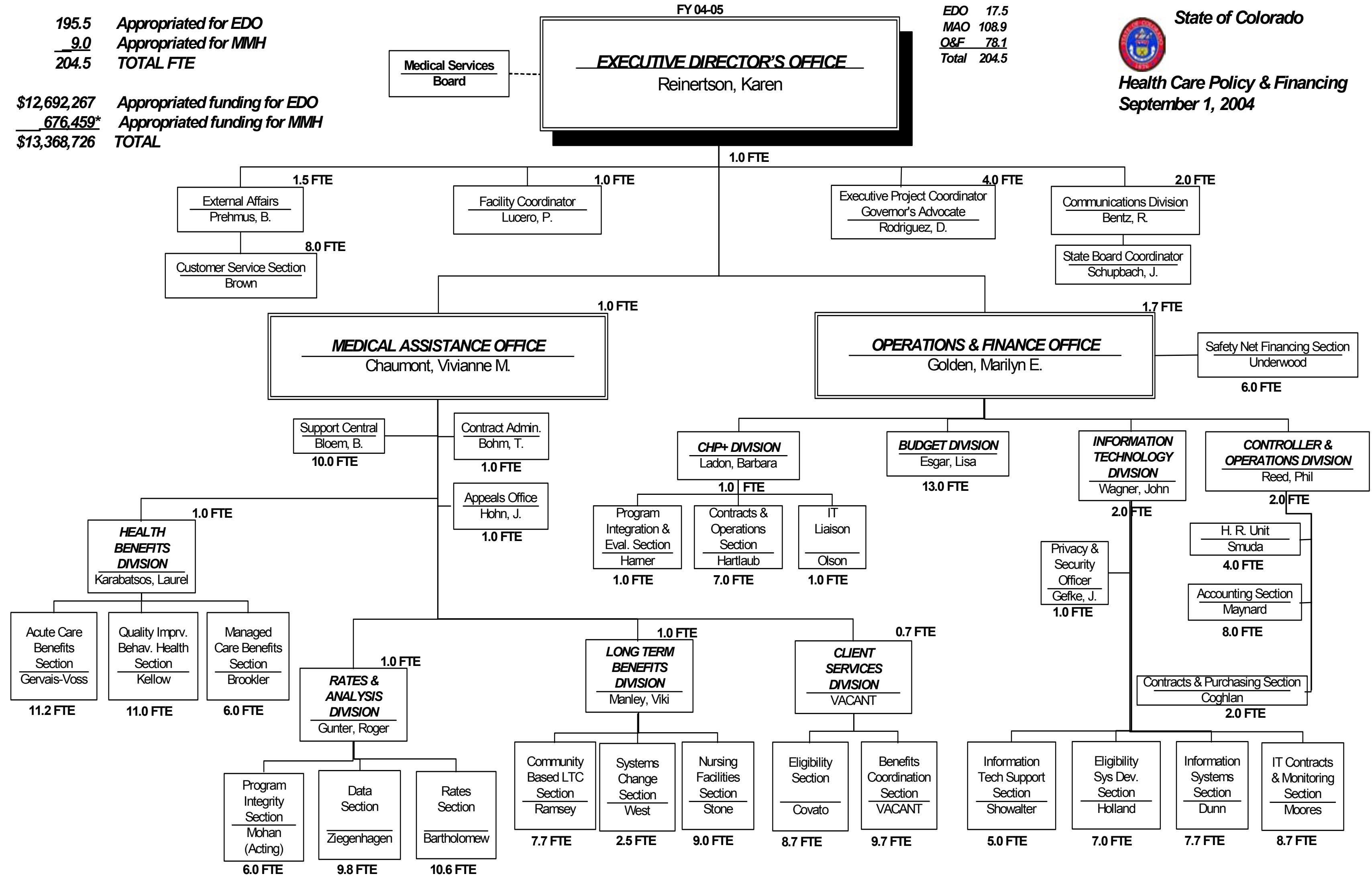
The appropriation for FY 04-05 (including new legislation) exceeds $3.0 billion total funds. On July 1, 2004, the federal match for Colorado's Medicaid program returned to the lowest federal match level available to states (50% federal fund) from a temporary adjustment to 52.95% from April 1, 2003 until June 30, 2004. The federal match is computed from statewide per capita income using a nationally standardized formula and is reported by the Federal Funds Information Service. The federal match rate available for the Children's Basic Health Plan is 65%.

Most of the Department's administration costs are privatized or, in some cases, are contracted out to other executive departments. The FY 04-05 Long Bill (HB 04-1422) and special bills during the 2003 Legislative Session result in the following approximate allocation for Department programs:

Total FY 04-05 Appropriation	**$3,014,426,097**	**100.00%**
Direct Care Services (including Mental Health) administered by Health Care Policy and Financing	$2,536,586,552	84.15%
Department of Human Services Programs	$419,307,363	13.91%
Contractual Services (including with other State departments except Department of Human Services)	$42,711,040	1.42%
Department Administration (Personal Services, Operating, etc.)	$15,821,142	0.52%

A Department organizational chart is provided on the following page.

Figure A.1 Organizational Chart



*The Medicaid Mental Health amount excludes operating and EQRO amounts.

A2. Overview of Staffing

The following table delineates appropriated FTE for past fiscal years as well as the variance from year to year.

Health Care Policy and Financing FTE History

FISCAL YEAR	FTEs	PERCENT CHANGE
FY 94-95	137.2	N/A
FY 95-96	136.7	-0.3%
FY 96-97	133.0	-2.7%
FY 97-98	146.0	9.8%
FY 98-99	151.0	3.4%
FY 99-00	162.4	7.5%
FY 00-01	167.7	3.3%
FY 01-02	177.6	5.9%
FY 02-03	188.4	6.1%
FY 03-04	200.4	6.4%
FY 04-05*	204.5	2.0%

* Long Bill HB 04-1422 + Special Bills

A3. Health Care Policy and Financing and its Programs

In 1993, Governor Roy Romer signed into law House Bill 93-1317 restructuring health and human services delivery systems in Colorado. The goal of this law was to streamline government functions and to make more efficient and effective use of state and local resources. Prior to restructuring, the Departments of Social Services performed health and human services functions and administered the Medicaid program. Under the new structure effective July 1, 1994, the Departments of Institutions, the Alcohol and Drug Abuse Division, and most of Social Services were combined into the new Department of Human Services. The Medicaid program was moved from the Department of Social Services to the Department of Health Care Policy and Financing, along with several other non-Medicaid health care programs and health policy functions.

The Department of Health Care Policy and Financing is the federally recognized Single State Agency for the Medicaid program; as such, in order to receive federal financial participation, the Department is responsible for the provision of all health care services to persons who qualify as categorically needy under Title XIX of the Social Security Act. The Department oversees services and distributes administrative costs through interagency agreements with other departments. Because Health Care Policy and Financing is the Single State Agency, a number of programs and services statewide are financed through the Department's budget each fiscal year. Included in these programs and services are services for developmentally disabled individuals, mental health institutes, and nurse aide certifications. Programs housed within the Department of Health Care Policy and Financing include:

- Medicaid (Title XIX of the Social Security Act);
- Medicaid Mental Health Community Programs;
- Colorado Indigent Care Program;
- Children's Basic Health Plan or Child Health Plan Plus (Title XXI of the Social Security Act);
- Old Age Pension State Medical Program;
- Home Care Allowance Program; and,
- Adult Foster Care Program.

A4. Colorado Budget Environment

Beginning in FY 01-02, the Department's budget began to experience significant reductions due to the combined strain of the lagging economy, spending limits, and revenue growth limits. In the years ahead, Health Care Policy and Financing will need to continue to balance ensuring access to health care for the elderly, persons with disabilities, and certain low-income populations with limited revenue, the increasing pressure on the State's spending limit, and the need to finance other statewide concerns such as roads, schools, and correctional facilities.

The Department is cognizant of the pressure that the Health Care Policy and Financing programs have placed on the tight Colorado State budget. Because Medicaid is an entitlement program and because costs have been rising at rates in excess of State spending limits, this program has been constricting other State needs and priorities. In reviewing the November 1, 2004 Budget Request, one should see that priorities have been put first on funding base services for entitlement programs, secondly on funding the Children's Basic Health Plan, next on other federal and statutory mandates, and lastly on technical and administrative needs. Where the ability to return unneeded funds has been possible, these have been identified. When additional dollars are requested, they have been carefully considered, laid out, and analyzed.

A5. HIPAA Information Regions

The Health Insurance Portability and Accountability Act (HIPAA) was signed into federal law in 1996 (Public Law 104-191). The federal law resulted eight rules. The second rule, the Privacy rule, pertains to all of the patient's individually identifiable health information. Medicaid providers and health plans, which include Medicaid and the Children's Basic Health Plan, are covered entities and, as such, must comply with all provisions of the Privacy rule.

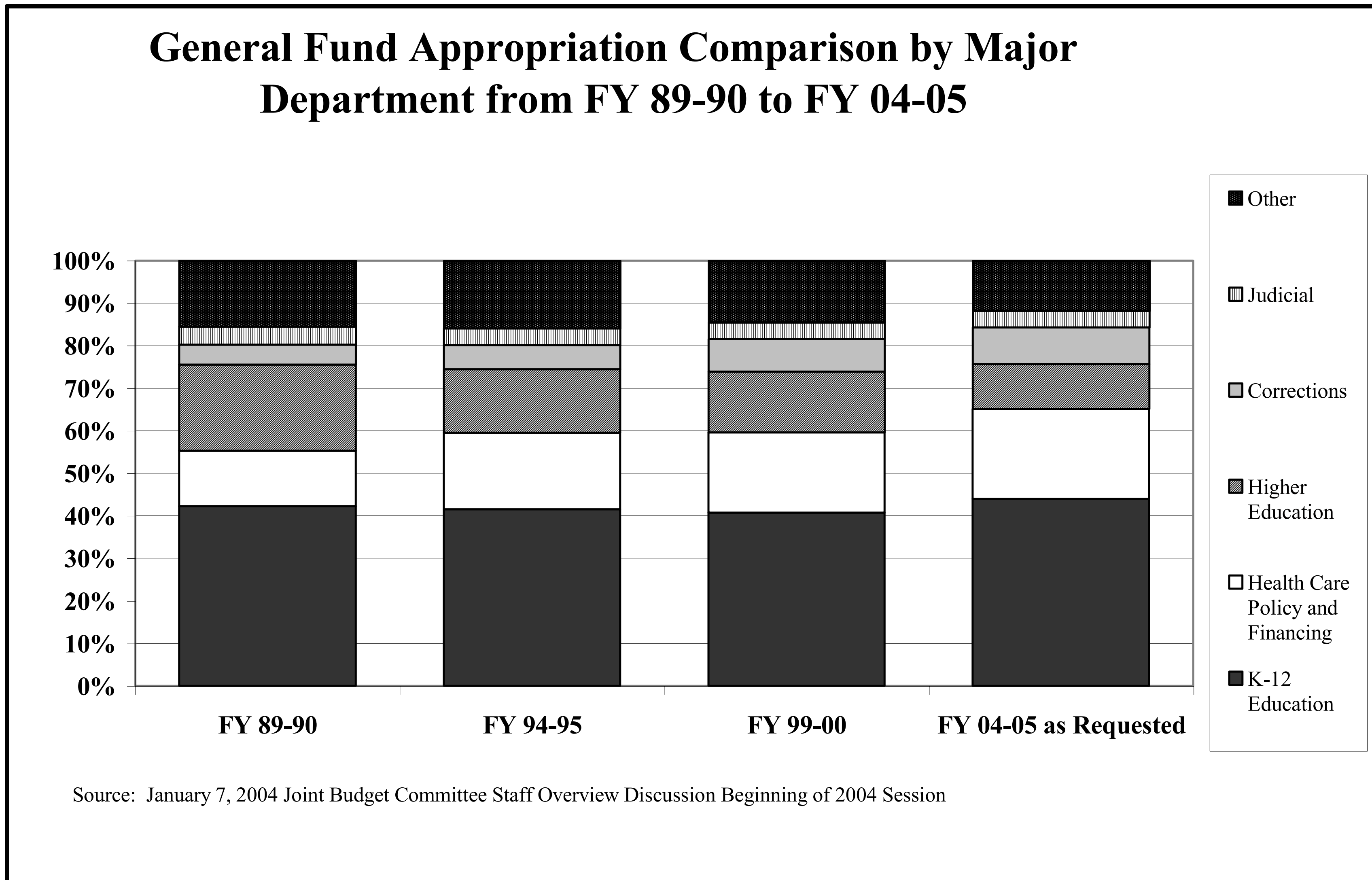
It is under this Privacy rule that the Department must now release client information in a larger aggregation in order to maintain client confidentiality and anonymity in smaller counties. To do this, twenty "HIPAA Regions" were developed for the provision of Department information. Some individual counties have large enough populations to be stand-alone HIPAA Regions. The map on the following page shows how the State is separated into these 20 regions. Any inquiry for information is responded to either on a statewide basis or by these HIPAA Regions.

HIPAA Regions	
1 = Garfield, Moffat, Rio Blanco	11 = Logan, Morgan, Phillips, Sedgwick, Washington, Yuma
2 = Eagle, Grand, Jackson, Pitkin, Routt, Summit	12 = Cheyenne, Elbert, Kit Carson, Lincoln
3 = Mesa	13 = Douglas
4 = Delta, Montrose, Ouray, San Miguel	14 = Boulder, Broomfield
5 = Archuleta, Dolores, La Plata, Montezuma, San Juan	15 = Larimer
6 = Chaffee, Custer, Fremont, Gunnison, Lake, Park	16 = Weld
7 = Alamosa, Conejos, Costilla, Hinsdale, Mineral, Rio Grande, Saguache	17 = Adams
8 = Baca, Bent, Crowley, Huerfano, Kiowa, Las Animas, Otero, Prowers	18 = Arapahoe
9 = Pueblo	19 = Clear Creek, Gilpin, Jefferson
10 = El Paso, Teller	20 = Denver

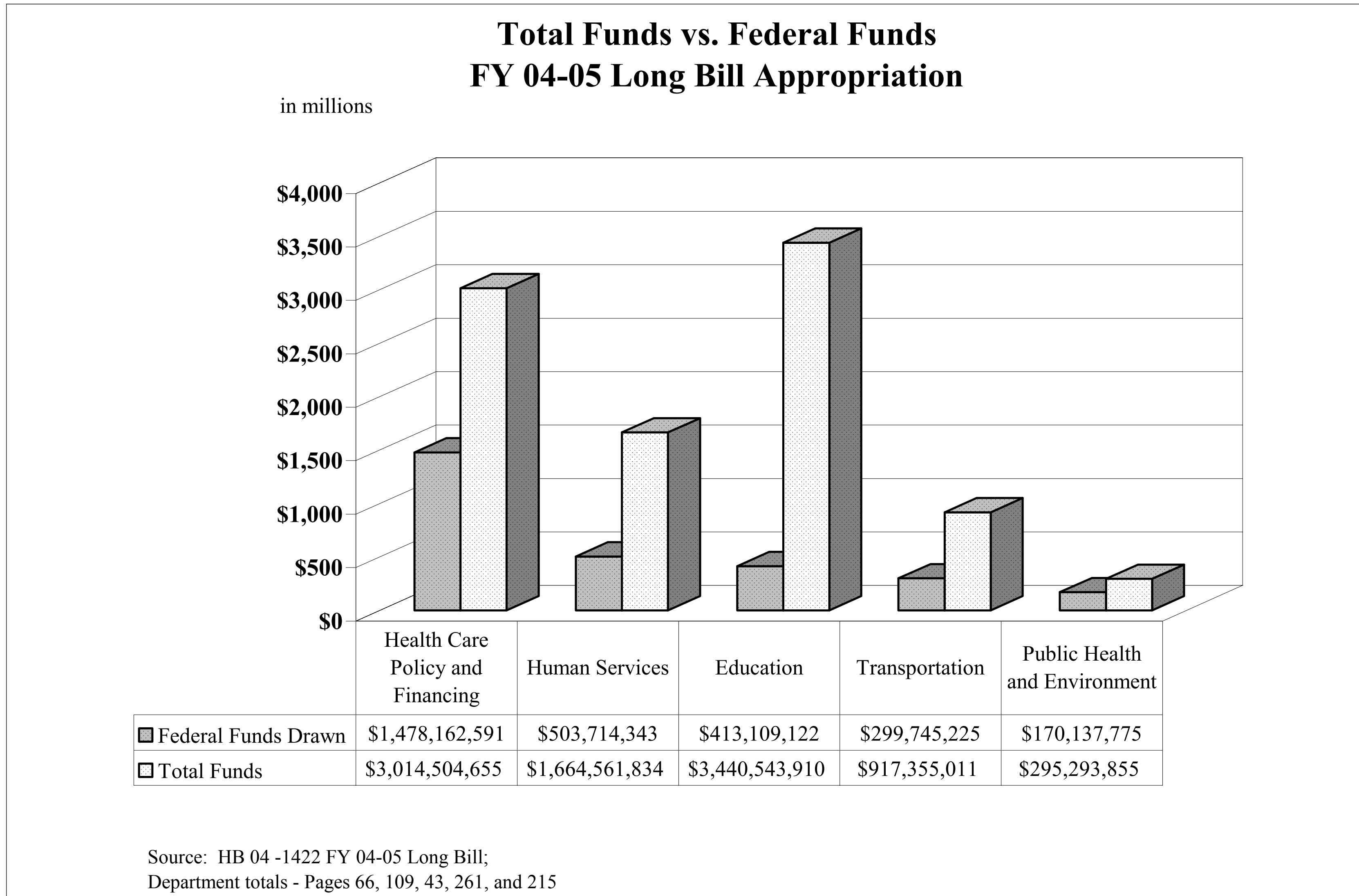
Replace page with HIPAA Region Map 1

B. STATE BUDGET

B1. State Agency Budgets as a Percentage of the State Budget in General Fund



B2. Highest Draw of Federal Funds, by Agency



	Health Care Policy and Financing	Human Services	Education	Transportation	Public Health and Environment
Federal Funds Drawn	$1,478,162,591	$503,714,343	$413,109,122	$299,745,225	$170,137,775
Total Funds	$3,014,504,655	$1,664,561,834	$3,440,543,910	$917,355,011	$295,293,855

Source: HB 04 -1422 FY 04-05 Long Bill;
Department totals - Pages 66, 109, 43, 261, and 215

B3. Health Care Policy and Financing Expenditure Growth for FY 99-00 to FY 03-04

The graph below compares Medicaid health care services to Indigent Care, Children's Basic Health Plan, and Home Care Allowance Programs for FY 99-00 through FY 03-04.

