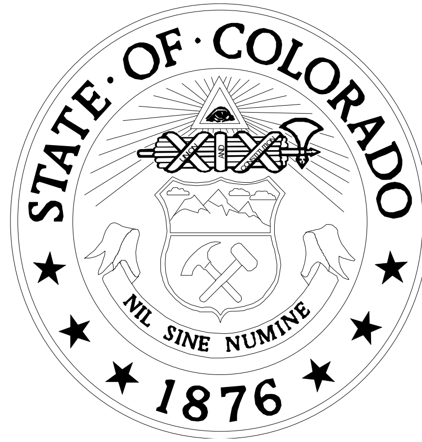

Department of Health Care Policy and Financing
Strategic Plan
FY 07-08 Budget Request

NOVEMBER 1, 2006

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DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
FY 07-08 STRATEGIC PLAN

I. INTRODUCTION

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

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

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

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

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

- The Comprehensive Primary and Preventive Care Grant Program: This program was established to provide grants to health care providers in order to expand primary and preventive care services to Colorado's low-income, uninsured residents. The program is paid through the Comprehensive Primary and Preventive Care Fund created in Section 25.5-3-207, C.R.S. (2006).

- The Primary Care Fund: This fund was created to provide an allocation of moneys to health care providers that make basic health care services available in an outpatient setting to residents of Colorado who are considered medically indigent. Allocations are based on the number of medically indigent patients that received services from a health care provider in an amount proportionate to the total number of medically indigent patients served by all health care providers who qualify for moneys from this fund. This program is funded through an increase in Colorado's tax on cigarettes and tobacco products which became effective January 1, 2005, in accordance with Section 21 of Article X (Tobacco Taxes for Health Related Purposes) of the State Constitution.

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

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

IMPORTANT NOTE:

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

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

II. STRATEGIC PLAN DIRECTION

Vision

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

Mission

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

Guiding Principles

- The Department will treat clients with respect and consideration.
- The Department will be honest in relationships with its internal and external customers.
- The Department will be focused, accountable, and efficient in accomplishing its mission.
- The Department will work to ensure access to appropriate, medically necessary health care for eligible individuals.
- The Department will purchase and finance health care in a cost-effective manner.
- The Department will evaluate success and continually search for methods to improve quality, accessibility, and cost-effectiveness.

Goals

A. The Department will operate its programs to assure that the health care the Department purchases is medically necessary, appropriate, and cost-effective.
B. The Department will continuously improve the oversight of activities delegated to agencies, counties, and contractors.
C. The Department will partner with public and private entities to maximize the resources to improve the health status of Coloradans.
D. The Department will evaluate client health and satisfaction and will model program design to promote improved health care delivery. Clients will be furnished information about quality of care and general client satisfaction so that they may make informed choices about the care they receive.
E. The Department will value its personnel through effective recruitment, hiring, training, and retention. The Department will allocate its staff and resources in ways to ensure that it addresses the organization’s priorities.
F. The Department will appropriately and effectively respond to changing requirements with the federal government, such as the Deficit Reduction Act, while considering client needs and State budgeting concerns.

III. SCHEDULE 1-PRIORITIZED OBJECTIVES

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

1.1 To maximize the opportunity to preserve health care services through the purchase of services in the most cost-effective manner possible.
1.2 To support timely and accurate client eligibility determination.
1.3 To assure payments in support of the programs are accurate and timely, and to procure an effective fiscal agent.
1.4 To assure delivery of appropriate, high quality health care. To design programs that result in improved health status for clients served and to improve health outcomes. To ensure that the Department's programs are responsive to the service needs of enrolled clients in a cost-effective manner.
1.5 To accurately project, report, and manage budgetary requirements to effect Executive and Legislative intent with program and budget development and operations. To accurately record and monitor expenditures for programs managed by the Department so there may be accurate financial reporting at all times.

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

2.1 To build and maintain a high quality, customer-focused team.
2.2 To assess the need to consolidate federally-funded health care programs within the Single State Agency.
2.3 To audit expenditures for fraud, abuse, client eligibility, and accuracy in third party payments both internally and with the use of contingency contractors.
2.4 To maintain efficient management of the Department's information systems technology.
2.5 To hold accountable the Department's administrative contractors, including other State and local agencies, through outcome-based contracting and dedicated contract management.

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

3.1 To consolidate Department statutory requirements into Title 25.5, C.R.S. (2006)
3.2 To improve customer satisfaction with programs, services, and care.
3.3 To enhance customer service, providers, clients, stakeholders and eligibility personnel's understanding of program requirements, benefits, and responsibilities through effective communication.

3.4 To streamline health care services for children and families.
3.5 To develop a more direct relationship with counties and improve two-way communication.

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

4.1 To increase the use and consistency of data analysis to drive Department program decisions.
4.2 To develop enhanced training and retention strategies for Departmental staff.
4.3 To seek grants as applicable to improve the administration of programs.
4.4 To pursue options for improved physical space for our employees.
4.5 To increase communication with our county partners.

IV. PERFORMANCE MEASURES

New FY 07-08 Performance Measures for the November 1, 2006 Budget Request

FY 07-08 OBJECTIVE:
1.1 To maximize the opportunity to preserve health care services through the purchase of services in the most cost-effective manner possible. (Supportive of Goals A and B)

Division / Section	FY 07-08 PERFORMANCE MEASURE
Client Services Division-Pharmacy Section	Based on identifying opportunities within the pharmacy program and utilizing the Drug Utilization Review Board recommendations, the Pharmacy Section will provide recommendations on a quarterly basis for prior authorizations, limits and controls to effectively manage the prescription drug expenditures.
Client Services Division-Pharmacy Section	The Pharmacy Section will effectively utilize the Drug Utilization Review Board to identify opportunities for cost avoidance and to realize savings from the prescriber education program. The savings from the prescriber education program is measured by the decrease in the cost of all drugs used by the clients for whom the prescribers receive the letters. Savings are estimated to be between $100,000 and $500,000 for FY 07-08.
Finance Division-Safety Net Financing Section	To maintain program expenditures within the appropriation, the Safety Net Financing Section will review and analyze the Old Age Pension Health and Medical Care Program and implement necessary changes to the benefit structure or eligibility criteria by July 1, 2007 or propose to the General Assembly on November 1, 2007 if necessary.
Health Benefits Division-Managed Care Benefits Section	The Managed Care Benefits Section will implement an automated passive enrollment process by June 30, 2007 which will increase the number of clients that select a medical home/managed care health plan option. The Section estimates this increase in enrollment will be at least 10% with a resulting cost savings of 5% of FY 06-07 fee-for-service costs. This measurement will be completed by December 31, 2007.
Long Term Benefits Division-Community Based Long Term Care Section	The Community Based Long Term Care Section will enroll, to at least 80% waiver capacity, the Supported Living Program benefit of the Home and Community Based Services waiver for persons with Brain Injury (HCBS-BI). As part of this waiver, four providers with six sites will be surveyed and certified by September 2007. Case managers will receive training to identify clients from the eligibility population, conduct assessments and assist clients to move into the sites by October 2007.

FY 07-08 OBJECTIVE: 1.2 To support timely and accurate client eligibility determination. (Supportive of Goal A)	
Division / Section	**FY 07-08 PERFORMANCE MEASURE**
Client Services Division- Eligibility Policy Unit	The Eligibility Policy Unit will host monthly policy information sharing sessions for county and medical assistance site staff. Eligibility Policy will collaborate with Eligibility Operations and high level program groups to provide Medicaid specific training and support at two Social Service Technical and Business Staff conferences. Policies and procedures will be updated on the internet monthly.
Audits Section- Medicaid Eligibility Control Unit	The Audits Section, Medicaid Eligibility Control Unit will assess its revised audit plan implemented during FY 06-07 in FY 07-08. The Unit will meet with counties to discuss review findings and explain results.
Audits Section	The Audits Section will implement three pilot medical assistance sites within school districts as required by HB 06-1270.
Eligibility Operations Section	The Eligibility Operations Section will monitor the exceeding processing guidelines report and work with counties/medical assistance sites that consistently appear on the report with a high number of cases. The Section estimates that of the exceeding processing guideline cases in FY 07-08, 56% will be resolved to move the case out of a pending status on a monthly basis. Cases are reviewed, researched and resolved by the Section, unless they can be resolved by the county department of social services or the medical assistance site. In FY 07-08, the Section will increase the number of cases resolved by counties (by increased training and experience) by 20% over FY 05-06.
Operations and Finance Office	The County Oversight Liaison will continue to expand expertise on county roles in Department programs, and will intervene on a face to face level with at least three county departments of social services in FY 07-08 in attempts to improve eligibility administration performance.
Information Technology Division-Eligibility Systems Section	The Information Technology Division, Eligibility Systems Section will continue to prioritize and implement at least three system changes in FY 07-08 that will increase the accuracy of system generated eligibility determinations, in addition to legislatively required changes.

FY 07-08 OBJECTIVE: **1.3 To assure payments in support of the programs are accurate and timely, and to procure an effective fiscal agent. (Supportive of Goals A and B)**	
Division / Section	**FY 07-08 PERFORMANCE MEASURE**
Long Term Benefits Division, Community-Based Long Term Care Section	The Community Based Long Term Care Section will create system changes in the Benefits Utilization System by December 2007 to accurately collect client and utilization review data, such that quarterly contract payment adjustments can be made within 10 working days of the end of the quarter and contract reconciliation can be made within 30 days of the end of the contract period.
Client Services Division-Program Integrity Section	The Program Integrity Section will conduct 10-12 comprehensive post-payment reviews of at least three of the following provider types in FY 07-08 to assess provider compliance regarding service documentation, medical necessity and identify overpayments for recovery. The provider types include home health agencies, home and community based services waivered services, pharmacies, durable medical equipment/supply providers, hospital providers and physician services.
Controller Division-Accounting Section	The Accounting Section will work with other sections within the Department and with outside agencies to complete the implementation of SB 06-219 as they relate to the direct payment of Medicaid funding to counties. Payments to counties will be completed by the last day of the month following the month in which expenditures occurred.
Information Technology Division-Information Technology Contracts and Monitoring Section	The Information Technology Division, Information Technology Contracts and Monitoring Section will assure the new contract for fiscal agent services is implemented with no payment interruptions to providers. The error rate for payment interruptions to providers will be 0%.
Audits Section	The Audits Section will review 100% of county audit reports submitted in FY 07-08 and will follow up in person to review at least three counties with highest audit concerns.
Finance Division-Safety Net Financing Section	Quarterly payments to providers who qualify for Primary Care Fund will be made according to the schedule for disbursement per regulation 8.950.5.C.
Finance Division-Safety Net Financing Section	Quarterly payments to providers who are awarded funds through the Comprehensive Primary and Preventive Care Grant Program will be made within one month of receiving the provider's quarterly report.

FY 07-08 OBJECTIVE:
1.4 To assure delivery of appropriate, high quality care. To design programs that result in improved health status for clients served and to improve health outcomes. To ensure that the Department's programs are responsive to the service needs of enrolled clients in a cost-effective manner. (Supportive of Goals B and C)

Division / Section	FY 07-08 PERFORMANCE MEASURE
Child Health Plan Plus Division-Health Care Delivery Section	The Child Health Plan Plus Division (CHP+), Delivery Systems Section will require CHP+ managed care organizations to be responsible for the collection of data and calculation of up to 7 Health Plan Employment and Data Information Set (HEDIS) measures according to the HEDIS 2007 technical specifications in 2007, for calendar year 2006 HEDIS measures. CHP+ will require the contracted managed care organizations to undergo a National Council of Quality Assurance (NCQA) HEDIS compliance audit of the HEDIS data collected. Contractors will submit the results to the Department's External Quality Review Organization. CHP+ will use these results to implement appropriate policy changes that assure the delivery of appropriate, high quality care.
Child Health Plan Plus Division-Program Evaluation and Contract Operations Section	The Child Health Plan Plus Division, Program Evaluation and Contract Operations Section will evaluate the effectiveness of the Premium Assistance Pilot Program in creating a public/private partnership to maximize the use of resources to purchase health care through an annual enrollee survey conducted by January 2008. The survey will be used to monitor satisfaction with the pilot, cost effectiveness of purchasing health insurance through employers, and effectiveness of marketing materials. The results of the survey will be used to refine and develop the pilot program in order to expand coverage to a larger population.
Health Benefits Division-Quality Improvement Section	The Quality Improvement Section will measure and report the quality of health care services provided to Medicaid clients through nationally recognized performance measures (HEDIS) and plan an intervention to improve the score of at least one measure.
Health Benefits Division-Acute Care Benefits Section	The Acute Care Benefits Section will address the request of stakeholders by implementing an outpatient substance abuse benefit. The benefit was effective July 1, 2006 and the Section will track an estimated caseload of at least 4,668 per HB 05-1015 benefiting from the new service.
Long Term Benefits Division-Nursing Facilities Section	The Nursing Facilities Section will pursue a tiered assisted care facility model with reimbursement rates to be paid consistent with the level of care a client needs. A preliminary study in FY 06-07 will help identify costs, savings and benefits associated with nursing facilities which will help in implementation of the tiered assisted care facility model to be completed in FY 08-09.

FY 07-08 OBJECTIVE: **1.5 To accurately project, report, and manage budgetary requirements to effect Executive and Legislative intent with program and budget development and operations. To accurately record and monitor expenditures for programs managed by the Department so there may be accurate financial reporting at all times. (Supportive of Goals A and D)**	
Division / Section	**FY 07-08 PERFORMANCE MEASURE**
Controller Division-Accounting Section	The Accounting Section will continue 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 any new monthly reporting mechanisms for provider recoveries by December 2006. Areas for refinement will be identified and implemented in FY 07-08. This reporting will assist in the effort to properly account for recoveries in the Department's Budget process.
Budget Division	The Budget Division will provide the Office of State Planning and Budgeting with 100% budget requests (Supplementals, Budget Amendments, Decision Items, FY 07-08 Budget Request) by the requested Executive and Legislative branches due dates.
Budget Division-Budget and Financing Section	The Budget and Financing Section will create and distribute monthly expenditure tracking reports by appropriation for at least the last 9 months of the fiscal year and twice in June. 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 managers each month within 15 days at the end of the month.
Finance Division-Safety Net Financing Section	The Safety Net Financing Section will submit a report to the Finance Division Director and Office of Operations and Finance Director by December 1, 2006 recommending changes to the Old Age Pension State Medical Program benefit structure or eligibility criteria in order to maintain expenditures within the appropriation limit for FY 2007-08.
Finance Division-Data Section	Working with the Budget Division, the Data Section will prepare a draft of the Background section of the Strategic Plan by the end of May 2008.

FY 07-08 OBJECTIVE: **2.1 To build and manage a high quality, customer focused team. (Supportive of Goal D)**	
Division / Section	**FY 07-08 PERFORMANCE MEASURE**
Executive Director's Office	The Department will improve morale and effectiveness through well-planned trainings. By FY 07-08, the following training will have been made available to staff: HIPAA/Privacy/Security Training, Sexual Harassment, Workplace Violence, Healthy Environment, Management, PDQ, FMLA, Purchasing and New Employee Orientation.

FY 07-08 OBJECTIVE: **2.1 To build and manage a high quality, customer focused team. (Supportive of Goal D)**	
Executive Director's Office	The Department will hold annual Employee Appreciation meetings in a location where all staff can attend.
Executive Director's Office	The Department will assess the impacts of its fall 2006 expansion into 225 E. 16th Street to ensure that the needs are met and to ascertain any modifications that may be necessary.
Client Services Division- Eligibility Policy Unit	The Eligibility Policy Unit will cross-train to learn all Medicaid eligibility programs in order to provide immediate, high-quality customer support. Policy will develop and provide professional training for internal and external customers. The Unit will arrange and provide a minimum of six training sessions, in addition to Social Service Technical and Business Staff, to counties and medical assistance site staff.

FY 07-08 OBJECTIVE: **2.2 To assess the need to consolidate federally-funded health care programs within the Single State Agency. (Supportive of Goals F)**	
Division / Section	**FY 07-08 PERFORMANCE MEASURE**
Audits Section	The Department is requesting funding for FY 07-08 and FY 08-09 to hire a third-party audit firm to review the allocation model for direct and indirect costs for administration and services administered by sister agencies. If this funding is approved, the Department will receive audit results in June 2008 for the first portion of the audit. The first portion of the audit would review select program and administrative lines at the Department of Human Services.
Long Term Benefits Care Division- Community Based Long Term Care Section	By November 2007, a proposal shall be made to the General Assembly to reintegrate all Medicaid run programs back under the oversight of the Department. These programs shall include for the HCBS - Developmentally Disabled, Supported Living Services, Children's Extensive Support, and Children's Habilitation Residential Program waivers and Psychiatric Residential Treatment Facilities. The reintegration will save on duplicated administrative costs and allow the Department more program oversight, which is being demanded by the Centers for Medicare and Medicaid Services.

FY 07-08 OBJECTIVE: **2.3 To audit expenditures for fraud, abuse, client eligibility, and accuracy in third party payments both internally and with the use of contingency contractors. (Supportive of Goal B)**	
Division / Section	**FY 07-08 PERFORMANCE MEASURE**
Long Term Benefits-Nursing Facilities Section	The Nursing Facilities Section will schedule audits by December 2007 to be accomplished via the proactive assessment of major payment fluctuations and quality of facility survey results, resulting in potential recoveries of at least 2% of total recoveries to the Department.
Client Services Division-Benefits Coordination Section	The Benefits Coordination Section will continue to actively audit expenditures monthly through data matches conducted by the Department's third party contractor and internal staff. The data matches will compare information from our fiscal agent, medical providers, outside attorneys, insurers, other responsible third parties and the counties against prior years. Benefits Coordination will pursue recovery against third parties on any matches that are found.
Audits Section	The Medicaid Eligibility Quality Control Unit will review timelines and accuracy of Medicaid and Child Health Plan Plus Applications twice during FY 07-08.
Finance Division-Rates Section	The Rates Section will continue to examine capitation payments and will reconcile to ensure accuracy in payments for both contractual obligations and client eligibility. These reconciliations will be performed no less then twice a year. The second of the two will be completed and sent to the managed care plans no later than April 30, 2008.

FY 07-08 OBJECTIVE: **2.4 To maintain efficient management of the Department's information systems technology. (Supportive of Goal A)**	
Division / Section	**FY 07-08 PERFORMANCE MEASURE**
Safety Net Financing Section	The Safety Net Financing Section will propose to the federal government at least one new procedure to maximize federal revenue to sustain or increase payments to providers by January 1, 2008.
Information Technology Division-Eligibility Systems Section	The Information Technology Division, Eligibility Systems Section will assure the transition (if necessary) of the Colorado Benefits Management System operations and maintenance responsibilities to a competitively procured vendor to be complete by June 30, 2008.

FY 07-08 OBJECTIVE: 2.4 To maintain efficient management of the Department's information systems technology. (Supportive of Goal A)	
Division / Section	**FY 07-08 PERFORMANCE MEASURE**
Information Technology Division-Information Technology Support Section	The Information Technology Division, Information Technology Support Section will request annual upgrades and replacements to Department infrastructure to support changing business needs. The section will track upgrades, replacements and related costs to the Department annually.
Information Technology Division-Information Technology Contracts and Monitoring Section	The Information Technology Division, Information Technology Contracts and Monitoring Section will assure efficient Medicaid Management Information System processing of claims by maintaining the time between the time filed to the time paid at or below nine days on average.

FY 07-08 OBJECTIVE: 2.5 To hold accountable the Department's administrative contractors, including other State and local agencies, through outcome-based contracting and dedicated contract management. (Supportive of Goal C)	
Division / Section	**FY 07-08 PERFORMANCE MEASURE**
Controller Division-Contracts and Purchasing Section	The Contracts and Purchasing Section, with the assistance of the State Controller's and Attorney General's Offices, will ensure that: 1) the Department's contracts contain detailed performance, accountability, and monitoring measures and standards, along with mechanisms for resolving noncompliance; and 2) all Department program staff responsible for managing contracts receive at least one training session in contract management.
Budget Division-Budget and Financing Section	The Budget and Financing Section will hold structured monthly meetings with budget staff from the Department of Human Services and the Department of Public Health and Environment to create greater accuracy and consistency within expenditure tracking, projections, and budget requests.

FY 07-08 OBJECTIVE: **2.5 To hold accountable the Department's administrative contractors, including other State and local agencies, through outcome-based contracting and dedicated contract management. (Supportive of Goal C)**	
Information Technology Division- Information Technology Contracts and Monitoring Section	The Information Technology Division, Information Technology Contracts and Monitoring Section will develop, with vendor approval, a service level agreement for at least four information technology contracts by January 1, 2008 and monitor and evaluate monthly thereafter. A service level agreement is a document that details response time expectations for work performed by the vendor.
Finance Division- Safety Net Financing Section	The Safety Net Financing Section will monitor Comprehensive Primary and Preventive Care Grant Program contracts on a quarterly basis and review quarterly reports to ensure the contractor is adhering to contractual terms and conditions. Quarterly reports will help in identifying if contracted deliverables are met or if appropriate action needs to be taken. Appropriate action will include issuing an amendment to the original contract or adjusting payment to the contractor.

FY 07-08 OBJECTIVE: **3.1 To consolidate Department statutory requirements into Title 25.5. (Supportive of Goals A, B, D and F)**	
Division / Section	**FY 07-08 PERFORMANCE MEASURE**
Operations and Finance Office	The Department will meet with county representatives in the fall of 2007 to obtain feedback on the transition process towards two county payments. The Department will incorporate identified changes into the November 1, 2007 Budget Request as needed.
Privacy and Public Policy Division	After one year of experience with the new statutory changes to Title 25.5, C.R.S. (2006) the Department will consolidate needed technical corrections and consider a technical correction bill for the 2008 session. The need for a technical correction bill will be identified to the Governor's Office by August 1, 2007.

FY 07-08 OBJECTIVE: **3.2 To improve customer satisfaction with programs, services, and care. (Supportive of Goal C)**	
Division / Section	**FY 07-08 PERFORMANCE MEASURE**
Child Health Plan Plus Division- Contract Operations Section	The Child Health Plan Plus Division, Contract Operations Section will evaluate the effectiveness of the marketing plan semi-annually, and will adjust the marketing plan accordingly.

FY 07-08 OBJECTIVE: **3.2 To improve customer satisfaction with programs, services, and care. (Supportive of Goal C)**	
Division / Section	**FY 07-08 PERFORMANCE MEASURE**
Privacy and Public Policy Division	The Privacy and Public Policy Division will enhance external communications with Health Care Policy and Financing clients and providers with provider bulletins and publications at least once a year during FY 07-08; and by providing written or verbal responses to clients within 48 hours.
Privacy and Public Policy Division-Customer Service Section	Less than 1% percent of customer calls answered by the customer service staff will receive complaints at the Governor's Office.
Finance Division-Safety Net Financing Section	The Safety Net Financing Section will solicit feedback by December 31, 2007 from providers regarding the administrative processes and responsiveness to questions and needs regarding the Comprehensive Primary and Preventative Grant Program and the Primary Care Fund.
Finance Division-Safety Net Financing Section	The Safety Net Financing Section will offer Colorado Indigent Care Program eligibility training to providers in 5 geographic regions of Colorado on a yearly basis and in-house training at provider request. As a result of this training, the Safety Net Financing Section will create and make available the Colorado Indigent Care Program provider manual by June 30, 2008.
Audits Section	After completing one year of county oversight authorized under SB 06-219, the Section will meet with counties and the Department of Human Services in the summer of 2007 to determine areas for improvement.
Eligibility Operations Section	The Eligibility Operations Section will work closely with counties and medical assistance sites on a daily basis to ensure prompt application processing and follow up with applicant/client issues and work with internal Department clients to resolve identified client/applicant issues. The Section will follow up on issues reported by the Customer Service Section and resolve 98% of all issues per month.
Health Benefits Division-Quality Improvement and Behavioral Health Benefits Unit	The Quality Improvement Section and Behavioral Health Benefits Unit will conduct an annual survey/measurement of client satisfaction with the behavioral health program and report the results by October 2007 in terms of prior year's performance.

FY 07-08 OBJECTIVE: 3.3 To enhance customer service, providers, clients, stakeholders and eligibility personnel's understanding of program requirements, benefits and responsibilities through effective communication. (Supportive of Goal C)	
Division / Section	**FY 07-08 PERFORMANCE MEASURE**
Information Technology Division-Information Technology Contracts and Monitoring Section	The Information Technology Division, Information Technology Contracts and Monitoring Section will enhance provider communication on claims payment information or alerts with monthly bulletins to target those providers that need accurate, timely information.
Client Services Division-Eligibility Policy Unit	The Eligibility Policy Unit will attend a minimum of one training session with the Centers for Medicare and Medicaid Services, and participate in Departmental training sessions as offered to increase understanding of program requirements. The unit will meet with the county and medical assistance sites, presumptive eligibility sites, and single entry point providers to understand the daily processes and obstacles they encounter quarterly.
Privacy and Public Policy Division-Customer Service Section	The Customer Service Section will maintain the call abandonment rate at the FY 05-06 level of 36.74%.
Eligibility Operations Section	The Eligibility Operations Section will train counties at least twice annually on how to enter application data and how to maintain and transfer application cases accurately.

FY 07-08 OBJECTIVE: 3.4 To streamline health care services for children and families. (Supportive of Goal C)	
Division / Section	**FY 07-08 PERFORMANCE MEASURE**
Child Health Plan Plus Division	The Division will propose strategies to streamline the Children's Basic Health Plan and Medicaid within existing statutes and regulations to the Executive Director by December 2007. If approved the Department will seek to implement changes.

FY 07-08 OBJECTIVE: **3.5 To develop a more direct relationship with counties and improve two-way communication. (Supportive of Goal C)**	
Division / Section	**FY 07-08 PERFORMANCE MEASURE**
Eligibility Operations Section	The Eligibility Operations Section will monitor cases exceeding processing guideline on a monthly basis and will improve county timeliness through communication with and training for the counties.
Information and Technology Division-Eligibility Systems Section	The Information Technology Division, Eligibility Systems Section will attend at least six county-sponsored information exchanges related to Colorado Benefits Management System issues and respond to eligibility determination concerns which will improve county relationships and communications.
Information and Technology Division-Eligibility Systems Section	The Information Technology Division, Eligibility Systems Section will provide quarterly communications to counties and medical assistance sites detailing Colorado Benefits Management System changes.
Client Services Division	The Client Services Division will host monthly Departmental informational sessions and invite counties to participate in person and by phone. The purpose of the meetings will be to keep the counties informed and discuss their concerns/issues. Client Services staff will participate in at least three other agency meetings with county staff to represent the Department and become more accessible to their needs.
Executive Director's Office	The Executive Director and Office Senior Directors will continue to meet quarterly with the members of the County Advisory Group and continue to provide a co-chair for the group.

