Department of Health Care Policy and Financing
Program Crosswalks
FY 06-07

Budget Request

NOVEMBER 15, 2005

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Federal/State Statutory and Other Authority

25.5-1-104, C.R.S. (2005):
1) There is hereby created the department of health care policy and financing, the head of which shall be the executive director of the department of health care policy and financing, which office is hereby created. The executive director shall be appointed by the governor, with the consent of the senate, and shall serve at the pleasure of the governor. The reappointment of an executive director after an initial election of a governor shall be subject to the provisions of section 24-20-109, C.R.S. (2005) The executive director has

those powers, duties, and functions prescribed for the heads of principal departments in the "Administrative Organization Act of 1968", article 1 of title 24, C.R.S., and any powers, duties, and functions set forth in this title.
(2) The department of health care policy and financing shall consist of an executive director of the department of health care policy and financing, the medical services board, and such divisions, sections, and other units as shall be established by the executive director pursuant to the provisions of subsection (3) of this section.
(3) The executive director may establish such divisions, sections, and other units within the state department as are necessary for the proper and efficient discharge of the powers, duties, and functions of the state department; except that such action by the executive director shall not conflict with the implementation requirements for the plan for restructuring the delivery of health and human services in this state, as set forth in article 1.7 of title 24, C.R.S.
(4) The department of health care policy and financing shall be responsible for the administration of the functions and programs as set forth in part 2 of this article.

Program Description

Steve Tool was appointed Executive Director effective August 17, 2005. Areas of responsibility for the Executive Director include general governance and financial accountability for the Department, communication with partners within and outside of state government, and research and development for current and future refinement of Department operations. The Executive Director is appointed by the Governor and sits on his Cabinet. Three Offices report directly to the Executive Director:

- Medical Assistance Office
- Operations and Finance Office
- Child Health Plan *Plus* Office

FY 06-07 Prioritized Objectives and Performance Measures

All departmental objectives and performance measures are of interest to the Executive Director. They are assigned into sub-units of the Offices in this document (Divisions, Sections, and Units). A complete list of Prioritized Objectives is found in the Strategic Plan, III. Schedule 1 - Prioritized Objectives starting on page 8.

HIPAA Compliance

The Executive Director's Office coordinates Health Insurance Portability and Accountability Act (HIPAA) work. HIPAA affects many state agencies, as well as all health care providers, plans, and payers across the country. HIPAA is an effort to standardize

health care transactions and assure privacy/security of the health information. For these reasons, coordination with other affected entities is important to the success with any HIPAA effort.
HIPAA requires change throughout the Department's systems and across many business processes. HIPAA implementation efforts in the last few years include standardizing the electronic claim submission process for both batch and interactive claims. National standard coding is now used on all transactions. Privacy and security rules have been fully implemented in the Department. The work began in earnest in FY 05-06.

There is a new HIPAA rule applying administrative simplification. The final rule for the National Provider Identifier for HIPAA was published by the federal government on January 23, 2004, with a compliance date of May 23, 2007. This rule is unique in that the normal two-year implementation time line does not apply. The centralized data bank began operations May 23, 2005, at which time the two-year time clock started. The impact of this rule will be in the Medicaid Management Information System, run by the fiscal agent. The fiscal agent will conduct an assessment for and provide options for compliance with the rule that should be completed early 2006.

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

The HIPAA Compliance Officer continues to work extensively with departmental contractors for the Medicaid Management Information System and the web portal application to specify and direct changes to the automated systems they operate, to review changes and accept deliverables. Staff works with program experts throughout the Department to make the business changes necessary to achieve HIPAA compliance.

Similar or Cooperating Programs and Stakeholders

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

- The Department of Human Services
- The Department of Public Health and Environment
- The Department of Regulatory Agencies
- The Department of Corrections
- The Department of Education

- The Department of Personnel and Administration
- Governor's Office
- General Assembly
- Constituents eligible to receive services through Department programs
- County Departments of Social Servicesand other eligibility sites
- Providers of care and services
- Federal government through the Centers for Medicare and Medicaid Services

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

Communications and External Affairs

Customer Service Section

PROGRAM CROSSWALK

Summary Section

Program Title: Customer Service Section

Change Request(s): None

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Health, Life and Dental
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Capitol Complex Leased Space

Federal/State Statutory and Other Authority

25.5-1-104, C.R.S. (2005) (3): *The executive director may establish such division, sections and other units...as are necessary for the proper and efficient discharge of the powers, duties and functions of the state department: …*

26-4-117, C.R.S. (2005) (1) (b): Complaints and grievances. Each MCO shall utilize a complaint and grievance procedure and a process for expedited reviews that comply with regulations established by the state department. The complaint and grievance procedure shall provide a means by which enrollees may complain about or grieve any action or failure to act that impacts an enrollee's access to, satisfaction with, or the quality of health care services, treatments, or providers. The state department shall establish the position of ombudsman for Medicaid managed care. It is the intent of the general assembly that the ombudsman for

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

Program Description

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

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

The Customer Service Call Center:

The Customer Service Section now uses the state of the art Definity® Business Communications and Centre Vu® Call Center Management System from Avaya, and the Conversant Menu Builder provider by Interactive Northwest, Inc. Using these innovative call management systems, customer calls are processed in a highly efficient and effective manner. Call Center reports are generated through the CentreVu® Supervisor software, which monitors the operations and collects data. The data is organized in real time, historical, or integrated formats, which help manage call center facilities and personnel. Examples of reports available are: the number of calls waiting, oldest call waiting time, the numbers of calls received, the number and percentage of calls lost, and the average time it takes to process a call. In an effort to accommodate all non-English speaking callers, the Customer Service Section uses Language Line Services which allows the customer service staff instant access to interpreters in as many as 150 languages.

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

Future Directions

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

- Seek additional ways to efficiently and effectively meet the high call volume demands;
- Continue to seek ways to efficiently and effectively ensure high call quality;
- Continue to seek ways to ensure consistent and correct information is disseminated;
- Continue to seek ways to upgrade the automated attendant system;
- Continue to enhance the Customer Service Database;
- Continue to monitor and track the Section's performance;
- Continue to improve relations with county workers;
- Continue to provide quality training for section and Departmental staff;
- Continue to seek ways to reduce staff stress;
- Continue to hold the Ombudsman for Medicaid Managed Care contractor accountable for an outcome-based results contract; and,
- Continue to focus on employee retention.

FY 06-07 Prioritized Objectives and Performance Measures

3.2 To enhance customer service, provider and eligibility personnel's understanding of program requirements, benefits, and responsibilities. To improve the usefulness of communications with clients, constituents, partners, and stakeholders.
Customer Service Section will decrease the call abandonment rate by at least 5% from the FY 05-06 level.
4.1 To build and maintain a high quality, customer-focused team.
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.

Similar or Cooperating Programs and Stakeholders

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

Medical Assistance Office

Health Benefits Division
Acute Care Benefits Section
Quality Improvement Section
Managed Care Benefits Section

Rates and Analysis Division
Rates Section
Data Section
Program Integrity Section

Long Term Benefits Division
Community Based Long Term Care Section
Nursing Facilities Section
Systems Change Unit

Client Services Division
Benefits Coordination Section
Eligibility Policy Unit

PROGRAM CROSSWALK

Summary Section

Program Title: Acute Care Benefits Section

Change Request(s): Move Non-Emergency Medical Transportation Administrative Costs from County Administration

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Early and Periodic Screening, Diagnosis, and Treatment Program
Non-Emergency Transportation Services
(2) Medical Services Premiums
(6) Department of Human Services Medicaid-Funded Programs
(F) Alcohol and Drug Abuse Division, High Risk Pregnant Women Program

Federal/State Statutory and Other Authority

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

26-4-202, C.R.S. (2005): *Subject to the provisions of subsection (2) of this section and section 26-4-104, the program for the categorically needy shall include the following services as mandated and defined by federal law..*

26-4-302, C.R.S. (2005): This section outlines the optional services that are provided for the categorically needy.

26-4-422, C.R.S. (2005): This section outlines the substance abuse treatment for native Americans.

26-4-532, C.R.S. (2005): *The general assembly hereby finds and declares that breast and cervical cancer are significant health problems for women in this state. The general assembly further finds and declares that these cancers can and should be prevented and treated whenever possible. It is therefore the intent of the general assembly to enact this section to provide for the prevention and treatment of breast and cervical cancer to women where it is not otherwise available for reasons of cost.*

26-4-534, C.R.S. (2005): This section outlines the development and implementation of an obesity treatment pilot program for the purpose of treating a Medicaid recipient who has a body mass index of greater than thirty and who has a co-morbidity related to the recipient's obesity including but not limited to diabetes, hypertension and coronary heart disease.

Program Description

Medicaid Benefits

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

- Defines the amount, scope, and duration of services to be provided to eligible clients;
- Develops and implements health care policies and benefits through statute, regulations, and procedures;
- Coordinates a broad spectrum of programs and services to improve client access and limit duplication and gaps in services;

- Develops billing manuals, bulletins, and system changes for correct reimbursement and monitoring of services;
- Assists providers, clients, contractors, and advocates on the prior authorization process for durable medical equipment and supply approvals;
- Annually updates the Health Care Procedural Coding System; and,
- Coordinates with Parts B and C of the Individuals with Disabilities Education Act through the Department of Education.

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

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

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

FY 06-07 Prioritized Objectives and Performance Measures
1.4 To assure delivery of appropriate, high quality care. To design programs that result in improved health status for clients served and to improve health outcomes. To ensure that the Department's programs are responsive to the service needs of enrolled clients in a cost-effective manner.
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.

Similar or Cooperating Programs and Stakeholders

The Department of Health Care Policy and Financing is the Single State Agency responsible for administration of the Colorado Medical Assistance Program. The Department of Public Health and Environment assists in the administration of several programs. The Department of Public Health and Environment is responsible for the administration of the Infant Immunization Program, the Vaccine for Children program, the Health Care Program for Children with Special Needs including the developmental evaluation clinics, and the Prenatal Plus Program. The Department of Human Services is responsible for the administration of the Special Connections program. The county departments of social services assist with the administration of non-emergent medical transportation and Early and Periodic Screening, Diagnosis, and Treatment administration.

