Department of Health Care Policy and Financing
Program Crosswalks
FY 05-06

Budget Request

NOVEMBER 1, 2004

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PROGRAM CROSSWALK

Summary Section

Program Title: Executive Director's Office

Change Request(s): All

Long Bill Line Item
(1) Executive Director's Office
Personal Services
Health, Life and Dental
Short-term Disability
Salary Survey and Senior Executive Service
Performance-based Pay
Worker's Compensation
Operating Expenses
Legal Services and Third Party Recovery Legal Services for 12,684 hours
Administrative Law Judge Services
Purchases of Services from Computer Center
Payment to Risk Management and Property Funds
Capitol Complex Leased Space

Federal/State Statutory and Other Authority

25.5-1-104, C.R.S. (2004)
1) There is hereby created the department of health care policy and financing, the head of which shall be the executive director of the department of health care policy and financing, which office is hereby created. The executive director shall be appointed by the governor, with the consent of the senate, and shall serve at the pleasure of the governor. The reappointment of an executive director after an initial election of a governor shall be subject to the provisions of section 24-20-109, C.R.S. The executive director has those powers, duties, and functions prescribed for the heads of principal departments in the "Administrative Organization Act of 1968", article 1 of title 24, C.R.S., and any powers, duties, and functions set forth in this title.

(2) The department of health care policy and financing shall consist of an executive director of the department of health care policy and financing, the medical services board, and such divisions, sections, and other units as shall be established by the executive director pursuant to the provisions of subsection (3) of this section.
(3) The executive director may establish such divisions, sections, and other units within the state department as are necessary for the proper and efficient discharge of the powers, duties, and functions of the state department; except that such action by the executive director shall not conflict with the implementation requirements for the plan for restructuring the delivery of health and human services in this state, as set forth in article 1.7 of title 24, C.R.S.
(4) The department of health care policy and financing shall be responsible for the administration of the functions and programs as set forth in part 2 of this article.

Program Description

Karen Reinertson was appointed Executive Director effective March 1, 2001. The Executive Director has organized the Department to balance the spans of control and to allow for greater focus on key program and operational areas.

Areas of responsibility for the Executive Director include general governance and financial accountability for the Department, communication with partners within and outside of state government, and research and development for current and future refinement of Department operations. Two Offices report directly to the Executive Director:

- Medical Assistance Office
- Operations and Finance Office

In addition, the following functions report directly to the Executive Director:

- External Affairs
- Facility Coordination
- Communications Division

FY 05-06 Prioritized Objectives and Performance Measures

All departmental objectives and performance measures are of interest to the Executive Director. They are assigned into subunits of the Offices in this document (Divisions, Sections, and Units).

Similar or Cooperating Programs and Stakeholders

The Department of Health Care Policy and Financing has cooperating programs managed by other state agencies and important relationships with other stakeholders, some of which are:

- The Department of Human Services
- The Department of Public Health and Environment
- The Department of Regulatory Affairs
- The Department of Corrections
- The Department of Education
- The Department of Personnel and Administration
- Governor's Office
- General Assembly
- Constituents eligible to receive services through Department programs
- County Departments of Human Services and other eligibility sites
- Providers of care and services
- Federal government through the Centers for Medicare and Medicaid Services

The Colorado Department of Health Care Policy and Financing is the federally designated Single State Agency to receive Medicaid or Title XIX funding from the federal government. Therefore, all Colorado Medicaid programs, including those managed by other departments of state government, are financed through the Department, in part by the federal government. In addition, the Department is ultimately responsible for the conformance of such programs with Medicaid requirements.

External Affairs

- Customer Service Section

Summary Section

Program Title: Customer Service Section

Change Request(s): None

Long Bill Line Item
(1) Executive Director's Office
Personal Services
Health, Life and Dental
Short-term Disability
Salary Survey and Senior Executive Service
Performance-based Pay
Worker's Compensation
Operating Expenses
Legal Services and Third Party Recovery Legal Services for 12,684 hours
Administrative Law Judge Services
Payment to Risk Management and Property Funds
Capitol Complex Leased Space

Federal/State Statutory and Other Authority

25.5-1-104, C.R.S. (2004): (3) *The executive director may establish such division, sections and other units...as are necessary for the proper and efficient discharge of the powers, duties and functions of the state department: …*

26-4-117, C.R.S. (2004): (3)(b) *Complaints and grievances. Each MCO shall utilize a complaint and grievance procedure and a process for expedited reviews that comply with regulations established by the state department. The complaint and grievance procedure shall provide a means by which enrollees may complain about or grieve any action or failure to act that impacts an enrollee's access to, satisfaction with, or the quality of health care services, treatments, or providers. The state department shall establish the position of ombudsman for medicaid managed care. It is the intent of the general assembly that the ombudsman for*

medicaid managed care be independent from the state department and selected through a competitive bidding process… The ombudsman shall, if the enrollee requests, act as the enrollee's representative in resolving complaints and grievances with the MCO.

Program Description

The mission of the Customer Service Section is to provide an excellent level of communications and assistance to all customers who contact the Department of Health Care Policy and Financing. The Section acts as a single focal point for customers that require assistance with questions and who need help in navigating a very complex and confusing health care system. The staff refers customers to community and philanthropic services for assistance with health care benefits and services not available through departmental programs.

Because each of the customer groups served have different needs and requirements, the Customer Service Section responds to an array of complex concerns and issues. Due to the diversity of the customers served, and the issues that are presented, the development and implementation of standard policies, procedures and responses enhance communications and the quality of information given. The Section has developed a customer service database that captures such items as the number of calls received, a profile of the callers and the reasons for contacting the Department.

The Customer Service Call Center:

The Customer Service Section now uses the state of the art Definity® Business Communications and Centre Vu® Call Center Management System from Avaya, and the Conversant Menu Builder provider by Interactive Northwest, Inc. Using these innovative call management systems, customer calls are processed in a highly efficient and effective manner. Call Center reports are generated through the CentreVu® Supervisor software, which monitors the operations and collects data. The data is organized in real time, historical, or integrated formats, that help manage call center facilities and personnel. Examples of reports available are: the number of calls waiting; oldest call waiting time; the numbers of calls received; the number and percentage of calls lost; and, the average time it takes to process a call.

The Customer Service Section coordinates activities with Department contractors, other State departments such as the Department of Human Services; Department of Regulatory Agencies, Division of Insurance; and the Department of Public Health and Environment for the resolution and tracking of client, managed care, and provider complaints. Staff refers appropriate calls to each of these departments for information, assistance, and problem resolution.

Future Directions

The Customer Service Section will continue to develop and implement initiatives to improve and enhance the Department's communications with clients and other customers including:

- Seek additional ways to efficiently and effectively meet the high call volume demands;
- Continue to seek ways to efficiently and effectively ensure high call quality;
- Continue to seek ways to ensure consistent and correct information is disseminated;
- Continue to seek ways to upgrade the automated attendant system;
- Expand the Customer Service Database;
- Continue to monitor and track the Section's performance;
- Improve relations with county workers;
- Continue to provide quality training for section and departmental staff, especially with the Colorado Benefits Management System;
- Continue to seek ways to reduce staff stress;
- Hold accountable the Ombudsman for Medicaid Managed Care contractor to a more outcome-based results contract; and,
- Focus on employee retention.

FY 05-06 Prioritized Objectives and Performance Measures

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.
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.
3.1 To improve customer satisfaction with programs, services, and care.
Less than one percent of customer calls answered by the customer service staff will receive complaints at the Governor's Office.
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.
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).
4.1 To build and maintain a high quality, customer-focused team.
By June 30, 2006, the Customer Service Section, with sufficient staff, will reduce the call abandonment rate by 10% over the previous year.

Similar or Cooperating Programs and Stakeholders

The Enrollment Broker (HealthColorado) and the Department's Fiscal Agent (ACS) both maintain customer service lines for client enrollment and provider services. The Customer Service Section works closely with these contractors to address common issues.

Medical Assistance Office

- **Health Benefits Division**

Acute Care Benefits Section
Quality Improvement and Behavioral Health Benefits Section
Managed Care Benefits Section

- **Rates, Analysis, and Program Integrity Division**

Rates Section
Data Section
Program Integrity Section

- **Long Term Benefits Division**

Community Based Long Term Care Section
Nursing Facilities Section
Systems Change Section

- **Client Services Division**

Eligibility Section
Benefits Coordination Section

PROGRAM CROSSWALK

Summary Section

Program Title: Acute Care Benefits Section

Change Request: None

Long Bill Line Item
(1) Executive Director's Office
Personal Services
Health, Life and Dental
Short-term Disability
Salary Survey and Senior Executive Service
Performance-based Pay
Worker's Compensation
Operating Expenses
Legal Services and Third Party Recovery Legal Services for 12,684 hours
Administrative Law Judge Services
Payment to Risk Management and Property Funds
Capitol Complex Leased Space
Early and Periodic Screening, Diagnosis, and Treatment Program
Non-Emergency Transportation Services
(2) Medical Services Premiums
(6) Department of Human Services Medicaid Funded Programs
(G) Alcohol and Drug Abuse Division, High Risk Pregnant Women Program

Federal/State Statutory and Other Authority

42 CFR 441.50-441.62: *This subpart implements sections 1902(a)(43) and 1905(a)(4)(B) of the Social Security Act, by prescribing State plan requirements for providing early and periodic screening and diagnosis of eligible Medicaid recipients under age 21 to ascertain physical and mental defects, and providing treatment to correct or ameliorate defects and chronic conditions found.*

26-4-202, C.R.S. (2004): *Subject to the provisions of subsection (2) of this section and section 26-4-104, the program for the categorically needy shall include the following services as mandated and defined by federal law: . . .*

26-4-302, C.R.S. (2004): This section outlines the optional services that are provided for the categorically needy.

26-4-532, C.R.S. (2004): *The general assembly hereby finds and declares that breast and cervical cancer are significant health problems for women in this state. The general assembly further finds and declares that these cancers can and should be prevented and treated whenever possible. It is therefore the intent of the general assembly to enact this section to provide for the prevention and treatment of breast and cervical cancer to women where it is not otherwise available for reasons of cost.*

Program Description

Medicaid Benefits

Colorado Medicaid clients are provided with a comprehensive package of health care services. The Medicaid program reimburses providers for medically necessary services furnished to enrolled Medicaid clients. The Acute Care Benefits Section designs, implements, and administers Medicaid benefits as follows:

- Defines the amount, scope, and duration of services to be provided to eligible clients;
- Develops and implements health care policies and benefits through statute, regulations, and procedures;
- Coordinates a broad spectrum of programs and services to improve client access and limit duplication and gaps in services;
- Develops billing manuals, bulletins, and system changes for correct reimbursement and monitoring of services;
- Assists providers, clients, contractors, and advocates on the prior authorization process for durable medical equipment and supply approvals;
- Annually updates the Health Care Procedural Coding System; and,

- Coordinates with Parts B and C of the Individuals with Disabilities Education Act through the Department of Education.

The Acute Care Benefit Section administers several special programs as follows:

- Develops and implements the Medicaid Breast and Cervical Cancer Program for women who have not attained age 65 with a diagnosis of breast or cervical cancer as identified through the Colorado Women's Cancer Control Initiative;
- Monitors and assists with program operations, billing, coding and reimbursement to Federally Qualified Health Centers, Rural Health Centers, and Indian Health Services;
- Monitors the Special Connections and Prenatal Plus programs for pregnant women at risk for substance abuse or low birth-weight babies;
- Manages transportation as an administrative service as of July 1, 2004;
- Identifies, researches and analyzes Medicaid recipients for abuse, misuse and over-utilization of medical services; and,
- Develops and implements Early and Periodic Screening, Diagnosis and Treatment Program.

The Section also sets physician and other practitioner services rates. Most physicians and other practitioners are reimbursed for their services using Relative Value Units and conversion factors. The relative value of a particular service (called a "procedure") is a measure of its complexity and resource intensity. Every practitioner procedure is assigned a relative value by the Department. The rates are derived from the relative values multiplied by a conversion factor, resulting in a dollar amount per procedure. State policy establishes the conversion factor.

FY 05-06 Prioritized Objectives and Performance Measures

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.
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.

Similar or Cooperating Programs and Stakeholders

The Department of Health Care Policy and Financing is the Single State Agency responsible for administration of the Colorado Medical Assistance Program. The Department of Public Health and Environment assists in the administration of several programs. The Department of Public Health and Environment is responsible for the administration of the Infant Immunization Program, the

Vaccine for Children program, the Health Care Program for Children with Special Needs including the developmental evaluation clinics, and the Prenatal Plus Program. The Department of Human Services is responsible for the administration of the Special Connections program. The County Departments of Human/Social Services assist with the administration of non-emergent medical transportation and Early and Periodic Screening, Diagnosis, and Treatment administration.