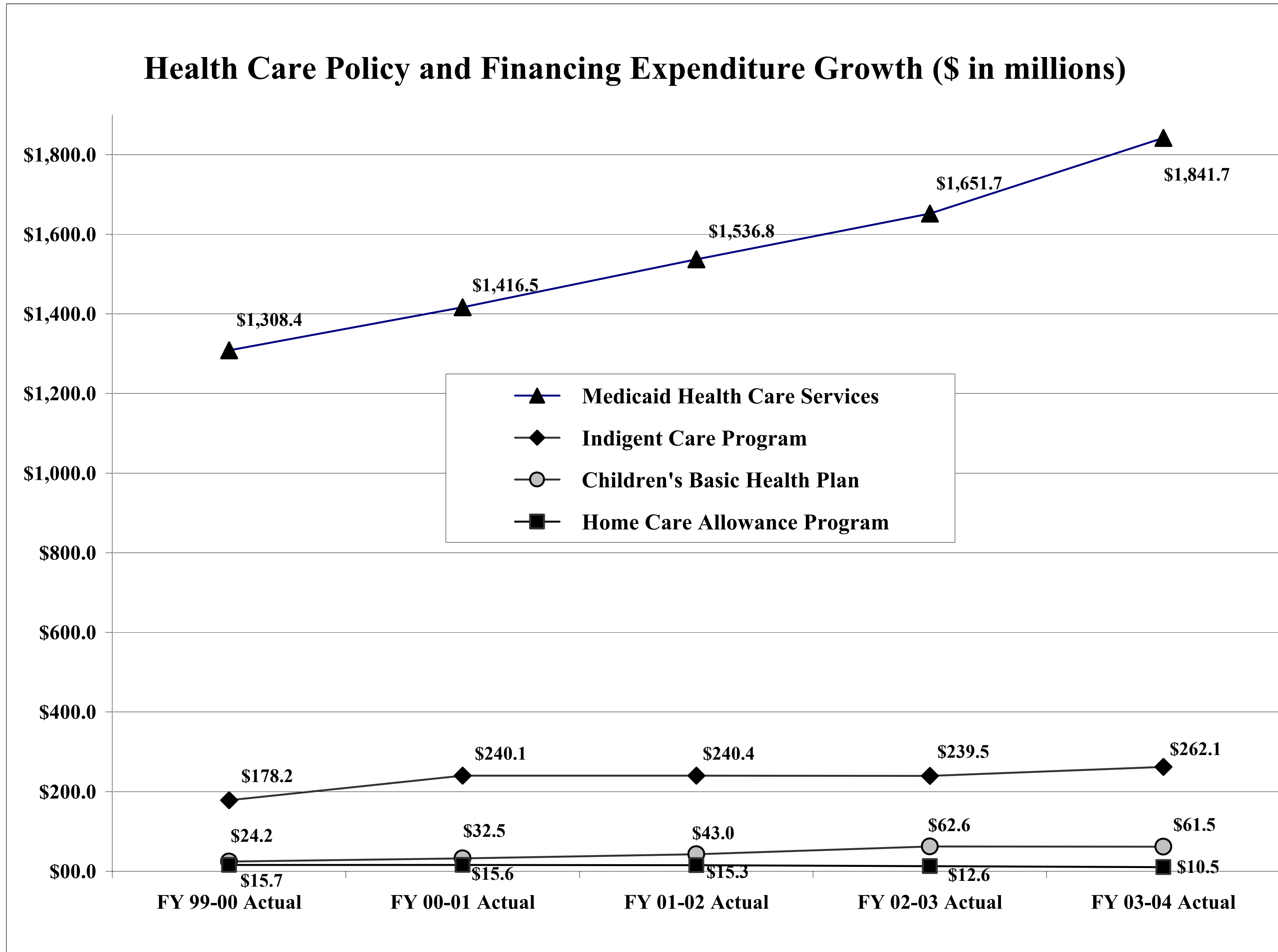
The Indigent Care Program provides partial reimbursement to hospital and clinic providers for medical services given to the State's non-Medicaid, medically indigent, and uninsured or underinsured individuals.

Effective in FY 00-01 via SB 01-183, Children's Basic Health Plan line items and appropriations were moved from the "Other Medical Services" Long Bill group to the "Indigent Care Program" Long Bill group. Thus, from FY 00-01 on, total indigent care expenditures are the net of total Indigent Care less Children's Basic Health Plan expenditures. The Children's Basic Health Plan provides health insurance for children under age 19 in families at or below 185% of the federal poverty level who are not eligible for Medicaid due to a higher income level.

The Home Care Allowance program provides monthly payments to qualifying individuals for the purchase of services to allow them to remain in their homes, such as personal care and shopping.

Sources for the following graph are as follows:

- Medicaid Health Care Services: Budget Request FY 05-06, Exhibit T Expenditure History by Service Category for the Medical Services Premiums from COFRS Page ET-1
- Schedule 3s of the Budget Requests for FY 02-03 for FY 99-00 and FY 00-01 Actuals; Schedule 3s of the Budget Request for FY 04-05 for FY 01-02 and FY 02-03 Actuals; and Schedule 3s of the Budget Requests for FY 05-06 for the FY 03-04 Actuals
- Indigent Care Program: Budget Request FY 02-03, pages 3.4-8 to 23; Budget Request FY 04-05, page D.3.6 to 3.21; Budget Request FY 05-06, pages D.4-1 to 4-40
- Children's Basic Health Plan: Budget Request FY 02-03, pages 3.4-26 to 3-34 and 3.5-23 to 3.5-27; Budget Request FY 04-05, pages D.3-26 to 3-35; Budget Request FY 05-06, pages D.4-16 to 4-28;
- Home Care Allowance: FY 02-03 Budget Request, Other Medical Services, page 3.5-1 and FY 04-05 Budget Request, Other Medical Services, page D.4-5; Budget Request FY 05-06, page D.5-3.


Health Care Policy and Financing Expenditure Growth ($ in millions)
$1,800.0
$1,600.0
$1,400.0
$1,200.0
$1,000.0
$800.0
$600.0
$400.0
$200.0
$00.0
$1,308.4
$1,416.5
$1,536.8
$1,651.7
$1,841.7
$178.2
$240.1
$240.4
$239.5
$262.1
$24.2
$32.5
$43.0
$62.6
$61.5
$15.7
$15.6
$15.3
$12.6
$10.5
Medicaid Health Care Services
Indigent Care Program
Children's Basic Health Plan
Home Care Allowance Program
FY 99-00 Actual
FY 00-01 Actual
FY 01-02 Actual
FY 02-03 Actual
FY 03-04 Actual

B4. Comparing Colorado to Other States in Federal Region

For administrative purposes, the Centers for Medicare and Medicaid Services divides the country into 10 regions, each home to a regional office. The Regional Offices are responsible for the administration of the Medicare, Medicaid and the State Children's Health Insurance Program and range in size from two to seven states. Some regional offices have responsibilities for the U.S. Territories in the Caribbean and South Pacific. Colorado is in Region VIII, as are Montana, North Dakota, South Dakota, Utah, and Wyoming.

The following information shows data for the six states comprising Region VIII, to better understand how Colorado compares to its neighboring states. The following information is from the Kaiser Family Foundation’s State Facts Online website as of September 2004. *Some components differ from data reported directly by the Department*.

Regional Comparison from Kaiser Family Foundation’s State Facts Online

	FY 03-04 FMAP*	FY 04-05 FMAP*	Total State Population 2002	FFY 2000 Medicaid Enrollees	Medicaid Enrollees as % of State Population	Medicaid Expenditures for Benefits and DSH in FFY 2002	SCHIP Federal Match 2005	SCHIP Monthly Enrollment December 2003	Income Eligibility as Percent of FPL for SCHIP 2003	SCHIP Total Expenditures 2002
Colorado	50.00%	50.00%	4,409,790	377,700	8.57%	$2,333,477,836	65%	49,978	185%	$47,971,251
Montana	72.85%	71.90%	893,600	97,100	10.87%	$578,471,497	80%	10,626	150%	$14,935,804
North Dakota	68.31%	67.49%	619,280	62,200	10.04%	$464,918,216	77%	3,495	140%	$4,847,508
South Dakota	65.67%	66.03%	740,970	98,700	13.32%	$554,692,812	76%	9,595	200%	$11,370,254
Utah	71.72%	72.14%	2,283,860	203,800	8.92%	$998,424,299	81%	27,943	200%	$32,706,432
Wyoming	59.77%	57.90%	485,510	52,500	10.81%	$277,941,073	71%	3,121	133%	$4,304,677

FMAP = Federal Medical Assistance Percentage
FFY = Federal Fiscal Year
FPL = Federal Poverty Level
DSH = Disproportionate Share Hospitals
SCHIP = State Children’s Health Insurance Plan (federal term)
*Source of FMAP is the Federal Register, FFY 2004 in November 15, 2002; FFY 2005 in December 3, 2003. The Federal Medical Assistance Percentage does not include the 2.95% Temporary Increase in Medicaid FMAP for the last 2 quarters of federal fiscal year 2003 and the first 3 quarters of federal fiscal year 2004. All states received the additional 2.95% for Medicaid Services.
Colorado, Montana, and Utah suspended enrollment in the State Children’s Health Insurance Plan between June 2002 and April 2003.

B5. Cost Containment Measures within the Region

In the past several years, cost containment measures in the Medicaid program have been necessary to meet budgetary requirements of most states. The table below shows the primary cost containment measures and which of these actions were implemented by the states in Region VIII. Within each category of cost containment, there may be several different types of measures implemented. The following information is from the Kaiser Commission on Medicaid and the Uninsured. Some components may differ from data reported directly by the Department.

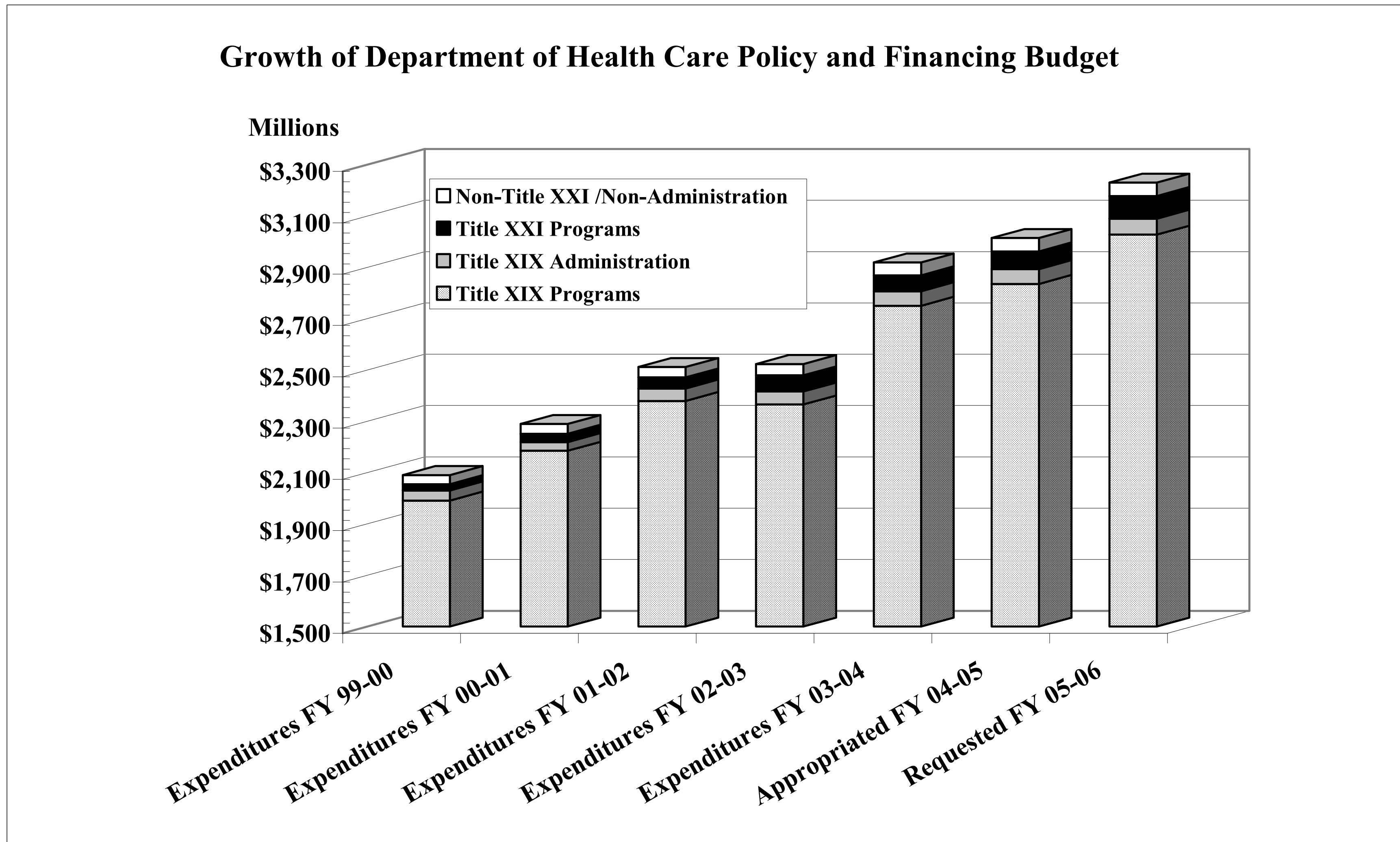
Cost Containment Measure	Colorado	Montana	North Dakota	South Dakota	Utah *	Wyoming *
Provider Payments	X		X		X	
Pharmacy Controls	X	X		X	X	X
Benefit Reductions	X					
Eligibility Cuts **	X		X			
Copayments	X				X	
Disease Management / Case Management	X	X				X
Fraud and Abuse	X					X
Long Term Care ***						X

Source: Kaiser Commission on Medicaid and the Uninsured, *States Respond to Fiscal Pressure: A 50-State Update of State Medicaid Spending Growth and Cost Containment Actions,* pages 15-16, January 2004.
*Additional cuts were made after the beginning of FY 03-04.
** Cuts in eligibility include changes to application and enrollment procedures.
*** Includes reductions in Home and Community Based Services.

C. DEPARTMENT BUDGET

C1. Department Budget Growth and Outlook for FY 04-05 and FY 05-06

Title XXI of the federal Social Security Act is the State Children's Health Insurance Plan (SCHIP), also known in Colorado as Children's Basic Health Plan or Child Health Plan Plus. Title XIX of the Social Security Act is Grants to States for Medical Assistance Programs, better known as the Medicaid program.



Sources: Schedule 3 in the Health Care Policy and Financing November Budget Requests for FY 02-03, FY 03-04, FY 04-05, and FY 05-06 were the source of line item information for the chart and distributed into the four categories.
The Schedule 3s for each budget request year are as follows:
Page 3.0-1 to 3.6-66 submitted November 1, 2001 for FY 99-00 and FY 00-01 Expenditures (Actuals)
Pages D.0-1 to D.5-113 submitted November 3, 2003 for FY 01-02 and FY 02-03 Expenditures (Actuals)
Pages D.0-1 to D.6-84 submitted November 1, 2004 for FY 03-04 Expenditures (Actuals), FY 04-05 Appropriated, and FY 05-06 Requested

D. CLIENTS

D1. 2004 Federal Poverty Levels

The table below reports the federal poverty levels for all states except Hawaii and Alaska from the Department of Health and Human Services, for federal fiscal year 2004.

Federal Poverty Levels for Annual Income

Family Size	100%	120%	133%	135%	150%	175%	185%	200%
1	$9,310.00	$11,172.00	$12,382.30	$12,658.50	$13,965.00	$16,292.50	$17,223.50	$18,620.00
2	$12,490.00	$14,988.00	$16,611.70	$16,861.50	$18,735.00	$21,857.50	$23,106.50	$24,980.00
3	$15,670.00	$18,804.00	$20,841.10	$21,154.50	$23,505.00	$27,422.50	$28,989.50	$31,340.00
4	$18,850.00	$22,620.00	$25,070.50	$25,447.50	$28,275.00	$32,987.50	$34,872.50	$37,700.00
5	$22,030.00	$26,436.00	$29,299.90	$29,740.50	$33,045.00	$38,552.50	$40,755.50	$44,060.00
6	$25,210.00	$30,252.00	$33,529.30	$34,033.50	$37,815.00	$44,117.50	$46,638.50	$50,420.00
7	$28,390.00	$34,068.00	$37,758.70	$38,326.50	$42,585.00	$49,682.50	$52,521.50	$56,780.00
8	$31,570.00	$37,884.00	$41,988.10	$42,619.50	$47,355.00	$55,247.50	$58,404.50	$63,140.00

Source: State Medicaid Directors letter dated February 17, 2004 and published in the Federal Register February 3, 2004

For family units of more than 8 members, add $3,180 for each additional family member.

D2. Regional Demographics and Expenditures

From FY 93-94 to FY 02-03 the Medicaid caseload, without retroactivity included, increased 26%. This expansion can be attributed to a number of factors including: population growth, in-State migration, an aging population, changes in State and federal regulations, and recent economic conditions. However, the effect of these factors is not uniform across geographic regions within the State. For example, in a region where a disproportionate quantity of individuals aged 65 and older reside, long-term care expenditures will be higher. To obtain a better understanding of the within-State variation of medical care, statistical information for each of the State's twenty HIPAA Information Regions was collected.

Demographic data was collected from the United States Bureau of Statistics April 2000 Report for the following statistics:

- Population;
- Percent of Total Colorado Population;
- Percent of Population in the Labor Force;
- Percent of Homes Where a Language Other Than English is Spoken;
- Percent of Families Below Poverty; and
- Percent of Female Headed Households.

Demographic statistics provide valuable insight to the demand for medical care within each region. More populated areas will have a greater demand for medical care. Therefore, a region that is more populated will have higher medical expenditures and caseloads. Likewise, as Colorado's population increases, the demand for medical care will also increase.

The percent of population in the labor force is computed by dividing the number of individuals in the labor force by the total population aged 16 and older. It is important to note that the number of individuals in the labor force is not equal to the population. Generally, the number of individuals in the labor force does not count individuals in the armed forces, institutionalized citizens, individuals below the legal employment age, retirees, and workers that have voluntarily removed themselves from the labor force (such as full time college students). The residual group of individuals is classified as either employed or unemployed. A higher percent of the population in the labor force will result in reduced utilization of State provided medical care.

The percent of homes where a language other than English is spoken is frequently used as a proxy for migration. Migration has a direct affect on the amount of State provided medical care that each region provides. Traditionally, families that migrate into the State do so without employer provided insurance. As the percentage of families that speak a language other than English increases, the demand for Medicaid and participation in the Colorado Indigent Care Program will increase.

Statistics were amassed for the percent of families that are below the poverty level. The United States Census Bureau derives its definition of poverty from the Office of Management and Budget's Strategic Policy Directive 14. This definition of poverty accounts for family size, income, and the age of each family member. As the percentage of families living below poverty increases, the demand for medical care provided by the State will increase.

The percent of female headed households is defined by the United States Census Bureau as a household of two or more persons, with no husband present. While this definition encompasses several different family situations, in general, it accounts for a single income household. As the percentage of female headed households increases, the utilization of State provided medical care may increase.

Medicaid

Using the Department's Business Objects of America database, FY 03-04 Medicaid data was collected for the following statistics and reported for the State in the following table, and reported by county or HIPAA region at Attachment 1 (see section A5 regarding HIPAA Information Regions):

- Medicaid Clients;
- Percent of Regional Population that are Medicaid Clients;
- Medicaid Expenditures; and
- Percent of Total Medicaid Expenditures.