PROGRAM CROSSWALK

Summary Section

Program Title: Quality Improvement Section

Change Request(s): None

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Acute Care Utilization Review
Long Term Utilization Review
External Quality Review
Mental Health External Review
(2) Medical Services Premium

Federal/State Statutory and Other Authority

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

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

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

26-4-116, C.R.S. (2005): Requires the Department to administer quality measurements for managed care.

26-4-117 (1) (b), C.R.S. (2005): Requires the Department to establish a complaint and grievance procedure and a process for expedited reviews for managed care organizations to use.

26-4-123 (1), C.R.S. (2005): Requires the Department to administer all Medicaid community mental health services.

26-4-408.5, C.R.S. (2005): This section authorizes the Department to develop and implement disease management programs for fee-for-service and primary care physician program recipients with the intent to reduce total health care cost without compromising quality of care.

Program Description

The Quality Improvement Section is responsible for the quality assessment and performance improvement endeavors across Medicaid fee-for-service, managed care populations, and administration of the disease management programs. Quality activities are performed for both the physical health and mental health care systems. Specific functions include fee-for-service utilization review activities, external quality review of managed care and fee-for-service programs, compliance and monitoring, compilation of quality measurement and improvement activities, and administration of the disease management programs. The mission of the Quality Improvement Section is to facilitate, monitor and improve access, fiscal accountability, and quality health care for all Medicaid clients. Access to care, the provision of quality health care services, and the appropriate use of Medicaid resources are facilitated and monitored through a variety of activities performed by the section. The overall Quality Improvement strategy and specific initiatives focus on both fee-for-service and managed care programs.

Quality Improvement and Intervention

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

- **Client Satisfaction Surveys:** Satisfaction surveys are conducted for clients in managed care and fee-for-service programs. The results are reported to clients to assist them in choosing the best health plan or program to meet their needs. In 2004, the Consumer Assessment of Health Plans Study's client satisfaction survey was completed for Colorado Medicaid managed care organizations, the Primary Care Physician Program, and all of fee-for-service. Results were summarized in a Provider Report Card that was mailed to all clients at annual enrollment. The Mental Health Statistics Improvement Program survey is used to monitor consumer satisfaction for the behavioral health care organizations. This data became part of the overall quality improvement plan.

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

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

- **Focused Studies:** The Department conducts quality of care focused studies that compare the results of the managed care organizations, the Primary Care Physician Program, and the fee-for-service program. This enables the Department to take an in-depth look at the quality of care delivered to Medicaid clients. FY 04-05 focused studies included Early Periodic Screening Diagnosis and Treatment and Preventive Care for the Disabled. The Department will make the results available to the clients as part of a report card, as well as post the information on the Department's webpage. The Department selected two new studies for FY 05-06 that will build upon the findings of earlier studies and measurement, as will the studies selected for FY 06-07.

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

- **Quality Improvement Projects:** Federal regulations require the Department to validate performance improvement projects conducted by the health plans. Performance improvement projects conducted by the managed care organizations and the behavioral health organizations are evaluated by the external quality review organization.

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

Plan Compliance and Monitoring

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

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

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

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

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

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

Utilization Review

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

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

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

Disease Management

The Department entered into two statewide disease management programs during FY 04-05. These disease management programs provide medical assessment, case management, care coordination, client and provider education, and health risk screening. These programs are geared toward improving the quality of care for clients, reducing utilization of costly services, and assisting physicians in caring for high-risk clients. The Department has two disease management programs:

- **Asthma Disease Management:** National Jewish Medical and Research Center contracts with the Department to provide asthma disease management services for up to 500 high risk clients.

- **Diabetes Disease Management**: McKesson Health Solutions contracts with the Department to provide diabetes disease management services for up to 300 high risk clients.

FY 06-07 Prioritized Objectives and Performance Measures

1.1 To maximize the opportunity to maintain health care services through the purchase of services in the most cost-effective manner possible.
The 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.
3.1 To improve customer satisfaction with programs, services, and care.
The Division will monitor customer satisfaction with the Mental Health Community Services program through the use of annual adult and child satisfaction surveys, quarterly grievances and appeal reporting, and feedback received in open forums with customers.

Similar or Cooperating Programs and Stakeholders

Single Entry Points – utilization review activities
Division of Insurance and the Department of Public Health and Environment – health maintenance organization monitoring activities
Federally Qualified Health Centers – quality initiatives
Division of Human Services, Mental Health Service – mental health performance measurement

PROGRAM CROSSWALK

Summary Section

Program Title: Managed Care Benefits Section

Change Request(s): None

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SB 97-05 Enrollment Broker
(2) Medical Services Premiums
(3) Medicaid Mental Health Community Programs
(A) Mental Health Capitation Payments for 410,171 Estimated Medicaid Eligible Clients
(B) Other Medicaid Mental Health Payments
Medicaid Mental Health Fee For Service Payments
Medicaid Mental Health Child Placement Agency

Federal/State Statutory and Other Authority

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

Sections 26-4-111 through 26-4-127 C.R.S. (2005): Statewide System of Managed Care: This statute defines managed care and describes the requirements for the "Statewide Managed Care System."

26-4-123 (1), C.R.S. (2005): Requires the Department to administer all Medicaid community mental health services.

Program Description

The Managed Care Benefits Section develops, implements, and monitors contracts with managed care organizations, prepaid inpatient health plans and primary care case management plans. These include: administrative service organizations, behavioral health organizations, physical health plans, other managed care providers, and the enrollment broker. The Section also administers the Primary Care Physician Program. The Section's purpose is to assist Medicaid clients' enrollment into physical health managed care programs and to ensure that all managed care contractors provide high quality and cost-efficient health care. The Managed Care Benefits Section:

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

Medicaid's Managed Care Programs

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

- Managed Care Organizations and Prepaid Inpatient Health Plans: Medicaid clients may select a capitated physical health plan which operates under a comprehensive risk contract. Medicaid clients are assigned to one of five regional capitated behavioral

health organizations (prepaid inpatient health plans) that operate under a comprehensive risk contract. Unlike providers participating in the non-capitated managed care programs, the capitated plans have full responsibility, not only for the management of care, but also for the financing and delivery of all necessary and covered health care services. These plans receive a fixed monthly payment from Medicaid for each enrolled Medicaid client.

- Administrative Service Organizations: Administrative Service Organizations provide a variety of managed care services (without a comprehensive risk contract) to Medicaid clients. The services (e.g. case management, care coordination, client and provider education, health risk screening, provider profiling, etc.) are designed to improve quality of care for clients, reduce utilization of costly services, and assist physicians in caring for high-risk clients.

FY 06-07 Prioritized Objectives and Performance Measures

1.1 To maximize the opportunity to maintain health care services through the purchase of services in the most cost-effective manner possible.
The 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 of 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.
3.1 To improve customer satisfaction with programs, services, and care.
The Division will monitor customer satisfaction with the Mental Health Community Services program through the use of annual adult and child satisfaction surveys, quarterly grievances and appeal reporting, and feedback received in open forums with customers.

Similar or Cooperating Programs and Stakeholders

Employers and the Colorado Business Group on Health have similar issues in the commercial managed care market.
Division of Insurance and the Department of Public Health and Environment - health maintenance organization monitoring activities
Department of Human Services, Division of Mental Health - Mental health performance measurement

PROGRAM CROSSWALK

Summary Section

Program Title: Rates Section

Change Request(s): Revisions to the Medicare Modernization Act Implementation
Hospital and Federally Qualified Health Center Audits - Increase for COLA Provision in Contract

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Workers' Compensation
Operating Expenses
Legal Services and Third Party Recovery Legal Services for 12,684 hours
Administrative Law Judge Services
Purchases of Services from Computer Center
Payment to Risk Management and Property Funds
Capitol Complex Leased Space
Drug Utilization Review
Hospital and Federally Qualified Health Clinic Audits
(2) Medical Services Premiums
(3) Medicaid Mental Health Community Programs
(A) Mental Health Capitation Payments for 410,171 Estimated Medicaid Eligible Clients

Federal/State Statutory and Other Authority

26-4-119, C.R.S. (2005): *Capitation Payments:* Requirements regarding rate setting for managed care organizations, including Program of All-inclusive Care for the Elderly and behavioral health organizations.

26-4-124, C.R.S. (2005): Program of all-inclusive care for the elderly - services – eligibility: This section provides for the creation and implementation of the Program of All-inclusive Care for the Elderly.

26-4-405, C.R.S. (2005): Providers – hospital reimbursement: Requirements regarding rate setting for hospitals.

26-4-406 through 26-4-408, C.R.S. (2005): Requirements regarding administration of the pharmacy program.

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

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

Program Description

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

Functions of the Rates Section include:

- Set and administer rates for federally qualified health centers, rural health clinics, hospitals, and other provider services, including dental services;
- Set rates for managed care organizations including health maintenance organizations;
- Set rates for Programs of All-Inclusive Care for the Elderly and behavioral health organizations;
- Set rates for, and administer, the Pharmacy Unit; and,
- Set rates for internal clients as requested, such as Single Entry Point providers and the Children's Pediatric Hospice waiver.

Summary of Activities

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

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

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

Behavioral Health Organizations: Capitation rates are calculated for behavioral health organizations, formerly known as mental health assessment and services agencies. This rate calculation relies on encounter data and plan financials to develop an experience

rate. Rates are separately priced for State Plan services and non-State Plan waivered services for the regions using the behavioral health organization's experience.

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

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

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

FY 06-07 Prioritized Objectives and Performance Measures

1.1 To maximize the opportunity to maintain health care services through the purchase of services in the most cost-effective manner possible.
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.
The Division will effectively utilize the Drug Utilization Review Board to identify opportunities for cost savings; the Board will meet on a quarterly basis.

1.1 To maximize the opportunity to maintain health care services through the purchase of services in the most cost-effective manner possible.
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.
1.3 To assure payments in support of the programs are accurate and timely.
The Division will provide payment assessments to the managed care organizations, programs of all-inclusive care to the elderly, and administrative service organizations, to assure all payments are accurate for eligible clients for FY 06-07 by June 2007. The Division will assess any provider requests for offline payments within 45 days after submission.
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.

