Department of Health Care Policy and Financing
Strategic Plan
FY 06-07

Budget Request

NOVEMBER 15, 2005

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DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
FY 06-07 STRATEGIC PLAN

I. INTRODUCTION

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

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

In addition to the Medicaid program and Child Health Plan Plus Office, the Department manages:

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

- Old Age Pension State Medical Program: This State-only program provides limited medical care for non-Medicaid individuals receiving Old Age Pension grants. Eligible recipients for program benefits are over the age of sixty, but do not meet the Supplemental Security Income criteria, and are therefore ineligible for Medicaid. This program is funded with $10 million established in the State's constitution and additional funding through statute. HB 05-1262 states that three percent of annual Tobacco Tax revenue shall be appropriated to the Cash Fund for Health-Related Purposes, and 50% of this fund shall be annually transferred to the Supplemental Old Age Pension Health and Medical Care Fund. This is in addition to the $750,000 appropriated to the Supplemental Fund each year.

- The Home Care Allowance and Adult Foster Care Programs: Home Care Allowance provides direct payment to eligible clients enabling them to purchase community-based services. Adult Foster Care purchases non-medical residential care for eligible individuals. Both programs are financed by at least 95% General Fund and up to 5% local funds.

- Low Income Subsidy for Medicare Part D Program: On January 1, 2006, the Medicare program will begin to provide prescription drugs for people with low incomes, or those under 150 percent of the federal poverty level (FPL). Low-income beneficiaries will receive assistance in paying for their Medicare Part D costs, including premiums, co-payments and co-insurance. Depending on an individuals' income and resources, they may be qualified for a full or partial subsidy.

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

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

IMPORTANT NOTE:

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

When the Department transitioned to Cash Accounting at the end of FY 02-03, caseload reporting was changed. Caseload reporting in budget documents no longer contains retroactive eligibility adjustments. However, retroactivity is still a function of Medicaid eligibility; that is, in practice, caseload does vary over time because clients are, generally, eligible back to the date of their application.

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

II. STRATEGIC PLAN DIRECTION

Vision

In the stewardship of the Department's programs, the Department strives to achieve effective health care security for Coloradans while being sensitive to the fiscal pressures of the State budget.

Mission

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

Guiding Principles

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

Goals

A. The Department will evaluate cost control mechanisms now operating in its programs to ascertain if it is getting the maximum value and cost benefit. Alternative recommendations should assure that the care that the Department purchases is medically necessary and appropriate.

B. The Department will partner with contractors and other public and private sector entities to maximize the resources brought to bear on improving the health status of Coloradans. The Department will improve the oversight of contracts with sister agencies, and employ more performance based contracting with private contractors.

C. The Department will evaluate client health and satisfaction and will model program design and purchase of service decisions in such a way as to promote improved care delivery. Clients will be furnished information about quality of care and general client satisfaction so that they may make informed choices about the care they receive.

D. The Department will value its personnel through effective recruitment, hiring, and retention. Through concerted efforts, as determined appropriate and meaningful in staff development, training, and employee morale, the Department will make staff stability and technical expertise a priority. The Department will examine what motivates employees to work effectively and consider strategies to reinforce employee development. The Department will allocate its staff and resources in a way to ensure that it addresses the organization's priorities. The Department will focus on areas of health care risk, financial risk, and exposure as a way to prioritize the assignment of resources.

E. The Department will appropriately and effectively respond to changing requirements with the federal government such as the Medicare Modernization Act, while considering client needs and State budgeting concerns.

III. SCHEDULE 1 – PRIORITIZED OBJECTIVES

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

1.1 To maximize the opportunity to preserve health care services through the purchase of services in the most cost-effective manner possible. (Supportive of Goals A and B)
1.2 To support timely and accurate client eligibility determination. (Supportive of Goal A)
1.3 To assure payments in support of the programs are accurate and timely. (Supportive of Goals A and B)
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. (Supportive of Goals B and C)
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. (Supportive of Goals A and D)
1.6 To work towards systemic improvement in the Department's operations to expand efficiencies, minimize waste, ensure coordination, and eliminate discrepancies. (Supportive of Goals A and E)

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

2.1 To continue areas of potential financial recovery such as third party insurance (should be the primary payer) and cases of fraud and abuse. (Supportive of Goals A and B)
2.2 To improve management of the Department's information systems technology. (Supportive of Goals B and E)
2.3 To hold accountable the Department's administrative contractors, including other State and local agencies, by more outcome-based contracting and more sophisticated contract management. (Supportive of Goal B)
2.4 To ensure program safeguards and controls. (Supportive of Goal A)

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

3.1 To improve customer satisfaction with programs, services, and care. (Supportive of Goal C)
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. (Supportive of Goal C)

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

4.1 To build and maintain a high quality, customer-focused team. (Supportive of Goal D)
4.2 To develop enhanced training and retention strategies for departmental staff. (Supportive of Goal D)

IV. PERFORMANCE MEASURES

New FY 06-07 Performance Measures for the November 15, 2005 Budget Request

FY 06-07 OBJECTIVE: **1.1 To maximize the opportunity to preserve health care services through the purchase of services in the most cost-effective manner possible. (Supportive of Goals A and B)**	
Division / Section	**FY 06-07 PERFORMANCE MEASURE**
Rates and Analysis Division	Based on identifying opportunities within the pharmacy program and utilizing the Drug Utilization Review Board recommendations, the Rates and Analysis Division will provide recommendations for prior authorizations, limits, and controls to effectively manage the prescription drug expenditures on a quarterly basis.
Rates and Analysis Division	The Division will effectively utilize the Drug Utilization Review Board to identify opportunities for cost savings; the Board will meet on a quarterly basis.
Child Health Plan Plus Office	The Child Health Plan Plus Office will promote private sector insurance in Colorado by implementing a pilot program for employer sponsored insurance with two large employers by January 2007.
Health Benefits and Rates and Analysis Divisions	The Health Benefits and Rates and Analysis Divisions will monitor the cost-effectiveness of disease management, physical health pre-paid inpatient health plans and enhanced primary care case management programs on at least an annual basis, holding costs for diabetics to less than or equal to $681,735, and $317,500 for asthmatics. These amounts are estimated for 300 diabetic clients and 500 asthmatic clients, respectively.
Long Term Benefits Division	The Community Based Long Term Care Section will ensure a 90% accuracy rate in the submission and payment of claims that are for services delivered as benefits of the Home and Community Based Services (HCBS) Persons with Brain Injury Waiver program by December 31, 2006.

FY 06-07 OBJECTIVE: **1.2 To support timely and accurate client eligibility determination. (Supportive of Goal A)**	
Division / Section	**FY 06-07 PERFORMANCE MEASURE**
Eligibility Policy Unit, Client Services Division	The Eligibility Policy Unit will conduct at least six Health Care Policy and Financing Informational Meetings, including the Colorado Benefits Management System procedural training for counties and medical assistance sites, holding one meeting every other month throughout the fiscal year. At least one internal training will be provided for Health Care Policy and Financing staff, and at least two county medical assistance site training sessions will be held.
Eligibility Operations Section	The Eligibility Operations Section will research inaccurate eligibility determinations and recommend Colorado Benefits Management System changes that will reduce the number of "trouble tickets" reported in FY 05-06 by counties and medical assistance sites by at least 10%.
Eligibility Operations Section	Monitor counties and medical assistance sites (MA Sites) showing cases that are pending and exceed processing guidelines. Ensure that MA sites continue to work the pending reports by sending out reports as they are received by the Section from the Colorado Benefits Management System project. Identify and follow up with counties that are having difficulties keeping their pending cases, exceeding processing guidelines, to a minimum.
Benefits Coordination Section	The Medicaid Eligibility Quality Control Unit will conduct needs assessments for critical eligibility issues and implement at least two pilot proposals for FY 06-07.
Information Technology Division	The interface between the Colorado Benefits Management System and the Medicaid Management Information System will be reviewed at least twice during the fiscal year to verify that clients are within an accuracy rate of 0.1% between systems.

FY 06-07 OBJECTIVE: **1.3 To assure payments in support of the programs are accurate and timely. (Supportive of Goals A and B)**	
Division / Section	**FY 06-07 PERFORMANCE MEASURE**
Rates and Analysis Division	The Division will provide payment assessments to managed care organizations, programs of all-inclusive care to the elderly, and administrative service organizations, to assure all payments are accurate for eligible clients in FY 06-07 by June 2007. The Division will assess any provider requests for offline payments within 45 days after submission.

FY 06-07 OBJECTIVE: **1.3 To assure payments in support of the programs are accurate and timely. (Supportive of Goals A and B)**	
Division / Section	**FY 06-07 PERFORMANCE MEASURE**
Long Term Benefits Division, Community-Based Long Term Care Section	Long Term Benefits will implement a process to have 90% of the prior authorization requests electronically submitted directly to the fiscal agent from providers and/or contracted utilization review agencies by December 31, 2006. This is a continuation of FY 05-06 Performance Measure 1.3.
Rates and Analysis Division	The Division will respond to requests for ad hoc reports within ten business days, 90% of the time.
Rates and Analysis Division	The Division will conduct a validation assessment on the accuracy and timeliness of all managed care programs' payments compared to the rates identified in the various contracts throughout the fiscal year.
Rates and Analysis Division	Rates will be calculated in a timely manner for managed care, programs of all inclusive care to the elderly and administrative service organizations, and will meet all required actuarial standards.
Controller Division	The Accounting Section of the Controller Division, with the assistance of the Department's Information Technology Division, will work to ensure that the interface between the Medicaid Management Information System and the Statewide accounting system operates effectively and efficiently, through two specific system interface fixes to be completed prior to December 2006.
Information Technology Division	The Division will review each Medicaid Management Information System subsystem during FY 06-07 to assure that the payments made are accurate and timely. The Department will increase internal audits of the claims processing system.
Safety Net Financing Section	Quarterly payments to Colorado Indigent Care Program providers will be made according to the published schedule as supplied to the providers.

FY 06-07 OBJECTIVE: **1.4 To assure delivery of appropriate, high quality care. To design programs that result in improved health status for clients served and to improve health outcomes. To ensure that the Department's programs are responsive to the service needs of enrolled clients in a cost-effective manner. (Supportive of Goals B and C)**	
Division / Section	**FY 06-07 PERFORMANCE MEASURE**
Child Health Plan Plus Office	The Department will implement performance based contracting with managed care plans using the Health Plan Employer Data and Information Set and Consumer Assessment of Health Care Study measures, to begin July 1, 2006.
Health Benefits Division	Pending the Centers for Medicare and Medicaid Services approval of two waivers in FY 05-06, the Division will provide substance abuse treatment for at least 42 Native Americans and expand the substance abuse treatment for pregnant women in the Special Connections program to at least 67 clients.
Long Term Benefits Division	The Community Based Long Term Care Section will fully implement the Children's Autism waiver with enrollment equal to 100% of capacity by December 21, 2006.

FY 06-07 OBJECTIVE: **1.5 To accurately project, report, and manage budgetary requirements to effect Executive and Legislative intent with program and budget development and operations. To accurately record and monitor expenditures for programs managed by the Department so there may be accurate financial reporting at all times. (Supportive of Goals A and D)**	
Division / Section	**FY 06-07 PERFORMANCE MEASURE**
Controller Division	The Accounting Section of the Controller Division will continue its project to improve the accounting and reporting of provider recoveries by documenting all sources of recoveries and the processes associated with those recoveries. Based on that understanding, the section will develop routine reporting mechanisms for provider recoveries. This reporting will assist in the effort to properly account for recoveries in the Department's Budget process.
Budget Division	The Division will provide the Office of State Planning and Budgeting with all budget requests (Supplementals, Budget Amendments, Decision Items, FY 07-08 Budget Request) by the requested due dates.
Safety Net Financing Section	The Colorado Indigent Care Program Annual Report, which details utilization and financial trends for the indigent care programs administered by the Department, will be delivered to the General Assembly on February 1, 2007.

FY 06-07 OBJECTIVE: **1.6 To work towards systemic improvement in the Department's operations to expand efficiencies, minimize waste, ensure coordination, and eliminate discrepancies. (Supportive of Goals A and E)**	
Division / Section	**FY 06-07 PERFORMANCE MEASURE**
Long Term Benefits Division	The Nursing Facilities Section will work with providers on the development of a new nursing facility reimbursement methodology to propose during the 2006 Legislative session. The intent of the proposal will be to combine price based reimbursement with quality indicators, resulting in fewer nursing facility rate appeals. If the legislature approves this proposed reimbursement methodology, the Department will work with providers to develop new Volume 8 rules before the end of the fiscal year.

FY 06-07 OBJECTIVE: **2.1 To expand areas of potential financial recovery such as third party insurance (that should be a primary payer) and cases of fraud and abuse. (Supportive of Goals A and B)**	
Division / Section	**FY 06-07 PERFORMANCE MEASURE**
Rates and Analysis Division	A comprehensive post payment review of at least three of the following provider types will be conducted in FY 06-07 to assess provider compliance regarding service documentation, medical necessity and payment accuracy. The provider types include - home health, emergency transportation, Home and Community Based Services waivered services, Durable Medical Equipment providers, Federally Qualified Health Clinics and school based services.
Benefits Coordination Section	Benefits Coordination Section will maintain or increase recoveries from third party insurance over the prior year's level and strive to identify other cost-avoidance practices.

FY 06-07 OBJECTIVE: **2.2 To improve management of the Department's information systems technology. (Supportive of Goals B and E)**	
Division / Section	**FY 06-07 PERFORMANCE MEASURE**
Information Technology Division	The Division will focus ongoing efforts to centralize the information systems used by the agency, to improve both security and management of vast amounts of client data used by the Department.

FY 06-07 OBJECTIVE: **2.3 To hold accountable the Department's administrative contractors, including other State and local agencies, by more outcome-based contracting and more sophisticated contract management. (Supportive of Goal B)**	
Division / Section	**FY 06-07 PERFORMANCE MEASURE**
Controller Division	The Contracts and Purchasing Section of the Controller Division will develop and hold at least one contract management training session for the Department's program staff responsible for managing contracts.
Budget Division	The Budget Division will hold structured monthly meetings with budget staff from the Department of Human Services and the Department of Public Health and Environment to create greater accuracy and consistency within expenditure tracking, projections, and Budget Requests.

FY 06-07 OBJECTIVE: **2.4 To ensure program safeguards and controls. (Supportive of Goal A)**	
Division / Section	**FY 06-07 PERFORMANCE MEASURE**
Budget Division	The Division will create and distribute an internal monthly expenditure tracking report by appropriation. This document will be used to assist program staff in awareness of program trends and to create more awareness regarding provider billing habits. This report will be distributed to all program staff within two weeks after each period close.
Safety Net Financing Section	The Section will establish additional procedures to maximize federal revenue to sustain or increase payments to providers that conform to federal guidelines by January 1, 2007.

FY 06-07 OBJECTIVE: **3.1 To improve customer satisfaction with programs, services, and care. (Supportive of Goal C)**	
Division / Section	**FY 06-07 PERFORMANCE MEASURE**
Health Benefits Division	The Division will monitor customer satisfaction with the Mental Health Community Services program through the use of annual adult and child satisfaction surveys, quarterly grievance and appeal reporting, and feedback received in open forums with consumers.
Long Term Benefits Division	The Nursing Facilities section will obtain at least three internal trainings from other sections and divisions within the Department to broaden staff's knowledge base and improve customer service.

FY 06-07 OBJECTIVE: **3.2 To enhance customer service, provider and eligibility personnel's understanding of program requirements, benefits, and responsibilities. To improve the usefulness of communications with clients, constituents, partners, and stakeholders. (Supportive of Goal C)**	
Division / Section	**FY 06-07 PERFORMANCE MEASURE**
Child Health Plan Plus Office	The Child Health Plan Plus Office will evaluate the effectiveness of the marketing plan implemented in FY 05-06, and will develop new targeted marketing programs using the results of this evaluation by January 2007.
Communications and External Affairs Division	The Division will prepare an analysis of the success of the Consumer Directed Attendant Support public outreach by December 2006, and educate program staff based on information obtained during FY 05-06. Based on this analysis, the Division will make recommendations regarding future activities for sustainability or changes that might need to be made. The Division will continue to enhance external communications with Health Care Policy and Financing clients and providers.
Communications and External Affairs Division	The Customer Service Section will decrease the call abandonment rate by at least 5% from the FY 05-06 level.
Information Technology Division	The Information Technology Division will explore new mediums for provider communication to facilitate timely communication of changes, issues and impacts to providers.
Budget Division	The Budget Division will conduct training sessions during FY 06-07 for Department staff to educate on budget-related activities and responsibilities. At least two sessions in each of the following areas will be conducted: the budget cycle, change requests, fiscal notes, and operating budgets. As appropriate or timely, new legislation affecting the Department will be presented.

FY 06-07 OBJECTIVE: **4.1 To build and maintain a high quality, customer-focused team. (Supportive of Goal D)**	
Division / Section	**FY 06-07 PERFORMANCE MEASURE**
Communications and External Affairs Division	The Customer Service Section will conduct informative staff meetings on a weekly basis during the fiscal year, and will also have at least one team building meeting each month.

FY 06-07 OBJECTIVE: **4.2 To develop enhanced training and retention strategies for departmental staff. (Supportive of Goal D)**	
Division / Section	**FY 06-07 PERFORMANCE MEASURE**
Controller Division	The Human Resources Section of the Controller Division will fully implement its training program for Department managers on State Personnel Rules and processes, including hiring, reclassification, employee performance management, and employee discipline.

The following two tables delineate performance measures from the November 1, 2004 Budget Request and provide a status on the Department's progress towards these measures for both FY 04-05 and FY 05-06.

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

FY 04-05 OBJECTIVE: **1.1 To maximize the opportunity to maintain health care services through the purchase of services in the most cost-effective manner possible.**		
Division / Section	**FY 04-05 Performance Measure**	**Achievements towards FY 04-05 Performance Measures as of November 15, 2005**
Safety Net Financing Section	Prior to July 1, 2005, the Safety Net Financing Section will research a benefit package for the Old Age Pension State Medical Program that can be delivered within the constraints of constitutional funding limits.	The Department submitted a report to the General Assembly on November 1, 2004 to comply with Footnote 42 of HB 04-1422 which addressed this performance measure.
Health Benefits Division	The Health Benefits Division will monitor administrative service organization contracts on a quarterly basis to ensure contract compliance and cost-effectiveness.	Department staff monitored administrative service organizations (plans) for contract compliance on a quarterly basis through the submission of reports, and on an annual basis through the site visit and desk audit process. Site reviews occur on an annual basis during various times throughout the year. A complete site visit review has been done on all plans for FY 03-04, and reviews for FY 04-05 are currently underway. For FY 03-04 the Department saved approximately $1.8 million, identified through annual cost savings analysis completed by the Department.

FY 04-05 OBJECTIVE: **1.1 To maximize the opportunity to maintain health care services through the purchase of services in the most cost-effective manner possible.**		
Division / Section	**FY 04-05 Performance Measure**	**Achievements towards FY 04-05 Performance Measures as of November 15, 2005**
Rates and Analysis Division	Based on identifying opportunities within the pharmacy program, the Rates and Analysis Division will implement prior authorizations, limits, and controls to effectively manage the prescription drug premiums line.	In FY 04-05, the Pharmacy Unit revised prior authorizations on several drugs and drug classes, including: Accolate, Singulair, Bactroban Nasal, Bactroban Cream, Palladone, Proton Pump Inhibitors, Atypical antipsychotics, Amphetamines, Fentanyl patches, COX-2's and Growth Hormones.
Rates and Analysis Division	The Division will effectively utilize the Drug Utilization Review Board to identify opportunities for cost savings; the Board will meet on a quarterly basis.	The Pharmacy Unit worked closely with the Drug Utilization Review Board, as well as the Colorado Medical Society, and other interested parties to identify opportunities for costs savings though prior authorizations, drug limits, and other cost containment strategies. The Drug Utilization Review Board meets on a quarterly basis in January, April, July and October on the third Tuesday of the month.
Information Technology Division, Eligibility Systems Development Section	The Colorado Benefits Management System will be implemented Statewide and the rules-based system will become stable and reliable in terms of eligibility determinations.	The Colorado Benefits Management System was implemented statewide on September 1, 2004. The Division has dedicated staff to increasing the stability and reliability of the system. Examples include: 1. Hired and trained sufficient staff and trained Help Desk workers to resolve Colorado Benefits Management System Trouble Tickets on a more timely basis. The number of severe Trouble Tickets was reduced significantly shortly after implementation – severe trouble tickets that used to number in the hundreds, now are numbering less than fifty. 2. Hired and trained two additional testers dedicated to thoroughly review new Decision Tables and Interface modifications prior to implementation. 3. Significantly reduced the number of client correspondence letters mailed to clients out of the Colorado Benefits Management System

FY 04-05 OBJECTIVE: **1.1 To maximize the opportunity to maintain health care services through the purchase of services in the most cost-effective manner possible.**		
Division / Section	**FY 04-05 Performance Measure**	**Achievements towards FY 04-05 Performance Measures as of November 15, 2005**
Child Health Plan Plus	The Child Health Plan Plus Office will complete the modeling for implementation of a streamlined Medicaid and Child Health Plan Plus Office by June 30, 2005 for the Health Insurance Flexibility and Accountability Waiver.	Enabling legislation (SB 05-221) was passed by the General Assembly in May 2005 and modeling of the streamlining initiative was completed in July 2005.

FY 04-05 OBJECTIVE: **1.2 To support timely and accurate client eligibility determination.**		
Division / Section	**FY 04-05 Performance Measure**	**Achievements towards FY 04-05 Performance Measures as of November 15, 2005**
Eligibility Operations Section	In coordination with Colorado Benefits Management System staff, Benefits Coordination's Medicaid Eligibility Quality Control Unit will develop a quality control process to test that eligibility is being determined by the benefits management system correctly.	The Medicaid Eligibility Quality Control Unit used a Business Objects of America query to pull data from the Medicaid Management Information System to validate eligibility decisions determined in the Colorado Benefits Management System. Queries were done seven times during FY 04-05. The Business Objects of America queries pull a random sample based on specific study data approved by Centers for Medicare and Medicaid Services.
Eligibility Operations Section	The majority of Medicaid eligibility policy changes will be programmed, tested, and implemented in Colorado Benefits Management System by the effective date of the change.	During FY 04-05, all eligibility policy changes were programmed, tested and implemented by their effective dates.