PROGRAM CROSSWALK

Summary Section

Program Title: Quality Improvement and Behavioral Health Benefits Section

Change Request(s): Balance Mental Health FTE to Department Need

Long Bill Line Item
(1) Executive Director's Office
Personal Services
Health, Life and Dental
Short-term Disability
Salary Survey and Senior Executive Service
Performance-based Pay
Worker's Compensation
Operating Expenses
Legal Services and Third Party Recovery Legal Services for 12,684 hours
Administrative Law Judge Services
Payment to Risk Management and Property Funds
Capitol Complex Leased Space
Acute Care Utilization Review
Long Term Utilization Review
External Quality Review
(3) Medicaid Mental Health Community Programs
(A) Mental Health Program Administration
(B) Mental Health Programs, (1) Medicaid Mental Health Capitation Base Payments
Mental Health Services for Breast and Cervical Cancer Patients
Mental Health Institute Rate Refinance Adjustment
Alternatives to Inpatient Hospitalization at the Mental Health Institute at Pueblo
Alternatives to Inpatient Hospitalization at the Mental Health Institute at Fort Logan

Alternatives to the Fort Logan Aftercare Program
(2) Other Medicaid Mental Health Payments, Medicaid Mental Health Fee For Service Payments
Medicaid Mental Health Child Placement Agency
Medicaid Anti-Psychotic Pharmaceuticals

Federal/State Statutory and Other Authority

42 CFR Part 456, Utilization Control: This regulation prescribes requirements concerning control of the utilization of Medicaid services including a statewide program of control of the utilization of all Medicaid services, specific requirements for the control of the utilization of Medicaid services in institutions, and specific requirements for an outpatient drug use review program.

42 CFR Part 476, Utilization and Quality Control Review: Admission review means a review and determination by a PRO of the medical necessity and appropriateness of a patient's admission to a specific facility. Continued stay review means PRO review that is performed after admission review and during a patient's hospitalization to determine the medical necessity and appropriateness of continuing the patient's stay at a hospital level of care.

42 CFR Part 438, Subpart E, External Quality Review: Under these sections each contract between a State Medicaid agency and an MCO must provide for an annual external quality review of the quality outcome, the timeliness, and access to the services for which the MCO is responsible under the contract.

26-4-116, C.R.S. (2004): Requires the Department to administer quality measurements for managed care.

26-4-117 (b), C.R.S. (2004): Requires the Department to establish a complaint and grievance procedure and a process for expedited reviews for managed care organizations to use.

Program Description

The Quality Improvement and Behavioral Health Benefits Section is comprised of the Quality Improvement workgroup and the Behavioral Health Benefits unit. The activities conducted in the Quality Improvement workgroup are fee-for-service utilization review activities, external quality review of managed care and fee-for-service programs, compliance and monitoring, and a compilation of quality measurement and improvement activities. The Behavioral Health Benefits Unit administers the Mental Health Capitation and Managed Care Program. The mission of the Quality Improvement and Behavioral Health Benefits Section is to facilitate, monitor and

improve access, fiscal accountability, and quality health care for all Medicaid clients. Access to care, the provision of quality health care services, and the appropriate use of Medicaid resources are facilitated and monitored through a variety of activities performed by each of the units/individuals in the section. The overall Quality Improvement strategy and specific initiatives focus on both fee-for-service and managed care programs. In addition, the Section develops, implements, and monitors contracts with pre-paid behavioral health plans.

Specific activities that are performed within the Quality Improvement and Behavioral Health Benefits Section fall into the following major areas:

1. Quality Improvement and Intervention;
2. Utilization Management;
3. Plan Compliance and Monitoring; and,
4. Administration of the Medicaid Community Mental Health Services Program

<u>Quality Improvement and Intervention</u>

The Quality Improvement and Behavioral Health Benefits Section generates, collects, compiles, and analyzes data from various sources in order to assure that Medicaid clients receive quality care and access to services. This data is used for contract monitoring, evaluation of the performance of contracting health plans and providers, and evaluation of the effectiveness of managed care and fee-for-service programs. The quality and cost effectiveness data analyzed and reported include:

- **Client Satisfaction Surveys:** Satisfaction surveys are conducted for clients in managed care and fee-for-service programs. The results are reported to clients to assist them in choosing the best health plan or program to meet their needs. In 2002, the Consumer Assessment of Health Plans Study client satisfaction survey was completed in Colorado Medicaid health maintenance organizations, the Primary Care Physician Program, and fee-for-service. Results are summarized in a Provider Report Card that is mailed to all clients at annual enrollment. The Mental Health Statistics Improvement Program survey is used to monitor consumer satisfaction for the behavioral health care plans. This data becomes part of the overall quality improvement plan.

- **Quality and Performance Measures:** The Department collects quality and utilization indicators that enable evaluation of the contracting managed care health plans, services provided to clients by fee-for-service providers, and the Primary Care Physician Program. For the physical health plans, these indicators are from the Health Plan Employer Data and Information Set. Health plans submit this data annually and the Department calculates the indicators for the fee-for-service and the Primary Care Physician Program providers via contract with the external quality review organization. Results of key indicators are printed on the Provider Report Card and a full report of results is available on the Department's web site.

For the behavioral health program, the health plans send encounter and functional assessment data to the Department. Performance measures are calculated from this data. These measures are validated by an external quality review organization. The performance measures are also used as part of the overall quality strategy.

- **Focused Studies:** The Department conducts quality of care focused studies that compare the results of the health maintenance organizations, Primary Care Physician Program, and fee-for-service program. This enables the Department to take an in-depth look at the quality of care delivered to Medicaid clients. The 2003-2004 focused studies included prenatal/postpartum care and the appropriate use of asthma medications. The Department will make the results available to the clients as part of a report card and also post the information on the Department's web page. The Department has yet to select the two new studies for 2004-2005 that will build upon the findings of earlier studies and measurement, as will the studies selected for 2005-2006.

- **Individual Case Review and Quality of Care Complaints:** The Department allocates resources devoted to identifying quality concerns and investigating complaints regarding quality of care or services provided and aspects of interpersonal relationships such as rudeness of provider or employee, or failure to respect the client's rights. Individual cases referred for review may be client- or provider-based studies. If a potential quality of care concern is identified, the case will be referred to a physician reviewer for final disposition.

- **Quality Improvement Projects:** Federal regulations require the Department to validate performance improvement projects conducted by the health plans. For the physical plans, the Department validates the performance improvement projects utilizing the mandated federal protocol. The performance improvement projects conducted by the behavioral health plans are evaluated by the external quality review organization.

  The Department also conducts limited quality improvement interventions or remeasurement for selected Medicaid populations. The intervention or remeasurement has a single quality focus and is generally derived from previous quality improvement activities and studies. The intervention is geared toward improving quality in an area where opportunities have been previously identified. In the case of a remeasurement, the Department seeks to evaluate the outcome in a particular area of quality care to determine if previous interventions have resulted in improved performance.

- **Collaborative Studies and Activities:** The Department participates in community collaboratives and national initiatives aimed at improving health care in Colorado. In 2003, the Department participated in the Centers for Medicare and Medicaid Services' Government Performance Results project to measure childhood immunization rates in Colorado.

Plan Compliance and Monitoring

- **Site Reviews:** The physical health plans that serve Medicaid clients are visited each year by the Department to ensure they comply with contractual and regulatory standards. The behavioral health plans are monitored by an external quality review organization to ensure that they are in compliance with all contractual and regulatory standards. The site reviews follow the mandated federal protocols (Code of Federal Regulations, Title 42, Section 438, Subpart E). For any area that the Department mandates as a required action, the health plan must submit a corrective action to address the deficiencies. The Department follows-up on the action plans throughout the year to ensure changes are made.

- **External Quality Review:** The Department contracts with an independent entity, an external quality review organization, to perform medical quality improvement studies. Fee-for-service programs are included in applicable studies to facilitate comparison. Studies are often focused on specific areas important for the Medicaid population and typically involve medical record reviews. Summary results of the focused studies are released to clients in the form of a report card. Other external quality review organization activities for the physical/medical programs include collecting performance measures and consumer survey information for the Primary Care Physician Program.

  External quality review activities on the behavioral health side include validating performance measures, monitoring compliance of the health plans, and validating performance improvement projects.

  The external quality review organization also produces a technical report for both physical and mental health plans. The report includes an assessment of each health plan's strengths and weaknesses, recommendations for improving the quality of health care services furnished by each health plan, comparative information about all health plans, and an assessment of the degree to which each health plan has addressed effectively the recommendation for quality improvement during the previous year's activities.

- **Physician Profiles:** The Department provides physicians in the Primary Care Physician Program with clinical practice profiles. Through the profiles, the Department is able to educate physicians regarding ways to provide cost-effective, quality care.

- **Credentialing:** The Department has implemented the third cycle of the credentialing and recredentialing program. This program is a process that evaluates the ability of practitioners in the Primary Care Physician Program to deliver health care. The credentialing process has been streamlined this year in order to reduce the duplication and burden for physicians completing the required paperwork. The process includes the verification of the status of licensure, validity of Drug Enforcement Agency and/or Controlled Dangerous Substances certification, relevant training and experiences, board certification, and work history.

Utilization Review

The Department's utilization review contractors support Medicaid's acute care and long term care programs by ensuring that Medicaid services are used appropriately. Using a prior authorization process and eligibility determinations, the utilization review contracts help ensure that the services provided to Medicaid clients are medically necessary and appropriate. Additional utilization management services provided by the Department contractor include:

- **Management Reports:** The Department continues to evaluate all utilization review data reports in an effort to enhance the usefulness of data reports. A new reporting system will provide management and program staff with information necessary to manage and make decisions regarding Medicaid programs. The management data reports will analyze client specific data and provide decision-makers and program staff with a greater understanding of the trends and dynamics of Medicaid utilization.

- **Special Studies/Consultation:** The Department has allocated resources to be used for in-depth analysis of utilization trends, exploration of potential problem areas, the development of medical necessity criteria, ad hoc inquiries of data, the investigation of quality of care concerns, and diagnostic related groups for hospital rate setting.

Administration of the Medicaid Community Mental Health Services Program

The Quality Improvement and Behavioral Health Benefits Section administers the Medicaid Community Mental Health Services Program including contract implementation and quality compliance monitoring. Eight managed care organizations contract with the Department to provide a range of mental health services. Section staff perform the following activities:

- Develop requests for proposals to ensure a fair and competitive process to all potential bidders;
- Negotiate, implement, and manage contracts with managed care organizations to ensure that Medicaid clients receive high quality, timely, and cost-effective health services;
- Provide technical assistance to managed care organizations and providers to help them understand the special needs of the Medicaid population and to support their ability to meet these needs;
- Monitor the marketing, enrollment, and subcontracting activities of contracted providers;
- Monitor the performance of managed care organizations to ensure contractor's compliance with contract requirements; and,
- Analyze cost, quality, and utilization data to identify areas for improvement.

FY 05-06 Prioritized Objectives and Performance Measures

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.
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.

Similar or Cooperating Programs and Stakeholders

Single Entry Points – utilization review activities
Division of Insurance and the Department of Public Health and Environment – health maintenance organization monitoring activities
Federally Qualified Health Centers – quality initiatives

PROGRAM CROSSWALK

Summary Section

Program Title: Managed Care Benefits Section

Change Request(s): None

Long Bill Line Item
(1) Executive Director's Office
Personal Services
Health, Life and Dental
Short-term Disability
Salary Survey and Senior Executive Service
Performance-based Pay
Worker's Compensation
Operating Expenses
Legal Services and Third Party Recovery Legal Services for 12,684 hours
Administrative Law Judge Services
Payment to Risk Management and Property Funds
Capitol Complex Leased Space
SB 97-05 Enrollment Broker
(2) Medical Services Premiums

Federal/State Statutory and Other Authority

42 CFR 438, Managed Care: This regulation defines managed care and describes the program requirements.

Sections 26-4-111 through 127 C.R.S. (2004), Statewide System of Managed Care: This statute defines managed care and describes the requirements for the "Statewide Managed Care System."

Program Description

The Managed Care Benefits Section develops, implements, and monitors contracts with managed care organizations, administrative service organizations, other managed care providers, and the enrollment broker. The Section also administers the Primary Care Physician Program. The Section's purpose is to assist Medicaid clients enroll in managed care programs and to ensure that managed care contractors provide high quality and cost-efficient health care. The Managed Care Benefits Section:

- Negotiates, implements, and manages contracts with managed care organizations and other providers to ensure that Medicaid clients receive high quality, timely, and cost-effective health services;
- Provides technical assistance to managed care organizations and providers to help them understand the special needs of the Medicaid population and to support their ability to meet these needs;
- Monitors the marketing, enrollment, and subcontracting activities of contracted providers;
- Monitors the performance of managed care organizations to ensure contractor's compliance with contract requirements;
- Analyzes cost, quality, and utilization data to identify areas for improvement; and,
- Negotiates and manages the contract to provide enrollment services for all Medicaid clients.

Medicaid's Managed Care Programs

- In the Primary Care Physician Program, Medicaid clients may select a primary care physician who is solely authorized to provide primary care and make referrals to specialty services. That physician, physician group, or health clinic is responsible for coordinating, managing, and authorizing all health care services for the client. Medicaid pays for care delivered on a fee-for-service basis.

- Managed Care Organizations: Medicaid clients may select a capitated health plan. Unlike providers participating in the non-capitated managed care programs, the capitated plans have full responsibility, not only for the management of care, but also for the financing and delivery of all necessary and covered health care services. These plans receive a fixed monthly payment from Medicaid for each enrolled Medicaid client.

- Administrative Service Organizations: Administrative Service Organizations provide a variety of managed care services to Medicaid clients. The services (e.g. case management, care coordination, client and provider education, health risk screening, provider profiling, etc.) are designed to improve quality of care for clients, reduce utilization of costly services, and assist physicians in caring for high-risk clients.

FY 05-06 Prioritized Objectives and Performance Measures

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.
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.

Similar or Cooperating Programs and Stakeholders

Employers, the Alliance, and the Colorado Business Group on Health have similar issues in the commercial managed care market.