Similar or Cooperating Programs and Stakeholders

Residential Treatment Programs
Health Maintenance Organizations
Child Health Plan Plus Office
Colorado Community Health Network
Colorado Department of Public Health and Environment
Colorado Health and Hospital Association
Colorado Rural Health Centers
Community Centered Boards
Community Mental Health Centers
Colorado Behavioral Healthcare Council
Healthcare Financial Management Association Reimbursement Committee
Pharmacies, drug manufacturers, and advocates
Prescription Drug Card Services
Drug Utilization Review Board
Behavioral Health Organizations
Federally Qualified Health Centers
Program for All-Inclusive Care for the Elderly

PROGRAM CROSSWALK

Summary Section

Program Title: Data Section

Change Request(s): Address Outstanding Audit Recommendations Related to Prescription Drugs within Medicaid Management Information System (MMIS)

Long Bill Line Item
(1) Executive Director's Office
Personal Services
Health, Life and Dental
Short-term Disability
S.B. 04-257 Amortization Equalization Disbursement
Salary Survey and Senior Executive Service
Workers' Compensation
Operating Expenses
Legal Services and Third Party Recovery Legal Services for 12,684 hours
Administrative Law Judge Services
Purchases of Services from Computer Center
Payment to Risk Management and Property Funds
Capitol Complex Leased Space
(2) Medical Services Premiums
(5) Other Medical Services
SB 97-101 Public School Health Services

Federal/State Statutory and Other Authority

25.5-1-104 (3), C.R.S. (2005): *The executive director may establish such divisions, sections, and other units within the state department as are necessary for the proper and efficient discharge of the powers, duties, and functions of the state department.*

26-4-531, C.R.S. (2005): *Health Services – provision by school districts: Allows school districts to contract with the Department to receive federal matching funds for amounts spent in providing health services through the public schools to students who are receiving Medicaid benefits pursuant to this article.*

Program Description

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

Functions of the Data Analysis Section

The Section provides services that:

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

Summary of Activities

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

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

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

Additional Activities

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

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

School Health Services Program: The program reimburses public school districts for the provision of health services to students with Medicaid funds. These funds are the federal share of the cost of providing the health care for Medicaid eligible students in the schools. The school district certifies that local and state funds are spent to meet the State share of the cost of providing health care services. These funds can then be used by schools to provide additional health services for all students. The Department works jointly with the Department of Education to ensure that funds are expended in a manner consistent with 26-4-531, C.R.S. (2005). Both Departments' administrative costs are paid from the reimbursed funds.

FY 06-07 Prioritized Objectives and Performance Measures

1.3 To assure payments in support of the programs are accurate and timely.
The Division will provide payment assessments to the managed care organizations, programs of all-inclusive care to the elderly, and administrative service organizations, to assure all payments are accurate for eligible clients for FY 06-07 by June 2007. The Division will assess any provider requests for offline payments within 45 days after submission.
The Division will respond to requests for ad hoc reports within ten business days, 90% of the time.
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.
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.

Similar or Cooperating Programs and Stakeholders

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

PROGRAM CROSSWALK

Summary Section

Program Title: Program Integrity Section

Change Request(s): None

Long Bill Line Item
(1) Executive Director's Office
Personal Services
Health, Life and Dental
Short-term Disability
S.B. 04-257 Amortization Equalization Disbursement
Salary Survey and Senior Executive Service
Workers' Compensation
Operating Expenses
Legal Services and Third Party Recovery Legal Services for 12,684 hours
Administrative Law Judge Services
Purchases of Services from Computer Center
Payment to Risk Management and Property Funds
Capitol Complex Leased Space
Payment Error Rate Measurement Project
(2) Medical Services Premiums

Federal/State Statutory and Other Authority

42 CFR Part 455: *Program Integrity: Medicaid sets federal requirements for detection of and preliminary and full investigation of fraud and abuse. Sets the requirements for cooperation with Medicaid Fraud Control Unit and referral of fraud issues. Sets the requirements of providers for disclosure of ownership and controlling interest information.*

26-4-403 C.R.S. (2005): *Year Recoveries - overpayments - penalties - interest - adjustments – liens – review or audit procedures: Identifies the authority for recovery of overpayments, penalties and interest that may be applied, methods of recovery, and expectations when conducting audits or reviews and utilizing a contingency based contractor.*

Program Description

The mission of the Program Integrity Section is to monitor and improve provider accountability to the Medicaid program. Program Integrity staff identify potentially excessive or improper utilization, or improper billing of the Medicaid program by providers. If a situation is identified, staff follow-up to investigate, classify, and recover payments and/or refer the providers to legal authorities for possible prosecution when appropriate. Providers are selected for review in one of three ways. The first way is when the section receives complaints or referrals questioning improper or incorrect payments, and a preliminary investigation is conducted. If it is deemed necessary based on this preliminary review, a case is opened to perform a full investigation of the provider. The second way of identifying a provider for review is through review of comparison reports of like providers – if a particular provider is not similar to those in the same group, the Department opens a case for review. Finally, the third way providers are selected for review is by developing a study by which payments to all providers in the same category of service will be examined under the criteria developed for the study. Interventions for improper use of the Medicaid program can range from education and recovery of overpayments, to restriction or exclusion from participation in the program. Civil and criminal sanctions may also be pursued by the Department and the Medicaid Fraud Control Unit.

Specific Program Integrity activities include:

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

- **Provider Sanctioning:** Program Integrity monitors the exclusion database maintained by the Department of Health and Human Service, Office of Inspector General (OIG), and sends notification of Medicaid exclusion to all providers who have been excluded from participation by the OIG. Disciplinary actions of all licensed Medicaid providers imposed by the Department of Regulatory Agencies are also monitored. When a Medicaid provider is identified as having a relevant action against their license, the Department takes appropriate action within the Medicaid program. Actions may include letters of admonishment, practice restrictions, practice monitoring, suspension, and/or termination from the program.

- **Explanation of Medical Benefits:** In compliance with federal requirements, a random number of paid claims are identified each month and sent to clients to verify that services were provided. Program Integrity follows up on all questionnaires returned indicating that services were not provided as identified. A full investigation and case opening takes place as indicated by the preliminary investigation.

- **Facility Credit Balance Audits:** The Department has a contingency-based contract with Health Management Systems to conduct credit balance auditing activities on Medicaid providers. This contract allows for on-site auditing or self-monitoring activities conducted by the providers. The contractor coordinates recovery of all credit balances identified.

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

- **Payment Error Rate Measurement:** In preparation for federal mandates requiring an assessment of payment accuracy, Program Integrity has coordinated the Department's participation in pilot studies the past two years.

FY 06-07 Prioritized Objectives and Performance Measures

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

Similar or Cooperating Programs and Stakeholders

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

PROGRAM CROSSWALK

Summary Section

Program Title: Community Based Long Term Care Section

Change Request(s): Increased Funding for Single Entry Point Audits

Long Bill Line Item
(1) Executive Director's Office
Personal Services
Health, Life and Dental
Short-term Disability
SB 05-203 Amortization Equalization Disbursement
Salary Survey and Senior Executive Service
Workers' Compensation
Operating Expenses
Legal Services and Third Party Recovery Legal Services for 12,684 hours
Administrative Law Judge Services
Purchases of Services from Computer Center
Payment to Risk Management and Property Funds
Capitol Complex Leased Space
Single Entry Point Administration
Single Entry Point Audits
Long Term Care Utilization Review
(2) Medical Services Premiums
(5) Other Medical Services
Colorado Autism Treatment Fund
(6) Department of Human Services Medicaid Funded Programs
(E) Division of Child Welfare-Medicaid Funding, Child Welfare Services

Federal/State Statutory and Other Authority

26-4-105.8, C.R.S. (2005): Authorizes the Department to amend the existing Children's HCBS and Children's Extensive Support Waivers to increase the number of children authorized to be enrolled in the programs.

26-4-202 (1) (f), C.R.S. (2005): Home health services are mandated services.

26-4-1301, C.R.S. (2005): Authorizes the implementation of a consumer-directed service program and makes an appropriation for this program.

26-4-302, C.R.S. (2005): Home and Community-Based services, intermediate care facilities for the mentally retarded, case management, therapies under home health services, private duty nursing services, hospice care, and the Program of All-inclusive Care for the Elderly are optional services.

26-4-509, C.R.S (2005): Establishes the children's Home and Community-Based Services program.

26-4-522, C.R.S. (2005): Establishes the single entry point system enabling persons eighteen years of age or older in need of long-term care to access appropriate long-term care services.

26-4-527 (1), C.R.S. (2005): Authorizes the Department, in cooperation with the Department of Human Services, to implement a program concerning residential child health care to Medicaid eligible children.

26-4-602, C.R.S. (2005): Authorizes the Department to provide, under a federal waiver of statutory requirements, for an array of home- and community-based services to eligible elderly, blind, and disabled individuals as an alternative to nursing facility placement.

26-4-621, C.R.S. (2005): Authorizes the Department to seek a federal waiver to provide home and community-based service for persons with developmental disabilities.

26-4-124, C.R.S (2005): Authorizes the Department to develop Program of All-Inclusive Care for the Elderly (PACE) sites.

26-4-624, C.R.S. (2005): Authorizes the Department and the Department of Human Services to establish a system of reimbursement for home and community-based services for persons with developmental disabilities and to utilize state and federal Medicaid funds.

26-4-641, C.R.S. (2005): Authorizes the Department to establish a program to provide home and community-based services for persons with acquired immunodeficiency syndrome.

26-4-676, C.R.S. (2005): Authorizes the Department to establish a program to provide home and community-based services to persons with major mental illness.

26-4-682, C.R.S. (2005): Authorizes the Department establish a program to provide home and community-based services to persons with brain injuries.

26-4-691, C.R.S. (2005): Authorizes the Department establish a program to provide home and community-based services to children with autism.

Program Description

State Plan Benefits in Long-term Care

All long-term care services for Medicaid clients that are not provided in a nursing facility or hospital are called "community-based services". These services are provided in clients' homes, as well as in other types of residential care settings such as assisted living facilities. Services for these clients include skilled services available to all Medicaid clients as part of the Medicaid State Plan, such as home health care, private duty nursing, and hospice care.