FY 07-08 OBJECTIVE: **4.1 To increase the use and consistency of data analysis to drive Department program decisions. (Supportive of Goal D)**	
Division / Section	**FY 07-08 PERFORMANCE MEASURE**
Information and Technology Division-Eligibility Systems Section	The Information Technology Division, Eligibility Systems Section will implement a Colorado Benefits Management System Decision Support System training plan that will educate and inform the Department's data analysts and managers about the capabilities of the Colorado Benefits Management System Decision Support System by December 1, 2007.

FY 07-08 OBJECTIVE: 4.1 To increase the use and consistency of data analysis to drive Department program decisions. (Supportive of Goal D)	
Information and Technology Division- Claims Systems Section	The Information Technology Division, Claims Systems Section will increase consistency of data analysis by assuring at least four new user trainings for the Medicaid Management Information System Decision Support System during the year, including one specialty training focused on mastering data analysis.
Finance Division- Rates Section	The Rates Section will conduct a review of its capitated rate setting process by July 31, 2007. This review will include benchmarking of best practices.
Finance Division- Data Section	The Data Section will establish standardized reports, when feasible, to assist in programmatic decisions and to ensure reporting consistency by July 31, 2007.

FY 07-08 OBJECTIVE: 4.2 To develop enhanced training and retention strategies for Departmental staff. (Supportive of Goal E)	
Division / Section	**FY 07-08 PERFORMANCE MEASURE**
Controller Division- Human Resources Section	The Human Resources Section will fully implement six training sessions for Department managers on State Personnel Rules and processes, including hiring, reclassification, employee performance management, and employee discipline for the fiscal year.
Budget Division and Budget and Financing Section	Budget will conduct training sessions during FY 07-08 for the Department to educate staff on budget-related activities and responsibilities. These training sessions will include information on Change Requests (to be held April - May 2008) and trainings on fiscal notes (to be held November-December 2007).
Budget Division and Budget and Financing Section	The Budget and Financing Section will conduct training sessions on the budget cycle and operating budgets during FY 07-08 for Department staff. These sessions will be held April-May 2008.

FY 07-08 OBJECTIVE: **4.3 To seek grants as applicable to improve the administration of programs. (Supportive of Goal C)**	
Division / Section	**FY 07-08 PERFORMANCE MEASURE**
Child Health Plan Plus Division-Program Evaluation and Contract Operations Section	The Child Health Plan Plus Division, Program Evaluation and Contract Operations Section will seek a minimum of two grants in FY 07-08 to improve the administration of programs as applicable. These may involve grants for program evaluation or development depending on the focus of the grant.

FY 07-08 OBJECTIVE: **4.4 To pursue options for improved physical space for our employees. (Supportive of Goal E)**	
Division / Section	**FY 07-08 PERFORMANCE MEASURE**
Executive Director's Office	The Department will expand into 225 E. 16th Street, therefore running business from two nearly adjacent locations one block from the Capitol. The execution of that proposed plan will be accomplished by November 2006. During FY 07-08, the Department will assess if further moves are necessary and if the expansion met employees' needs.

FY 07-08 OBJECTIVE: **4.5 To increase communication with our county partners. (Supportive of Goal C)**	
Division / Section	**FY 07-08 PERFORMANCE MEASURE**
Operations and Finance Office and the Office of Medical Assistance	The Department will meet at least quarterly in FY 07-08 with the Health Care Policy and Financing County Advisory Group to resolve problems, distribute draft county letters for feedback, and to strategize policy issues.
Operations and Finance Office	The Department will attend the two semi-annual County Social Services Directors Association conferences to strengthen relationships, participate in discussions, and address issues.
Operations and Finance Office	The Department will attend all County Allocation meetings and create a co-partnership with the Department of Human Services to address financial issues of county departments of social or human services.

FY 07-08 OBJECTIVE: **4.5 To increase communication with our county partners. (Supportive of Goal C)**	
Controller Division-Accounting Section and Budget Division-Budget and Financing Section	The Department will submit allocation letters to counties on time by July 2007 and as appropriations change. The Department will work with the Department of Human Services to ensure allocation letters are correct and coordinated.

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

FY 05-06 OBJECTIVE: 1.1 To maximize the opportunity to maintain health care services through the purchase of services in the most cost-effective manner possible.		
Division / Section	**FY 05-06 Performance Measure**	**Achievements towards FY 05-06 Performance Measures**
Client Services Division-Pharmacy Section	The Division will continue to implement prior authorizations, limits, and controls to effectively manage the prescription drug expenditures, based on opportunities identified within the pharmacy program.	The Pharmacy Section incorporated changes as required by the Medicare Modernization Act and State statute to no longer pay for Part D drugs for dual eligibles but to continue covering excluded drugs for that population. The Pharmacy Section is reviewing drug reports and claims to assist Affiliated Computer Systems with provider education on pharmacy claims issues. The required change for Medicare Modernization Act was implemented on January 1, 2006 and the Department is reviewing various drug categories and billing requirements to determine where additional cost-savings may be realized.
Client Services Division– Pharmacy Section	The Division will effectively utilize the Drug Utilization Review Board to identify opportunities for cost savings, and schedule the Board to meet on a quarterly basis.	The Pharmacy Section held quarterly meetings with the Drug Utilization Review Board on drug limits and utilization issues. The Board recommended placing Zantac liquid on prior authorization, which the Department is reviewing. The Department also implemented a recommendation to place promethazine on prior authorization. In addition, through the Drug Utilization Review program, monthly letters are sent to prescribers discussing misutilization issues. Although the primary goal of the program is to educate prescribers about utilization issues, the Department can realize a savings if misutilization issues are addressed.

FY 05-06 OBJECTIVE: 1.2 To support timely and accurate client eligibility determination.		
Division / Section	**FY 05-06 Performance Measure**	**Achievements towards FY 05-06 Performance Measures**
Eligibility Operations Section	The Medicaid Eligibility Quality Control Unit will utilize Colorado Benefits Management System quality control programming in two of three pilots for FY 05-06.	The Colorado Benefits Management System programming could not be used by the Medicaid Eligibility Quality Control Unit. As a result, sampling for the FY 05-06 pilots were drawn from the Medicaid Management Information System data.
Eligibility Operations Section	Ninety-eight percent of the Medicaid eligibility policy changes will be programmed, tested, and implemented in Colorado Benefits Management System by the effective date of the change.	Only one major policy change was effective in FY 05-06. This was <u>Medicare Part D - Low Income Subsidy</u> which was tested, programmed and implemented in FY 05-06. Other rule changes included: <u>Tobacco Tax</u>: Implementation of rule changes was split into three phases. Phase I & II were tested and programmed in FY 05-06 with implemented in FY 06-07 (July 2006). Phase III was tested, programmed and implemented in October 2006. <u>Autism Waiver</u> was tested in FY 05-06 with final programming completed in October 2006.
Long Term Benefits Division-Nursing Facility Section	Patient payments for nursing facilities will be automated into the Medicaid Management Information System by June 2005. The client/patient portion of care is currently tracked manually at the county level.	The Nursing Facilities Section with the assistance of the Eligibility Systems Section projects that the necessary system change will occur by December 2006.

FY 05-06 OBJECTIVE: 1.2 To support timely and accurate client eligibility determination.		
Division / Section	**FY 05-06 Performance Measure**	**Achievements towards FY 05-06 Performance Measures**
Information Technology Division- Eligibility Systems Development Section	The Colorado Benefits Management System will be implemented Statewide and the rules-based system will become stable and reliable in terms of eligibility determinations.	The Colorado Benefits Management System was implemented on September 1, 2004. Since then, the Department has worked to make sure the system is stable and reliable. The Department made major enhancements to the federal interfaces to assure accurate capture and posting of Supplemental Security Income in June 2005, and Medicare and Unearned Income information was captured in the Colorado Benefits Management System in December 2005. On August 1, 2005 the Department implemented a decision table change control process that includes extensive review by policy and operations staff prior to Change Request submission to increase stability and reliability in terms of eligibility determination. On June 30, 2006, the Department accepted the CBMS system.
Information Technology Division- Eligibility Systems Section	The Information Technology Division will monitor and enhance the Colorado Benefits Management System eligibility determination system and Department's decision tables to improve the accuracy of the client eligibility determination.	The Colorado Benefits Management System included Medicare Part D in November 2005 and Low Income Subsidy in February 2006, and expanded Tobacco Tax population tracking in June 2006. Many decision table changes were made to resolve outstanding accuracy issues. The Division implemented the decision table project tracking system to plan, prioritize and track decision table changes, assuring priorities of the Department were handled. The number of Health Care Policy and Financing tickets decreased from 2057 in January 2005 to 1062 in June 2006.

FY 05-06 OBJECTIVE: 1.3 To assure payments in support of the programs are accurate and timely.		
Division / Section	**FY 05-06 Performance Measure**	**Achievements towards FY 05-06 Performance Measures**
Finance Division-Safety Net Financing Section	Quarterly payments to Colorado Indigent Care Program providers will be made according to a published schedule.	The Safety Net Financing Section staff processed 100% of the first quarter payments, 99.6% of the second quarter payments, 98.2% of the third quarter Colorado Indigent Care Program payments, and 99% of the fourth quarter payments by June 30, 2006.
Long Term Benefits Division-Community Based Long Term Care Section	Long Term Benefits will implement a process to have 90% of the prior authorization requests electronically submitted directly to the fiscal agent from providers and/or contracted utilization review agencies by December 31, 2005.	This objective was met for all Home and Community Based Services waiver programs except the waiver for persons with Brain Injury (HCBS-BI). The process was established with the fiscal agent for handling the prior authorization requests for the HCBS-BI waiver. Training for providers, case managers and utilization review agencies was completed in October 2005. The rule change to implement the process was drafted, and was brought before the Medical Services Board. The Centers for Medicare and Medicaid Services needed to approve the HCBS-BI waiver amendment submitted by the Department on July 15, 2005. All rules changes are expected to be approved by June 30, 2007.
Finance Division-Rates Section	The Division will provide assessment of payments to the managed care organizations, Programs of All Inclusive Care to the Elderly, and administrative service organizations, to assure accurate payments for eligible clients for FY 05-06 by March 2006. These provider requests for offline payments will be analyzed within 45 days after submission.	The Rates Section has made all offline payments within the 45 day timeframe. Health maintenance organization payment reconciliation for FY 03-04 was completed and delivered to the HMOs on March 31, 2006.

FY 05-06 OBJECTIVE: **1.3 To assure payments in support of the programs are accurate and timely.**		
Information Technology Division- Information Technology Contracts and Monitoring Section	The Information Technology Division will continue the internal audit of Department transmittals to the fiscal agent to assure that complete and accurate rate changes occur, based on requests.	The Department audited 100% of transmittals outgoing to Affiliated Computer Systems totaling 1,460. All of Affiliated Computer Systems completed transmittals involving rate changes were reviewed by the information technology contracts staff. Claims processing reports were monitored on a daily basis and problems were quickly corrected. The Claims Processing Assessment audit was performed on a quarterly basis with no payment error identified.
Child Health Plan Plus Division- Program Evaluation and Contract Operations Section	A claims audit process will be implemented in the Child Health Plan Plus Division.	During the audit for the Child Health Plan Plus Division, the Department realized that the Payment Error Rate Measurement program would not audit claims in the Child Health Plan Plus Division since the clients were capitated. As a result, only eligibility and the amount of capitation paid was audited.

FY 05-06 OBJECTIVE: **1.4 To assure delivery of appropriate, high quality care. To design programs that result in improved health status for clients served and to improve health outcomes. To ensure that the Department's programs are responsive to the service needs of enrolled clients in a cost-effective manner.**		
Division / Section	**FY 05-06 Performance Measure**	**Achievements towards FY 05-06 Performance Measures**
Long Term Benefits Division- Community Based Long Term Care Section	By October 1, 2005, Community-Based Long Term Care will release a Request for Information to develop a list of specialty facilities that provide cost efficient services for long-term care brain injury waiver clients with behavioral issues.	This objective was not pursued. The home and community based services brain injury waiver was modified to allow for supported living as an appropriate benefit.

FY 05-06 OBJECTIVE: 1.4 To assure delivery of appropriate, high quality care. To design programs that result in improved health status for clients served and to improve health outcomes. To ensure that the Department's programs are responsive to the service needs of enrolled clients in a cost-effective manner.		
Health Benefits Division-Acute Care Benefits Section	The Health Benefits Division will implement at least one provider or client intervention based on the results of a quality improvement study or measurement to improve health care in the Medicaid program.	In follow-up to the FY 05-06 Early Periodic Screening and Diagnostic Training focus study, the Department implemented an Early Periodic Screening and Diagnostic Training web-based tool kit for providers and outreach workers. The web-based kit was finalized in March 2006. The tool kit will help increase awareness of Early Periodic Screening and Diagnostic Training and give providers access to Early Periodic Screening and Diagnostic Training assessment tools and forms. Feedback has been very positive.

FY 05-06 OBJECTIVE: 1.5 To accurately project, report, and manage budgetary requirements to effect executive and legislative intent with program and budget development and operations. To accurately record and monitor expenditures for programs managed by the Department so there may be accurate financial reporting at all times.		
Division / Section	**FY 05-06 Performance Measure**	**Achievements towards FY 05-06 Performance Measures**
Finance Division-Safety Net Financing Section	Safety Net Financing Section staff will track monthly expenditures under the Colorado Indigent Care Program to ensure that the program expenditures remain within available appropriations.	The expenditures for the Colorado Indigent Care Program were reviewed on a quarterly basis and the appropriation was spent as follows: first quarter, 25.48%; second quarter, 64.59% of total appropriation; third quarter, 69.40% of total appropriation; and fourth quarter 100% of total appropriation.

FY 05-06 OBJECTIVE: 1.5 To accurately project, report, and manage budgetary requirements to effect executive and legislative intent with program and budget development and operations. To accurately record and monitor expenditures for programs managed by the Department so there may be accurate financial reporting at all times.		
Division / Section	**FY 05-06 Performance Measure**	**Achievements towards FY 05-06 Performance Measures**
Finance Division-Safety Net Financing Section	Safety Net Financing Section staff will track and forecast expenditures under the Old Age Pension State Medical Program to ensure that the program remains within constitutional and statutory budget boundaries.	Expenditures for the Old Age Pension (OAP) State Medical Program were reviewed on a quarterly basis and the appropriation was spent up to the following percentages: 23.13% through first quarter, 56.04%; through second quarter, 72.28%; through third quarter, and 100% through fourth quarter. A 1331 Emergency Supplemental was approved by the Joint Budget Committee on June 20, 2006 in the amount of $1,140,484. Without this 1331 Emergency Supplemental, the Old Age Pension State Medical Program would have been 108.6% spent for the 4th quarter.
Finance Division-Data Section	The Finance Division will respond to requests for ad hoc reports within 10 business days, 90% of the time.	The Data Section has established a set of written protocols for data analysis. Not only will these protocols provide a higher degree of standardization in reporting results, they will also speed the average turnaround time between ad hoc report request and delivery date. Large projects have been completed on or before their agreed-upon due dates 90% of the time. Well over 90% of the time, smaller ad hoc requests have been completed within ten days of the original request.
Finance Division-Rates Section	Rates for managed care organizations, Programs of All Inclusive Care to the Elderly, and administrative service organizations will be calculated in a timely manner, meeting all actuarial standards.	Calculation of the FY 05-06 health maintenance organization rates was completed on April 29, 2005 and received final certification on May 18, 2005. The FY 05-06 behavioral health organization rates were updated on July 1, 2005. The Division received a purchase order on May 19, 2005 to contract for actuarial certification. The Rates Section updated health maintenance organization and the program for all inclusive care for the elderly rates effective January 1, 2006 to reflect the change in plan responsibility due to the implementation of the Medicare pharmacy benefit within the Medicare Modernization Act.

FY 05-06 OBJECTIVE: **1.5 To accurately project, report, and manage budgetary requirements to effect executive and legislative intent with program and budget development and operations. To accurately record and monitor expenditures for programs managed by the Department so there may be accurate financial reporting at all times.**		
Division / Section	**FY 05-06 Performance Measure**	**Achievements towards FY 05-06 Performance Measures**
Information Technology Division-Claims Systems Section	Information Technology will increase decision support capacity from 5 years of history data to 7 years to allow increased trending capability.	The Department decided that the expansion of decision support capabilities will be accomplished through the competitive bid process for the fiscal agent contract. If approved, the new contract will have upgrades in place no later than July 1, 2007.

FY 05-06 OBJECTIVE: **1.6 To work towards systemic improvement in the Department's operations to expand efficiencies, minimize waste, ensure coordination, and eliminate discrepancies.**		
Division / Section	**FY 05-06 Performance Measure**	**Achievements towards FY 05-06 Performance Measures**
Controller Division-Contracts and Purchasing Section	Based on work with the State Controller's Office and the Attorney General's Office, the Controller Division will implement a new contract document for contracts with Medicaid and Child Health Plan Plus Division medical providers that is different from the standard state contract, but yet meets the core needs of the State in its contracting requirements.	The Division developed a template contract in August 2005 for use throughout the Department that complies with the State's contract language requirements, as established by the State Controller's and Attorney General's Offices. The passage of SB 06-063 requires the Office of Innovation and Technology to certify to the State Controller that a major IT project undertaken by a State agency is in compliance with best practices before approving disbursement of funds which may mandate standardized contract language.

FY 05-06 OBJECTIVE: 1.6 To work towards systemic improvement in the Department's operations to expand efficiencies, minimize waste, ensure coordination, and eliminate discrepancies.		
Child Health Plan Plus Division	The Child Health Plan Plus Division will continue the process for the Centers for Medicare and Medicaid Services' approval of the streamlining of Medicaid and Child Health Plan Plus.	The Department submitted the proposal to the Health and Human Services Committees for approval in July 2005. The proposal was not approved. However, after reviewing the proposal, members of the Health and Human Services Committees expressed interest in working with the Department to further explore this initiative. The Joint Health and Human Services Committees voted not to pursue the proposed Colorado Family Cares Program in August 2005. The Department continues to look for strategies to streamline Medicaid and the Children's Basic Health Plan. The Department is working with the behavioral health community on a possible pilot program that would give Children's Basic Health Plan enrollees that are severely emotionally disabled expanded access to services similar to Medicaid benefits. These enhanced benefits are not currently covered under the Children's Basic Health Plan.

FY 05-06 OBJECTIVE: 2.1 To expand areas of potential financial recovery such as third party insurance (that should be a primary payer) and cases of fraud and abuse.		
Division / Section	**FY 05-06 Performance Measure**	**Achievements towards FY 05-06 Performance Measures**
Client Services Division-Benefits Coordination Section	The Benefits Coordination Section will maintain or increase recoveries over the prior year's level.	The Client Services Division has increased recoveries from prior year's level year to date by 36%. This figure includes: estate recovery recoveries of $5,740,617, trust and repayment recoveries of $3,036,906, tort/casualty recoveries of $3,502,153, and post-pay recoveries of $12,446,404.
Client Services Division-Benefits Coordination Section	Benefits Coordination will implement a process to increase enrollment in the Health Insurance Buy-In program, pending Departmental approval of the project plan.	The Client Services Division did not implement a process to increase enrollment. Due to the implementation of Medicare Part D, health insurance premiums have increased, while benefits decreased, thereby making availability of a cost-effective health plan rare.

FY 05-06 OBJECTIVE: 2.1 To expand areas of potential financial recovery such as third party insurance (that should be a primary payer) and cases of fraud and abuse.		
Division / Section	**FY 05-06 Performance Measure**	**Achievements towards FY 05-06 Performance Measures**
FY 05-06 OBJECTIVE: 2.2 Improve management of the Department's information systems technology.		
Division / Section	**FY 05-06 Performance Measure**	**Achievements towards FY 05-06 Performance Measures**
Information Technology Division-Information Technology Support Section	The Information Technology Division will provide upgrades and replacements to Department infrastructure to support changing business needs, based upon available funding.	67 new workstations were installed, eliminating a number of older, less capable workstations from use within the Department. A network firewall was also installed, providing additional security for the agencies data and environment in August 2005.
Information Technology Division-Information Technology Contracts and Monitoring Section	Information Technology will award the new fiscal agent contract and begin transition to the new contractor.	The Division completed, obtained federal approval, and released a request for proposals for a consultant vendor to assist the staff in procuring a new fiscal agent on September 16, 2005. The contract award was made in November. Federal approval of the contract and final signatures were completed by January 1, 2006. A revised Advanced Planning Document and take over request for proposals received federal approval on May 25, 2006. The request for proposals was posted on June 16 and closed August 9, 2006 with final award made in August.
Information Technology Division-Information Technology Contracts and Monitoring Section	Web support and maintenance staff will be hired to build and deliver web applications for providers and clients based on program direction, depending on available funding.	The Department did not pursue this initiative for FY 05-06 due to other priorities.

FY 05-06 OBJECTIVE: 2.3 To hold accountable the Department's administrative contractors, including state and local agencies, by more outcome-based contracting and more sophisticated contract management.		
Division / Section	**FY 05-06 Performance Measure**	**Achievements towards FY 05-06 Performance Measures**
Privacy and Public Policy Division- Customer Service Section	By July 1, 2005, an outcome-based Ombudsman for Medicaid Managed Care contract (including mental health) will be in place. A review of the contract will be completed by January 30, 2006.	An Ombudsman for managed care contract was in place by July 1, 2005. A contract review was done by the contract administrator in March 2006 with no notable issues.

FY 05-06 OBJECTIVE: 3.1 To improve customer satisfaction with programs, services, and care.		
Division / Section	**FY 05-06 Performance Measure**	**Achievements towards FY 05-06 Performance Measures**
Privacy and Public Policy Division- Customer Service Section	Less than one percent of customer calls answered by the customer service staff will receive complaints at the Governor's Office.	No complaints concerning customer service were received at the Governor's Office.
Privacy and Public Policy Division- Customer Service Section	Customer Service will increase the number of incoming customer calls answered by 10% over the total FY 04-05 calls (estimated to be 90,000 incoming calls).	85,708 total incoming calls were answered for FY 04-05, or an average of 7,143 calls monthly. In FY 05-06, 115,156 total incoming calls were or 9,596 average calls answered monthly. The average incoming calls monthly for FY 05-06 is 34.3% above the FY 04-05 levels.

FY 05-06 OBJECTIVE: **3.2 To enhance customer service, provider and eligibility personnel's understanding of program requirements, benefits, and responsibilities. To improve the usefulness of communications with clients, constituents, partners, and stakeholders.**		
Division / Section	**FY 05-06 Performance Measure**	**Achievements towards FY 05-06 Performance Measures**
Budget Division	The Budget Division will conduct training sessions during FY 05-06 for Department staff to educate on budget-related activities and responsibilities. At least two sessions in each of the following areas will be conducted: the budget cycle, change requests, fiscal notes, and operating budgets. As appropriate or timely, new legislation affecting the Department will be presented.	Operating Expenses training was held on May 24, 2006 and June 7, 2006 for all program managers. Two training sessions for fiscal notes were completed on November 14, 2005 and December 5, 2005, prior to the start of the legislative session. Budget staff completed training with Departmental staff on Change Requests and the Budget Cycle on May 30, 2006 and June 16, 2006.
Client Services Division	Client Services will conduct semi-annual Eligibility Trainings for county and medical assistant site technicians.	During Social Services Technical and Business Staff conferences on September 9, 2005, September 21, 2005, April 27, 2006 and April 28, 2006, Client Services Division staff attended and provided several training sessions to county workers and Denver Health and Hospital Authority through medical assistance site meetings and knowledge transfer calls. Knowledge transfer calls were held August 24, 2005 and September 7, 2005 while Departmental informational sessions for county workers were held on September 27, 2005, February 28, 2006, March 3, 2006, May 23, 2006 and June 27, 2006.

FY 05-06 OBJECTIVE: **3.2 To enhance customer service, provider and eligibility personnel's understanding of program requirements, benefits, and responsibilities. To improve the usefulness of communications with clients, constituents, partners, and stakeholders.**		
Division / Section	**FY 05-06 Performance Measure**	**Achievements towards FY 05-06 Performance Measures**
Long Term Benefits Division-Systems Change Section	By December 31, 2005, the Department will have an outreach and awareness campaign underway to inform clients and collateral supporters about the opportunities and advantages of consumer direction. This campaign will achieve a 75% success rate, as measured by follow-up surveys.	The Department contracted with Policy Studies Inc. to design and implement a statewide marketing and outreach campaign. Policy Studies Inc. conducted extensive research through key informant interviews and held focus groups with eligible consumers and family members to develop a comprehensive report which identified barriers and recommendations to increase public awareness and participation in consumer directed programs. Policy Studies Inc. has developed brochures and revised the Consumer Directed Attendant System training reference manual based on feedback from consumers and continues to create products to assist the Department in providing information and increasing awareness of consumer directed options that are available to clients. Policy Studies Inc. continues to assess the effectiveness of the outreach and marketing campaign by conducting follow up surveys with key stakeholders. They have collected valuable information through focus group meetings, telephone interviews, and informational sessions with clients, family members, and professionals that serve the disabled and elderly community. Survey results indicate an increase in consumer direction awareness among key stakeholders and have allowed Policy Studies Inc. to identify barriers and develop marketing tools and strategies to ensure a successful consumer direction awareness campaign.

FY 05-06 OBJECTIVE: 4.1 To build and maintain a high quality, customer-focused team.		
Division / Section	**FY 05-06 Performance Measure**	**Achievements towards FY 05-06 Performance Measures**
Privacy and Public Policy Division-Customer Service Section	By June 30, 2006, the Customer Service Section, with sufficient staff, will reduce the call abandonment rate by 10% over the previous year.	The actual average abandonment rate for FY 04-05 was 42.82%. The actual average abandonment rate for FY 05-06 was 31.90% or a reduction of 10.92% in the abandonment rate over FY 04-05.

FY 05-06 OBJECTIVE: 4.2 To enhance program safeguards and controls.		
Division / Section	**FY 05-06 Performance Measure**	**Achievements towards FY 05-06 Performance Measures**
Finance Division-Safety Net Financing Section	Safety Net Financing will establish procedures to maximize federal revenue to sustain or increase payments to providers that conform to federal guidelines. Federal revenue will not be included in the Department's budget until approved by the Centers for Medicare and Medicaid Services.	The Safety Net Financing Section received approval on written rules related to Medicaid outstationing from the Centers for Medicare and Medicaid Services and Medical Services Board, with an effective date of June 1, 2006 and received an appropriation in FY 05-06 for $2,925,270. Payments were implemented in the last quarter of FY 05-06 with no cost to the State in General Fund due to certification of public expenditures.
Controller Division	The Division will review procedures and fiscal rules and ensure compliance with State regulations.	The Division reviewed monthly reports, financial and quarterly reports from the State Controller's Office to ensure compliance with fiscal rules and State regulations. The Division was in full compliance with fiscal rules and State regulations.