PROGRAM CROSSWALK

Summary Section

Program Title: Rates Section

Change Request(s): Implementation of the Medicare Modernization Act
Funding for Hospital and Federally Qualified Health Clinic Audits to Increase Recoveries
Drug Utilization Review Fund Split Correction

Long Bill Line Item
(1) Executive Director's Office
Personal Services
Health, Life and Dental
Short-term Disability
Salary Survey and Senior Executive Service
Performance-based Pay
Worker's Compensation
Operating Expenses
Legal Services and Third Party Recovery Legal Services for 12,684 hours
Administrative Law Judge Services
Payment to Risk Management and Property Funds
Capitol Complex Leased Space
Drug Utilization Review
Hospital and Federally Qualified Health Clinic Audits
(2) Medical Services Premiums
(3) Medicaid Mental Health Community Programs
(B) Mental Health Programs, (1) Mental Health Capitation
(B) Mental Health Programs, (2) Medicaid Anti-Psychotic Pharmaceuticals

Federal/State Statutory and Other Authority

26-4-119, C.R.S. (2004), Capitation Payments: Requirements regarding rate setting for managed care organizations, including Program of All-inclusive Care for the Elderly and behavioral health organizations.

26-4-124, C.R.S. (2004) Program of all-inclusive care for the elderly - services – eligibility: This section provides for the creation and implementation of the Program of All-inclusive Care for the Elderly.

26-4-405, C.R.S. (2004) Providers – hospital reimbursement: Requirements regarding rate setting for hospitals.

26-4-406 through 26-4-408, C.R.S. (2004): Requirements regarding administration of the pharmacy program.

42 CFR 447.250: *(a) This subpart implements section 1902 (a)(13)(A) of the Act, which requires that the State plan provide for payment for hospital and long-term care facility services through the use of rates that the State funds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities to provide services in conformity with State and Federal laws, regulations, and quality and safety standards; (b) Section 447.253(a)(2) implements section 1902(a)(30) of the Act, which requires that payments be consistent with efficiency, economy, and quality of care; (c) Sections 447.253 (c) and (d) implement sections 1902(a)(13)(B) and 1902(a)(13)(C) of the Act, which require a State Medicaid agency to make certain assurances to the Secretary regarding increases in payments resulting solely from changes in ownerships of hospitals, Nursing Facilities, and Intermediate Care Facility for the Mentally Retarded; (d) Section 447.271 implements section 1903(i)(3) of the Act, which requires that payments for inpatient hospital services not exceed the hospital's customary charges; (e) Section 447.280 implements section 1913(b) of the Act, which concerns reimbursement for long-term care services furnished by swing-bed hospitals.*

42 CFR Part 438, Managed Care: Requirements regarding managed care providers.

Program Description

The mission of the Rates Section is to establish rates for health care providers that ensure clients have access to quality care, while containing program expenditures and accurately reflecting legislative intent in the most cost-effective manner.

Functions of the Rates Section include:

- Set and administer rates for Federally Qualified Health Centers, Rural Health Clinics, hospitals, and other provider services, including dental services;
- Set rates for managed care organizations including health maintenance organizations;
- Set rates for Programs of All-Inclusive Care for the Elderly and Mental Health Assessment and Services Agencies; and,
- Set rates for and administer the Pharmacy Unit.

Summary of Activities

Federally Qualified Health Center and Rural Health Clinic Reimbursement Rates: A Federally Qualified Health Center is a community-based clinic that receives funding from the U.S. Department of Health and Human Services to serve low-income and indigent patients. Outpatient care provided at these centers or at a Rural Health Clinic is reimbursed according to the federal guidelines of the Benefits Improvement and Protection Act of 2000, which requires a reimbursement rate that is at least equal to the prospective payment system rate. The Act requires that payments be established on the 1999 and 2000 federal fiscal year cost reports that are trended forward based on the Medicare Economic Index, creating a prospective payment rate. The Department reimburses the facilities at the higher of 1) the prospective payment system rate, or 2) the rate set by methodology that was used prior to the enactment of the Benefits Improvement and Protection Act.

Hospital Services Rates: Except for fee-for-service psychiatric care, which is reimbursed with a per diem rate, inpatient hospital services are reimbursed using rates built with a prospective payment methodology based on diagnostic-related groupings. Outpatient hospital services are ultimately reimbursed at the lower of 72% of cost or 72% of charges. During the year, outpatient hospital services are reimbursed based on a percentage of charges. This percentage rate is determined by the State based upon an estimate of costs and is later reconciled to 72% of cost or charges when audited cost reports are available.

Managed Care Organization Capitation Rates: Rates for managed care organizations are calculated based on fee-for-service data consisting of the Primary Care Physician population and the unassigned population. Rates cannot exceed 95% of the direct health care cost of providing the same services on an actuarially equivalent Colorado Medicaid population group consisting of unassigned recipients and recipients in the Primary Care Physician Program. The Section also calculates rates for the Medicaid Community Mental Health Services Program.

Program for All-Inclusive Care for the Elderly Rate Setting: The Rates Section calculates blended premiums for the Program for All-Inclusive Care for the Elderly. The Program for All-Inclusive Care for the Elderly is a joint Medicare and Medicaid program that includes all of the health care costs to meet the need for acute care and long-term care for clients who qualify for long term care services. The program premium includes a geographic blend of rates and a blend of rates for the two different long-term care programs, nursing home facilities, and home and community based waiver programs. Each long-term care program cost is represented in the blend proportionally to the associated population identified from a health needs assessment completed for long term care.

Pharmacy Unit: Rates for prescription drugs are set at a percent of the Average Wholesale Price (a recognized standard from which drug prices are built), not to exceed the federal maximum allowable charge, plus a dispensing fee per prescription. The federal maximum allowable charge is an amount determined by the Centers for Medicare and Medicaid Services for every type of drug for which a multi-source generic substitute exists. Drugs for which no generic substitutes exist do not have a federally defined maximum charge. The following tasks are involved in the administration of the pharmacy program:

- Develop and implement pharmacy related policies, analyses, and reports using statistical methods;
- Develop cost estimates to modify current pharmacy policies in relation to long term fiscal planning in the fee-for service and managed care programs;
- Review and revise the current formulary and implement changes to the prior authorization criteria;
- Review claims processed by the fiscal agent to oversee quality assurance practices; and,
- Manage the fiscal agent contract that provides a retrospective drug utilization review program designed to improve clinical outcomes and reduce drug expenditures by eliminating inappropriate drug use and dosage.

FY 05-06 Prioritized Objectives and Performance Measures

1.1 To maximize the opportunity to maintain health care services through the purchase of services in the most cost-effective manner possible.
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 will effectively utilize the Drug Utilization Review Board to identify opportunities for cost savings, and schedule the Board to meet on a quarterly basis.
1.3 To assure payments in support of the programs are accurate and timely.
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.
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.
The Rates, Analysis, and Program Integrity Division will respond to requests for ad hoc reports within 10 business days, 90% of the time.
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.

Similar or Cooperating Programs and Stakeholders

Residential Treatment Programs
Health Maintenance Organizations
Child Health Plan Plus
Colorado Community Health Network
Colorado Department of Public Health and Environment
Colorado Health and Hospital Association
Colorado Rural Health Centers
Community Centered Boards
Community Mental Health Centers
Colorado Behavioral Healthcare Council
Healthcare Financial Management Association Reimbursement Committee
Pharmacies, drug manufacturers, and advocates
Prescription Drug Card Services
Drug Utilization Review Board

PROGRAM CROSSWALK

Summary Section

Program Title: Data Section

Change Request(s): None

Long Bill Line Item
(1) Executive Director's Office
Personal Services
Health, Life and Dental
Short-term Disability
Salary Survey and Senior Executive Service
Performance-based Pay
Worker's Compensation
Operating Expenses
Legal Services and Third Party Recovery Legal Services for 12,684 hours
Administrative Law Judge Services
Payment to Risk Management and Property Funds
Capitol Complex Leased Space
(2) Medical Services Premiums
(5) Other Medical Services
SB 97-101 Public School Health Services

Federal/State Statutory and Other Authority

25.5-1-104 (3), C.R.S. (2004): *The executive director may establish such divisions, sections, and other units within the state department as are necessary for the proper and efficient discharge of the powers, duties, and functions of the state department…*

26-4-531, C.R.S. (2004), Health Services – provision by school districts: Allows school districts to contract with the Department to receive federal matching funds for amounts spent in providing health services through the public schools to students who are receiving Medicaid benefits pursuant to this article.

Program Description

Information is a critical enabling factor that drives industry, commerce, education, and government. The implementation of technology systems has created a complex and sometimes overwhelming growth in the ability to accumulate and store information data. In addition, the rapid pace of technological advancement has changed expectations, creating a demand for the convenient and responsive delivery of complicated information. The Department recognizes the critical need for professional, efficient, consistent, and appropriate analysis of the information, and as such, staffs a Data Section. The Data Section provides an integral piece of the foundation for an effective and well-managed use of departmental information. The focus of the Section is to address the difficult and complex data analysis needs presented by many interrelated entities.

Functions of the Data Analysis Section

The Section provides services that:

- Enhance the quality and quantity of available analytical products and services;
- Lay the foundation for departmental analytical data needs planning;
- Promote, pursue, and leverage analytical data resources of the Department;
- Establish standards for the use of appropriate and disciplined analytical methodologies for use in making strategic and fiscally responsible decisions;
- Develop practices for the request, reporting and use of data section products, thereby presenting a consistent delivery of information in internal and external reports, irrespective of section boundaries;
- Promote coordination of analytical data information across multiple sections and systems;
- Provide benchmarks and peer comparisons of providers and managed care organizations to find negative and positive outliers.
- Assist program sections to achieve their own missions by providing professional analytical data support;
- Process certain managed care enrollments and disenrollments;
- Administer the Drug Rebate Program; and,
- Administer the School Health Services Program.

Summary of Activities

The Section extracts and manipulates data for research, policy formation, report writing, forecasting, and rate setting for Department programs. Some examples of Data Section products and services are:

- Assist in calculating the fiscal impact of new legislation;
- Acquire and organize data from various information systems;
- Meet the Department's mandate to report quantitatively to the state legislature, the federal government and others;
- Determine trends and projections on eligibility data, costs, and benefit services;
- Provide samples and alternatives demonstrating the implications of various policy decisions; and,
- Measure provider performance via peer benchmarking.

This Section also analyzes historical changes in rates through providing a more efficient identification of cost drivers and comparing data over time and categories. The Section establishes a consistent and reliable framework for the appropriate use of historical data by identifying system parameters, configuring information, and developing accurate graphic representations.

Additional Activities

Managed Care: In addition to data analysis, the Section has the responsibility to assist rate setting and benefits staff in ensuring a) correct payment to the managed care organizations, and b) correct and efficient interface between the fiscal agent and the Department for payment to managed care providers.

Drug Rebate Program: Medicaid covers for any drug made by a manufacturer that contracted with the Centers for Medicare and Medicaid Services. In exchange, those manufacturers agreed to rebate an amount of funds based on utilization data for each drug covered under the Medicaid program. The Data Section researches pharmaceutical claims data, reconciles data with manufacturer invoices, submits the results to manufacturers to obtain rebate payment, conducts follow-up on non-payment, and settles dispute differences.

School Health Services Program: The program reimburses public school districts for the provision of health services to students with Medicaid funds. These funds are the federal share of the cost of providing the health care for Medicaid eligible students in the schools. The school district certifies that local and state funds are spent to meet the State share of the cost of providing health care services. These funds can then be used by schools to provide additional health services for all students. The Department works jointly

with the Department of Education to ensure that funds are expended in a manner consistent with 26-4-531, C.R.S. (2004). Both Departments' administrative costs are paid from the reimbursed funds.

FY 05-06 Prioritized Objectives and Performance Measures

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.
The Rates, Analysis, and Program Integrity Division will respond to requests for ad hoc reports within 10 business days, 90% of the time.

Similar or Cooperating Programs and Stakeholders

ACS (fiscal agent)
Advocates for children with special needs
Boards of Cooperative Education Services and Public School Districts
Colorado Assisted Housing Services Association
Residential Treatment Programs
Colorado Community Health Network
Colorado Department of Education
Colorado Department of Public Health and Environment
Colorado Health and Hospital Association
Colorado Residential Care Association
University of Colorado, School of Nursing
Colorado Rural Health Centers
Colorado School for the Deaf and the Blind
Community Centered Boards
Community Mental Health Centers
Home Care Association of Colorado
Parent-teacher-student associations

PROGRAM CROSSWALK

Summary Section

Program Title: Program Integrity Section

Change Request(s): None

Long Bill Line Item
(1) Executive Director's Office
Personal Services
Health, Life and Dental
Short-term Disability
Salary Survey and Senior Executive Service
Performance-based Pay
Worker's Compensation
Operating Expenses
Legal Services and Third Party Recovery Legal Services for 12,684 hours
Administrative Law Judge Services
Payment to Risk Management and Property Funds
Capitol Complex Leased Space
(2) Medical Services Premiums

Federal/State Statutory and Other Authority

42 CFR Part 455, Program Integrity: Sets federal requirements for detection and investigation of fraud and for disclosure of information by providers and fiscal agents.

26-4-403 (2), C.R.S. (2004), Recoveries - overpayments - penalties - interest - adjustments – liens: Provides for recovery of overpayments to providers.

Program Description

The Program Integrity Section conducts post payment reviews on Medicaid providers that are either randomly selected for review or when complaints received warrant a full investigation. The mission of the Program Integrity Section is to monitor, and improve provider accountability to the Medicaid program. When Program Integrity staff identify potentially excessive or improper utilization or improper billing of the Medicaid program by providers, they follow up to investigate, classify, and recover payments and refer to the providers legal authorities for possible prosecution when appropriate. Interventions for improper use of the Medicaid program may be imposed for fraudulent or abusive practices by clients or providers, and can range from education and recovery of overpayments to restriction or exclusion from participation in the program. Civil and criminal sanctions may also be imposed by the State.