Home and Community Based Services Waivers

The Department has obtained waivers from the Centers for Medicare and Medicaid Services to provide services for special populations that are in addition to the services allowed in the Medicaid State Plan. Through these waivers the Department provides services such as personal care, homemaker, home modifications, electronic monitoring, adult day care, alternate care facility, non-medical transportation, and Supported Living services. Additionally, skilled services such as mental health counseling and occupational, physical, and speech therapies are provided beyond the limits set in the State Plan. The Section is directly responsible for the administration of seven Home and Community Based Services (HCBS) waiver programs: the Waiver for persons with Brain Injury, the Waiver for persons with Mental Illness, the Waiver for Persons Living With AIDS, the Waiver for the Elderly, Blind and Disabled, the Children's Waiver, the Waiver for Children with Autism, and the Children's Pediatric Hospice Waiver. Administration includes: determining client appropriateness for services, benefit development, rate setting, provider certification, quality control, and utilization review.

PACE

The Section has responsibility for contractual oversight of the Program of All-Inclusive Care for the Elderly (PACE). The program serves individuals who are aged 55 or older, certified to be in need of nursing home level of care, able to live safely in the community at the time of enrollment, and who live in a PACE service area. Services include all medical care, adult day care, nursing care, physical, occupational and recreational therapies, meals, nutritional counseling, social work, personal care, home health care, prescription drugs, audiology, dentistry, optometry, podiatry, speech therapy, respite care, hospital, nursing home, and hospice care. PACE is funded as a capitated Medicaid and Medicare program which creates an incentive for providers to prevent institutionalization of participants and help them to live successfully in their communities.

Single Entry Point Agencies

The Department contracts with twenty-five regional Single Entry Point agencies for the assessment and case management of long-term care clients living in the community. These agencies administer level-of-care needs assessment for community based and nursing home clients, assess community clients for waiver placement, develop individual community client care plans, process community clients' prior authorization requests, and provide utilization review for community based and nursing facility clients.

Interagency Agreements

The Department contracts with the Department of Public Health and Environment, Health Facilities Division to survey alternative care facilities, home health agencies and personal care agencies as well as a sample of psychiatric residential treatment facilities. The Department contracts with the Department of Human Services to administer four Home and Community Based Services waivers for adults and children with developmental disabilities: the Waiver for persons with Developmental Disability, the Supported Living Services waiver, the Children's Extensive Support Waiver, and the Children's Habilitative Residential Program. In addition, the Department contracts with the Department of Human Services to administer two Medicaid State Plan Benefits: residential treatment and targeted case management for person with developmental disabilities.

FY 06-07 Prioritized Objectives and Performance Measures
1.1 To maximize the opportunity to maintain health care services through the purchase of services in the most cost-effective manner possible.
The Community Based Long Term Care Division 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) for Persons with Brain Injury Waiver program by December 31, 2006.

1.3 To assure payments in support of the programs are accurate and timely.
Long Term Benefits will implement a process to have 90% of the prior authorization requests electronically submitted directly to the fiscal agent from providers and/or contracted utilization review agencies by December 31, 2006. This is a continuation of FY 05-06 Performance Measure 1.3.
1.4 To assure delivery of appropriate, high quality care. To design programs that result in improved health status for clients served and to improve health outcomes. To ensure that the Department's programs are responsive to the service needs of enrolled clients in a cost-effective manner.
The 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.

Similar or Cooperating Programs and Stakeholders

Home health and hospice care are also benefits of Medicare and some private insurance plans. Many community-based elderly and disabled clients (Medicaid and non-Medicaid) receive substantial unpaid care from family, friends, and non-profit organizations. Medicaid pays for home modifications for waiver clients, but when the lifetime benefit has been exhausted, the Homebuilder's Foundation of Metro Denver has provided additional modifications, when needed.

Stakeholders include:

- Clients and their families who require accessible quality care in order to live as independently as possible.
- Medicaid participating providers who require accurate, timely claims reimbursement to enable them to provide quality care.
- Single Entry Point agencies that require adequate reimbursement and training to enable them to properly assess and manage community based clients in a cost effective manner.
- County Departments of Human Service who make eligibility determination for Medicaid clients.
- Advocacy groups for the clients served by community based services.

PROGRAM CROSSWALK

Summary Section

Program Title: Nursing Facilities Section

Change Request(s): Periodic Nursing Facilities Appraisals Contract

Long Bill Line Item
(1) Executive Director's Office
Personal Services
Health, Life and Dental
Short-term Disability
S.B. 04-257 Amortization Equalization Disbursement
Salary Survey and Senior Executive Service
Workers' Compensation
Operating Expenses
Legal Services and Third Party Recovery Legal Services for 12,684 hours
Administrative Law Judge Services
Payment to Risk Management and Property Funds
Capitol Complex Leased Space
Nursing Home Preadmission and Resident Assessments
Nursing Home Quality Assessments
(2) Medical Services Premiums

Federal/State Statutory and Other Authority

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

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

26-4-410, C.R.S. (2005): Requires the Department to set rates for nursing facilities and intermediate care facilities for the mentally retarded.

26-4-501 through 26-4-505, C.R.S. (2005): Instructs the Department on how to set nursing facility rates.

Program Description

The Nursing Facilities Section is responsible for financial, contractual, and policy development for the Colorado Medicaid Nursing Facility and Alternative Care Facility Programs. Specifically, the Nursing Facilities Section is responsible for the setting of reimbursement rates for providers that conform with statutory methodology, and ensuring that provider performance is evaluated for: appropriate access to services, compliance with federal and state law, judicious use of State resources, and accountability among providers for the delivery of services to Medicaid clients.

Nursing Facilities Section functions include:

- Implementing nursing facility, alternative care facility, and intermediate care facilities for the mentally retarded rates;
- Responding to facility rate informal reconsiderations and appeals, and representing the Department as subject experts in litigation;
- Administering rate adjustments and cost settlements as relates to provider rate appeals;
- Researching and administering provider billing reconciliations;
- Administering contracts for facility audits, appraisals, and surveys;
- Monitoring facility change-of-ownership processes to ensure that the new owners are financially viable and can meet Medicaid quality standards and administrative procedures;
- Monitoring the Pre-Admission Screening and Annual Resident Review process;
- Administering the Medicaid bed certification procedures;
- Administering the Hospital Level of Care Program; and
- Administering the Post-Eligibility Treatment of Income (PETI) program.

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

The Department contracts with two types of nursing facilities: Class 1 skilled nursing facilities, and Class 2 / Class 4 intermediate care facilities for the mentally retarded (there were 196 and 3 facilities, respectively for Class 1 and Class 2 / Class 4 facilities as of July 1, 2005). For each class, the Department establishes a maximum reasonable payment for three categories of cost: direct health care costs (nursing, therapy, social services, activities, food, medical supplies, etc.), administrative and general costs, and fair rental allowance for capital-related assets (physical plant costs).

The Nursing Facilities Section implements rates and monitors the performance of approximately 200 skilled nursing facilities and approximately 275 alternative care facilities. These providers deliver services to approximately 15,000 Medicaid clients at any given time. During FY 04-05, the Department accomplished several policy and operational objectives, including implementation of rule re-writes to clarify, enhance, and assure the appropriateness of the Hospital Back Up Level of Care program and the Nursing Facilities reimbursement process.

FY 06-07 Prioritized Objectives and Performance Measures

1.6 To work towards systematic improvement in the Department's operations to expand efficiencies, minimize waste, ensure coordination, and eliminate discrepancies.
The Nursing Facilities Section will work with providers on 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 purposed reimbursement methodology, the Department will work with providers to develop new Volume 8 rules before the end of the fiscal year.
3.1 To improve customer satisfaction with programs, services, and care.
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.

Similar or Cooperating Programs and Stakeholders

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

PROGRAM CROSSWALK

Summary Section

Program Title: Benefits Coordination Section

Change Request(s): None

Long Bill Line Item
(1) Executive Director's Office
Personal Services
Health, Life and Dental
Short-term Disability
S.B. 04-257 Amortization Equalization Disbursement
Salary Survey and Senior Executive Service
Workers' Compensation
Operating Expenses
Legal Services and Third Party Recovery Legal Services for 12,684 hours
Administrative Law Judge Services
Purchases of Services from Computer Center
Payment to Risk Management and Property Funds
Capitol Complex Leased Space
Estate Recovery
(2) Medical Services Premiums

Federal/State Statutory and Other Authority

26-4-403, C.R.S. (2005): Recoveries - overpayments - penalties - interest - adjustments - liens: Requires the Department to recover medical assistance benefits paid on behalf of recipients from liable third parties.

26-4-403.3, C.R.S. (2005): Estate Recovery: Requires the Department to recover the cost of medical assistance paid on behalf of recipients from the estates of recipients.

26-4-518.5, C.R.S. (2005): Purchase of health insurance for recipients: Requires the Department to purchase group health insurance for a medical assistance recipient who is eligible to enroll for such coverage if enrollment of such recipient in the group plan would be cost-effective.

26-4-506.5, C.R.S. (2005): Requires the Department to review trusts created for the purpose of obtaining Medicaid eligibility to ensure compliance with state and federal law.

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

Program Description

Benefits Coordination exists to determine whether or not there is another payer who has liability for part or all of the costs of purchasing care on behalf of Medicaid beneficiaries and to reduce Medicaid costs by purchasing health insurance for qualified clients. The Section's Medicaid Eligibility Quality Control (MEQC) unit assesses eligibility determinations to assure accuracy and avoid misspent Medicaid dollars.

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

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

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

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

Cost Avoidance Resulting from Payment by Non-Medicaid Health Care Sources

In FY 04-05, approximately 4,583 clients were known at any given time to have other sources of health coverage, not including Medicare. When reported, this coverage was verified and loaded into a resource file that the fiscal agent utilized to set denial edits on billed claims, which without third party payment information, would have resulted in Medicaid being billed as the primary payer. These cost avoidance activities saved Colorado over $14.97 million in FY 04-05.