FY 04-05 OBJECTIVE: **1.2 To support timely and accurate client eligibility determination.**		
Division / Section	**FY 04-05 Performance Measure**	**Achievements towards FY 04-05 Performance Measures as of November 15, 2005**
Information Technology Division	The Information Technology Division will monitor and enhance the Colorado Benefits Management System eligibility determination system and the Department's decision tables to improve accuracy of the client eligibility determination.	The Department implemented the following changes to provide greater accuracy during the determination process: 1. Established new Colorado Benefits Management System Change Control procedures to control the quality of Decision Table changes and to assure that Policy Staff input was included in the process. 2. Established a process to log that helped prioritize and track all necessary Health Care Policy and Financing changes to the Colorado Benefits Management System.

FY 04-05 OBJECTIVE: **1.3 To assure payments in support of the programs are accurate and timely.**		
Division / Section	**FY 04-05 Performance Measure**	**Achievements towards FY 04-05 Performance Measures as of November 15, 2005**
Safety Net Financing Section	Quarterly payments to Colorado Indigent Care Program providers will be made according to a published schedule.	FY 04-05 payments were made according to the schedule as presented in the provider's rate letters, which were sent out multiple times during the fiscal year.
Rates and Analysis Division	The Division will provide assessment of payments to the managed care organizations, Programs of All Inclusive Care to the Elderly, and administrative service organizations, to assure accurate payments for eligible clients for FY 04-05 by March 2005. The Division will assess any provider requests for offline payments within 45 days after submission.	In FY 04-05, the Division continued its ongoing recoupment of improper payments to managed care organizations, administrative service organizations, and behavioral health organizations. There is a one year lag in the recoupment process due to the need for eligibility run out. Expected recoveries for FY 03-04 are approximately $500,000 for managed care and administrative service organizations, and approximately $2,000,000 for behavioral health organizations. Offline payment requests were assessed throughout FY 04-05 within 45 days of submission.

FY 04-05 OBJECTIVE: **1.3 To assure payments in support of the programs are accurate and timely.**		
Division / Section	**FY 04-05 Performance Measure**	**Achievements towards FY 04-05 Performance Measures as of November 15, 2005**
Rates and Analysis Division	The Rates and Analysis Division will respond to requests for ad hoc reports within 10 business days, 90% of the time.	For requests that were not completed within 10 business days, the Department followed an internal protocol that requires establishing a time frame for when the ad hoc report can be completed, and to communicate that with the requesting party prior to the 10 business day period.
Rates and Analysis Division	Managed care organization, Programs of All Inclusive Care to the Elderly, and administrative service organization rates will be calculated in a timely manner, meeting all actuarial standards.	FY 04-05 health maintenance organization rates received actuarial certification on June 29, 2004. Behavioral health organization rates for the period July 1, 2004 to December 31, 2004 received actuarial certification on July 2, 2004. Behavioral health organization rates for the period January 1, 2005 to June 30, 2005 received actuarial certification on September 1, 2004. Rates for calendar year 2004 and 2005 for Programs of All Inclusive Care for the Elderly received actuarial certification on February 24, 2004 and October 14, 2004, respectively.
Information Technology Division	Information Technology will conduct at least one systematic system review of the Medicaid Management Information System to assure its accuracy.	All edits and audits within the Medicaid Management Information System were reviewed to assure that they are processed correctly throughout the fiscal year. For example, an edit was thoroughly reviewed and upgraded in May 2005, to assure that payments for all claim types processed through the system are made accurately, without duplication.

FY 04-05 OBJECTIVE: **1.4 To assure delivery of appropriate, high quality care. To design programs that result in improved health status for clients served and to improve health outcomes. To ensure that the Department's programs are responsive to the service needs of enrolled clients in a cost-effective manner.**		
Division / Section	**FY 04-05 Performance Measure**	**Achievements towards FY 04-05 Performance Measures as of November 15, 2005**
Long Term Benefits Division, Community-Based Long Term Care Section	By May 1, 2005, Community-Based Long Term Care will develop two additional sites to provide services to long-term clients enrolled in the Brain Injury Waiver.	Two additional sites, one in Colorado Springs and one Greeley, have been developed and are pending certification. Certification is anticipated by October 31, 2005.
Long Term Benefits Division, Nursing Facilities Section	Nursing Facilities will develop a specific placement and care plan for the estimated 170 clients with mental illness living in nursing facilities.	This was a proposed program change which would have given nursing facilities servicing clients with mental illness an increase in their per diem rate. This proposal was abandoned after it was determined to have a larger fiscal impact than previously estimated.
Child Health Plan Plus Office	Child Health Plan Plus Office contracted with a quality improvement vendor to collect baseline data for calendar year 2004 to evaluate Health Plan Employer Data and Information Set measures. A report of the data is due by June 30, 2005.	The Child Health Plan Plus Office contracted with an External Quality Review Organization to collect quality performance measures. The measures were calculated and submitted to the External Quality Review Organization by June 30, 2005. The Department received a draft report in August 2005 and will receive a final report in October 2005.

FY 04-05 OBJECTIVE: **1.5 To accurately project, report, and manage budgetary requirements to effect executive and legislative intent with program and budget development and operations. To accurately record and monitor expenditures for programs managed by the Department so there may be accurate financial reporting at all times.**		
Division / Section	**FY 04-05 Performance Measure**	**Achievements towards FY 04-05 Performance Measures as of November 15, 2005**
Budget Division	For the November 1, 2004 Budget Request, the Budget Schedules Analyst will improve the current Schedule 3 spreadsheets, creating a more automated and standardized process, including instructions and structured audits, to ensure greater accuracy in budget deliverables.	The Schedules Analyst created internal balance formulas, standardized layouts and labeling, and color coded manual entries versus automated calculations to provide greater confidence in the final product. Additionally, the Schedules Analyst required regular feedback from the individual Analyst responsible for each line, to verify the accuracy of the final appropriation.
Controller Division	The Controller Division will improve the accounting and reporting of provider recoveries by developing a routine reporting mechanism for provider recoveries. A routine report will be provided to interested parties of provider recoveries collected by provider payment, by accounts receivable recoupment within the Medicaid Management Information System, and by direct payment offset within the information system.	Controller Division staff worked with Department program staff to develop a full inventory of all sources of provider recoveries, and to gain a better understanding of the nature, source and process of those recoveries. In addition, the Division's staff worked with representatives of the State Treasurer's Office and the State's bank to ensure that information from the bank regarding provider recoveries deposited in the Department's Lock Box account could be properly identified. This background and process understanding was necessary to properly develop the reporting mechanisms as desired.

FY 04-05 OBJECTIVE: **1.6 To work towards systemic improvement in the Department's operations to expand efficiencies, minimize waste, ensure coordination, and eliminate discrepancies.**		
Division / Section	**FY 04-05 Performance Measure**	**Achievements towards FY 04-05 Performance Measures as of November 15, 2005**
Budget Division	For data requests from Joint Budget Committee staff, Legislative Council, the Office of State Planning and Budgeting, the Legislative Liaison, or the Communications Director, the Budget Division's Data Analyst will create a log, which includes the abbreviated question and response, a listing of the methodology used, and any errors identified after submission. Necessary corrections will be identified in the log. No more than three corrections will be acceptable for FY 04-05.	A log was created and maintained by the Budget Division's Data Analyst from October 2004 until January 2005. Subsequently, the Division's Data Analyst was transferred to another section within the Department. The log included the method for which the data was extracted, and feedback from reviewing parties for auditing purposes.
Controller Division	The Controller Division will fully implement a newly designed internal clearance processed for all procurement activities (requests for proposals, contracts, purchase orders, etc.). The process will be adjusted as necessary, as experience identifies flaws or additional needs. Full implementation will occur in April 2005, after one full fiscal year of using and adjusting the new process.	This new clearance process has been fully implemented as of September 2004, and has proven to be very efficient and effective.
Information Technology Division	The Information Technology Division will obtain consultant services to assist in the reprocurement of fiscal agent services and will publish a Request for Proposals for those services.	As of September 16, 2005, the Request for Proposal for the consultant services was posted and the Department expects to know results by November 30, 2005.

FY 04-05 OBJECTIVE: **2.1 To expand areas of potential financial recovery such as third party insurance (that should be a primary payer) and cases of fraud and abuse.**		
Division / Section	**FY 04-05 Performance Measure**	**Achievements towards FY 04-05 Performance Measures as of November 15, 2005**
Client Services Division, Benefits Coordination Section	The Benefits Coordination Section will maintain or increase third party recoveries over the prior year's level.	Due to FY 03-04 recoveries greatly exceeding normal recovery levels, the actual recoveries were $20, 607,609. For FY 04-05, recoveries were expected to be 90% of those experienced during FY 03-04. The actual recoveries were $18,151,062.
Client Services Division	The Client Services Division will research methods to increase enrollment in the Health Insurance Buy-In program through the Colorado Benefits Management System.	Implementation issues with the Colorado Benefits Management System have interfered with gathering the necessary data to isolate the target population. Therefore, this project has been postponed.
Rates and Analysis Division	The Division will develop and conduct three new provider review types during the fiscal year to assess whether the service provided was documented, provided as outlined according to Department policy, and paid correctly. The provider types selected for review in FY 04-05 are: federally qualified health centers, dialysis centers, and orthodontic dental providers.	All identified provider types (federally qualified health centers, dialysis centers, and orthodontic dental providers) were reviewed. To date, $28,776 in overpayments has been recovered from the federally qualified health centers, and $20,176 from dialysis centers. Orthodontia services were discovered to be well managed via prior authorization of services and no overpayment has been identified from review. In FY 04-05, the net overpayment recovery collected by the Program Integrity section and the Department's two contractors is $6,518,847.

FY 04-05 OBJECTIVE: **2.2 Improve management of the Department's information systems technology.**		
Division / Section	**FY 04-05 Performance Measure**	**Achievements towards FY 04-05 Performance Measures as of November 15, 2005**
Information Technology Division	Information Technology will provide upgrades and replacements to the Department's infrastructure to support changing business needs, as funding allows.	The Department replaced and upgraded 70 workstations, and upgraded all workstations from Windows NT to Windows XP. The Department installed a firewall to segment and protect Department network traffic to the Internet, and added a special system update server to continuously provide operating system fixes. Finally, the Department replaced one of its core switches to a new high speed switch between servers.
Information Technology Division	Health Insurance Portability and Accountability Act security regulations will be implemented and the Information Technology Division will conduct security audits to assure the safety of electronic health information on the Department's local area network. Operating system changes to Microsoft XP will be completed to allow greater security control on individual workstations from centralized administration.	The Department updated the operating systems by the security deadline of April 20, 2005. Periodic vulnerability scans/audits are made of Department devices to check for potential vulnerabilities of attack. All workstations were upgraded from Windows NT to Windows XP, workstation-based firewalls have been implemented on all user workstations, and critical security upgrades to workstations are now automated so that upgrades are rapidly deployed upon release. Finally, Active Directory group security policies have been implemented to provide greater control over workstations with regards to appropriate use.

FY 04-05 OBJECTIVE: **2.3 To hold accountable the Department's administrative contractors, including state and local agencies, by more outcome-based contracting and more sophisticated contract management.**		
Division / Section	**FY 04-05 Performance Measure**	**Achievements towards FY 04-05 Performance Measures as of November 15, 2005**
Customer Service Section	Customer Service will establish an outcome-based contract for the Ombudsman for Medicaid Managed Care contract for FY 04-05, with a contract administrator in place by August 1, 2004. A review of the Ombudsman for Medicaid managed care contract will be completed by January 30, 2005. Integration of mental health is planned in FY 04-05.	The Ombudsman contract was fully executed and a contract administrator was in place by August 2004. The contractor is required to respond to and analyze complaints around an action or failure by the Department which affected a client's access to quality health care services, treatments, or providers. Monthly, quarterly and annual reports are received by the Ombudsman, and contract reviews were done as necessary. Mental Health was integrated, effective July 2004.

FY 04-05 OBJECTIVE: **2.3 To hold accountable the Department's administrative contractors, including state and local agencies, by more outcome-based contracting and more sophisticated contract management.**		
Division / Section	**FY 04-05 Performance Measure**	**Achievements towards FY 04-05 Performance Measures as of November 15, 2005**
Long Term Benefits Division, Community-Based Long Term Care Section	For the FY 05-06 contract period, Long Term Benefits will develop contract deliverables directly associated with payment in order to support timely and effective service delivery, and to clearly define the areas of non-payment for non-compliance in at least two waiver programs. Development will be completed by February 15, 2005, and training of the contracted providers will occur by May 1, 2005.	FY 05-06 contracts have been re-evaluated and additional clarity has been added to the scope of work required by contractors. Cost categories are identified and contractors were trained on June 16, 2005. Specific modifications to the contracts are as follows: • Added the requirement that the contractor shall use Benefits Utilization System (BUS) for client information management. • Added language for Health Insurance Portability and Accountability Act of 1996 (HIPAA) versus the statement of 'protecting the client's rights as defined by the Department…' and 'protecting the confidentiality of all applicants and recipient records'. • Added the requirement that a contractor shall maintain a complaint log, available for review by the Department with complaints regarding quality of care issues forwarded to the Department of Public Health and Environment within 42 hours. • Added the requirement that the contractor shall follow 10 C.R.R., Section 8.393.31 when transferring a client from one district to another, versus 'Contractor shall develop procedures for the transfer of clients…' • Added the requirement the contractor shall have a plan to overcome any geographic barriers within the district.

FY 04-05 OBJECTIVE: **3.1 To improve customer satisfaction with programs, services, and care.**		
Division / Section	**FY 04-05 Performance Measure**	**Achievements towards FY 04-05 Performance Measures as of November 15, 2005**
Long Term Benefits Division, Systems Change Section	By December 31, 2004, the Department will be administering three legislatively based, consumer-directed programs: Consumer Directed Attendant Support, Consumer Directed Care for Elderly, and In-Home Support Services. The programs have similar and even overlapping requirements and target populations. The Department will engage in an intense educational campaign to ensure that clients and case managers are not confused by the subtle similarities and differences. The Department will seek waiver modifications to permit serving greater numbers with greater flexibility.	The Consumer Directed Attendant Support Waiver was increased from 150 allowable clients to 500 allowable clients. Through a contract with Policy Studies Inc., effective till January 2006, the Department established a statewide outreach program which is focused on appropriate trainings for Single Entry Point agencies and peer trainers. In addition, the Consumer Directed Care for the Elderly program and the In-Home Support Services program were both implemented during FY 04-05.

FY 04-05 OBJECTIVE: **3.2 To enhance customer service, provider, and eligibility personnel's understanding of program requirements, benefits, and responsibilities. To improve the usefulness of communications with clients, constituents, partners, and stakeholders.**		
Division / Section	**FY 04-05 Performance Measure**	**Achievements towards FY 04-05 Performance Measures as of November 15, 2005**
Customer Service Section	By June 30, 2005, Customer Service will answer 90,000 incoming customer calls for FY 04-05.	Customer Service answered approximately 84,708 incoming calls for the period of July 1, 2004 to June 30, 2005.
Safety Net Financing Section	Prior to July 1, 2005, the Safety Net Financing Section will research a benefit package or purchasing strategy for the Old Age Pension State Medical Program that can be delivered within the constraints of constitutional funding limits.	The Department submitted a report to the General Assembly on November 1, 2004 to comply with Footnote 42 of HB 04-1422.

FY 04-05 OBJECTIVE: **3.2 To enhance customer service, provider, and eligibility personnel's understanding of program requirements, benefits, and responsibilities. To improve the usefulness of communications with clients, constituents, partners, and stakeholders.**		
Division / Section	**FY 04-05 Performance Measure**	**Achievements towards FY 04-05 Performance Measures as of November 15, 2005**
Budget Division	The Budget Division will expand the availability of commonly requested information in the formulation and presentation of the Department's FY 05-06 Strategic Plan. This information will be displayed in the form of charts, tables, and graphs, as appropriate.	The Department's Strategic Plan in FY 03-04 was comprised of three main components, the Prioritized Objectives and Performance Measures, the Department Background, and the Policy and Program Trends sections. In total, these sections comprised 50 pages of information. In FY 04-05, the Department expanded these sections to contain commonly requested information such as Top Ten and Top Fifteen lists for services, prescribed drugs, and inpatient and outpatient diagnoses; as well as providing caseload information separated by different criteria such as gender, regional views, average costs per client, etc. These changes expanded the Department's Strategic Plan to over 100 pages.
Budget Division	The Budget Division will conduct training sessions during FY 04-05 to Department staff to educate on budget-related activities and responsibilities. A minimum of one session in each of the following areas will be provided: the Budget Cycle, Change Requests, Fiscal Notes, and Operating Budgets. As appropriate or timely, new legislation affecting the Department will be presented.	The Schedules Analyst, Premiums Analyst, and Fiscal Note Coordinator provided three separate training sessions during FY 04-05 to Department staff regarding the Long Bill and Special Bills that affected the Department's Budget, the methodology and different components of Medical Services Premiums, and fiscal note procedures and instruction on the Legislative process. Budget staff also provided a department-wide operating budget training session for FY 04-05 in June 2004.
Long Term Benefits Division, Systems Change Section	By December 31, 2004, the Systems Change Section will produce a resource guide of community-based programs in Medicaid for people interested in employment and will distribute it to clients and supporting agencies.	The resource guide was complete and distributed to over 50 agencies between October 2004 and December 2004.

FY 04-05 OBJECTIVE: **4.1 To build and maintain a high quality, customer-focused team.**		
Division / Section	**FY 04-05 Performance Measure**	**Achievements towards FY 04-05 Performance Measures as of November 15, 2005**
Information Technology Division, Information Technology Contracts and Monitoring Section	All employees will receive Health Insurance Portability and Accountability Act Privacy and Customer Service training within 60 days of hire.	The Department provided training for Health Insurance Portability and Accountability Act privacy to all staff including new employees and temporary staff. There were also several requests by different groups, counties, and Medical Assistance sites in which the Department was asked to provide training. This process is now part of the Department's ongoing business process, with Privacy Training provided to all new users within the sixty day period following employment.

FY 04-05 OBJECTIVE: **4.2 To enhance program safeguards and controls.**		
Division / Section	**FY 04-05 Performance Measure**	**Achievements towards FY 04-05 Performance Measures as of November 15, 2005**
Safety Net Financing Section	The Safety Net Financing Section will establish procedures to maximize federal revenue to sustain or increase payments to providers that conform to federal guidelines. Federal revenue will not be included in the Department's budget until plans are approved by the Centers for Medicare and Medicaid Services.	The Safety Net Financing Section increased federal revenue under the Colorado Indigent Care Program by $30.1 million, per the Medically Indigent and Colorado Indigent Care Program Fiscal Year 2003-2004 Annual Report. Payments to providers and adjustments to the Department's budget were not made until official approval was received by the Centers for Medicare and Medicaid Services. The Department's Budget was amended with the passage of SB 05-209 Add-ons.

FY 04-05 OBJECTIVE: **4.3 To increase public knowledge of and involvement in the financing and delivery of health care.**		
Division / Section	**FY 04-05 Performance Measure**	**Achievements towards FY 04-05 Performance Measures as of November 15, 2005**
Safety Net Financing Section	The Colorado Indigent Care Program Annual Report, which details utilization and financial trends for the indigent care programs administered by the Department, will be delivered to the General Assembly on February 1, 2005.	The FY 03-04 Annual Report for the Medically Indigent and Colorado Indigent Care Program was delivered to the General Assembly on February 1, 2005.

FY 04-05 OBJECTIVE: **4.4 To develop enhanced training and retention strategies for departmental staff.**		
Division / Section	**FY 04-05 Performance Measure**	**Achievements towards FY 04-05 Performance Measures as of November 15, 2005**
Budget Division	New analysts will receive training on the Long Bill, Change Requests, the Legislative Process, fiscal notes, Medical Services Premiums, and Strategic Planning within 21 days of hire in the Budget Division.	New Budget staff received Long Bill, Change Request and Strategic Plan training in their first week with the Department. Additional training for the Legislative Process and fiscal notes was covered in their second week of employment.

FY 05-06 Achievements towards Performance Measures from Last Year's Budget Request

FY 05-06 OBJECTIVE: **1.1 To maximize the opportunity to maintain health care services through the purchase of services in the most cost-effective manner possible.**		
Division / Section	**FY 05-06 Performance Measure**	**Achievements towards FY 05-06 Performance Measures as of November 15, 2005**
Rates and Analysis Division	The Division will continue to implement prior authorizations, limits, and controls to effectively manage the prescription drug expenditures, based on opportunities identified within the pharmacy program.	The Unit will incorporate changes as required by the Medicare Modernization Act, or other state legislation, to control the amount of prescription drug usage. New rates were calculated and sent to the actuary for review. In addition, the Unit will be reviewing drug reports throughout the year to assist with provider education on pharmacy claims issues.

FY 05-06 OBJECTIVE: **1.1 To maximize the opportunity to maintain health care services through the purchase of services in the most cost-effective manner possible.**		
Division / Section	**FY 05-06 Performance Measure**	**Achievements towards FY 05-06 Performance Measures as of November 15, 2005**
Rates and Analysis Division	Rates and Analysis 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.	The Unit has held meetings with the Drug Utilization Review Board on drug limits and utilization issues.

FY 05-06 OBJECTIVE: **1.2 To support timely and accurate client eligibility determination.**		
Division / Section	**FY 05-06 Performance Measure**	**Achievements towards FY 05-06 Performance Measures as of November 15, 2005**
Eligibility Operations Section	The Medicaid Eligibility Quality Control Unit will utilize Colorado Benefits Management System quality control programming in two of three pilots for FY 05-06.	An active quality control pilot was conducted from January 2005 to September 2005, to evaluate family and children Medicaid eligibility. A negative quality control pilot is being conducted from July 2005 to March 2006 to study claims paid for deceased nursing facility clients.
Eligibility Operations Section	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.	The Eligibility Operations Section has identified changes necessary for implementing HB 05-1262 for expanding coverage to children and pregnant women enrolled in the Child Health Plan Plus, for removing the Medicaid Asset Test, and adjustments to client correspondence within the Colorado Benefits Management System. Additionally, the Section has identified changes needed to implement the Medicare Modernization Act of 2003 as it relates to drug coverage for dual eligibles, processing applications, etc. The Section has established an implementation timetable for each of these Medicaid reforms and has increased its resources to address these policy changes on time.