FY 05-06 OBJECTIVE: 4.3 To increase public knowledge of and involvement in the financing and delivery of health care.		
Division / Section	**FY 05-06 Performance Measure**	**Achievements towards FY 05-06 Performance Measures**
Finance Division-Safety Net Financing Section	The Colorado Indigent Care Program Annual Report, which details utilization and financial trends for the indigent care programs administered by the Department, will be delivered to the General Assembly by February 1, 2006.	The Colorado Indigent Care Program annual report, which details utilization and financial trends for the indigent care programs administered by the Department, was delivered to the General Assembly on February 7, 2006.

FY 05-06 OBJECTIVE: 4.4 To develop enhanced training and retention strategies for departmental staff.		
Division / Section	**FY 05-06 Performance Measure**	**Achievements towards FY 05-06 Performance Measures**
Controller Division-Human Resources Section	The Controller Division will develop and implement a full-scale training for Department managers in the State Personnel Rules and processes, including hiring, reclassification, employee performance management, and employee discipline.	The Human Resources Section provided one family medical leave act training and trainings on sexual harassment and violence in the workplace training to all staff in FY 05-06.

FY 06-07 Achievements towards Performance Measures from Last Year's Budget Request

FY 06-07 OBJECTIVE: **1.1 To maximize the opportunity to maintain health care services through the purchase of services in the most cost-effective manner possible.**		
Division / Section	**FY 06-07 Performance Measure**	**Achievements towards FY 06-07 Performance Measures as of November 1, 2006**
Client Services Division-Pharmacy Section	The Board will effectively utilize the Drug Utilization Review Board to identify opportunities for cost savings; the Board will meet on a quarterly basis.	The Drug Utilization Review Board meets on a quarterly basis and makes recommendations to the Department regarding certain cost savings opportunities. The first meeting quarterly meeting occurred on July 18, 2006 and the second quarterly meeting on October 17, 2006. The Pharmacy Section will continue to utilize the Drug Utilization Review Board during their upcoming meetings for such recommendations. The savings from future prior authorizations, limits and other controls will depend greatly on the number of medications involved, the cost of those medications, the extent of the restrictions placed on the medications, and the alternative treatments available for the clients. In addition, monthly letters were sent in July through October 2006 to prescribers discussing misutilization issues.
Client Services Division-Pharmacy Section	Based on identifying opportunities with the pharmacy program and Utilizing the Drug Utilization Review Board recommendations, the Finance Division will provide recommendations for prior authorizations, limits, and controls to effectively manage the prescription drug expenditures on a quarterly basis.	Since SB 06-001 did not become law, which would have changed the Unit's focus from prior authorizations to a preferred drug list, the Pharmacy Section is moving forward with several recommendations on prior authorizations. The Pharmacy Section placed promethazine on prior authorization based on the recommendations of the Drug Utilization Review Board. With all of the dual eligibles moving to Medicare prescription drug coverage, the impact on the Medicaid pharmacy line is substantial. It is important and cost-effective to determine the full impact of Medicare Modernization Act before making additional policy changes.

FY 06-07 OBJECTIVE: 1.1 To maximize the opportunity to maintain health care services through the purchase of services in the most cost-effective manner possible.		
Division / Section	**FY 06-07 Performance Measure**	**Achievements towards FY 06-07 Performance Measures as of November 1, 2006**
Child Health Plan Plus Division-Program Evaluation and Contract Operations Section	The Child Health Plan Office will promote private sector insurance in Colorado by implementing a pilot program for employer sponsored insurance with two large employers by January 2007.	The pilot program began on October 1, 2006 to solicit applications from interested employees. The first enrollees will have coverage beginning January 1, 2007 at the start of the employer's benefit year.
Long Term Benefits Division-Community Based Long Term Care Section	The Community Based Long Term Care Section will ensure a 90% accuracy rate in the submission and payment of claims that are for services delivered as benefits of the Home and Community Based Services (HCBS) Persons with Brain Injury Waiver program by December 31, 2006.	The Community Based Long Term Care section will conduct 124 annual case reviews, claims reviews, and technical assistance to providers and case managers to adequately identify the benefits a client needs and appropriately bill for services delivery. Additionally, the Department will seek approval for prior authorization for those benefits most frequently inappropriately claimed. This effort is projected to result in $287,554 reduction in independent living skills training claims over the previous fiscal year.

FY 06-07 OBJECTIVE:
1.1 To maximize the opportunity to maintain health care services through the purchase of services in the most cost-effective manner possible.

Division / Section	FY 06-07 Performance Measure	Achievements towards FY 06-07 Performance Measures as of November 1, 2006
Health Benefits and Finance Divisions	The Health Benefits and Finance Divisions will monitor the cost-effectiveness of disease management, physical health pre-paid inpatient health plans and enhanced primary 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.	During FY 06-07, the State will review the current cost savings measurement that is part of the contract and adjust it if and/or as appropriate to reflect a better measurement of the programs cost effectiveness. The administration of the Primary Care Physician Program will be reviewed with opportunities to better manage care/increase cost effectiveness identified. The Department is managing up to 300 diabetic for less than or equal to $681,735 and 500 asthmatic clients holding costs for $317,500 in FY 06-07. A report on diabetes and asthma cost savings analysis will be submitted to the Joint Budget Committee in February 2007.

FY 06-07 OBJECTIVE:
1.2 To support timely and accurate client eligibility determination.

Division / Section	FY 06-07 Performance Measure	Achievements towards FY 06-07 Performance Measures as of November 1, 2006
Eligibility Operations Section	The Eligibility Operations Section will research inaccurate eligibility determinations and recommend Colorado Benefits Management System Changes that will reduce the number of "trouble tickets" reported in FY 05-06 by counties and Medical assistance sites by at least 10%.	By October 1, 2006, the number of trouble tickets when compared to the same time in FY 05-06 has decreased by 18%.

FY 06-07 OBJECTIVE: **1.2 To support timely and accurate client eligibility determination.**		
Division / Section	**FY 06-07 Performance Measure**	**Achievements towards FY 06-07 Performance Measures as of November 1, 2006**
Eligibility Operations Section	Monitor counties and medical assistance sites showing cases that are pending and exceed processing guidelines. Ensure that medical assistance sites continue to work the pending reports by sending out reports as they are received by the Section from the Colorado Benefits Management Report 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 monitors counties and medical assistance sites for cases that exceed processing guidelines on a daily basis. The Section works with the counties and medical assistance office sites to correctly resolve the pending status of the cases. Section staff provides data entry error training to counties and medical assistance sites as needed. By the end of FY 06-07, the Section proposes to reduce cases that exceed processing guidelines by 25%.
Eligibility Operations Section	The Eligibility Operations Section will conduct Colorado Benefits Management System procedural training for counties and Medical assistance sites. 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.	The Section planned four trainings: 1) family medical bi-monthly training for Affiliated Computer Systems at medical assistance site meetings, 2) bi-monthly training support for Denver Health at medical assistance site meetings, 3) Deficit Reduction Act and HB 06S-1023 ongoing training and 4) attend Colorado Benefits Management System hosted monthly conference call trainings. Additionally, the Department has participated in Colorado Department of Human Services adult supervisor meetings every other month.
Client Services Division-Benefits Coordination Section	The Medicaid Eligibility Quality Control Unit will conduct needs assessment for critical eligibility issues and implement at least two pilot proposals for FY 06-07.	The Medicaid Eligibility Quality Control Unit began two new six-month pilots on July 1, 2006 and may begin another one in December 2006. Improvements to the process for measurability are planned for FY 06-07. Two of the unit's three staff is new in FY 06-07, so training is an issue.

FY 06-07 OBJECTIVE: 1.2 To support timely and accurate client eligibility determination.		
Division / Section	**FY 06-07 Performance Measure**	**Achievements towards FY 06-07 Performance Measures as of November 1, 2006**
Client Services Division-Eligibility Policy Unit	The Eligibility Policy Unit will conduct at least six Health Care Policy and Financing Informational Meetings, 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.	In February 2006, the Eligibility Policy Unit changed the informational meetings to monthly meetings, and included outlying counties by offering the ability to participate by phone. As of November 1, 2006 there have been 14 eligibility policy trainings and 15 more trainings are expected to be offered for the rest of the fiscal year for all high level eligibility areas.
Information Technology Division-Claims Systems Section	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.	Comparisons of data between the two systems are performed bi-weekly and the root cause of discrepancies are identified and resolved. As of October 31, 2006, the discrepancy of one measure is 0.007%. The Department will review the match between the two systems on a weekly basis. By October 31, 2006, the Department anticipates that clients in the Colorado Benefits Management System but not in the Medicaid Management Information System will be at least less than 0.1% inaccurate. Similarly, clients in the Medicaid Management Information System but not in the Colorado Benefits Management Information System will have an inaccurate rate of less than 0.6%.

FY 06-07 OBJECTIVE:
1.3 To assure payments in support of the programs are accurate and timely.

Division / Section	**FY 06-07 Performance Measure**	**Achievements towards FY 06-07 Performance Measures as of November 1, 2006**
Finance Division-Safety Net Financing Section	Quarterly payments to Colorado Indigent Care Program providers will be made according to a published schedule.	The first quarter payments were made according to the published schedule on August 18, 2006.
Long Term Benefits Division, Community-Based Long Term Care Section	Long Term Benefits will implement a process to have 90% of the prior authorization requests electronically submitted directly to the fiscal agent from providers and/or contracted utilization review agencies by December 31, 2006. This is a continuation of FY 05-06 Performance Measure 1.3.	The rule to implement the final change in the Home and Community Based Services waiver for persons with brain injury will be presented at the December 8, 2006 meeting of the Medical Services Board. Implementation will be completed by June 30, 2007 with prior authorization requests for all Home and Community Based Services benefits being submitted to the fiscal agent in an electronic format.
Finance Division-Data Section	The Division will respond to requests for ad hoc reports within ten business days, 90% of the time.	The Data Section provides project results and ad hoc analysis on a timely basis. Projects are completed within ten days of the original request over 90% of the time.
Finance Division-Rates Section	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.	The Rates Section is on track to completing a reconciliation of all managed care payments through the end of FY 05-06. Calculations for years prior to the most recent will be completed by June 30, 2006. This review will include an examination of the timeframes of the process to ensure adequate time for methodological review of the process by federal staff and provider partners.

FY 06-07 OBJECTIVE: **1.3 To assure payments in support of the programs are accurate and timely.**		
Division / Section	**FY 06-07 Performance Measure**	**Achievements towards FY 06-07 Performance Measures as of November 1, 2006**
Finance Division-Rates Section	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.	For four of the five behavioral health organizations, rates effective July 1, 2006 were finalized in May 2006, and were included in contract amendments that were executed in a timely fashion for FY 06-07. The remaining behavioral health organization, Access Behavioral Care, had rates that included a monthly pass through payment for services performed under the terms of the Goebel lawsuit settlement. The Department met with staff from the Centers for Medicare and Medicaid Services after the dismissal of the Goebel lawsuit and learned that the pass through payment, in the absence of the court's order, would no longer earn federal matching funds. The Department worked to transition to a federally approvable per member per month capitation payment methodology. The resulting rates calculation was completed after July 1, 2006, but the rates were retroactively applied in a contract amendment effective July 1. Health maintenance organization rates were completed and distributed on May 22, 2006. Due to statutorily mandated rebasing, the rates were considerably lower than in the prior year. The Department and its health maintenance organization contractors had extensive discussions about the rates. To aid these discussions, the prior year contracts, including payment at the prior year rates were extended through August 31, 2006. Ultimately, Colorado Access, declined to continue to participate as a health maintenance organization. Under an additional one month contract amendment, Denver Health provided health maintenance organization services during September at the prior year rates. The Department executed a contract with Denver Health containing the new rates effective October 1, 2006.

FY 06-07 OBJECTIVE:
1.3 To assure payments in support of the programs are accurate and timely.

Division / Section	**FY 06-07 Performance Measure**	**Achievements towards FY 06-07 Performance Measures as of November 1, 2006**
Information Technology Division- Claims Systems Section	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 Claims Systems Section will review two subsystems by November 1, 2006: pharmacy claims processing and electronic claims subsystems. The Department and the fiscal agent will review reports weekly to assure payments are made accurately and timely. This will assure that the subsystem processing is accurate for all required benefits.
Information Technology Division Information Technology Contracts and Monitoring Section	The Department will increase internal audits of the claims processing system.	The claims processing assessment system auditing process evaluates claim payments and is being done quarterly. One quarterly processing audit will be completed by the Department by October 31, 2006 in its monitoring effort of the claims payment system. The Department's fiscal agent also plans to complete four processing audits.
Controller Division- Accounting Section	The Accounting Section of the Controller Division, with the assistance of the Department's Information Technology Division, will work to ensure that the interface between the Medicaid Management Information System and the Statewide accounting system operates effectively and efficiently, through two specific systems interface fixes to be completed prior to December 2006.	The Accounting Section works consistently with the Information Technology Division and the Department's fiscal agent to resolve issues that exist in the interaction between the Medicaid Management Information System and the Colorado Financial Reporting System. Other system interface changes related to the automated update between the Medicaid Management Information System and the Colorado Financial Reporting System for provider records is in the process of finalization and should be finalized by March 31, 2007.

FY 06-07 OBJECTIVE: **1.4 To assure delivery of appropriate, high quality care. To design programs that result in improved health status for clients served and to improve the health outcomes. To ensure that he Department's programs are responsive to the service needs of enrolled clients in a cost-effective manner.**		
Division / Section	**FY 06-07 Performance Measure**	**Achievements towards FY 06-07 Performance Measures as of November 1, 2006**
Long Term Benefits Division, Community-Based Long Term Care Section	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.	The rule was read initially at the April 14, 2006 Medical Services Board with an effective date of July 1, 2006. Contracts were negotiated with Community Centered Boards, and provider rates were established and is planned to be loaded into the Medicaid Management Information System by October 13, 2006. Plans for provider enrollment and fiscal agent changes are in process and enrollment equal to 100% of capacity is expected by December 21, 2006.
Health Benefits Division-Acute Care Benefits Section	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.	Approval for the substance abuse waiver from the Centers for Medicare and Medicaid Services is pending. Per the Centers for Medicare and Medicaid Services, Native Americans will be removed from the waiver since they will be available to receive services through the substance abuse benefit and through the Indian Health services available through federal programs. The waiver will be amended to only include pregnant women for months 3-12 post-partum. The anticipated enrollment is 4,668 in FY 06-07.
Child Health Plan Plus Division-Health Care Delivery Section	The Department will implement performance based contracting with managed care plans using the Health Employer Data and Information Set and Consumer Assessment of Health Care Study measures, to begin July 1, 2006.	The managed care organization will submit HEDIS measures to the Department's external quality review organization by March, 2007. Child Health Plan Plus will use the results to implement appropriate policy changes that assure the delivery of appropriate, high quality care.

FY 06-07 OBJECTIVE:
1.5 To accurately project, report, and manage budgetary requirements to effect executive and legislative intent with program and budget development and operations. To accurately record and monitor expenditures for programs managed by the Department so there may be accurate financial reporting at all times.

Division / Section	**FY 06-07 Performance Measure**	**Achievements towards FY 06-07 Performance Measures as of November 1, 2006**
Finance Section-Safety Net Financing Section	Safety Net Financing Section staff will track monthly expenditures under the Colorado Indigent Care Program to ensure that the program expenditures remain within available appropriations.	The Safety Net Financing Section has received monthly audit information from Colorado Indigent Care Program providers which will be used to create an annual report and will indicate if expenditures will remain within available appropriations. An additional external audit will be scheduled to ensure compliance with HB 06S-1023, if funded by the General Assembly.
Controller Division-Accounting Section	The Accounting Section of the Controller Division will continue its projects 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.	The Accounting Section has begun reviewing all provider recovery processes and has made some changes/improvements to previously created reporting methods such as the drug rebate reconciliation and Medicaid Management Information System reconciliation. Other provider recovery projects are in progress. Two meetings have taken place since July 1, 2006 between both program and accounting to discuss new procedures that need to be implemented for tracking. Final implementation is scheduled for December 2006.
Budget Division	The Division will provide the Office of State Planning and Budget with all budget requests (Supplementals, Budget Amendments, Decision Items, FY 07-08 Budget Request) by the requested due dates.	The Division will provide the Office of State Planning and Budgeting with the Strategic Plan, Program Crosswalks, Executive Budget Request for FY 07-08 and Schedules 2, 3, 4, 5, and 11 by October 27, 2006. All other budget requests including Supplementals, Budget Amendments and Decision Items will be provided by the requested due dates.

FY 06-07 OBJECTIVE: **1.6 To work toward systemic improvement in the Department's operations to expand efficiencies, minimize waste, ensure coordination, and eliminate discrepancies.**		
Division / Section	**FY 06-07 Performance Measure**	**Achievements towards FY 06-07 Performance Measures as of November 1, 2006**
Long Term Benefits Division- Nursing Facilities Section	The Nursing Facilities Section will work with providers on the development of a new nursing facility reimbursement methodology to propose during the 2006 Legislative session. The intent of the proposal will be to combine price based reimbursement with quality indicators, resulting in fewer nursing facility rate appeals. If the legislature approves this proposed reimbursement methodology, the Department will work with providers to develop new Volume 8 rules before the end of the fiscal year.	The Department discontinued this performance measure in FY 05-06. Pursuant to SB 06-131, the Department will conduct a feasibility study of nursing facility reimbursement methodologies to be reported to the Health and Human Services Committee of the Senate and House of Representatives and the joint Budget Committee on November 1, 2006.

FY 06-07 OBJECTIVE: **2.1 To expand areas of potential financial recovery such as third party insurance (that should be a primary payer) and cases of fraud and abuse.**		
Division / Section	**FY 06-07 Performance Measure**	**Achievements towards FY 06-07 Performance Measures as of November 1, 2006**
Client Services Division- Benefits Coordination Section	Benefits Coordination Section will maintain or increase recoveries from third party insurance over the prior year's level and strive to identify other cost-avoidance practices.	A contract amendment extending the post-pay, estate recovery and tort and casualty contracts through December 31, 2006 was executed September 19, 2006. A request for proposals for a new contract was posted in September 2006 for the post-pay, estate and tort and casualty recoveries. The new contract is expected to be executed January 1, 2007. The Benefits Coordination Section projects that the Department will equal to or exceed FY 05-06 overall recoveries. Although tort and casualty recoveries may decline due to the Ahlborn Supreme Court Decision, recoveries through expended recovery efforts are expected to make up for any reductions in other recovery areas.
Client Services Division- Program Integrity Section	A comprehensive post payment 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 and School Based waivered services, Durable Medical Equipment providers, Federally Qualified Health Clinics and school based services.	In the Program Integrity Section, three nurse reviewers and two post-payment reviewer each focus on six or more cases related to home health, emergency transportation, Home and Community Based waivered services, durable medical equipment providers, Federally Qualified Health Clinics and school based services. These reviews will be selected through the analysis of exception reports and direct referrals to the Program Integrity Section. Reviews are typically completed within two months of opening.

FY 06-07 OBJECTIVE: 2.2 To improve management of the Department's information systems technology.		
Division / Section	**FY 06-07 Performance Measure**	**Achievements towards FY 06-07 Performance Measures as of November 1, 2006**
Information Technology Division-Claims Systems Section	The Division will focus ongoing efforts to centralize the information systems used by the agency, to improve both security and management of vast amounts of client data used by the Department.	The Department will eliminate a free-standing SQL server and will relocate needed data to the rates data warehouse, a special feature of the Medicaid Management Information System Decision Support System by December 1, 2006. This system will have specific security protocols and professional database management.

FY 06-07 OBJECTIVE: 2.3 To hold accountable the Department's administrative contractors, including state and local agencies, by more outcome-based contracting and more sophisticated contract management.		
Division / Section	**FY 06-07 Performance Measure**	**Achievements towards FY 06-07 Performance Measures as of November 1, 2006**
Budget Division-Budget and Financing Section	The Budget and Financing Section will hold structured monthly meetings with budget staff from the Department of Human Services and the Department of Public Health and Environment to create greater accuracy and consistency within expenditure tracking, projections, and Budget Requests.	The Budget and Financing Section held structured monthly meetings on with budget staff from the Department of Human Services and the Department of Public Health and Environment, creating greater accuracy and consistency within expenditure tracking, projections, and Budget Requests. Meetings with Department of Human Services were held on July 20, August 17, and September 21. Meetings with the Department of Public Health and Environment were held on July 26, August 23, and September 27.
Controller Division-Contracts and Purchasing Section	The Contracts and Purchasing Section of the Controller Division will develop and hold at least one contract management training session for the Department's program staff responsible for managing contracts.	The Contracts and Purchasing Section began development of a contract management training program for Department staff, and anticipates it will be completed by December 2006. Further development is awaiting outcomes of Legislative initiatives - specifically SB 06-063 and SB 06-064, which will mandate certain contract management activities including two trainings for staff to be completed by January 31, 2007.

FY 06-07 OBJECTIVE:
2.4 To ensure program safeguards and controls.

Division / Section	FY 06-07 Performance Measure	Achievements towards FY 06-07 Performance Measures as of November 1, 2006
Budget Division-Budget and Financing Section	The Budget and Financing Section will create and distribute 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.	The Budget and Financing Section has created and distributed monthly expenditure tracking report by appropriation for the months of July – September 2006. This document is used to assist program staff in awareness of program trends and to create more awareness regarding vendor billing habits. This report has been distributed to all program managers and office directors.
Finance Division-Safety Net Financing Section	The Section will establish additional procedures to maximize federal revenue to sustain or increase payments to providers that conform to federal guidelines by January 1, 2007.	The Safety Net Financing Section is working with the Centers for Medicare and Medicaid Services to finalize an annual financing plan for supplemental payments to governmental hospitals for physician services. This allows qualified government hospitals who employ physicians to certify uncompensated costs and receive a federal match.

FY 06-07 OBJECTIVE:
3.1 To improve customer satisfaction with programs, services, and care.

Division / Section	FY 06-07 Performance Measure	Achievements towards FY 06-07 Performance Measures as of November 1, 2006
Long Term Benefits Division-Nursing Facilities Section	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.	The Nursing Facilities Section will complete one cross training by October 31, 2006 and will complete three section cross trainings for the remainder of FY 06-07.

FY 06-07 OBJECTIVE:
3.1 To improve customer satisfaction with programs, services, and care.

Division / Section	FY 06-07 Performance Measure	Achievements towards FY 06-07 Performance Measures as of November 1, 2006
Health Benefits Division-Managed Care Section	The Division will monitor customer satisfaction with Mental Health Community Services program through the use of annual adult and child satisfaction surveys, quarterly grievance appeal reporting, and feedback receive in open forums with consumers.	Annual survey results across the past two years consistently report that customers are 61.6% to 84.4% satisfied with the Community Mental Health Service Program and results for the survey were received by October 2006. Systemic areas of concern will be identified in the quarterly grievance and appeal reports. Feedback from stakeholder meetings will indicate overall satisfaction with the program.

FY 06-07 OBJECTIVE:
3.2 To enhance customer service, provider and eligibility personnel's understanding of program requirements, benefits, and responsibilities. To improve the usefulness of communications with clients, constituents, partners and stakeholders.

Division / Section	FY 06-07 Performance Measure	Achievements towards FY 06-07 Performance Measures as of November 1, 2006
Budget Division	The Budget Division will conduct training sessions during FY 06-07 for Department staff to educate on budget-related activities and responsibilities. At least two sessions in each of the following areas will be conducted: the budget cycle, change requests, fiscal notes, and operating budgets. As appropriate or timely, new legislation affecting the Department will be presented.	The Budget Division plans to complete training on the FY 07-08 Change Request Cycle and Budget Cycle by June 2007. Two training sessions for fiscal notes will be completed by December 15, 2006, prior to the start of the legislative session. The Budget and Financing Section plans to complete the Operating Budget training conducted by the Personal Services and Operating Budget Analyst by May 2007 for all program managers. The budget cycle training will be completed by May 31,2007.

FY 06-07 OBJECTIVE: **3.2 To enhance customer service, provider and eligibility personnel's understanding of program requirements, benefits, and responsibilities. To improve the usefulness of communications with clients, constituents, partners and stakeholders.**		
Division / Section	**FY 06-07 Performance Measure**	**Achievements towards FY 06-07 Performance Measures as of November 1, 2006**
Long Term Benefits Division-Systems Change Section	By December 31, 2006, the Department will have an outreach and awareness campaign underway to inform clients and collateral supporters about the opportunities and advantages of consumer direction. This campaign will achieve a 75% success rate, as measured by follow-up surveys.	The Department has begun developing a statewide marketing and outreach campaign to inform clients and the general public about the opportunities and advantages of consumer direction. The Department will identify target audiences and complete background research. Focus groups and key informant interviews will be conducted. The structure for a web-based on-line registry of attendants was completed and a variety of training materials will be developed by December 31, 2006. By January 31, 2007, an evaluation will determine the effectiveness and success of the marketing and outreach campaign and the training materials to meet the 75% success rate.
Privacy and Public Policy Division	The Division will continue to enhance external communications with Health Care Policy and Financing clients and providers.	<u>Privacy</u> -- All privacy forms for clients are made available in English and Spanish; privacy calls are returned within 24 hours; and requests for privacy forms are distributed within three days. <u>Custodian of Records</u> -- Open record requests have been responded to within 72 hours. <u>Medical Services Board (MSB)</u> – By June 30, 2007, the Medical Services Board webpage will be enhanced to offer easier accessibility to rule changes and information pertaining to rules. The Division staff has begun working on a monthly basis with Department staff to improve the format and content of existing and future rules, and has worked with the Secretary of State's Office to improve the interface between the Department and the published rules.

FY 06-07 OBJECTIVE: **3.2 To enhance customer service, provider and eligibility personnel's understanding of program requirements, benefits, and responsibilities. To improve the usefulness of communications with clients, constituents, partners and stakeholders.**		
Division / Section	**FY 06-07 Performance Measure**	**Achievements towards FY 06-07 Performance Measures as of November 1, 2006**
Privacy and Public Policy Division-Customer Service Section	The Customer Service Section will decrease the call abandonment rate by 5% from the FY 05-06 level.	As of October 1, 2005, the call abandonment rate was 38.97%. As of October 1, 2006, the call abandonment rate was 35.94%.
Information Technology Division-Information Technology Contracts and Monitoring Section	The Information Technology Contracts and Monitoring Section will explore new mediums for provider communication to facilitate timely communication of changes, issues and impacts to providers.	In FY 05-06, provider bulletins from the fiscal agent began delivery via email. Providers in FY 06-07 received the bulletin by the first of each month and can retrieve all past bulletins via the provider services web site. Previously, 17,000 bulletins each month were mailed. That number will be reduced by 5% in FY 06-07. In addition, web portal messages are posted for urgent information. Email broadcast messages are also sent to appropriate trade associations to disseminate information quickly to about 150 non-provider recipients.
Child Health Plan Plus Division-Program Evaluation and Contract Operations Section	The Child Health Plan Office will evaluate the effectiveness of the marketing plan implemented in FY 05-06, and will use the results to refine the marketing plan by January 2007.	The Child Health Plan Plus Division, Contract Operations Section has planned the first semi-annual evaluation for February, 2007.