Specific Program Integrity activities include:

- **Complaint Investigation, Overpayment Identification, and Referral Process:** When complaints are received about abuse of the Medicaid program by providers that may have resulted in overpayments, a preliminary investigation is initiated. Based on findings from the preliminary investigation a full investigation and recovery efforts may take place. If intentional program abuse is indicated or suspected, referral to the Medicaid Fraud Control Unit is made.

- **Provider Sanctioning:** In addition to the sanction databases that Program Integrity accesses from the Office of Inspector General and the Centers for Medicare and Medicaid Services, Program Integrity will access the disciplinary actions of all providers licensed through the Department of Regulatory Agencies. When a Medicaid provider is identified as having a relevant action against their license, the Department takes appropriate action within the Medicaid program. Actions may include letters of admonishment, practice restrictions, practice monitoring, suspension, and/or termination from the program.

- **Explanation of Medical Benefits:** The Department, in compliance with federal requirements, randomly surveys a percentage of clients to verify that the client has received services billed to Medicaid. Any incidents of potential billing error reported by the client are investigated.

- **Facility Credit Balance Audits:** The Department has a contingency-based contract with Health Management Systems to conduct audits of facility credit balances due Medicaid. The program includes a provider/facility education component. Credit balances due to Medicaid are investigated and recovered.

- **Post Payment Review:** The Department has a contingency-based contract with Health Watch Technologies to provide post payment review of billed/paid Medicaid claims. Health Watch Technologies uses the latest claims analysis software to assist the Department in identifying, investigating, and recovering payment for potentially fraudulent, abusive, or inappropriate billing of services.

- **Provider Self Disclosure and Self-Audit:** The Department has implemented a pilot project to encourage and improve provider compliance with Medicaid requirements, decrease provider billing abnormalities, improve provider documentation, and increase provider accountability. The pilot educates providers regarding the option to self-disclose billing errors and work in collaboration with the Department to implement a corrective action plan, which will include repayment when indicated.

FY 05-06 Prioritized Objectives and Performance Measures

1.1 To maximize the opportunity to maintain health care services through the purchase of services in the most cost-effective manner possible.
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.

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.
The Rates, Analysis, and Program Integrity Division will respond to requests for ad hoc reports within 10 business days, 90% of the time.

Similar or Cooperating Programs and Stakeholders

Medicaid Fraud Control Unit in the Department of Law– investigation of Medicaid criminal fraud
Single Entry Points – utilization review activities

PROGRAM CROSSWALK

Summary Section

Program Title: Community Based Long Term Care Section

Change Request(s): Move Case Management from Mental Health Community Programs to Medical Services Premiums

Long Bill Line Item
(1) Executive Director's Office
Personal Services
Health, Life and Dental
Short-term Disability
Salary Survey and Senior Executive Service
Performance-based Pay
Worker's Compensation
Operating Expenses
Legal Services and Third Party Recovery Legal Services for 12,684 hours
Administrative Law Judge Services
Payment to Risk Management and Property Funds
Capitol Complex Leased Space
Single Entry Point Administration
Single Entry Point Audits
(2) Medical Services Premiums
(5) Other Medical Services
Home Care Allowance
Adult Foster Care

Federal/State Statutory and Other Authority

26-2-122.3, C.R.S. (2004): Establishes the Adult Foster Care and Home Care Allowance programs.

26-4-202 (1), C.R.S. (2004): Home health services are mandated services.

26-4-302, C.R.S. (2004): Home- and community-based services, intermediate care facilities for the mentally retarded, case management, therapies under home health services, private duty nursing services, hospice care, and the Program of All-inclusive Care for the Elderly are optional services.

26-4-509, C.R.S (2004): Establishes the children's Home- and Community-Based Services program.

26-4-522, C.R.S. (2004): Establishes the single entry point system enabling persons eighteen years of age or older in need of long-term care to access appropriate long-term care services.

Program Description

All long-term care services not provided in a nursing facility or hospital are called "community-based services." These include services provided in patients' homes, as well as in residential care settings of various types. Services include home health, private duty nursing, and hospice, which are skilled services available to all Medicaid clients; various unskilled waiver services, that are available only to clients enrolled in waiver programs; and two state-only programs – Home Care Allowance and Adult Foster Care. Waiver services include personal care, homemaker, home modification, electronic monitoring, adult day care, alternate care facility, and specialized services for clients in the Brain Injury Waiver.

Currently, the only community-based service reimbursed with a cost-based methodology is adult day services. The Department is exploring strategies to develop effective reimbursement systems for alternative care facilities, home health, and personal care agencies. Federal regulations determine hospice rates. Rates for various service categories are periodically increased for inflation and to move towards more effectively covering providers' costs. Community-based services are reimbursed in various ways, depending on the type of service.

The Section has responsibility for contractual oversight of the Program of All-Inclusive Care for the Elderly. This program is an integrated care and financing model where Medicaid and Medicare capitate the provider. The provider then has an incentive to prevent institutionalization of members and assure their success and well being in the community.

The Section also cooperates through contractual arrangements with other state and local entities for key long term care services. Twenty-five regional Single Entry Point agencies are responsible for assessment and case management of long-term care clients living in the community. The Department contracts with the Department of Public Health and Environment, Health Facilities Division to survey alternative care facilities, home health agencies and personal care agencies. The Department of Human Services is contracted to operate the Developmentally Disabled Waiver, the Residential Treatment Center Waiver, the Supported Living Services Waiver and the Children's Habilitation Residential Waiver. The Department contracts with an independent party to conduct financial audits of Single Entry Point agencies.

FY 05-06 Prioritized Objectives and Performance Measures

1.3 To assure payments in support of the programs are accurate and timely.
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.
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.
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.

Similar or Cooperating Programs and Stakeholders

The Department provides necessary Medicaid funded community based long term care services to clients in waiver programs for children; for those with mental illness; persons living with AIDS; persons with brain injury; the elderly, blind and disabled; and, developmentally disabled individuals. Home health and hospice are also benefits of Medicare and some private insurance plans. Many community-based elderly and disabled clients (Medicaid and non-Medicaid) receive substantial unpaid care from family, friends, and non-profit organizations. Stakeholders include:

- Clients who require accessible quality care in order to live as independently as possible;

- Medicaid participating providers who require accurate, timely payments of sufficient amount to enable them to provide quality care; and,
- Single Entry Point agencies that require adequate reimbursement and training to enable them to properly assess and manage community based clients in a cost effective manner.

PROGRAM CROSSWALK

Summary Section

Program Title: Nursing Facilities Section

Change Request(s): Nursing Facility Audits

Long Bill Line Item
(1) Executive Director's Office
Personal Services
Health, Life and Dental
Short-term Disability
Salary Survey and Senior Executive Service
Performance-based Pay
Worker's Compensation
Operating Expenses
Legal Services and Third Party Recovery Legal Services for 12,684 hours
Administrative Law Judge Services
Payment to Risk Management and Property Funds
Capitol Complex Leased Space
Nursing Facility Audits
Nursing Home Preadmission and Resident Assessments
Nursing Home Quality Assessments
(2) Medical Services Premiums
(5) Other Medical Services
State Nursing Facility Service Program

Federal/State Statutory and Other Authority

42 U.S.C. 1396a Sec 1902 (a)(10)(A) mandates that nursing facilities be part of the state plan.

42 U.S.C. 1396a Sec 1919 consists of nursing facility service requirements and definitions.

26-4-410, C.R.S. (2004): Requires the Department to set rates for nursing facilities and intermediate care facilities for the mentally retarded.

26-4-501 through 26-4-505.5, C.R.S. (2004) instructs the Department on how to set nursing facility rates.

Program Description

The Nursing Facilities Section is responsible for financial, contractual and policy development functions within the Colorado Medicaid Nursing Facility Program. Specifically, the Section is responsible for the calculation of reimbursement rates for providers that comport with the statutory methodology and for decisions regarding cost reporting, client placement and provider performance evaluation in a manner that ensures: appropriate access to necessary services, compliance with federal and state law, judicious use of State resources, and accountability among providers for the delivery of services to Medicaid clients.

<u>Nursing Facilities Section functions include</u>:

- Implementing nursing facility rates and intermediate care facilities for the mentally retarded rates;
- Responding to facility rate appeals and representing the Department in litigation;
- Administering rate adjustments, cost settlements and billing reconciliations;
- Administering contracts for facilities auditing and appraisal services;
- Assisting in and monitoring facility change-of-ownership processes to ensure that the new owners are financially viable and can meet Medicaid quality standards and administrative procedures;
- Administering quality incentive programs set forth in State statutes and regulations;
- Monitors Pre-Admission Screening and Annual Resident Reviews;
- Administering the Medicaid bed certification procedures and related provider requests;
- Administering appropriate placement of Medicaid clients with medically complex conditions in the Hospital Back-up program; and,

- Administering the Post-Eligibility Treatment of Income (PETI) program, as required under federal regulations.

Specific reimbursement methods vary by type of provider, due to variations in the law and health care delivery environment. The Department reimburses nursing facilities using a cost-based methodology that is set and described in State statute.

The Department contracts with the following two types of nursing facilities:
- Class 1: skilled/intermediate nursing facilities (193 facilities at the time of this writing)
- Classes 2 and 4: intermediate care facilities for the mentally retarded (3 facilities at the time of this writing)

For each class, the Department establishes a maximum reasonable payment of each of three categories of cost:
- Direct health care costs (nursing, therapy, social services, activities, food, medical supplies, etc.)
- Administrative costs
- Fair rental allowance for capital-related assets (physical plant costs)

The Nursing Facilities Section implements rates and monitors the performance of approximately 200 skilled nursing facility providers. These providers deliver services to approximately 10,000 Medicaid clients at any given time. During FY 03-04, the Department accomplished several policy and operational objectives, including implementation of new rule re-writes to clarify, enhance, and assure the appropriateness of the Post-Eligibility Treatment of Income program, out-of-state placements and the licensing of Medicaid nursing facility beds.

FY 05-06 Prioritized Objectives and Performance Measures

1.2 To support timely and accurate client eligibility determination.
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.

Similar or Cooperating Programs and Stakeholders

Medicare provides for skilled nursing care in long term care facilities under Title 18 of the Social Security Act (Medicare), within the Part A Hospital coverage. This care is limited to medically necessary skilled services with a maximum of 100 days coverage per “spell of illness.” Medicare covers 100% for the first 20 days with a 20% per diem co-pay for the remainder of the stay, up to an additional 80 days.

PROGRAM CROSSWALK

Summary Section

Program Title: Systems Change Section

Change Request(s): None

Long Bill Line Item
(1) Executive Director's Office
Personal Services
Health, Life and Dental
Short-term Disability
Salary Survey and Senior Executive Service
Performance-based Pay
Worker's Compensation
Operating Expenses
Legal Services and Third Party Recovery Legal Services for 12,684 hours
Administrative Law Judge Services
Purchases of Services from Computer Center
Payment to Risk Management and Property Funds
Capitol Complex Leased Space
HB 01-1271 Medicaid Buy-in
(2) Medical Services Premiums

Federal/State Statutory and Other Authority

26-4-903, C.R.S. (2004): Authorizes the consumer-directed attendant support pilot program for persons with disabilities.

26-4-1403, C.R.S. (2004): Authorizes the Department to offer in-home support services as an option for eligible persons who receive home-and community-based services.

26-4-1302, C.R.S. (2004): Authorizes the consumer-directed care for the elderly for eligible persons who receive home-and community-based services.

Program Description

The Section administers three federal grants under the Systems Change for Community Living initiative, sponsored by the Centers for Medicare and Medicaid Services. These grants are part of the federal New Freedom Initiative, and are designed to help states address issues raised by the Olmstead decision. [1] The Section also provides a home for three legislative initiatives related to consumer direction, as well as for a federal Medicaid Infrastructure Grant. Below is a listing of the grants and consumer direction initiatives that are the responsibility of this Section.

Grants	**Consumer Direction Initiatives**
Systems Change for Real Choices	Consumer Directed Attendant Support
Community Personal Assistance Services and Supports	Consumer Directed Care for Elderly
New Employment Incentives for Independence	In-Home Support Services
Independence Plus	

FY 05-06 Prioritized Objectives and Performance Measures

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.
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.

Similar or Cooperating Programs and Stakeholders

Stakeholders and cooperating agencies vary with the different projects, but typically include Medicaid consumers, health care advocates, community-based long-term care providers and representatives from the Department of Human Services.

[1] The Olmstead Decision was a 1999 Supreme Court ruling, which indicated that states could be in violation of the Americans with Disabilities Act if they were not ensuring that individuals were receiving services in the most integrated setting appropriate for the individual.

PROGRAM CROSSWALK

Summary Section

Program Title: Eligibility Section

Change Request(s): None

Long Bill Line Item
(1) Executive Director's Office
Personal Services
Health, Life and Dental
Short-term Disability
Salary Survey and Senior Executive Service
Performance-based Pay
Worker's Compensation
Operating Expenses
Legal Services and Third Party Recovery Legal Services for 12,684 hours
Administrative Law Judge Services
Payment to Risk Management and Property Funds
Capitol Complex Leased Space
Disability Determination Services
(6) Department of Human Services Medicaid Funded Programs
(D) County Administration – Medicaid Funding

Federal/State Statutory and Other Authority

26-4-106, C.R.S. (2004): Provides the Department, county departments and medical assistance sites may accept applications for, and determine eligibility for medical assistance.