Comparing Medicaid caseload and expenditures across regions demonstrates the variation of Medicaid usage within the State. Some *important caveats* must be mentioned concerning the Medicaid data presented in Attachment 1. Overall Medicaid caseload and expenditure figures by region will not equal the FY 03-04 appropriated or actual amounts. This phenomenon is due to several factors:

1) Medicaid caseload (without retroactivity) for June 2004 of 382,902 clients was retrieved through a system query and will not match exactly to the June 2004 number in the July 28, 2004 Joint Budget Committee report because the data was pulled from a different source in order to obtain regional numbers. This number also does not match the caseload at Exhibit A because the total Medicaid client number here is one month's caseload at a point in time, not an average of all months for FY 03-04.
2) Regional Medicaid expenditures represent actual fiscal year totals for Medical Services Premiums only;
3) Women who are presumed eligible under the State-only Prenatal Program do not receive a county code until they receive full Medicaid eligibility and are not included in the regional caseload or expenditure totals. In FY 03-04, there were 2,936 presumptively eligible women who expended $12,722,914, and these numbers are in the following summary table;
4) $64,262,394 of all Medicaid expenditures are not linked to a unique client identification number since they are either paid to providers as a lump sum payment, or the client is enrolled in the Health Insurance Buy-In program; therefore, these clients and expenditures are in the following summary table, but cannot be reported by region;
5) Expenditures and offsets for Drug Rebates, Consumer Directed Attendant Support, Single Entry Point, and Specialized Medicare Insurance Beneficiaries are not included in the total or by region expenditure amounts by region since they are not processed in the Medicaid Management Information System, and therefore will not match to Exhibit S;
6) Expenditures do not include $100,654 from the row "Other Medical Services" in Exhibit S because they are Colorado Financial Reporting System adjustments; and,
7) Expenditures do not include financial transaction payments made to the Administrative Service Organizations since they are not processed in the Medicaid Management Information System.

Total expenditures presented in this document will not exactly reconcile with the August 16, 2004 Monthly Joint Budget Committee report for FY 03-04 close. The Business Objects of America database extracts data on a different time span than the Computer Output to Laser Disk database. Monthly expenditures reported are derived from the Computer Output to Laser Disk system. It is also important to note that expenditures are presented by region where the provider is located, not by where the client resides.

Children's Basic Health Plan

Using FY 03-04 expenditures and caseload data for the Children's Basic Health Plan, the Department compiled the following data and reported it for the State in the following table, and reported it by county or HIPAA region at Attachment 1 (see section A5 regarding HIPAA Information Regions):

- Number of Children;
- Percent of Regional Population that are Children's Basic Health Plan Clients;
- Children's Basic Health Plan Expenditures; and
- Percent of Total Children's Basic Health Plan Expenditures.

The Children's Basic Health Plan provides medical services to children under age 19, who are at or below 185% of the Federal Poverty Level. The program also provides prenatal care and delivery for adult pregnant women within the same income guidelines. The Prenatal and Delivery program was temporarily suspended in November, 2003; however, a State-only Prenatal and Delivery Program was established to fund the prenatal care and delivery for women who were still enrolled at that time. The estimated number of deliveries for the entire state is presented in the statewide table below. This figure was estimated based on program expenditures and includes $240,448 from the State-only Prenatal Program. The total Children's Basic Health Plan expenditures presented in the statewide table below include: State-only Prenatal Program; Children's Basic Health Plan Premium Costs; Children's Basic Health Plan Dental Benefit Costs; and, Children's Basic Health Plan Administration line items.

Again, some *important caveats* must be mentioned about the statistics presented in Attachment 1:

- The caseload figure in the following summary table represents the average monthly enrollment for FY 03-04, as reported to the Joint Budget Committee Staff on August 16, 2004. To allocate this total across HIPAA regions, the Department obtained several months of distribution of children by county as supplied by the program's eligibility and enrollment administrative contractor. The months were summed then averaged, and a percent of total for each HIPAA region was calculated. The percents were applied to the total in the summary table, to obtain the individual region numbers in Attachment 1.
- Data was not available to allocate the number of deliveries for women in the program across regions in Attachment 1.

- The Department estimated the regional expenditures by dividing the total expenditures in the Schedule 3 (including Children's Basic Health Plan Premium Costs, Dental Benefit Costs, and Administration line but excluding the State-only Prenatal and Delivery Program) by the total caseload (46,694) to create a per capita cost. The per capita cost was then multiplied times the allocated caseload for each region.

Colorado Indigent Care Program

Using the Medically Indigent and Colorado Indigent Care Program Fiscal Year 2002-03 Annual Report, data for the Colorado Indigent Care Program was compiled for the following:

- Number of Colorado Indigent Care Program Providers;
- Colorado Indigent Care Program Expenditures; and
- Percent of Total Colorado Indigent Care Program Expenditures.

The number of Colorado Indigent Care Program providers includes both primary and satellite providers. A primary provider receives payments from the State and then distributes them to any satellite providers it may have. Therefore, Colorado Indigent Care Program expenditures are reported solely by the location of the primary provider.

The Colorado Indigent Care Program partially reimburses qualified providers for uncompensated care they dispense to underinsured and uninsured clients. The Colorado Indigent Care program enrolls clients who have incomes at or below 185% of the Federal Poverty Level and do not qualify for Medicaid or the Children's Basic Health Plan. Colorado Indigent Care Program expenditures only include cash payments made to providers, they do not include Cash Funds Exempt funds. Cash Funds Exempt monies are reported in the appropriation do not represent a cash payment and are strictly an accounting record.
The table below summarizes the demographic, Medicaid, Children's Basic Health Plan, and Colorado Indigent Care Program characteristics for the State. Attachment 1 in this binder reports the same information listed by each Colorado region. Attachment 2 lists the primary and satellite Colorado Indigent Care Program providers by each HIPAA region, to show the geographic distribution of Colorado Indigent Care Program providers across the State.

Colorado's Demographics, Medicaid, Children's Basic Health Plan, and Indigent Care – A Statewide View

Characteristics	State Totals
Demographic Characteristics, 2000	
Population	4,516,847
Percent of Population in the Labor Force	70.13%
Percent of Homes Where Language Other Than English is Spoken	15.08%
Percent of Families Below Poverty	6.20%
Percent of Female Headed Households	8.62%
Medicaid Characteristics, FY 03-04	
Average Number of Medicaid Clients	382,902
Medicaid Expenditures**	$1,847,409,488
Percent of Total Medicaid Expenditures	100%
Children's Basic Health Plan Characteristics, FY 03-04	
Average Number of Children per Month	46,694
Number of Deliveries for Women	151
Children's Basic Health Plan Expenditures*	$61,761,825
Colorado Indigent Care Program Characteristics	
Number of Colorado Indigent Care Program Providers, FY 03-04	151
Colorado Indigent Care Program Expenditures, FY 02-03	$110,881,892

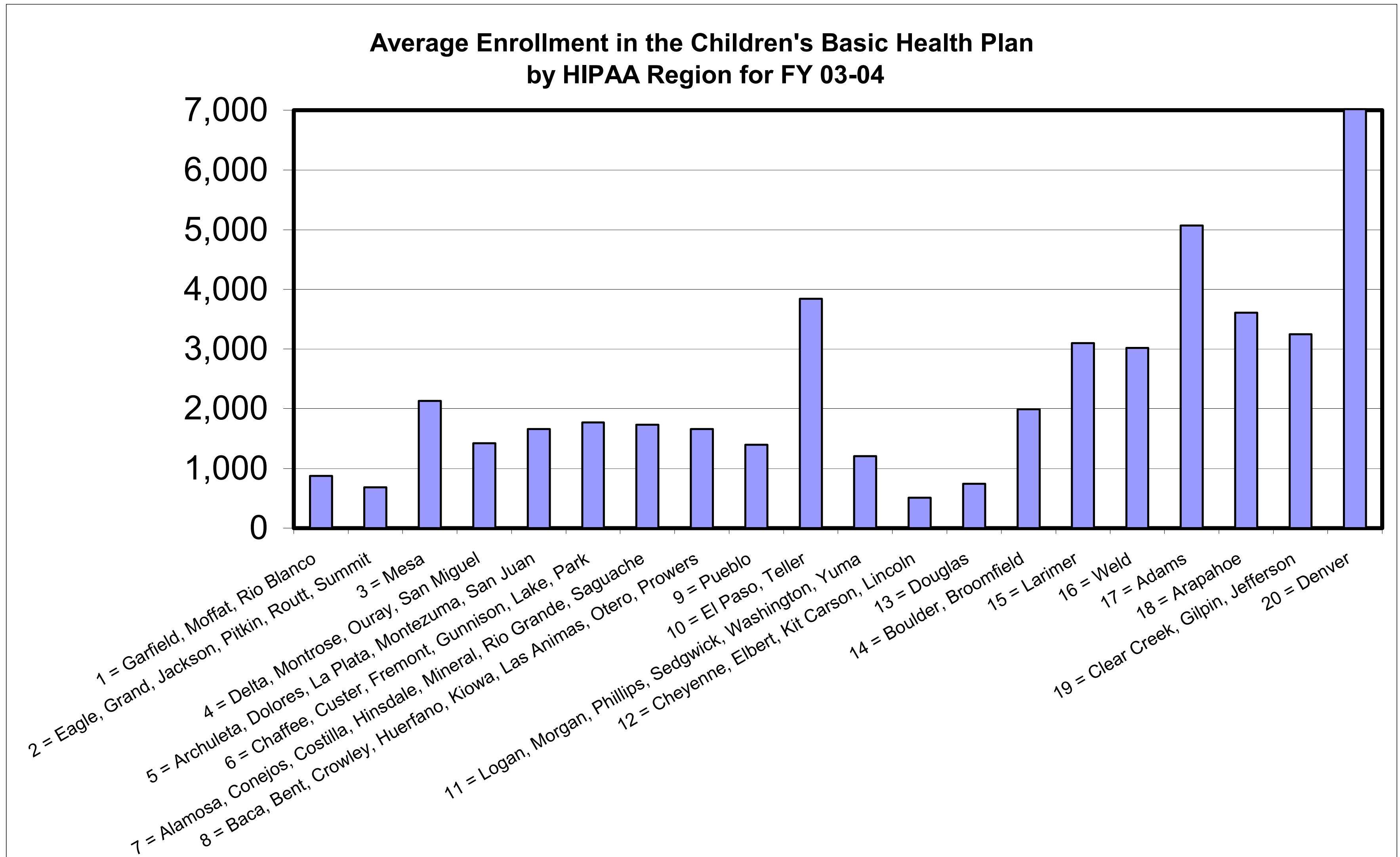
* Includes $240,448 in State-only Prenatal costs that are not broken down by region.
** This number is obtained via the following calculation:

Item	Amount	Source
Total Expenditures from Business Objects of America query of the Medicaid Management Information System	$1,835,685,878	Business Objects of America database extracts with assumptions as described above
Drug Rebate	($53,484,910)	Exhibit S, Colorado Financial Reporting System
Consumer Directed Attendant Support (CDAS)	$3,064,733	Exhibit S, Colorado Financial Reporting System
Single Entry Points	$14,530,561	Exhibit S, Colorado Financial Reporting System
Specialized Medicare Insurance Beneficiaries	$47,613,226	Exhibit S, Colorado Financial Reporting System
Net Result	$1,847,409,488	

The map on the following page also provides some key information by HIPAA Information Region regarding client volume: total population, Medicaid enrollment, and children's enrollment in the Children's Basic Health Plan:

Replace page with HIPAA Region Map 2

D3. Children's Basic Health Plan Enrollment by Region



Source: Affiliated Computer Systems Monthly Deliverables report, July 2003 through June 2004. Figures represent average monthly enrollment for FY 03-04 distributed between regions.

D4. Uninsured Coloradoans

The information in this section was gathered from a study on uninsured Coloradoans by Health Policy Solutions, Inc. Data represents a snapshot of time in 2001.

Methodology and Overview

The Colorado Household Survey (2001) represented the largest and most comprehensive survey to assess health insurance and health care access ever conducted in Colorado. It surveyed about 10,000 households by telephone from August 5 to September 6, 2001. The survey aimed to obtain state and sub-state estimates of the uninsured in Colorado and to describe the uninsured in terms of demographics, health status, and health care utilization patterns. The survey studied sub-state data and trends among insured and uninsured Coloradoans.

Uninsurance Rates by Marketplace

The survey sampled 13 sub-state regions based on health care marketplaces as developed by the Colorado Community Health Network, an agency for federally qualified health centers; Denver County was sampled as its own marketplace. The results for Denver was later added to other metropolitan counties to create a combined Metro Denver marketplace including Denver, Adams, Arapahoe, Clear Creek, and Douglas counties. As a result, the study has 12 marketplaces. Marketplaces were defined as one or more whole counties that are relatively self-contained units with respect to the provision of primary care services; their boundaries also consider hospital access. The first table identifies the marketplaces and their respective rates of uninsurance. As shown, uninsurance estimates in the Western Slope marketplace range from 14 to 20%. Three southwestern regions—San Luis Valley, Western Slope: Central, and Western Slope: South – have rates that are significantly higher than the statewide rate of uninsurance. In addition, population distribution estimates depict where the uninsured live in Colorado by marketplace. The majority of the uninsured live in urban areas.

Uninsurance Rates by Marketplace

Marketplace	Counties in the Marketplace	Uninsurance Rates by Marketplace	Percentage of Uninsured by Marketplace
Boulder	Boulder, Gilpin	10.0%	5.9%
Colorado Springs	El Paso, Elbert, Fremont, Lincoln, Park, Teller	11.3%	14.1%
East	Cheyenne, Kit Carson	12.3%	0.3%
Larimer	Larimer	9.3%	4.6%
Metro Denver	Adams, Arapahoe, Clear Creek, Denver, Douglas, Jefferson	10.3%	43.3%
Mountain	Chafee, Eagle, Grand, Gunnison, Lake, Pitkin, Summit	16.8%	4.4%
Northeast	Logan, Morgan, Phillips, Sedgwick, Washington, Weld, Yuma	15.1%	7.5%
Pueblo/Arkansas Valley	Baca, Bent, Crowley, Custer, Huerfano, Kiowa, Las Animas, Otero, Prowers, Pueblo	14.2%	6.2%
San Luis Valley	Alamosa, Conejos, Costilla, Mineral, Rio Grande, Saguache	17.6%	1.6%
Western Slope/Central	Delta, Mesa, Montrose	17.3%	6.1%
Western Slope/North	Garfield, Jackson, Moffat, Rio Blanco, Routt	14.0%	2.3%
Western Slope/South	Archuleta, Dolores, Hindsdale, La Plata, Montezuma, Ouray, San Juan, San Miguel	20.3%	3.7%
Total			100%

Source: Johnson, Tracy. "Hot Issues in Health Care." Health Policy Solutions, Inc. November 25, 2002

The following table provides estimates, using 2000 sample weights, on more information on Colorado's uninsured population. The information comes from the Current Population Survey (CPS), made available by the U.S. Census Bureau. In recent years, the insurance measurements have been made more accurate with the addition of the "verification question" on the census questionnaire. Also, the Current Population Survey 2002 includes a sample of children to better estimate child insurance rate. The Current Population Survey reports on the prior year's numbers.

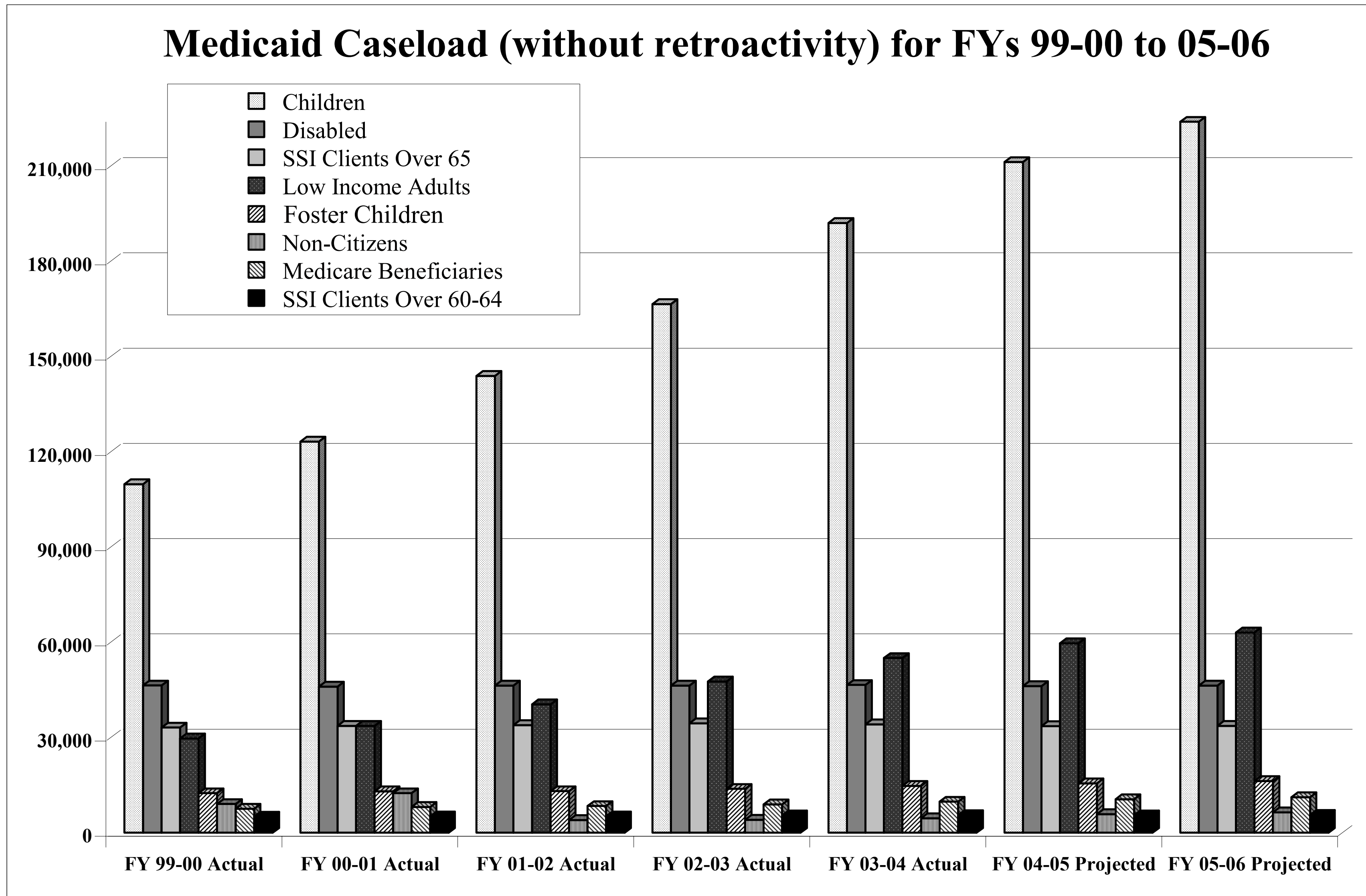
Estimates of Colorado's Uninsured Population

Eligibility Assumptions	Current Population Survey (2000) Year 1999	Current Population Survey (2001) Year 2000	Current Population Survey (2002) Year 2001	Current Population Survey 3-year Merge (2000-2002) Years 1999-2001
Statewide Uninsurance Rate Estimate	15.6%	14.3%	15.6%	15.1%
Statewide Child Uninsurance Rate Estimate	15.6%	14.8%	12.9%	14.3%
Population Counts				
Total Population	4,329,663	4,340,895	4,410,363	4,141,293
Child Population < 19 years	1,232,301	1,197,196	1,239,202	1,222,900
Child Population Excluding Foster Care < 19 Years	1,221,678	1,189,953	1,230,463	1,214,031
Children < 19 Years, < 186% FPL	319,120	351,738	351,107	340,655
Uninsured Children < 19 Years, < 186% FPL	91,394	111,411	89,300	97,368
Children < 19 Years, < 200% FPL	362,866	387,352	377,381	375,866
Uninsured Children < 19 Years, < 200% FPL	107,318	113,656	92,910	104,628
Children < 19 Years, < 250% FPL	500,986	506,446	490,783	499,405
Uninsured Children < 19 Years, < 250% FPL	126,841	136,626	113,928	125,798

Source: Johnson, Tracy. "Hot Issues in Health Care." Health Policy Solutions, Inc. November 25, 2002

D5. Medicaid Caseload for FYs 99-00 to 05-06

The figures below presented include caseload information without retroactivity for FYs 99-00 to 03-04 (FY 04-05 is estimated while FY 05-06 is projected). Retroactivity causes historical adjustments to caseload to account for clients who were found to be eligible for Medicaid for past months, thus increasing the count of persons eligible for Medicaid (even after caseload figures are presented to the Joint Budget Committee monthly). This causes much variability in the reporting of caseload, as monthly caseload is adjusted for months, even years, after the month has passed. Nevertheless, as shown below, eligible children comprise most of the caseload numbers while Supplemental Security Income Adults 65 and older comprise most of the expenditures.