FY 06-07 OBJECTIVE: 4.1 To build and maintain a high quality, customer-focused team.		
Division / Section	**FY 06-07 Performance Measure**	**Achievements towards FY 05-06 Performance Measures as of November 1, 2006**
Privacy and Public Policy Division-Customer Service Section	The Customer Services 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.	The Customer Service Section has conducted weekly staff meetings and held one team building meeting on September 8, 2006 and has planned for team building meetings on December 8, 2006, March 30, 2007 and June 1, 2007.

FY 06-07 OBJECTIVE: 4.2 To develop enhanced training and retention strategies for departmental staff.		
Division / Section	**FY 06-07 Performance Measure**	**Achievements towards FY 05-06 Performance Measures as of November 1, 2006**
Controller Division-Human Resources Section	The Human Resources Section of the Controller Division will fully implement its training program for Department managers on State Personnel Rules and processes, including hiring, reclassification, employee performance management, and employee discipline.	The Human Resources Section will implement nine trainings by October 31, 2006 and will implement ten trainings on State personnel rules and processes for the remainder of FY 06-07. Managers receive management training, training on how to develop Personnel Description Questionnaire's and employment performance training.

V. POLICY AND PROGRAM TRENDS

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

The Deficit Reduction Act of 2005 (S. 1932)

On February 8, 2006, President Bush signed S. 1932 (the "Deficit Reduction Act of 2005") into law. The Deficit Reduction Act contains numerous mandatory provisions affecting the states' Medicaid programs along with many additional optional provisions which states may choose to enact. In addition to changes for Medicaid, the Deficit Reduction Act also contained several significant changes to Medicare and other programs funded by the federal government. The Congressional Budget Office estimated that Medicaid provisions of the Deficit Reduction Act would reduce direct federal spending by $6.9 billion between 2006 and 2010, and $28.3 billion between 2006 and 2015.[1] The provisions in the Deficit Reduction Act affect prescription drug reimbursement methodology; asset transfers; regulations regarding fraud, waste, and abuse; cost-sharing and benefits; state financing; eligibility and waiver program expansions and health opportunity accounts.

In many cases, the Department was already conforming to the requirements specified by the Deficit Reduction Act. In those instances where the Deficit Reduction Act mandated something that is different than the Department's current practice, the Department has changed its policies accordingly. In March 2006, the Department began promulgating rules before the Medical Services Board to implement various provisions of the Deficit Reduction Act which were effective upon the Act's passage. The Department will continue to propose rule changes to keep the Department in compliance with the federal law as provisions become effective.

Mandatory Provisions

Prescription Drugs

The Deficit Reduction Act changes the maximum price Medicaid pays for multiple-source drugs from 150% of the lowest published price (usually the wholesale acquisition cost) for a drug to 250% of the lowest average manufacturer price (AMP). The average manufacturer price is the average price that manufacturers receive for sales to retail pharmacies. The revised limit takes effect on January 1, 2007. Like the current limit, it would apply only to a drug's ingredient costs and would not include dispensing fees, which

[1] Congressional Budget Office Cost Estimate, S. 1932 (Deficit Reduction Act of 2005). http://www.cbo.gov/ftpdocs/70xx/doc7028/s1932conf.pdf

would continue to be determined by the Department. Before the enactment of the Deficit Reduction Act, average manufacturer price information was proprietary, and unavailable to the states; however, the Deficit Reduction Act requires that pharmaceutical manufacturers provide this information to the Secretary of the federal Department of Health and Human Services and the Secretary will disseminate this information to the states. In addition, the Deficit Reduction Act requires states to collect rebates on certain physician-administered drugs, and allows certain children's hospitals to purchase prescription drugs at discounted prices (under section 340B of the Public Health Service Act).

Asset Transfers

Medicaid currently imposes a period of ineligibility for nursing home benefits on individuals who transfer assets for less than fair market value. The penalty period is based on the value of any assets transferred during the three years prior to application, known as the look-back period, and starts on the date the assets were transferred. Those rules have relatively little effect because any penalty period usually has expired by the time an individual applies for Medicaid. Under the Deficit Reduction Act, the penalty period will start when an individual becomes eligible for Medicaid and the look-back period is extended from three years to five years. The act also codifies certain protections against undue hardship for individuals who transfer assets. Those changes apply only to asset transfers that occur after the enactment date of the Deficit Reduction Act, so the effect of the longer look-back period will not be felt until January 1, 2009.

Previously, the value of an individual's home was not included when determining eligibility for Medicaid. The Deficit Reduction Act makes individuals with more than $500,000 in home equity ineligible for nursing home benefits; however, the State has the option to raise that limit to $750,000. This amount will be adjusted annually for inflation starting in 2011. The prohibition does not apply if an individual's spouse, minor child, or disabled child (regardless of age) lives in the house and allows exemptions in the case of hardship. This provision applies to individuals who apply for Medicaid after January 1, 2006.

The Deficit Reduction Act also requires Medicaid applicants with annuities to name the State as a remainder beneficiary to the extent of Medicaid's expenditures for that individual; changes the rules under which income and assets are allocated from beneficiaries to their spouses who are living in the community; and, prohibits the State from disregarding or rounding down any fraction period of ineligibility resulting from a transfer of assets at less than fair market value.

Fraud, Waste, and Abuse

The Deficit Reduction Act strengthens Medicaid's status as the payer of last resort relative to private health insurance by specifying that pharmacy benefit managers and self-insured plans are liable third parties, requiring insurers to submit eligibility and claims data

for Medicaid recipients to states on a regular basis, and requires insurers to pay claims for Medicaid recipients within three years of the date of service. The Deficit Reduction Act also mandates that certain employers conduct education campaigns for employees about false claims acts, and prohibits payment for the ingredient costs of a covered outpatient drug if the pharmacy has already received payment from Medicaid for the drug.

This chapter of the Deficit Reduction Act also contains a provision that requires the state to obtain evidence of citizenship and identity for all Medicaid applicants. The documentation requirements do not apply to individuals that are eligible for Medicaid and entitled to or enrolled in Medicare and those eligible for Medicaid by virtue of receiving Supplemental Security Income benefits, who are by definition aged, disabled, or blind, and therefore likely to have difficulty obtaining identification documentation. The provision does not affect the Department's ability to provide emergency services.

The Department projects that approximately 300,000 clients will be asked to provide proof of citizenship and identity, and that an estimated 340 of these clients will lose eligibility due to lack of proper identification. The overall impact on the Department is projected to be small, as some clients who lose eligibility will seek emergency services. Children who loose Medicaid eligibility are assumed to gain coverage from Children's Basic Health Plan which, as a state funded plan, does not fall under the Deficit Reduction Act guidelines.

Finally, this chapter creates the Medicaid Integrity Program under the Secretary of the Department of Health and Human Services, responsible for controlling provider fraud and abuse under Medicaid. States are required to comply with any requirements determined to be necessary for carrying out the federal Medicaid Integrity Program.

State Financing Under Medicaid

Effective January 1, 2006, this section defines the Medicaid targeted case management (TCM) benefit, and codifies the ability of the State to use an approved cost allocation plan for determining the amount that can be billed as Medicaid targeted case management services when case management is also reimbursable by another federally-funded program. Additionally, this section of the Deficit Reduction Act specifies that federal Medicaid funding is only available for targeted case management services if there are no other third parties liable to pay for such services, and restricts the ability of the State to finance its share of Medicaid spending by imposing taxes on health care providers.

Other Mandatory Provisions

In addition to the provisions described above, the Deficit Reduction Act also contains other requirements:

- Eligibility is expanded to persons who are under age 21 and who are eligible for Supplemental Security Income (SSI), effective on the later of: (1) the date the application was filed, or (2) the date Supplemental Security Income eligibility was granted;
- Transitional medical assistance and the abstinence education block grant programs are extended through December 31, 2006;
- Providers that provide emergency care to a beneficiary enrolled with a Medicaid managed care organization (MCO) that do not have a contract with that MCO may be paid a maximum of the fee-for-service rate applicable outside of managed care, less indirect costs; and
- Home and community-based services are established as an optional benefit for certain individuals. The State is no longer required to determine that the person would otherwise require the level of care provided in a hospital, nursing home, or intensive care facility (ICF-MR). The State is required to establish needs-based criteria for determining an individual's eligibility and specific services the individual will receive.

Optional Provisions

The Deficit Reduction Act contains a number of provisions which the State *may* implement at its discretion. These provisions include:

- Requiring residents of nursing facilities to spend resources declared for the purposes of admission on their care prior to applying for medical assistance;
- Imposing premiums or cost-sharing for some recipients not under 100% of the federal poverty level through Medicaid State plan amendments;
- Imposing higher cost-sharing amounts for non-preferred drugs;
- Imposing increased cost-sharing for non-emergency services provided in an emergency room;
- Providing medical assistance to some populations through enrollment in a plan that provides for a certain level of "benchmark" coverage, including the standard Blue Cross/Blue Shield preferred provider plan under the Federal Employees Health Benefit Plan; health coverage for state employees; health coverage offered by the largest commercial health maintenance organization in the state; or other coverage approved by the Secretary of Health and Human Services;
- Providing medical assistance to disabled children whose family income is above the financial standards for Supplemental Security Income but is not more than 300% of the federal poverty level. Medicaid coverage would be phased in depending on a child's age, beginning with qualifying children with disabilities up to age 6 beginning January 1, 2007; up to age 12 in federal fiscal year 2008, and up to age 18 in federal fiscal year 2009 thereafter; and
- Covering payment for part of the cost of self-directed personal assistance services (other than room and board).

In addition to the optional provisions, the Deficit Reduction Act also provides opportunities for states to participate in demonstration or grant funded projects:

- Upon approval from the Secretary of Health and Human Services, states may conduct a demonstration program to test the effectiveness of improving or maintaining a child's functional level, and cost-effectiveness of providing coverage of home and community-based alternatives to psychiatric residential treatment, for children enrolled in Medicaid. Up to 10 states can be approved for this demonstration project;
- Upon approval from the Secretary of Health and Human Services, states may establish a demonstration program to increase the use of home and community-based care, instead of institutions, for clients who are already in an institution or would otherwise be in an institution if not for home and community-based services. Participating states would receive an enhanced federal match for the project;
- States may apply for grants for the adoption of innovative methods to improve the effectiveness and efficiency in providing medical assistance; and
- Upon approval from the Secretary of Health and Human Services, states may conduct a demonstration project to allow participating beneficiaries to self-direct a pre-funded account (a "health opportunity account") for medical care, roll over unspent balances, and retain a portion of account funds after leaving Medicaid to spend on medical care, health insurance, job training, and tuition expenses.

The Department can only implement the optional provisions upon approval from the General Assembly.

HB 06S-1023 "Restrict Public Benefits"

HB 06S-1023 was a result of the 2006 special session on immigration issues, and was signed into law by the Governor on July 31, 2006. It became effective on August 1, 2006. HB 06S-1023 requires the Department to verify the lawful presence in the U.S. of applicants for medical benefits who are at least 18 years of age. For each beneficiary in this age range listed on an application, the Department must require a specified form of identification and a signed affidavit attesting to the applicant's lawful presence in the U.S. Affidavits from a lawfully present alien must be verified through the federal systematic alien verification of entitlement program. The act requires the Department to follow new procedures related to processing applications, revising application materials, making changes to computer systems, instituting temporary manual procedures before automated methods can be employed, conducting audits to ensure compliance, and providing training to those responsible for processing applications.

Client populations exempt from the requirements of the act include applicants for prenatal care (not "prenatal clients" who are enrolled in the Children's Health Plan Plus program, as these clients receive benefits in addition to just prenatal care) and applicants for emergency care not related to an organ transplant. In addition, because of the federal Deficit Reduction Act that went into effect July 1, 2006, the Department is already complying with the provisions of HB 06S-1023 for some client populations to a certain extent,

but not all. The Department has requested additional funding in a November 1, 2006 Change Request for FY 07-08 so it can verify the lawful U.S. presence of applicants not already being verified through the Department's compliance with the Deficit Reduction Act.

The Deficit Reduction Act exempts needy newborns, Supplemental Security Income recipients, and dual eligibles. Although these populations are exempt from the citizenship verification requirements of the Deficit Reduction Act, they are also assumed exempt from the requirements of HB 06S-1023 because:

- Needy newborns do not meet the age requirement;
- Supplemental Security Income clients do not submit applications for eligibility; rather, they are automatically eligible for Medicaid benefits under section 1634 of the Social Security Act.
- Dual eligibles are required to provide proof of identity and lawful U.S. presence to receive Medicare eligibility.

Based on the above, the only applicants neither covered by the Deficit Reduction Act nor by automatic eligibility criteria, i.e., the applicants for which the Department must verify identity and U.S. citizenship or legal residency status under HB 06S-1023 are clients age 18 and older applying for benefits under the following programs:

- Children's Health Plan Plus
- Old Age Pension State Medical Program
- Colorado Indigent Care Program
- Medicaid Title IV-E Foster Care
- Comprehensive Primary and Preventive Care Program

The requirements of HB 06S-1023 will not affect any of the Department's OAP-A, OAP-B, and AND/AB clients who are neither dual eligibles nor recipients of Supplemental Security Income, because the lawful U.S. presence of these clients will be verified under the Deficit Reduction Act.

SB 06-219: Reorganization of programs administered by the Department

Effective July 1, 2006, this bill reorganized and amended statutes relating to all programs administered by the Department. It consolidated all statute relating to the Department in Title 25.5 C.R.S. (2006), and included some duplication of existing county administrative and financial provisions that were currently only in the Department of Human Services' code. This bill also allowed for significant updating to the Department's statutes, as some language was outdated and obsolete.

In addition to the reorganization of statutory language related to the Department, this bill also transferred the administrative responsibilities of a number of programs and altered some budgetary line items in both the Department and the Department of Human Services. These programs include Home Care Allowance and Adult Foster Care, both of which have been transferred to the Department of Human Services. Home Care Allowance provides direct 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 a more restrictive, expensive placement. Adult Foster Care provides 24-hour non-medical supervision for adults, including: room and board, recreational activities, supervision of medications, protective oversight, and some assistance with activities of daily living. Both of these cash assistance programs are State and county-funded programs, receiving no federal funding from Medicaid.

Finally, beginning July 1, 2006, the Department now has a direct relationship with county governments which provide much of the administrative functions regarding Medicaid eligibility determinations and client case management. Previously, counties were reimbursed for both their Medicaid and non-Medicaid related costs associated with eligibility determinations and case management for public assistance programs from the Department of Human Services. The total amount in the Department of Human Services budget to reimburse these county governments included Medicaid funding that was transferred from the Department to the Department of Human Services. Beginning in FY 06-07, all Medicaid funding remains in the Department's budget, and the Department pays the counties directly for this work. This change, along with those changes described above for Home Care Allowance and Adult Foster Care, removed roughly $27 million in double counting of funds in the State's overall budget (all transfers to other agencies appear as Cash Funds Exempt).

Reprocurement of the Medicaid Management Information System Contract

Since December 1, 1998, the Department's fiscal agent for the Medicaid Management Information System has been Affiliated Computer Services, (Affiliated Computer Services, Inc. d/b/a Affiliated Computer Services State Healthcare or ACS). The primary responsibility of the fiscal agent is to process and pay all medical providers' claims and capitation payments. The last regularly renewable contract year under the prior request for proposals was anticipated to end November 30, 2006. However, due to limited resources and challenges associated with implementing the Colorado Benefits Management System, the Department had been working with the federal Centers for Medicare and Medicaid Services since the summer of 2001 to secure an extension of the renewal date. On January 13, 2006, the Centers for Medicare and Medicaid Services granted permission to the Department extending the contract with Affiliated Computer Services to November 30, 2007.

Because of the complexities of completing the reprocurement, the Department decided it would be beneficial to hire a consultant to assist with supervising the broad range of work activities necessary for a successful reprocurement of the fiscal agent. On November 15, 2005, Solutions Consulting Group, LLC d/b/a Public Knowledge LLC was awarded the contract. The consultant began work with

the Department in December 2005 to develop an advance planning document to submit to the federal Centers for Medicare and Medicaid Services, to identify enhancements needed for the Medicaid Management Information System. The consultant met with Departmental staff on the proposed request for proposals during the month of March 2006. Based on the work conducted by the consultant, the Department wrote the request for proposals in April-May 2006, and received final approval from the Centers for Medicare and Medicaid Services on May 25, 2006. The request for proposals for the future fiscal agent was released on June 16, 2006. The request for proposals responses were returned on August 10, 2006. Based on the selection process, the winning bidder was Affiliated Computer Services.

The transition phase began immediately with system upgrades and enhancements. The consultant, Public Knowledge, continues to assist with the transition by tracking all phases of progress and delivery dates for all measurable milestones. The Medicaid Management Information System will complete transition and be fully operational by June 30, 2007 with the first phase of the contract ending June 30, 2010 but with the option of extending the contract for five more years to June 30, 2015. Funding for completing the transition and enhancement phases of reprocurement with assistance from the consultant, Public Knowledge, LLC is expected to be needed through FY 07-08.

Non-Emergency Transportation Services

The Department of Health Care Policy and Financing assures non-emergency transportation to and from medically necessary services covered by the Colorado Medical Assistance Program for clients who have no other means of transportation throughout all sixty-four counties in Colorado. Section 25.5-5-202 (s) (2), C.R.S. (2006) and 42 C.F.R. Section 431.53 requires the Department to provide non-emergency medical transportation to eligible clients under the state Medical Assistance Program. The type of transportation authorized is determined by the distance to be traveled, treatment facilities available, and the physical condition and welfare of the client. Non-emergency transportation services include transportation between the client's home and Medicaid covered benefits. There are also administrative costs related to non-emergency medical transportation including, but not limited to, the intake of client calls, determining eligibility, and authorizing and arranging transportation. State designated entities (counties) have been responsible for operating non-emergency medical transportation within allocated funding.

The Department employs two mechanisms to meet non-emergency transportation needs for Medicaid clients. In 56 counties within the State, the counties are responsible for authorizing and arranging the transportation. In eight front-range counties, the Department contracts directly for the necessary services and administration with a broker.

Due to poor previous broker performance in previous years and increased utilization, the Department had difficulty in procuring a contract with a transportation broker. In FY 05-06, the Department entered into a nine-month emergency contract from July 2005 –

March 2006, with LogistiCare, to administer non-emergency medical transportation for the eight front-range counties. On January 5, 2006, the Department posted a new request for proposals for non-emergency medical transportation and secured a fixed price contract with LogistiCare to administer non-emergency medical transportation to the eight front-range counties which began July 1, 2006.

HB 06-1395: Redesign of the Residential Treatment Centers

In March 2005, the Centers for Medicare and Medicaid Services informed the State that the per diem billing in the residential treatment center program was no longer acceptable, and unless revisions to the program were made as of July 1, 2006, federal matching funds would not be available. The Centers for Medicare and Medicaid Services' largest concern was the use of bundled per diem rates for these clients, and their concern that these rates included reimbursement for non-Medicaid allowable services. Per federal regulations, only institutional providers are allowed to bill using a per diem rate. Institutions qualifying for a per diem shall be classified as psychiatric residential treatment facilities. All other providers must bill on a fee-for-service basis for units of service. At the time the Centers for Medicare and Medicaid Services notified the State of this requirement, there were 53 residential treatment centers, and only 16 had the appropriate certifications to be classified as psychiatric residential treatment facilities. Therefore, in response to the Centers for Medicare and Medicaid Services' notice, the Department (along with the Department of Human Services, county department representatives, and other key stakeholders) engaged in multiple work groups to propose a redesign of the mental health service delivery system in residential care.

As of April 2006, there were approximately 1,500 youth served by the residential treatment centers. To continue to receive Title XIX federal matching funds for this youth population, with the passage of HB 06-1395 on May 26, 2006, a redesign of the residential treatment center program has been completed. This redesign separated the old residential treatment centers into three new provider types, offering three different levels of care:

- Psychiatric Residential Treatment Facilities (PRTF)

Psychiatric residential treatment is considered the highest level of care short of inpatient hospitalization for children with the most severe mental disorders. This type of treatment is reserved for youth that have one of thirteen high-level mental disorders, some impairment in reality testing or communication, and/ or major impairment in several areas such as work, school, or family relations and exhibit other related problems. A physician determines if the child requires the restrictive level of care with the expectation that treatment in the psychiatric residential treatment facility would improve the current condition or prevent further regression. Only a small percentage of current youth, approximately 6.86%, qualify for placement in these facilities. Placement into this program costs approximately $300 per day, and an average stay is estimated to be six months.

• Treatment Residential Child Care Facilities (TRCCF)

Care provided by the treatment residential child care facilities is similar to the old residential treatment center model. However, billing for all care provided at these facilities must now be done on a fee-for-service basis, and will not include Medicaid funding for services which are not eligible for federal financial participation. Licensed therapists provide services at these facilities and are reimbursed at defined reimbursement rates set by the State Medical Services Board. Payment for Medicaid fee-for-service mental health therapies will be for services indicated in the client's care plan. Room and board (maintenance costs) is not covered under Medicaid funding.

• Community Based Residential Child Care Facilities

Community based residential child care facilities offer the least restrictive level of care for children with severe mental disorders and is designed to allow transition to the home or community, or to a less intensive level of care. Medicaid funding covers specific treatment which can be billed as fee-for-service on behalf of a licensed therapist providing these services at defined reimbursement rates set by the State Medical Services Board. Clients in this setting are covered by the behavioral health organization. Behavioral health organizations are managed care organizations that operate Colorado Medicaid's Community Mental Health Services program. They provide, deliver, arrange and pay for or reimburse any of the cost of mental health services through the consumer's use of mental health providers in the behavioral health organizations network. The behavioral health organizations assume the risk of providing medically necessary mental health services to all enrolled consumers in the geographic service area under a capitated payment system.

Home and Community Based Services for Persons with Developmental Disabilities Waiver (HCBS-DD)

The Centers for Medicare and Medicaid Services concluded an audit on April 26, 2004, of the Home and Community Based Services for Persons with Developmental Disabilities (HCBS-DD) waiver. As a result of this audit, the State is required to break apart the current bundled reimbursement rate into identifiable Medicaid allowable services, and provide a revised reimbursement plan to the Centers for Medicare and Medicaid Services for approval. Until this can be accomplished, with approval by the Centers for Medicare and Medicaid Services, an interim reimbursement rate for each category related to the Home and Community Based Services for Persons with Developmental Disabilities waiver was implemented on July 1, 2006.

Previously, payments were made to community centered boards that include reimbursement for some activities that were not eligible for Medicaid reimbursement. Therefore, a steering committee has been organized by the Office of State Planning and Budgeting to determine how to unbundle rates, identify the components, and set tiered rate structures. The steering committee is composed of

representatives from the Department, the Office of State Planning and Budgeting, the Department of Human Services and community centered boards.

Two of the nine benefits under the Home and Community Based Services for Persons with Developmental Disabilities waiver, day habilitation and residential habilitation, are anticipated to have seven tiers, each related to client's levels of acuity. Under this premise, the steering committee sent out surveys to determine the number and type of services provided at each acuity level. The surveys were compiled by program personnel from the Department of Human Services to ensure consistency of reporting. The data collected from these surveys was then forwarded to an actuary to determine the rates for the tiers anticipated to begin on March 1, 2007.

The plan of correction submitted to the Centers for Medicare and Medicaid Services on May 19, 2006 included a short-term solution and a long-term-solution. The short-term solution consists of two parts: (1) to establish and implement statewide interim uniform tiered rates based on analysis of existing rates – these rates were implemented beginning July 2006, and (2) by July 31, 2006 providers were given the option to enroll as Medicaid providers and to bill directly in time for submission of July 2006 claims. Prior to July 2006, providers had to bill the State through the community centered boards.

The long-term solution consists of five parts and are as follows: (1) by July 2006, an intensity tool would be used to identify a client's reimbursement tier based upon client need; (2) by December 31, 2006, a sample of clients sufficient in size for purposes of an actuarial study shall be evaluated using the intensity tool; (3) by March 31, 2007, an actuary study establishing the long term uniform rates by tier for residential services and day habilitation services should be completed; (4) by June 30, 2007, continued stay reviews on all clients to include application of intensity tool and identification of reimbursement tier shall be completed; and (5) by July 1, 2007, new rates based on the actuarial study shall be implemented.

The second facet of the plan of correction deals with the lack of waiver oversight by the Department. The plan of correction covers two areas: (1) Department staff will provide training to the Department of Human Services and community centered boards with regards to the Business Utilization System and appeal notifications; and (2) the Department hired an oversight coordinator who is dedicated to assuring all aspects of the waiver are administered according to the waiver document, and appropriate federal and State guidelines.

At the completion of this project, the un-bundling process will create a system that allows for a clean audit trail that separates Medicaid costs from non-Medicaid costs and administrative payments from benefit payments. Further, the payments made will identify the specific client, specific service, qualified provider and reimbursement amount. The plan of correction was submitted to the Centers for Medicare and Medicaid Services for its approval on May 19, 2006.

Passive Enrollment in Medicaid Managed Care Health Plans

Effective May 1, 2006, the Department instituted a new policy known as passive enrollment wherein certain clients in Adams, Arapahoe, Denver, and Jefferson counties are automatically enrolled in a Medicaid managed care plan. Passive enrollment encourages client participation in a Medicaid managed care health plan and promotes selecting a primary care physician as a client's medical home.

Newly eligible clients in the four counties are assigned a managed care plan via the passive enrollment process. In addition, each month, a portion of the existing Medicaid fee-for-service clients are notified of their option to remain in the Medicaid fee-for-service plan, or to enroll in one of the Medicaid managed care health plans, until all fee-for-service clients in the area have been given option to enroll. Clients may enroll in Denver Health, the Primary Care Physician Program, or elect to remain in the fee-for-service plan. After 30 days, any client who has not selected any of these options will be automatically enrolled in the plan specified in their notification letter. Clients who are automatically enrolled through the passive enrollment program may choose another health plan during their first 90 days of enrollment. Clients excluded from the passive enrollment program include foster care children, clients who are in a nursing home, and other Medicaid clients who do not qualify for full Medicaid benefits.