26-4-104, C.R.S. (2004): Requires the Department to establish a medical assistance program in compliance with federal law.

Program Description

The mission of the Medicaid Eligibility Section is to provide client-focused access to Medicaid for eligible families, children, elders, and persons with disabilities. The Section defines program eligibility through policy development and training to counties and other agencies. The Section provides policy expertise on Medicaid eligibility for all categories for the rules-based eligibility computer system, the Colorado Benefits Management System. Specifically, the Section is focused on assuring:

- An eligibility process that is efficient, accessible, and client focused and that fairly applies eligibility policy across the State;
- All county departments of social services/human services receive sufficient information and training to properly determine Medicaid eligibility promptly and accurately; and
- That the Colorado Benefits Management System accurately and fully reflects all Medicaid eligibility rules in an integrated eligibility determination system.

Trends and Other Baseline Information

The Section develops and disseminates policy information around medical assistance eligibility. The central charges to the Section related to this role are to:

- Design eligibility policy for Colorado Medicaid in response to state and federal statutory change;
- Design eligibility processes for Colorado Medicaid;
- Develop and disseminate program information to Medicaid clients; and,
- Develop training on Medicaid eligibility for field agents (county departments of social services, Single Entry Points agencies, presumptive eligibility sites, outreach workers).

Determining Medicaid Eligibility

An individual obtains Medicaid coverage by establishing eligibility under a particular Medicaid eligibility category. The Eligibility Section develops eligibility policy and administers eligibility functions through contracts with other agencies. A Colorado resident makes application at a county department or medical assistance site that makes the eligibility determination.

Development of Client Information and Staff Training Tools

The Eligibility Section staff develops client information materials. The Section also develops and conducts training for local agencies that carry out eligibility determination functions.

FY 05-06 Prioritized Objectives and Performance Measures

1.2 To support timely and accurate client eligibility determination.
The Medicaid Eligibility Quality Control Unit will utilize Colorado Benefits Management System quality control programming in two of three pilots for FY 05-06.
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.
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.
Client Services will conduct semi-annual Eligibility Trainings for county and Medical Assistance site technicians.

Similar or Cooperating Programs and Stakeholders

The federal Centers for Medicare and Medicaid Services administer the federal program Medicare, which does provide a range of health care benefits to elders and some disabled individuals. The Child Health Plan Plus also provides medical coverage to children up to 185% of poverty who are not Medicaid eligible. Disability Determinations for federal Supplemental Security Income are performed by Disability Determinations Services in the Department of Human Services. This Section also works closely with counties and the Department of Human Services in eligibility functions.

PROGRAM CROSSWALK

Summary Section

Program Title: Benefits Coordination Section

Change Request(s): None

Long Bill Line Item
(1) Executive Director's Office
Personal Services
Health, Life and Dental
Short-term Disability
Salary Survey and Senior Executive Service
Performance-based Pay
Worker's Compensation
Operating Expenses
Legal Services and Third Party Recovery Legal Services for 12,684 hours
Administrative Law Judge Services
Payment to Risk Management and Property Funds
Capitol Complex Leased Space
Estate Recovery
(2) Medical Services Premiums

Federal/State Statutory and Other Authority

26-4-403, C.R.S. (2004), Recoveries - overpayments - penalties - interest - adjustments - liens: Requires the Department to recover medical assistance benefits paid on behalf of recipients from liable third parties.

26-4-403.3, C.R.S. (2004), Estate Recovery: Requires the Department to recover the cost of medical assistance paid on behalf of recipients from the estates of recipients.

26-4-518.5, C.R.S. (2004), Purchase of health insurance for recipients: Requires the Department to purchase group health insurance for a medical assistance recipient who is eligible to enroll for such coverage if enrollment of such recipient in the group plan would be cost-effective.

26-4-506.5, C.R.S. (2004): Requires the Department to review trusts created for the purpose of obtaining Medicaid eligibility to ensure compliance with state and federal law.

42 CFR Part 431, Subpart P, Quality Control: Establishes requirements for Medicaid eligibility quality control (MEQC) program designed to reduce erroneous expenditures by monitoring eligibility determinations.

Program Description

Benefits Coordination exists to determine whether or not there is another payer who has liability for part or all of the costs of purchasing care on behalf of Medicaid beneficiaries and to reduce Medicaid costs by purchasing health insurance for qualified clients.

The mission of the Benefits Coordination Section is to extend public purchasing power by pursuing third party payment of medical costs for Medicaid-eligible persons. The Benefits Coordination Section pursues responsible payment sources to recover costs for medical care paid for by Medicaid, to include trusts and estate recoveries in addition to recovering payments from clients who were discovered to be ineligible for Medicaid retroactively. Federal law requires that Medicaid be the "payer of last resort." Medicaid should not pay for health care services for which any other entity is responsible. Applicants for Medicaid coverage are required to provide information on any resource(s) they have that may pay for health care services. Recoveries are offset against expenditures in the Medical Services Premiums line, resulting in lower net expenditures for Medicaid.

Other payer sources that are liable for payment prior to Medicaid include, but are not limited to, Medicare, CHAMPUS, commercial health insurance policies, or health maintenance organization plans that are a benefit of employment or retirement, or that are individual plans, as well as liability coverage such as auto insurance and homeowner policies. In addition to obtaining information directly from Medicaid applicants, Colorado receives notice of other health care resources through sources such as the Social Security Administration, Workers' Compensation, Office of Child Support Enforcement, and the Department of Labor and Employment (for non-custodial parents who provide medical support for their children). The Department utilizes a contractor on a contingency fee arrangement for data matching of Medicaid eligible clients with insurance carriers in Colorado and with Medicare.

Cost avoidance and post-payment programs administered by the Benefits Coordination section include:

1. Cost avoidance through obtaining payment by non-Medicaid sources including absent parents' medical support coverage;
2. Health insurance buy-in program;
3. Tort/casualty recovery;
4. Trust recovery;
5. Estate recovery;
6. Recipient Recovery;
7. Commercial insurance recovery;
8. Medicare Part A and B recovery;
9. CHAMPUS recovery;
10. Medicaid Eligibility Quality Control pilots and audits of client eligibility determinations processed by county departments of social and/or human services; and,
11. Trust review and approval.

- **Cost Avoidance Resulting from Payment by Non-Medicaid Health Care Sources:** In FY 03-04, approximately 4,163 clients were known at any given time to have other sources of health coverage, not including Medicare. When reported, this coverage is verified and loaded into a resource file that the fiscal agent utilizes to set denial edits on billed claims, that without third party payment information, result in Medicaid being billed as the primary payer. These cost avoidance activities saved Colorado over $14.97 million in FY 03-04.

- **Cost Avoidance Resulting from Medicare and Health Insurance Buy-In Program:** To reduce Medicaid costs, the State pays monthly premiums to "buy in" Medicaid clients into Medicare or private health insurance plans. The cost of the premiums is much less than the cost of claims the State would have to pay for health services rendered under Medicaid. During FY 03-04, approximately 59,504 Medicaid clients per month had Medicare Part B coverage purchased by the State, an increase in Part B "buy-in" clients over FY 02-03 (58,645). A total of $49,805,688 in Medicare Part B premiums was paid under the buy-in program. Medicaid saved an estimated $139,292,028 in FY 03-04 for health care payments through this purchased coverage. A total of $1,530,425 in Medicare Part A premiums was paid under the buy-in program for an average of 349 clients per month. The Department saved an estimated $128,686,225 in health care expenditures via this cost avoidance action in FY 03-04.

  The Health Insurance Buy-in program, paying cost-effective premiums for commercial insurance, paid $687,446 in FY 03-04, for a monthly average of 368 Medicaid clients. The total cost avoidance associated with the health insurance buy-in program for FY 03-04 is estimated at $1,649,644, for a net savings of $962,198.

- **Tort/Casualty Recovery:** The Medicaid program attempts to recover payments made from third parties who are liable as insurers in the case of auto, accident, homeowner's policies, worker's compensation, or through tort litigation. Benefit Coordination staff manage these recovery activities which also include malpractice cases, often coordinating efforts with the Attorney General staff in particularly difficult legal cases. As a result, the program recovered $2,114,750 in FY 03-04.

  Health Management Systems was awarded a contingency fee contract in FY 03-04 to pursue tort recoveries previously unknown to the Department, as well as assume the responsibility for the non-reported Worker's Compensation cases that are listed on a quarterly report. This contract recovered the net amount of $48,730 in FY 03-04.

- **Trust Recovery:** Income and disability qualifying trusts provide a mechanism for individuals, whose incomes and/or assets would otherwise make them ineligible, to qualify for Medicaid. For income trusts, the client's income, minus a small personal needs amount, is placed in a trust. Disability trusts are created from settlement agreements that provide an income source for the client for non-Medicaid services. The Medicaid program pays for the client's medical care and is the beneficiary of the trust monies when the trust is closed. In FY 03-04, $1,449,835 was recovered. The Benefits Coordination Section administers the approval, closing, and accounting for these trusts.

- **Estate Recovery:** The Estate Recovery program, operated by a contractor under supervision of State staff, recovers funds from estates and places Tax Equity and Financial Responsibility Act of 1992 liens on real property held by Medicaid clients in nursing facilities. The total net estate recoveries for FY 03-04 were $4,281,906.

- **Retractions/Recoveries:** The State contracts with Health Management Systems, a contingency-based contractor, to identify recovery opportunities through the use of expanded data matches. The State retracts the value of Medicaid-paid claims if a third party is later identified as a primary payer. Health Management Systems recouped a net amount of $11,512,388 in FY 03-04.

Recoveries by Program Areas

Summary of Third Party Cost Avoidance and Post-Payment Recovery	
Program	**FY 03-04**
Cost Avoidance	
Payment by Non-Medicaid Health Care Sources	$14,970,000
Medicare Buy-In	$216,642,140
Private Health Insurance Buy-In	$962,198
Subtotal, Cost Avoidance	**$232,574,338**
Cost Recovery	
Tort/Casualty Recovery	$2,163,480
Estate Recovery	$4,281,906
Income Trust Recovery	$1,449,835
Subtotal, Cost Recovery	**$7,895,221**
Contractor Recoveries	
Family Planning Federal Financial Participation	$2,723,276
Medicare Part A retractions	$3,772,558
Medicare Part B payments	$52,124
Commercial Insurance Payments	$4,534,207
Other Recoveries (includes adjustments for refunds)	$430,223
Subtotal, Contractor Recovery	**$11,512,388**
Total Avoided And Recovered Costs	**$237,011,947**

Note: All recoveries are net of any premiums or contingency fees paid.

FY 05-06 Prioritized Objectives and Performance Measures

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.
The Client Services Division will maintain or increase recoveries over the prior year's level.
Client Services will implement a process to increase enrollment in the Health Insurance Buy-In program, pending Departmental approval of the project plan.

Similar or Cooperating Programs and Stakeholders

Tort and Casualty-private insurers (auto, homeowners, etc)
Attorneys (client attorneys, defense attorneys, district attorney, Attorney General's Office)
Medicaid clients
Centers for Medicare and Medicaid Services
County Departments of Human/Social Services
Social Security Administration
Third Party Liability Technical Advisory Group

Operations and Finance Office

- **Information Technology Division**
  IT Contract Monitoring Section
  Eligibility Systems Development
  Information Technology Support Section

- **Safety Net Financing Section** (includes Colorado Indigent Care Program, Comprehensive Primary and Preventive Care Grant Program, and the Old Age Pension State Medical Program)

- **Child Health Plan *Plus* Division** (includes the Program Integration and Evaluation Section, Contracts and Operations Section, and the Information Technology Liaison)

- **Controller and Operations Division** (includes the Human Resources Unit, the Accounting Section, and the Purchasing Unit)

- **Budget Division**

PROGRAM CROSSWALK

Summary Section

Program Title: Information Technology Contract Monitoring Section

Change Request(s): Fiscal Agent Fixed Price Contract Adjustments
MMIS Federally-Mandated Reprocurement

Long Bill Line Item
(1) Executive Director's Office
Personal Services
Health, Life and Dental
Short-term Disability
Salary Survey and Senior Executive Service
Performance-based Pay
Worker's Compensation
Operating Expenses
Legal Services and Third Party Recovery Legal Services for 12,684 hours
Administrative Law Judge Services
Purchases of Services from Computer Center
Payment to Risk Management and Property Funds
Capitol Complex Leased Space
Medicaid Management Information System Contract
Health Insurance Portability and Accountability Act of 1996 (HIPAA) Web Portal Maintenance
Health Insurance Portability and Accountability Act of 1996 (HIPAA) Security Rule Implementation
Medicaid Authorization Cards and Identification Cards

Federal/State Statutory and Other Authority

45 CFR 95.601 – 641: Part 95 General Administration – Grant Programs (Public Assistance and Medical Assistance), Subpart F – Automated Data Processing Equipment and Services – Conditions for Federal Financial Participation Defines the MMIS and describes conditions for receipt of FFP.

42 CFR 433.110 – 131: Part 433—State Fiscal Administration, Subpart C – Mechanized Claims Processing and Information Retrieval Systems Describes what the MMIS must do in order to claim FFP, describes when and how the 90% rate is to be claimed.

26-4-403.7, C.R.S. (2004): Automated medical assistance administration.
(1) The general assembly hereby finds and declares that the agency responsible for the administration of the state's medical assistance program would be more effective in its ability to streamline administrative functions of program administrators and providers under the program through the implementation of an automated system that will provide for the following: (a) Electronic claim submittals; (b) On-line eligibility determinations; (c) Electronic remittance statements; (d) Electronic fund transfers; and (e) Automation of other administrative functions associated with the medical assistance program.