Cost Avoidance Resulting from Medicare and Health Insurance Buy-In Program

To reduce Medicaid costs, the State pays monthly premiums to "buy in" Medicaid clients into Medicare or private health insurance plans. The cost of the premiums is much less than the cost of claims the State would have to pay for health services rendered under Medicaid. During FY 04-05, approximately 61,541 Medicaid clients per month had Medicare Part B coverage purchased by the State, an increase of 2,307 in Part B "buy-in" clients over FY 03-04. A total of $57,156,359 in Medicare Part B premiums was paid under the buy-in program. Medicaid saved an estimated $242,691,503 in FY 04-05 for health care payments through this purchased coverage. A total of $1,293,395 in Medicare Part A premiums was paid under the buy-in program for an average of 308 clients per month. The Department saved an estimated $135,381,174 in health care expenditures via this cost avoidance action in FY 04-05.

The Health Insurance Buy-in program, paying cost-effective premiums for commercial insurance, paid $454,560 in FY 04-05, for a monthly average of 358 Medicaid clients. The total cost avoidance associated with the health insurance buy-in program for FY 04-05 is estimated at $1,312,140, for a net savings of $857,580.

Tort/Casualty Recovery

The Medicaid program attempts to recover payments made from third parties who are liable as insurers in the case of auto, accident, homeowner's policies, workers' compensation, or through tort litigation. Benefits Coordination staff manage these recovery activities; however, often there is a need for coordination with the Attorney General's staff in particularly difficult legal cases where there is malpractice litigation. As a result, the program recovered $2,869,042 in FY 04-05.

A contingency fee contract was awarded in FY 04-05 to pursue tort recoveries previously unknown to the Department, as well as assume the responsibility for the non-reported workers' compensation cases that are listed on a quarterly report. This contract recovered the net amount of $203,380 in FY 04-05.

Trust Recovery

Income and disability qualifying trusts provide a mechanism for individuals, whose incomes and/or assets would otherwise make them ineligible, to qualify for Medicaid. For income trusts, the client's income, minus a small personal needs amount, is placed in a trust. Disability trusts are created from settlement agreements that provide an income source for the client for non-Medicaid services. The Medicaid program pays for the client's medical care and is the beneficiary of the trust monies when the trust is closed. In FY 04-05, $1,766,756 was recovered. The Benefits Coordination Section administers the approval, closing, and accounting for these trusts.

Estate Recovery

The Estate Recovery program, operated by a contractor under supervision of State staff, recovers funds from estates and places Tax Equity and Financial Responsibility Act of 1992 liens on real property held by Medicaid clients in nursing facilities. The total net estate recoveries for FY 04-05 were $4,918,434.

Retractions/Recoveries:

The State contracts with a contingency-based contractor, to identify recovery opportunities through the use of expanded data matches. The State retracts the value of Medicaid-paid claims if a third party is later identified as a primary payer. This contract recouped a net amount of $8,393,451 in FY 04-05.

Recoveries by Program Areas

Summary of Third Party Cost Avoidance and Post-Payment Recovery	
Program	**FY 04-05**
Cost Avoidance	
Payment by Non-Medicaid Health Care Sources	$14,970,000
Medicare Buy-In	$378,072,677
Private Health Insurance Buy-In	$1,312,140
Subtotal, Cost Avoidance	**$394,354,817**
Cost Recovery	
Tort/Casualty Recovery	$2,869,042
Estate Recovery	$4,918,434
Income Trust Recovery	$1,766,756
Subtotal, Cost Recovery	**$9,554,232**
Contractor Recoveries	
Family Planning Federal Financial Participation - Repayment to CMS for disallowance	($971,669)
Medicare Part A retractions	$2,913,669
Medicare Part B payments	$186,892
Commercial Insurance Payments	$4,919,743
Other Recoveries (includes adjustments for refunds)	$1,344,816
Tort/Casualty Recovery	$203,380
Subtotal, Contractor Recovery	**$8,596,831**
Total Avoided And Recovered Costs	**$412,505,880**

FY 06-07 Prioritized Objectives and Performance Measures

1.2 To support timely and accurate client eligibility determination.
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.
2.1 To expand areas of potential financial recovery such as third party insurance (that should be a primary payer) and cases of fraud and abuse.
The 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.

Similar or Cooperating Programs and Stakeholders

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

PROGRAM CROSSWALK

Summary Section

Program Title: Eligibility Policy Unit

Change Request(s): None

Long Bill Line Item
(1) Executive Director's Office
Personal Services
Health, Life and Dental
Short-term Disability
S.B. 04-257 Amortization Equalization Disbursement
Salary Survey and Senior Executive Service
Workers' Compensation
Operating Expenses
Legal Services and Third Party Recovery Legal Services for 12,684 hours
Administrative Law Judge Services
Purchases of Services from Computer Center
Payment to Risk Management and Property Funds
Capitol Complex Leased Space
Commercial Leased Space
(6) Department of Human Services Medicaid-Funded Programs
(B) Office of information Technology Services-Medicaid Funding, Colorado Benefits Management System
(D) County Administration – Medicaid Funding, County Administration

Federal/State Statutory and Other Authority

26-4-106, C.R.S. (2005): Provides the Department, county departments and medical assistance sites may accept applications for, and determine eligibility for medical assistance.

26-4-104, C.R.S. (2005): *Requires the Department to establish a medical assistance program in compliance with federal law.*

Program Description

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

- An eligibility process that applies eligibility policy fairly across the State;
- All county departments of social services/human services receive sufficient information and training to properly determine Medicaid eligibility promptly and accurately; and
- That the Eligibility Operations Section has the most accurate policy information to ensure that the Colorado Benefits Management System accurately and fully reflects all Medicaid eligibility rules in an integrated eligibility determination system.

Trends and Other Baseline Information

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

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

Determining Medicaid Eligibility

An individual obtains Medicaid coverage by meeting the eligibility criteria under a particular Medicaid category. The Eligibility Policy Unit develops eligibility policy and administers eligibility functions through contracts with other agencies. A Colorado resident submits an application to their county departments of social services or to a medical assistance site, which will then determine the applicants Medicaid eligibility based on the information provided.

Development of Client Information and Staff Training Tools

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

FY 06-07 Prioritized Objectives and Performance Measures

1.2 To support timely and accurate client eligibility determination.

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.

Similar or Cooperating Programs and Stakeholders

The federal Centers for Medicare and Medicaid Services administer the federal Medicare program, which provides a range of health care benefits to elders and some disabled individuals. The Children's Basic Health Plan also provides medical coverage through State selected vendor to children up to 200% of poverty who are not Medicaid eligible. This Unit also works closely with counties and the Department of Human Services in eligibility functions.

Operations and Finance Office

Information Technology Division
Information Technology Contracts and Monitoring Section
Eligibility Systems Section
Information Technology Support Section
Claims System Section

Safety Net Financing Section

Eligibility Operations Section

Controller Division
Human Resources Section
Accounting Section
Contracts and Purchasing Section

Budget Division

PROGRAM CROSSWALK

Summary Section

Program Title: Information Technology Contracts and Monitoring Section and Claims System Section

Change Request(s): Fiscal Agent Reduction in Federal Funds
MMIS Federally-Mandated Reprocurement
HIPAA National Provider Identifier Assessment and Implementation in MMIS
Address Outstanding Audit Recommendations Related to Prescription Drugs within MMIS
Reduce Funding for Medical Identification Cards

Long Bill Line Item
(1) Executive Director's Office
Personal Services
Health, Life and Dental
Short-term Disability
S.B. 04-257 Amortization Equalization Disbursement
Salary Survey and Senior Executive Service
Workers' Compensation
Operating Expenses
Legal Services and Third Party Recovery Legal Services for 12,684 hours
Administrative Law Judge Services
Purchases of Services from Computer Center
Payment to Risk Management and Property Funds
Capitol Complex Leased Space
Medicaid Management Information System Contract
Medicaid Management Information System Reprocurement
Health Insurance Portability and Accountability Act of 1996 (HIPAA) Web Portal Maintenance
Medicaid Identification Cards

Federal/State Statutory and Other Authority

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

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

26-4-403.7, C.R.S. (2005): *Automated medical assistance administration.*
(1) The general assembly hereby finds and declares that the agency responsible for the administration of the state's medical assistance program would be more effective in its ability to streamline administrative functions of program administrators and providers under the program through the implementation of an automated system that will provide for the following: (a) Electronic claim submittals; (b) On-line eligibility determinations; (c) Electronic remittance statements; (d) Electronic fund transfers; and (e) Automation of other administrative functions associated with the medical assistance program.

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

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

Program Description

The mission of the Information Technology Contracts and Monitoring Section as well as the Claims System Sections is to ensure client access to medical services by assuring timely and accurate reimbursement to Medicaid and Child Health Plan Plus providers; timely access to medical eligibility data by service providers; and reimbursement compliance with all aspects of State and federal regulations by implementing the policies governing the administration of Medicaid and the Child Health Plan Plus Office dollars within computerized systems.

The mission of the Claims System Section is to oversee the technical administration of the Medicaid Management Information System. This system receives eligibility information from the Colorado Benefits Management System. The information system

processes claims and submits payment requests to the Colorado Financial Reporting System for actual warrants or electronic funds transfers. In addition to the Medicaid Management Information System, the Section also manages the Medicaid Management Information System Decision Support System that provides the data and analysis tools to research and manage Medicaid and the Child Health Plan Plus Office programs. Enhancements to the system are developed with policy and the fiscal agent and are implemented after State approval.

The mission of the Information Technology Contracts and Monitoring Section is to assure compliance with State and federal regulations which affect Medicaid Management Information System operations and contracts associated with claims processing. These activities include timely submission of Advance Planning Documents to the Centers for Medicare and Medicaid Services, timely execution of contracts, monitoring of legislation that may impact systems, and operational changes at the fiscal agent. In addition, this section is responsible for other information technology contracts and the implementation of Health Insurance Portability and Accountability Act (HIPAA) regulations.

The Information Systems and the Information Technology Contracts and Monitoring Sections direct the implementation and support of the fiscal agent contract for Medicaid Management Information System services. Medicaid is the primary payment source for health care services for over 400,000 of Colorado's low-income citizens each month. The Child Health Plan Plus Office covers services for about 35,000 children and pregnant women each month.

Contract Management and Budget Development and Administration

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

Major Accomplishments

Major accomplishments over the last year include incorporating the payment of capitations for the Children's Basic Health Plan into the Medicaid Management Information System and bringing eligibility information from the Colorado Benefit Management System into the Medicaid Management Information System. Working with providers to assure continuity of services while the systems were upgraded to accurately reflect the client's eligibility was of prime importance in this last year. The Claims System Section has been involved in assuring data from Colorado Benefit Management System correctly transfers to the Medicaid Management Information System.