Contact information is provided to Medicaid clients wishing to choose a health plan or with questions about the Primary Care Physician Program by the Department's enrollment broker, Health Colorado. Clients with questions about the Medicaid fee-for-service plan may contract the Department's customer service section. Clients with questions regarding a specific Medicaid managed care health plans are given contract information for the specific plan.

On July 18, 2006, Colorado Access withdrew from Medicaid managed care various due to various financial concerns. The Department worked with Colorado Access, the Division of Insurance and the Centers for Medicare and Medicaid Services to ensure a smooth transition for clients.

Tobacco Tax Update

On February 15, 2006, the Department submitted an update on Tobacco Tax to the Joint Budget Committee regarding HB 05-1262.

The update focused on how moneys were allocated, expended and tracked for various programs receiving tobacco tax moneys. The following provides current information on each of these programs. Additional information on tobacco tax expenditures and estimated need and projected revenue can be found in volume II of this November 1, 2006 Budget Request, tab P.

I. The Health Care Expansion Fund:

The Health Care Expansion Fund receives 46% of the Tobacco Tax moneys at $78.1 million in FY 05-06 and is estimated at $73.3 in FY 06-07. HB 05-1262 specifies that the Health Care Expansion Fund shall be used for the following purposes:

(a) Increase eligibility in the Children's Basic Health Plan for children and pregnant women from 185% to 200% of the federal poverty level.

The expansion of pregnant women to 200% of the federal poverty level was implemented July 1, 2005. The Department set up a new income rating code in the Colorado Benefits Management System to track clients from 186% to 200% of the federal poverty level for both children and pregnant women. Modifications to the Medical Management Information System were made to allow for monthly reporting of these populations on December 2005. The interface between the Colorado Benefits Management System and the Medicaid Management Information System has enabled the Department to generate monthly reports on caseload and expenditures. The Child Health Plan Plus Report (COMH4300-R4300) provides monthly data for this population.

(b) Remove the Medicaid asset test.

Removing the Medicaid asset test is an expansion to Medicaid eligibility, as clients who were previously found ineligible for Medicaid would now qualify. July 1, 2006 was the effective date to accommodate the time needed to implement necessary eligibility system changes and to ensure proper noticing. With modifications to the Colorado Benefits Management System and the Medicaid Management Information System, the Department set a "flag" indicator for those clients who would have failed the asset test for Medicaid eligibility had the asset test still been in effect. The Department is currently working on reports to show all payments and client counts for clients that are eligible in a reporting month and have the Asset Test Indicator set to "Y" as of the first date of service. The Department will produce a similar report for clients that have the Asset Test indicator set to "N."

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

Children's Home Community Based Services and Children's Extensive Support Services are both 1915 (c) waivers. HB 05-1262 added 478 children to the current 630 capacity available for Children's Home and Community Based Services and 148 children to the current 217 capacity available for Children's Extensive Support Services on January 1, 2005. In FY 06-07 Figure Setting, the Joint Budget Committee added 200 additional Children's Home and Community Based Service slots and an additional 30 slots Children's Extensive Support Service expansion slots. However, due to the time required to enroll children, funding for only half of these (100 and 15 respectively) was appropriated in FY 06-07.

For Children's Home and Community Based Services, the Department produces three monthly payment reports. The first report shows all payments for the first 630 "traditional" clients that were eligible as of the first date of service or entry in the program. The second report shows all payments for "expansion" clients, clients filling slots 631-1108, that were Medicaid eligible at the time they entered the waiver and are in addition to the 630 "traditional" clients. The third report shows all payments for "expansion" clients that were not Medicaid eligible at the time they entered the waiver and are in addition to the 630 "traditional" clients.

For Children's Extensive Support Services, the Department produces three monthly payment reports. The first report shows all payments for the 217 "traditional" clients that were eligible as of the first date of service or entry into the program. The second report shows all payments for "expansion" clients that were Medicaid eligible at the time they entered the waiver and are in addition to the 217 "traditional" clients. The third report shows all payments for "expansion" clients that were not Medicaid eligible at the time they entered the waiver and are in addition to the 217 "traditional" clients.

(d) Increase Medicaid eligibility to parents of enrolled children up to at least 60% of the federal poverty level.
HB 05-1262 provides funding to increase the eligibility for low income parents of enrolled children from 36% up to at least 60% of the federal poverty level. This eligibility expansion was implemented July 1, 2006 and tracked as a separate eligibility group. A new program aid code was created in the Colorado Benefits Management System to track this population separately. Both expenditures and caseload are tracked at the actual level. This program aid code will be added to the Medicaid Management Information System and Decision Support System by December 2006 to produce a separate tracking report.

(e) Fund Medicaid to legal immigrants.
The Department is still developing reports that will track optional legal immigrants in the Colorado Benefits Management System. When the indicators are in place, the Department will produce two reports: (1) the first report will show all payments and client counts for clients who were eligible as of the first date of service for the payment in the reporting month and have a legal permanent resident flag of "M", mandatory and the second report for clients having a legal permanent resident of "N", optional status.

(f) Pay for enrollment increases above the FY 03-04 level in the Children's Basic Health Plan.
Due to budget constraints, enrollment into the Prenatal and Delivery Program was suspended during FY 03-04. As a result, there were 1,428 member months for pregnant women in FY 03-04. All enrollments of pregnant women above this level will be funded by the Health Care Expansion Fund. In addition, the FY 03-04 average monthly enrollment for children was 46,694, so any client count above this level will be considered an expansion population, and may be funded with monies from the Health Care Expansion Fund. However, due to the impact of removing the Medicaid asset test, the children's caseload is not expected to exceed this level for several years. The Department produces a year-to-date payment report for all Child Health Plan Plus eligibles, excluding prenatal clients that are between 186% - 200% of federal poverty level. The report will be on a per member per month basis.

(g) Provide cost-effective marketing of the Children's Basic Health Plan.
The Children's Basic Health Plan has a marketing contract with Maximus, effective January 19, 2005. The Department requested $100,000 for contract services in order to conduct a survey of the number of children on the Medicaid program that are enrolled because of additional marketing of the Children's Basic Health Plan. The Joint Budget Committee denied this request since they did not believe the Health Care Expansion Fund can be used for this purpose. Tobacco tax monies are to be used only to increase eligibility in the Medicaid program. Eligibility is different than enrollment. The Joint Budget Committee does not believe that the Health Care Expansion Fund can be used for these "woodwork" children from Children's Basic Health Plan marketing. The Department will therefore not be tracking the impact of Medicaid from Children's Basic Health Plan marketing (Figure Setting, March 13, 2006, page 25).

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

Presumptive eligibility was reinstated July 1, 2005 by utilizing the presumptive eligibility process in place for the Children's Basic Health Plan within the Anthem self-funded network. Presumptive eligibility for Medicaid is handled though the Anthem network. Once eligibility is determined, the client is taken off presumptive eligibility and may go to fee-for-service or another Medicaid health maintenance organization. The Department makes payments based on the estimated cost per client per month and annually reconciles actual costs to the estimated payments. The Department checks for duplicate payments to assure that payments are not also made through the Medicaid Management Information System for these clients.

II. Cash Fund for Health-Related Purposes

(a) Old Age Pension Health and Medical Care Fund
The Old Age Pension Health and Medical Fund was established through Article XXIV of the Colorado Constitution and Section 25.5-2-101, C.R.S. (2006) to provide a health and medical program to persons who qualify to receive old age pensions but who are not eligible for Medicaid, and who are not patients in an institution for tuberculosis or mental diseases. Since this is not an expansion of eligibility, there are no new clients to track. Due to changes in reimbursement rates, the Department requested a FY 05-06 Emergency Supplemental and received approval on June 20, 2006 for $1,140,484 in addition to the original appropriation of $13,286,483.

(b) Pediatric Specialty Hospital Fund
Per HB 05-1262, the Pediatric Specialty Fund was created for the purposes of augmenting hospital reimbursement rates for regional pediatric trauma centers, beginning FY 06-07. The Children's Hospital is currently the only provider qualified for this funding. There is no population to track since a specified amount is paid directly to Children's Hospital. Using financial transactions, the Department will make payments to the Children's Hospital on a quarterly basis.

III. Primary Care Fund

(a) Primary Care Fund

The Primary Care Fund was created in Section 25.5-3-301, C.R.S. (2006). HB 05-1262 appropriated $44,099,000 of Cash Funds Exempt to the Primary Care Fund. Of the total appropriation, $99,000 was appropriated for administrative expenses. The Department makes quarterly payments from this fund.

IV. The Prevention, Early Detection, and Treatment Fund

(a) Breast and Cervical Cancer Program

A portion of the Prevention, Early Detection and Treatment Fund is dedicated to increasing the number of cancer screenings performed by the Department of Public Health and Environment. In FY 05-06, the Department of Public Health and Environment began funding approximately 30% of these screenings with tobacco tax revenues from the Prevention, Early, Detection, and Treatment Fund and 70% from federal grants. This percentage is likely to change over time, based on the budgetary needs of the Colorado Women's Cancer Control Initiative; however, the Department is planning to use this percentage as a reasonable allocation of treatment cost.

(b) Medicaid Disease Management Program

The Department investigated the appropriate conditions for disease management programs and contracted with a disease management vendor in October 2006. Actual expenditures began in October 2006. The expenditure analysis by general ledger and eligibility category report provides the data for this population.

Consumer Assessment of Health Plans Study (CAHPS)

The Consumer Assessment of Health Plans Study (CAHPS®) is a nationally recognized survey that measures client satisfaction within a given health plan and may be used to compare satisfaction across health plans.[2] The goal of the CAHPS surveys is to effectively and efficiently obtain client information.

The Department requires Medicaid physical health plans to conduct client satisfaction surveys to ascertain differences between managed care clients, Primary Care Provider Program and fee-for-service clients. As part of a comprehensive quality improvement effort, the Department required physical health plans to conduct the CAHPS 3.0H Survey of Adults and 3.0H Survey of Children with

Note: Only the 2006 Child CAHPS was required of managed care organizations

Medicaid clients that had been continuously enrolled in a managed care plan for at least five of the last six months of calendar year 2005. The survey period for this questionnaire was July through December, 2005. The data were collected between February and May 2006. National averages for 2005 (the most recent comparative data available) are included.

CAHPS 2006 Summary of Results, Reporting Year 2005

CAHPS Measure	Colorado Access	Rocky Mountain Health Plans	Denver Health and Hospital Authority	Primary Care Physician Program	Fee For Service	2005 National Average
Overall Rating of Health Plan *"Using any number from 0 to 10 where 0 is the worst health plan possible, and 10 is the best health plan possible, what number would you use to rate your health plan?"* Percent rating a 9 or 10.						
Adult	Not reported	64.41	54.50	53.68	46.39	51
Child	58.03	66.23	62.73	61.71	53.39	60
Overall Rating of Health Care *Of those respondents who reported going to a doctor's office or clinic: "Using any number from 0 to 10, where 0 is the worst health care possible, and 10 is the best, what number would you use to rate all your health care in the last 6 months?"* Percent rating a 9 or 10.						
Adult	Not reported	59.85	58.42	58.84	51.72	54
Child	56.27	71.24	60.29	64.84	53.66	65
Overall Rating of Personal Doctor or Nurse *Of those respondents who saw a primary care provider: "Using any number from 0 to 10, where 0 is the worst personal doctor or nurse possible, and 10 is the best possible, what number would you use to rate your personal doctor or nurse?"* Percent rating a 9 or 10.						
Adult	Not reported	64.21	68.91	60.05	46.62	59
Child	60.13	70.84	71.11	65.87	56.18	64
Getting Needed Care *Getting needed care is a composite of questions regarding the ease of finding a doctor or nurse, obtaining a referral to a specialist, getting the care the respondent or a doctor believed necessary, and delays in health care while waiting for an approval.* Percent rating "not a problem."						
Adult	Not reported	84.72	75.21	75.50	71.09	66

CAHPS Measure	Colorado Access	Rocky Mountain Health Plans	Denver Health and Hospital Authority	Primary Care Physician Program	Fee For Service	2005 National Average
Child	77.14	87.97	77.14	77.53	78.52	71
Getting Care Quickly *Getting care quickly is a composite of questions regarding receiving help or advice over the telephone, obtaining routine appointments, obtaining care for an illness or injury, and waiting time in an office or clinic.* Percent rating "always and usually."						
Adult	Not reported	86.26	68.75	76.64	73.34	72
Child	76.42	87.89	70.17	83.06	78.54	56
Doctors Who Communicate Well *How well doctors communicate is a composed of questions regarding how well providers listen to and explain things, whether they show respect and whether they spend enough time with the respondent.* Percent rating "always and usually."						
Adult	Not reported	91.86	84.88	89.86	87.39	86
Child	88.17	94.60	90.52	92.51	88.78	90
Courteous and Helpful Office Staff *Questions regarding whether office staff at the respondent's doctor's office or clinic treated respondents with courtesy and respect and whether they were as helpful as respondents thought they should be made up the courteous and helpful office staff composite measure.* Percent rating "always and usually."						
Adult	Not reported	95.31	88.05	89.29	92.06	88
Child	89.64	94.82	88.28	92.46	90.00	91

Health Plan Employer Data Information Set (HEDIS)

The Health Plan Employer Data Information Set (HEDIS®) is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of managed health care plans.[3] The performance measures are related to many significant public health issues such as cancer, heart disease, smoking, asthma, and diabetes

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

that affect Medicaid populations. Each year, different HEDIS measures are selected for measurements that relate to quality improvement efforts outlined in the State Quality Improvement Work Plan.

The Department requires Medicaid health plans to conduct HEDIS measures to ascertain differences between managed care clients, Primary Care Provider Program, and fee-for-service clients. As part of a comprehensive quality improvement effort, the Department required health plans to conduct ten clinical measures on both adults and children. The 2006 data collection period for each of the reported measures was January 1, 2005 through December 31, 2005.

Colorado Medicaid Averages are calculated by the Department to use as comparison among itself and nationally. Where available, 2005 Colorado Medicaid Averages are compared for 2006.

2006 HEDIS Colorado Medicaid (Calendar Year 2005 Data Collection) **HEDIS Rates for All Medicaid Health Plans** HEDIS is a registered trademarked product of the National Committee for Quality Assurance							
HEDIS Measure	**Access**	**Denver Health**	**Rocky**	**PCPP**	**FFS**	**Total HMO**	**Total Colorado Medicaid**
Childhood Immunization Status **Percent of Children receiving immunizations by 2 years old**							
4 Diphtheria, Tetanus, Pertussis	64.7% Average	88.9% Above	85.8% Above	65.7% Average	46.0% Below	75.9% Above	66.3%
1 Measles, Mumps, Rubella	75.9% Average	93.8% Above	93.7% Above	82.2% Average	64.7% Below	85.1% Above	79.5%
3 Polio Virus immunizations	74.7% Average	95.1% Above	92.4% Above	74.5% Average	55.7% Below	84.1% Above	75.0%
2 Haemophilus Influenzae Type B	74.7% Average	95.1% Above	93.4% Above	81.0% Average	60.1% Below	84.5% Above	77.8%
3 Hepatitis B immunizations	72.2% Average	92.6% Above	96.1% Above	71.8% Average	53.5% Below	84.2% Above	73.9%
1 Chicken Pox vaccines	74.9% Average	92.6% Above	90.3% Above	80.3% Average	62.8% Below	83.1% Above	77.5%
Pneumococcal Conjugate	20.6% Below	86.4% Above	52.9% Above	32.6% Average	24.1% Below	40.4% Above	34.6%
Combo 2 Rate -- 4 DTP or DTaP, 3 OPV or IPV, 1 MMR, 2 hepatitis B, 1 Hib, and VZV	56.8% Average	85.2% Above	79.2% Above	54.7% Average	38.4% Below	68.9% Above	58.2%

2006 HEDIS Colorado Medicaid (Calendar Year 2005 Data Collection)
HEDIS Rates for All Medicaid Health Plans
HEDIS is a registered trademarked product of the National Committee for Quality Assurance

HEDIS Measure	Access	Denver Health	Rocky	PCPP	FFS	Total HMO	Total Colorado Medicaid
Combo 3 Rate - DTaP, IPV, MMR, HiB, hepatitis B, VZV, pneumococcal conjugate	18.8% Below	79.0% Above	48.7% Above	26.3% Average	20.0% Below	37.0% Above	30.3%
Adolescent Immunizations **Percent of adolescents who received immunizations by 13 years old**							
2 Measles, Mumps, Rubella	51.0% Average	93.0% Above	78.2% Above	50.6% Average	35.8% Below	65.2% Above	52.6%
1 Hepatitis B immunizations	42.9% Below	89.5% Above	81.6% Above	44.5% Average	32.1% Below	61.2% Above	48.3%
1 Chicken Pox vaccines	28.8% Average	85.1% Above	53.1% Above	27.3% Average	12.9% Below	44.2% Above	31.1%
Combo 2 - MMR, Hepatitis B, and VZV	21.8% Below	84.2% Above	46.0% Above	23.6% Average	10.9% Below	38.1% Above	26.8%
Comprehensive Diabetes							
HbA1c Testing	79.4% Average	83.9% Above	90.5% Above	76.6% Average	67.2% Below	84.5% Above	79.5%
Poor HbA1c Control (Lower is Better)	45.1% Average	42.3% Below	17.3% Below	70.1% Above	74.9% Above	35.1% Below	49.9%
Eye Exam	51.2% Above	45.5% Average	69.6% Above	32.4% Below	29.9% Below	55.3% Above	45.8%
Lipid Profile	81.7% Average	86.9% Above	87.8% Above	81.5% Average	73.0% Below	85.4% Above	82.2%
LDL-C Level <130 mg/dL	51.9% Average	72.3% Above	72.3% Above	27.5% Below	21.9% Below	65.2% Above	49.2%
LDL-C Level <100 mg/dL	35.0% Average	59.9% Above	46.5% Above	20.9% Below	15.6% Below	46.9% Above	35.5%
Monitoring for Diabetic Nephropathy	44.9% Average	58.9% Above	57.2% Above	37.5% Below	40.1% Below	53.5% Above	47.7%

2006 HEDIS Colorado Medicaid (Calendar Year 2005 Data Collection)
HEDIS Rates for All Medicaid Health Plans
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HEDIS Measure	Access	Denver Health	Rocky	PCPP	FFS	Total HMO	Total Colorado Medicaid
Prenatal & Postpartum Care - HMO reporting not required for 2006							
Timeliness of Prenatal Care	NR NR	71.2% Average	95.5% Above	58.2% Below	54.5% Below	89.4% Above	67.5%
Postpartum Care	NR NR	36.5% Below	78.0% Above	51.3% Average	42.8% Below	67.6% Above	54.0%
Adult's Access to Preventive/Ambulatory Health Services - HMO reporting not required for 2006							
Ages 20-44	NR NR	70.2% Above	80.6% Above	65.3% Above	58.1% Below	75.8% Above	60.3%
Ages 45-64	NR NR	79.6% Above	90.4% Above	65.2% Above	43.8% Below	83.9% Above	52.7%
Ages 65 and Above	NR NR	81.0% Above	93.0% Above	28.6% Above	18.2% Below	87.2% Above	24.4%
Combined	NR NR	77.0% Above	87.4% Above	55.5% Above	41.4% Below	82.0% Above	46.7%
Children's Access to Primary Care Providers							
Age 12-24 Months	91.6% Above	99.0% Above	98.1% Above	36.0% Below	55.1% Below	93.7% Above	58.5%
Age 25 Months - 6 Years	78.1% Above	79.9% Above	89.6% Above	30.2% Below	38.0% Below	80.2% Above	46.0%
Age 7-11 Years	79.0% Above	NR NR	90.8% Above	33.0% Below	33.2% Below	81.2% Above	43.7%
Age 12-19 Years	79.3% Above	NR NR	90.3% Above	37.9% Below	34.5% Below	81.5% Above	44.5%
Well Child Visits in the First 15 Months of Life							
No Visits	3.9% Below	NR NR	1.2% Below	31.6% Above	26.8% Above	2.6% Below	17.8%
1 Visit	4.2% Average	NR NR	1.2% Below	9.6% Above	5.1% Average	2.8% Below	5.2%

2006 HEDIS Colorado Medicaid (Calendar Year 2005 Data Collection)
HEDIS Rates for All Medicaid Health Plans
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HEDIS Measure	Access	Denver Health	Rocky	PCPP	FFS	Total HMO	Total Colorado Medicaid
2 Visits	6.9% Average	NR NR	6.4% Average	5.2% Average	4.1% Average	6.7% Average	5.5%
3 Visits	9.7% Average	NR NR	8.4% Average	6.5% Average	7.5% Average	9.1% Average	7.9%
4 Visits	13.5% Average	NR NR	18.9% Above	8.2% Below	10.5% Average	16.1% Above	12.3%
5 Visits	18.1% Average	NR NR	30.1% Above	6.9% Below	12.7% Below	24.0% Above	16.0%
6 or More Visits	43.6% Above	NR NR	33.7% Average	32.0% Average	33.3% Average	38.8% Average	35.3%
Well Child Visits in the 3rd, 4th, 5th & 6th Years of Life							
	50.1% Above	55.5% Above	61.5% Above	21.4% Below	26.0% Below	52.6% Above	31.4%
Adolescent Well-Care Visits							
	27.7% Average	27.4% Average	35.7% Above	23.1% Below	20.9% Below	29.1% Average	28.4%
Annual Dental Visit **All Client Receive Care Via PCCP and FFS**							
Age 2-3	NA NA	NA NA	NA NA	35.9% Above	25.5% Below	NA NA	26.8%
Age 4-6	NA NA	NA NA	NA NA	57.3% Above	45.4% Below	NA NA	47.6%
Age 7-10	NA NA	NA NA	NA NA	60.3% Above	48.9% Below	NA NA	51.0%
Age 11 - 14	NA NA	NA NA	NA NA	57.3% Above	45.2% Below	NA NA	47.3%
Age 15-18	NA NA	NA NA	NA NA	47.8% Above	41.0% Below	NA NA	42.1%
Age 19 -21	NA NA	NA NA	NA NA	31.5% Above	23.8% Average	NA NA	24.5%

2006 HEDIS Colorado Medicaid (Calendar Year 2005 Data Collection) **HEDIS Rates for All Medicaid Health Plans** HEDIS is a registered trademarked product of the National Committee for Quality Assurance							
HEDIS Measure	**Access**	**Denver Health**	**Rocky**	**PCPP**	**FFS**	**Total HMO**	**Total Colorado Medicaid**
Combined	NA NA	NA NA	NA NA	52.7% Above	40.3% Below	NA NA	42.3%
Controlling High Blood Pressure							
	55.3% Average	55.5% Average	69.3% Above	59.9% Above	49.6% Average	55.7% Above	52.2%
Cholesterol Management							
LDL-C level of <100 mg/dL 60-365 days	31.3% Above	NR NR	41.0% Above	18.5% Below	15.3% Below	34.5% Above	23.1%
LDL-C level of <130 mg/dL 60-365 days	39.5% Above	NR NR	54.8% Above	24.6% Below	20.0% Below	44.7% Above	30.1%
LDL-C screening 60-365 days	61.7% Above	NR NR	65.4% Above	47.2% Below	47.9% Average	62.7% Above	51.9%
Appropriate Treatment for Children with Upper Respiratory Infection - HMO reporting not required for 2006							
	NR NR	94.3% Above	90.3% Above	86.0% Average	86.6% Average	91.4% Above	86.9%
Ambulatory Care (Total)							
Outpatient Visits/1,000 Member Months	282.17	291.03	431.94	299.42	272.16	310.39	281.94
Ambulatory Surgery Procedures/ 1,000 Member Months	5.65	5.76	10.32	6.88	4.57	6.51	5.16
Emergency Room Visits/ 1,000 Member Months	60.75	30.59	48.26	57.31	52.64	53.86	53.36
Observation Room Stays Resulting in Discharge/ 1,000 Member Months	1.99	1.03	1.47	1.94	3.38	1.75	2.94

Colorado Benefits Management System Update

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

- Client Oriented Information Network (COIN);
- Colorado Automated Food Assistance System (CAFSS);

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

The development of the Colorado Benefits Management System for eligibility determination, benefits issuance, and periodic redetermination of continued eligibility has been a collaborative project by the two Departments. The Department of Human Services manages several cash assistance and social services programs that utilize the Colorado Benefits Management System. The Department of Health Care Policy and Financing relies on the new system to determine eligibility for the following health-related programs: Medicaid, Old Age Pension State Medical Program, and the Children's Basic Health Plan. The collaborative efforts for the design and development of the system formally began in 1996. The statewide infrastructure was rolled out in all of Colorado's 64 counties and its two medical assistance sites. The Colorado Benefits Management System was implemented on September 1, 2004. In June 2005, the Office of CBMS was created in the Governor's Office, making the management team a party of three. The Governor's Executive Order of May 27, 2005 requires that the Office of the Colorado Benefits Management System will be accountable for planning, management, and delivery of the system.

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

The Department of Human Services and the Department of Health Care Policy and Financing have been involved in a lawsuit about CBMS since August of 2004. A preliminary injunction was ordered by the court in December of that year, and since that time, multiple motions have been filed, discovery requests been submitted, and hearings been attended. A trial was scheduled for June 2006, but was continued after the Departments and plaintiffs' lawyers negotiated a joint stipulation on April 6, 2006 to address the Departments' ongoing activities vis-à-vis the Preliminary Injunction. The joint stipulation allowed the Department to lift the Benefits Freeze Flag, which protects eligibility of clients who were converted from the legacy systems, as cases are reviewed and updated (called cleansing) and to lift the flags on cases that were closed prior to the conversion. The joint stipulation also stopped the requirement for further reports on noticing, and allowed some ability for the Departments to proceed to collect overpayments that were not caused by system error. In addition, the Joint Stipulation allowed the dissolution of the formal Emergency Processing Unit that had been established in January 2005, requiring that client resolution at a minimum be absorbed into normal business. Lastly, the joint stipulation continued the requirement that the Departments report cases exceeding processing guidelines, as calculated in the monthly Federal Statistical Reports – Applications, but did away with all other previous reporting requirements.

As of October 2006, the Departments were in ongoing mediation with the plaintiffs through the Judicial Arbiter group in hopes of achieving settlement of the lawsuit.