FY 05-06 OBJECTIVE: **1.2 To support timely and accurate client eligibility determination.**		
Division / Section	**FY 05-06 Performance Measure**	**Achievements towards FY 05-06 Performance Measures as of November 15, 2005**
Long Term Benefits Division, Nursing Facility Section	Patient payments for nursing facilities will be automated into the Medicaid Management Information System by June 2005. The client/patient portion of care is currently tracked manually at the county level.	Nursing facility patient payments have not been automated into the Medicaid Management Information System. To do so would have required a larger fiscal impact than originally anticipated. The counties continue to be responsible for manually tracking the nursing facility patient payment while other options are being assessed.
Information Technology Division, Eligibility Systems Development Section	The Colorado Benefit Management System will be implemented Statewide and the rules-based system will become stable and reliable in terms of eligibility determinations.	The Colorado Benefits Management System went live in September 2005. Since that time, the Department has worked through a number of programming fixes, and has identified what it believes are the remaining outstanding issues that jeopardize the reliability of the State's new eligibility system. These issues have been prioritized and are in progress to be completed during FY 05-06.
Information Technology Division	The Information Technology Division will monitor and enhance the Colorado Benefits Management System eligibility determination system and Department's decision tables to improve the accuracy of the client eligibility determination.	The Division has been continuously monitoring the performance of the decision tables and how eligibility is determined. Corrections and enhancements have been performed, as necessary, to improve accuracy in system determinations.

FY 05-06 OBJECTIVE: **1.3 To assure payments in support of the programs are accurate and timely.**		
Division / Section	**FY 05-06 Performance Measure**	**Achievements towards FY 05-06 Performance Measures as of November 15, 2005**
Safety Net Financing Section	Quarterly payments to Colorado Indigent Care Program providers will be made according to a published schedule.	On August 15, 2005, and on November 15, 2005 payments were made for $35,554,200 according to the schedule communicated in the providers' rate letters.

FY 05-06 OBJECTIVE: **1.3 To assure payments in support of the programs are accurate and timely.**		
Long Term Benefits Division, Community-Based Long Term Care Section	Long Term Benefits will implement a process to have 90% of the prior authorization requests electronically submitted directly to the fiscal agent from providers and/or contracted utilization review agencies by December 31, 2005.	Successful and timely completion of this process is contingent upon the systems change requirements, the contract limitations with the Department's fiscal agent, and the fact that the fiscal agent contract is being reprocured. However, establishing this process represents an important efficiency savings for the Department, and the Section will continue to further its efforts in achieving this measure. Therefore, the Section has set a new target date of December 2006 for this project.
Rates and Analysis Division	The Division will provide assessment of payments to the managed care organizations, Programs of All Inclusive Care to the Elderly, and administrative service organizations, to assure accurate payments for eligible clients for FY 05-06 by March 2006. These provider requests for offline payments will be analyzed within 45 days after submission.	The Division has started the recoupment process for FY 04-05. Recoupment calculations for FY 04-05 will be finalized in July 2006, once there has been enough run out in the data. Calculation of recoupments for FY 05-06 is projected to begin in July 2006.
Information Technology Division	The Information Technology Division will continue the internal audit of Department transmittals to the fiscal agent to assure that complete and accurate rate changes occur, based on requests.	To date, 100% of all transmittals changing rates are currently reviewed by staff to insure accuracy.
Child Health Plan Plus Office	A claims audit process will be implemented in the Child Health Plan Plus Office.	The Child Health Plan Plus Office Administration line item contains an appropriation for $100,000 for this purpose. Additionally, the Department has begun conducting a Payment Error Rate Measurement project in October 2005 that may satisfy the requirements of the State Auditor's Office, which would eliminate the need for a separate claims audit.

FY 05-06 OBJECTIVE:
1.4 To assure delivery of appropriate, high quality care. To design programs that result in improved health status for clients served and to improve health outcomes. To ensure that the Department's programs are responsive to the service needs of enrolled clients in a cost-effective manner.

Division / Section	FY 05-06 Performance Measure	Achievements towards FY 05-06 Performance Measures as of November 15, 2005
Long Term Benefits Division, Community-Based Long Term Care Section	By October 1, 2005, Community-Based Long Term Care will release a Request for Information to develop a list of specialty facilities that provide cost efficient services for long-term care brain injury waiver clients with behavioral issues.	To assist in the creation of a quality long term care delivery system, pursuant to SB 05-173, the Community Based Long Term Care section convened an advisory committee and will hire an independent facilitator by July 1, 2006, contingent upon receiving the funding gift in order to develop criteria for the Department to use in evaluating and approving coordinated care pilot program proposals.
Health Benefits Division	The Health Benefits Division will implement at least one provider or client intervention based on the results of a quality improvement study or measurement to improve health care in the Medicaid program.	In FY 04-05, the Department's External Quality Review Organization conducted a clinical focus study to assess each of the Department's health plans' Early Periodic Screening and Diagnosis Treatment (EPSDT) Programs. In April 2005, the External Quality Review Organization started a limited client and provider intervention to enhance the Department's health plans' EPSDT programs and to improve processes for clients to access immunizations and blood lead screening. The intervention method and target population will be finalized by the end of November.

FY 05-06 OBJECTIVE:
1.5 To accurately project, report, and manage budgetary requirements to effect executive and legislative intent with program and budget development and operations. To accurately record and monitor expenditures for programs managed by the Department so there may be accurate financial reporting at all times.

Division / Section	FY 05-06 Performance Measure	Achievements towards FY 05-06 Performance Measures as of November 15, 2005
Safety Net Financing Section	Safety Net Financing Section staff will track monthly expenditures under the Colorado Indigent Care Program to ensure that the program expenditures remain within available appropriations.	The Safety Net Financing Section has tracked Colorado Indigent Care Program expenditures for July through October to ensure that the program expenditures remain within available appropriations.

FY 05-06 OBJECTIVE: **1.5 To accurately project, report, and manage budgetary requirements to effect executive and legislative intent with program and budget development and operations. To accurately record and monitor expenditures for programs managed by the Department so there may be accurate financial reporting at all times.**		
Division / Section	**FY 05-06 Performance Measure**	**Achievements towards FY 05-06 Performance Measures as of November 15, 2005**
Safety Net Financing Section	Safety Net Financing Section staff will track and forecast expenditures under the Old Age Pension State Medical Program to ensure that the program remains within constitutional and statutory budget boundaries.	The Safety Net Financing Section established procedures and has tracked Old Age Pension State Medical Program expenditures for July through October to ensure that the program expenditures remain within available constitutional and statutory budget boundaries.
Rates and Analysis Division	The Rates and Analysis Division will respond to requests for ad hoc reports within 10 business days, 90% of the time.	The Division established a set of written protocols for data analysis. Not only will these protocols provide a higher degree of standardization in reporting results, they will also speed the average turnaround time between ad hoc report request and delivery date.
Rates and Analysis Division	Rates for managed care organizations, Programs of All Inclusive Care to the Elderly, and administrative service organizations will be calculated in a timely manner, meeting all actuarial standards.	Calculation of the FY 05-06 health maintenance organization rates was completed on April 29, 2005 and received final certification on May 18, 2005. The FY 05-06 behavioral health organization rates were updated on July 1, 2005. The Division received a Purchase Order on May 19, 2005 to contract for actuarial certification. Rate development for the calendar year 2006 Programs of All Inclusive Care to the Elderly rates began in July of 2005 and should be completed in November 2005. Note that the Division will need to update the health maintenance organization and behavior health organization rates effective January 1, 2006 to account for the Medicare Modernization Act; the Division is currently working on procuring funds for actuarial certification of these January 1, 2006 rates.
Information Technology Division	Information Technology will increase decision support capacity from 5 years of history data to 7 years to allow increased trending capability.	The Department was not able to pursue this initiative for FY 05-06 due to implementing the Colorado Benefits Management System.

FY 05-06 OBJECTIVE: **1.6 To work towards systemic improvement in the Department's operations to expand efficiencies, minimize waste, ensure coordination, and eliminate discrepancies.**		
Division / Section	**FY 05-06 Performance Measure**	**Achievements towards FY 05-06 Performance Measures as of November 15, 2005**
Controller Division	Based on work with the State Controller's Office and the Attorney General's Office, the Controller Division will implement a new contract document for contracts with Medicaid and Child Health Plan Plus Office medical providers that is different from the standard state contract, but yet meets the core needs of the State in its contracting requirements.	No progress was made on this performance measure as of November 15, 2005, due to competing priorities and a number of changes within the Division.
Child Health Plan Plus Office	The Child Health Plan Plus Office will continue the process for the Centers for Medicare and Medicaid Services' approval of the streamlining of Medicaid and Child Health Plan Plus.	The Department submitted the proposal to the Health and Human Services Committees for approval in July 2005. The proposal was not approved. However, after reviewing the proposal, members of the Health and Human Services Committees expressed interest in working with the Department to further explore this initiative.

FY 05-06 OBJECTIVE: **2.1 To expand areas of potential financial recovery such as third party insurance (that should be a primary payer) and cases of fraud and abuse.**		
Division / Section	**FY 05-06 Performance Measure**	**Achievements towards FY 05-06 Performance Measures as of November 15, 2005**
Client Services Division, Benefits Coordination Section	The Benefits Coordination Section will maintain or increase recoveries over the prior year's level.	The Section anticipates that maintaining or increasing recoveries for FY 05-06 is feasible. The Department anticipates maintaining recoveries based on prior history of increasing recoveries. There is no anticipated reduction or increase in available resources, and the Department continues to contract with Health Management Systems for post-pay, estate and tort and casualty recoveries. As of October 2005, recoveries to date are $2,911,571as compared to $18,151,062 the prior year.

FY 05-06 OBJECTIVE: **2.1 To expand areas of potential financial recovery such as third party insurance (that should be a primary payer) and cases of fraud and abuse.**		
Division / Section	**FY 05-06 Performance Measure**	**Achievements towards FY 05-06 Performance Measures as of November 15, 2005**
Benefits Coordination Section	Benefits Coordination will implement a process to increase enrollment in the Health Insurance Buy-In program, pending Departmental approval of the project plan.	Benefits Coordination did not implement a process to increase enrollment in the Health Insurance Buy-In program. There is no record of the project plan or information to support the intention of this measure left from the previous manager. The Buy-In officer has reported the previous manager believed the implementation of CBMS would have the capability to identify potential individuals and perform a cost-effective analysis automatically. This is not a feature that exists within CBMS. The officer does not believe a project plan was ever created.

FY 05-06 OBJECTIVE: **2.2 Improve management of the Department's information systems technology.**		
Division / Section	**FY 05-06 Performance Measure**	**Achievements towards FY 05-06 Performance Measures as of November 15, 2005**
Information Technology Division	The Information Technology Division will provide upgrades and replacements to Department infrastructure to support changing business needs, based upon available funding.	The Department expects to upgrade the Local Area Network for increased speed to support the Department's growing data needs by December 1, 2005. The Division also expects to move to Microsoft software management systems to assist in automating software updates by that time.
Information Technology Division	Information Technology will award the new fiscal agent contract and begin transition to the new contractor.	The Department began this project and released the Request for Proposal on September 16, 2005 for a consulting vendor to assist the Department in preparing for the reprocurement of a fiscal agent. However, a new fiscal agent contract will not be awarded by the end of this fiscal year. The goal date for a new fiscal agent contract is now July 1, 2007.
Information Technology Division	Web support and maintenance staff will be hired to build and deliver web applications for providers and clients based on program direction, depending on available funding.	The Department did not pursue this initiative for FY 05-06 due to budget constraints.

FY 05-06 OBJECTIVE: **2.2 Improve management of the Department's information systems technology.**		
Division / Section	**FY 05-06 Performance Measure**	**Achievements towards FY 05-06 Performance Measures as of November 15, 2005**
FY 05-06 OBJECTIVE: **2.3 To hold accountable the Department's administrative contractors, including state and local agencies, by more outcome-based contracting and more sophisticated contract management.**		
Division / Section	**FY 05-06 Performance Measure**	**Achievements towards FY 05-06 Performance Measures as of November 15, 2005**
Customer Service Section	By July 1, 2005, an outcome-based Ombudsman for Medicaid Managed Care contract (including mental health) will be in place. A review of the contract will be completed by January 30, 2006.	Effective July 1, 2005, a fully executed Ombudsman contact was in place with the mental health component included. Monthly, quarterly and annual reports are received by the Ombudsman, and contract review is done as necessary.

FY 05-06 OBJECTIVE: **3.1 To improve customer satisfaction with programs, services, and care.**		
Division / Section	**FY 05-06 Performance Measure**	**Achievements towards FY 05-06 Performance Measures as of November 15, 2005**
Customer Service Section	Less than one percent of customer calls answered by the customer service staff will receive complaints at the Governor's Office.	As of October 2005, the Department is not aware of any customer service complaints against the Health Care Policy and Financing received by the Governor's office.
Customer Service Section	Customer Service will increase the number of incoming customer calls answered by 10% over the total FY 04-05 calls (estimated to be 90,000 incoming calls).	Customer Service answered approximately 85,708 calls in FY 04-05. The number of answered calls is anticipated to increase in FY 05-06 as inexperienced employees gain relevant skills and job knowledge. As of October 2005, Customer Service has answered approximately 34,000 calls.

FY 05-06 OBJECTIVE: **3.2 To enhance customer service, provider and eligibility personnel's understanding of program requirements, benefits, and responsibilities. To improve the usefulness of communications with clients, constituents, partners, and stakeholders.**		
Division / Section	**FY 05-06 Performance Measure**	**Achievements towards FY 05-06 Performance Measures as of November 15, 2005**
Budget Division	The Budget Division will conduct training sessions during FY 05-06 for Department staff to educate on budget-related activities and responsibilities. At least two sessions in each of the following areas will be conducted: the budget cycle, change requests, fiscal notes, and operating budgets. As appropriate or timely, new legislation affecting the Department will be presented.	Operating training conducted by the Personal Services and Operating Budget Analyst was held on June 21, 2005 for all Program Managers. Three training sessions for fiscal notes will be completed prior to December 10, 2005, roughly the start of the Legislative Session.
Eligibility Operations Section	The Eligibility Operations Section will conduct semi-annual Eligibility Trainings for county and medical assistant site technicians.	There was a lack of training in FY 04-05 due to implementation for the Colorado Benefits Management System. Therefore, the Department plans to conduct ten eligibility training sessions in FY 05-06 and broaden the scope of training. As of October 2005, five of these sessions have been held.
Long Term Benefits Division, Systems Change Section	By December 31, 2005, the Department will have an outreach and awareness campaign underway to inform clients and collateral supporters about the opportunities and advantages of consumer direction. This campaign will achieve a 75% success rate, as measured by follow-up surveys.	The Department has begun developing a statewide marketing and outreach campaign to inform clients and the general public about the opportunities and advantages of consumer direction. The Department has identified target audiences and completed background research. Focus groups and key informant interviews are currently underway. An on-line registry of attendants and a variety of training materials are in development. By January 31, 2006, an evaluation will determine the effectiveness and success of the marketing and outreach campaign and the training materials.

FY 05-06 OBJECTIVE: **4.1 To build and maintain a high quality, customer-focused team.**		
Division / Section	**FY 05-06 Performance Measure**	**Achievements towards FY 05-06 Performance Measures as of November 15, 2005**
Customer Service Section	By June 30, 2006, the Customer Service Section, with sufficient staff, will reduce the call abandonment rate by 10% over the previous year.	The monthly call volume is expected to increase due to programmatic changes related to implementation of Medicare Part D; however, the Division plans to increase staff beginning in July 2005, to help control the call abandonment rate.

FY 05-06 OBJECTIVE: **4.2 To enhance program safeguards and controls.**		
Division / Section	**FY 05-06 Performance Measure**	**Achievements towards FY 05-06 Performance Measures as of November 15, 2005**
Safety Net Financing Section	Safety Net Financing will establish procedures to maximize federal revenue to sustain or increase payments to providers that conform to federal guidelines. Federal revenue will not be included in the Department's budget until approved by the Centers for Medicare and Medicaid Services.	The Safety Net Financing Section continues to research other financing opportunities such as the refinancing that increased federal revenue under the Colorado Indigent Care Program by $30.1 million in FY 04-05 and FY 05-06. As these are identified and approved by the Office of State Planning and Budgeting, they are and have been submitted to the Joint Budget Committee.
Controller Division	The Division will review procedures and fiscal rules and ensure compliance with State regulations.	By March 31, 2006, the Division will review the Department's use of the State Procurement Card to ensure that the processes established when the card was first implemented in the Department are still effective and still in compliance with State Procurement and Fiscal Rules.

FY 05-06 OBJECTIVE: **4.3 To increase public knowledge of and involvement in the financing and delivery of health care.**		
Division / Section	**FY 05-06 Performance Measure**	**Achievements towards FY 05-06 Performance Measures as of November 15, 2005**
Safety Net Financing Section	The Colorado Indigent Care Program Annual Report, which details utilization and financial trends for the indigent care programs administered by the Department, will be delivered to the General Assembly by February 1, 2006.	The FY 04-05 Annual Report for the Medically Indigent and Colorado Indigent Care Program will be delivered to the General Assembly on February 1, 2006.

FY 05-06 OBJECTIVE: **4.4 To develop enhanced training and retention strategies for departmental staff.**		
Division / Section	**FY 05-06 Performance Measure**	**Achievements towards FY 05-06 Performance Measures as of November 15, 2005**
Controller Division	The Controller Division will develop and implement a full-scale training for Department managers in the State Personnel Rules and processes, including hiring, reclassification, employee performance management, and employee discipline.	The Controller Division has begun its manager and employee training program. To date, training has been provided on Progressive Discipline and State health and dental benefits. Additional trainings are being developed to meet the overall goal of this performance measure.

V. POLICY AND PROGRAM TRENDS

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

Medicare Modernization Act of 2003

Beginning January 1, 2006, Medicare beneficiaries will have the option of enrolling in the Medicare Modernization Act Drug Benefit program. Individuals who are dually eligible for Medicare and Medicaid will automatically be enrolled into a program, in which the enrollee will be responsible for selecting a Prescription Drug Benefit Plan. The Prescription Drug Plan is designed to manage the client's drug benefit including: 1) tracking utilization, 2) administering federal subsidies to enrollees, 3) imposing cost-sharing obligations such as capping pharmacy charges, 4) arranging for manufacturer discounts and 5) establishing a formulary for the drugs covered by their plan. If the dual eligible client does not select a Prescription Drug Benefit Plan, one will be assigned to the enrollee. Per federal regulations regarding the Medicare Modernization Act, the individual has the option of disenrolling if they so choose. However, if an individual electing to disenroll is dually eligible for both Medicare and Medicaid, he/she will no longer receive State or federal support for the purchase of any Medicare Part D covered drug.

The Medicare Modernization Act allows prescription drug plans and Medicare advantage drug plans to establish their own formulary of covered Part D drugs, with oversight by the Centers for Medicare and Medicaid Services. In the formularies, Medicare drug plans are required to provide only two drugs in every class and one drug for each medical indication covered in that therapeutic class. One notable exception is that the plans must cover all or substantially all of the drugs in certain drug categories including antipsychotics, antidepressants and immunosuppressants. This exception was created in part because many recipients of these drugs have adverse reactions to switching medications. The formulary restrictions are significant to Medicaid clients because current Medicaid prescription drug coverage is much less restrictive than minimum coverage will be upon implementation of the Medicare Modernization Act. It is likely that each Prescription Drug Benefit Plan will have a different formulary from other Prescription Drug Benefit Plans in the region. It is also possible that not all pharmaceuticals currently covered by Medicaid will be included in the Prescription Drug Benefit Plans. Centers for Medicare and Medicaid Services has created a formulary tool through which recipients may enter in a number of drugs and determine which plans will cover those drugs. The tool may be found on the CMS website at: http://plancompare.medicare.gov/formularyfinder/selectstate.asp or information may be obtained by calling 1-800-MEDICARE.

Federal regulations outlining the Medicare Modernization Act require each state to check eligibility for any client applying for low-income subsidies for other applicable Medicaid programs. As a result, the Department estimates that Medicaid caseload will experience a "woodwork" effect wherein additional individuals being screened for the low-income subsidy will also be found eligible

for Medicaid. The administrative costs and the additional caseload will result in financial obligations to the State for the implementation of this federal program.

States will retain responsibility for the majority of the drug costs due to the phased-down State contribution, commonly referred to as the "Clawback", which is a maintenance of effort requirement. The Clawback is a monthly payment due to the federal Medicare program from the state, beginning January 2006, which roughly reflects the expenditures that the state would make if it continued to pay for outpatient prescription drugs through Medicaid on behalf of the dual eligibles.

Transitions in Community-Based Programs

Community-based programs have been well received in Colorado. The programs, designed to keep long term care clients in alternative programs in the community, are both cost efficient and more effective than institutional settings. Over time, the programs and the communities have identified new services that would assist participants qualifying for the Home and Community Based Service waivers in Colorado's Medicaid program.

Consumer Directed Attendant Support

During the 2005 legislative session, the Colorado General Assembly passed HB 05-1243 directing the Department of Health Care Policy and Financing to extend the option of receiving Home and Community Based Services through the consumer-directed care service model to all Medicaid recipients who are enrolled in an HCBS waiver. The consumer-directed care service model will include attendant support defined as "any action to assist an eligible person in accomplishing activities of daily living, instrumental activities of daily living, and habilitative and health-related tasks." This legislation also amends the eligibility criteria for the Consumer Directed Attendant Support pilot program to repeal the requirement that a person must have received Medicaid-funded attendant support for the past 12 months to be eligible for the program.

The expansion of the consumer-directed service model will provide Home and Community-Based Service clients and/or their authorized representatives the opportunity to direct attendant support services. Currently, 26,890 clients are being served through Home and Community Based programs. The Department estimates that 40% of this population may elect to direct attendant support services. Clients and/or authorized representatives who choose to direct attendant support services will receive training on attendant and related fiscal management. The client and/or authorized representative will hire, train, supervise, manage and fire their attendants rather than having these services provided through an agency.

The amendment of the eligibility criteria for the Consumer Directed Attendant Support program will allow a greater number of Medicaid eligible clients and or their authorized representatives the opportunity to enroll in this self directed support program. The Department is working with the Centers for Medicare and Medicaid Services on appropriate language.