The following are additional accomplishments for FY 04-05:

- System changes done to receive managed care encounter claim submissions. Managed care plans continue to test their ability to transmit error free claims files.
- Added Children's Basic Health Plan to eligibility verification messages so that providers will know if a child is covered by Medicaid or Children's Basic Health Plan.
- Several updates to the Pharmacy system to add drugs, to add prior authorization, and to limit distribution to the approved unit dose.
- Upgraded the billing processes for physical and occupational therapies.
- Extensive upgrades to the edits to prevent duplicate payments were done in May 2005.
- Enhanced system to send reports to the File and Report Server, the outbound file delivery system of the Web Portal.
- Updated federal reporting for seven of the Home and Community Based Services programs.
- Installed Diagnostic Related Groupings (DRG) version 22 to assure inpatient hospital claims pay the appropriate rates.
- Added email address capability for communications to providers.
- Switched all Mental Health Assessment and Service Agency records to Behavioral Health Organization contract records in December 2004.
- Allow audiologists to bill directly for services under the Colorado Home Intervention Program.
- Updated edits to limit acute care home health services.
- Completed development of the web portal applications to replace WINASAP for interactive billing.
- Implemented a special operational unit to manage and monitor the activities of the fiscal agent.

In FY 04-05, the fiscal agent processed 18,914,683 claims, 5.7% more than the previous fiscal year. These claims amounted to $2,494,219,600 processed through the Medicaid Management Information System, 6.13% higher than in FY 03-04. It should be noted that not all payments or adjustments to expenditures are recorded through the Medicaid Management Information System and

therefore this figure is for comparison purposes only. Caseload growth and declining enrollment in health maintenance organizations are the primary causes for the increase in claim counts.

FY 06-07 Prioritized Objectives and Performance Measures

1.2 To support timely and accurate client eligibility determination.
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.
1.3 To assure payments in support of the programs are accurate and timely.
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.
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.
Information Technology Division will explore new mediums for provider communication to facilitate timely communication of changes, issues, and impacts to providers.

Similar or Cooperating Programs and Stakeholders

Other states operate Medicaid Management Information Systems and eligibility systems, but there are no other systems in Colorado that provide similar functionality for Medicaid or Child Health Plan Plus clients.

The following is a list of some of the departments and major stakeholders involved in successful implementation of the federal rules and State laws related to the claims payment systems:

Governor's Office of State Planning and Budgeting
Governor's Office of Innovation and Technology
Colorado Department of Human Services
Centers for Medicare and Medicaid Services
All clients, health plans and providers, and certain business associates participating in the Colorado Medicaid or Child Health Plan Plus Office programs whose continuity of services depends on timely and effectively implementation
Health Care Providers and Managed Care Organizations (medical, behavioral, and dental care)

PROGRAM CROSSWALK

Summary Section

Program Title: Eligibility Systems Section

Change Request(s): None

Long Bill Line Item
(1) Executive Director's Office
Personal Services
Health, Life and Dental
Short-term Disability
S.B. 04-257 Amortization Equalization Disbursement
Salary Survey and Senior Executive Service
Workers' Compensation
Operating Expenses
Legal Services and Third Party Recovery Legal Services for 12,684 hours
Administrative Law Judge Services
Purchases of Services from Computer Center
Payment to Risk Management and Property Funds
Capitol Complex Leased Space
Medicare Modernization Act of 2003, Colorado Benefits Management System Development Costs
(6) Department of Human Services Medicaid-Funded Programs
Office of Information Technology Services-Medicaid Funding, Colorado Benefits Management System

Federal/State Statutory and Other Authority

26-4-106 (1) (a) (2005): *Determination of eligibility for medical benefits shall be made by the county department in which the applicant resides, except as otherwise specified in this section. Local social security offices also determine eligibility for Medicaid benefits at the same time they determine eligibility for supplemental security income. The state department may accept medical assistance applications and determine medical assistance eligibility and may designate the private contractor that administers the*

Child Health Plan Plus, Denver health and hospitals, and a hospital that is designated as a regional pediatric trauma center, as defined in section 25-3.5-703 (4) (f) (2005), C.R.S., to accept medical assistance applications and to determine medical assistance eligibility. Any person who is determined to be eligible pursuant to the requirements of this article shall be eligible for benefits until such person is determined to be ineligible. Upon determination that any person is ineligible for medical benefits, the county department, the state department, or other entity designated by the state department shall notify the applicant in writing of its decision and the reason therefore. Separate determination of eligibility and formal application for benefits under this article for persons eligible as provided in sections 26-4-201 and 26-4-301 shall be made in accordance with the rules of the state department.

Program Description

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

The Colorado Benefits Management system is a joint system implemented by the following:

- Colorado Department of Human Services;
- Colorado Department of Health Care Policy and Financing;
- County Departments of Social Services (64 counties); and,
- Non-county Medical Assistance sites.

The Colorado Benefits Management System streamlines eligibility determination in the counties and in non-county Medical Assistance sites, consolidating and replacing existing systems. The System replaced the following "stove-piped" series of systems with a single, integrated system built upon a shared infrastructure:

- Client Oriented Information Network;
- Colorado Automated Food Stamp System;
- Child Health Plan Plus;
- Colorado Automated Client Tracking Information System;
- Colorado Employment First; and,
- Adult Family and Children System.

The Section performs operations and maintenance tasks, including the following:

- Requests for programming changes to support legislative and policy changes;
- Coordinates changes to rules-based decision tables that implement eligibility rules in the system;
- Coordinates the maintenance and support of the Colorado Benefits Management System Decision Support System;
- Works with departmental staff to clarify business needs and development requirements for change;
- Develops requests for programming changes to support legislative and program rule changes;
- Coordinates issue resolution related to policy clarification;
- Assures quality data is being created and maintained by the Office of Colorado Benefits Management System;
- Works with all department staff in assuring the appropriate reporting needs are being met;
- Coordinates changes to rule-based decision tables that implement the Department's medical eligibility rule within the system;
- Works with the Department of Human Services to resolve cross agency policy and operational issues;
- Assumes interfaces are operating appropriately.; and,
- Coordinates automated and ad-hoc reporting from the Colorado Benefits Management System decision support system in meeting the Department needs.

FY 06-07 Prioritized Objectives and Performance Measures

1.2 To support timely and accurate client eligibility determination.
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.
2.2 Improve management of the Department's information systems technology.
The Division will focus ongoing efforts to centralize the information systems used by the agency, to improve the security and management of vast amounts of client data used by the Department.

Similar or Cooperating Programs and Stakeholders

The General Assembly
Governor's Office of Innovation and Technology
Governor's Office of Colorado Benefits Management System
Colorado Department of Human Services
Colorado Department of Health Care Policy and Financing
Colorado Social Services Directors Association

County departments of social services
Non-county Medical Application sites
Federal government

PROGRAM CROSSWALK

Summary Section

Program Title: Information Technology Support Section

Change Request(s): None

Long Bill Line Item
(1) Executive Director's Office
Personal Services
Health, Life and Dental
Short-term Disability
S.B. 04-257 Amortization Equalization Disbursement
Salary Survey and Senior Executive Service
Workers' Compensation
Operating Expenses
Legal Services and Third Party Recovery Legal Services for 12,684 hours
Administrative Law Judge Services
Purchases of Services for Computer Center
Payment to Risk Management and Property Funds
Capitol Complex Leased Space
Health Insurance Portability and Accountability Act of 1996 (HIPAA) Web Portal Maintenance

Federal/State Statutory and Other Authority

25.5-1-104 (3), C.R.S. (2005) (3): *The executive director may establish such divisions, sections, and other units within the state department as are necessary for the proper and efficient discharge of the powers, duties, and functions of the state department.*

Program Description

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

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

Major accomplishments for the Section include:

- Upgraded all user workstations to the Windows XP operating system to provide better user functionality and systems security;
- Continued maintenance and enhancement of the Department's web site;
- Implemented Windows system policy based security on Department LAN users;
- Provided infrastructure support to both the Department's Colorado Benefits Management System and web portal efforts;
- Reviewed and modified Department networks systems to support HIPAA security compliance; and
- Monitored and responded to increased security needs to assure the Department remained unaffected by external attacks.

FY 06-07 Prioritized Objectives and Performance Measures

2.2 Improve management of the Department's information systems technology.

The Division will focus ongoing efforts to centralize the information systems used by the agency, to improve the security and management of vast amounts of client data used by the Department.

Similar or Cooperating Programs and Stakeholders

The Information Technology Support Section coordinates with the Governor's Office of Innovation and Technology. The Office of Innovation and Technology initiates many statewide departmental policies, standards, and guidelines that are the responsibilities of the

individual departments to either implement, document, or enforce. For many of these initiatives from the Office of Innovation and Technology, the responsibility for execution within the Department rests on the Information Technology Support Section.

PROGRAM CROSSWALK

Summary Section

Program Title: Safety Net Financing Section

Change Request(s): Adjust Cash Funds Exempt in Medical Services Premiums Upper Payment Limit; Denver Health Medical Center Medicaid Outstationing Alternative Financing Plan

Long Bill Line Item
(1) Executive Director's Office
Personal Services
Health, Life and Dental
Short-term Disability
S.B. 04-257 Amortization Equalization Disbursement
Salary Survey and Senior Executive Service
Workers' Compensation
Operating Expenses
Legal Services and Third Party Recovery Legal Services for 12,684 hours
Administrative Law Judge Services
Purchases of Services from Computer Center
Payment to Risk Management and Property Funds
Capitol Complex Leased Space
(2) Medical Services Premiums
(4) Indigent Care Program
Safety Net Provider Payments
Pediatric Specialty Hospital
The Children's Hospital Clinic Based Indigent Care
Comprehensive Primary and Preventive Care Fund
Comprehensive Primary and Preventive Grants Program
Comprehensive Primary Care Program

(5) Other Medical Services
Old Age Pension State Medical Program
Home Care Allowance
Adult Foster Care
University of Colorado Family Medicine Residency Training Programs

Federal/State Statutory and Other Authority

26-15-101, C.R.S. (2005), et seq.: Reform Act for the Provision of Health Care for the Medically Indigent.