Joint Budget Committee staff reported[4] that the State has provided counties $13.4 million in county administration dollars related to CBMS implementation and that complying with the court order against the state has cost approximately $6.9 million over the last two fiscal years (Centralized Data Entry Team, Emergency Processing Unit, change requests specifically devoted to client noticing).
For FY 06-07, the Departments did not submit a request because a trial set for the week of June 5, 2006 had been planned. However, Joint Budget Committee staff did recommend funding for legal services and other court order resources, including funding for temporary staff to process cases exceeding processing guidelines, and this recommendation was approved by the Joint Budget Committee on March 8, 2006 during Figure Setting (see page 71 of the March 8, 2006 Figure Setting document). The recommended amount was for $192,000 for Personal Services and $13,000 for Operating Expenses within the Department's Budget, for a total of $205,000. However, the Joint Budget Committee reversed this decision on March 22, 2006 due to requirements of submitting a balanced budget. In September 2006, the Department submitted requests for ongoing resources to ensure timeliness with cases. Since April 2006, the Department has applied dedicated resources to work cases exceeding timeliness guidelines and to work with counties to improve timeliness. On September 20, 2006, the Joint Budget Committee approved this request. Therefore, the Department now has 4.0 permanent FTE dedicated to minimizing cases that are exceeding timeliness guidelines.

Legislative Summary 2006

The following is a summary of House and Senate Bills that have passed or been adopted in FY 05-06 that are considered important to the Department.

HB 06-1079 (Frangas, Johnson) Penalties Against Medical Providers for Unlawful Receipt of Payment
This bill makes a provider of medical services liable to a recipient or the estate of a recipient if the provider knowingly receives payment in violation of medical benefits authorized by Title XIX of the Social Security Act. The bill establishes a claim for the penalty, the Medicaid recipient or the estate of the recipient to forward a notice of the claim to the Department and to the provider.

HB 06-1157 (Coleman, May R.) Security of Communication and Information Resources in Public Agencies
This bill requires the Governor to appoint a Chief Information Security Officer to develop and update information security policies, standards, and guidelines for public agencies; promulgate rules; ensure compliance by public agencies and approve State agency budget requests related to information security systems. The bill requires the Department to develop a new information security plan

[4] JBC Staff Briefing, December 14, 2005

by July 1, 2007 using the information security policies, standards, and guidelines promulgated by the newly appointed Chief Information Security Officer.

HB 06-1211 (Frangas, Keller) Sanctions Under the Medical Assistance Program
This bill defines retaliation as adverse action taken against a recipient, failure to take appropriate action to address the health needs of a recipient, or indicating to a recipient that the recipient cannot have an advocate, family member, or other authorized representative assist the recipient. Excludes from the definition instances where a recipient is not eligible for a service or program or where a provider documents a problem with a recipient and shares the documentation with the recipient or a third party prior to the recipient filing a complaint.

HB 06-1266 (Larson, Veiga) Recovery of Public Assistance Payments
This bill provides for recapture of funds from a person's estate if they acquire property or possessions above the provisions of section 26-2-109. The bill increases the disqualification period for fraudulently obtained assistance from six months to twelve months for the first incident, from one year to twenty-four months for the second incident, and permanently for a third or subsequent incident.

HB 06-1270 (Merrifield, Gordon) Public Schools Determine Eligibility for Public Medical Benefits
This bill establishes a schools-based demonstration project to make eligibility determinations by qualified personnel in FY 07-08. The bill establishes an advisory committee to create a model free or reduced cost lunch application form that includes information regarding qualifying for Medicaid or the Children's Basic Health Plan. The bill requires the Department to investigate and inform the school districts whether the schools can receive federal financial participation for determining eligibility.

HB 06-1299 (McCluskey, Sandoval) Requirements for Providers of Durable Medical Equipment
This bill prohibits reimbursement to fee-for-service providers and primary care physician program recipients for disposable medical supplies and durable medical equipment, including but not limited to prosthetic and orthotic devices, unless they have one or more physical locations within the State of Colorado or within 50 miles of a Colorado border and the ability to repair or service the durable medical equipment as necessary.

HB 06-1351 (Rose, Isgar) Teen Pregnancy and Dropout Prevention Program
This bill authorizes the Department to implement a statewide community support and assistance program for teen pregnancy and dropout prevention to reduce the incidence of teen pregnancy and school dropout in Colorado. The Department was authorized to begin this pilot program with the passage of SB 95-101, and statewide implementation of the Teen Pregnancy Prevention Program began January 1, 1996. HB 06-1395 removes the word "pilot" and extends the date of the repeal, but does not increase the scope or delivery of services currently offered through the program.

HB 06-1395 (Buescher, Keller) Residential Child Health Care
This bill defines "psychiatric residential treatment facility" as a licensed residential child care facility providing inpatient psychiatric services to those under 21 years of age. The bill requires the Department to cooperate with the Department of Human Services (DHS) to provide rehabilitative or medical assistance services to Medicaid-eligible children residing in psychiatric residential treatment facilities. The bill allows the Medical Services Board (MSB) to issue a provisional license to an applicant who has completed a post-graduate degree and who is working in a residential child care facility under the supervision of a licensee.

HB 06S-1023 (Romanoff, Fitz-Gerald) Restrictions on Public Benefits
HB 06S-1023 was enacted July 31, 2006 with an effective date of August 1, 2006. It requires the Department to verify the identity of all applicants for benefits (including clients, contractors, providers and grantees) who are natural persons age 18 and older, and obtain from them a signed affidavit of lawful presence. Affidavits from lawfully present non-citizens must be verified through the federal Systematic Alien Verification of Entitlement (SAVE) program. Client populations exempt from HB 06S-1023 include those exempted by federal law (such as those covered under the Deficit Reduction Act of 2005) and applicants for prenatal care or emergency care not related to an organ transplant.

SB 06-044 (Hagedorn, Boyd) Primary Care Program for Low Income Adults
This bill requires the Medical Services Board (MSB) to set eligibility requirements for the Colorado Indigent Care Program not lower than 250% of the federal poverty level and creates the Colorado Health Care Services Fund, appropriating $14,962,408 in FY 05-06 for expenditure in FY 06-07 as General Fund Exempt to provide primary care services to low-income adults by community health clinics. Eighteen percent (18%) of the annual appropriation is to go to Denver Health and Hospitals for providing primary care to low-income adults, and the remaining 82% is to be shared between community health clinics (receiving 82% of the remainder) and primary care clinics (receiving 18% of the remainder).

SB 06-063 (Teck, Weissmann) Procurement of Information Technology Systems
This bill requires the Office of Innovation and Technology to certify to the State Controller that a major information technology project undertaken by a State agency is in compliance with best practices before approving disbursement of funds. This bill also requires State agencies to use certified project managers and project management analysts for majorinformation technology projects.

SB 06-079 (Weins, McKinley) Post-Enactment Review of Implemented Bills by Nonpartisan Legislative Staff
The bill requires the nonpartisan legislative service agencies to conduct a post-enactment review of the implementation of any bill enacted after January 1, 2009, that becomes law and contains an accountability clause and a legislative declaration. The bill specifies

what shall be reviewed and the time frame for conducting a post-enactment review and reporting findings. The bill also authorizes the adoption of legislative rules to implement accountability clauses and post-enactment reviews.

SB 06-106 (Grossman, McGihon) Expiration of Agency Rules and Regulations
This bill postpones the expiration of all rules adopted or amended by the Department between November 1, 2004 and November 1, 2005 that are scheduled to expire on May 15, 2006. However, three rules of the Medical Services Board concerning presumptive eligibility period, home modification, and home care allowance were not extended.

SB 06-128 (Owen, Riesberg) Services for Disabled under State Medical Assistance Program
This bill directs the Department to review a proposal from a nonprofit organization for a pilot program to improve the overall quality of care received by persons with disabilities. The bill requires the pilot program to provide a comprehensive approach to primary, acute, and long-term care and to report on the cost-effectiveness of the program and conduct client-satisfaction surveys to consider expansion of the program. The bill creates the Coordinated Care for People with Disabilities Fund consisting of interest or income earned on moneys in the Breast and Cervical Cancer Prevention and Treatment Fund to support the disabilities pilot program.

SB 06-129 (Keller, Buescher) Cash Accounting for Nonadministrative Expenditures the Qualify for FFP
This bill clarifies that the Department is to utilize the cash system of accounting, regardless of the source of revenues involved, for any nonadministrative expenditure that qualifies for Title XIX federal financial participation except for expenditures under the program for the medically indigent. The bill requires the Department to promulgate rules to identify programs using cash accounting.

SB 06-131 (Tochtrop, McFadyen) Reimbursement Under MAP for Nursing Facility Providers
Directs the Department to review a proposal from a nonprofit organization for a pilot program to improve the overall quality of care received by persons with disabilities. The bill requires the pilot program to provide a comprehensive approach to primary, acute, and long-term care. The bill also requires the Department to request federal approval, implement the program, report on its cost-effectiveness, and conduct client-satisfaction surveys and creates the Coordinated Care for People with Disabilities Fund consisting of interest or income earned on moneys in the Breast and Cervical Cancer Prevention and Treatment Fund to support the disabilities pilot program. The bill establishes interim reimbursement rates for FY 06-07 and states that the 8% cap on increases in health care services costs shall not apply to a class I nursing facility with resident Medicaid population over 64% during FY 06-07.

SB 06-135 (Owen, Plant) Enrollment of Pregnant Women in Children's Basic Health Plan Using Tobacco Tax Funds
This bill corrects a technical error to increase the income limit for eligibility for pregnant women in Children's Basic Health Plan from 185% to 200% of FPL. The bill also authorizes the Department to use moneys from the Health Care Expansion Fund (CFE) for payments made between July 1, 2005 and January 31, 2006 for these pregnant women due to the timelag between the implementation

date for expanded eligibility of pregnant women (July 1, 2005) and the Department's receipt of federal approval for federal financial participation (effective February 1, 2006; not retroactive).

SB 06-145 (Shaffer, McCluskey) Authority of Local Government to Impose Fee on Providers to Obtain FFP

This bill authorizes local governments to impose a fee on certain medical providers to assist in financing unreimbursed costs and requires the Department to amend the State plan effective July 1, 2006. The bill requires the Medical Services Board (MSB) to define unreimbursed costs by rule and for the Department to calculate unreimbursed Medicaid costs for qualified providers within local government upon notice from a local government. The bill also requires the Department to distribute federal financial participation to local governments.

SB 06-165 Reengrossed (Hagedorn, Gardner) Telemedicine Pilot Programs

This bill permits the use of telemedicine services and requires reimbursement under Medicaid effective July 1, 2006 as long as the comparable in-person services are eligible for reimbursement. The bill requires the Department to issue a Request for Proposal (RFP) by August 1, 2006 for the creation of a pilot program to provide telemedicine services to recipients with chronic medical conditions such as congestive heart failure, diabetes, or chronic obstructive pulmonary disease.

SB 06-219 (Keller, Jahn) Administrative Reorganization of Programs Administered by HCPF

This bill relocates statutes related to the Department programs such as the Colorado Medical Assistance Act and Articles, Children's Basic Health Plan and the Colorado Indigent Care Program from Title 26 to Title 25.5, C.R.S. (2006) It provides the Department with a direct relationship with the counties, transfers the administrative responsibilities of Home Care Allowance and Adult Foster Care to the Department of Human Services, and removes some double-counting of funds within the State due to eliminating a transfer to the Department of Human Services from the Department of Health Care Policy and Financing for County Administration.

VI. DEPARTMENTAL BACKGROUND

A. OVERVIEW

A1. Department Structure

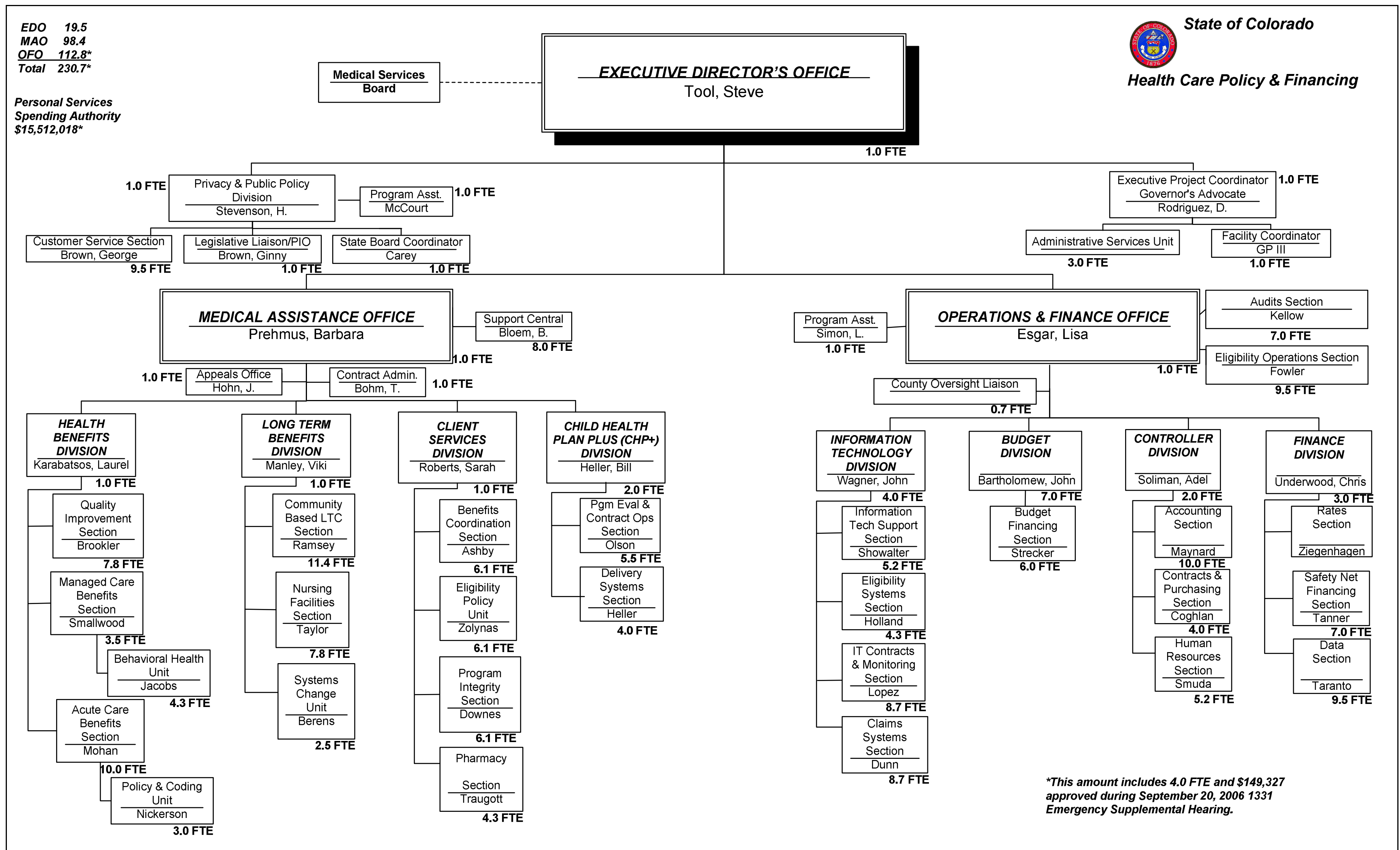
The Department of Health Care Policy and Financing was established July 1, 1994. Steve Tool serves as the Executive Director. The Department is split into two primary offices. The Department's Senior Director of the Operations and Finance Office is Lisa Esgar and the Senior Director of the Medical Assistance Office is Barbara Prehmus. The Medical Services Board is the entity authorized under statute to pass rules for the Department's programs, and its members are appointed by the Governor. The Medical Services Board is chaired by Joe Rall. With 226.7 FTEs, Health Care Policy and Financing is the fourth smallest department in terms of staff size, but, after K-12 Education, Health Care Policy and Financing is the:

- Second largest budget in State government,
- Second largest consumer of General Fund (19%) based on the FY 06-07 Long Bill (HB 06-1385) and
- First in federal funds drawn.

The appropriation for FY 06-07 (including new legislation) exceeds $3.3 billion total funds. The federal match is computed from statewide per capita income using a nationally standardized formula and is reported by the Federal Funds Information Service. The federal match rate available for the Children's Basic Health Plan is 65%; the State's Medicaid match is 50%. Most of the Department's administration costs are privatized or, in some cases, are contracted out to other executive departments. The FY 06-07 Long Bill (HB 06-1385) and special bills during the 2006 Legislative Session resulted in the following approximate allocation for Department programs:

Total FY 06-07 Long Bill Appropriation (HB 06-1385)	**$3,388,531,182**	**100.0%**
Direct Care Services administered by Health Care Policy and Financing	$2,910,609,099	86.0%
Department of Human Services Programs	$410,943,898	12.0%
Contractual Services (including other State departments except Department of Human Services)	$50,580,588	1.5%
Department Administration (Personal Services, Operating, Health, Life and Dental, Amoritization Equalization Disbursement, Worker's Compensation and Salary Survey)	$16,397,597	0.5%

A Departmental organizational chart is provided.



A2. Overview of Staffing

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

Health Care Policy and Financing FTE History

FISCAL YEAR	FTEs	PERCENT CHANGE
FY 94-95	137.2	N/A
FY 95-96	136.7	-0.3%
FY 96-97	133.0	-2.7%
FY 97-98	146.0	9.8%
FY 98-99	151.0	3.4%
FY 99-00	162.4	7.5%
FY 00-01	167.7	3.3%
FY 01-02	177.6	5.9%
FY 02-03	188.4	6.1%
FY 03-04	200.4	6.4%
FY 04-05	202.8	1.2%
FY 05-06	213.4	5.2%
FY 06-07	226.7	6.2%

Source: Joint Budget Committee Appropriation Reports

A3. Health Care Policy and Financing and its Programs

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

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

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

A4. Colorado Budget Environment

Colorado's economy has shown significant improvement from last fiscal year. Referenda C give Colorado State government a five-year reprieve from the spending limits of the TABOR amendment. Referenda C is expected to raise State revenues by as much as $3.7 billion over the five years, to be specifically used for public K-12 and higher education, health care, transportation and financing

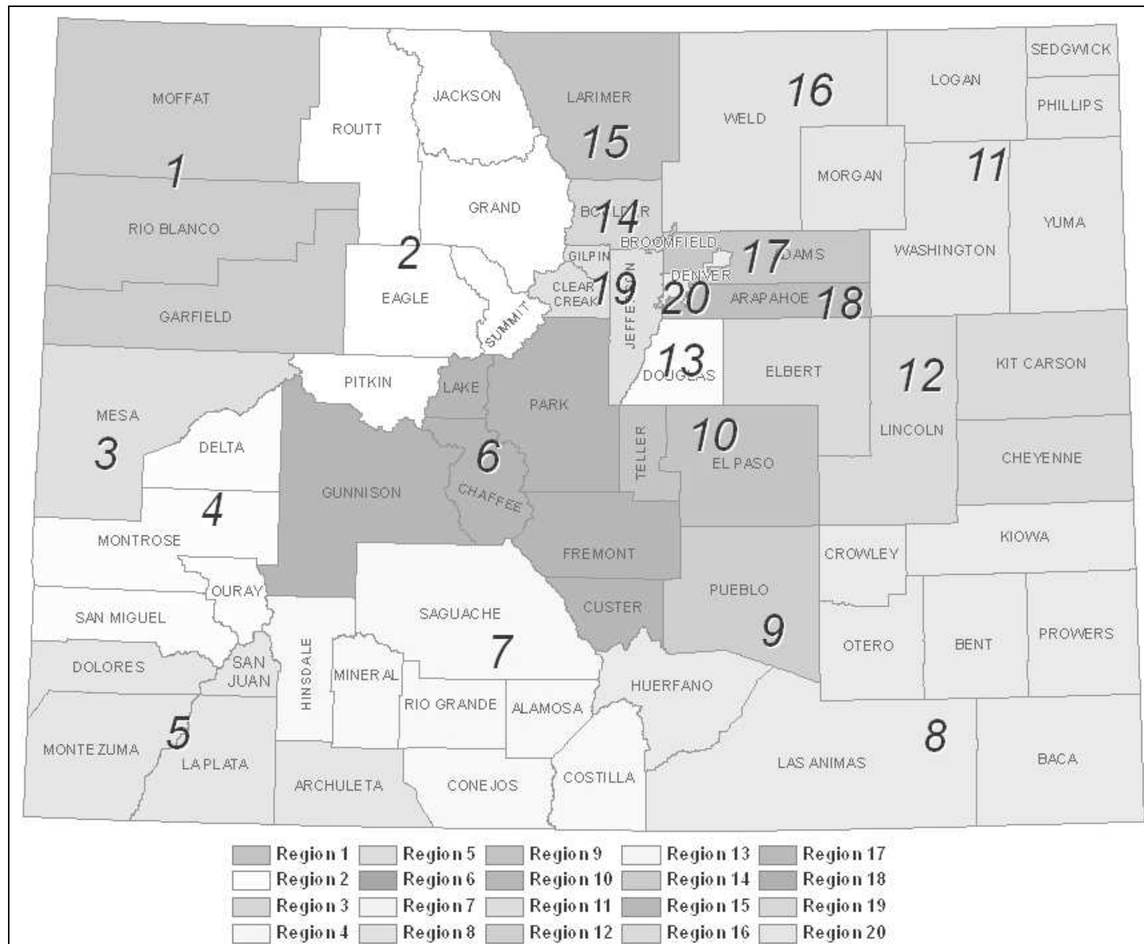
Referendum D bonds (The Bell Policy Center, 2005). However, there are still many difficult challenges that the General Assembly faces to comply with current statutory and constitutional spending restraints. Because of this, the Department realizes that Medicaid, as an entitlement program, has a limiting effect on the amount of funding for other State needs and priorities. Thus, in reviewing the November 1, 2006 Budget Request, the Department has prioritized its request beginning with funding base services for entitlement programs, then for funding to support the Children's Basic Health Plan, next on other federal and statutory mandates, and lastly on technical and administrative needs. Where the ability to return unneeded funds has been possible, these have been identified. When additional dollars are requested, they have been carefully considered, laid out, and analyzed.

A5. HIPAA Information Regions

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

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

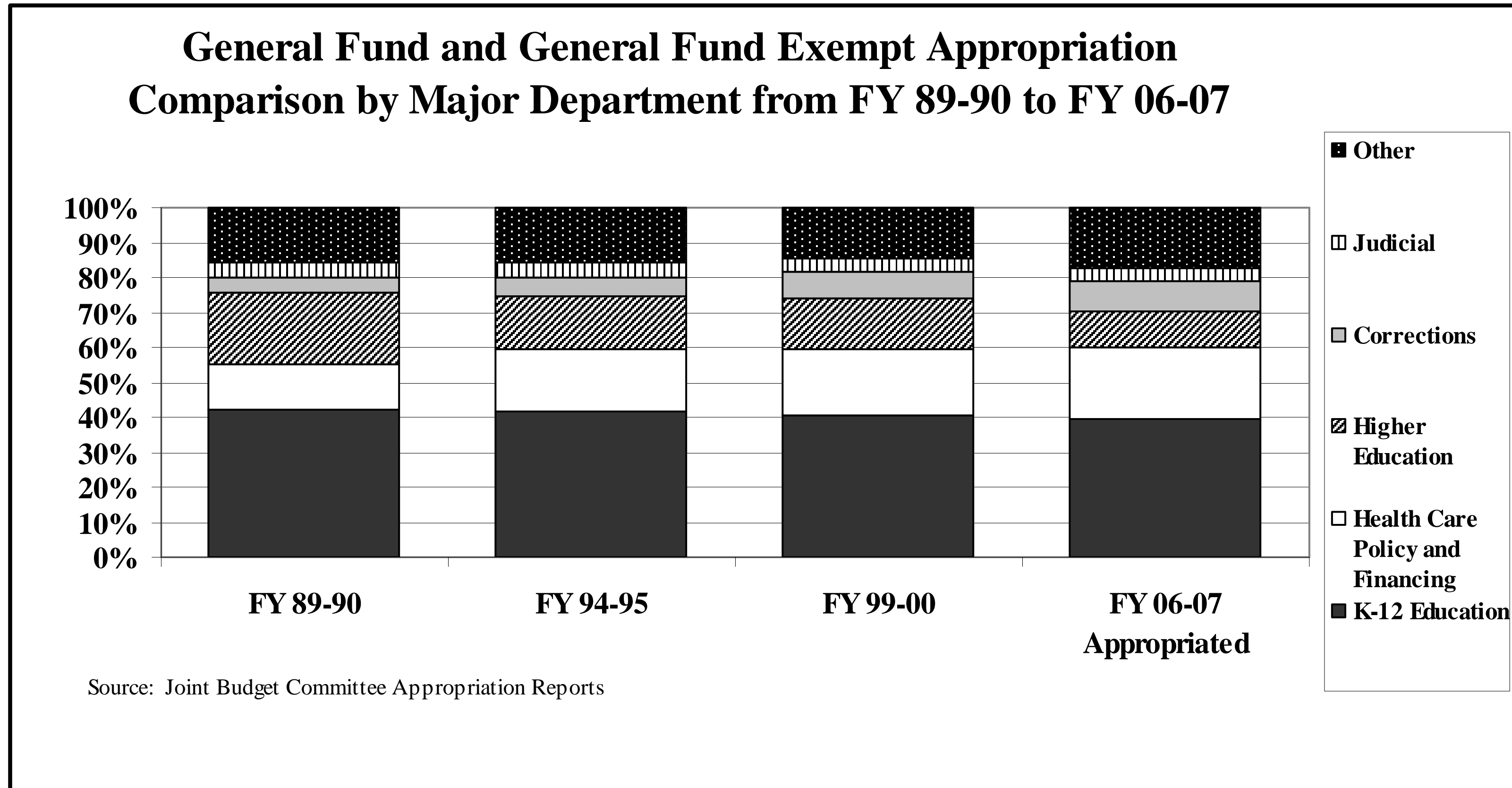
<u>Map of HIPAA regions</u>



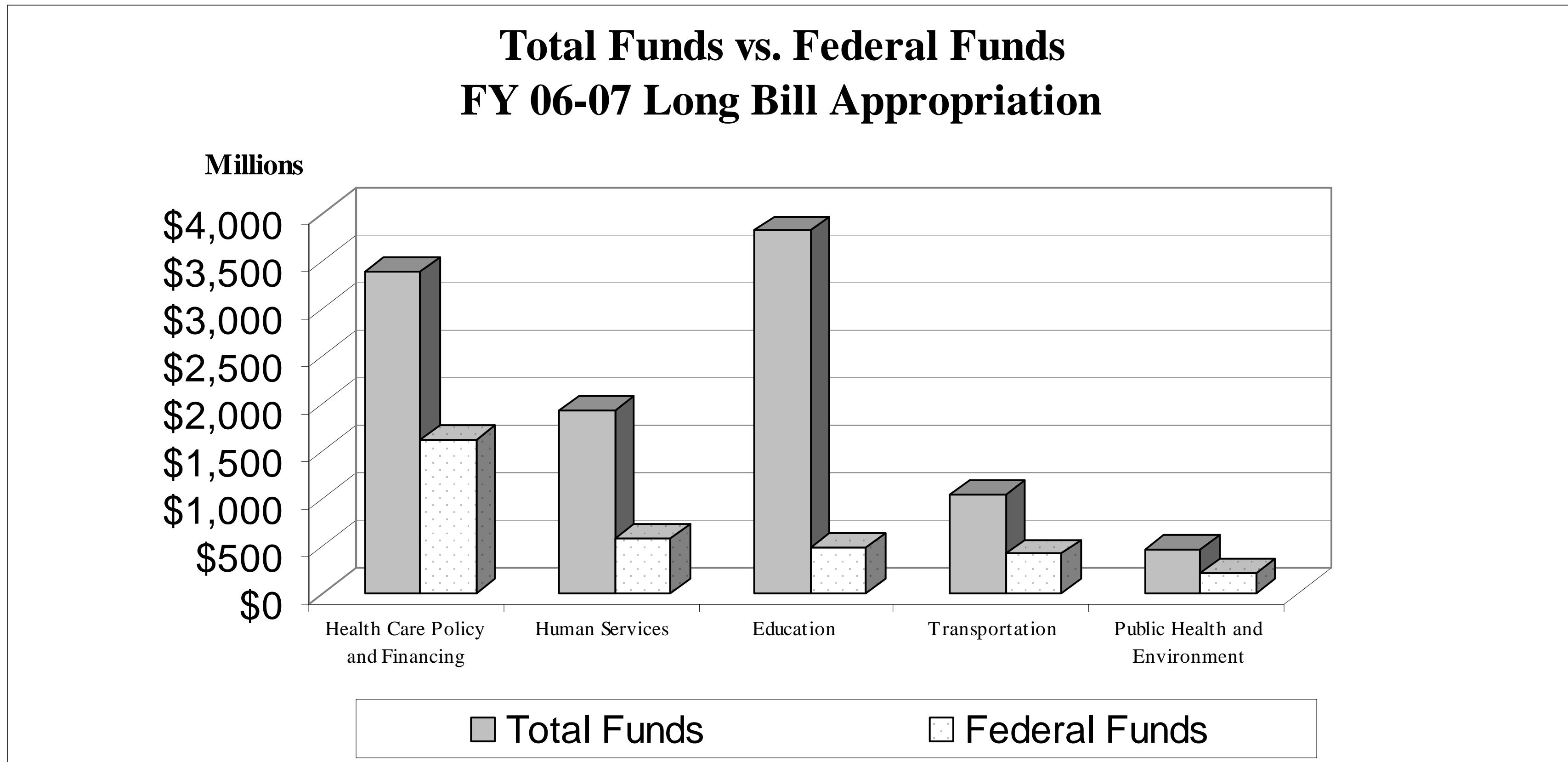
Source: Colorado Division of Local Government