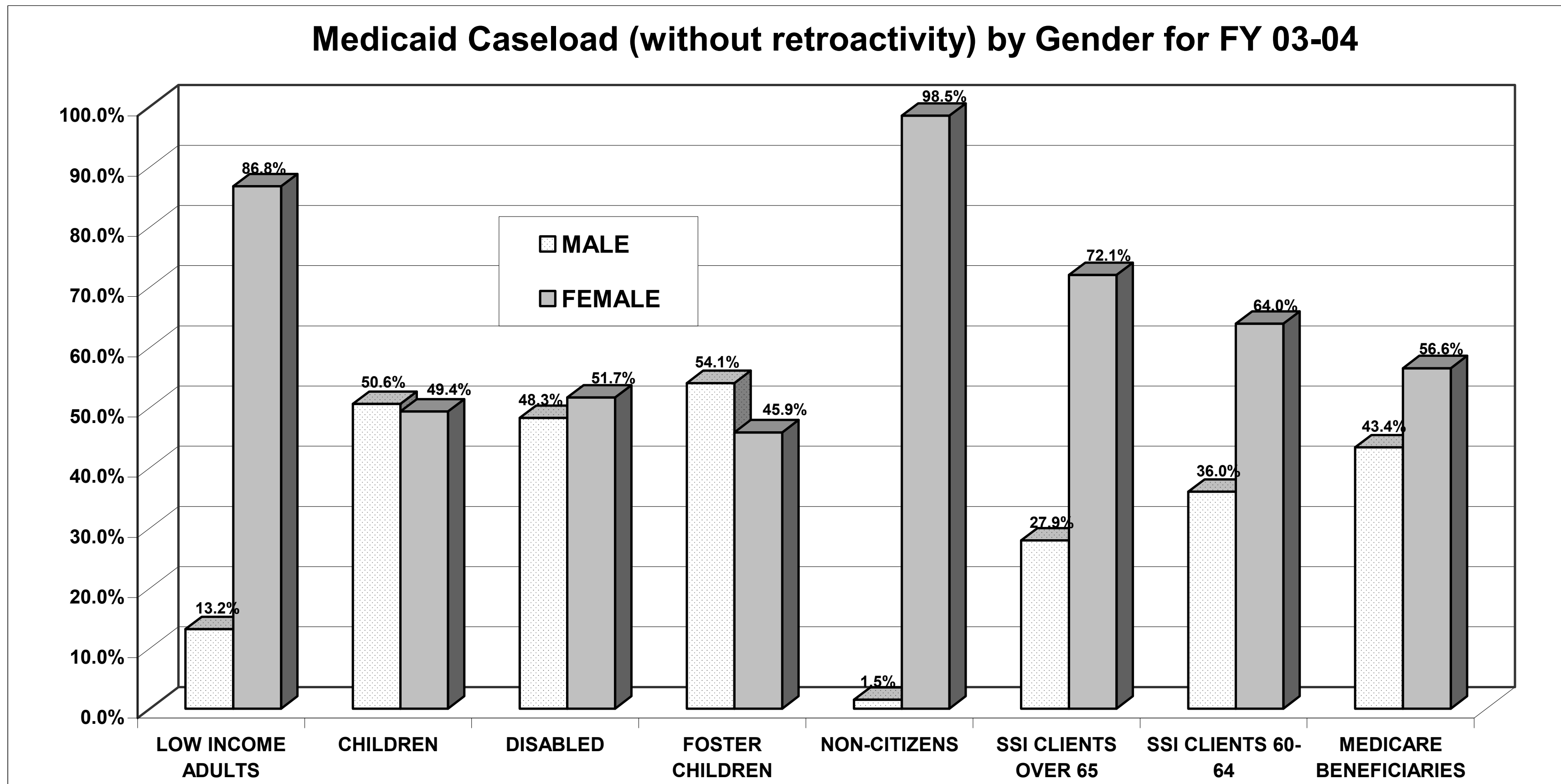


Source: November 1, 2004 Legislative Budget Request, "Exhibit A - Medicaid Caseload Forecast"'

1) Low-income adults include Categorically Eligible Adults, Baby Care Program-Adults, and Breast and Cervical Cancer Treatment Clients
2) Medicare Beneficiaries include Qualified Medicare and Special Low Income clients.

D6. Medicaid Caseload (without Retroactivity) by Gender for FY 03-04

The figure below summarizes caseload by gender without retroactivity for FY 03-04. Data shown is Medicaid caseload (without retroactivity) from June 30, 2004 retrieved through a system query (there were a total of 382,902 clients), and will not match exactly to the July 28, 2004 Joint Budget Committee report number for June 2004 because the data was pulled from a different source in order to obtain gender. This number does not match caseload at Exhibit A because this is one month's caseload, not an average of all months for FY 03-04.



Source: Business Objects of America Query 6/30/04
1) Low-income adults include Categorically Eligible Adults, Baby Care Program-Adults, and Breast and Cervical Cancer Treatment Clients
2) "Medicare Beneficiaries" are Qualified Medicare Beneficiaries and Special Low Income Beneficiaries.

D7. Medicaid Enrollment by Type of Managed Care Provider

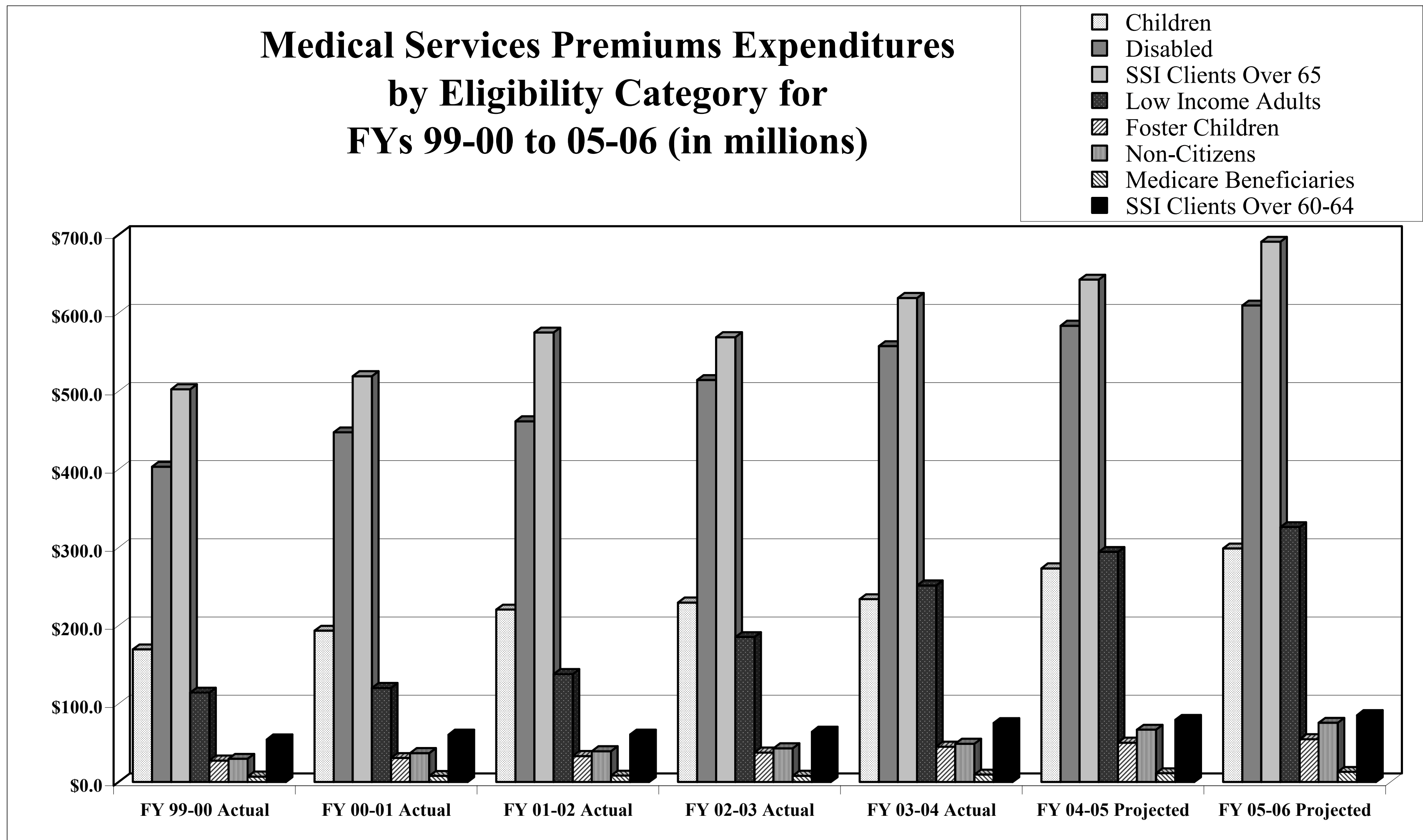
The table below shows the breakdown by client count for FY 99-00 through FY 03-04 for health maintenance organizations, those in the Primary Care Physician Program, those in unassigned via fee-for-service, and those enrolled in administrative service organizations. Health maintenance organizations, administrative service organizations, and Primary Care Physician Program numbers are based on year-to-date averages (for the months of the fiscal year). In addition, health maintenance organizations, administrative service organizations, and Primary Care Physician Program enrollment figures were subtracted from total caseload numbers (without retroactivity) to balance to the fee-for-service enrollment figures. However, this methodology could cause some duplication or fee-for-service to be underrepresented.

Medicaid Enrollment for Fiscal Years 1999-2004

Membership Category	FY 99-00 Count	FY 00-01 Count	FY 01-02 Count	FY 02-03 Count	FY 03-04 Count
Health Maintenance Organizations	90,505	112,824	135,518	126,669	74,439
Primary Care Physician Program	50,412	52,214	54,086	65,475	68,557
Administrative Service Organization	N/A	N/A	N/A	N/A	12,380
Fee-for-Service	112,337	110,361	105,809	135,251	207,155
TOTALS	**253,254**	**275,399**	**295,413**	**327,395**	**362,531**

Sources:
Health maintenance organization, administrative service organizations, and Primary Care Physician Program enrollment numbers are from the Managed Care Enrollment Report and are based on year-to-date averages (for the months of the fiscal year).
November 2003 was the first round of Primary Care Physician Program disenrollments due to contracts not being returned by physicians. This occurred again during May and June of 2004.
Enrollment totals are from the November 1, 2004 Budget Request, Exhibit A, page E.A-1. Numbers are an average of the fiscal year's caseload for each month, without retroactivity, instead of a point in time. Fee-for-Service enrollment is derived by the total enrollment minus enrollment in the health maintenance organizations, administrative service organizations, and the Primary Care Physician Program. The FY 03-04 total in this table and in Exhibit A differ from the FY 03-04 Monthly Report to the Joint Budget Committee dated July 28, 2004 due to rounding.

D8. Historical Medicaid Expenditures by Eligibility Category

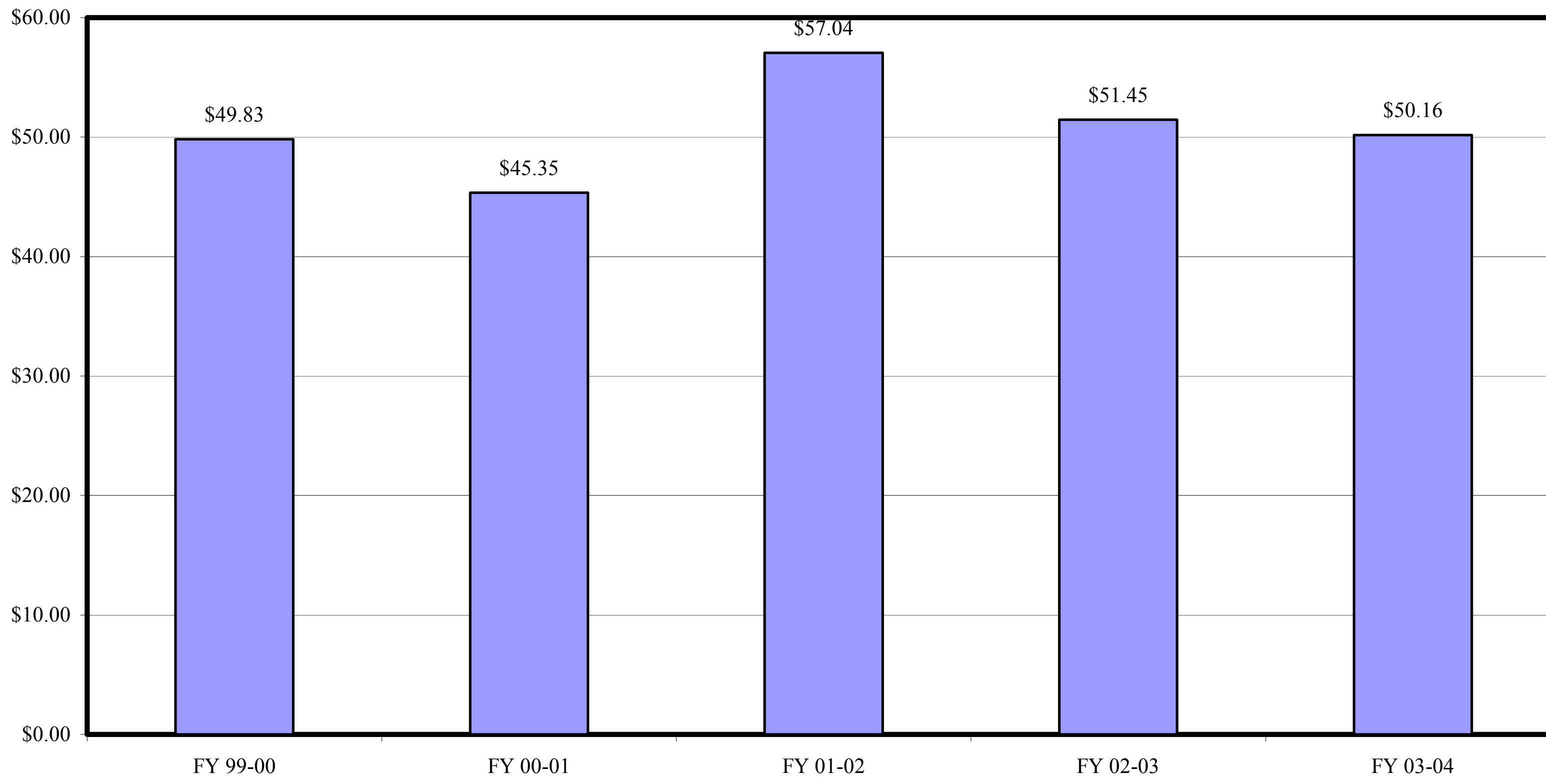


Source: November 1, 2004 Budget Request, “Exhibit S - Cashed Based Actuals,” page 18 and “Exhibit O - Summary of Request by Service Group,” page 2
1) Low-income adults include Categorically Eligible Adults, Baby Care Program-Adults, and Breast and Cervical Cancer Treatment Clients
2) Medicare Beneficiaries include Qualified Medicare Beneficiaries and Special Low Income Beneficiaries.
3) Expenditures include “Medical Services Premiums” only. FY 05-06 Projected does not include Decisions Items #11 or #12.
4) Totals exclude Upper Payment Limit financing.

D9. Medicaid Management Information Systems – Average Cost per Client

The following tables estimate two of the caseload-relevant administrative costs (Medicaid Management Information System and Medical Identification Cards) against the numbers of clients to illustrate a rough cost per client. This table includes Medicaid clients and client in the Old Age Pension State Medical Program.

Medicaid Management Information System Average Expenditure per Caseload Client

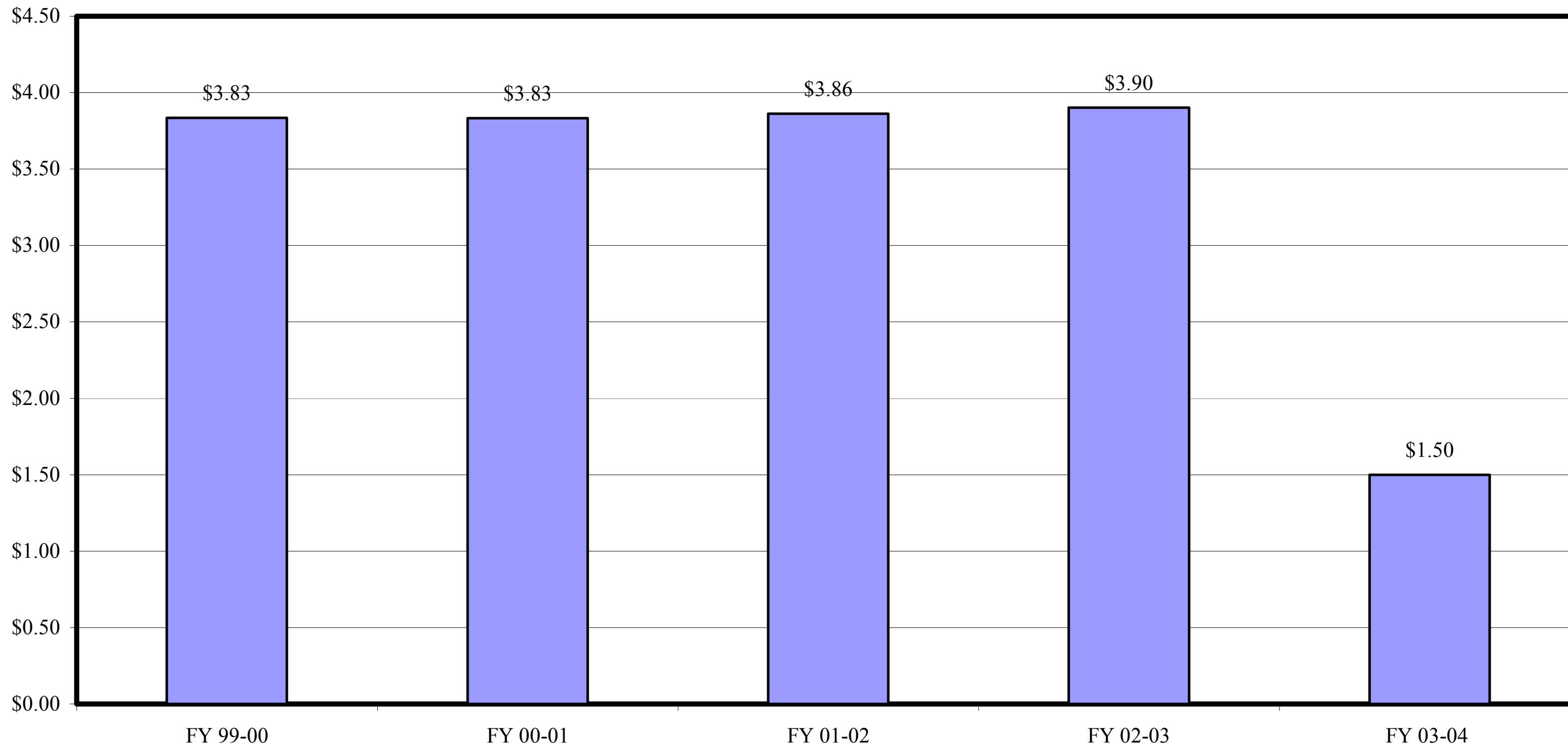


Sources:
Actual Expenditures for FY 99-00 and FY 00-01 from Schedule 3 submitted November 1, 2001. Actual Expenditures for FY 01-02 and FY 02-03 from Schedule 3 submitted November 3, 2003. Actual Expenditures for FY 03-04 from Schedule 3 submitted November 1, 2004.
Medicaid Caseload from Exhibit A submitted November 1, 2004.
Old Age Pension State Medical Caseload from Business Objects America query.