Reprocurement of the Medicaid Management Information System Contract

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

As required by the Centers for Medicare and Medicaid Services, the transition to the new Medicaid Management Information Operations vendor (or renewal with current vendor) was expected to take place with an effective implementation date of December 1, 2006. However, due to reprioritizing the resources needed to support this transition, the reprocurement process will occur during FY 05-06, with implementation estimated to begin July 1, 2007. The Request for Proposal was released September 16, 2005 and the Department expects to know results by November, 2005. Prior to transitioning, the Department will communicate with medical providers to disseminate information about the new vendor (if applicable) and the location where claims are to be sent, what processes will be used for submitting claims, and how and where to contact a help desk for assistance in working with the new vendor. Timely communications to the providers will smooth the transition and assure the providers that payments will continue without interruption.

The Department will commit staff resources to ensure completion of updates to policies, procedures, systems, and outcomes during this transition period. In recent years, the fiscal agent contract has required over $20 million per year in appropriations to operate the Medicaid Management Information System. Emergency funds were made available to the Department in FY 04-05 to begin the reprocurement process, which a limited amount was utilized during the fiscal year to begin the project. Due to the postponement of the project, the remaining funds were reverted back to the General Assembly.

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

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

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

The regulations require that a federal depository be established for a single identifying code to be used by each medical service provider in the United States. Each provider who bills medical claims electronically will have his or her own unique code. The same identifying code will be used on all medical insurance claims, whether Medicare, Medicaid, or private insurance. Ultimately, the standardization of National Provider Identifiers will eliminate the need for providers to keep track of multiple codes to identify themselves in standard transaction types occurring in more than one health plan. In May 2005, the Centers of Medicare and Medicaid Services began the notification process to providers to begin registering for their new National Provider Identifier number.

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

Health Insurance Flexibility and Accountability Waiver

In the fall of 2001, the U.S. Department of Health and Human Services invited states to participate in the Health Insurance Flexibility and Accountability waiver. Health Insurance Flexibility and Accountability (HIFA) waivers encourage new, comprehensive state approaches that will increase the number of individuals with health insurance coverage. HIFA waivers require that state proposals:

- Expand access to the uninsured;
- Remain budget neutral to the federal government considering what would otherwise be spent under traditional reimbursement rules and approaches; and
- Do not reduce services to mandatory populations.

In considering HIFA waivers, the federal government also seeks proposals that:

- Give priority to expansions of coverage to individuals under 200% of the federal poverty level;
- Include both Medicaid and Child Health Plan Plus Office populations; and
- Improve coordination with employer-sponsored health insurance coverage.

Developing a new health care purchasing system involves two competing, and potentially contradictory, concepts: First, these are Colorado's most financially vulnerable populations who require a safety-net that does not eliminate essential medical benefits; Second, in order for these programs to be sustainable for the long-term, they must be efficient, follow a business model, and must leverage the combined purchasing power of both programs, which should be reflected in how these services are purchased and delivered.

In May 2005, SB 05-221 was passed which outlined a process for the Department to seek approval for the Health Insurance Flexibility and Accountability Waiver, "to streamline the Medicaid and Child Health Plan Plus programs." The Department submitted a plan to the Colorado General Assembly's Health and Human Services Committees and the Joint Budget Committee on July 5, 2005, outlining the Department's proposal.

The Department's proposal was to create a new program, named Colorado Family Care, which will serve low-income non-disabled children, pregnant women, and families eligible for Medicaid or the Child Health Plan Plus Office using the waiver process in a streamlined, comprehensive health insurance program. The Colorado Family Care program reduces the number of low-income uninsured individuals in the state while building on the successes of the Child Health Plan Plus. The ultimate goal was to improve health outcomes for Colorado's low-income children and families in a public private partnership that uses private sector best practices and supports and strengthens the safety net. After sixty days of consideration, the Committees voted not to proceed with the Department's proposal. However, after reviewing the Department's proposal, members of the Health and Human Services Committees expressed interest in working with the Department to further explore this initiative.

Tobacco Tax Funding

Overview:

In the fall of 2004, the citizens of Colorado voted in favor of Amendment 35 to the State Constitution, increasing taxes on tobacco products purchased within the State. This tax increase went into effect January 2005 and was projected to increase State revenues by $62.9 million in FY 04-05 and $169.2 million in FY 05-06. All revenues collected from tobacco taxes are deposited into the Tobacco Tax Cash Fund and are dispersed to other cash funds in the following manner:

- 46% to the Health Care Expansion Fund, administered by the Department of Health Care Policy and Financing,
- 19% to the Primary Care Fund, administered by the Department of Health Care Policy and Financing,
- 16% to the Tobacco Education Programs Fund, administered by the Department of Public Health and Environment,
- 16% to the Prevention, Detection, and Treatment Fund, administered by the Department of Public Health and Environment, and
- 3% to the Cash Fund for Health-Related Purposes to provide revenue for the State's General Fund, the Old Age Pension Fund, and for municipal and county governments.

HB 05-1262, signed by the Governor on May 31, 2005, specifies how the monies in each of the Cash Funds are to be used and provides an appropriation to the State Departments for the purpose of implementing the legislation. The Health Care Expansion Fund and the Primary Care Fund are administered by the Department; however the Department is also appropriated funds from the Prevention, Detection, and Treatment Fund and the Cash Fund for Health Related Purposes.

The Health Care Expansion Fund:

The Health Care Expansion Fund receives 46% of the Tobacco Tax monies which is estimated at $28.9 million in FY 04-05 and $77.8 million in FY 05-06. HB 05-1262 specifies that the Health Care Expansion Fund shall be used for the following purposes:

(A) Increase eligibility in the Child Health Plan Plus Office for children and pregnant women from 185% to 200% of the federal poverty level.

The Department's fiscal note assumed that this provision could be implemented by July 1, 2005 and that an additional 4,246 children would enroll in FY 05-06. This fiscal note also estimated that the number of member months in the Prenatal and Delivery Program would increase by 3,684 for FY 05-06.

(B) Remove the Medicaid asset test.

The fiscal note assumed that this provision could be implemented by October 1, 2005. Removing the Medicaid asset test is an expansion to Medicaid eligibility, as clients who were previously found ineligible for Medicaid would now qualify. Because the Child Health Plan Plus Office does not apply an asset test as a condition of eligibility, many of the clients affected by the asset test provision were already enrolled in the Children's Basic Health Plan. Approximately 39.5% of clients enrolled in the Children's Basic Health Plan had incomes low enough to qualify for Medicaid, but were denied for Medicaid due to the asset test. A provision in HB 05-1262 allows the Department to seek federal approval to continue providing benefits to these children under the Children's Basic Health Plan network until July 1, 2006, however the children will be Medicaid eligible and will draw a 50% federal match under Title XIX. This provision is designed to assure patient continuity of care and provider network stabilization. Since the federal approval has not been received, the asset test has not been lifted.

(C) Expand children's enrollment under the Children's Home and Community-Based Services Waiver and the Children's Extensive Support Waiver programs.

Due to funding constraints, these programs had been capped to allow a limited number of children to be enrolled. There is a waiting list to enter the programs because the demand for these programs far exceeds the capacity. HB 05-1262 expands the capacity of these two waiver programs by the number of children on the waiting list as of January 1, 2005. At that time there were 148 children on the Children's Extensive Support Waiver Program and 478 children on the Children's Home and Community Based Services waiting list. The Centers for Medicare and Medicaid Services approved the waiver in October 2005 which resulted in lifting the cap.

(D) Increase Medicaid eligibility to parents of enrolled children up to at least 60% of the federal poverty level.

Through Section 1931 of the federal Medicaid statutes, parents are eligible for Medicaid benefits up to approximately 36% of the federal poverty level. HB 05-1262 provides funding to increase the eligibility for low income parents of enrolled children up to at least 60% of the federal poverty level. This provision takes effect on July 1, 2006, except that the Department may delay the effective date until January 1, 2007 if it is necessary to achieve federal approval of a waiver to deliver streamlined health care to families and children.

(E) Fund Medicaid to legal immigrants.

SB 03-176 eliminated Medicaid coverage for certain optional legal immigrant populations, however the implementation of this bill was delayed due to a court order stay. Through the passage of HB 05-1086 and SB 05-209, $2,638,343 was appropriated in FY 04-

05 and $6,216,752 for FY 05-06, as the State's share of funding for Medicaid coverage for the optional legal immigrant population. Both of these amounts were funded from Tobacco Tax funds. As a result, the legal immigrant population received continuous eligibility in Medicaid. HB 05-1262 also contains a provision to provide funding from the Health Care Expansion Fund for this population on an ongoing basis.

(F) Pay for enrollment increases above the FY 03-04 level in the Child Health Plan Plus.

Due to budget constraints, enrollment into the Prenatal and Delivery Program was suspended during FY 03-04. As a result, there were 1,428 member months for pregnant women in FY 03-04. All enrollments of pregnant women above this level will be funded by the Health Care Expansion Fund. In addition, the FY 03-04 average monthly enrollment for children was 46,694, so any client count above this level will be considered an expansion population, and may be funded with monies from the Health Care Expansion Fund. However, due to the impact of removing the Medicaid asset test (discussed above), the children's caseload is not expected to exceed this level for several years.

(G) Provide cost-effective marketing of the Child Health Plan Plus.

Maximus Inc. won the bid for marketing Child Health Plan Plus and is in the process of contract negotiations. The Child Health Plan Plus Office is expected to increase enrollments in both the Child Health Plan Plus Office and in Medicaid, as new applicants to the Child Health Plan Plus Office are first screened for Medicaid eligibility. Any additional caseload as a result of this marketing effort may be funded with Health Care Expansion Fund monies.

(H) Provide presumptive eligibility to pregnant women in Medicaid.

Presumptive eligibility for Medicaid was discontinued on September 1, 2004. Through the passage of HB 05-1025 and HB 05-1262, the Department reinstated the presumptive eligibility process and will fund the State's share of these costs with Tobacco Tax monies. Presumptive eligibility was reinstated using the same network provider (Anthem) already in use for the Child Health Plan Plus Prenatal and Delivery Program.

Consumer Assessment of Health Plans Study

The Consumer Assessment of Health Plans Study (CAHPS®) is a nationally recognized survey that measures client satisfaction within a given health plan and may be used to compare satisfaction across health plans.[2] The goal of the CAHPS surveys is to effectively and efficiently obtain information that is not available from any other source—the person receiving care.

The Department requires Medicaid health plans to conduct client satisfaction surveys to ascertain differences between managed care clients, Primary Care Provider Program, and fee-for-service clients. As part of a comprehensive quality improvement effort, the

[2] CAHPS is a registered trademark of the Agency for Health Care Research and Quality.

Department required health plans to conduct the CAHPS 3.0H Survey of Adults and 3.0H Survey of Children with Medicaid clients that had been continuously enrolled in a managed care plan for twelve months during 2004. The survey period for this questionnaire was January 1, 2004 through May 1, 2004. Colorado Medicaid averages are calculated by the Department to use as comparison among itself and nationally. 2004 Colorado Medicaid averages are provided.

CAHPS 2005 Summary of Results

CAHPS Measure	Colorado Access	Rocky Mountain Health Plans	Primary Care Physician Program	Unassigned Fee-For-Service	2004 Colorado Medicaid Average
Overall Rating of Health Plan *"Using any number from 0 to 10 where 0 is the worst health plan possible, and 10 is the best health plan possible, what number would you use to rate your health plan?"* Percent rating an 8, 9 or 10.					
Adult	63%	79%	67%	69%	**69%**
Child	77%	82%	76%	74%	**77%**
Overall Rating of Health Care *Of those respondents who reported going to a doctor's office or clinic: "Using any number from 0 to 10, where 0 is the worst health care possible, and 10 is the best, what number would you use to rate all your health care in the last 6 months?"* Percent rating an 8, 9 or 10.					
Adult	68%	82%	74%	77%	**75%**
Child	77%	85%	83%	80%	**81%**
Overall Rating of Personal Doctor or Nurse *Of those respondents who saw a primary care provider: "Using any number from 0 to 10, where 0 is the worst personal doctor or nurse possible, and 10 is the best possible, what number would you use to rate your personal doctor or nurse?"* Percent rating an 8, 9 or 10.					
Adult	76%	85%	76%	80%	**79%**
Child	80%	87%	84%	83%	**83%**
Getting Needed Care *Getting needed care is a composite of questions regarding the ease of finding a doctor or nurse, obtaining a referral to a specialist, getting the care the respondent or a doctor believed necessary, and delays in health care while waiting for an approval.* Percent rating "not a problem.."					
Adult	67%	85%	69%	75%	**74%**
Child	78%	84%	80%	79%	**80%**
Getting Care Quickly *Getting care quickly is a composite of questions regarding receiving help or advice over the telephone, obtaining routine appointments, obtaining care for an illness or injury, and waiting time in an office or clinic.* Percent rating "always and usually."					

CAHPS Measure	Colorado Access	Rocky Mountain Health Plans	Primary Care Physician Program	Unassigned Fee-For-Service	2004 Colorado Medicaid Average
Adult	70%	88%	74%	77%	**77%**
Child	74%	88%	82%	81%	**81%**
Doctors Who Communicate Well *How well doctors communicate is a composed of questions regarding how well providers listen to and explain things, whether they show respect and whether they spend enough time with the respondent.* Percent rating "always and usually."					
Adult	85%	93%	87%	90%	**89%**
Child	88%	94%	90%	91%	**91%**
Courteous and Helpful Office Staff *Questions regarding whether office staff at the respondent's doctor's office or clinic treated respondents with courtesy and respect and whether they were as helpful as respondents thought they should be made up the courteous and helpful office staff composite measure.* Percent rating "always and usually."					
Adult	84%	95%	89%	91%	**89%**
Child	85%	95%	90%	89%	**90%**

*National Average for 2003 is displayed. The 2004 average is not yet available.

Health Plan Employer Data Information Set

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

The Department requires Medicaid health plans to conduct HEDIS measures to ascertain differences between managed care clients, Primary Care Provider Program, and fee-for-service clients. As part of a comprehensive quality improvement effort, the Department required health plans to conduct ten clinical measures on both adults and children. The 2005 data collection period for each of the reported measures was January 1, 2004 through December 31, 2004.

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

Colorado Medicaid Averages are calculated by the Department to use as comparison among itself and nationally. Where available, 2004 Colorado Medicaid Averages are compared for 2005.

2005 HEDIS Colorado Medicaid, Reporting Year 2004
Final HEDIS Rates for All Health Plans
HEDIS is a registered trademarked product of the National Committee for Quality Assurance

HEDIS Measure	Access	Rocky	PCPP	Fee-for-Service	Total HMO	Total Colorado Medicaid
Childhood Immunization Status	Percent of children receiving immunizations by 2 years old					
4 Diphtheria, Tetanus, Pertussis	67.6%	85.5%	54.3%	24.1%	76.1%	57.7%
1 Measles, Mumps, Rubella	84.3%	92.3%	71.3%	42.3%	88.1%	72.5%
3 Polio Virus immunizations	81.3%	89.3%	62.0%	32.6%	85.1%	66.2%
2 Haemophilus Influenzae Type B	70.6%	85.2%	60.1%	28.0%	77.5%	60.8%
3 Hepatitis B immuniztions	75.2%	90.3%	58.2%	29.7%	82.4%	63.2%
1 Chicken Pox vaccines	84.7%	83.9%	69.1%	40.9%	84.3%	69.7%
Combo 1 Rate -- 4 DTP or DTaP, 3 OPV or IPV, 1 MMR, 2 hepatitis B, and 1 Hib	57.4%	73.5%	41.1%	17.3%	65.0%	47.1%
Combo 2 Rate -- 4 DTP or DTaP, 3 OPV or IPV, 1 MMR, 2 hepatitis B, 1 Hib, and VZV	56.9%	68.4%	39.9%	16.8%	62.4%	45.4%
Adolescent Immunizations	Percent of adolescents who received immunizations by 13 years old					
2 Measles, Mumps, Rubella	NA	NA	40.9%	14.1%	NA	27.5%
1 Hepatitis B immunizations	NA	NA	34.3%	10.7%	NA	22.5%
1 Chicken Pox vaccines	NA	NA	22.1%	8.3%	NA	15.2%
Combo 1 -- MMR and Hepatitis B	NA	NA	31.6%	8.8%	NA	20.2%
Combo 2 - MMR, Hepatitis B, and VZV	NA	NA	17.5%	6.6%	NA	12.0%

2005 HEDIS Colorado Medicaid, Reporting Year 2004
Final HEDIS Rates for All Health Plans
HEDIS is a registered trademarked product of the National Committee for Quality Assurance

HEDIS Measure	Access	Rocky	PCPP	Fee-for-Service	Total HMO	Total Colorado Medicaid
Breast Cancer Screening						
	46.3%	61.6%	32.4%	12.7%	53.5%	37.9%
Cervical Cancer Screening						
	58.6%	74.4%	38.1%	32.6%	65.4%	34.5%
Comprehensive Diabetes						
HbA1c Testing	75.9%	92.2%	55.2%	34.3%	84.0%	64.5%
Poor HbA1c Control (Lower is Better)	49.1%	16.5%	79.1%	90.8%	33.1%	58.8%
Eye Exam	44.3%	65.0%	7.8%	3.6%	54.5%	30.3%
Lipid Profile	76.2%	87.1%	58.2%	38.2%	81.6%	65.0%
Lipid Control	47.4%	68.9%	17.8%	8.0%	58.0%	35.6%
Monitoring for Diabetic Nephropathy	35.8%	58.2%	24.6%	18.0%	46.8%	34.2%
Prenatal & Postpartum Care						
Timeliness of Prenatal Care	NA	NA	35.5%	19.2%	NA	27.4%
Postpartum Care	NA	NA	49.1%	39.2%	NA	44.2%
Children's Access to Primary Care Providers						
Age 12-24 Months	91.3%	99.1%	26.2%	14.8%	93.5%	21.1%
Age 25 Months - 6 Years	78.4%	89.3%	19.8%	9.6%	80.0%	26.6%
Age 7-11 Years	82.4%	92.9%	29.8%	10.7%	84.0%	33.5%
Well Child Visits in the First 15 Months of Life						
No Visits	2.8%	0.6%	32.4%	70.1%	2.2%	30.5%
1 Visit	4.2%	1.2%	2.2%	3.6%	3.3%	3.1%
2 Visits	5.8%	3.5%	5.4%	3.9%	5.1%	4.8%
3 Visits	10.9%	8.1%	6.1%	2.2%	10.1%	6.7%
4 Visits	16.7%	18.0%	8.3%	4.4%	17.1%	10.9%
5 Visits	20.2%	28.5%	10.9%	6.6%	22.6%	14.6%

2005 HEDIS Colorado Medicaid, Reporting Year 2004
Final HEDIS Rates for All Health Plans
HEDIS is a registered trademarked product of the National Committee for Quality Assurance

HEDIS Measure	Access	Rocky	PCPP	Fee-for-Service	Total HMO	Total Colorado Medicaid
6 or More Visits	39.4%	40.1%	34.8%	9.2%	39.6%	29.5%
Adolescent Well-Care Visits						
	34.4%	35.9%	19.2%	9.5%	35.5%	29.4%
Appropriate Treatment for Children with Upper Respiratory Infection						
	NA	NA	84.5%	87.7%	NA	86.7%
Annual Dental Visit						
Age 4-6	NA	NA	56.6%	27.7%	NA	33.7%
Age 7-10	NA	NA	61.5%	28.4%	NA	34.6%
Age 11 - 14	NA	NA	55.0%	26.5%	NA	31.7%
Age 15-18	NA	NA	46.8%	24.5%	NA	28.2%
Age 19 -21	NA	NA	33.4%	19.6%	NA	22.0%
Combined	NA	NA	54.7%	26.5%	NA	31.8%
Controlling High Blood Pressure						
	NA	NA	41.1%	20.0%	NA	30.5%
Inpatient Utilization - General Hospital/Acute Care (Total)						
Discharges/1,000 Member Months	NA	NA	8.25	10.71	NA	10.32
Days/1,000 Member Months	NA	NA	34.63	32.72	NA	33.03
Average Length of Stay	NA	NA	4.20	3.05	NA	3.20
Ambulatory Care (Total)						
Outpatient Visits/1,000 Member Months	304.69	407.77	299.74	220.27	324.70	246.78
Ambulatory Surgery Procedures/ 1,000 Member Months	6.18	9.83	8.72	4.68	6.89	5.56
Emergency Room Visits/ 1,000 Member Months	56.83	45.34	53.76	39.27	54.60	43.55

2005 HEDIS Colorado Medicaid, Reporting Year 2004 **Final HEDIS Rates for All Health Plans** HEDIS is a registered trademarked product of the National Committee for Quality Assurance						
HEDIS Measure	**Access**	**Rocky**	**PCPP**	**Fee-for-Service**	**Total HMO**	**Total Colorado Medicaid**
Observation Room Stays Resulting in Discharge/ 1,000 Member Months	2.22	1.88	2.97	3.67	2.16	3.34

Legislative Summary 2005

- ***HB 05-1015*** adds outpatient substance abuse treatment as an optional service under the Medical Assistance program. Requires the State Auditor to report to the Legislative Audit Committee on whether the provisioning of substance abuse treatment services result in an increase or decrease in the overall cost of the program.

- ***HB 05-1017*** restructures the existing statute regarding prohibited provider referrals under the state's Medicaid program and makes changes to conform to federal law. This bill specifies that if a financial relationship between an entity which delivers designated health services and a provider is not prohibited by federal law, then the financial relationship is not prohibited under this act. The act specifies that a financial relationship or referral for designated health services is not prohibited if the referral would not violate 42 U.S.C. section 1395n if the designated health services were eligible for payment under Medicare rather than the State's Medicaid program. It also clarifies that an entity that provides designated health services as a result of a prohibited referral is prohibited from billing the Department for the service, and may face other sanctions.
- ***HB 05-1025*** allows a pregnant woman to be presumptively eligible for specified services under the State's Medicaid program. It authorizes the Department to designate additional medical assistance sites, as necessary, to accept medical assistance applications, to determine medical assistance eligibility, and to determine presumptive eligibility. Requires the Department to develop training that will prevent medical assistance site staff from actions that could affect food and cash assistance.

- ***HB 05-1037*** clarifies that children for whom adoption assistance or foster care maintenance payments are made under Title IV-E of the "Social Security Act", as amended, are mandated under federal law to receive medical assistance under the State's Medicaid program. Adds children for whom adoption assistance payments are made by the State, but who do not qualify for Title IV-E assistance under the Social Security Act, to the groups that Colorado has selected as optional groups to receive medical assistance under the State's Medicaid program.