26-4-1001, C.R.S. (2005), et seq.: Comprehensive Primary and Preventive Care Grant Program Act.

Article XXIV of the Colorado Constitution and 26-2-117, C.R.S. (2005): Establishment of the Old Age Pension Health and Medical Care Fund and Supplemental Old Age Pension Health and Medical Care Fund.

26-2-122.3, C.R.S (2005), et seq.: Establishment of the Adult Foster Care and Home Care Allowance Programs.

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

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

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

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

Program Description

Colorado Indigent Care Program

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

The program has been known by several names: the Medically Indigent Program, the Colorado Resident Discount Program, and the Colorado Indigent Care Program. This program primarily compensates providers that have contracted with the program to provide health care services to persons with income and assets at or below 185% of the federal poverty level. The program directly contracts with hospitals and community health clinics. Providers are required to provide on-site eligibility and co-payment determination. The services offered to clients under this program vary from clinic to clinic and from hospital to hospital. The Colorado Indigent Care Program is not an insurance program but rather a financial vehicle for providers to recoup their medical costs at a discount. By statute, Colorado Indigent Care Program providers are required to prioritize care in the following order:

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

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

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

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

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

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

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

Medicare Upper Payment Limit for Inpatient Hospital Services: Under current Centers for Medicare and Medicaid Services regulations, Medicaid is allowed to reimburse hospital providers for inpatient Medicaid services up to an estimated limit and still

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

Comprehensive Primary and Preventive Care Grant Program

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

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

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

In FY 04-05, grants were awarded in the amount of $2,244,900 to the following facilities:

Provider	Amount
Catholic Health Initiative, St. Mary-Corwin Foundation	$150,000
Colorado Coalition for the Homeless	$400,000
High Plains Community Health Center	$91,127
Inner City Health Center	$290,170
Marillac Clinic	$617,898
Metro Community Provider Network	$150,000
Mountain Family Health Centers	$245,705

Provider	Amount
Plan De Salud del Valle	$150,000
Pueblo Community Health Center	$150,000

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

Old Age Pension State Medical Program

The Old Age Pension State Medical Program Long Bill line item, also known as the Old Age Pension Health and Medical Care Program, provides limited medical care for non-Medicaid individuals receiving Old Age Pension grants. The Old Age Pension State Medical Program provides limited medical care for individuals receiving Old Age Pension grants. Those eligible for this program are over age 60, but may not meet Supplemental Security Income criteria or residence requirements, and are therefore ineligible for Medicaid. This population could be disabled to some degree, but not sufficiently to qualify for Supplemental Security Income. This program is funded with 100% State funds and is not an entitlement. Accordingly, the appropriation cannot be exceeded.

Pursuant to SB 03-022, on July 1, 2003 the Department of Health Care Policy and Financing became responsible for the administration of the Old Age Pension State Medical Program and Supplemental Old Age Pension Health and Medical Care Fund. The Old Age Pension State Medical Program was established through Article XXIV of the Colorado Constitution and 26-2-117(2) C.R.S. to provide a health and medical care program to persons who are not eligible for Medicaid, who qualify to receive Old Age Pensions, and who are not patients in an institution for tuberculosis or mental diseases. To provide additional resources, HB 02-1276 established the Supplemental Old Age Pension Health and Medical Care Fund. Together, these two funds provide necessary medical services under the Old Age Pension State Medical Program, within the constraints that expenditures shall not exceed appropriations by the General Assembly. In FY 05-06, appropriations for the Old Age Pension Health and Medical Care Fund and the Supplemental Old Age Pension Health and Medical Care Fund are $10,000,000 and $750,000 respectively. H.B. 05-1262 annually increased funding to the Supplemental Old Age Pension Health and Medical Care Fund by approximately $943,500 for FY 2004-05, and $2,538,000 for FY 2005-06, which may be made available to the Old Age Pension State Medical Program by appropriation from the General Assembly.

Home Care Allowance and Adult Foster Care

Home Care Allowance, first authorized in 1979, is a State and county funded program, which provides direct cash payments to eligible individuals for the purchase of services related to activities of daily living that are necessary to enable the client to remain at

home and prevent more restrictive, expensive placements. Adult Foster Care, first authorized in 1977, is a non-federally funded program providing 24 hour supervised residential non-medical supervision. Services include room and board, recreational activities, supervision of medications, protective oversight, and some assistance with activities of daily living. Both of these programs contribute to the State's Maintenance of Effort agreement between the State and the Social Security Administration.

Primary Care Fund

Effective July 1, 2005, H.B. 05-1262 established the Primary Care Fund which allocates money to all qualified providers in the state who serve uninsured or medically indigent patients. The Primary Care Fund receives revenue from the cigarette and tobacco taxes imposed pursuant to Section 21 of Article X of the State Constitution. The Primary Care Fund allocates funds based on a proportionate share of uninsured or medically indigent patients served.

Financing Opportunities

One of the goals of the Safety Net Financing Section is to identify, define, develop, implement, coordinate, and promote refinancing opportunities first within the Department, and second within other State agencies. This function reviews federal and state regulations and statutes, existing financing mechanisms, and other states to identify opportunities to increase reimbursement to providers and to decrease General Fund expenditures. This function is responsible for financing calculations and the associated State Plan amendments, Medical Services Board rules changes, and payments to providers.

FY 06-07 Prioritized Objectives and Performance Measures
1.3 To assure payments in support of the programs are accurate and timely.
Quarterly payments to Colorado Indigent Care Program providers will be made according to the published schedule as supplied to the providers.
1.5 To accurately project, report, and manage budgetary requirements to effect Executive and Legislative intent with program and budget development and operations. To accurately record and monitor expenditures for programs managed by the Department so there may be accurate financial reporting at all times.
The 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.
2.4 To ensure program safeguards and controls.
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.

Similar or Cooperating Programs and Stakeholders

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

PROGRAM CROSSWALK

Summary Section

Program Title: Eligibility Operations Section

Change Request(s): Revisions to the Medicare Modernization Act Implementation

Long Bill Line Item
(1) Executive Director's Office
Personal Services
Health, Life and Dental
Short-term Disability
S.B. 04-257 Amortization Equalization Disbursement
Salary Survey and Senior Executive Service
Workers' Compensation
Operating Expenses
Legal Services and Third Party Recovery Legal Services for 12,684 hours
Administrative Law Judge Services
Purchases of Services from Computer Center
Payment to Risk Management and Property Funds
Capitol Complex Leased Space
Commercial Leased Space
Disability Determination Services
Medicare Modernization Act of 2003, Colorado Benefits Management Systems Development Costs
(6) Department of Human Services Medicaid-Funded Programs
Office of Information Technology Services-Medicaid Funding, Colorado Benefits Management System
County Administration – Medicaid Funding. County Administration

Federal/State Statutory and Other Authority

26-4-106, C.R.S. (2005): Provides the Department, county departments and medical assistance sites may accept applications for, and determine eligibility for medical assistance.

26-4-104, C.R.S. (2005): Requires the Department to establish a medical assistance program in compliance with federal law.

26-4-406.5, C.R.S. (2005): Authorizes the department to ensure the participation of Colorado Medicaid recipients, who are also eligible for Medicare, in a federal prescription drug benefit enacted for Medicare recipients. Prescribed drugs are not a covered benefit under the medical assistance program for a recipient who is enrolled in a prescription drug benefit program under Medicare, except that, if a prescribed drug is not a covered Part D drug, the prescribed drug may be a covered benefit.

Program Description

The mission of the Eligibility Operations Section is to ensure that Colorado Benefits Management System determines Medicaid and CHP+ eligibility correctly for families, children, elders, and persons with disabilities. The Section provides policy interpretation and program expertise on Medicaid and CHP+ eligibility for all categories for the rules-based eligibility computer system, the Colorado Benefits Management System. Specifically, the Section is focused on assuring:

- An eligibility process that is efficient, accurate, and timely;
- All county departments of social services receive sufficient information and system training to properly determine Medicaid eligibility promptly and accurately; and
- That the Colorado Benefits Management System accurately and fully reflects all Medicaid and CHP+ eligibility rules in an integrated eligibility determination system.

The Section receives revised policy information around medical assistance eligibility and implements the revisions or new policy rules into CBMS. The central charges to the Section related to this role are to:

- Define and implement eligibility processes for Colorado Medicaid and Child Health Plan Plus Office programs in the Colorado Benefits Management System;
- Implement the Medicare Modernization Act as it relates to the Medicare Prescription Drug Benefit;
- Resolve client issues related to medical emergencies affected by CBMS;
- Investigate case-specific issues to identify and resolve issues in CMBS; and,
- Problem solve program-related Help Desk Tickets, Decision Table issues, and cases exceeding processing guidelines.

An individual obtains Medicaid or CHP+ coverage by meeting the eligibility criteria under a particular Medicaid or CHP+ category. The Eligibility Operations Section interprets and implements eligibility policy rules in CBMS and administers eligibility operations.

A Colorado resident submits an application to his/her county department of social services or to a medical assistance site. Colorado Benefits Management System then determines the applicants' Medicaid or CHP+ eligibility based on the information provided.

Eligibility Operations Section staff assists and provides input to material being disseminated regarding training for local agencies that carry out eligibility determination functions.

FY 06-07 Prioritized Objectives and Performance Measures

1. 2 To support timely and accurate client eligibility determination.
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.
The Eligibility Operations Section will research inaccurate eligibility determinations and recommend and administer changes to the Colorado Benefits Management System that will reduce the number of "trouble tickets" reported in FY 06-07 by counties and medical assistance sites by at least 10%.

Similar or Cooperating Programs and Stakeholders

The federal Centers for Medicare and Medicaid Services administer the federal Medicare program, which does provide a range of health care benefits to elders and some disabled individuals. The Social Security Administration will continue to provide updates and new records for clients who receive Social Security Administration or Supplemental Security Income benefits. Social Security Administration records are sent to the Colorado Benefits Management System as inbound records that either updates or creates new records in Colorado Benefits Management System and impacts applicant/client eligibility. The Child Health Plan Plus Office programs also provide medical coverage through the State selected vendor to children up to 200% of poverty who are not Medicaid eligible. This Section also works closely with counties, Office of Colorado Benefits Management System and the Department of Human Services in eligibility operations functions.