D10. Medical Identification Cards – Average Cost per Client

The average administrative cost per client for medical identification cards decreased significantly starting in FY 03-04 when the Department moved from monthly paper "cards" to one-time (with replacements) plastic cards. This table includes Medicaid clients and client in the Old Age Pension State Medical Program.

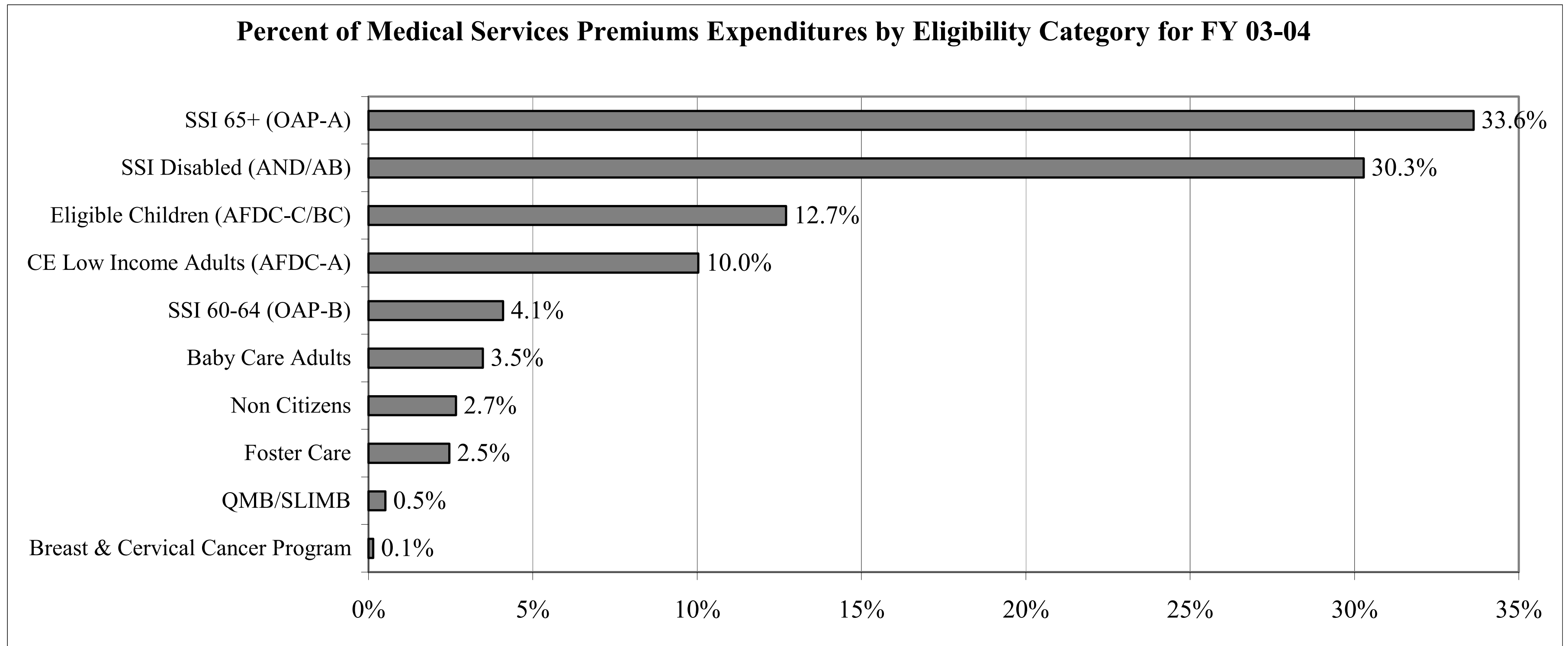
Medical Identification Card Average Expenditure per Caseload Client



Sources:
Actual Expenditures for FY 99-00 and FY 00-01 from Schedule 3 submitted November 1, 2001. Actual Expenditures for FY 01-02 and FY 02-03 from Schedule 3 submitted November 3, 2003. Actual Expenditures for FY 03-04 from Schedule 3 submitted November 1, 2004.
Medicaid Caseload from Exhibit A submitted November 1, 2004.
Old Age Pension State Medical Caseload from Business Objects America query.

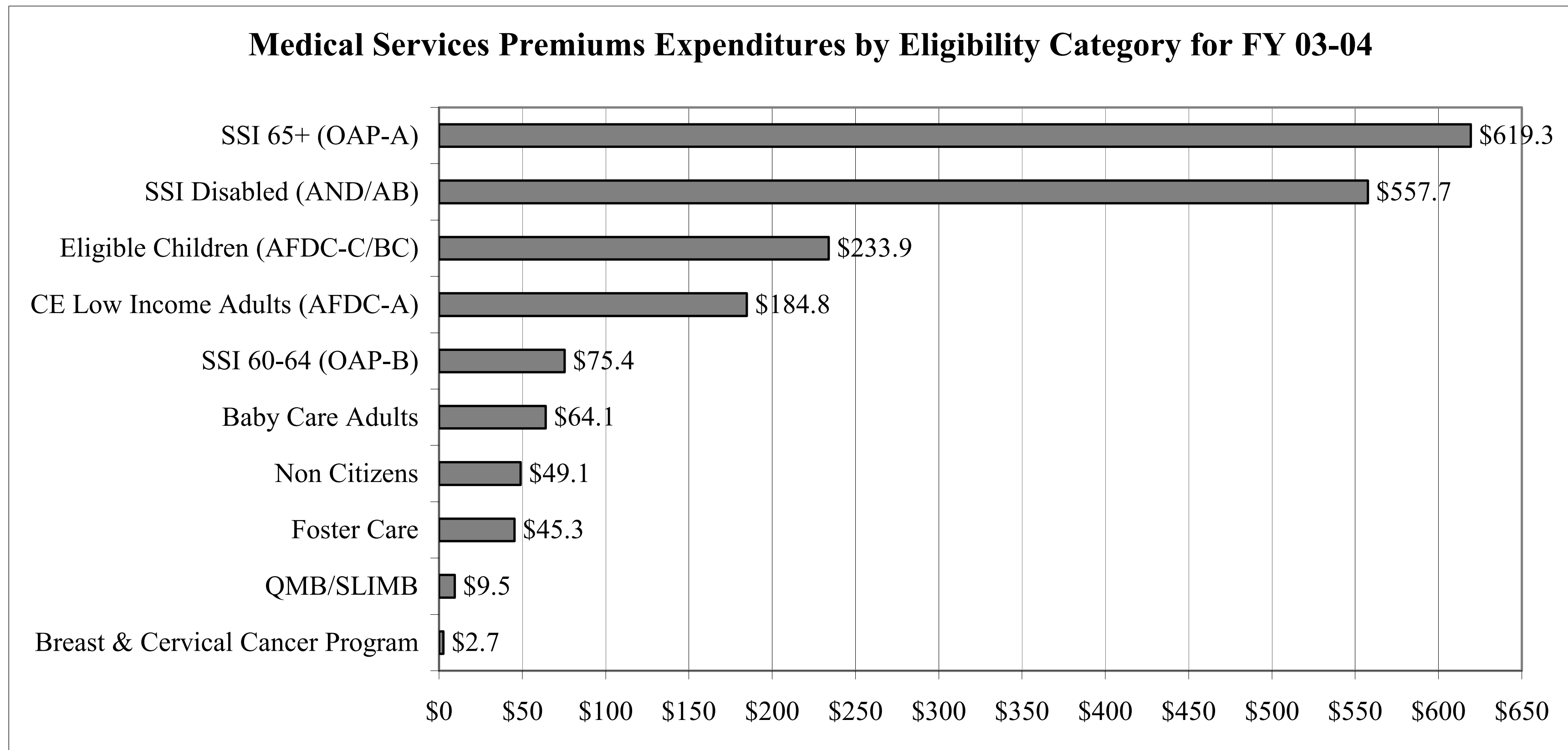
D11. Percent of Medical Services Premiums Expenditures by Eligibility Category

The next figures show the percent of Medicaid expenditures by eligibility category for FY 03-04.



Source: November 1, 2004 Budget Request, “Exhibit S - Cashed Based Actuals,” page 18
Notes:
1) SSI 65+ (OAP-A) = Supplemental Security Income for persons 65 years of age or older (Old Age Pension Group A).
2) SSI Disabled (AND/AB) = Supplemental Security Income for Disabled Individuals (Aid to the Needy Disabled and Aid to the Blind).
3) Eligible Children (AFDC-C/BC) = Eligible Children (Aid to Families with Dependent Children – Children, and Baby Care Children).
4) CE Low Income Adults (AFDC-A) = Categorically Eligible Low Income Adults (Aid to Families with Dependent Children - Adults).
5) SSI 60-64 (OAP-B) = Supplemental Security Income for disabled persons 60-64 years of age (Old Age Pension Group B).
6) QMB/SLIMB = Qualified and Special Low Income Medicare Beneficiaries.
7) Expenditures include “Medical Services Premiums” only.
8) Percentages exclude Upper Payment Limit financing.

D12. Medical Services Premiums Expenditures by Eligibility Category



Source: November 1, 2004 Legislative Budget Request, "Exhibit S - Cashed Based Actuals," page 18

Notes:

1) SSI 65+ (OAP-A) = Old Age Pension A - Supplemental Security Income for persons 65 years of age or older.
2) SSI Disabled (AND/AB) = Supplemental Security Income Disabled (Aid to the Needy Disabled/Aid to the Blind).
3) Eligible Children (AFDC-C/BC) = Eligible Children (Aid to Families with Dependent Children - Children/Baby Care Children).
4) CE Low Income Adults (AFDC-A) = Categorically Eligible Low Income Adults (Aid to Families with Dependent Children - Adults).
5) SSI 60-64 (OAP-B) = Old Age Pension B - Supplemental Security Income for disabled persons 60-64 years of age.
6) QMB/SLIMB = Qualified Medicare Beneficiaries and Special Low Income Medicare Beneficiaries.
7) Expenditures include "Medical Services Premiums" only.
8) Totals exclude Upper Payment Limit financing.

D13. What Medicaid Clients Drive 75% of the Medicaid Budget?

Increasing Medicaid spending is a source of budget pressure for all of the fifty states. Colorado, with its challenging budgetary environment is no exception, as the Medicaid program is the second largest consumer of General Fund. A remarkably large percentage of the rapidly growing Medicaid program is incurred on behalf of a relatively small group of people. The expenditure patterns and demographics of this group of high expenditure clients are detailed in the following analysis.

Summary of Demographic Statistics:

A. This group of high cost clients was responsible for 75% of total Medicaid expenditures in FY 03-04.
B. 75% of all Medicaid expenditures equaled $1.71 billion in FY 03-04 (including Medical Services Premiums, Primary Care Physician Program Market Rate Reimbursement, Public School Health Services, mental health, and Department of Human Services Medicaid funding)
C. This group comprised only 13.3% of the clients for whom claims were paid in FY 03-04.
D. The least expensive person among this costly group of clients incurred $7,213 in Medicaid cost for the year.
E. The most expensive person among this costly group of clients incurred $1,008,252 in Medicaid cost.
F. The Mean Medicaid payment for these high cost clients equaled $26,172.
G. The Median Medicaid payment for this group equaled $16,243
H. Of these 65,367 clients that drove 75% of Medicaid expenditures:
   - 44,824 of these clients were disabled clients and clients over 65
   - Those 44,824 disabled and elderly clients drove $1.322 billion of the $1.71 billion for high expenditure clients in FY 03-04

Important Note:

Claims analysis includes $2.281 billion from the Department's decision support system, Business Objects of America. These claims are records of FY 03-04 expenditures made from a variety of departmental Long Bill line items. These line items include Medical Services Premiums, Primary Care Physician Program Market Rate Reimbursement, SB 97-101 Public School Health Services, Mental Health Capitation, Goebel Lawsuit, Mental Health Fee For Service Payments, Mental Health Institutes, High Risk Pregnant Women Program, Community Services (Developmentally Disability Waiver), Regional Centers, Division of Youth Corrections, and Children's Mental Health Services- Residential Treatment for Youth.

The total dollars from this claims analysis does not include a variety of adjustments that are found in the Colorado Financing Reporting System, such as Upper Payment Limit financing, Estate Recovery, Income Trust payments, Specialized Medicare Insurance Beneficiaries, Single Entry Points, Health Maintenance Organization Litigation Settlements, Tort and Casualty Recoveries, Fraud and Abuse Recoveries, and other Colorado Financing Reporting System-only offline payments.

Dual Eligibility Statistics for the High Expenditure Population:

- 25,961 (or 41%) of the high-expenditure clients were dually eligible in both Medicare and Medicaid
- These clients accounted for $823.25 million (48%) of the expenditures for the high-expenditure clients
- Drug expenditures for this group equal $76.07 million

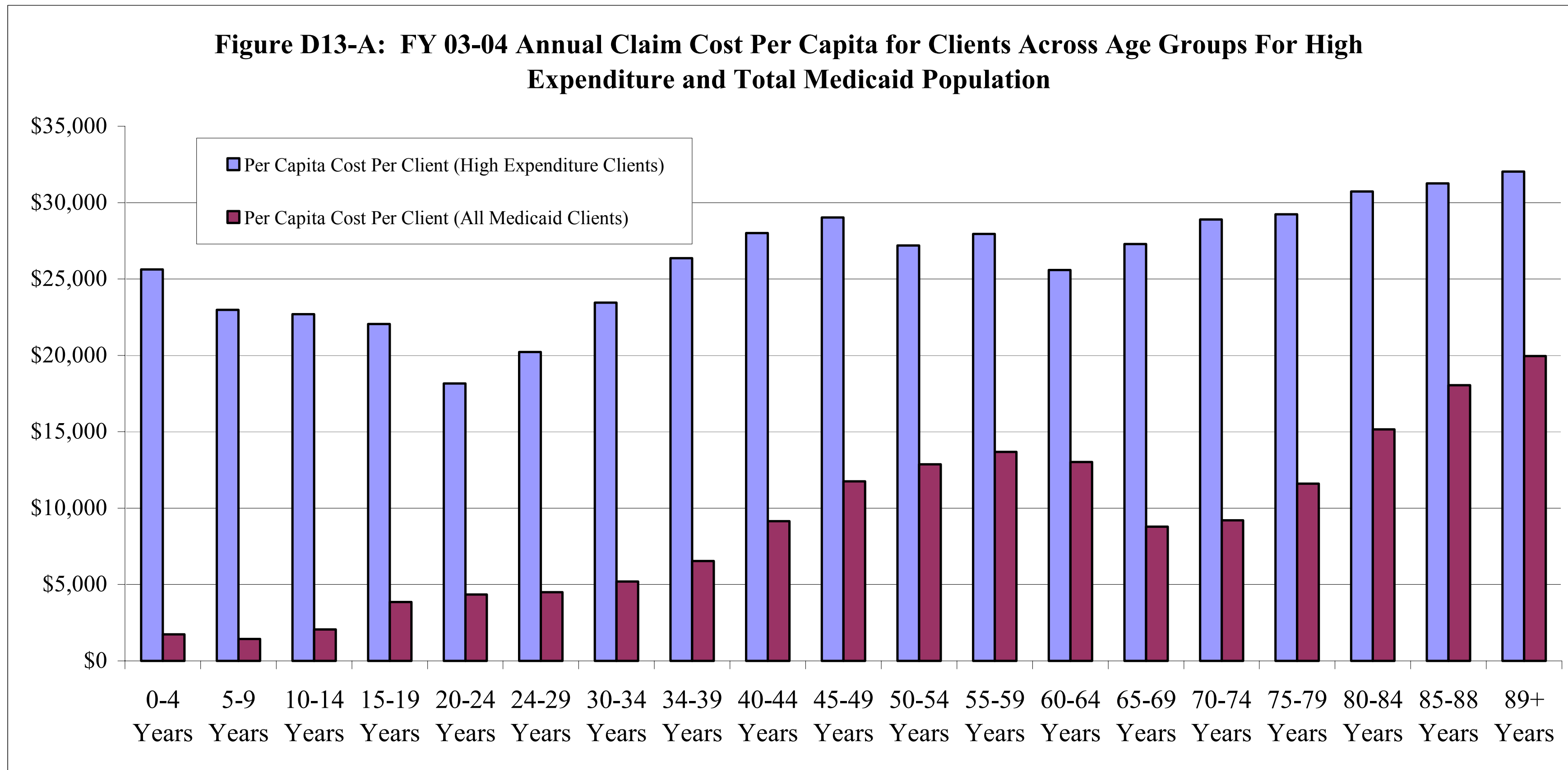
These statistics demonstrate that even though Medicare pays much of the medical services for these clients, Medicaid incurs a substantial cost. Although drug expenditures for this group are high, they are proportionate to this group's total Medicaid cost.

The expenditures for high expenditure clients by mean age are also broken into quartiles in the following table. The graph that follows illustrates that as expenditures increase the number of clients decrease with no consistent pattern across mean age. This provides initial evidence that there is not a strong correlation between age and expenditures among this population of high expenditure clients. The graph also provides additional evidence that the cost experience of the high expenditure group is markedly different from the Medicaid population as a whole.