- ***HB 05-1066*** requires the Department to develop and implement an obesity treatment pilot program for the purpose of treating Medicaid recipients with a body mass index that is equal to or greater than 30 and who have a comorbidity related to the obesity. It requires the pilot program to be designed to treat recipients through the use of behavioral modification, self management training and medication. Authorizes the Department to develop and implement the pilot program only if sufficient gifts, grants, and donations are received for the pilot program. In addition, no General Fund monies are to be appropriated for this program in FY 05-06 or FY 06-07. Contains a reporting requirement, the pilot program is to sunset effective July 1, 2010.

- ***HB 05-1084*** requires the Department of Human Services to develop a rate-setting process for providers of residential treatment services in Colorado. It specifies that counties and the provider community shall be involved in the development of the rate-setting process. It also specifies factors that may be included in the rate-setting process. It requires the Department of Human Services, when auditing residential treatment providers, to apply compliance requirements and monitoring functions consistently across all divisions and monitoring teams. Finally, it contains a reporting requirement regarding the rate setting process by July 1, 2006 and every two years after that.

- ***HB 05-1086*** retains medical assistance eligibility, effective January 1, 2005, to specific groups of qualified legal immigrants and that these legal immigrants qualify as an optional group under the State's Medicaid program. Requires the Department to amend the State Plan consistent with the provisions of this act. This bill repeals the State Nursing Facility Service program and makes conforming amendments.

- ***HB 05-1131*** allows a patient of a licensed facility, or the patient's family, to return unused, individually packaged medication to a pharmacist to be redispensed to another patient of the facility. The bill requires the State Board of Pharmacy to adopt rules to implement this act. The bill also allows pharmacists to accept and distribute medications to non profit organizations that provide medical care. In addition, pharmacist must reimburse the Department for the cost of medications that the Department had paid if the medications are available to be dispensed to another person.

- ***HB 05-1209*** clarifies that a pharmacist may compound a drug. The compounded drug must be administered to the patient in the practitioner's office or under the practitioner's supervision. The board of pharmacy is to promulgate rules authorizing a pharmacist to compound drugs. Limits the amount of drugs a pharmacist may compound to 10% of the total drugs units dispensed. Creates a task force to study the compounding of drugs by pharmacists, and has a reporting requirement.

- ***HB 05-1243*** extends the option of receiving Home and Community-Based Services through the Consumer-Directed Care Service model to all Medicaid recipients who are enrolled in a Home and Community-Based Services waiver for which the Department has federal waiver authority. An eligible person shall not be required to disenroll from the person's current Home and Community-Based Services waiver in order to receive services through the Consumer-Directed Care Service model. Certain professional licensing requirements do not apply to a person who is directly employed by an individual participating in the Consumer-Directed

Care Service model and who is acting within the scope and course of such employment. This bill specifies the restrictions that apply to this professional licensure exclusion and the circumstances under which the exclusion does not apply. A consumer of attendant support may have an authorized representative who has the judgment and ability to assist the consumer in acquiring and utilizing services under the Consumer-Directed Attendant Support program. The act repeals the requirement that a person must have received Medicaid-funded attendant support for the past twelve months in order to be eligible for Consumer-Directed Attendant Support, and makes conforming changes.

- ***HB 05-1261*** creates the Tobacco Tax Cash Fund in the State Treasury and specifies that the Fund shall consist of monies collected from the cigarette and tobacco taxes imposed pursuant to Section 21 of Article X of the State Constitution. All interest derived from the deposit and investment monies in the Fund shall be credited to the Fund. The General Assembly is required to annually appropriate 3% of the monies deposited in the Fund for health-related purposes to provide revenue for the State's General Fund and Old Age Pension Fund, and for municipal and county governments to compensate proportionately for tax revenue reductions attributable to lower cigarette and tobacco sales resulting from the tax imposed.

- ***HB 05-1262*** creates the Tobacco Tax Cash Fund in the State Treasury. The cash fund consists of monies collected from the cigarette and tobacco taxes imposed pursuant to Section 21 of Article X of the State Constitution. The General Assembly is required to annually appropriate 3% of the monies in the cash fund for health-related purposes to provide revenue for the State's General Fund and Old Age Pension Fund and for municipal and county governments to compensate them for tax revenue reductions attributable to lower cigarette and tobacco sales. Establishes separate funds for the allocation of the monies collected as follows: 46% of the monies to the Health Care Expansion Fund; 19% to the Primary Care Fund; 16% to the Tobacco Education Programs Fund; and 16% to the Prevention, Early Detection, and Treatment Fund. It also specifies how the monies collected and the interest earned on the monies shall be distributed. It makes the necessary statutory changes to implement the tobacco taxes.

  This bill specifies that the Health Care Expansion fund shall be used for the following purposes: to increase eligibility in the Child Health Plan Plus Office for children and pregnant women from 185% to 200% of the federal poverty level; to remove the asset test under the Medical Assistance program for children and families; to expand the number of children that can be enrolled in specified children's home and community-based service waiver programs; to increase eligibility in the Medical Assistance program to 133% of the federal poverty level for specified children; to increase eligibility in the Medical Assistance program to at least 60% of the federal poverty level for a parent of a child who is eligible for the Medical Assistance program or the Child Health Plan Plus Office beginning in fiscal year 2006-07; to fund Medical Assistance to specified legal immigrants; to pay for enrollment increases above average enrollment for fiscal year 2003-04 in the Child Health Plan Plus; to seek federal approval to keep children affected by the removal of the asset test in the Child Health Plan Plus network until July 1, 2006 for purposes of provider network stabilization; to provide monies for cost-effective marketing to increase the enrollment of eligible children and pregnant women in the Child Health Plan Plus; and to provide presumptive eligibility to pregnant women under the Medical Assistance program.

Monies in the Tobacco Education Programs Fund will be allocated to the Department of Public Health and Environment to be used to fund the "Tobacco Education, Prevention, and Cessation Act". The bill establishes a review committee to establish program priorities and strategies, and administer the program.

Monies in the Prevention, Early Detection, and Treatment Fund will be allocated to the Department of Public Health and Environment. The use of these funds includes a competitive grant program that provides funding for programs and initiatives that provide evidence-based education and intervention strategies for cancer, cardiovascular disease, and chronic pulmonary disease prevention, early detection, and treatment. Additionally, funds will be transferred to the Department of Health Care Policy and Financing in the amount of $2 million annually for Medicaid Disease Management programs and an amount not to exceed $5 million annually, based on predetermined allocation percentages, for the Breast and Cervical Cancer Treatment program.
The monies in the Primary Care Fund is to be used for annual allocations by the Department to eligible qualified providers in the state who comply with the reporting requirements in the act. An eligible qualified provider's allocation shall be based on the number of uninsured or medically indigent patients served by the provider in proportion to the total number of uninsured or medically indigent patients served by all eligible qualified providers in the previous calendar year, disbursements made to eligible qualified providers under this section will be exempt from the "Procurement Code", articles 101 to 112 of Title 24, C.R.S.

- ***HB 05-1325*** requires mental health providers under the Medical Assistance program to ensure that recipients with complex or multiple needs receive treatment from appropriate providers in collaboration with other providers, and inform recipients of their right to appeal a denial, reduction, or termination of requested services. In the case of mental health managed care recipients, it requires a patient representative program that complies with federal requirements and has specific duties and posting requirements.

- ***HB 05-1349*** requires a transfer of $3.1 million in interest earnings on the Controlled Maintenance Trust Fund to the General Fund for the purpose of funding Safety-Net Provider Payments for private hospitals under the Colorado Indigent Care Program. The transfer of monies is to occur on February 1, 2006.

- ***SB 05-149*** continues assistance to inmates in applying for supplemental security income and Medicaid within facilities administered by the Department of Corrections. It does not continue this function within facilities administered by the Community Corrections Board.

- ***SB 05-162*** prohibits a Medicaid recipient from receiving prescription drug benefits if the recipient is also enrolled in a prescription drug benefits plan under Medicare, with the following exception: if a prescribed drug is not a Part D drug, as defined in the "Medicare Prescription Drug, Improvement, and Modernization Act of 2003" (MMA), a recipient may be eligible for the prescribed drug if it is otherwise covered in the Medicaid program and federal financial participation is available. The Department submitted a letter to the Joint Budget Committee on September 6, 2005 requesting guidance on the coverage of non-Part D drugs. The Department has not yet received any feedback from the Joint Budget Committee.

- ***SB 05-173*** requires the Department to convene an advisory committee no later than August 15, 2005 if sufficient grants, gifts, and donations are received. A meeting was convened by August 15. The advisory committee is to assist in the creation of a community long-term care delivery system that will provide an opportunity for excellence in management and that fosters a continuum of community long-term care services and service delivery. The act specifies the members of the committee and the charge of the committee. It contains a reporting requirement for the committee and the Department regarding the committee's recommendations. Requires the Department to accept and it may approve proposals to develop and implement a 3-year coordinated care pilot program for community long-term care services, it also requires oversight of the pilot program. Specifies the components and target populations of the pilot program. Grants the department flexibility in determining the reimbursement for acute care providers, long-term care community providers, and class I nursing facilities when it is necessary to serve a pilot program participant in a more medically appropriate and cost-effective setting.

- ***SB 05-221*** implemented a process for the Department to seek state and federal approval for a Health Insurance Flexibility and Accountability waiver. The Department submitted a proposal to the Health and Human Services Committees of the Colorado State Legislature in July 2004. The proposal was aimed at creating a streamlined health care delivery system called the Colorado Family Care program for low-income children and families in the Children's Basic Health Plan and Medicaid. The proposal was not approved by the Health and Human Services Committees and therefore did not go forward to the Joint Budget Committee or the Centers for Medicare and Medicaid Services for approval. However, after reviewing the Department's proposal, members of the Health and Human Services Committees expressed interest in working with the Department to further explore this initiative.

- ***SB 05-249*** increases the allocation of tobacco settlement monies to the read-to-achieve program from 5% to 19% in FY 04-05, not to exceed $19 million. The act adjusts the appropriation for the read-to-achieve program in the FY 04-05 Long Bill (HB 05-1422), as amended by the FY 05-06 Long Bill (SB 05-209), to reflect the change in the allocation. Additionally it adjusts appropriations in the FY 05-06 Long Bill to reflect changes.

VI. DEPARTMENTAL BACKGROUND

A. OVERVIEW

A1. Department Structure

The Department of Health Care Policy and Financing was established July 1, 1994. Stephen C. Tool serves as the Executive Director. The Department is split into three primary offices. The Department's Director of Operations and Finance Office is Lisa Esgar, the Director of the Medical Assistance Office is Barbara Prehmus, and the Director of the Child Health Plan *Plus* Office is Barbara Ladon. The Medical Services Board is the entity authorized under statute to pass rules for the Department's programs, and its members are appointed by the Governor. The Medical Services Board is chaired by Joe Rall. With 214.4 FTEs, Health Care Policy and Financing is one of the smallest departments in terms of staff size, but, after K-12 Education, Health Care Policy and Financing is the:

- Second largest budget in State government,
- Second largest consumer of General Fund (22%) based on the FY 05-06 Long Bill (Source: Budget Committee Appropriation Report, FY 05-06, page 16), and
- First in federal funds drawn.

The appropriation for FY 05-06 (including new legislation) exceeds $3.3 billion total funds. The federal match is computed from statewide per capita income using a nationally standardized formula and is reported by the Federal Funds Information Service. The federal match rate available for the Child Health Plan Plus Office is 65%, the State's Medicaid match is 50%.

Most of the Department's administration costs are privatized or, in some cases, are contracted out to other executive departments. The FY 05-06 Long Bill (SB 05-209) and special bills during the 2005 Legislative Session result in the following approximate allocation for Department programs:

Total FY 05-06 Appropriation	**$3,376,566,860**	**100.00%**
Direct Care Services administered by Health Care Policy and Financing	$2,877,969,215	85.23%
Department of Human Services Programs	$431,686,840	12.95%
Contractual Services (including with other State departments except Department of Human Services)	$50,006,200	1.48%
Department Administration (Personal Services, Operating, etc.)	$16,904,605	0.50%

A Department organizational chart is provided on the following page.

Organizational Chart

A2. Overview of Staffing

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

Health Care Policy and Financing FTE History

FISCAL YEAR	FTEs	PERCENT CHANGE
FY 94-95	137.2	N/A
FY 95-96	136.7	-0.3%
FY 96-97	133.0	-2.7%
FY 97-98	146.0	9.8%
FY 98-99	151.0	3.4%
FY 99-00	162.4	7.5%
FY 00-01	167.7	3.3%
FY 01-02	177.6	5.9%
FY 02-03	188.4	6.1%
FY 03-04	200.4	6.4%
FY 04-05	202.8	1.2%
FY 05-06*	214.4	5.7%

* FY 05-06 Long Bill (SB 05-209) plus Special Bills

A3. Health Care Policy and Financing and its Programs

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

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

- Medicaid (Title XIX of the Social Security Act);
- Medicaid Mental Health Community Programs;
- Colorado Indigent Care Program;
- Child Health Plan Plus Officeor Child Health Plan Plus (Title XXI of the Social Security Act);
- Old Age Pension State Medical Program;
- Home Care Allowance Program;
- Adult Foster Care Program; and,
- Low Income Subsidy for Medicare Part D Program.

A4. Colorado Budget Environment

While the Colorado economy has shown significant improvement from last fiscal year, there are still many difficult challenges that the General Assembly faces to comply with current statutory and constitutional spending restraints. Because of this, the Department realizes that Medicaid, as an entitlement program, has a limiting effect on the amount of funding for other State needs and priorities. Thus, in reviewing the November 15, 2005 Budget Request, the Department has prioritized its request beginning with funding base services for entitlement programs, then for funding to support the Child Health Plan Plus, next on other federal and statutory mandates, and lastly on technical and administrative needs. Where the ability to return unneeded funds has been possible, these have been identified. When additional dollars are requested, they have been carefully considered, laid out, and analyzed.

A5. HIPAA Information Regions

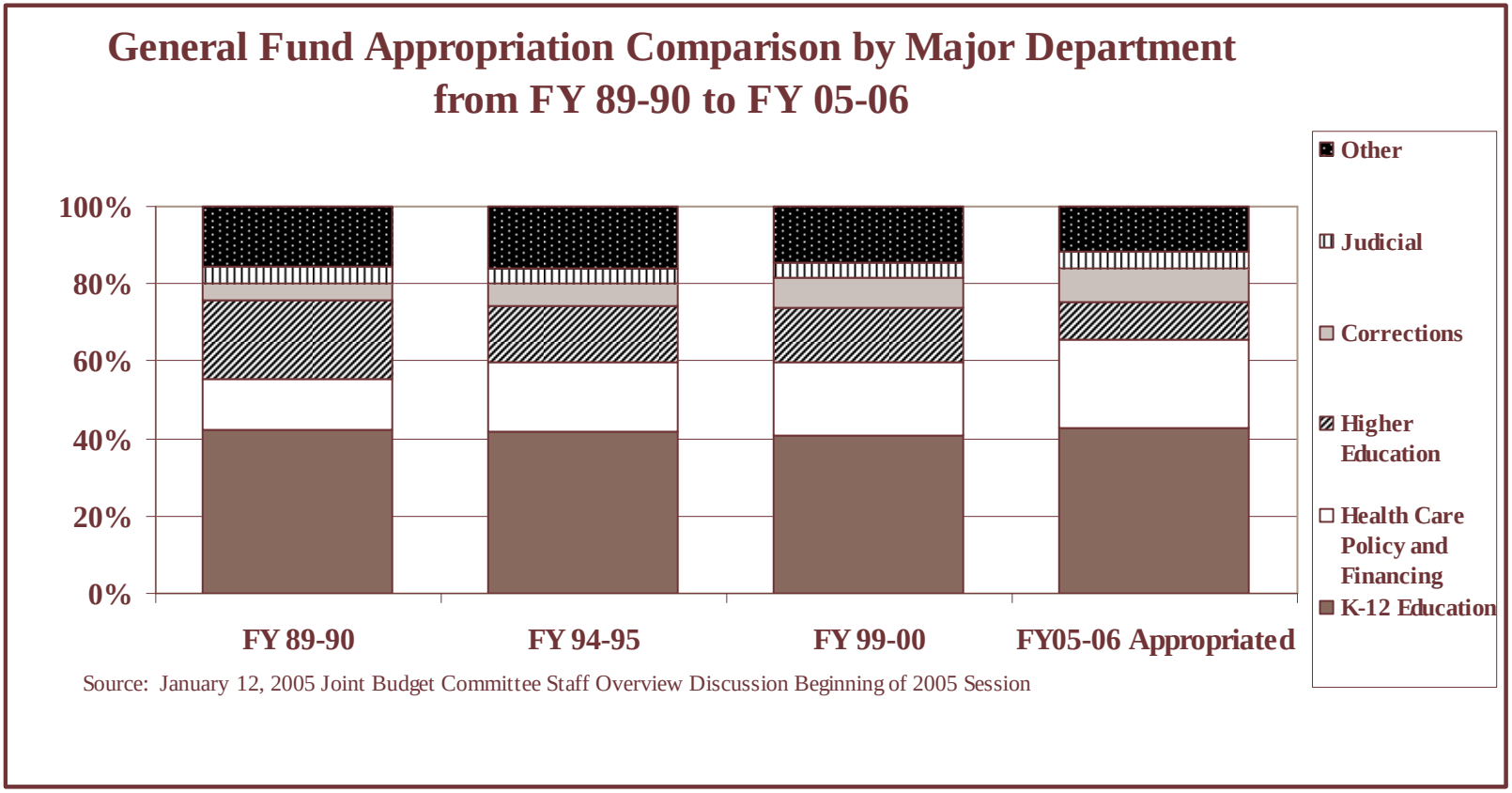
The Health Insurance Portability and Accountability Act (HIPAA) was signed into federal law in 1996 (Public Law 104-191). This federal law resulted in eight rules. The second rule, the Privacy rule, pertains to all of a patient's individually identifiable health information. Medical providers and health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

Under this Privacy rule the Department must now release client information in a larger aggregation than individual counties in order to maintain client confidentiality and anonymity in smaller counties. To do so, twenty "HIPAA Regions" were developed in order to provide Department information. Some individual counties have large enough populations to be stand-alone HIPAA Regions. The map on the following page shows how the State is separated into these 20 regions.

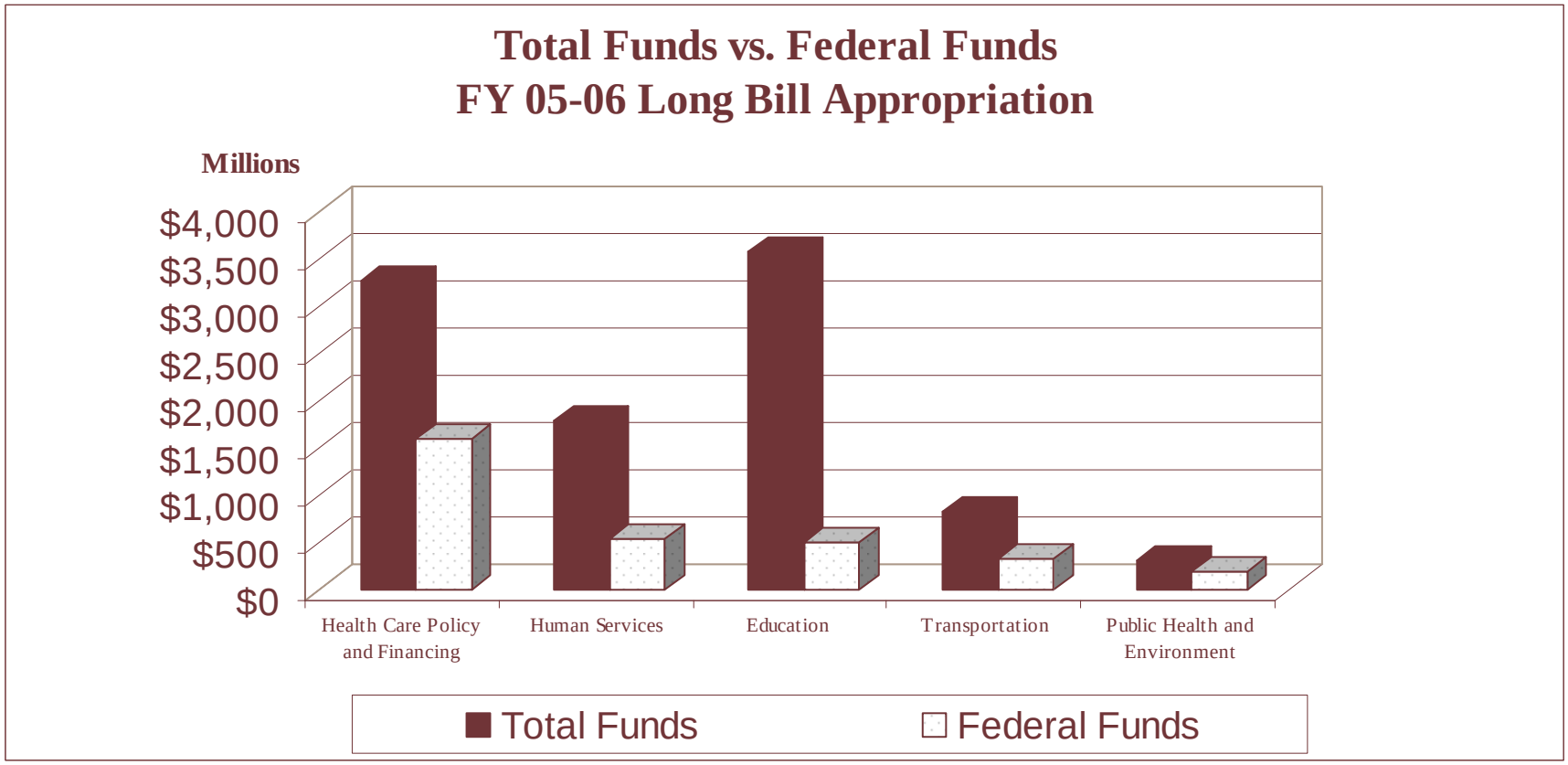
HIPAA Regions	
1 = Garfield, Moffat, Rio Blanco	11 = Logan, Morgan, Phillips, Sedgwick, Washington, Yuma
2 = Eagle, Grand, Jackson, Pitkin, Routt, Summit	12 = Cheyenne, Elbert, Kit Carson, Lincoln
3 = Mesa	13 = Douglas
4 = Delta, Montrose, Ouray, San Miguel	14 = Boulder, Broomfield
5 = Archuleta, Dolores,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