PROGRAM CROSSWALK

Summary Section

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

Change Request(s): None

Long Bill Line Item
(1) Executive Director's Office
Personal Services
Health, Life and Dental
Short-term Disability
S.B. 04-257 Amortization Equalization Disbursement
Salary Survey and Senior Executive Service
Workers' Compensation
Operating Expenses
Legal Services and Third Party Recovery Legal Services for 12,684 hours
Administrative Law Judge Services
Purchases of Services from Computer Center
Payment to Risk Management and Property Funds
Capitol Complex Leased Space
Payments to Transfer to State Auditor's Office

Federal/State Statutory and Other Authority

25.5-1-104 (2) and (3), C.R.S. (2005) (2): *"The Department of health care policy and financing shall consist of an executive director of the Department of health care policy and financing…and other units as shall be established by the executive director pursuant to the provisions of subsection (3) of this section." "(3) The executive director may establish such divisions, section, and other units...as are necessary for the proper and efficient discharge of the powers, duties, and functions of the state department..."*

26-4-110.7, C.R.S. (2005): Requires the Department to utilize the cash system of accounting following general accounting standards.

Program Description

The purpose of the Controller Division is to provide many of the internal administrative functions necessary for overall Department operations. These functions include accounting, financial reporting, procurement, contract review, and human resources. It is also the Division staff's responsibility to ensure that all of these functions are conducted in compliance with federal and/or state rules, policies and requirements. The Division is under the direction of the Department Controller, and is comprised of three separate sections: Accounting, Contracts and Purchasing, and Human Resources.

Division Major Functions:

- The Accounting Section is responsible for all financial accounting and financial control functions of the Department, and many of the critical financial reporting functions. This includes quarterly financial reports of expenditures and revenues to the federal government for the Medicaid and Child Health Plan Plus Office programs, and any other federal grant funds received by the Department. The section is responsible for conducting the financial closing processes (monthly, quarterly and annually), which are the basis for all financial reports and the financial portions of the Department's budget. It also includes accurate and timely processing of Medicaid provider and administrative payments, cash receipt processes for $1.2 billion worth of annual cash received by the Department, internal accounting and financial control systems, tax reporting through IRS forms 10999 and W2, and employee payroll processing.
- The Contracts and Purchasing Section is responsible for ensuring that all Department purchases of goods or services comply with all applicable federal and state procurement rules and policies. This includes proper solicitation, vendor selection, proper procurement forms (both purchase orders and contracts), and proper and timely approvals (both internal to the Department and external).
- The Human Resources Section is responsible for all functions necessary to properly classify Department staff positions and to fill those positions in accordance with the state constitution and the state personnel rules and procedures. This includes proper classification of positions, announcing job openings, reviewing applications, testing candidates, and referring qualified candidates to departmental appointing authorities. Human Resources staff participates in corrective action meetings, disciplinary hearings, and any appeals related to the results of those functions.

Division Accomplishments:

- In FY 04-05, the Department attained Group II purchasing delegation. This delegation allows the Department to be nearly fully independent in all procurement activities. The formal delegation is from the State Purchasing Director to the Department's

Executive Director. The Department's Executive Director has sub-delegated the authority to the Section Manager of the Contracts and Purchasing Section.

- In FY 04-05, the Department regained it delegation for Personnel functions under the Rules and Procedures of the state Board of Personnel. This delegation was lost when the previous Human Resources manager left the Department. A new manager was promoted internally, but that manager had to obtain certification from the Department of Personnel and Administration. The new Human Resources manager passed all of the required tests and became certified in 2004, which allowed the delegation to once again be obtained. The formal delegation is from the Executive Director of the Department of Personnel and Administration to the Department's Executive Director. The Department's Executive Director has sub-delegated the authority to the Section Manager of the Human Resources Section.

FY 06-07 Prioritized Objectives and Performance Measures

1.3 To assure payments in support of the programs are accurate and timely.
The Accounting Section of the Controller Division, with assistance of the Department's Information Technology Division, will work to ensure that the interface between the Department's 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.
1.5 To accurately project, report, and manage budgetary requirements to effect Executive and Legislative intent with program and budget development and operations. To accurately record and monitor expenditures for programs managed by the Department so there may be accurate financial reporting at all times.
The 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.
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.
The Contracts and Purchasing Section of the Controller and Operations Division will develop and hold at least one contract management training session for the Department's program staff responsible for managing contracts.
4.2 To develop enhanced training and retention strategies for departmental staff.
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.

Similar or Cooperating Programs and Stakeholders

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

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

PROGRAM CROSSWALK

Summary Section

Program Title: Budget Division

Change Request(s): None

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

Federal/State Statutory and Other Authority

25.5-1-104, C.R.S. (2005) (3): *"The executive director may establish such divisions, sections, and other units within the state department as are necessary for the proper and efficient discharge of the powers, duties, and functions of the state department… "*

26-4-110.7, C.R.S. (2005): Requires the Department to utilize the cash system of accounting following general accounting standards.

Program Description

The Department's budget is approximately $3.3 billion. The Budget Division's five key responsibilities are to project, construct, present, monitor, and manage the departmental budgets, acting as a conduit for the Department to the Executive and Legislative branches, translating the Department's policy needs and objectives into monetary terms.

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

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

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

FY 06-07 Prioritized Objectives and Performance Measures

1.5 To accurately project, report, and manage budgetary requirements to effect Executive and Legislative intent with program and budget development and operations. To accurately record and monitor expenditures for programs managed by the Department so there may be accurate financial reporting at all times.
The Budget Division will provide the Office of State Planning and Budgeting with all budget requests (Supplementals, Budget Amendments, Decision Items, and FY 06-07 Budget Request) by the requested due dates.
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.
The Budget Division will set up 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.
2.4 To ensure program safeguards and controls.
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.

Similar or Cooperating Programs and Stakeholders

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

Child Health Plan *Plus* Office

Program Integration and Evaluation Section
Contracts and Operations Section
Delivery Systems Section

PROGRAM CROSSWALK

Summary Section

Program Title: Child Health Plan Plus Office (includes Program Integration and Evaluation Section, Contracts and Operations Section and Delivery Systems Section)

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

Long Bill Line Item
(1) Executive Director's Office
Personal Services
Health, Life and Dental
Short-term Disability
S.B. 04-257 Amortization Equalization Disbursement
Salary Survey and Senior Executive Service
Workers' Compensation
Operating Expenses
Legal Services and Third Party Recovery Legal Services for 12,684 hours
Administrative Law Judge Services
Purchases of Services from Computer Center
Payment to Risk Management and Property Funds
Capitol Complex Leased Space
Medicaid Management Information System Contract
(4) Indigent Care Program
HB 97-1304 Children's Basic Health Plan Trust Fund
Children's Basic Health Plan Administration
Children's Basic Health Plan Premium Costs
Children's Basic Health Plan Dental Benefit Costs
(6) Department of Human Services Medicaid Funded Program
(B) Office of Information Technology Services, Colorado Benefits Management System

Federal/State Statutory and Other Authority

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

26-19-101, C.R.S. (2005) et seq. : *"This article shall be known and may be cited as the 'Child Health Plan Plus Act'."*

Program Description

The Child Health Plan Plus Office (aka The Child Health Plan Plus) is a public/private partnership providing subsidized health insurance statewide for children under age 19 in families with incomes at or below 200% of the federal poverty level who are not eligible for Medicaid. The Child Health Plan Plus Office offers a wide variety of services to children including check-ups, immunizations, doctor visits, hospital services, prescribed medications, mental health services, dental services, hearing aids, and glasses.

Families pay an annual enrollment fee of $25 for one child and $35 for two or more, along with a small co-payment for each provider visit or dental service. The enrollment fee applies to families with incomes between 151% and 200% of the federal poverty level. Families with incomes at 150% of the federal poverty level and below are not subject to the enrollment fee.

Accomplishments

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

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

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 Child Health Plan Plus Office 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.

Administration

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

Health Care Service Delivery

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

Health Maintenance Organizations: Statute requires the Child Health Plan Plus Office to enroll children in managed care organizations for their health care services. The Department has contracted with four health maintenance organizations, which are available to 84% of the eligible population. In 39 Colorado counties, enrollees receive health care services through the following health maintenance organizations: Colorado Access, Denver Health Medical Plan, Kaiser Permanente, and Rocky Mountain Health Plans. These health maintenance organizations operate under full risk contracts with the Department.

State Managed Care Network: The Department offers a managed care network by contracting directly with health care providers in counties where health maintenance organizations have been unable to offer coverage. In addition, the Child Health Plan Plus Office programs enrolled children in counties served by health maintenance organizations and can receive services through the state managed care network while they are waiting for enrollment in a health maintenance organization. The Department contracts with over 2,650 providers: 1,551 primary care physicians; 1095 specialists; 21 hospitals systems in 44 locations; and, a number of ancillary service providers, which include essential community providers, to create a state-run managed care network. Anthem Blue Cross Clue Shield manages the network.

Dental Program

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

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

Prenatal Program

Pregnant women of any age with incomes at or below 200% of the federal poverty level, who are not eligible for Medicaid, are eligible for the Children's Basic Health Plan Prenatal Program. These women receive prenatal, delivery, and post-partum medical care. There are no co-pays or enrollment fees for these clients. Enrollment into the prenatal program was temporarily suspended in May 2003 but was reinstated July 1, 2004.

Outreach

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

Enrollment and Disenrollment

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

FY 06-07 Prioritized Objectives and Performance Measures

1.1 To maximize the opportunity to maintain health care services through the purchase of services in the most cost-effective manner possible.
The 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.
1.4 To assure delivery of appropriate, high quality care. To design programs that result in improved health status for clients served and to improve health outcomes. To ensure that the Department's programs are responsive to the service needs of enrolled clients in a cost-effective manner.
The 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.
3.2 To enhance customer service, provider and eligibility personnel's understanding of program requirements, benefits, and responsibilities. To improve the usefulness of communications with clients, constituents, partners, and stakeholders.
The 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.

Similar or Cooperating Programs and Stakeholders

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