FY 03-04 High Expenditure Clients Partitioned into Quartiles Based on Per Capita Expenditure

Quartile	Expenditure Range	Number of Clients	Mean Age
Top	$57,930 - $1,008,252	5,046	45.76 (45 years and 9 months)
Second	$43,119-$57,929	8,422	58.54 (58 years and 6 months)
Third	$19,799-$43,117	14,346	56.23 (56 years and 3 months)
Bottom	$7,213-$19,798	37,553	40.65 (40 years and 8 months)

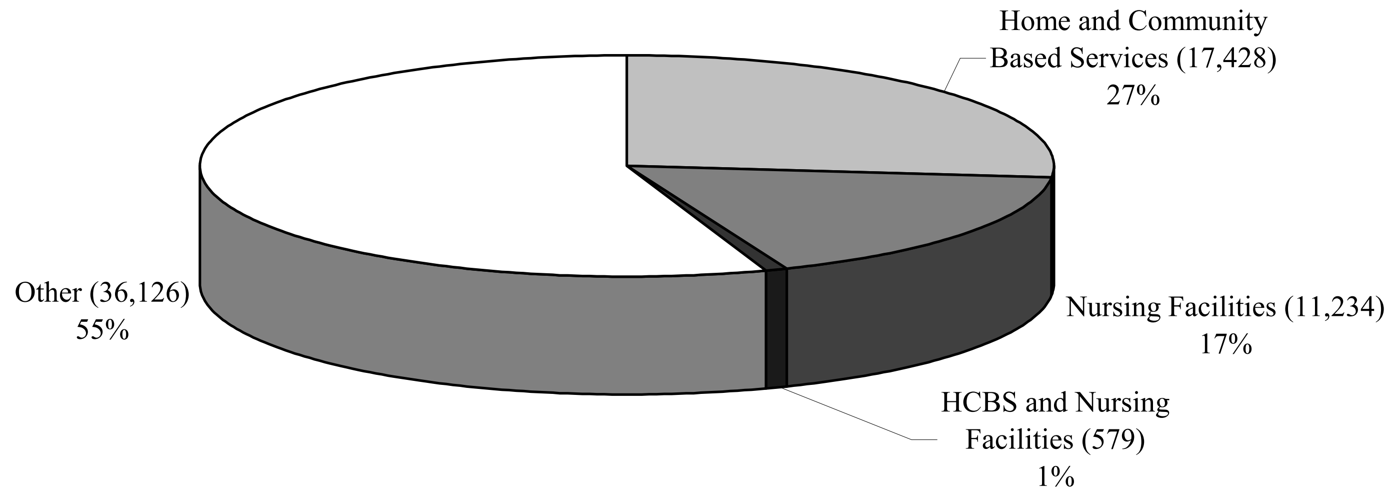
Source: Business Objects of America Query 9/13/2004



Source: Business Objects of America Query 8/16/2004, updated 10/7/2004
Note: Medicaid expenditures by client's age as of first date of service. Per capita totals include all Medicaid claims, including Medical Services Premiums, Medicaid mental health services, Department of Human Services Medicaid expenditures, Primary Care Physician Program Incentive Fee, and School Based Services.

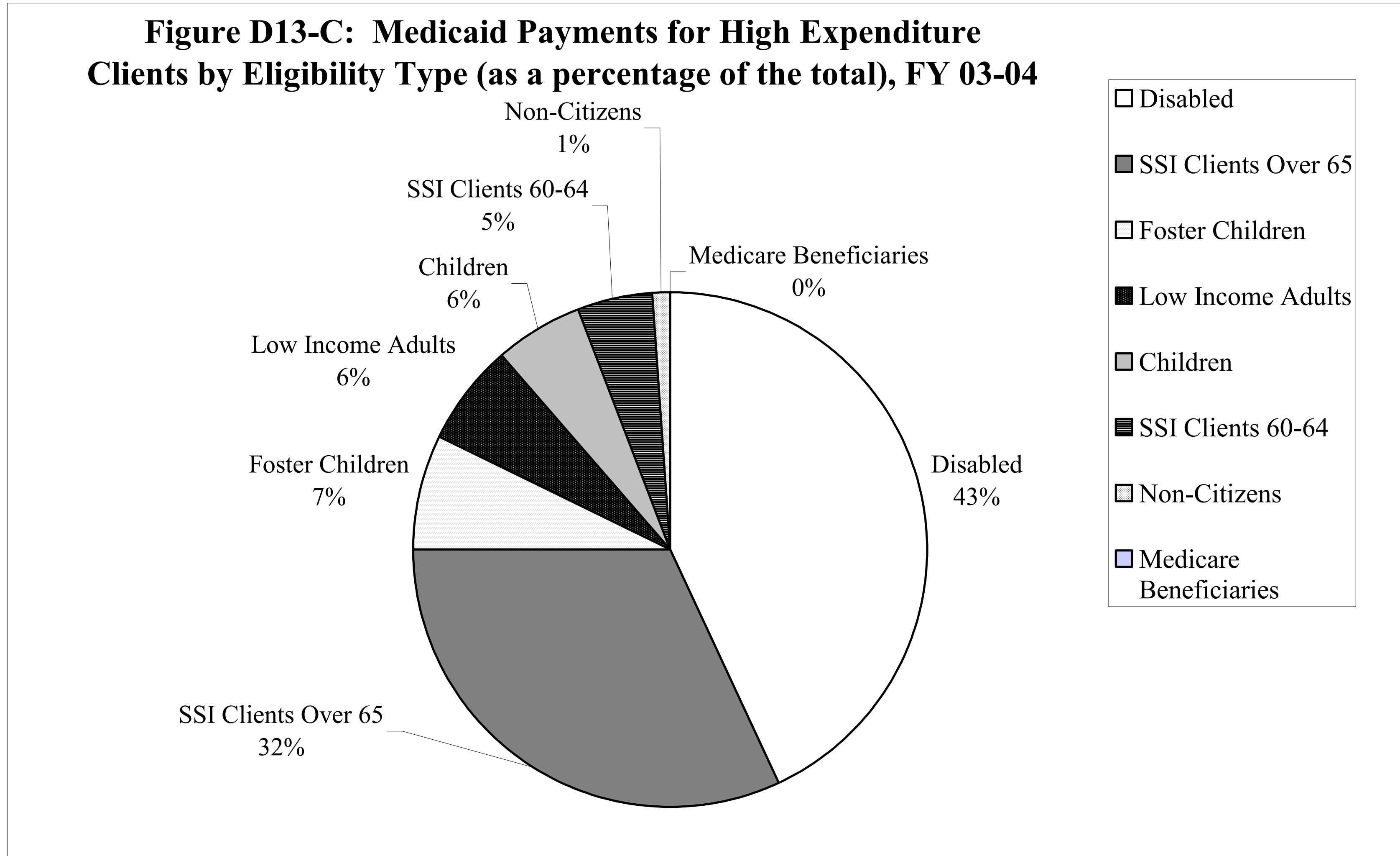
The following data shown in Figure D.13-B shows that almost 45% of all high expenditure clients were on Home and Community Based Services or received services via nursing facilities.

Figure D13-B: High Expenditure Clients Counts by Home and Community Based Services and Nursing Facilities
(some clients counted in more than one category)



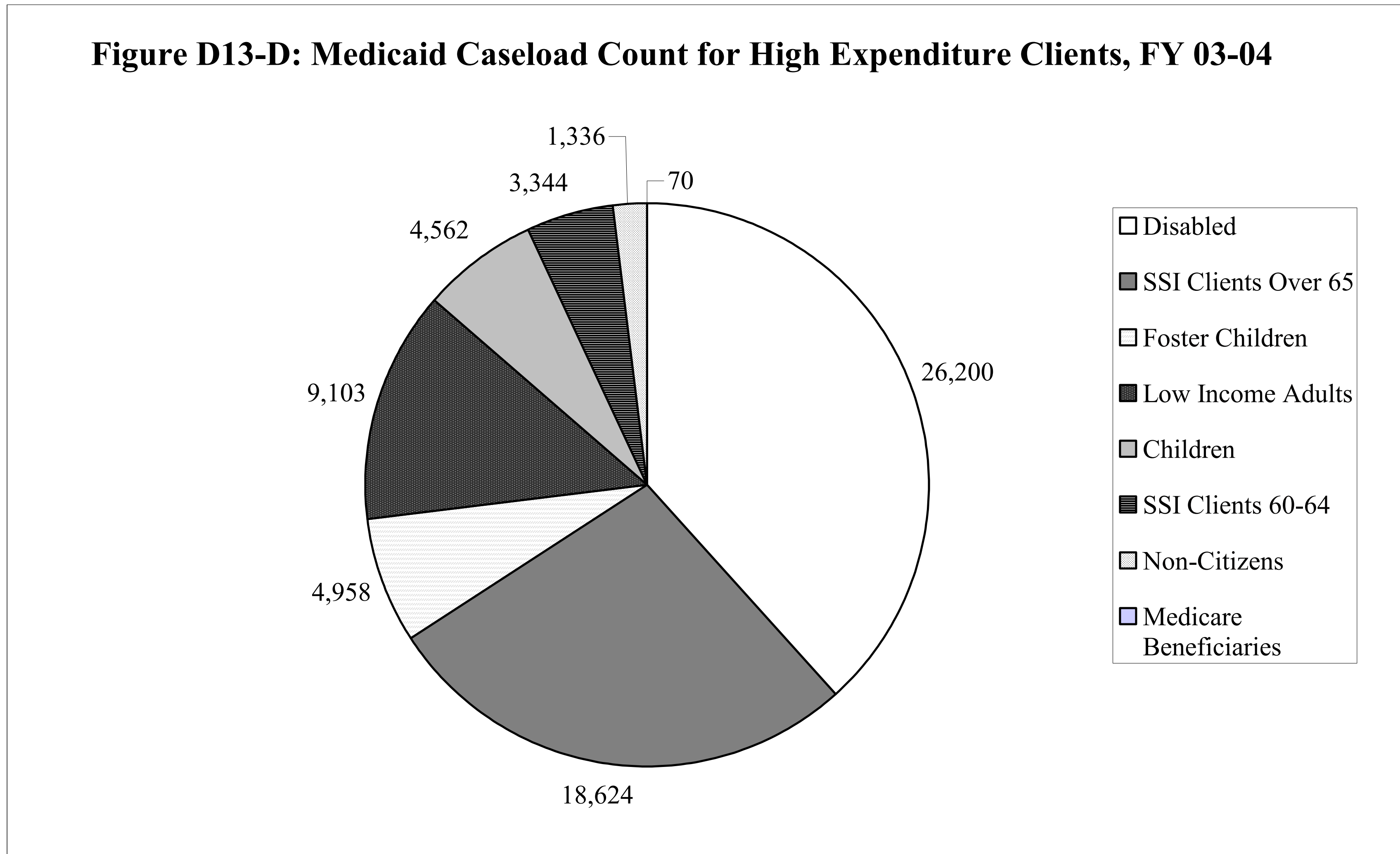
Source: Updated Business Objects of America Query 9/10/2004
1) HCBS data is built from and based on organization codes that define "Home and Community Based Services."
2) Nursing facility data is built from and based on organization codes that define "Class 1 Nursing Homes."
3) Limited numbers of clients were in both the Home and Community Based Services program and nursing facilities -- client counts are duplicated.

Figure D.13-C shows that the majority of expenditures for the high expenditure clients are in the Supplemental Security Income Disabled (AND/AB) and Supplemental Security Income Clients Over 65 (OAP-A) eligibility categories.



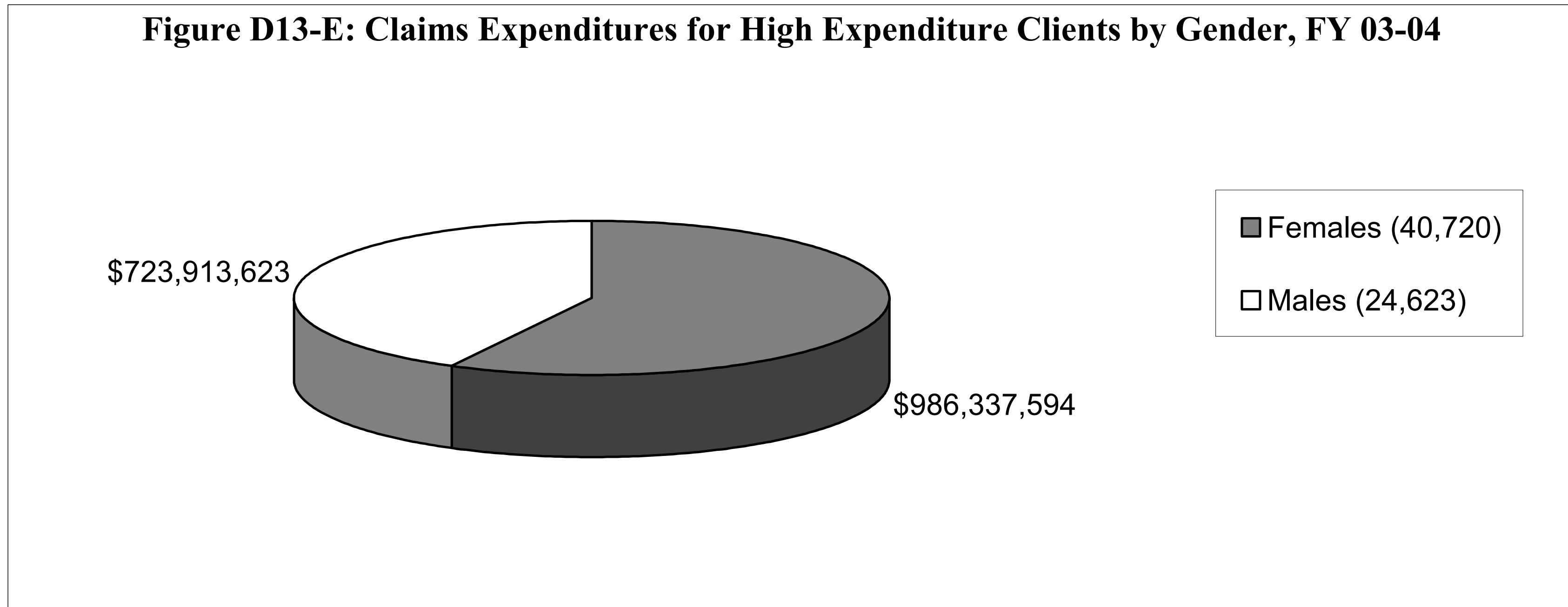
Source: Business Objects of America Query 8/17/2004
Low-income adults include Categorically Eligible Adults, Baby Care Program-Adults, and Breast and Cervical Cancer Treatment Clients
Medicare Beneficiaries include Qualified Medicare Beneficiaries and Special Low Income Beneficiaries.

Figure D.13-D is consistent with the previous figure. Not only do the Supplemental Security Income Disabled and Supplemental Security Income Over 65 clients comprise the majority of expenditures, they comprise the majority of caseload as well.



Source: Business Objects of America Query 8/17/2004
Low-income adults include Categorically Eligible Adults, Baby Care Program-Adults, and Breast and Cervical Cancer Treatment Clients
Medicare Beneficiaries include Qualified Medicare Beneficiaries and Special Low Income Beneficiaries.

Figure D.13-E shows that women comprised almost two-thirds of the total number of clients, accounting for $986 million of the $1.71 billion of Medicaid claims for high expenditure clients. Although females make up 62% of this population, they account for only 58% of expenditures.



Source: Business Objects of America Query 8/16/2004

Methodology

In order to examine the characteristics of high expenditure clients, the following methodology was used. First, data were queried from Business Objects of America on Medicaid clients for FY 03-04 based on header adjudicated and line item adjudicated Medicaid claims. These claims include:

- Capitation
- Crossovers
- Dental
- EPSDT (Early and Periodic Screening, Diagnosis, and Treatment for clients up to age 21)
- Financial Transaction

- Home and Community Based Services Waiver
- Home Health
- Independent Laboratory
- Inpatient Services
- Medical Supply
- Nursing Facilities
- Outpatient Services
- Pharmacy
- Practitioner/Physician
- Transportation

Second, the data were analyzed for the following Medicaid caseload categories:

- SSI 65+ (OAP-A): Old Age Pension A - Supplemental Security Income for persons 65 years of age or older
- SSI 60-64 (OAP-B): Old Age Pension B - Supplemental Security Income for disabled persons 60-64 years of age
- SSI Disabled (AND/AB): Supplemental Security Income Disabled (Aid to the Needy Disabled/Aid to the Blind)
- CE Low Income Adults (AFDC-A): Categorically Eligible Low Income Adults (Aid to Families with Dependent Children - Adults)
- Breast and Cervical Cancer Program
- Eligible Children (AFDC-C/BC): Eligible Children (Aid to Families with Dependent Children - Children/Baby Care Children)
- Foster Care
- Baby Care Adults
- Non-Citizens
- QMB/SLIMB: Qualified Medicare Beneficiaries and Special Low Income Medicare Beneficiaries

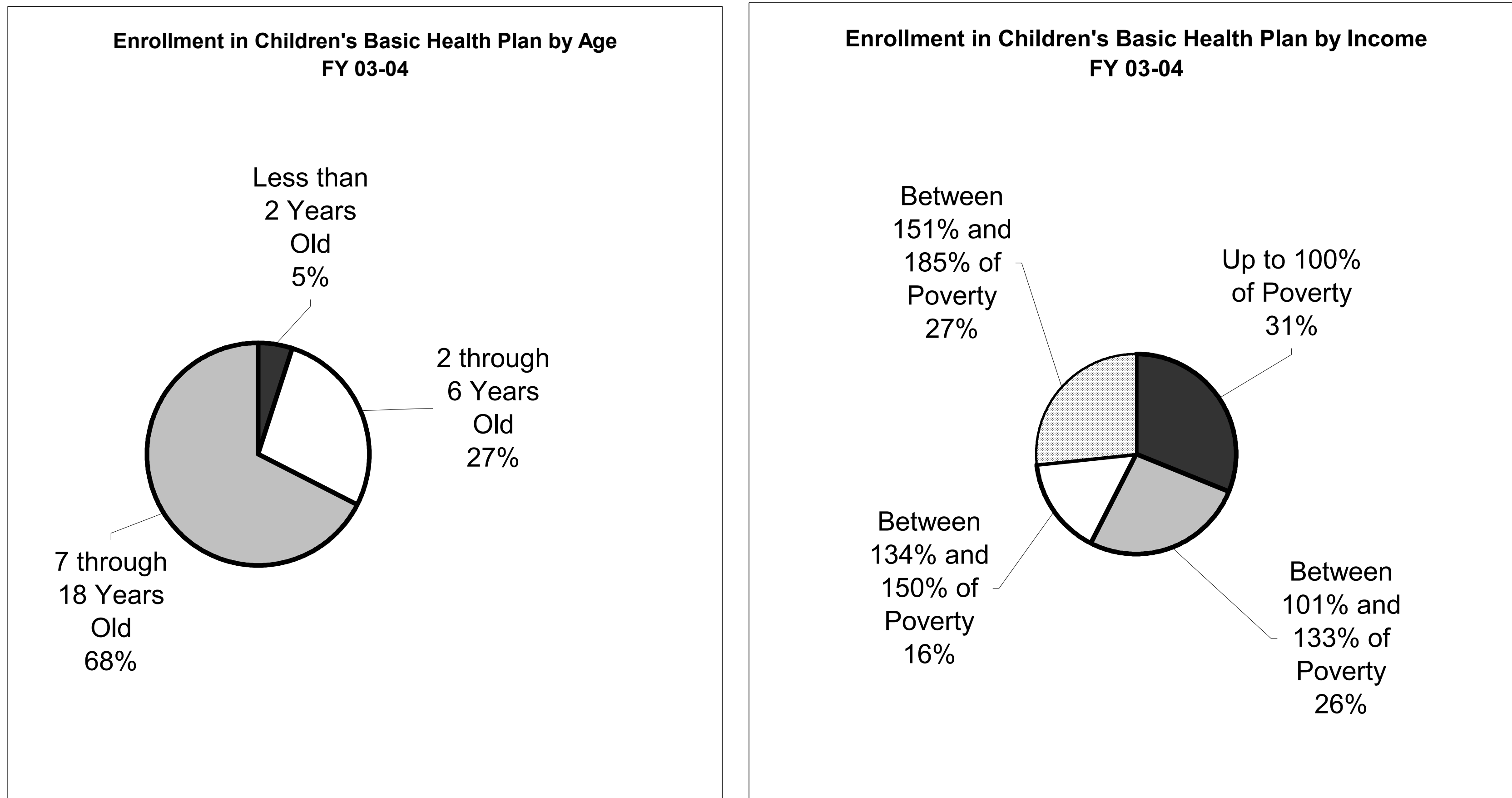
Third, it should be noted that because of cash accounting payments made in FY 03-04, the data includes some clients eligible for services in FY 02-03 and FY 03-04. As a result, and based on the above caseload categories, total Medicaid payments of $2.281 billion[6] were grouped by each unique client. This results in the true total payment made per client for the FY 03-04 time span. The data was then sorted by payment amount in descending order.