B. STATE BUDGET

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

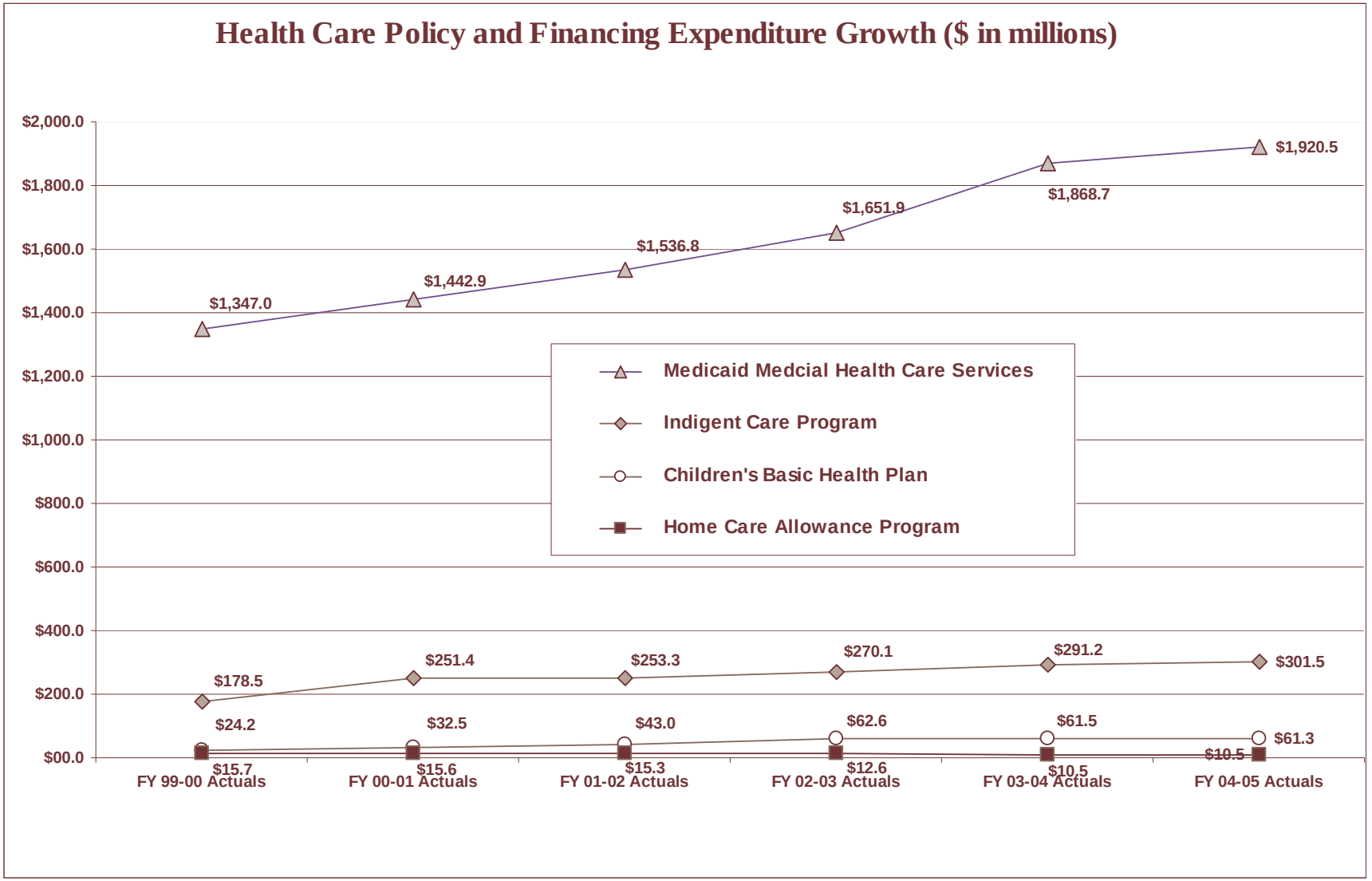


B2. Highest Draw of Federal Funds, by Agency



Source: SB 05-209

B3. Health Care Policy and Financing Expenditure Growth for FY 99-00 to FY 04-05



Note: Medicaid Medical Health Care Services does not include Mental Health, Developmentally Disabled, School Based Services, Nurse Home Visitor Program, Department of Human Services

Source: November 1, 2001 Budget Request for FY 99-00 and FY 00-01;
November 3, 2003 for FY 01-02 and FY 02-03;
November 15, 2005 Budget Request for FY 03-04 and FY 04-05.

B4. Comparing Colorado to Other States in Federal Region

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

The following information shows data for the six states comprising Region VIII, to better understand how Colorado compares to its neighboring states. The following information is from the Kaiser Family Foundation's State Facts Online website as of September 2005. Some components differ from data reported directly by the Department.

Regional Comparison from Kaiser Family Foundation's State Health Facts Online

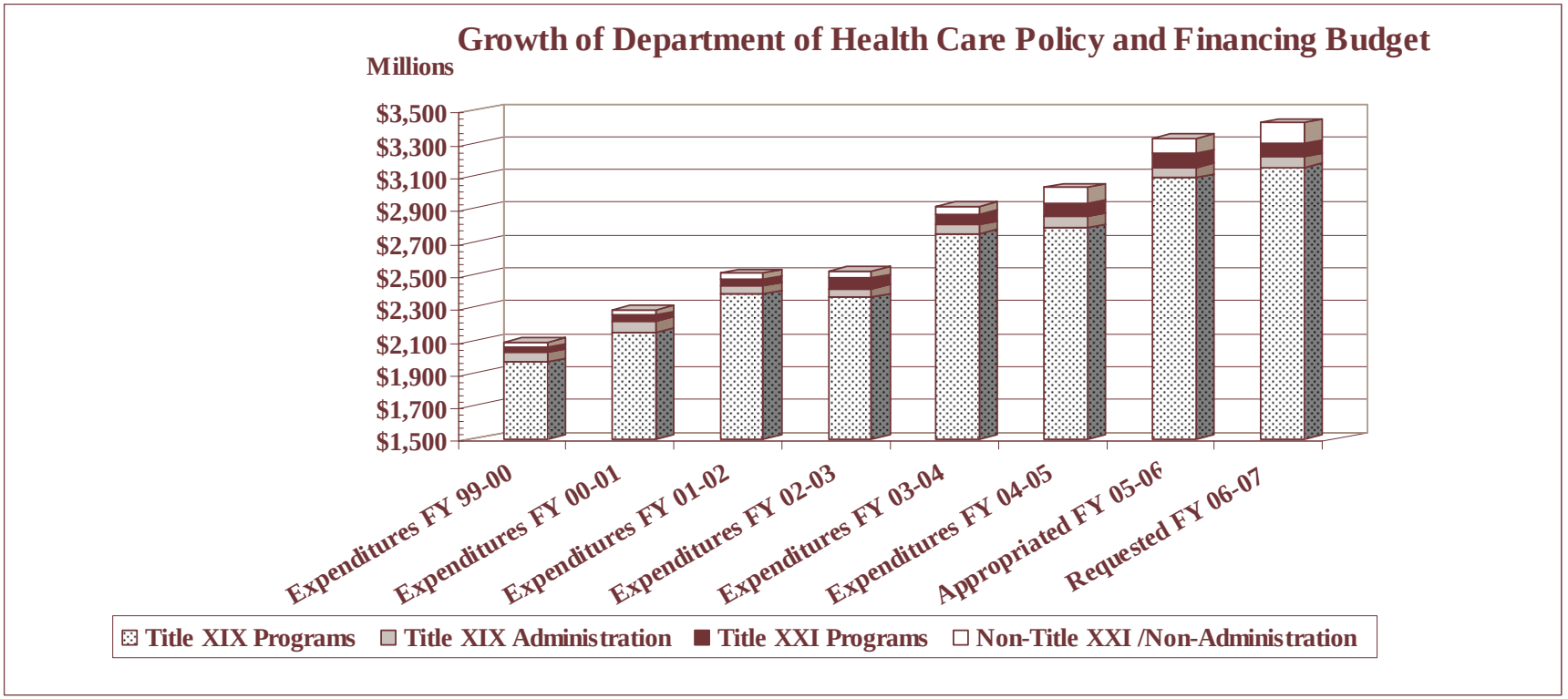
	FY 04-05 FMAP	FY 05-06 FMAP	Estimated Total State Population 2003	FFY 2001 Medicaid Enrollees	Medicaid Enrollees as % of State Population	Medicaid Expenditures for Benefits and DSH in FFY 2003	SCHIP Federal Match 2005	SCHIP Monthly Enrollment December 2004	Income Eligibility as Percent of FPL for SCHIP 2004	SCHIP Total Expenditures 2003
Colorado	50.00%	50.00%	4,441,080	410,700	9.25%	$2,567,544,672	65.00%	38,189	185%	$62,458,057
Montana	71.90%	70.54%	904,900	101,900	11.26%	$518,435,135	80.33%	10,929	150%	$14,854,663
North Dakota	67.49%	65.85%	625,460	65,400	10.46%	$473,413,870	77.24%	3,671	140%	$6,551,951
South Dakota	66.03%	65.07%	746,070	106,200	14.23%	$542,231,325	76.22%	10,466	200%	$12,071,262
Utah	72.14%	70.76%	2,328,320	214,700	9.22%	$1,111,138,429	80.50%	24,021	200%	$25,153,690
Wyoming	57.90%	54.23%	484,770	57,900	11.94%	$340,510,859	70.53%	3,854	185%	$5,360,591

FMAP = Federal Medical Assistance Percentage
FFY = Federal Fiscal Year
FPL = Federal Poverty Level
DSH = Disproportionate Share Hospitals
SCHIP = State Children's Health Insurance Plan (federal term)
Source is Statehealthfacts.org website
Colorado, Montana, and Utah suspended enrollment in the State Children's Health Insurance Plan between June 2002 and April 2003.

C. DEPARTMENT BUDGET

C1. Department Budget Growth and Outlook for FY 05-06 and FY 06-07

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



Source: November 1, 2001 Budget Request for FY 99-00 and FY 00-01;
November 3, 2003 for FY 01-02 and FY 02-03;
November 15, 2005 Budget Request for FY 03-04, FY 04-05, and FY 05-06

D. CLIENTS

D1. 2005 Federal Poverty Levels

The table below reports the federal poverty levels for all states except Hawaii and Alaska from the Department of Health and Human Services, for federal fiscal year 2005. For family units of more than 8 members, add $3,260 for each additional family member.

Federal Poverty Levels for Annual Income

Family Size	100%	120%	133%	135%	150%	175%	185%	200%
1	$9,570	$11,484	$12,728	$12,920	$14,355	$16,748	$17,705	$19,140
2	$12,830	$15,396	$17,064	$17,321	$19,945	$22,453	$23,736	$25,660
3	$16,090	$19,308	$21,400	$21,722	$24,135	$28,158	$29,767	$32,180
4	$19,350	$23,220	$25,736	$26,123	$29,025	$33,863	$35,798	$38,700
5	$22,610	$27,132	$30,071	$30,524	$33,915	$39,568	$41,829	$45,220
6	$25,870	$31,044	$34,407	$34,925	$38,805	$45,273	$47,860	$51,740
7	$29,130	$34,956	$38,743	$39,326	$43,695	$50,978	$53,891	$58,260
8	$32,390	$38,868	$43,079	$42,727	$48,585	$56,683	$59,922	$64,780

Source: Federal Register published on February 18, 2005

D2. Demographics and Expenditures

Demographic statistics provide valuable insight on the demand for medical care within each region. More populated areas tend to have a greater demand for medical care. Therefore, a region that is more populated is likely to have higher medical expenditures and caseloads. Likewise, as Colorado's population increases, the demand for medical care will also increase. The Department collected 2003 demographic data from the Colorado Demographer Office's November 2004 Report, "Estimates of Population and Households for Colorado Counties and Municipalities 2003" for: 1) population; and 2) percent of total Colorado population.

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

of female headed households increases, utilization of State provided medical care may increase. Conversely, a higher percent of the population in the labor force should result in a reduction of State provided medical care.

Medicaid

Using the Department's Business Objects of America database, FY 04-05 Medicaid data was collected for the following statistics and reported for the State in the following table, and reported by HIPAA Information Region:

- Medicaid Clients;
- Medicaid Expenditures; and
- Percentage Share of Medicaid Premium Expenditures, Statewide Total

Please note that monthly expenditures reported to the Joint Budget Committee are derived from the Colorado Financial Reporting System. Business Objects of America database extracts data on a different time span and from a different source (i.e., Medicaid Management Information System) than the Colorado Financial Reporting System. Therefore, total expenditures presented in this document will not exactly reconcile with the $1.893 billion for actual medical services reported in Exhibit M, page 3, in the November 15, 2005 FY 06-07 Budget Request.

Children's Basic Health Plan

Using FY 04-05 expenditures and caseload data for the Children's Basic Health Plan, the Department compiled the following data and reported it for the State in the following table.

- Average Number of Children per Month;
- Number of Deliveries for Women; and
- Child Health Plan Plus Office Expenditures.

The Child Health Plan Plus Office provides medical and dental services to children under age 19, and provides prenatal care and delivery for adult pregnant women who are at or below 200% of the Federal Poverty Level. The total Child Health Plan Plus expenditures presented in the statewide table below include: Child Health Plan Plus Premium Costs; Child Health Plan Plus Dental Benefit Costs; and, Child Health Plan Plus Administration line items.

Colorado's Demographics, Medicaid, and the Child Health Plan Plus Office– A Statewide View

Characteristics	State Totals
Demographic Characteristics, 2003	
Population	4,586,455
Percent of Population in the Labor Force*	70.7%
Percent of Families Below Poverty	8.6%
Percent of Female Headed Households	10.1%
Medicaid Characteristics, FY 04-05	
Average Number of Medicaid Clients	402,802
Medicaid Service Premiums Expenditures**	$1,897,863,850
Percent of Total Medicaid Expenditures	100%
Child Health Plan Plus Characteristics, FY 04-05***	
Average Number of Children per Month	41,101
Number of Member Months for Pregnant Women	6,684
Child Health Plan Plus Expenditures	$61,314,697

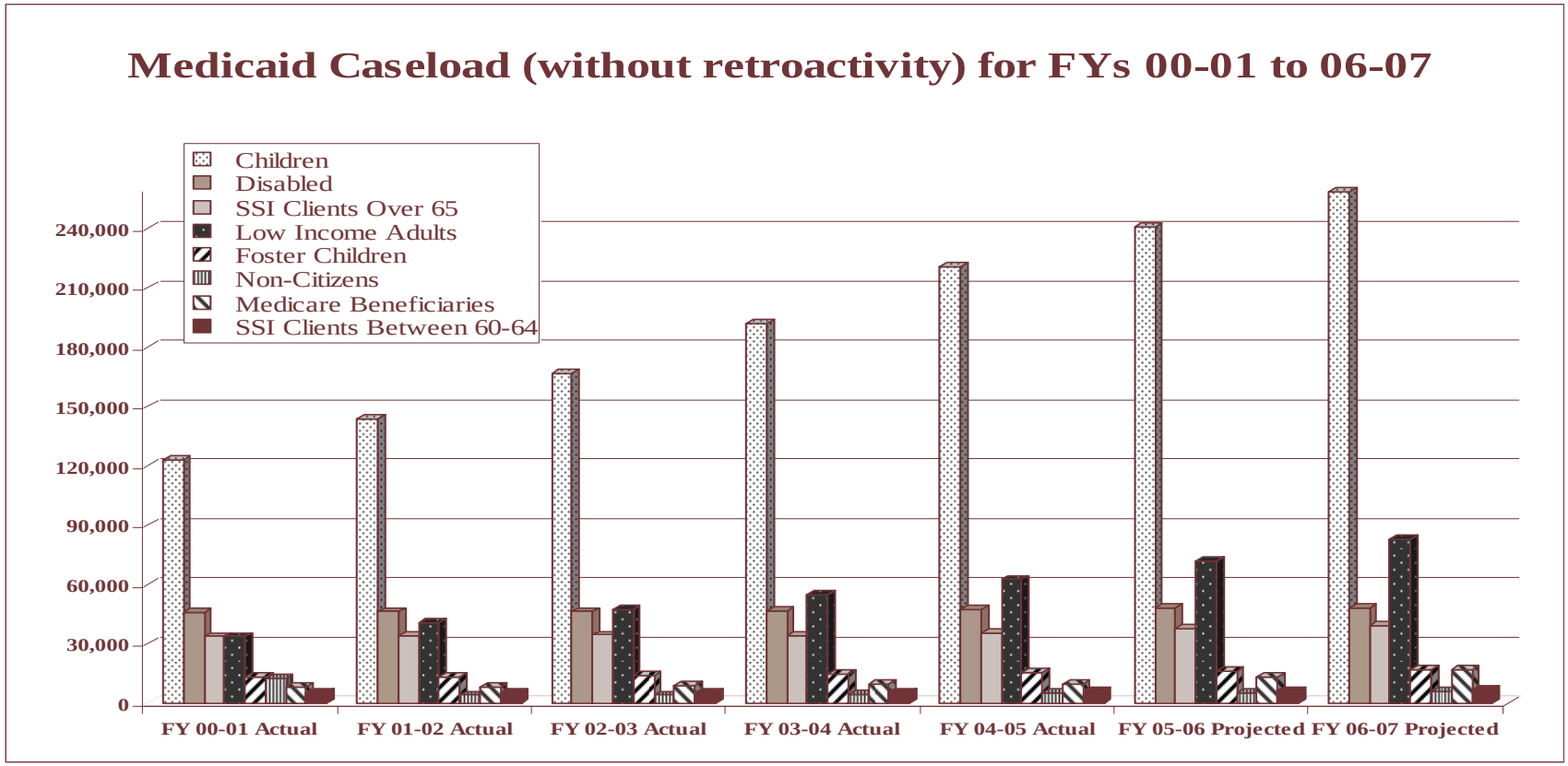
* The percent of population in the labor force is computed by dividing the number of individuals in the labor force by the total population aged 16 and older for the State. It is important to note that the number of individuals in the labor force is not equal to the population.

** Equal to $1,912,717,842 in total expenditures from a Business Objects of America query from the Medicaid Management Information System less $25,020,958 for Administrative Service Organization expenditures that were reclassed to other Departmental Long Bill Items. The balance of this figure also approximates 'Exhibit M: FY 04-05 Cash-Based COFRS Actuals Report Total By Aid Category,' (page 1) less $71,656,675 in drug rebates plus $58,449,753 for Supplemental Medicare Insurance Beneficiaries, $17,256,835 for Single Entry Points, $5,912,371 for Consumer Directed Attendant Support, and $204,682 for Disease Management.

***Caseload for the Child Health Plan Plus Officeincludes an adjustment for retroactive enrollments. Expenditures include medical costs, dental costs and external administrative contractor costs.

D3. Medicaid Caseload for FYs 00-01 to 06-07

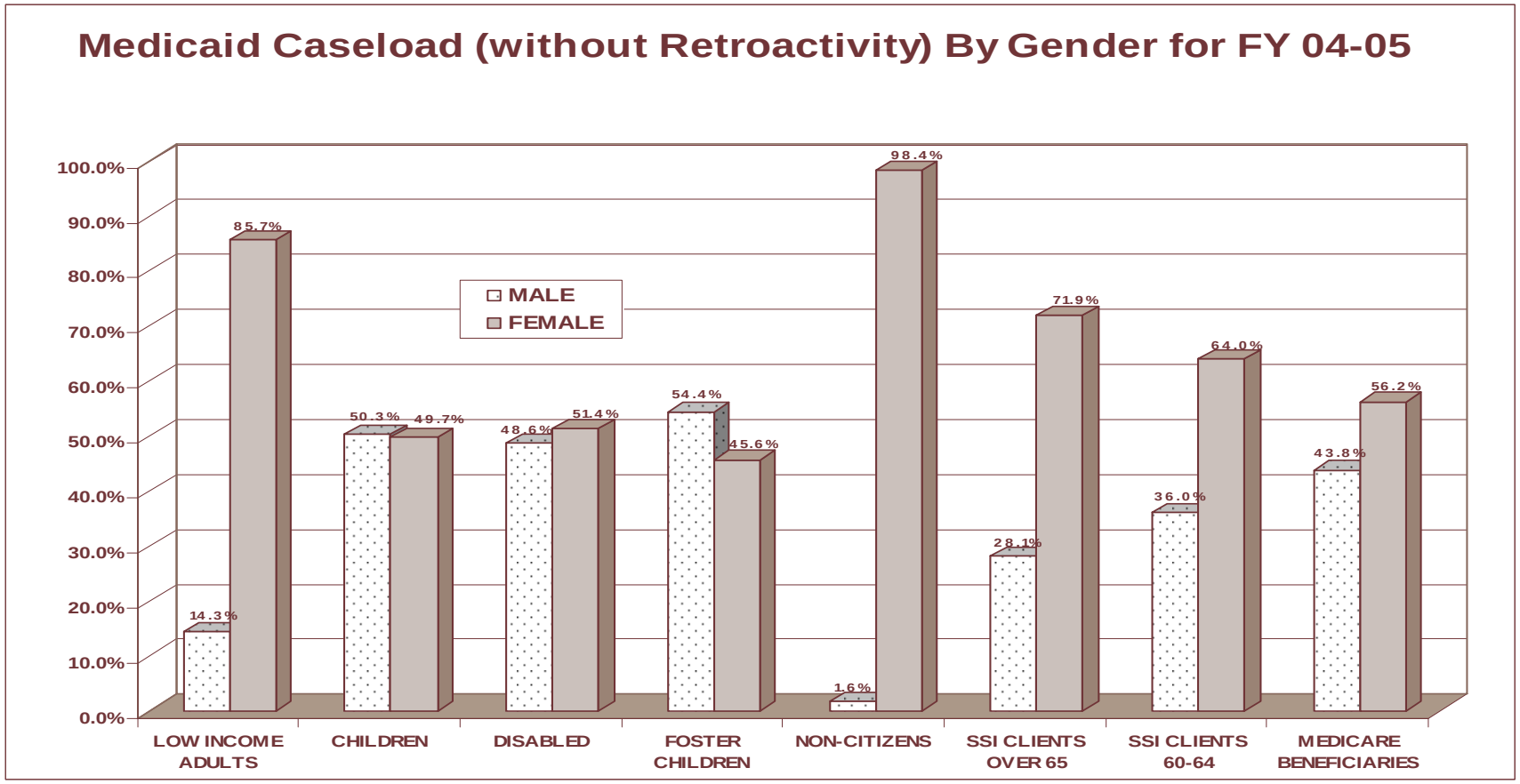
The figures presented include caseload information without retroactivity for FYs 00-01 to 04-05 (FY 05-06 and FY 06-07 are projected). Retroactivity causes historical adjustments to caseload to account for clients who were found to be eligible for Medicaid for past months, thus increasing the count of persons eligible for Medicaid (even after caseload figures are presented to the Joint Budget Committee monthly). This causes much variability in the reporting of caseload, as monthly caseload is adjusted for months after the month has passed.