45 CFR 160.101 – 162.1802 Part 95 General Administration – Grant Programs (Public Assistance and Medical Assistance), Subtitle A, Subchapter C -- Health Insurance Portability and Accountability Act of 1996 (HIPAA) transactions and code sets.

45 CFR 165.101—524 Part 95 General Administration – Grant Programs (Public Assistance and Medical Assistance), Subtitle A, Subchapter C -- Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy provisions.

Program Description

The mission of the Information Systems Section is to ensure client access to medical services by assuring timely and accurate reimbursement to Medicaid and Children's Basic Health Plan providers; timely access to medical eligibility data by service providers; and reimbursement compliance with all aspects of State and federal regulations by implementing the policies governing the administration of Medicaid and Children's Basic Health Plan dollars within the computerized systems.

The Medicaid Management Information System receives eligibility information from the Colorado Benefits Management System. The information system processes claims and submits payment requests to the Colorado Financial Reporting System for actual warrants or

electronic funds transfers. In addition to the Medicaid Management Information System, the Section also manages the newly designed Decision Support System that provides the data and analysis tools to research and manage the multitude of Medicaid and Children's Basic Health Plan programs.

The mission of the Information Technology Contract Monitoring Section is to assure compliance with State and federal regulations affecting the Medicaid Management Information System operations and contracts associated with claims processing in order to support the mission of the Information Systems section. These activities include timely submission of Advance Planning Documents to the Centers for Medicare and Medicaid Services, contracts executed timely, monitoring of legislation leading to systems, and operational changes at the fiscal agent. In addition, this section is responsible for other information technology contracts and the implementation of Health Insurance Portability and Accountability Act (HIPAA) regulations as they become final from the federal government.

The Information Systems Section and the Information Technology Contract Monitoring Section direct the implementation and support of the fiscal agent contract for Medicaid Management Information System services. Medicaid is the primary payment source for health care services for over 365,000 (excluding retroactivity) of Colorado's low-income citizens. Medicaid coverage includes a broad array of services including such services as physician care, prescription drugs, hospital care, mental health care, long-term nursing facility care, and long-term home and community-based care. The Children's Basic Health Plan also covers physician care, prescription drugs, hospital care, and mental health care services for children, as well as dental services.

HIPAA Compliance

The Section coordinates a central Health Insurance Portability and Accountability Act (HIPAA) work plan that includes a wide range of contracts. This effort has included contracts with the fiscal agent, quality assurance and Independent Verification and Validation vendors as well as a security assessment vendor. HIPAA affects many state agencies, and all health care providers, plans and payers across the country. HIPAA also restricts reliance on local solutions in an effort to standardize health care transactions. For these reasons, coordination with other affected entities is important to success with any HIPAA effort. This Section has membership on the Governor's HIPAA Task Force, the Colorado Strategic National Implementation Task Force (to coordinate implementation with the statewide health care industry), and the National Medicaid HIPAA Work Group appointed by the National Association of Medicaid Directors. This Section is charged to contribute a national Medicaid voice to the development of national standards and guidelines for HIPAA implementation.

HIPAA requires change throughout the Department's systems and across many business processes. The Section is working extensively with departmental contractors for the Medicaid Management Information System and the third party administrator for

Child Health Plan Plus to specify and direct changes to the automated systems they operate, to review changes and accept deliverables. Staff works with program experts throughout the Department to make the business changes necessary to achieve HIPAA compliance.

Contract Management and Budget Development and Administration

The contracts this section is responsible for include Colorado Benefits Management System (CBMS), the web portal, the Medicaid Management Information System (MMIS), and the Medicaid identification card contract. The MMIS contract is a fixed price contract that encompasses the day-to-day operations of the system. When new initiatives are developed either through legislation or policy change, there are usually system and/or operational changes to the MMIS. New work requires new contract language, which is an integral part of the work this section does. To address changes adequately, a new information technology projects process has been initiated to identify any and all impacts to any and all information technology systems, including the web environment, CBMS, and infrastructure. By monitoring policy changes with potential system changes, budget impacts are identified early in order to establish a funding source and federal approval early for the necessary system changes. Given the complexity of the systems associated with claims submission and claims payment, it drives a high degree of budget activity.

Major Accomplishments:
Major accomplishments over the last year include the elements of the MMIS remediation to achieve HIPAA compliance in 2003 - 2004: 1) a new decision support system that complies with privacy and security, as well as better meeting the business needs of the Department; 2) phasing out of the old decision support system – Services, Tracking, Analysis, and Reporting System (STARS); 3) HIPAA transaction and code set implementation and training, eliminating the use of local codes by December 31, 2003. The Information Systems Section has been involved in design, development, and implementation processes necessary to allow claims to be received and information sent out in the HIPAA compliant formats; and 4) updating provider manuals and companion guides with the changes created by HIPAA compliance.

The following are additional accomplishments for FY 03-04:

- Added new prior authorization requirements to the prescription drug program for drugs identified as potential for inappropriate utilization in March 2004;
- Achieved compliance with the Federal Managed Care Mandate for reporting race, ethnicity, and language spoken on enrollment files submitted to our managed care contractors monthly;
- Facilitated the reenrollment of all Primary Care Physicians in the MMIS;
- Restructured and implemented copayment amounts and maximums in July in accordance with the Long Bill;

- SB 03-294 regarding generic drug mandates was implemented and the system now limits drugs based on number of tablets or units each 30 days; and,
- A new Diagnostic Related Grouping system change was installed with advanced logic for alcohol/drug rehab providers.

With the advent of the Colorado Benefits Management System, the Medicaid Management Information System will now be able to determine which clients are eligible for copayments and will do the purchasing of Medicare Buy-In using the new federal format. The old eligibility system (Client Oriented Information Network) used to do some of these functions.

In FY 03-04, the fiscal agent processed 16,721,888 claims, 18% more than the previous contract year (December 2002 – November 2003). These claims amounted to $2,417,767,646 processed through the Medicaid Management Information System, 11% higher than in FY 02-03. It should be noted that not all payments or adjustments to expenditures are recorded through the Medicaid Management Information System and therefore this figure is for comparison purposes only. Caseload growth and declining enrollment in health maintenance organizations are the primary causes for this increase.

Critical Issues

One new rule was made final this past year further applying administrative simplification. The final rule for the National Provider Identifier for HIPAA was published by the federal government on January 23, 2004, with a compliance date of May 23, 2007. This rule is unique in that the normal two-year implementation time line does not apply. The centralized data bank will begin operation by May 23, 2005, at which time the two-year time clock will start. The impact of this rule will be in the Medicaid Management Information System, run by our fiscal agent. The fiscal agent will conduct an assessment for and provide options for compliance with the rule that should be completed early 2005.

Other published rules will further implement provisions of the law, but a final effective date for full HIPAA implementation has not been estimated by the Centers for Medicare and Medicaid Services at this time. Each new rule must be implemented within 2 years of being made final. Further, each HIPAA rule can be revised annually, and revised rules must be incorporated within a year of promulgation.

As of August 16, 2004, the Centers for Medicare and Medicaid Services reported time frames for the release of the Notice of Proposed Rule Making (NPRM) for the following regulations:

- Claims Attachment, and — expected 2004 - 2005
- National Health Plan Identifier. — expected 2004 - 2005

FY 05-06 Prioritized Objectives and Performance Measures

1.3 To assure payments in support of the programs are accurate and timely.
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.
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.
Information Technology will increase decision support capacity from 5 years of history data to 7 years to allow increased trending capability.
2.2 Improve management of the Department's information systems technology.
The Information Technology Division will provide upgrades and replacements to Department infrastructure to support changing business needs, based upon available funding.
Information Technology will award the new fiscal agent contract and begin transition to the new contractor.
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.

Similar or Cooperating Programs and Stakeholders

Other states operate Medicaid Management Information Systems and eligibility systems, but there are no other systems in Colorado that provide similar services for Medicaid clients.

The following is a list of some of the departments and major stakeholders involved in successful implementation of the federal rules related to HIPAA for Colorado:
Governor's Office of State Planning and Budgeting
Governor's Office of Innovation and Technology
Colorado Department of Human Services
Centers for Medicare and Medicaid Services
All clients, health plans and providers, and certain business associates participating in the Colorado Medicaid or Child Health Plan Plus programs whose continuity of services depends on timely and effectively implementation.
Providers

PROGRAM CROSSWALK

Summary Section

Program Title: Eligibility Systems Development

Change Request(s): Fund Colorado Benefits Management System Maintenance

Long Bill Line Item
(1) Executive Director's Office
Personal Services
Health, Life and Dental
Short-term Disability
Salary Survey and Senior Executive Service
Performance-based Pay
Worker's Compensation
Operating Expenses
Legal Services and Third Party Recovery Legal Services for 12,684 hours
Administrative Law Judge Services
Purchases of Services from Computer Center
Payment to Risk Management and Property Funds
Capitol Complex Leased Space
(6) Department of Human Services Medicaid Funded Programs
(B) Office of Information Technology Services, Medicaid Funding, Colorado Benefits Management System

Federal/State Statutory and Other Authority

HB 04-1058 *(1) Determination of eligibility for medical benefits shall be made by the county department in which the applicant resides, except as otherwise specified in this section. Local social security offices also determine eligibility for medicaid benefits at the same time they determine eligibility for supplemental security income. The state department may accept medical assistance applications and determine medical assistance eligibility and may designate the private contractor that administers the children's basic health plan, denver health and hospitals, and a hospital that is designated as a regional pediatric trauma center, as defined in*

section 25-3.5-703 (4) (f), C.R.S., to accept medical assistance applications and to determine medical assistance eligibility. Any person who is determined to be eligible pursuant to the requirements of this article shall be eligible for benefits until such person is determined to be ineligible. Upon determination that any person is ineligible for medical benefits, the county department, the state department, or other entity designated by the state department shall notify the applicant in writing of its decision and the reason therefore. Separate determination of eligibility and formal application for benefits under this article for persons eligible as provided in sections 26-4-201 and 26-4-301 shall be made in accordance with the rules of the state department.

Program Description

The Colorado Benefits Management System is an information technology system which implements a single automated system to support application, eligibility determination, benefits issuance, and reporting for medical, food, and public assistance programs. The Colorado Benefits Management System Project development and implementation officially started with the signing of the design vendor contract, Electronic Data Systems, on July 17, 2000. The budget for development began in 1996.

The Colorado Benefits Management system is a joint system implemented by the following:
- Colorado Department of Human Services;
- Colorado Department of Health Care Policy and Financing;
- County Departments of Social Services (64 counties); and,
- Non-county Medical Assistance sites.

The Colorado Benefits Management System streamlines eligibility determination in the counties and in non-county Medical Assistance sites, consolidating and replacing existing systems. The System replaced the following “stove-piped” series of systems with a single, integrated system built upon a shared infrastructure:
- Client Oriented Information Network;
- Colorado Automated Food Stamp System;
- Child Health Plan Plus;
- Colorado Automated Client Tracking Information System;
- Colorado Employment First; and,
- Adult Family and Children System.

The Section performs operations and maintenance tasks, including the following:
- Requests for programming changes to support legislative and policy changes;

- Maintenance of rules-based Decision Tables that implement eligibility rules in the system; and,
- Maintenance and support of the Colorado Benefits Management System Decision Support System.

See the Strategic Plan under Policy and Program trends for more updates on Colorado Benefits Management System.

FY 05-06 Prioritized Objectives and Performance Measures

1.2 To support timely and accurate client eligibility determination.
The Colorado Benefit Management System will be implemented Statewide and the rules-based system will become stable and reliable in terms of eligibility determinations.

Similar or Cooperating Programs and Stakeholders

The citizens of Colorado
The General Assembly
Governor's Office of Innovation and Technology
Colorado Department of Human Services
Colorado Department of Health Care Policy and Financing
County departments of social services
Non-county Medical Application sites
Federal government
Clients

PROGRAM CROSSWALK

Summary Section

Program Title: Information Technology Support Section

Change Request(s): None

Long Bill Line Item
(1) Executive Director's Office
Personal Services
Health, Life and Dental
Short-term Disability
Salary Survey and Senior Executive Service
Performance-based Pay
Worker's Compensation
Operating Expenses
Legal Services and Third Party Recovery Legal Services for 12,684 hours
Administrative Law Judge Services
Payment to Risk Management and Property Funds
Capitol Complex Leased Space
Health Insurance Portability and Accountability Act of 1996 (HIPAA) Web Portal Maintenance

Federal/State Statutory and Other Authority

25.5-1-104 (3), C.R.S. (2004): (3) *The executive director may establish such divisions, sections, and other units within the state department as are necessary for the proper and efficient discharge of the powers, duties, and functions of the state department...*

Program Description

The mission of the Information Technology Support Section is to design, develop, and maintain the information systems infrastructure that supports the Department's mission and goals.

The Information Technology Support Section guides and supports the information technology requirements of initiatives sponsored by business units. In doing so, the Information Technology Support Section supports the technical Local Area Network infrastructure, access to fiscal agent resources, customer support services, inventory management, and, planning and consulting services. This Section establishes the standards for business applications, telecommunications architecture, and technology infrastructure to be used internally by the Department. The Section, along with other information technology sections in the Information Technology Division, provides technical consulting to business units in preparing to outsource business functions.