[6]This amount includes all Medicaid services costs, including Medical Services Premiums, Primary Care Physician Program Market Rate Reimbursement, SB 97-101 Public School Health Services, Mental Health Capitation, Goebel Lawsuit, Mental Health Fee For Service Payments, Mental Health Institutes, High Risk Pregnant Women Program, Community Services (Developmentally Disability Waiver), Regional Centers, Division of Youth Corrections, and Children's Mental Health Services - Residential Treatment for Youth.

Fourth, 24 clients were excluded from the high-expenditure clients because they had multiple categories for gender.

Finally, 2,830 clients were included who were enrolled in more than one eligibility category during the time period, resulting in a double counting of these clients. Therefore, 4.53% of all high expenditure clients are due to double counting.

D14. Children's Basic Health Plan Enrollment by Age and Family Income



Source: Figures are based on May 2004 enrollment data extracted from the September 2004 Affiliated Computer Systems' Monthly Deliverables report.

E. SERVICES

E1. A 15 Year History of Medicaid

History of Medicaid Expenditures Including Federal Financing

Fiscal Year	Total Expenditures	% Change	General Fund	% Change	Cash Funds and Cash Fund Exempt	% Change	Federal Funds	% Change	Number of Medicaid Eligibles	% Change
FY 95-96	$1,420,081,416	N/A	$680,610,132	N/A	$0	N/A	$739,471,285	N/A	254,083	N/A
FY 96-97	$1,505,946,527	6.05%	$722,567,868	6.16%	$5,654	100.00%	$783,373,005	5.94%	250,098	-1.57%
FY 97-98	$1,591,279,319	5.67%	$750,200,151	3.82%	$21,081,302	**	$819,997,866	4.68%	238,594	-4.60%
FY 98-99	$1,720,981,562	8.15%	$762,316,089	1.62%	$47,249,810	124.13%	$911,415,663	11.15%	237,598	-0.42%
FY 99-00	$1,960,855,915	13.94%	$905,445,127	18.78%	$77,075,188	63.12%	$978,335,601	7.34%	253,254	6.59%
FY 00-01	$2,158,496,868	10.08%	$977,460,249	7.95%	$109,112,804	41.57%	$1,071,923,815	9.57%	275,399	8.74%
FY 01-02	$2,347,333,097	8.75%	$1,031,029,536	5.48%	$141,249,660	29.45%	$1,175,053,901	9.62%	295,413	7.27%
FY 02-03*	$2,320,339,164	-1.15%	$972,304,078	-5.70%	$171,220,419	21.22%	$1,176,814,667	0.15%	327,395	10.83%
FY 03-04	$2,660,900,623	14.68%	$1,107,668,382	13.92%	$153,512,197	-10.34%	$1,399,720,044	18.94%	362,531	8.78%

Sources: Colorado Financial Reporting System based on String Query Language queries in August 2004; Medicaid Eligibles from Exhibit A, November 1, 2004, page E.A-1.

* Includes one-time savings for change to cash based accounting for Medicaid Premiums.

**FY 97-98 is the first year the Disproportionate Share Hospital cap was established ($19.986 million) and the first year of School Based Health ($1.087 million), thus there is 372,756.42% increase over FY 96-97. Total Expenditures include all Medicaid Program costs: Medical Services Premiums, Department of Human Services, School Health Services, Primary Care Physician Program Incentive Fee, Disproportionate Share Hospital and Indigent Care payments (now Safety Net Provider Payments), and Family Medical Residency Training.

Total Expenditures excludes Medicaid Administrative costs and State-only Programs.

Medicaid Eligibles caseload is an average of all months for FY 03-04, without retroactivity.

E2. Paid Medicaid Claims Expenditures across Age Groups for FY 03-04

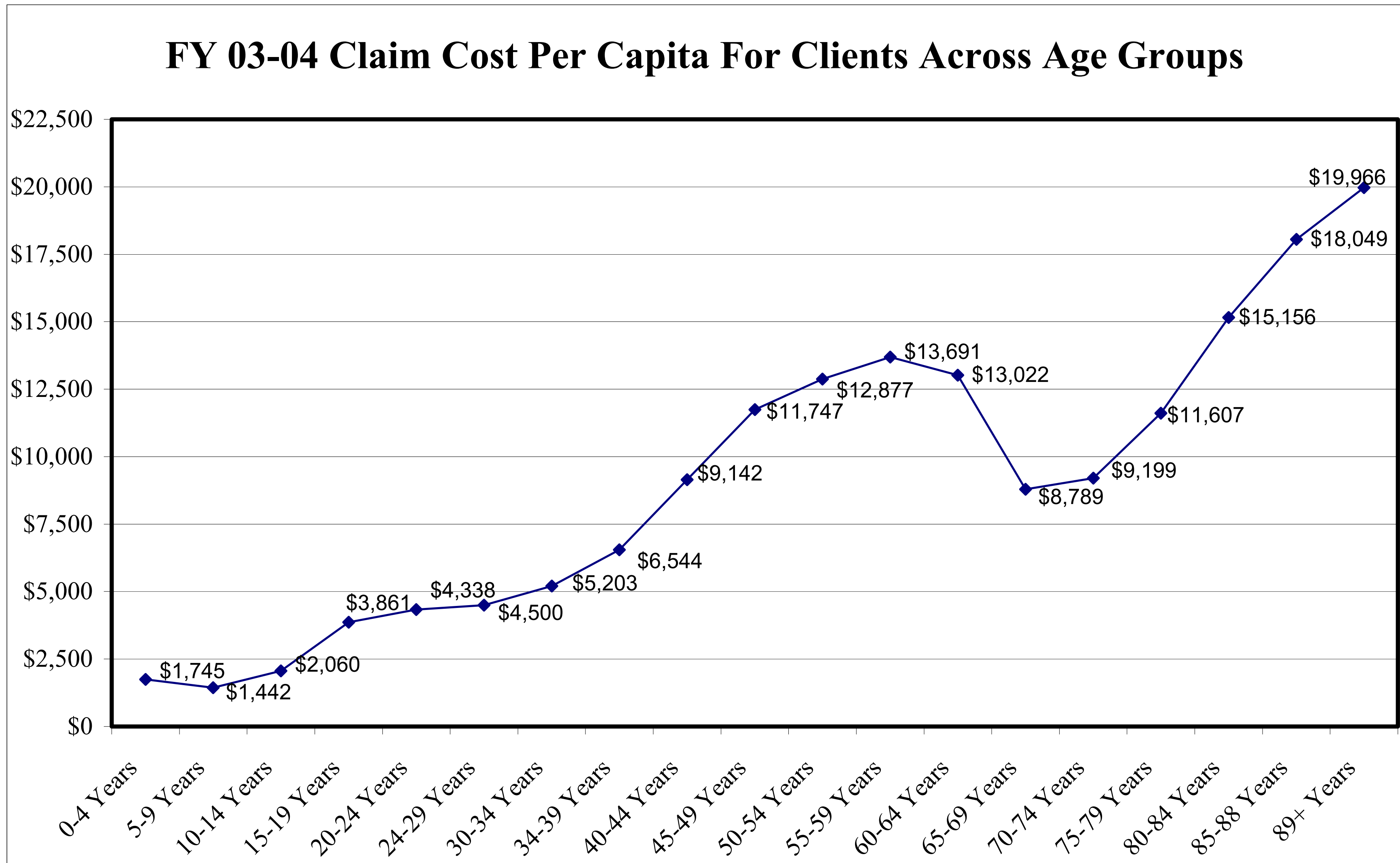
The figure below represents Medicaid expenditures by client age as of first date of service. The following are Medicaid caseload categories--

- SSI 65+ (OAP-A): Old Age Pension A - Supplemental Security Income for persons 65 years of age or older
- SSI 60-64 (OAP-B): Old Age Pension B - Supplemental Security Income for disabled persons 60-64 years of age
- SSI Disabled (AND/AB): Supplemental Security Income Disabled (Aid to the Needy Disabled/Aid to the Blind)
- CE Low Income Adults (AFDC-A): Categorically Eligible Low Income Adults (Aid to Families with Dependent Children - Adults)
- Breast and Cervical Cancer Program
- Eligible Children (AFDC-C/BC): Eligible Children (Aid to Families with Dependent Children - Children/Baby Care Children)
- Foster Care
- Baby Care Adults
- Non Citizens
- QMB/SLIMB: Qualified Medicare Beneficiaries and Special Low Income Medicare Beneficiaries

This graph shows that per capita expenditures rise steadily with age with two exceptions:

- The group containing newborns has higher per capita costs than the next older age group. Young children, especially those under 1 year of age, receive postnatal care and have a frequent schedule of medically appropriate preventative services as compared to older children.

- The largest dip in per capita costs is at the 65-69 age range. Clients aged 65 and older do not necessarily have to be disabled to be eligible for Medicaid, while adult Medicaid eligibles under 65, who are not part of an eligible family, must have a determination of a disability to be Medicaid eligible. Also, clients aged 65 years and older are more likely to be eligible for Medicare than younger clients. Since this group is less likely to be disabled and more likely to have insurance, other than Medicaid, than the next youngest group, their average per capita cost to the Medicaid program is less. Starting with this group, however, there continues to be a steady rise of per capita cost as age increases.



Source: Business Objects of America Queries on 8/20/04, updated 10/6/2004
Data includes all client identifiable claims in the Medicaid Management Information System Decision Support Subsystem.
Data includes Medicaid services outside of Medical Services Premiums.

E3. Utilization of Services by HIPAA Region for FY 03-04

The table below depicts by HIPAA Information Region (refer to A5), how many Medicaid-eligible persons utilize inpatient and outpatient hospital services, Home and Community Based Services (HCBS), nursing facility services, and any Medicaid service. The following should be noted:

- The following count of clients is not comparable to eligible clients. Some eligibles do not receive services.
- Since Medicaid clients have entered and exited the program throughout the year, the number receiving services is higher than the average caseload count reported for any given month.
- Payments made in FY 03-04 under cash accounting include claims for clients eligible during FY 02-03 as well as FY 03-04.

The following information is based on Medicaid paid claims in FY 03-04. Each client is included in all regions in which she or he lived in FY 03-04. Therefore, the sum of clients by region exceeds the unique Colorado counts. The sum total of unique client counts is also provided.

Utilization of Services by Information Region for FY 03-04

HIPAA Information Region	Clients Receiving Services (not unique clients, may overlap categories)				Clients Who Received Any Services Within Each Region
	HCBS	**Nursing Facilities**	**Inpatient Hospital**	**Outpatient Hospital Services**	
1 = Garfield, Moffat, Rio Blanco	476	332	1,079	3,117	8,338
2 = Eagle, Grand, Jackson, Pitkin, Routt, Summit	187	82	776	1,405	5,103
3 = Mesa	1,557	596	1,050	3,655	19,571
4 = Delta, Montrose, Ouray, San Miguel	737	503	726	2,141	9,783
5 = Archuleta, Dolores, La Plata, Montezuma, San Juan	742	350	1,180	4,206	10,368
6 = Chaffee, Custer, Fremont, Gunnison, Lake, Park	866	632	1,437	5,002	11,377
7 = Alamosa, Conejos, Costilla, Hinsdale, Mineral, Rio Grande, Saguache	990	353	1,321	3,626	13,494
8 = Baca, Bent, Crowley, Huerfano, Kiowa, Las Animas, Otero, Prowers	1,380	866	2,051	7,160	16,364
9 = Pueblo	2,019	1,128	3,475	14,005	32,573
10 = El Paso, Teller	2,460	1,635	6,356	20,680	55,658
11 = Logan, Morgan, Phillips, Sedgwick, Washington, Yuma	677	704	1,414	3,959	10,171
12 = Cheyenne, Elbert, Kit Carson, Lincoln	154	154	336	1,097	3,031
13 = Douglas	302	345	513	1,427	4,994
14 = Boulder, Broomfield	1,212	771	2,348	6,662	20,112
15 = Larimer	1,276	1,012	2,255	6,615	21,398
16 = Weld	956	830	2,849	7,393	22,892
17 = Adams	1,867	1,507	6,195	17,108	54,317
18 = Arapahoe	2,232	1,515	5,612	16,037	52,222
19 = Clear Creek, Gilpin, Jefferson	2,583	2,175	4,001	12,541	38,588
20 = Denver	4,194	2,675	11,300	25,900	97,680
TOTALS	26,867	18,165	56,274	163,736	508,034
TOTAL NUMBER OF UNIQUE CLIENTS	**26,109**	**17,210**	**56,007**	**159,539**	**490,859**

Source: Business Objects of America Queries 8/19/04 and 8/20/04. Data from claims with paid dates between July 1, 2003 and June 30, 2004 and are grouped on clients' county of residence. Home and Community Based Services (HCBS) data are defined as per FY 03-04 current and prior year organization codes used by the Department's Accounting Section which include the following: Brain Injury, Children's HCBS, Children's Habilitation Residential Program, Children's Extensive Services, HCBS for Developmentally Disabled, Support Living Services; HCBS for Elderly Blind and Disabled, Mentally Ill, and HCBS for Persons Living with AIDS. Nursing facility data is built from and based on organization codes that define "Class 1 Nursing Homes." Limited numbers of clients participate in both the HCBS and nursing facility program -- client counts are duplicated. Outpatient data are defined as per FY 03-04 current and prior year organization codes used by the Department's Accounting Section.

E4. Physician Services

This table illustrates the top procedure codes used by primary care providers by Medicaid clients for FY 03-04.

	Top 5 Medicaid Primary Care Physician Provider Codes	FY 03-04 Actuals		
		Clients Served*	**Billing Providers***	**Total Expended**
1	99203 - Office or Outpatient Visit New Patient; Low Complexity	27,399	2,719	$1,557,948
2	99212 - Office or Outpatient Visit Established Patient; 2 of 3 Key Complexities	58,733	4,269	$1,729,232
3	99213 - Office or Outpatient Visit Established Patient; Low Complexity	132,126	5,678	$9,383,499
4	99214 - Office or Outpatient Visit Established Patient; Moderate Complexity	58,820	4,381	$4,248,189
5	99232 - Subsequent Hospital Care; Moderate Complexity	18,132	2,943	$2,266,457
			TOTAL	**$19,185,325**

*Unduplicated count. Source: Business Objects of America queries on September 21, 2004

E5. Top 10 Service Categories in the Medical Services Premiums

This table illustrates the top 10 service categories for Medical Services Premiums expenditures over the past three fiscal years.

Top 10 Service Categories in the Medical Services Premiums						
Service Category	**FY 01-02 Expenditures**	**% of Total Expenditures**	**FY 02-03 Expenditures**	**% of Total Expenditures**	**FY 03-04 Expenditures**	**% of Total Expenditures**
Class I Nursing Facilities	$377,241,370	24.55%	$380,354,855	23.03%	$416,011,012	22.59%
Inpatient Hospitals	$192,032,620	12.50%	$213,735,470	12.94%	$273,247,361	14.84%
Prescription Drugs	$181,651,740	11.82%	$201,539,466	12.20%	$265,797,673	14.43%
Health Maintenance Organizations	$314,117,532	20.44%	$317,583,086	19.23%	$201,206,258	10.92%
Physician Services and EPSDT	$64,876,365	4.22%	$83,003,347	5.03%	$122,673,666	6.66%
Home and Community Based	$85,713,835	5.58%	$91,416,381	5.53%	$94,741,923	5.14%
Outpatient Hospitals	$43,252,843	2.81%	$49,308,708	2.99%	$89,047,191	4.83%
Home Health	$62,123,816	4.04%	$64,887,909	3.93%	$69,697,057	3.78%
Federally Qualified Health Centers	$16,363,132	1.06%	$26,899,779	1.63%	$51,398,899	2.79%
Durable Medical Equipment	$36,403,798	2.37%	$40,309,959	2.44%	$49,245,516	2.67%

Source: Medical Services Premiums Budget Request, November 1, 2004, Page ET-2.

E6. Top 10 Prescribed Drugs in Medicaid

Top 10 Medicaid Prescription Drugs by FY 03-04 Expenditures					
Rank	**Drug Name**	**Drug Type**	**Brand/Generic**	**Total Expended**	**Total Prescriptions**
1	Seroquel - 200mg	Antipsychotic	Brand Name Drug	$3,655,130	9,923
2	Zyprexa - 10mg	Antipsychotic	Brand Name Drug	$3,391,946	11,715
3	Zyprexa - 20mg	Antipsychotic	Brand Name Drug	$3,282,895	5,914
4	Neurontin - 300 mg	Anticonvulsant	Brand Name Drug	$2,483,474	19,940
5	Zyprexa - 5mg	Antipsychotic	Brand Name Drug	$2,476,258	14,299
6	Zyprexa - 15 mg	Antipsychotic	Brand Name Drug	$2,307,115	5,503
7	Celebrex - 200mg	Non-steroidal Anti-inflammatory (COX-2 Inhibitor)	Brand Name Drug	$2,237,314	20,389
8	Prevacid - 30mg	Gastric Acid Secretion Reducer	Brand Name Drug	$2,143,452	16,146
9	Seroquel - 100mg	Antipsychotic	Brand Name Drug	$2,126,073	12,258
10	Zoloft - 100mg	Selective Serotonin Reuptake Inhibitor (Antidepressant)	Brand Name Drug	$1,894,225	20,823

Source: Computer Output to Laser Disk (COLD) Report RXMM1600-R001

Top 10 Medicaid Prescription Drugs by FY 03-04 Total Prescriptions Written					
Rank	**Drug Name**	**Drug Type**	**Brand/ Generic**	**Total Prescriptions**	**Total Expenditures**
1	Hydrocodone - 5/500 mg	Analgesic	Generic	86,502	$693,676
2	Albuterol 90 mcg Inhaler	Bronchial Dilator	Generic	38,349	$699,060
3	Lipitor - 10mg	Atorvastatin (used to treat high cholesterol)	Brand Name	27,648	$1,918,272
4	Zyrtec - 10mg	Antihistamine	Brand Name	26,487	$1,524,252
5	Zoloft - 100mg	Antidepressant	Brand Name	20,823	$1,894,225
6	Celebrex - 200mg	Non-steroidal Anti-inflammatory (COX-2 Inhibitor)	Brand Name	20,389	$2,237,314
7	Fosamax - 70 mg	Alendronate (used to treat osteoporosis)	Brand Name	20,339	$1,420,588
8	Neurontin - 300 mg	Anticonvulsant	Brand Name	19,940	$2,483,474
9	Zoloft - 50mg	Antidepressant	Brand Name	19,806	$1,697,483
10	Flonase 0.5% Nasal Spray	Nasal Steroid (used for allergies)	Brand Name	18,623	$1,125,175

Source: Computer Output to Laser Disk (COLD) Report RXMM1610-R001

Exhibits E7 – E17 Top Diagnoses, Procedures, Diagnosis Related Groups (DRGs), Durable Medical Equipment (DME) and Supplies, Laboratory Services, and Radiology Services

Tables E7 thru E17 show the breakdown by volume or expenditures (in descending order) by diagnoses, procedures, Diagnosis Related Groups (DRGs), durable medical equipment and supplies, clinical laboratory services, and radiology services. The following tables provide a general overview of the distribution of top various services. The analyses count claims and claim lines where the service was presented; if the service was repriced during the year, then the Department counted that service more than once.