Source: Actual and projected are derived from November 15, 2005's Budget Request, "Exhibit B - Medicaid Caseload Forecast," page EB-1
1) Low-income adults also includes Baby Care Program-Adults, Breast and Cervical Cancer Program Clients, and Health Care Expansion Fund Adults.
2) Medicare Beneficiaries include Qualified Medicare & Supplemental Low Income Medicare clients.

D4. Medicaid Caseload (without Retroactivity) by Gender for FY 04-05

For FY 04-05, Medicaid caseload (without retroactivity) averaged 402,802 clients as shown in the figure below. It should be noted that the data was pulled from a different source in order to obtain gender numbers. A small spread percentage was performed (i.e., allocated gender figures to unallocated gender numbers) to ensure that the higher average Medicaid client counts for FY 04-05, pulled from Business Objects of America (BOA), matched the official caseload count in Exhibit A. The figure below was retrieved through a system query and will match exactly to the June 2005 number in the July 18, 2005 Joint Budget Committee report.



Source: Business Objects of America queries, processed typically by the first business week of each month
1) Low-income adults also includes Baby Care Program-Adults, Breast and Cervical Cancer Program Clients, and Health Care Expansion Fund Adults.
2) Medicare Beneficiaries include Qualified Medicare & Supplemental Low Income clients.
3) Medicaid caseload is an average of the twelve months of this fiscal year.

D5. Medicaid Enrollment by Type of Managed Care Provider

The following table shows the breakdown by client count for FY 00-01 through FY 04-05 for clients enrolled in health maintenance organizations, Primary Care Physician Program, unassigned fee-for-service and administrative service organizations. Health maintenance organizations, administrative service organizations, and Primary Care Physician Program enrollment figures were subtracted from total caseload numbers (without retroactivity) to calculate the fee-for-service enrollment figures. However, this methodology may cause the fee-for-service counts to be underrepresented.

Medicaid Enrollment for Fiscal Years 2001-2005

Membership Category	FY 00-01 Count	FY 01-02 Count	FY 02-03 Count	FY 03-04 Count	FY 04-05 Count
Administrative Service Organizations	n/a	n/a	n/a	12,380	15,860
Health Maintenance Organizations	112,824	135,518	126,669	74,439	77,354
Primary Care Physician Program	52,214	54,086	65,475	68,557	51,669
Unassigned Fee-for-Service	110,361	105,809	135,251	207,155	257,919
TOTALS	**275,399**	**295,413**	**327,395**	**362,531**	**402,802**

Sources: Administrative service organization, health maintenance organization, and Primary Care Physician Program enrollment numbers are from the Managed Care Report. FY 04-05 total Medicaid count comes from the averages for twelve months of this fiscal year as reported to the Joint Budget Committee and Office of State Planning and Budgeting on July 18, 2005. Caseload numbers are an average of the fiscal year's caseload for each month, without retroactivity.

Notes:

1) Fee-for-Service enrollment is derived by the total enrollment minus enrollment in the administrative service organization, health maintenance organization, and the Primary Care Physician Program.

D6. Medicaid Clients Who Drive 75% of the Medicaid Budget

Medicaid is Colorado's largest health care program, providing health and long term care services to over 400,000 low-income pregnant women, children, persons with disabilities, and seniors. Colorado's Medicaid spending has increased over 46% in the last five years (from $1.294 billion in FY 00-01 to $1.893 billion in FY 04-05 as reported in 'Exhibit M: FY 04-05 Cash-Based Actuals' (page EM-2) in the FY 06-07 Budget Request, November 15, 2005. A disproportionate percentage of the rapidly growing Medicaid program is incurred on behalf of a relatively small group of people (98,283). The expenditure patterns and demographics of this group of high expenditure clients are detailed in the following analysis based on the Department's decision support system, Business Objects of America.

Important Note:
As stated earlier, claims pulled from the Department's decision support system, Business Objects of America (BOA), will not tie precisely to Colorado Financial Support System. Business Objects of America database extracts data on a different time span and from a different source (i.e., Medicaid Management Information System) than the Colorado Financial Reporting System. The decision support system contains a full extract of all paid claims in the MMIS. Certain Colorado Financial Reporting System-only transactions, however, are not triggered by a paid claim in the MMIS resulting in a variance between the two systems. Therefore, total expenditures presented for high expenditure clients in BOA will not reconcile exactly to total expenditures in COFRS. While 75% percent of Medicaid expenditures equaled $1.435 billion in FY 04-05 per Business Objects of America calculations, $1.420 billion of total actual Medical Services Premiums expenditures ($1.893 billion) per Colorado Financial Reporting System was reported in Exhibit EM-3, in November 15, 2005's FY 06-07 Budget Request.

Claims analysis include $1.913 billion of $2.494 billion of total Medicaid claim expenditures recorded in the Department's decision support system, Business Objects of America. These claims are records of expenditures in the twelve months of FY 04-05 made from the Medical Services Premiums Long Bill line item. Of all Medicaid expenditures, $49,330,893 is not linked to a unique client identification number or eligibility type. This is due to the following:

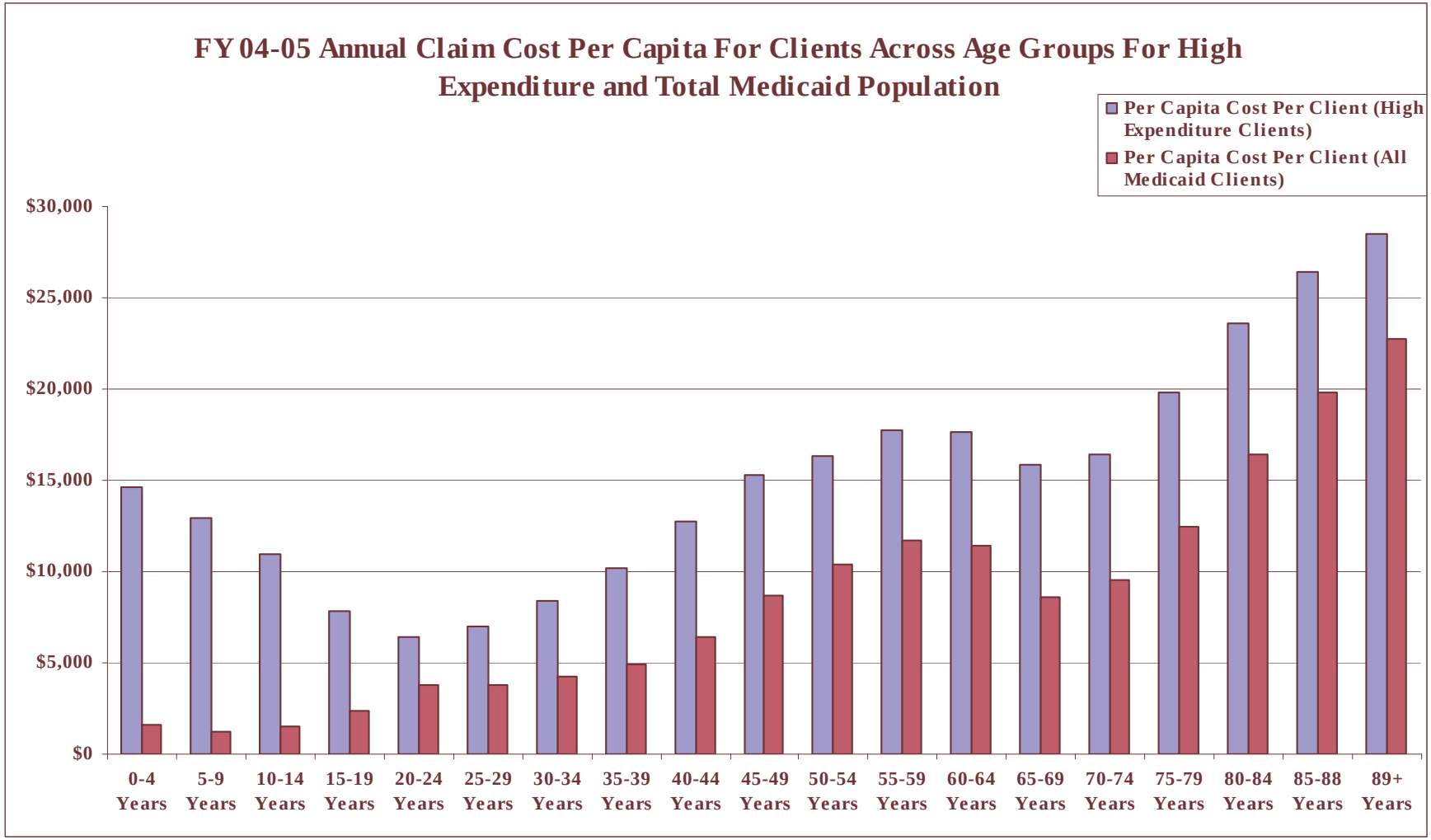
- These expenditures are paid to providers as a lump sum payments made to health maintenance organizations for federally qualified health centers' wraps and delivery incentive, financial transaction payments made to the health maintenance organizations and administrative service organizations, or other lump sum payments made to other providers; or

- Over $25 million worth of expenditures under administrative service organizations were reclassed to other Long Bill groups, such as the Department of Human Services' Medicaid Funded Programs.

Summary of Demographic Statistics of High Expenditure Clients:
A. High expenditure clients were responsible for 75% of total Medicaid services premium expenditures in FY 04-05 (costs incurred).

B. 75% percent of Medicaid expenditures equaled $1.435 billion in FY 04-05.
C. High expenditure clients comprised of only 21.8% of the clients for whom claims were paid in FY 04-05.
D. The least amount of claims expenditures incurred was $2,456 in Medicaid cost for the fiscal year.
E. The highest amount of claims expenditures incurred was $1,455,087 in Medicaid cost for the fiscal year.
F. The mean Medicaid service premium payment for this group equaled $9,794.
H. The median Medicaid service premium payment for this group equaled $4,884.
I. Of a total of 98,283 clients who drove 75% of the Medicaid service premiums expenditures, 55,579 clients were disabled and had Supplemental Security Income clients over the age of 65.
J. These 55,579 clients drove $1.041 billion of the $1.435 billion paid for high expenditure clients in FY 04-05.

Please note that the $49.3 million in expenditures included in the above demographics cannot be reported in the figures and tables below. In addition, data for the below tables and graphs are available for 98,251 clients only. Thirty-two clients under the health maintenance organizations, administrative service organizations, or the Health Insurance Buy-In program service categories that had no eligibility type, undefined genders, and/or indeterminate county codes were not included in the analysis below. This exclusion amounted to claims cost of $379,238 that was excluded in the analysis as well.



Source: Business Objects of America queries during the first week of July 2005

Note: Medicaid Service Premiums expenditures by client age as of first date of service as reported on each client's most recent claim in FY 05. Per capita totals include only Medicaid claims from the Medical Services Premiums line but do not reconcile to Colorado Financial Reporting System, so the data will not match exactly Medical Services Premiums exhibits.

The following table is comprised of the high expenditure clients in rank order. The clients are aggregated so that each group expenditure equals one quarter of all expenditures incurred on behalf of all the high expenditure clients. High expenditure clients are broken into first, second, third, and fourth rank categories of approximately $346.22 million. This is different than breaking up the data into quartiles. Quartiles are statistics that divide a set of data into four groups containing (as far as possible) equal numbers of observations.

FY 04-05 High Cost Clients Partitioned into Equal Expenditure Groups Based on Per Capita Expenditure

Rank	Expenditure Range	Number of Clients	Mean Age
First	$53,962 - $1,455,087	4,426	55 years and 8 months
Second	$35,236 - $53,961	7,753	69 years and 11 months
Third	$11,351 - $32,235	17,220	56 Years and 3 months
Fourth	$2,456 - $11,350	68,852	37 years and 5 months

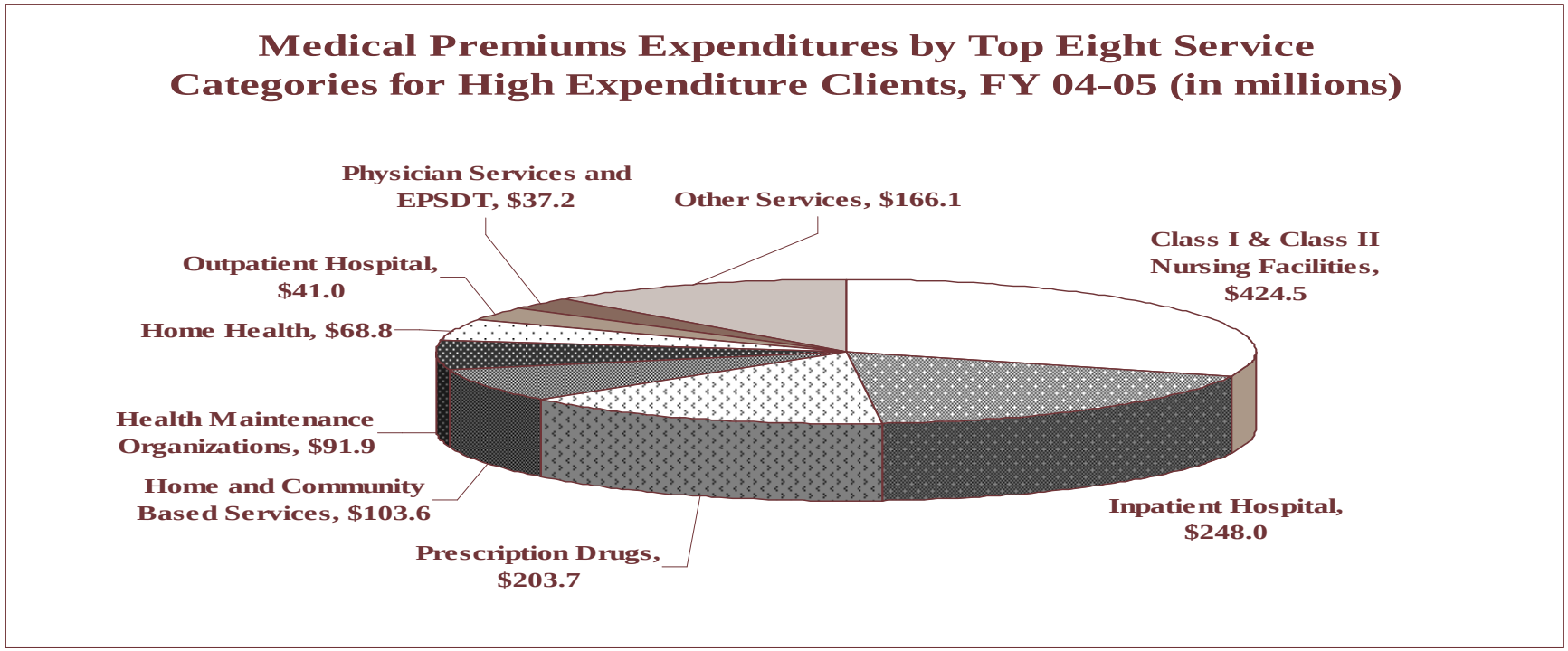
Source: Business Objects of America query during the first week of July 2005

The following table shows high expenditure clients who received services relating to long-term care. Please note that the analysis provided in the November 1, 2004 Budget Request for FY 03-04 only included those in nursing facilities and Home and Community-Based Services. For FY 04-05, additional categories were included. These categories of services include hospice, private duty nursing, and the Program of All-Inclusive Care for the Elderly. Twenty-seven percent of all high expenditure clients received services relating to long-term care in FY 04-05. The following table details how many clients utilized services from specific long-term care provider types.

FY 04-05 High Expenditure Clients Who Received Services Relating to Long-Term Care

Long Term Care Service Type	Number of FY 04-05 High Expenditure Clients	Percent of FY 04-05 High Expenditure Clients
Class I and Class II Nursing Facilities	12,916	48%
Home and Community Based Services (including Client Services) Mentally Ill, Children's, Persons Living with AIDS, and Brain Injury)	11,100	41%
Private Duty Nursing	1,523	6%
Program of All-Inclusive Care for the Elderly	1,129	4%
Hospice	184	1%

Of all clients, high expenditure clients account for large shares of total Medicaid expenditures for certain service categories. For instance, high expenditure clients alone account for over 63% of all FY 04-05 expenditures related to nursing facilities, inpatient hospitals and pharmacy. In fact, virtually everyone in nursing facilities are high expenditure clients. In addition, high expenditure clients are likely to have longer inpatient hospital admissions and are high utilizers of prescription drugs.



Source: Business Objects of America queries during the first week of July 2005

Notes:

1) Class I and II Nursing Facilities, Inpatient Hospital, Prescription Drugs, Home and Community Based Services, Health Maintenance Organizations, Home Health, Outpatient Hospital, and Physician Services/EPSDT data are based on Medical Service Premiums' definition of these service categories.

2) Expenditures for prescription drugs do not include drug rebates.

3) High expenditure client data was gathered from Business Objects of America. The process included sorting of data by payment amount in descending order. Total Medicaid payments of $1.913 billion were then grouped by each unique client. This resulted in the total payment made per client for the FY 04-05 time span. Therefore, high expenditure clients accounted for 75% percent of Medicaid expenditures equaled $1.435 billion in FY 04-05.

4) Of all Medicaid expenditures, $49.3 million is not linked to a unique client identification number or eligibility type. This is due to the following: (a) these expenditures are paid to providers as lump sum payments made to health maintenance organizations for federally qualified health centers' wraps and delivery incentive as well as financial transaction payments made to the health maintenance organizations and administrative service organizations (including administrative service organizations reclasses to other Long Bill groups, such as the Department of Human Services' Medicaid Funded Programs); and (b) clients under the health maintenance organizations, administrative service organizations, or the Health Insurance Buy-In program service categories who had no eligibility type, undefined genders, and/or indeterminate county codes were not included in the above figure (this exclusion amounted to costs of $0.4 million).

The table below illustrates that most of the Medical Services Premiums expenditure for high expenditure clients are made by those in the Supplemental Security Income Clients Over 65 and Supplemental Security Income Disabled eligibility categories. These two categories (Supplemental Security Income Clients Over 65 and Supplemental Security Income Disabled) comprise 42% of the average cost per client expenditures and 56% of client counts. In comparison, Low Income Adults represent 21% of the Medicaid clients but make up only 6% of the average cost per client. The enrollment type with the lowest average cost per client is the Non-Citizens.

FY 04-05 High Expenditure Clients by Enrollment Type Including Client Counts, Average Costs per Client, Medical Services Premiums Payments, and Share of Total Payment

Enrollment Type	Client Counts	Average Cost per Client	Medical Services Premiums Expenditures	Share of Total Payments Incurred by High Expenditure Clients
SSI Clients Over 65	25,991	$21,702.03	$564,057,568	41%
SSI Disabled	29,764	$16,047.15	$477,627,409	34%
Low Income Adults	20,973	$5,458.05	$114,471,767	8%
Children	10,136	$9,739.55	$98,720,099	7%
SSI Clients 60-64	4,501	$15,332.56	$69,011,845	5%
Foster Children	2,575	$11,595.27	$29,857,811	2%
Non-Citizens	6,287	$4,852.11	$30,505,228	2%
Medicare Beneficiaries	74	$5,673.94	$419,872	0%

Source: Business Objects of America query, during the first week of July 2005

1) Low-income adults also include Baby Care Program-Adults and Breast and Cervical Cancer Program Clients

2) Medicare Beneficiaries include Qualified Medicare and Supplemental Low Income clients

3) The sum of the client counts in the above table is 100,301. This includes the 2,072 clients who were enrolled in more than one eligibility category during the time period but does not include 22 clients in the 'Unspecifieds' group. The Department does not report the 'Unspecifieds' group separately to the Joint Budget Committee, but they are reconciled in the totals for the Medical Services Premiums expenditures and spread out over the other Medicaid categories. However, client counts and expenditures for the 'Unspecifieds' group are not included in the above table. The unduplicated number of clients is 98,251.

4) Totals include only Medicaid claims from the Medical Services Premiums line.

Attachment Two, 'Comparing Demographics, Medicaid High Expenditure Clients and Medicaid Clients, by Colorado Region' provides key information by HIPAA Information Region regarding high expenditure client volume. The graph compares high expenditure client counts by region with the unique client counts by region.

Methodology

In order to examine the characteristics of high expenditure clients, the following methodology was used.
First, using Business Objects of America, data were queried for Medicaid clients for FY 04-05 based on services found on the Medicaid Services Premiums Long Bill Group. As mentioned above, claims pulled from the Department's decision support system, Business Objects of America (BOA), will not tie precisely to Colorado Financial Support System. Business Objects of America database extracts data on a different time span and from a different source (i.e., Medicaid Management Information System) than the Colorado Financial Reporting System. The decision support system contains a full extract of all paid claims in the MMIS. Certain Colorado Financial Reporting System -only transactions, however, are not triggered by a paid claim in the MMIS resulting in a variance between the two systems. Therefore, total expenditures presented here for high expenditure clients will not exactly reconcile to an approximate $1.420 billion figure of total actual medical services expenditures ($1.893 billion) reported in Exhibit EM-3, in November 15, 2005's FY 06-07 Budget Request.

Acute Care	**Community Based Long Term Care**
Physician Services and EPSDT	Home and Community Based Service – Client Services
Emergency Transportation	Home and Community Based Service - Mentally Ill
County Transportation	Home and Community Based Service - Children's
Dental Services	Home and Community Based Service - Persons Living with AIDS
Family Planning	Private Duty Nursing
Health Maintenance Organization	Hospice
Inpatient Hospital	Home and Community Based Service - Brain Injury
Outpatient Hospital	
Lab & X-Ray	**Long Term Care and Insurance**
Durable Medical Equipment	Class I Nursing Facilities
Prescription Drugs	Class II Nursing Facilities
Rural Health Centers	Program of All-Inclusive Care for the Elderly
Federally Qualified Health Centers	Health Insurance Buy-In Program
Co-Insurance (Title XVIII-Medicare)	
Breast and Cervical Cancer Program	
Administrative Service Organizations	
Home Health	

Secondly, the data was analyzed for the following Medicaid caseload categories:

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

In addition, since the Department does not report the "Unspecifieds" group separately to the Joint Budget Committee; they are reconciled in the totals for the Medical Services Premiums expenditures and spread out over the other Medicaid categories.