Major accomplishments for the Section include:

- Maintained and enhanced the Department's web site;
- Provided infrastructure support to both the Department's Colorado Benefits Management System and web portal efforts;
- Reviewed and modified Department networks systems to support HIPAA compliance;
- Upgraded the Department's email system (both hardware and software) in order to better support user demands and load;
- Monitored and responded to increased security needs to assure the Department remained unaffected by external attacks; and,
- Upgraded Network Servers to Windows 2003.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) affects the Department's infrastructure in areas of privacy and security as defined in the rules. Although the majority of the effort will be completed in FY 04-05, some activities are expected to continue into FY 05-06, as new rules are published and implemented.

FY 05-06 Prioritized Objectives and Performance Measures

2.2 Improve management of the Department's information systems technology.
The Information Technology Division will provide upgrades and replacements to Department infrastructure to support changing business needs, based upon available funding.
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.

Similar or Cooperating Programs and Stakeholders

The Information Technology Support Section coordinated with the Governor's Office of Innovation and Technology. The Office of Innovation and Technology initiates many statewide departmental policies, standards, and guidelines that are the responsibilities of the individual departments to either implement, document, or enforce. For many of these initiatives from the Office of Innovation and Technology, the responsibility for execution within the Department of Health Care Policy and Financing rests on the Information Technology Support Section.

PROGRAM CROSSWALK

Summary Section

Program Title: Safety Net Financing Section (includes Colorado Indigent Care Program, Comprehensive Primary and Preventive Care Grant Program, and the Old Age Pension State Medical Program)

Change Request(s): None

Long Bill Line Item
(1) Executive Director's Office
Personal Services
Health, Life and Dental
Short-term Disability
Salary Survey and Senior Executive Service
Performance-based Pay
Worker's Compensation
Operating Expenses
Legal Services and Third Party Recovery Legal Services for 12,684 hours
Administrative Law Judge Services
Payment to Risk Management and Property Funds
Capitol Complex Leased Space
(2) Medical Services Premiums
(4) Indigent Care Program
Safety Net Provider Payments
The Children’s Hospital Clinic Based Indigent Care
Comprehensive Primary and Preventive Care Fund
Comprehensive Primary and Preventive Grants Program
(5) Other Medical Services
Old Age Pension State Medical Program
University of Colorado Family Medicine Residency Training Programs

Federal/State Statutory and Other Authority

26-15-101, C.R.S. (2004), et seq. Reform Act for the Provision of Health Care for the Medically Indigent

26-4-1001, C.R.S. (2004), et seq. Comprehensive Primary and Preventive Care Grant Program Act

Article XXIV of the Colorado Constitution and 26-2-117, C.R.S. (2004). Establishment of the Old Age Pension Health and Medical Care Fund and Supplemental Old Age Pension Health and Medical Care Fund

Title 42, Chapter 7, Subchapter XIX, Sec. 1396r-4. Adjustment in Payment for Inpatient Hospital Services Furnished by Disproportionate Share Hospitals

42 CFR 447.296 through 447.299. Payment Adjustments for Hospitals that Serve a Disproportionate Number of Low-Income Patients

42 CFR 447.272. Inpatient Services (Hospitals, Nursing Facilities and Intermediate Care Facility Services for the Mentally Retarded): Application of Upper Payment Limits

42 CFR 447.321. Outpatient Hospital and Clinic Services: Application of Upper Payment Limits

Program Description

Colorado Indigent Care Program

The Colorado Indigent Care Program distributes federal and State funds to partially compensate qualified health care providers for uncompensated costs associated with services rendered to the indigent population. Qualified health care providers who receive this funding render discounted health care services to Colorado citizens, migrant workers and legal immigrants with limited financial resources who are uninsured or underinsured and not eligible for benefits under the Medicaid Program or the Children's Basic Health Plan. Clients can have third party insurance, but this resource must be exhausted prior to the Colorado Indigent Care Program reimbursing providers. There are no age limitations for clients who receive services through the Colorado Indigent Care Program.

The program has been known by several names: the Medically Indigent Program, the Colorado Resident Discount Program and the Colorado Indigent Care Program. This program primarily compensates providers that have contracted with the program to provide health care services to persons with income and assets at or below 185% of the federal poverty level. The program directly contracts

with hospitals and community health clinics. Providers are required to provide on-site eligibility and copayment determination. The services offered to clients under this program vary from clinic to clinic and from hospital to hospital. The Colorado Indigent Care Program is not an insurance program but rather a financial vehicle for providers to recoup their medical costs at a discount. By statute, Colorado Indigent Care Program providers are required to prioritize care in the following order:

1. Emergency care for the full year;
2. Additional medical care for those conditions determined to be the most serious threat to the health of indigent persons; and,
3. Any other medical care.

Based on guidelines from the Department, providers assign a rating to clients based on their total income and assets. The Colorado Indigent Care Program rating process takes a measurement of the applicants' financial resources (income and assets) as of the date the rating takes place and usually occurs on the initial date of service. Ratings are retroactive for services received up to 90 days prior to application and are valid for one year. Therefore, when an applicant who has received services applies for the Colorado Indigent Care Program, the applicant is applying for a discount on already incurred medical charges. Clients are required to pay a minimal copayment, which varies depending on the service received and the clients' Colorado Indigent Care Program rating. For all client ratings, annual copayments cannot exceed 10% of the family's income and equity in assets.

Funding for the Colorado Indigent Care Program is through two unique funding sources. These funding sources are the Disproportionate Share Hospital Allotment and the Medicare Upper Payment Limit for Inpatient Hospital Services, which are financed with General Fund, federal funds and certification of public expenditures. Any provider who participates in the program is qualified to receive funding from both funding sources and uses those funds as partial compensation for providing medical care to those individuals who qualify to receive discounted services.

Payments made under either the Disproportionate Share Hospital Allotment or Medicare Upper Payment Limit for Inpatient Hospital Services to publicly-owned (State or local government) providers consist entirely of federal funds. This is accomplished by the utilization of certification of public expenditures. Certification of public expenditures document the uncompensated cost by a publicly-owned entity incurred in association with providing a qualified medical service to an eligible Medicaid or indigent client, which are eligible for a federal match.

Disproportionate Share Hospital Allotment: Disproportionate Share Hospital payments help defray part of the cost of treating uninsured and low income patients, thereby supporting the hospitals' financial viability, preserving access to care for clients and reducing cost-shifting onto private payers. Since FY 91-92, a number of disproportionate share hospital plans have been approved by the federal Centers for Medicare and Medicaid Services and implemented. The payments made to the qualifying hospitals are eligible

for federal matching funds at the same Medicaid rate paid for services for Medicaid clients. This rate is subject to change each federal fiscal year.

For most of the disproportionate share hospital payments made between FY 91-92 and FY 97-98, the State share of the payments has been financed from intergovernmental transfers from the public hospitals and voluntary contributions from the private hospitals that qualified for the disproportionate share hospital payments. Under this arrangement, the hospitals had a net benefit of the difference between the payments received less their transfer or contribution to the State. The State had a net benefit to the extent that the transfer or contributions from the hospitals exceeded the State share of the disproportionate share hospital payments made to the hospitals.

Starting with FY 97-98 in a supplemental appropriation, the historical mechanism for financing the State share of the payments using transfers and contributions was augmented and adjusted with certification of public expenditures. Use of this financing mechanism arose out of the desire of the General Assembly to allow increased disproportionate share hospital payments without increasing the existing General Fund appropriation and to maintain the same level of total transfers and contributions and net financial benefit to the State. Beginning in FY 99-00, the General Assembly acted to maximize the use of certified public expenditures as the primary mechanism for financing the State share of disproportionate share hospital payments.

Medicare Upper Payment Limit for Inpatient Hospital Services: Under current Centers for Medicare and Medicaid Services regulations, Medicaid is allowed to reimburse hospital providers for inpatient Medicaid services up to an estimated limit and still receive a federal match. This calculated limit is a reasonable estimate of the amount Medicare would have reimbursed hospital providers for providing Medicaid inpatient services and is called the Medicare Upper Payment Limit for Inpatient Hospital Services. Medicaid fee-for-service rates reimburse providers below this limit, which provides an opportunity for the State to use certification of public expenditures (State or local expenditures) to gain a federal match that is distributed to providers.

Comprehensive Primary and Preventive Care Grant Program

The Comprehensive Primary and Preventive Care Grant Program was established to provide grants to health care providers in order to expand primary and preventive health care services to Colorado’s low-income residents. The program is funded through the Comprehensive Primary and Preventive Care Fund established pursuant to the tobacco litigation settlement referred to as the Master Settlement Agreement. Because primary and preventive care are two of the most cost effective means of keeping people healthy, the Comprehensive Primary and Preventive Care Grant Program is intended to expand these services to Colorado’s uninsured or medically indigent populations. However, it is not intended to supplant or expand Medicaid, the Children’s Basic Health Plan, or the Colorado Indigent Care Program.

Comprehensive Primary and Preventive Care grants are to be used to:

- Increase access to comprehensive primary care services for uninsured or medically indigent patients who are served by qualified providers;
- Create new services or augment existing services provided to uninsured or medically indigent patients; or
- Establish new sites that offer comprehensive primary care services in medically underserved areas of the state or to medically underserved populations.

In FY 03-04, grants were awarded in the amount of $5,057,965, to the following facilities:

Provider	Amount
Health Initiative, St. Anthony Foundation	$490,261
Catholic Health Initiative, St. Mary-Corwin Foundation	$250,000
Clinica Campesina Family Health Services	$500,000
Colorado Coalition for the Homeless	$250,000
Columbine Family Health, Glenwood Springs	$141,585
Community Health Centers	$397,457
Inner City Health Center	$383,662
Marillac Clinic	$500,000
Metro Community Provider Network	$550,000
Plan De Salud del Valle	$250,000
Pueblo Community Health Center	$479,250
Sunrise Community Health Center	$229,250
Uncompahgre Medical Center	$136,500
Valley Wide Health Centers	$500,000

There was broad geographic distribution in Colorado with grants being awarded across the State with grantees representing areas as diverse as Colorado Springs, Denver metropolitan area, Durango, Glenwood Springs, Grand Junction, Greeley, Lafayette, Longmont, Norwood, and Pueblo. The scopes of work were varied and represented the diverse needs of the safety net providers in serving the uninsured.

Old Age Pension State Medical Program

The Old Age Pension State Medical Program provides limited medical care for individuals receiving Old Age Pension grants. Those eligible for this program are over age 60, but may not meet Supplemental Security Income criteria or residence requirements, and are therefore ineligible for Medicaid. This population could be disabled to some degree, but not sufficiently to qualify for Supplemental Security Income. This program is funded with 100% State funds and is not an entitlement. Accordingly, the authorized expenditures of $10,750,000 a year cannot be exceeded.

Pursuant to SB 03-022, on July 1, 2003 the Department of Health Care Policy and Financing became responsible for the administration of the Old Age Pension Health and Medical Care Fund and Supplemental Old Age Pension Health and Medical Care Fund. The Old Age Pension Health and Medical Care Fund was established through Article XXIV of the Colorado Constitution and 26-2-117(2) C.R.S. to provide a health and medical care program to persons who are not eligible for Medicaid, who qualify to receive Old Age Pensions and who are not patients in an institution for tuberculosis or mental diseases. To provide additional resources, HB 02-1276 established the Supplemental Old Age Pension Health and Medical Care Fund. Together, these two funds provide necessary medical services under the Old Age Pension Health and Medical Care Program, within the constraints that expenditures shall not exceed appropriations by the General Assembly. In FY 04-05, appropriations for the Old Age Pension Health and Medical Care Fund and the Supplemental Old Age Pension Health and Medical Care Fund were $10,000,000 and $750,000 respectively.

Financing Opportunities

One of the goals of the Safety Net Financing Section is to identify, define, develop, implement, coordinate and promote refinancing opportunities first within the Department and second, within other State agencies. This function reviews federal and state regulations and statutes, existing financing mechanisms, and other states to identify opportunities to increase reimbursement to providers and to decrease General Fund expenditures. This function is responsible for financing calculations and the associated State Plan amendments, Medical Services Board rules changes, and payments to providers. The Unit keeps up with and analyzes changes in federal and State rules and regulations that pertain to this work, and works closely with and assists the Colorado Indigent Care Program.

FY 05-06 Prioritized Objectives and Performance Measures

1.3 To assure payments in support of the programs are accurate and timely.
Quarterly payments to Colorado Indigent Care Program providers will be made according to a published schedule.

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.
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 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.
4.2 To enhance program safeguards and controls.
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.
4.3 To increase public knowledge of and involvement in the financing and delivery of health care.
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.

Similar or Cooperating Programs and Stakeholders

Several other states attempt to provide health care at a discounted rate to the uninsured or under-insured non-Medicaid population. Program staff coordinates with providers, provider representatives, eligible clients, the Governor's Office of State Planning and Budgeting, the General Assembly, and the Centers for Medicare and Medicaid Services.