B. STATE BUDGET

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

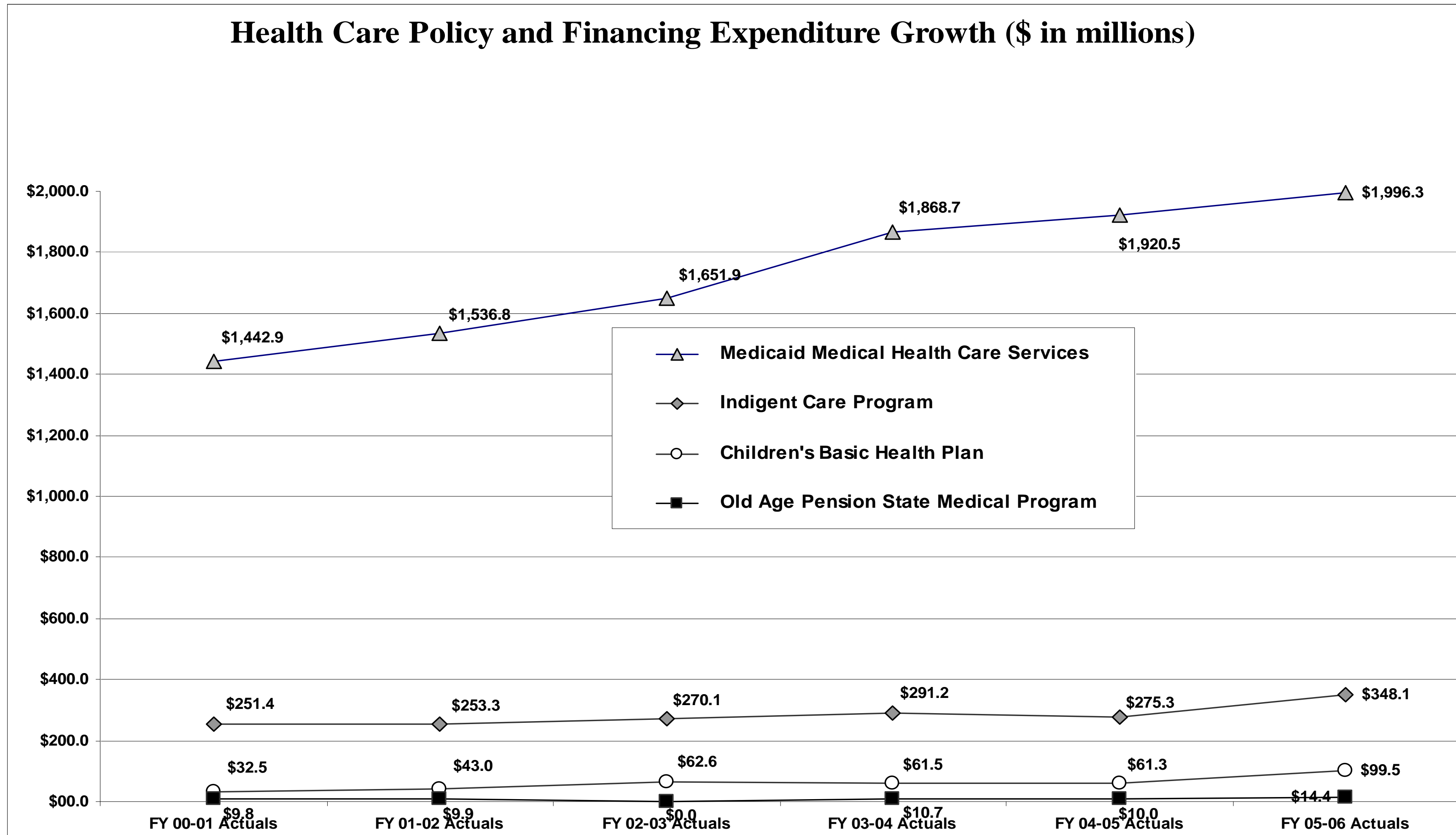


B2. Highest Draw of Federal Funds, by Agency



Source: HB 06-1385

B3. Health Care Policy and Financing Expenditure Growth for FY 00-01 to FY 05-06



Source: November 1, 2001 Budget Request for FY 99-00 and FY 00-01;
November 1, 2003 for FY 01-02 and FY 02-03;
November 3, 2004 Budget Request for FY 03-04; November 15, 2005 Budget Request for FY 04-05
November 1, 2006 Budget Request for FY 05-06
Note: Old Age Pension expenditures for FY 02-03 were equal to $0 as this program was transferred to the Department of Human Services.

B4. Comparing Colorado to Other States in Federal Region

For administrative purposes, the Centers for Medicare and Medicaid Services divide the country into ten regions, each home to a regional office. The regional offices are responsible for the administration of the Medicare, Medicaid and the State Children's Health Insurance Program and range in size from two to seven states. Some regional offices have responsibilities for the U.S. Territories in the Caribbean and South Pacific. Colorado is in Region VIII, as are Montana, North Dakota, South Dakota, Utah, and Wyoming. The following information shows data for the six states comprising Region VIII, to better understand how Colorado compares to its neighboring states. The following information is from the Kaiser Family Foundation's State Facts Online website as of June 2006. *Some components differ from data reported directly by the Department.*

Regional Comparison from Kaiser Family Foundation's State Facts Online

	FY 05-06 FMAP	FY 06-07 FMAP	Estimated Total State Population 2005	Total Medicaid Enrollment in FY 2003	Medicaid Enrollees as % of State Population in FY 2003	Medicaid Expenditures for Benefits and DSH in FY 2004	SCHIP Federal Match in FY 2006	SCHIP Monthly Enrollment December 2004	Income Eligibility as Percent of FPL for SCHIP in FY 2004	SCHIP Total Expenditures in FY 2004
Colorado	50.00%	50.00%	4,665,177	473,700	10%	$2,662,082,595	65.00%	38,189	200%	$57,889,088
Montana	70.54%	69.11%	935,670	110,400	12%	$672,844,371	79.38%	10,929	150%	$17,682,790
North Dakota	65.85%	64.72%	636,677	76,700	12%	$490,521,915	76.10%	3,671	140%	$8,813,154
South Dakota	65.07%	62.92%	775,933	119,700	16%	$568,872,712	75.55%	10,466	200%	$14,287,632
Utah	70.76%	70.14%	2,469,585	278,000	12%	$1,251,709,507	79.53%	24,021	200%	$34,957,127
Wyoming	54.23%	52.91%	509,294	76,800	15%	$370,141,941	67.96%	3,854	200%	$7,201,506

FMAP = Federal Medical Assistance Percentage

FFY = Federal Fiscal Year

FPL = Federal Poverty Level

DSH = Disproportionate Share Hospitals

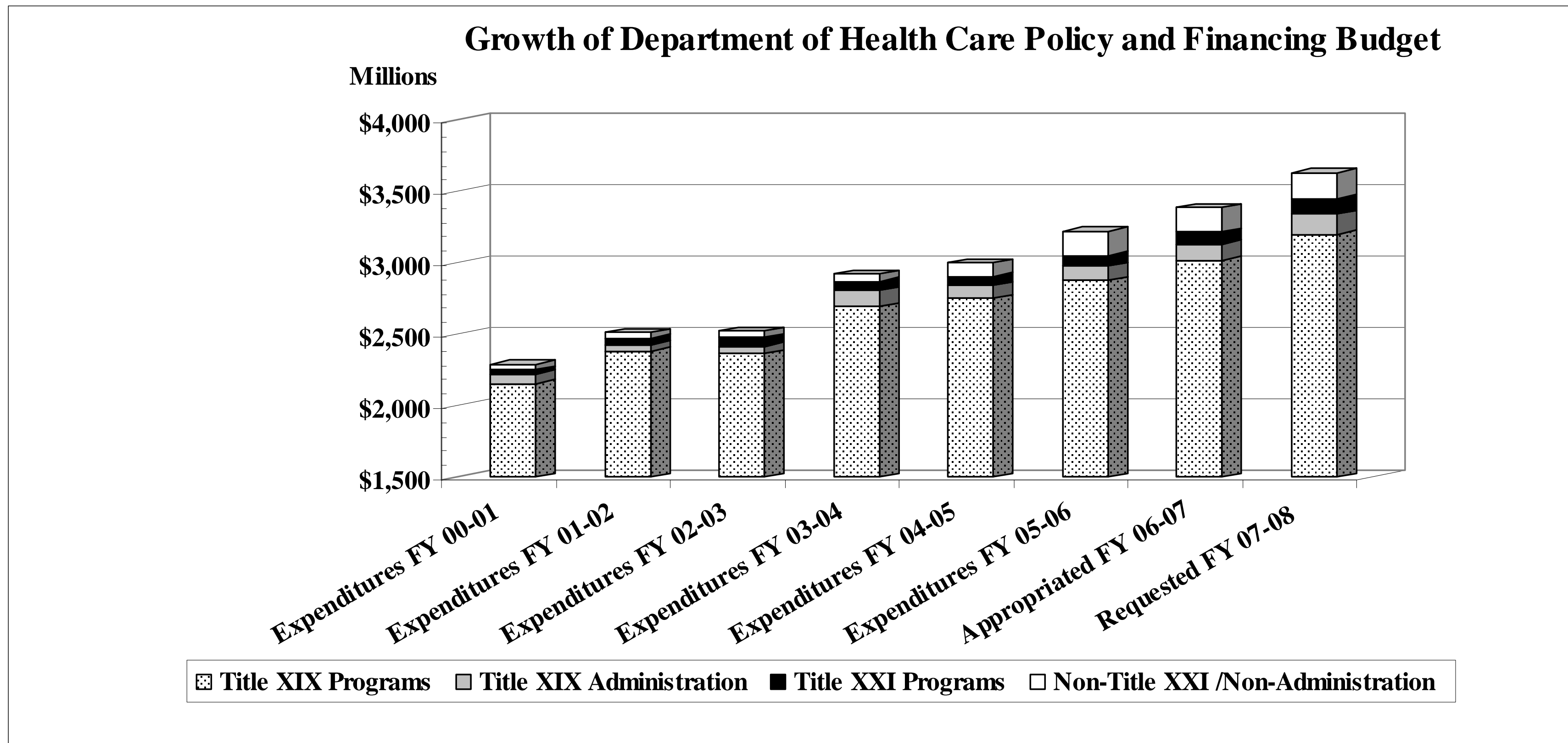
SCHIP = State Children's Health Insurance Plan (federal term)

Source: Statehealthfacts.org website for all columns excluding population estimates. Estimated total State population is census.gov/popest/sates/tables/NST-EST
Colorado, Montana, and Utah suspended enrollment in the State Children's Health Insurance Plan between June 2002 and April 2003.

C. DEPARTMENT BUDGET

C1. Department Budget Growth and Outlook for FY 06-07 and FY 07-08

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



Source: November 1, 2001 Budget Request for FY 99-00 and FY 00-01;
November 1, 2003 for FY 01-02 and FY 02-03; November 3, 2004 Budget Request for FY 03-04;
November 15, 2005 Budget Request for FY 04-05; November 1, 2006 Budget Request for FY 05-06, FY 06-07 and FY 07-08

D. CLIENTS

D1. 2006 Federal Poverty Levels

The table below reports the federal poverty levels for all states except Hawaii and Alaska from the Department of Health and Human Services, for federal fiscal year 2006. For family units of more than 8 members, add $3,400 for each additional family member.

Federal Poverty Levels for Annual Income

Family Size	100%	120%	133%	135%	150%	175%	185%	200%	250%
1	$9,800	$11,760	$13,034	$13,230	$14,700	$17,150	$18,130	$19,600	$24,500
2	$13,200	$15,840	$17,556	$17,820	$19,800	$23,100	$24,420	$26,400	$33,000
3	$16,600	$19,920	$22,078	$22,410	$24,900	$29,050	$30,710	$33,200	$41,500
4	$20,000	$24,000	$26,600	$27,000	$30,000	$35,000	$37,000	$40,000	$50,000
5	$23,400	$28,000	$31,122	$31,590	$35,100	$40,950	$43,290	$46,800	$58,500
6	$26,800	$32,160	$35,644	$36,100	$40,200	$46,900	$49,580	$53,600	$67,000
7	$30,200	$36,240	$40,166	$40,770	$45,300	$52,850	$55,870	$60,400	$75,500
8	$33,600	$40,320	$44,688	$45,360	$50,400	$58,800	$62,160	$67,200	$84,000

Source: Federal Register published on January 24, 2006

D2. Demographics and Expenditures

Demographic statistics provide valuable insight on the demand for medical care within each region. More populated areas tend to have a greater demand for medical care. Therefore, a region that is more populated is likely to have higher medical expenditures and caseloads. Likewise, as Colorado's population increases, the demand for medical care will also increase. The Department collected 2004 demographic data from the United States Census Report, "2004 American Community Survey" for: 1) population; and 2) percent of total Colorado population. However, this survey does not present data for all geographic areas.

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

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

Medicaid

Using the Department's Business Objects of America database, FY 05-06 Medicaid data was collected for the following statistics and reported for the State in the following table, and reported by HIPAA Information Region:

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

Please note that monthly expenditures reported to the Joint Budget Committee are derived from the Colorado Financial Reporting System. Business Objects of America database extracts data on a different time span and from a different source (i.e., Medicaid Management Information System) than the Colorado Financial Reporting System. Therefore, total expenditures presented in this document will not exactly reconcile with the $1.986 billion for actual medical services reported in Exhibit M, page 1, in the November 1, 2006 FY 07-08 Budget Request.

Children's Basic Health Plan

Using FY 05-06 expenditures and caseload data for the Children's Basic Health Plan, the Department compiled the following data and reported it for the State in the following table.

- Average Number of Children per Month;
- Number of Deliveries for Women; and
- Children's Basic Health Plan Expenditures.

The Children's Basic Health Plan provides medical and dental services to children under age 19, and provides prenatal care and delivery for adult pregnant women who are at or below 200% of the federal poverty level. The total Children's Basic Health Plan expenditures presented in the statewide table below include: State-only Prenatal Program; Children's Basic Health Plan Premium Costs; Children's Basic Health Plan Dental Benefit Costs; and, Children's Basic Health Plan Administration line items.

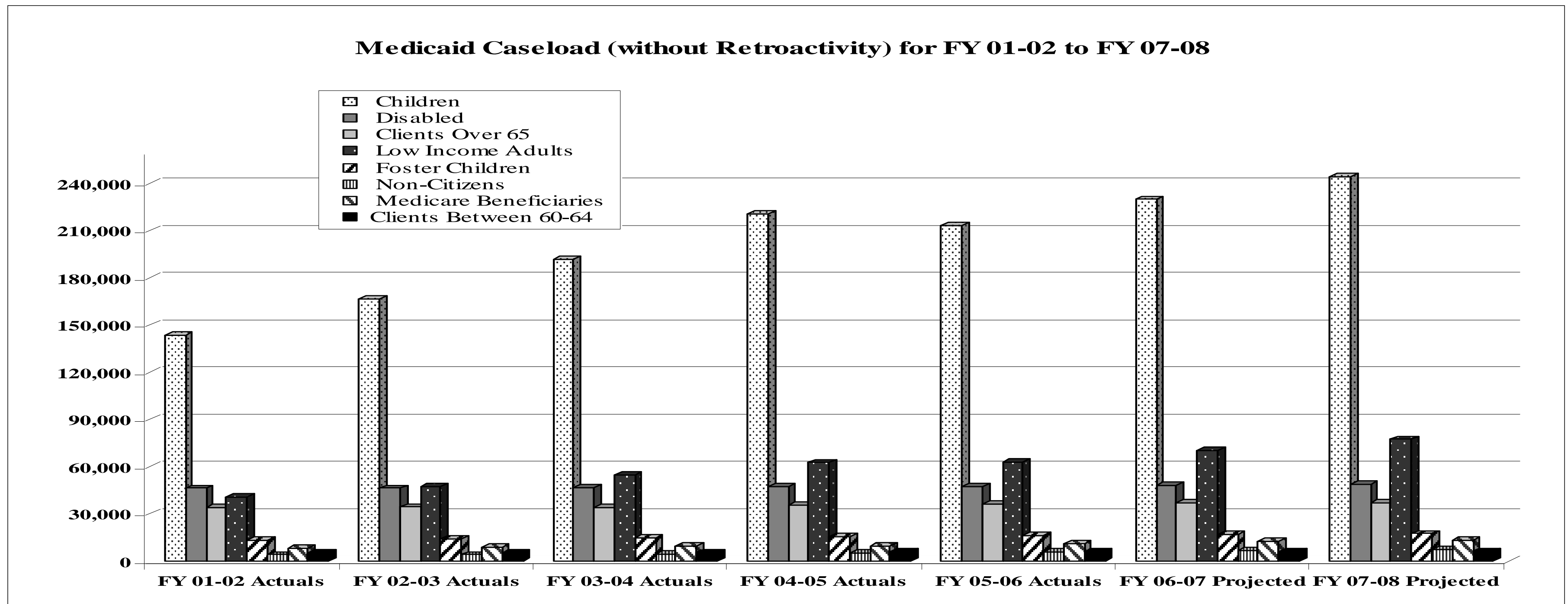
Colorado's Demographics, Medicaid, and the Child Health Plan Plus Office – A Statewide View

Characteristics	State Totals
Demographic Characteristics	
Population, 2004*	4,498,611
Percent of Population in the Labor Force, 2004[1]	70.7%
Percent of Families Below Poverty, 2004[1]	8.6%
Percent of Female Headed Households, 2004[1]	10.1%
Medicaid Characteristics, FY 05-06	
Average Number of Medicaid Clients[2]	399,705
Medicaid Service Premiums Expenditures	$1,996,264,308
Total Title XIX Service Expenditures[3]	$2,873,716,843
Percent of Total Medicaid Expenditures	69.5%
Child Health Plan Plus Characteristics, FY 05-06[4]	
Average Number of Children per Month	46,755
Number of Member Months for Pregnant Women	13,548
Child Health Plan Plus Expenditures	$76,562,384

1: Per '2004 American Community Survey' from the United States Census Bureau. The percent of population in the labor force includes those aged 16 and older for the State (2,442,651). It is important to note that the number of individuals in the labor force is not equal to the population.
2: June 17, 2006, Joint Budget Committee Report
3: Title XIX Service Expenditures equal $2,873,716,843. Of this $1,996,264,308 is Medical Services Expenditures, $166,070,612 is Medicaid Mental Health Community Programs, $298,867,968 from Indigent Care Program, $22,744,877 from Other Medical Services and $389,769,078 from the Department of Human Services Medicaid Funded Programs. During June accounting close, several adjustments were made to expenditures in the Medical Services Premiums appropriate, including: additional drug rebate for unallocated amounts, adjustments to co-insurance, estate recoveries for Class I nursing facilities, and finalizing expired warrants and duplicate payments. All adjustments were for services prior to July 2006.
4: Expenditure amounts include the Children's Basic Health Plan Premium Costs, Children's Basic Health Plan Dental Benefit Costs, and Children's Basic Health Plan Administration. All information was obtained from COFRS.

D3. Medicaid Caseload for FY 01-02 to FY 07-08

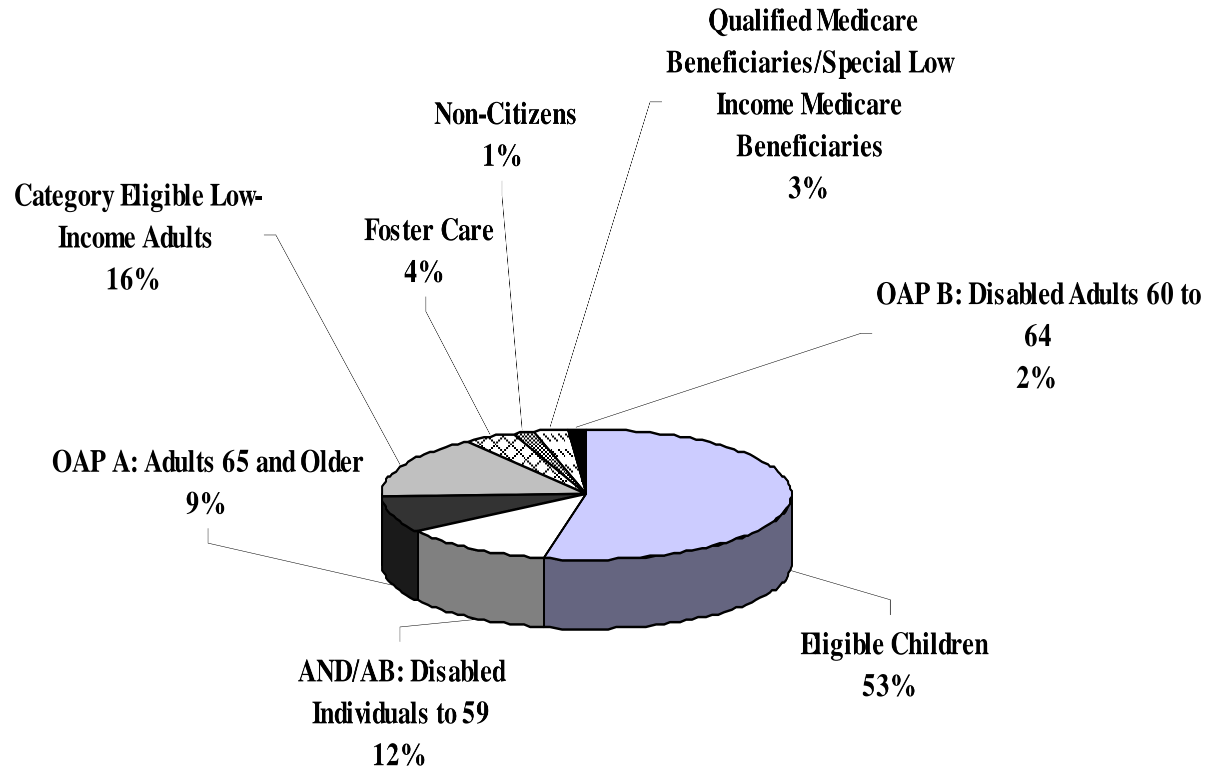
The figures presented include caseload information without retroactivity for FY 01-02 to FY 05-06 (FY 06-07 and FY 07-08 are projected). Retroactivity causes historical adjustments to caseload to account for clients who were found to be eligible for Medicaid for past months, thus increasing the count of persons eligible for Medicaid (even after caseload figures are presented to the Joint Budget Committee monthly). This causes much variability in the reporting of caseload, as monthly caseload is adjusted for months after the month has passed. The pie chart (on the following page) shows the percentage of each category as a total of Medicaid population.



Source: Actuals and Projected are derived from the Department's November 1, 2006 Budget Request, "Exhibit B – Medicaid Caseload Forecast," page EB-1. Caseload categories will be updated.