Thirdly, data was sorted by payment amount in descending order. It should be noted that because of cash accounting payments made during FY 04-05, the claims data includes services in FY 03-04 as well as FY 04-05. Based on the above caseload categories, total Medicaid payments of $1.913 billion were grouped by each unique client. This resulted in the total payment made per client for the FY 04-05 time span.

E. SERVICES

E1. Paid Medical Services Premiums Expenditures across Age Groups for FY 04-05

The graph below represents Medicaid expenditures by client age as of first date of service as reported on his or her most recent claim in FY 04-05. The graph also contains clients in the following caseload categories

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

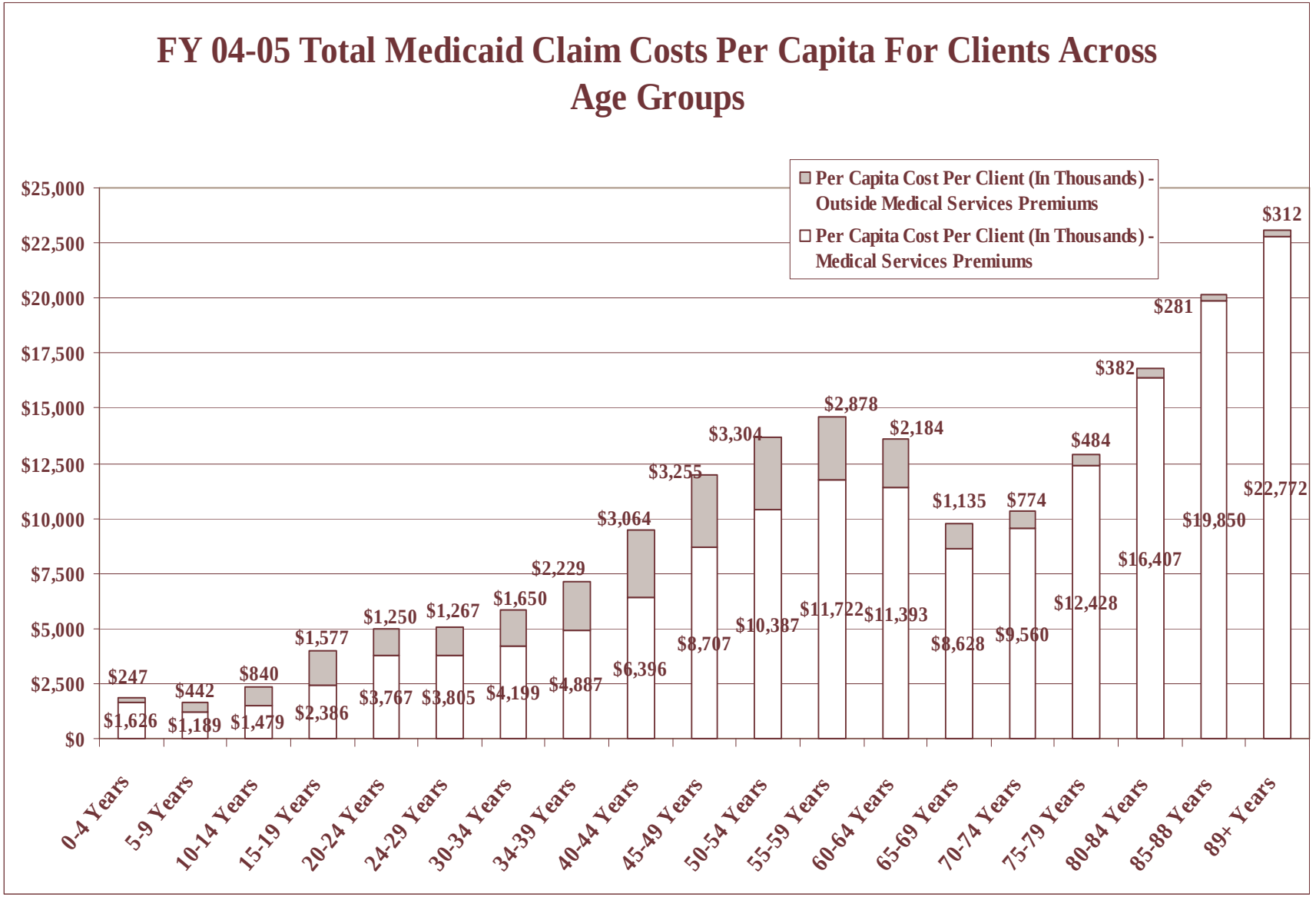
Since the Department does not report the "Unspecifieds" group separately to the Joint Budget Committee; they are reconciled in the totals for the Medical Services Premiums expenditures and spread out over the other Medicaid categories.

Excluding the exceptions listed below, the following graph shows increase in per capita expenditures with age:

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

- The largest dip in per capita costs is in the 65-69 age range. Clients aged 65 and older do not necessarily have to be disabled to be eligible for Medicaid, unlike adult Medicaid clients under 65 who are not part of an eligible family and must have a determination of a disability to be Medicaid eligible. Additionally, clients aged 65 years and older are more likely to be eligible for Medicare than younger clients, are less likely to be disabled and more likely to have insurance other than Medicaid. Thus, the average per capita cost for adult clients over 65 to the Medicaid program is less.

The Department has developed the following graph, to include not only a comparison of expenditure by age groupings, but also a comparison of Medical Services Premiums expenditures with all other Medicaid claims expenditures by age.



Source: Business Objects of America queries, July 13, 2005
Data includes Medicaid services within and outside the Medical Services Premiums appropriation, i.e., all identifiable claims in Medicaid Management Information System. Therefore, these per capita costs will not match to any in the Medical Services Premiums exhibits. Medicaid expenditures by client age as of first date of service as reported on each client's most recent claim in FY 04-05.

E2. Utilization of Services by HIPAA Information Region for FY 04-05

The tables below show utilization of the following medical services by HIPAA Information Region by the eligible population. Medical services were funded from Medical Services Premiums appropriation during FY 04-05:

- Home and Community Based Services (HCBS)
- Home Health
- Nursing Facilities
- Physician Services
- Federal Qualified Health Centers
- Inpatient Hospital
- Outpatient Hospital
- Prescription Drugs

The following should be noted:

- Clients with no HIPAA Information Region designation are not included in the tables below.
- Business Objects of America database, the Department's decision support system, extracts data on a different time span and from a different source (i.e., Medicaid Management Information System) than the Colorado Financial Reporting System. This decision support system contains a full extract of all county level data in the MMIS. However, there is no county level information in the Colorado Financial Reporting System, therefore the below tables uses analyses from Business Objects of America.
- Several tables display service utilization annualized per 1,000 Medicaid clients, that is, the number of services by each service category expected for 1,000 clients who are Medicaid eligible for an entire year. These include E2a: 'Utilization of Acute Care Services by HIPAA Information Region for FY 04-05' and "E2c: Utilization of Long Term Care Services by HIPAA Information Region for FY 04-05".
- The other tables, E2b and E2d, depict FY 04-05 mean costs per client for acute care and long-term care services by HIPAA region.
- Medicaid caseload (without retroactivity) for FY 04-05 averaged 402,802 clients. It should be noted that the data was pulled from a different source in order to obtain regional numbers for the tables below. However, for the first four tables (E2a – E2d) a spread percentage was performed (i.e., allocated regional figures to unallocated regions) to ensure that the higher average Medicaid client numbers for FY 04-05, pulled from Business Objects of America (BOA), matched the official caseload count in "Exhibit B: Medicaid Caseload Forecast" (page EB-1). These regional numbers were retrieved through a system query and will match exactly to the June 2005 number in the July 18, 2005 Joint Budget Committee report.
- The Department administers the following Home and Community Based Services (HCBS) waivers: Client Services, Mentally Ill, Children's, Persons Living with AIDS, and Brain Injury.

- The Department of Human Services administers the following Home and Community Services (HCBS): Developmentally Disabled, Supported Living Services, Children's Extensive Support, and Children's Habilitation Residential Program.

E2a: Utilization of Acute Care Services by HIPAA Information Region for FY 04-05

	Utilization Rates Per Thousand Medicaid Clients in FY 04-05					
HIPAA Information Region	**Federally Qualified Health Centers Encounters**	**Inpatient Admissions**	**Outpatient Visits**	**Pharmacy Prescriptions**	**Physician & EPSDT Service Counts**	**Full Benefit Fee-for-Service Medicaid Eligibles**
Garfield, Moffat, Rio Blanco	774.4	152.4	2,731.8	13,534.5	6,764.8	5,326
Eagle, Grand, Jackson, Pitkin, Routt, Summit	56.9	178.1	1,908.3	7,271.7	8,183.4	3,584
Mesa	12.1	95.8	1,999.3	9,833.0	6,130.2	6,360
Delta, Montrose, Ouray, San Miguel	57.3	111.2	1,925.2	11,132.1	5,530.3	3,393
Archuleta, Dolores, La Plata, Montezuma, San Juan	1,014.7	103.4	2,175.3	11,692.0	5,512.9	7,758
Gunnison, Chaffee, Lake, Fremont, Park, Custer	178.0	116.5	2,556.5	15,936.2	5,652.5	7,646
Hinsdale, Saguache, Mineral, Conejos, Rio Grande, Alamosa, Costilla	2,518.6	120.6	2,099.1	13,905.0	4,434.2	6,467
Huerfano, Las Animas, Baca, Otero, Crowley, Bent, Prowers, Kiowa	965.0	119.2	2,917.5	19,601.4	7,294.2	10,411
Pueblo	877.9	124.2	3,030.2	16,701.5	8,534.2	21,328
El Paso, Teller	1,171.7	123.9	3,054.3	11,490.3	6,651.5	42,823
Washington, Morgan, Logan, Yuma, Phillips, Sedgwick	947.0	121.7	2,499.2	17,809.7	5,443.0	6,443
Elbert, Lincoln, Kit Carson, Cheyenne	1,723.1	102.0	2,399.3	13,864.1	4,950.9	2,116
Douglas	124.9	110.2	2,109.2	10,997.1	6,926.0	3,845
Boulder, Broomfield	1,570.3	155.0	2,476.6	13,515.7	5,690.2	12,415
Larimer	894.6	115.1	2,236.7	14,286.4	7,214.2	14,643
Weld	1,327.8	129.9	2,228.3	10,526.9	6,528.4	16,243
Adams	1,111.5	151.6	2,376.4	9,305.0	6,661.4	33,247
Arapahoe	475.7	139.7	2,522.4	9,590.2	6,657.0	32,259
Jefferson, Gilpin, Clear Creek	443.7	121.5	2,478.1	13,585.1	7,686.4	25,922
Denver	1,484.1	167.3	2,370.2	10,237.4	5,073.7	53,384
Full benefit fee-for-service Medicaid clients, Totals	**1,002.8**	**135.8**	**2,523.9**	**12,055.9**	**6,468.0**	**315,614**

Source: Business Objects of America queries, August 22 - August 26, 2005 and Medicaid caseload BOA queries typically run at the beginning of each month.
Notes: (1) This table displays service utilization annualized per 1,000 Medicaid clients, that is, the number of services by each of the above service category expected for 1,000 clients who are Medicaid eligible for an entire year.
(2) Data based on utilization rate of above Medical Services Premiums per 1,000 Medicaid clients for the twelve months of this fiscal year.
(3) Full benefit fee-for-service Medicaid eligible average totals exclude Qualified Medicare and Supplemental Low Income Beneficiaries (9,572), health maintenance organization clients (77,323) and persons who did not have a county code (293). Adding Qualified Medicare and Supplemental Low Income Beneficiaries, health maintenance organization clients, persons who did not have a client code, and full benefit fee-for-service eligibles together equals 402,802, the official caseload reported in Exhibit B, page EB-1.
(4) The calculation for table E2a is as follows: total services divided by total average Medicaid caseload times one thousand.

E2b: Average Costs per Client for Acute Care Services by HIPAA Information Region for FY 04-05

	Average Service Category Costs For Medicaid Clients					
HIPAA Information Region	**Federally Qualified Health Centers**	**Inpatient**	**Outpatient**	**Pharmacy**	**Physician & EPSDT**	**Full Benefit Fee-for-Service Medicaid Eligibles**
Garfield, Moffat, Rio Blanco	$115.21	$772.71	$311.01	$1,051.30	$377.01	5,326
Eagle, Grand, Jackson, Pitkin, Routt, Summit	$9.15	$1,009.62	$222.53	$502.98	$450.92	3,584
Mesa	$1.61	$539.51	$212.95	$542.42	$298.89	6,360
Delta, Montrose, Ouray, San Miguel	$6.60	$563.45	$163.92	$666.50	$300.83	3,393
Archuleta, Dolores, La Plata, Montezuma, San Juan	$119.91	$441.80	$187.32	$721.73	$301.73	7,758
Gunnison, Chaffee, Lake, Fremont, Park, Custer	$22.72	$513.35	$243.62	$1,006.41	$320.92	7,646
Hinsdale, Saguache, Mineral, Conejos, Rio Grande, Alamosa, Costilla	$299.15	$665.10	$228.80	$678.93	$264.44	6,467
Huerfano, Las Animas, Baca, Otero, Crowley, Bent, Prowers, Kiowa	$110.31	$519.62	$243.11	$1,129.95	$341.15	10,411
Pueblo	$133.44	$611.02	$286.77	$1,054.59	$426.91	21,328
El Paso, Teller	$175.60	$547.23	$236.54	$732.37	$355.17	42,823
Washington, Morgan, Logan, Yuma, Phillips, Sedgwick	$125.89	$589.37	$302.32	$1,069.51	$310.11	6,443
Elbert, Lincoln, Kit Carson, Cheyenne	$159.69	$447.98	$274.90	$799.46	$236.99	2,116
Douglas	$18.18	$575.17	$287.69	$681.91	$360.45	3,845
Boulder, Broomfield	$215.73	$784.90	$273.25	$910.95	$336.99	12,415
Larimer	$116.77	$550.21	$220.62	$938.53	$409.17	14,643
Weld	$176.25	$654.94	$262.39	$661.46	$353.17	16,243
Adams	$162.28	$811.33	$254.67	$622.97	$358.45	33,247
Arapahoe	$71.16	$756.92	$275.43	$628.09	$379.46	32,259
Jefferson, Gilpin, Clear Creek	$68.42	$685.25	$270.96	$900.84	$396.36	25,922
Denver	$271.51	$1,069.81	$315.36	$672.62	$300.50	53,384
Full benefit fee-for-service Medicaid clients, Totals	**$151.01**	**$723.25**	**$265.10**	**$771.99**	**$352.29**	**315,614**

Notes: (1) Sources for E2b table, Business Objects of America queries, August 22 - August 26, 2005 and Medicaid caseload BOA queries typically run at the beginning of each month.

(2) Full benefit fee-for-service Medicaid eligible average totals exclude Qualified Medicare and Supplemental Low Income Beneficiaries (9,572), health maintenance organization clients (77,323) and persons who did not have a county code (293). Adding Qualified Medicare and Supplemental Low Income Beneficiaries, health maintenance organization clients, persons who did not have a client code, and full benefit fee-for-service eligibles together equals 402,802, the official caseload reported in Exhibit B, page EB-1.

(3) Data based on average expenditures for the above Medical Services Premiums per average FY 04-05 Medicaid clients.

(4) The average service category costs for table E2b is calculated as follows: total payments divided by total average Medicaid caseload.

E2c: New Utilizers of Long Term Care Services by HIPAA Information Region for FY 04-05

	Count of New* Utilizers Per 1,000 Medicaid Eligible Clients				
HIPAA Information Region	**Home and Community Based Services administered by HCPF**	**Home and Community Based Services administered by DHS**	**Home Health**	**Nursing Facility**	**Full Benefit Long-Term Care Medicaid Eligibles**
Garfield, Moffat, Rio Blanco	11.2	0.2	5.9	33.5	5,444
Eagle, Grand, Jackson, Pitkin, Routt, Summit	4.7	0.2	9.0	9.5	3,585
Mesa	10.6	0.5	4.8	17.7	15,565
Delta, Montrose, Ouray, San Miguel	13.1	1.2	10.5	33.8	7,146
Archuleta, Dolores, La Plata, Montezuma, San Juan	12.9	0.7	6.3	19.6	7,759
Gunnison, Chaffee, Lake, Fremont, Park, Custer	13.3	0.2	8.7	39.3	8,249
Hinsdale, Saguache, Mineral, Conejos, Rio Grande, Alamosa, Costilla	14.2	0.1	16.7	17.3	9,219
Huerfano, Las Animas, Baca, Otero, Crowley, Bent, Prowers, Kiowa	14.3	0.9	8.8	40.5	12,426
Pueblo	9.4	0.8	13.1	18.7	26,688
El Paso, Teller	5.6	0.2	7.3	11.6	46,891
Washington, Morgan, Logan, Yuma, Phillips, Sedgwick	11.6	0.9	6.6	52.5	7,295
Elbert, Lincoln, Kit Carson, Cheyenne	8.4	0.4	3.3	33.8	2,290
Douglas	10.4	1.6	8.7	20.1	4,306
Boulder, Broomfield	10.1	1.3	9.1	24.4	15,431
Larimer	8.7	1.0	6.9	26.8	16,712
Weld	6.7	0.7	6.8	19.1	18,995
Adams	4.0	0.3	7.5	17.6	41,882
Arapahoe	3.3	0.6	6.8	13.3	41,477
Jefferson, Gilpin, Clear Creek	6.5	0.7	8.6	27.0	30,076
Denver	4.6	0.3	7.2	14.2	71,503
Full benefit long-term care Medicaid clients, Totals	**7.1**	**0.5**	**8.0**	**19.8**	**392,937**

Source: Business Objects of America (BOA) queries, August 22 - 26, 2005. Medicaid caseload BOA queries were typically run at the beginning of each month.
*New clients are those that do not have a claim for that service in the prior two years.
(1) Client Counts are per 1,000 Medicaid eligible clients.
(2) The data presented for Medicaid client counts are an average of the 12 months of FY 04-05. However, full benefit long-term care Medicaid client regional totals exclude Qualified Medicare and Supplemental Low Income Beneficiaries (9,572) and persons who did not have a county code (293). Adding Qualified Medicare and Supplemental Low Income Beneficiaries, persons who did not have a client code, and full benefit long-term care eligibles together equal 402,802, the official caseload reported in Exhibit B, page EB-1.
(3) HCBS waivers administered by Health Care Financing and Policy includes Brain Injury, Persons Living with AIDS, Elderly Blind and Disabled, Mental Illness, and Children's Home and Community-based Services. HCBS waivers administered by the Department of Human Services includes Developmentally Disabled, Supported Living Services, Children's Extensive Support, and Children's Habilitation Residential Program.

E2d: Average Costs per Client for Long Term Care Services by HIPAA Region for FY 04-05

	Average Service Category Costs per Full-Time Equivalent Client				
HIPAA Information Region	**Home and Community Based Services administered by HCPF**	**Home and Community Based Services administered by DHS**	**Home Health**	**Nursing Facility**	**Full Benefit Long-Term Care Medicaid Eligibles**
Garfield, Moffat, Rio Blanco	$168.65	$713.28	$9.01	$1,428.65	5,444
Eagle, Grand, Jackson, Pitkin, Routt, Summit	$85.56	$428.34	$65.92	$524.22	3,585
Mesa	$223.73	$243.07	$130.12	$402.58	15,565
Delta, Montrose, Ouray, San Miguel	$211.58	$39.02	$81.29	$958.94	7,146
Archuleta, Dolores, La Plata, Montezuma, San Juan	$350.74	$344.92	$181.22	$899.19	7,759
Gunnison, Chaffee, Lake, Fremont, Park, Custer	$412.75	$493.26	$107.02	$1,523.71	8,249
Hinsdale, Saguache, Mineral, Conejos, Rio Grande, Alamosa, Costilla	$396.15	$278.32	$85.45	$815.98	9,219
Huerfano, Las Animas, Baca, Otero, Crowley, Bent, Prowers, Kiowa	$367.01	$456.52	$74.54	$1,553.66	12,426
Pueblo	$363.51	$720.26	$192.50	$864.74	26,688
El Paso, Teller	$203.76	$428.14	$284.56	$837.53	46,891
Washington, Morgan, Logan, Yuma, Phillips, Sedgwick	$224.41	$539.26	$44.79	$1,741.77	7,295
Elbert, Lincoln, Kit Carson, Cheyenne	$222.15	$351.17	$58.77	$1,443.19	2,290
Douglas	$286.91	$355.44	$220.06	$1,387.28	4,306
Boulder, Broomfield	$242.06	$881.25	$202.33	$1,329.07	15,431
Larimer	$171.86	$740.09	$175.21	$1,217.69	16,712
Weld	$147.48	$495.41	$182.68	$784.95	18,995
Adams	$163.50	$469.84	$138.37	$844.34	41,882
Arapahoe	$253.63	$496.80	$164.58	$812.59	41,477
Jefferson, Gilpin, Clear Creek	$352.45	$1,121.83	$210.58	$1,693.88	30,076
Denver	$361.51	$262.79	$172.77	$756.41	71,503
Full benefit long-term care Medicaid clients, Totals	**$270.83**	**$504.46**	**$172.07**	**$975.60**	**392,937**

Source: Business Objects of America (BOA) queries, August 22 - 26, 2005. Medicaid caseload BOA queries were typically run at the beginning of each month.
(1) Data is based on average cost per client in FY 04-05.
(2) The average service category costs is calculated as follows: total expenditures divided by total average Medicaid caseload.
(3) The data presented for Medicaid client counts are an average of the 12 months of FY 04-05. However, full benefit long-term care Medicaid client regional totals exclude Qualified Medicare and Supplemental Low Income Beneficiaries (9,572) and persons who did not have a county code (293). Adding Qualified Medicare and Supplemental Low Income Beneficiaries, persons who did not have a client code, and full benefit long-term care eligibles together equal 402,802, the official caseload reported in Exhibit B, page EB-1.
(4) HCBS waivers administered by Health Care Financing and Policy includes Brain Injury, Persons Living with AIDS, Elderly Blind and Disabled, Mental Illness, and Children's Home and Community-based Services. HCBS waivers administered by the Department of Human Services includes Developmentally Disabled, Supported Living Services, Children's Extensive Support, and Children's Habilitation Residential Program.