PROGRAM CROSSWALK

Summary Section

Program Title: Child Health Plan *Plus* Division (includes the Program Integration and Evaluation Section, Contracts and Operations Section, and the Information Technology Liaison)

Change Request(s): Fund Children's Basic Health Plan Medical Premium for Caseload and Rate Changes
Adjust Children's Basic Health Plan Dental
Adjust Children's Basic Health Plan Trust Fund

Long Bill Line Item
(1) Executive Director's Office
Personal Services
Health, Life and Dental
Short-term Disability
Salary Survey and Senior Executive Service
Performance-based Pay
Worker's Compensation
Operating Expenses
Legal Services and Third Party Recovery Legal Services for 12,684 hours
Administrative Law Judge Services
Payment to Risk Management and Property Funds
Capitol Complex Leased Space
(4) Indigent Care Program
HB 97-1304 Children's Basic Health Plan Trust
Children's Basic Health Plan Administration
Children's Basic Health Plan Premium Costs
Children's Basic Health Plan Dental Benefit Costs

Federal/State Statutory and Other Authority

The Social Security Act, Title XXI (42 U.S.C. 1397aa through 1397jj) – Children's Health Insurance Plan

26-19-101, C.R.S. (2004) et seq. *"This article shall be known and may be cited as the 'Children's Basic Health Plan Act'."*

Program Description

The Children's Basic Health Plan (aka Child Health Plan Plus) is a public/private partnership providing subsidized health insurance statewide for children under age 19 in families with incomes at or below 185% of the federal poverty level who are not eligible for Medicaid. The Children's Basic Health Plan offers a wide variety of services to children including check-ups, immunizations, doctor visits, hospital services, prescribed medications, mental health services, dental services, hearing aids, and glasses.

Families pay an annual enrollment fee of $25 for one child and $35 for two or more, along with a small co-payment for each provider visit or dental service. The enrollment fee applies to families with incomes between 151% and 185% of the federal poverty level. Families with incomes at 150% of the federal poverty level and below are not subject to the enrollment fee.

Accomplishments

The Children's Basic Health Plan implemented an enrollment cap on November 1, 2003 to meet budget requirements. A State-only prenatal program, managed by the Division, was in place from November 1, 2003 through February 2004 to enable women enrolled in the Children's Basic Health Plan prenatal program as of March 1, 2003 to receive medical care through the delivery and post-partum periods.

The Department conducted a comprehensive review of health care utilization for children enrolled in Medicaid and the Children's Basic Health Plan and the benefit packages and delivery systems that they have access to. Using that information, a conceptual framework was established in which the Medicaid eligible children and families and Children's Basic Health Plan programs could be streamlined in order to purchase services for those populations more effectively, and encourage seamlessness and continuity of care for members enrolled in those programs.

Administration

By law, the Department of Health Care Policy and Financing administers the Children's Basic Health Plan through private contractors who provide various services including eligibility, enrollment, outreach, health services and dental services. This partnership allows the program to benefit from the expertise available in both the public and private sectors.

Health Care Service Delivery

The Children's Basic Health Plan uses a commercial insurance model to provide services to children and pregnant women. Four health maintenance organizations deliver medical care to covered clients where they are available. The Children's Basic Health Plan manages a network of health care providers to serve clients before they are enrolled in a health maintenance organization and maintains their membership in counties where health maintenance organizations are not available.

Health Maintenance Organizations: Statute requires the Children's Basic Health Plan to enroll children in managed care organizations for their health care services. The Department has contracted with four health maintenance organizations, which are available to 84% of the eligible population. In 37 Colorado counties, enrollees receive health care services through the following health maintenance organizations: Colorado Access, Denver Health Medical Plan, Kaiser Permanente, and Rocky Mountain Health Plans. These health maintenance organizations operate under full risk contracts with the Department.

State Managed Care Network: The Department offers a managed care network by contracting directly with health care providers in counties where health maintenance organizations have been unable to offer coverage. In addition, Children's Basic Health Plan enrolled children in counties served by health maintenance organizations can receive services through the state managed care network while they are waiting for enrollment in a health maintenance organization. The Department contracts directly with over 2,400 providers: 1,500 primary care physicians; 700 specialists; 18 hospitals systems; and, a number of ancillary service providers, which include essential community providers, to create a state-run managed care network. Anthem Blue Cross Clue Shield manages the network.

Dental Program

In February 2002, the State of Colorado implemented the dental benefit component to the Children's Basic Health Plan Children may see any dentist in Delta Dental Plan of Colorado's Basic Network. Eighty-five percent of all Colorado dentists belong to the Delta Dental network, which assures adequate access.

The dental plan provides preventive and diagnostic services, basic restorative services, oral surgery and endodontic care. Under the current plan, there is a maximum allowable amount of $500 per child per calendar year.

In CY 2003, 38,480 children received dental services. According to an October 28, 2003 dental program study performed by the University of Colorado Health Sciences Center School of Dentistry, 7% of children who received services reached the $500 limit.

Prenatal Program

Pregnant women of any age with incomes at or below 185% of the federal poverty level, who are not eligible for Medicaid, are eligible for the Children's Basic Health Plan Prenatal Program. These women receive prenatal, delivery, and post-partum medical care. There are no co-pays or enrollment fees for these clients. Enrollment into the prenatal program was temporarily suspended in May 2003 but was reinstated July 1, 2004.

Outreach

The Children's Basic Health Plan partners with approximately 2,000 community-based organizations including: schools; Head Start programs; family resource centers; community health centers; United Way agencies; public health departments; county departments of social services; Women, Infants, and Children programs; and many others. These extensive partnerships represent an extraordinary commitment statewide to enroll uninsured children as part of the Children's Basic Health Plan comprehensive outreach strategy.

Enrollment and Disenrollment

An enrollment cap went into effect for newly eligible children on November 1, 2003. Children enrolled in the program prior to the enrollment cap were able to re-enroll in the program, provided they continued to meet eligibility criteria. Siblings and newborns to existing enrollees were also enrolled in the Children's Basic Health Plan if determined ineligible for Medicaid. As required by federal law, all children were still screened for Medicaid eligibility before either being enrolled in the Children's Basic Health Plan or denied enrollment due to the cap. The enrollment cap was lifted effective July 1, 2004.

Medicaid/Children's Basic Health Plan Streamlining Health Insurance and Flexibility Act (HIFA) Waiver

The Department of Health Care Policy and Financing is considering how, through more prudent purchasing, to provide services to Colorado's Medicaid and Children's Basic Health Plan populations in a combined program. The Department seeks to implement such an initiative without increasing General Fund expenditures or decreasing available benefits. The Department has worked with internal

and external stakeholders to conduct a comprehensive review of children and families health care utilization and the benefit packages and delivery systems that they have access to. Using that information, a proposed framework was established in which the Medicaid eligible children and families and Children's Basic Health Plan programs could be streamlined in order to purchase services for those populations more effectively, and encourage seamlessness and continuity of care for members enrolled in those programs. The Department proposes that children and families Medicaid and Children's Basic Health Plan 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 would be provided with a "Core" benefit package, while children who require more extensive services would be provided with additional "Core Plus" services. There would be no reduction in eligibility criteria or covered benefits for either Medicaid or Children's Basic Health Plan.

The Department believes the joint purchasing of health services will both leverage the volume of the combined children and families Medicaid and the Children's Basic Health Plan programs, and use best practices from the public and private sector to encourage participation from both safety net and commercial plans.

FY 05-06 Prioritized Objectives and Performance Measures

1.3 To assure payments in support of the programs are accurate and timely.
A claims audit process will be implemented in the Children's Basic Health Plan.
1.6 To work towards systemic improvement in the Department's operations to expand efficiencies, minimize waste, ensure coordination, and eliminate discrepancies.
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.

Similar or Cooperating Programs and Stakeholders

Colorado Medicaid
Colorado Indigent Care Program
Health Care Program for Children with Special Needs at the Department of Public Health and Environment
Cover Colorado (Independent Authority, with oversight by Department of Regulatory Agencies, Division of Insurance)
Children's Basic Health Plan advocacy groups

PROGRAM CROSSWALK

Summary Section

Program Title: Controller and Operations Division (includes the Human Resources Unit, the Accounting Section, and the Purchasing Unit)

Change Request(s): None

Long Bill Line Item
(1) Executive Director's Office
Personal Services
Health, Life and Dental
Short-term Disability
Salary Survey and Senior Executive Service
Performance-based Pay
Worker's Compensation
Operating Expenses
Legal Services and Third Party Recovery Legal Services for 12,684 hours
Administrative Law Judge Services
Payment to Risk Management and Property Funds
Capitol Complex Leased Space
(5) Other Medical Services
SB 97-101 Public School Health Services

Federal/State Statutory and Other Authority

25.5-1-104 (2) and (3), C.R.S. (2004): *"(2) The Department of health care policy and financing shall consists of an executive director of the Department of health care policy and financing…and other units as shall be established by the executive director pursuant to the provisions of subsection (3) of this section." " (3) The executive director may establish such divisions, section, and other units...as are necessary for the proper and efficient discharge of the powers, duties, and functions of the state department..."*

Program Description

The purpose of the Controller and Operations Division is to provide many of the internal administrative functions necessary for overall Department operations. These functions include accounting, financial reporting, procurement, contract review, and human resources. All of these functions are required to maintain Department compliance with federal and/or statewide requirements. The Division is under the direction of the Department Controller, and comprises three units: Accounting, Procurement, and Human Resources.

Division Major Functions:

- The Accounting Section is responsible for all financial accounting and financial control functions of the Department, and many of the critical financial reporting functions. This includes quarterly financial reports of expenditures and revenues to the federal government for the Medicaid and Child Health Plan Plus programs and financial closing processes, which are the basis for reporting. It also includes accurate and timely processing of Medicaid provider and administrative payments, cash receipt processes for $1.2 billion worth of annual cash received by the Department, internal accounting and financial control systems, and employee payroll processing.
- The Procurement Unit is responsible for ensuring that all Department purchases of goods or services comply with all applicable federal and state procurement rules and policies. This includes proper solicitation, vendor selection, proper procurement forms (both purchase orders and contracts), and proper and timely approvals (both internal to the Department and external).
- The Human Resources Unit is responsible for all functions necessary to properly classify Department staff positions and to fill those positions in accordance with the state constitution and the state personnel rules and procedures. This includes proper classification of positions, announcing job openings, reviewing applications, testing candidates, and referring qualified candidates to departmental appointing authorities. Staff participate in any appeals related to the results of those functions.

Division Accomplishments:

- The Division has a comprehensive procedure that provides a complete reconciliation of federal cash receipts, federal revenue, total expenditures, and the federal share of those expenditures. These procedures reconcile the federal cash management system, the Department federal management reports, and the State's accounting system. These procedures treat each fiscal year as a completely unique set of events within the accounting system.

FY 05-06 Prioritized Objectives and Performance Measures

1.6 To work towards systematic improvement in the Department's operations to expand efficiencies, minimize waste, ensure coordination, and eliminate discrepancies.
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.
4.4 To develop enhanced training and retention strategies for department staff
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.

Similar or Cooperating Programs and Stakeholders

The State of Colorado has cooperating programs managed by the Department of Human Services, the Department of Public Health and Environment, the Department of Corrections, the Department of Education, the Department of Personnel and Administration, and the Department of Regulatory Affairs. Medicaid funding for these departments is appropriated to Health Care Policy and Financing as the Single State Agency for Medicaid funding and then is either expended by partner agencies for their Medicaid initiatives, or used by this Department to buy support services (e.g., purchase computer services from the General Government Computer Center).

The Department obtains support services (i.e., legal services, telecommunications, computer systems, etc.) from other state departments. The Controller and Operations Division operates under the statewide direction, procedures, and rules of the State Controller's Office, the state Division of Purchasing, and the Department of Personnel and Administration.

PROGRAM CROSSWALK

Summary Section

Program Title: Budget Division

Change Request(s): None

Long Bill Line Item
All Long Bill line items are critical to the Budget Division

Federal/State Statutory and Other Authority

25.5-1-104, C.R.S. (2004): (3) *The executive director may establish such divisions, sections, and other units within the state department as are necessary for the proper and efficient discharge of the powers, duties, and functions of the state department: …*

Program Description

Budget Division Key Responsibilities:

The Department's budget is approximately $3 billion. The Budget Division's five key responsibilities are to project, construct, present, monitor, and manage the departmental budgets, acting as a conduit for the Department to the Executive and Legislative branches, translating the Department's policy needs and objectives into monetary terms.

In pursuit of its responsibilities, the Budget Division performs several principle tasks for the Department. The Budget Division:

- Coordinates the development of the Department's Strategic Plan and Program Crosswalks, which encompasses all areas of departmental activity for each individual office, division, section, etc. The Strategic Plan is both an operational and a long-range plan, integrated with short-range planning and is the basis for the Department's Budget Request;
- Estimates, requests, presents, and defends program and operations budgetary needs to the Executive and Legislative authorities. Directs preparation of each of the phases of the budget request process deliverables, including preparation of requisite statistical forecasting of caseload and premiums and health care services pricing;

- Monitors, projects, and as appropriate, manages Department appropriations. This includes ensuring that expenditures meet legal requirements and that they support departmental requirements and objectives;
- Coordinates and reviews the preparation of fiscal notes for proposed legislation;
- Monitors caseload and expenditures throughout the fiscal year;
- Ensures the proper spending of Medicaid funds for departments that are financed through this budget;
- Assists Accounting in closing the financial records for the Department each year;
- Performs special studies and projects throughout the year, including research into possible areas for cost containment; and
- Provides ongoing department-wide budget training. Topics include the budget process and planning, Change Request development, and fiscal note preparation.

FY 05-06 Prioritized Objectives and Performance Measures

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.
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.
1.6 To work towards systemic improvement in the Department's operations to expand efficiencies, minimize waste, ensure coordination, and eliminate discrepancies.
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.
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.
The Budget Division will conduct training sessions during FY 05-06 to 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.

Similar or Cooperating Programs and Stakeholders

The Budget Division has the same cooperating programs and stakeholders as those listed for the Executive Director's Office. In particular, the Budget Division is a partner with the Governor's Office of State Planning and Budgeting, the Joint Budget Committee of the Colorado General Assembly, and Legislative Council of the Colorado General Assembly.