E7. Top 15 Inpatient Diagnoses for FY 03-04

Top 15 Medicaid Inpatient Diagnoses for FY 03-04

	Principal Diagnoses Code	Principal Diagnosis Description	Count
1	664.11	Delivery with Second Degree Laceration	2,674
2	664.01	Delivery with First Degree Laceration	2,651
3	654.21	Previous C-Section Not Otherwise Specified-Delivery	1,997
4	V30.00	Delivered without Mention of C-Section	1,913
5	659.71	Abnormal Fetal Heart Rate; Delivered	1,823
6	486	Pneumonia, Organism Not Otherwise Specified	1,812
7	650	Normal Delivery	1,739
8	645.11	Post Term Pregnancy-Delivered	1,365
9	466.11	Acute Bronchiolitis Due To Respiratory Syncytial Virus (RSV)	1,157
10	663.31	Unspecified Cord Entanglement Not Elsewhere Classified, W/out Complications from Delivery	1,038
11	644.21	Early Onset Delivery-Vaginal Delivered without Complications from Delivery	889
12	648.91	Other Current Condition- Classifiable Elsewhere of Mother, with delivery	843
13	466.19	Acute Bronchiolitis Due To Other Infectious Organisms	787
14	428.0	Congestive Heart Failure	757
15	V30.01	Delivered By C-Section	755
		Total of Top 15 Inpatient Diagnoses	**22,200**

Source: Business Objects of America Query 8/19/2004. This table counts claims and claim lines where the primary diagnosis code was present (often, there are subsidiary codes). Medicaid premium dollars are defined using a distinctly different set of criteria than that used for the above inpatient diagnosis counts. Here, inpatient hospitals have a Category of Service Code '05' (Inpatient Hospital), which includes Inpatient Hospitals (Title XIX), Indian Heath Services Inpatient Hospital, Inpatient Diagnosis Related Groups (Title XIX), and Crossovers (Title XVIII).

E8. Top 15 Outpatient Diagnoses for FY 03-04

Top 15 Medicaid Outpatient Diagnoses for FY 03-04

	Principal Diagnoses Code	Principal Diagnosis Description	Count
1	585	Chronic Renal Failure	67,648
2	V57.1	Other Outpatient Physical Therapy Services	27,761
3	382.9	Otitis Media Not Otherwise Specified	24,442
4	465.9	Acute Upper Respiratory Infection Not Otherwise Specified	22,943
5	789.00	Abdominal Pain Unspecified Site	19,449
6	648.93	Complications Mainly Related To Pregnancy, Nausea	17,833
7	786.5	Chest Pain	16,479
8	780.6	Fever	14,903
9	644.03	Labor, Threatened Premature, Undelivered, 22-37 Weeks	13,879
10	784.0	Headache	13,106
11	486	Pneumonia	11,966
12	079.99	Viral Infection, Unspecified	11,386
13	599.0	Urosepsis, Sepsis That Originated In Urinary Tract	11,219
14	521.00	Unspecified Dental Caries	11,120
15	V28.8	Other Special Antenatal Screening	10,820
		Total of Top 15 Outpatient Diagnoses	**294,954**

Source: Business Objects of America Query 8/19/2004

1) This table counts claims where the primary diagnosis code was present (however, often there are subsidiary codes).

2) Outpatient data are defined per FY 03-04 current and prior year organization codes used by the Department’s Accounting Section.

E9. Top 15 Inpatient Surgical Procedures for FY 03-04

Top 15 Medicaid Inpatient Surgical Procedures for FY 03-04

	Surgical Procedure Code	Surgical Procedure Code Description	Count
1	73.59	Other Manually Assisted Delivery	8,848
2	74.1	Low Cervical Cesarean Section	5,123
3	75.69	Repair of Other Current Obstetric Laceration	5,055
4	03.31	Spinal Tap	1,149
5	73.09	Other Artificial Rupture Membranes	1,102
6	73.6	Episiotomy	990
7	38.93	Venous Catheterization, Not Elsewhere Classified	868
8	99.04	Transfusion of Packed Cells	740
9	73.4	Medical Induction of Labor	717
10	96.71	Continuous Mechanical Ventilation For < 96 Hours	684
11	39.95	Hemodialysis	652
12	51.23	Laparoscopic Cholecystectomy	587
13	72.79	Other Vacuum Extraction	575
14	64.0	Circumcision	519
15	45.16	Esophagogastroduodenoscopy with Closed Biopsy	517
		Total of Top 15 Surgical Procedures	**28,126**

Source: Business Objects of America Query 8/19/2004

1) This table counts claims where the primary ICD-9 surgical procedure code was present (often there are subsidiary codes).

2) Medicaid premium dollars are defined using a distinctly different set of criteria than that used for the above inpatient surgical procedure counts. Here, inpatient hospitals have a Category of Service Code '05' (Inpatient Hospital), which includes Inpatient Hospitals (Title XIX), Indian Heath Services Inpatient Hospital, Inpatient Diagnosis Related Groups (Title XIX), and Crossovers (Title XVIII).

E10. Top 15 Outpatient Procedures Codes for FY 03-04

Top 15 Medicaid Outpatient Surgical Procedures for FY 03-04

	Surgical Procedure Code	Surgical Procedure Code Description	Count
1	99.29	Injection or Infusion of Other Therapeutic or Prophylactic Substance, Heparin	15,529
2	93.54	Other Immobilization, Pressure, and Attention to Wound; Application of Splint	12,526
3	86.59	Closure of Skin and Subcutaneous Tissue Other Sites	11,455
4	23.41	Application of Crown	5,138
5	20.01	Myringotomy with Insertion of Tube	4,202
6	23.70	Root Canal, Not Otherwise Specified	3,809
7	28.3	Tonsillectomy with Adenoidectomy	3,717
8	51.23	Laparoscopic Cholecystectomy	3,485
9	75.35	Other Diagnostic Procedures US and Amnion	3,433
10	66.29	Other Bilateral Destruction or Occlusion of Fallopian Tubes	3,151
11	03.31	Spinal Tap	3,141
12	69.52	Removal of Remaining Fallopian Tube	2,397
13	45.16	Endoscopy of Small Intestine with Closed Biopsy	2,108
14	69.02	Dilation and Curet Following Delivery/AB	2,086
15	86.04	Other Incision with Drainage of Skin and Subcut Tissue	1,430
		Total of Top 15 Outpatient Procedures	**77,607**

Source: Business Objects of America Query 10/6/2004

The analysis looks at only one surgical procedure code per claim (there are often subsidiary codes) and is defined from per FY 03-04 current and prior year Colorado Financial Reporting System organization codes used by the Department's Accounting Section.

E11. Top 15 Inpatients Diagnosis Related Groups (DRGs) for FY 03-04

Top 15 Medicaid Inpatient Diagnosis Related Groups (DRG) for FY 03-04

	DRG Code	Diagnosis Related Groups Code Description	Count
1	373	Vaginal Delivery without Complicating Diagnoses	16,432
2	371	Cesarean Section without Comorbidity or Complications	3,330
3	372	Vaginal Delivery with Complicating Diagnoses	3,230
4	098	Bronchitis and Asthma Age 0-17	1,918
5	370	Cesarean Section with Comorbidity or Complications	1,916
6	383	Other Antepartum Diagnoses with Medical Complications	1,291
7	089	Simple Pneumonia and Pleurisy Age >17 with Comorbidity or Complications	1,226
8	390	Neonate with Other Significant Problems	1,199
9	091	Simple Pneumonia and Pleurisy Age 0-17	1,049
10	374	Vaginal Delivery with Sterilization and/or D and C	902
11	182	Esophagitis, Gastroenteritis, and Miscellaneous Digestive Disorders	901
12	898	Bronchitis and Asthma, Age < 17 with Comorbidity or Complications	794
13	391	Normal Newborn	794
14	127	Heart Failure and Shock	792
15	389	Full Term Neonate with Major Problems	758
		Total of Top 15 DRGs	**36,532**

Source: Business Objects of America Query 8/19/2004

1) The analysis in the table counts claims where the DRG code was present.

2) Medicaid premium dollars are defined using a distinctly different set of criteria than that used for the above diagnosis related groups counts. Here, inpatient hospitals have a Category of Service Code ‘05’ (Inpatient Hospital), which includes Inpatient Hospitals (Title XIX), Indian Heath Services, Inpatient Hospital, Inpatient Diagnosis Related Groups (Title XIX), and Crossovers (Title XVIII).

E12. Top 25 Diagnosis Codes for Noninstitutional Claims for FY 03-04

Top 25 Medicaid Principle Diagnosis Codes for Noninstitutional Claims for FY 03-04

	Principal Diagnosis Code	Principal Diagnosis Description	Count
1	799.9	Illness of Unknown and Unspecific Cause, Some Condition But Not Clearly Defined	612,919
2	780	General Symptoms	338,394
3	V20.2	Routine Infant or Child Health Check	303,798
4	496	Chronic Airway Obstruct Not Elsewhere Classified	150,841
5	V22.1	Supervision of Other Normal Pregnancy	111,170
6	585	Chronic Renal Failure	87,012
7	250.00	Diabetes Uncomplicated Adult	73,952
8	V40.1	Mental and Behavioral Problems with Communication (Including Speech)	72,591
9	786.50	Chest Pain Not Otherwise Specified	69,609
10	465.9	Acute Upper Respiratory Infection Not Otherwise Specified	63,297
11	V22.2	Pregnant State, Incidental	59,550
12	428.0	Congestive Heart Failure	58,048
13	401.9	Hypertension Not Otherwise Specified	57,043
14	789.00	Other Symptoms Involving Abdomen and Pelvis - Abdominal Pain	52,448
15	799.0	Asphyxia	50,289
16	599.0	Urinary Tract Infection Not Otherwise Specified	47,629
17	486	Pneumonia, Organism Not Otherwise Specified	43,563
18	V22.0	Supervision of Normal First Pregnancy	43,493
19	367.1	Myopia	43,118
20	382.9	Otitis Media Not Otherwise Specified	40,036
21	462	Acute Pharyngitis	38,509
22	V30.00	Single Liveborn - Born In Hospital, Delivered without Mention of C-Section	37,490
23	493.90	Asthma - Extrinsic Asthma	35,188
24	780.6	Fever	32,571
25	786.09	Respiratory Distress Insufficiency, Other	32,369
		Total of Top 25 Diagnoses for Noninstitutional Claims	**2,554,927**

Source: Business Objects of America Query 9/3/2004. This analysis counts claim lines for Practitioner/Physician, Independent Laboratory, Medical Supply, Transportation, Dental, EPSDT, Part B Crossovers, and Home and Community Based Services claim types. Home and Community Based Services providers use code 799.9, so these claims comprise much of the 799.9 count.

E13. Top 25 Procedures for Noninstitutional Claims for FY 03-04

Top 25 Medicaid Procedure Codes for Noninstitutional Claims for FY 03-04

	Procedure Code	Procedure Code Description	Count
1	99213	Office or OP Visit Established Patient Low Complexity	399,022
2	T1019	Personal Care Services, 15 Minutes (Not Inpatient or Residential)	174,163
3	99214	Office or OP Visit Established Patient Moderate Complexity	138,690
4	99283	ER Department Visit For Evaluation and Management of Patient - Moderate Complexity	112,104
5	X1140	Personal Care	110,906
6	99212	Office or OP Visit Established Patient 2 or 3 Components	105,544
7	99232	Subsequent Hospital Care Moderate Complexity	97,401
8	D1330	Oral Hygiene Instruction	91,710
9	D0220	Radiographs-Itraoral Periapical-First Film	89,728
10	E1390	Oxygen Concentrator	80,899
11	D0272	Radiographs-Bitewings-Two Films	80,526
12	A0100	Non Emergency Transportation - Taxi One Way Trip	77,873
13	A0120	Non Emergency Transportation - Mini/Mtn Bus	77,092
14	D0230	Radiographs-Intraoral Periapical-Each Additional	75,009
15	71020	Radiologic Examination, Chest--2 Views	74,012
16	D0120	Periodic Oral Exam	70,462
17	D1201	Topical Fluoride (Including Prophylaxis)-Child	64,515
18	99284	ER Department Visit - Moderate Complexity	61,160
19	D2140	Amalgam One Surface Permanent	57,270
20	E0431	Port Gaseous Oxygen System Rental	54,291
21	99391	Periodic Re-Evaluation/Management Established Physical Therapy; Infant Under 1	53,405
22	71010	Radiologic Examination, Chest-- Single View	53,275
23	36415	RT V/P or Finger/Heel/Ear Stick-Collection	50,895
24	85025	Hemogram and Platelet Count Automated	50,659
25	S5130	Homemaker Service, Not Otherwise Specified, Per 15 Minutes	50,319
		Total of Top 25 Procedure Codes for Noninstitutional Claims	**2,350,930**

Source: Business Objects of America Query 9/3/2004. This analysis counts claim lines where the procedure code was present and is based on claim types including: Practitioner/Physician; Independent Laboratory; Medical Supply; Transportation, Dental; EPSDT; Part B Crossovers; and Home and Community Based Services Waiver.

E14. Top 10 Procedures for Children's Dental for FY 03-04

Top 10 Procedures for Medicaid Children's Dental for FY 03-04

	Procedure Code	Procedure Code Description	Count
1	D1330	Oral Hygiene Instruction	91,525
2	D0272	Radiographs-Bitewings-Two Films	79,945
3	D0220	Radiographs-Itraoral Periapical-First Film	79,536
4	D0120	Periodic Oral Exam	70,227
5	D0230	Radiographs-Intraoral Periapical-Each Additional	69,640
6	D1201	Topical Application Fluoride (Including Prophylaxis)	64,509
7	D2140	Amalgam One Surface Permanent	56,983
8	D0150	Comp Oral Evaluation	44,913
9	D2930	Prefabricated Stainless Steel Crown-Primary	41,908
10	D1351	Sealant - 1st Permanent Molar	35,512
		Total of Top 10 Procedures for Children's Dental	**634,698**

Source: Business Objects of America Query 8/19/2004. Note: Claim line counts include claim types 'F' (Dental) for children age 20 and under.

E15. Top 5 Lab Tests for FY 03-04

Top 5 Medicaid Laboratory Services for FY 03-04

	Procedure Code	Procedure Code Description	Count
1	85025	Hemogram and Platelet Count Automated	121,504
2	87086	Culture, Bacterial, Urine-- Quantitative Colony Count	54,178
3	80053	General Health Panel	51,501
4	87081	Culture, Bacterial, Screening Only	46,696
5	81002	Urinalysis without Microscopy	45,701
		Total of Top 5 Lab Procedures	**319,580**

Source: Business Objects of America Query 8/19/2004
This analysis includes a count of all claim lines for all claim types where clinical laboratory test procedure codes in the 80000 - 89999 range of the Current Procedural Terminology (CPT) - physician reimbursement guide were present. The analysis also includes those services rendered at a Federal Qualified Health Center, which do not report all procedure code detail.

E16. Top 25 Durable Medical Equipment Expenditures by Procedures for FY 03-04

Top 25 Medicaid Durable Medical Equipment and Supplies Expenditures by Procedure Codes for FY 03-04

	Procedure Code	Procedure Code Description	FY 03-04 Expenditures
1	E1390	Oxygen Concentrator	$5,016,662
2	S8121	Oxygen Contents, Liquid, Per Pound	$3,911,020
3	X2410	Oxygen Contents, Liquid, Per Pound-Nursing Home Patient	$3,241,162
4	K0108	Other Accessories	$1,752,151
5	K0011	Standard Mot/Pow Shch	$1,356,741
6	X2477	Oxygen Concentrator - Nursing Home Patient	$1,209,371
7	A4253	Blood Glucose Test/Reagent Strips Each	$1,134,920
8	B4035	Enteral Feeding Supply Kit Pump	$928,830
9	B4153	Enteral Formulae Category III Hydrolized	$920,528
10	B4150	Enteral Formulae Category I Semi-Synthetic Intact Protein	$884,288
11	E0434	Portable Liquid Oxygen System Rental	$881,199
12	E0445	Oxygen Concentrator or Extractor Included Equipment	$827,152
13	A4535	Disposable Incontinence Liner/Shield Each	$782,461
14	E1340	Repair DME - Labor Per 15 Minutes	$748,115
15	B4155	Enteral Formulae Category V Modular Comp	$733,908
16	E0439	Stationary Liquid Oxygen System, Rental	$700,680
17	X2437	Portable Liquid System; without Station Res-Nursing Home	$692,578
18	E0431	Portable Gaseous Oxygen System Rental	$672,716
19	X0410	Oxygen Contents, Per Pound, Rented Equipment	$585,350
20	E0570	Nebulizer, with Compressor	$581,671
21	A4527	Adult Size Brief Large Each	$575,426
22	K0014	Other Motor/Power	$573,785
23	E0450	Volume Ventilator; Stationary or Portable	$568,784
24	A4554	Disposable Under Pads, All Sizes	$560,195
25	E1399	Miscellaneous Durable Medical Equipment	$537,087
		Total of Top 25 Durable Medical Equipment Expenditures	**$30,376,780**

Source: Business Objects of America Query 8/27/2004. This analysis includes data where Category of Service Code equals '70' (Supplies) which consists of Medical Equipment (Titles XVIII and XIX), Nursing Facility Equipment (Title XIX), and Qualified Medicare Beneficiary Equipment (Title XIX), i.e., durable medical equipment, crossovers, contracted nursing facility oxygen, prosthetics, eyeglasses, and disposable supplies.

E17. Top 5 Radiology Procedures

Top 5 Radiology Procedures for FY 03-04

	Procedure Code	Procedure Code Description	Count
1	71020	Radiologic Examination, Chest--Two Views	105,570
2	71010	Radiologic Examination, Chest--Single View	58,008
3	70450	Head, without Intravenous Contrast, Only	26,828
4	76805	Echo Pregnant Uterus B-Scan/or Real Time	25,484
5	72193	Computerized Axial Tomography, Pelvis; without Contrast Material(s)	12,627
		Total of Top 5 Radiology Procedures	**228,517**

Source: Business Objects of America Query 8/19/2004

This analysis counts claims for all claim types where radiology procedure codes in the 70000 - 79999 range of the Current Procedural Terminology (CPT) - physician reimbursement guide were present. The above analysis also includes those services rendered at Federal Qualified Health Centers, which do not report all procedure code detail.