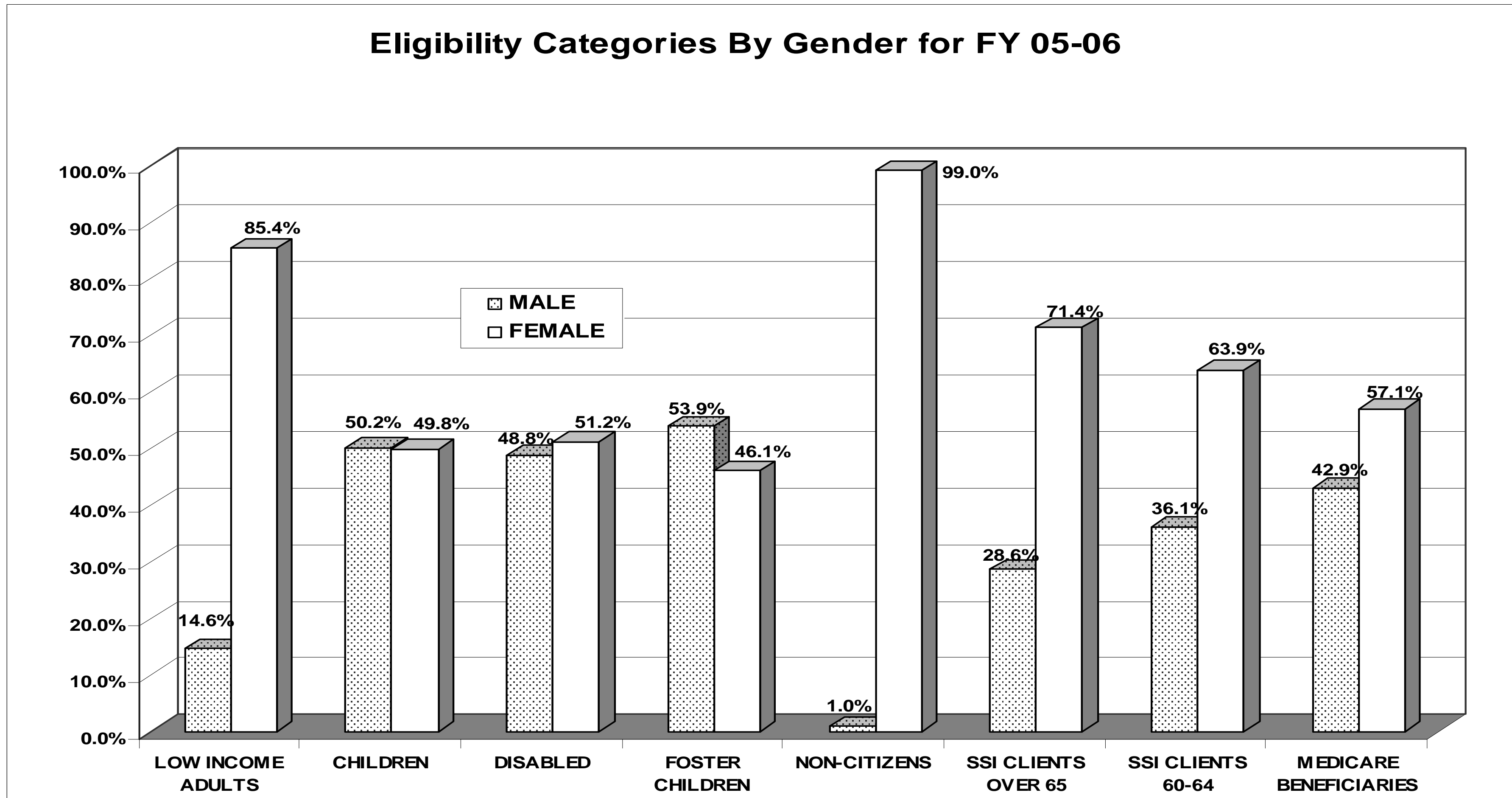
1) Low-income adults include 1931 Adults, Baby Care Program-Adults, Breast and Cervical Cancer Program Clients, and Health Care Expansion Fund Adults.

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



Source: July 17, Joint Budget Committee Report.

D4. Eligibility Categories by Gender for FY 05-06



Source: Business Objects of America monthly queries, processed typically by the first business week of each month
1) Low-income adults also include Baby Care Program-Adults and Breast and Cervical Cancer Program Clients.
2) Medicare Beneficiaries include Qualified Medicare and Supplemental Low Income clients.
3) Data was pulled using caseload averages for twelve months of this fiscal year.

D5. Medicaid Enrollment by Type of Managed Care Provider

The following table shows the breakdown by client count for FY 01-02 through FY 05-06 for clients enrolled in administrative service organizations, health maintenance organizations, Primary Care Physician Program, and unassigned fee-for-service. Administrative service organizations, health maintenance organizations, and Primary Care Physician Program enrollment figures were subtracted from total caseload numbers (without retroactivity) to calculate the fee-for-service enrollment figures, and as a result may cause the fee-for-service counts to be underrepresented.

Average Medicaid Enrollment for FY 01-02 through FY 05-06

Membership Category	FY 01-02 Count	FY 02-03 Count	FY 03-04 Count	FY 04-05 Count	FY 05-06 Count
Health Maintenance Organizations and Administrative Service Organizations	135,518	126,669	74,439	77,354	71,799
Primary Care Physician Program	54,086	65,475	68,557	51,669	36,563
Fee-for-Service	105,809	135,251	219,535	273,779	291,343
TOTALS	**295,413**	**327,395**	**362,531**	**402,802**	**399,705**

Sources: Administrative service organizations (that is, Rocky Mountain Health Plan), health maintenance organization, Primary Care Physician Program enrollment numbers are from the Managed Care Report. FY 05-06 total Medicaid count comes from the averages for twelve months of this fiscal year. Caseload numbers are an average of the fiscal year's caseload for each month, without retroactivity.

Note: Fee-for-service enrollment is derived by the total enrollment minus enrollment in administrative service organizations, health maintenance organization, and the Primary Care Physician Program.

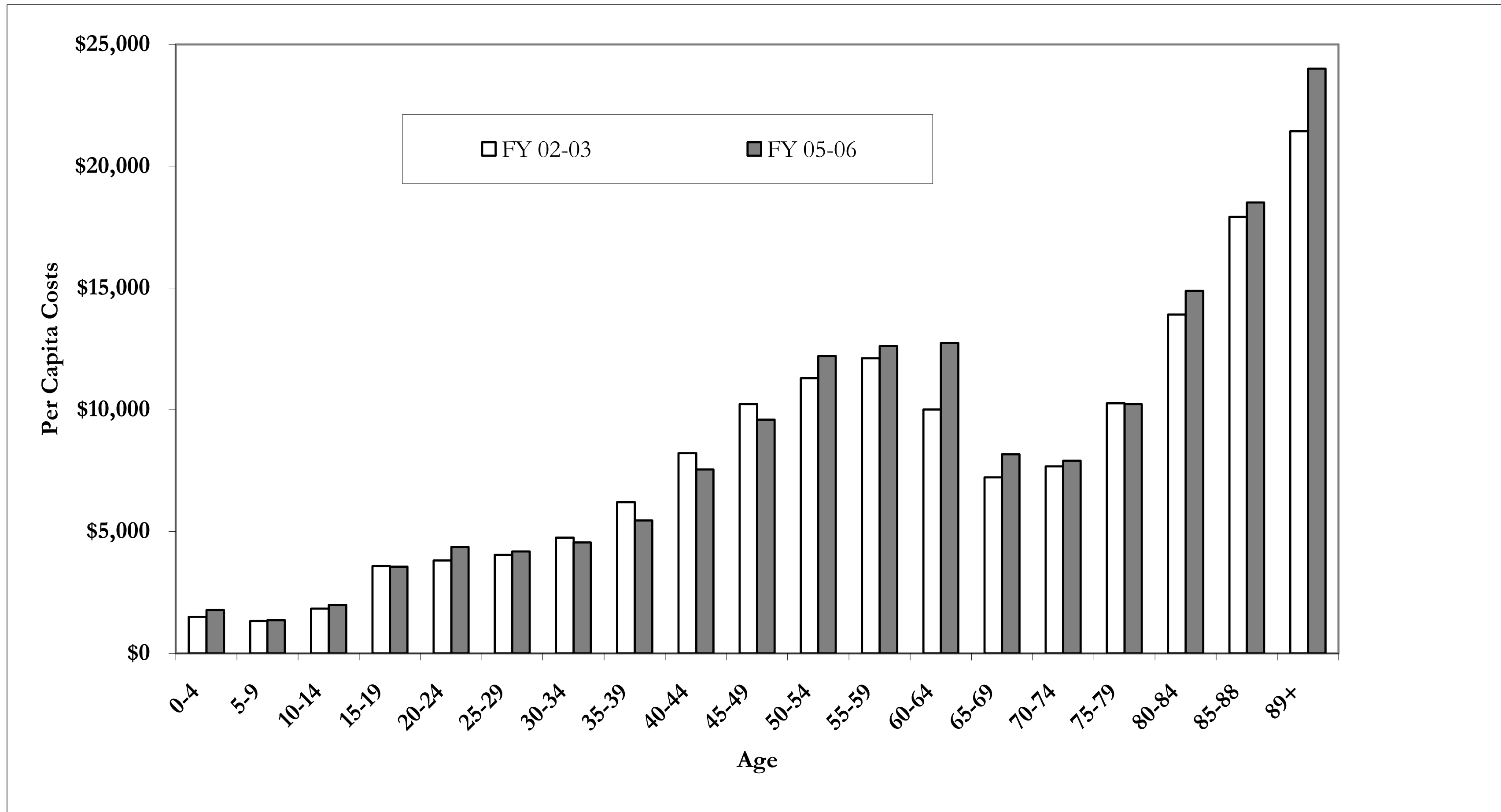
E. SERVICES

E1. Paid Medical Services Per Capita Costs (from all claims) Across Age Groups

The graph below represents Medicaid per capita costs by client age as of first date of service as reported on his or her most recent claim in FY 05-06. The graph also contains all clients in the following caseload categories:

- Adults 65 and Older (OAP-A): This includes persons with Supplemental Security Income for persons 65 years of age or older (Old Age Pension-A).
- Disabled Adults 60 to 64 (OAP-B): This includes Supplemental Security Income for disabled persons 60-64 years of age (Old Age Pension-B).
- Disabled Individuals to 59 (AND/AB): This includes Supplemental Security Income for disabled individuals upto the age of 59 (Aid to the Needy Disabled/Aid to the Blind).
- CE Low Income Adults: Categorically Eligible Low Income Adults (Aid to Families with Dependent Children - Adults)
- BCCP: Breast and Cervical Cancer Program
- Eligible Children: Eligible Children (Aid to Families with Dependent Children - Children/Baby Care Children)
- Foster Care: Foster care (Aid to Families with Dependent Children - Foster Care)
- Baby Care Adults: A Medicaid eligibility category appropriated in the Long Bill that deals only with pregnant women
- Non Citizens: Adults and/or children who have not established legal residency in the US and certain qualifications of legal immigrants who meet certain eligibility requirements
- QMB/SLMB: Qualified Medicare Beneficiaries and Special Low Income Medicare Beneficiaries

E1: Comparison of Per Capita Costs for All Medicaid Clients Across Age Groups For FY 02-03 and FY 05-06



Source: Medicaid paid claims and eligibility spans from MMIS-DSS. Notes: Financial transactions and other accounting adjustments are not included in the expenditures by age group.

E2. FY 05-06 Services by County

Exhibits E2a - E2d show utilization of the following medical services by HIPAA Information Region by unique client count and average cost per full time equivalent client:

Acute Care, including:

- Federal Qualified Health Centers
- Physician and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services
- Prescription Drugs
- Inpatient Hospital
- Outpatient Hospital

E3. Client Counts for Long Term Care and Home and Community Based Services

Exhibit E3 shows client counts for Long Term Care and Home Health and Long Term Care Services, including:

- Home and Community Based Services (HCBS)
- Program for All-Inclusive Care for the Elderly (PACE)
- Home Health
- Nursing Facilities

E4. Top Tens

Exhibits E4a – E4j shows expenditure and utilization for the top ten diagnoses and procedures for the following:

- Inpatient Hospital
- Outpatient Hospital
- Federal Qualified Health Centers
- Rural Health Centers
- Physician and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services
- Dental
- Laboratory
- Durable Medical Equipment and Supplies

Exhibits E4k and E4p show the top 10 prescription drug expenditures and the top ten prescription drugs by number of prescriptions filled, in total and pre and post implementation of Medicare Part D.

The following should be noted:

- Clients with no HIPAA Information Region designation are not included.
- The Department's decision support system (MMIS-DSS), extracts data on a different time span and from a different source (i.e., Medicaid Management Information System) than the Colorado Financial Reporting System. This decision support system contains a full extract of all county level data in the MMIS.
- The Department administers the following Home and Community Based Services waivers: Client Services, Mentally Ill, Children's, Persons Living with AIDS, and Brain Injury.
- The Department of Human Services administers the following Home and Community Based Services waivers: Developmentally Disabled, Supported Living Services, Children's Extensive Support, and Children's Habilitation Residential Program.
- The inpatient diagnosis related groups (DRGs) were categorized to improve the interpretation and evaluation of services (tables E4a and E4b). Research and reasonableness were used to determine the DRG categories As far as the naming of categories through the consultation of the ICD-10 (International Classification of Diseases). The logic was to create specific DRG categories without creating too many groupings, and that is partly why there is a group called *Non-Specific Symptoms, Disorders or Procedures*. Since the DRG descriptions were sometimes referring to diseases, sometimes to procedures, the term 'Disorders or Procedures' was often included in the names of categories, or groups.
- The tables exhibit the top 10 client counts, top 10 service utilizations, and top 10 expenditures by types of commonly used medical services. It should be noted that sometimes the ranking of top client counts and service utilizations are the same, but the expenditures rankings differ.
- The outpatient diagnosis groupings are based on ICD-9's three-digit categories.
- For the top ten prescription drug tables, the number of scripts filled was preferred to the number of prescriptions because it provides better insight on the frequency of pharmacy Medicaid payments. Excluded from the analysis were claims where the payment was zero.
- It is important to mention that the totals at the bottom of each of the top ten table reflect the sum of unique client count/count of services/expenditures for the top ten groupings only. These sums should not be mistaken for the totals of clients, services and expenditures for a type of medical service.

E2a: FY 05-06 Unduplicated Client Count for Selected Acute Care Service Categories by HIPAA Information Region

HIPAA Information Region	Federally Qualified Health Centers	Physician and EPSDT*	Pharmacy Prescriptions	Inpatient Hospital	Outpatient Hospital
Garfield, Moffat, Rio Blanco	1,117	4,440	4,367	765	2,586
Eagle, Grand, Jackson, Pitkin, Routt, Summit	96	3,964	2,666	775	1,464
Mesa	48	7,708	5,791	740	3,143
Delta, Montrose, Ouray, San Miguel	124	4,143	3,320	472	1,858
Archuleta, Dolores, La Plata, Montezuma, San Juan	2,192	5,804	5,878	767	3,320
Gunnison, Chaffee, Lake, Fremont, Park, Custer	514	6,310	6,862	850	3,787
Hinsdale, Saguache, Mineral, Conejos, Rio Grande, Alamosa, Costilla	5,146	4,747	6,027	716	3,033
Huerfano, Las Animas, Baca, Otero, Crowley, Bent, Prowers, Kiowa	3,631	8,458	9,791	1,043	5,235
Pueblo	5,133	19,650	19,931	2,197	11,380
El Paso, Teller	15,553	36,761	35,313	5,092	22,066
Washington, Morgan, Logan, Yuma, Phillips, Sedgwick	1,978	5,190	5,947	838	3,250
Elbert, Lincoln, Kit Carson, Cheyenne	707	1,684	1,854	233	946
Douglas	286	3,231	3,028	462	1,592
Boulder, Broomfield	6,364	10,114	9,898	1,812	6,175
Larimer	5,230	13,634	12,906	1,952	6,912
Weld	7,510	15,239	13,657	2,400	8,069
Adams	12,929	30,152	24,862	5,221	17,774
Arapahoe	7,313	29,442	23,733	4,732	16,515
Jefferson, Gilpin, Clear Creek	4,909	21,796	20,169	3,093	11,395
Denver	29,737	39,280	34,965	8,194	24,360
Statewide	**108,336**	**264,058**	**244,351**	**42,139**	**151,943**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to three months after the end of the fiscal year have been included. Unduplicated client counts represent the number of a unique clients who received a service in each category in that specific HIPAA Information Region only. Statewide totals represent an unduplicated client count for the entire State. Statewide totals are not the sum of all HIPAA Information Regions as a specific client may receive a service in one or multiple service categories, or may have received the same service in the same service category in one or multiple HIPAA Information Regions.
*Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program.

E2b: FY 05-06 Average Cost per Full Time Equivalent Client for Selected Acute Care Service Categories by HIPAA Information Region

HIPAA Information Region	Federally Qualified Health Centers	Physician and EPSDT*	Pharmacy Prescriptions	Inpatient Hospital	Outpatient Hospital
Garfield, Moffat, Rio Blanco	$138.29	$395.42	$675.97	$762.75	$335.36
Eagle, Grand, Jackson, Pitkin, Routt, Summit	$8.65	$586.51	$465.55	$1,111.21	$277.26
Mesa	$0.82	$175.75	$222.32	$296.27	$147.82
Delta, Montrose, Ouray, San Miguel	$6.96	$207.86	$312.99	$382.39	$134.28
Archuleta, Dolores, La Plata, Montezuma, San Juan	$104.20	$364.82	$647.61	$605.94	$248.07
Gunnison, Chaffee, Lake, Fremont, Park, Custer	$22.76	$416.26	$901.46	$662.36	$272.42
Hinsdale, Saguache, Mineral, Conejos, Rio Grande, Alamosa, Costilla	$271.67	$231.33	$445.62	$436.26	$235.37
Huerfano, Las Animas, Baca, Otero, Crowley, Bent, Prowers, Kiowa	$118.50	$316.47	$855.15	$448.48	$246.44
Pueblo	$121.47	$356.17	$694.35	$391.70	$239.37
El Paso, Teller	$175.92	$392.38	$597.72	$521.64	$273.25
Washington, Morgan, Logan, Yuma, Phillips, Sedgwick	$126.05	$342.65	$825.58	$686.34	$308.89
Elbert, Lincoln, Kit Carson, Cheyenne	$138.10	$281.65	$739.11	$581.98	$278.42
Douglas	$28.06	$505.22	$675.42	$767.02	$382.18
Boulder, Broomfield	$201.64	$345.31	$642.33	$693.08	$294.79
Larimer	$134.06	$449.63	$755.51	$665.95	$232.26
Weld	$191.98	$356.57	$541.99	$694.18	$272.40
Adams	$138.75	$351.42	$447.63	$749.47	$245.26
Arapahoe	$71.20	$386.56	$476.84	$751.61	$266.04
Jefferson, Gilpin, Clear Creek	$71.07	$423.98	$716.97	$759.22	$262.01
Denver	$243.18	$298.32	$459.64	$965.36	$286.05
Statewide	**$142.65**	**$353.15**	**$563.34**	**$682.85**	**$260.73**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent unduplicated average cost per full time equivalent client information presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to three months after the end of the fiscal year have been included. Average cost per full time equivalent client is total payments divided by a calculated full time eligible as determined by client eligibility months for that specific HIPAA Information Region only. Statewide averages represent the average for the entire State. Statewide averages are not an average of all HIPAA Information Regions as a specific client may receive a service in one or multiple service categories, or may have received the same service in the same service category in one or multiple HIPAA Information Regions. *Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program.

E2c: FY 05-06 Unduplicated Client Count for Home and Community Based Services (HCBS) Waiver Programs, Program for All-Inclusive Care for the Elderly (PACE), and Long Term Care Service Categories by HIPAA Information Region

HIPAA Information Region	HCBS Waiver Programs Administered by HCPF*	HCBS Waiver Programs Administered by DHS**	Program for All-Inclusive Care for the Elderly	Home Health	Nursing Facilities (Class I and Class II)
Garfield, Moffat, Rio Blanco	396	125	0	63	282
Eagle, Grand, Jackson, Pitkin, Routt, Summit	141	52	0	112	54
Mesa	1,102	163	0	238	407
Delta, Montrose, Ouray, San Miguel	582	90	0	246	382
Archuleta, Dolores, La Plata, Montezuma, San Juan	601	105	0	184	304
Gunnison, Chaffee, Lake, Fremont, Park, Custer	752	170	0	238	571
Hinsdale, Saguache, Mineral, Conejos, Rio Grande, Alamosa, Costilla	939	93	1	396	278
Huerfano, Las Animas, Baca, Otero, Crowley, Bent, Prowers, Kiowa	1,155	272	0	274	775
Pueblo	1,517	569	0	872	889
El Paso, Teller	1,872	772	0	1,181	1,427
Washington, Morgan, Logan, Yuma, Phillips, Sedgwick	564	179	0	125	559
Elbert, Lincoln, Kit Carson, Cheyenne	129	32	0	36	125
Douglas	273	116	1	142	206
Boulder, Broomfield	899	541	1	548	781
Larimer	983	488	0	493	827
Weld	726	368	1	518	625
Adams	1,156	706	306	833	1,355
Arapahoe	1,472	830	223	833	1,223
Jefferson, Gilpin, Clear Creek	1,710	950	355	836	1,801
Denver	3,186	822	479	1,522	1,879
Statewide	**19,534**	**7,212**	**1,271**	**9,430**	**14,299**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to three months after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category in that specific HIPAA Information Region only. Statewide totals represent an unduplicated client count for the entire State. Statewide totals are not the sum of all HIPAA Information Regions as a specific client may receive a service in one or multiple service categories, or may have received the same service in the same service category in one or multiple HIPAA Information Regions. *Department of Health Care Policy and Financing (HCPF), **Department of Human Services (DHS).

E2d: FY 05-06 Average Cost per Unduplicated Client Home and Community Based Services (HCBS) Waiver Programs, Program for All-Inclusive Care for the Elderly (PACE), and Long Term Care Service Categories by HIPAA Information Region

HIPAA Information Region	HCBS Waiver Programs Administered by HCPF*	HCBS Waiver Programs Administered by DHS**	Program for All-Inclusive Care for the Elderly	Home Health	Nursing Facilities (Class I and Class II)
Garfield, Moffat, Rio Blanco	$3,220.98	$36,962.35	$0.00	$1,503.81	$36,695.48
Eagle, Grand, Jackson, Pitkin, Routt, Summit	$3,220.88	$36,004.72	$0.00	$2,911.20	$36,020.17
Mesa	$4,321.81	$6,435.71	$0.00	$9,363.90	$17,388.14
Delta, Montrose, Ouray, San Miguel	$3,355.92	$6,617.96	$0.00	$3,753.66	$23,468.61
Archuleta, Dolores, La Plata, Montezuma, San Juan	$5,101.18	$30,394.07	$0.00	$10,615.22	$26,062.65
Gunnison, Chaffee, Lake, Fremont, Park, Custer	$6,444.95	$29,787.87	$0.00	$5,072.50	$28,815.37
Hinsdale, Saguache, Mineral, Conejos, Rio Grande, Alamosa, Costilla	$4,817.73	$34,115.12	$3,018.22	$2,643.96	$29,326.91
Huerfano, Las Animas, Baca, Otero, Crowley, Bent, Prowers, Kiowa	$5,009.74	$25,429.44	$0.00	$5,779.54	$30,517.14
Pueblo	$7,003.27	$37,494.77	$0.00	$7,903.34	$28,260.74
El Paso, Teller	$6,173.79	$30,277.14	$0.00	$14,858.79	$32,628.54
Washington, Morgan, Logan, Yuma, Phillips, Sedgwick	$3,698.91	$27,922.43	$0.00	$4,312.52	$27,564.57
Elbert, Lincoln, Kit Carson, Cheyenne	$4,903.83	$30,970.57	$0.00	$2,925.96	$35,692.07
Douglas	$6,406.72	$22,131.74	$18,445.70	$10,749.68	$35,867.25
Boulder, Broomfield	$5,136.11	$30,592.85	$42,275.04	$8,956.17	$31,318.52
Larimer	$4,008.87	$32,220.68	$0.00	$7,992.64	$30,386.53
Weld	$4,694.02	$32,079.22	$3,859.43	$8,747.13	$27,103.07
Adams	$6,692.96	$32,941.75	$32,173.92	$10,233.26	$30,770.87
Arapahoe	$8,367.46	$30,352.61	$27,841.31	$10,623.16	$32,160.10
Jefferson, Gilpin, Clear Creek	$7,036.47	$40,482.56	$30,111.30	$10,665.92	$32,615.40
Denver	$9,703.48	$26,914.40	$30,696.60	$10,008.53	$32,455.13
Statewide	**$6,567.25**	**$32,287.59**	**$32,662.95**	**$9,637.02**	**$31,522.32**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent unduplicated average cost per full time equivalent client information presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to three months after the end of the fiscal year have been included. Average cost per full time equivalent client is total payments divided by the unduplicated client count that specific HIPAA Information Region only. Statewide averages represent the average for the entire State. Statewide averages are not an average of all HIPAA Information Regions as a specific client may receive a service in one or multiple service categories, or may have received the same service in the same service category in one or multiple HIPAA Information Regions. *Department of Health Care Policy and Financing (HCPF), **Department of Human Services (DHS).

E3: FY 01-02 to FY 05-06 Unduplicated Client Count by Dates of Service for Home and Community Based Services (HCBS) Waiver Programs, Home Health, Program for All-Inclusive Care for the Elderly (PACE), and Nursing Facilities

HCBS Waiver Programs Administered by Department of Health Care Policy and Financing (HCPF)

Fiscal Year	Elderly Blind and Disabled	Children's Home and Community Based Services	Persons with Brain Injury	Persons with Mental Illness	Persons Living with AIDS	Total HCPF
FY 01-02	15,174	652	387	1,874	116	**18,136**
FY 02-03	15,702	638	407	2,062	106	**18,841**
FY 03-04	15,734	631	376	2,065	98	**18,559**
FY 04-05	14,833	618	322	1,844	66	**17,407**
FY 05-06	16,415	1,049	297	1,948	58	**19,534**

HCBS Waiver Programs Administered by Department of Human Services (DHS)

Fiscal Year	Children's Habilitation Residential Program	Supported Living Services	Developmentally Disabled	Children's Extensive Support	Total DHS	Total HCPF and DHS HCBS Waiver Programs
FY 01-02	279	2,963	3,771	241	**7,078**	**25,214**
FY 02-03	240	3,056	3,884	235	**7,243**	**26,084**
FY 03-04	214	3,113	3,958	226	**7,364**	**25,923**
FY 04-05	204	2,935	3,688	220	**6,927**	**24,334**
FY 05-06	191	3,092	3,690	375	**7,212**	**26,746**

Long Term Care Programs Administered by Department of Health Care Policy and Financing

Fiscal Year	Home Health	Program for All-Inclusive Care for the Elderly	Class I Nursing Facilities	Class II Nursing Facilities	Total Nursing Facilities (Class I and II)
FY 01-02	6,335	594	14,916	16	**14,932**
FY 02-03	7,326	688	14,645	17	**14,661**
FY 03-04	8,275	1,046	14,196	16	**14,212**
FY 04-05	8,687	1,187	13,919	17	**13,936**
FY 05-06	9,430	1,271	14,287	20	**14,299**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to three months after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only. Totals are not the sum of categories.

E4a: FY 05-06 Top 10 Inpatient Hospital Diagnosis Categories Ranked by Expenditures

Rank	Description	Expenditures	Unduplicated Client Count
1	Childbirth	$92,038,869	23,528
2	Circulatory System Disorders or Procedures (heart and cerebrovascular diseases)	$35,343,867	1,611
3	Neonate Related Complications or Procedures	$27,133,889	3,418
4	Pulmonary and/or Respiratory Related Disorders or Procedures	$25,282,350	3,888
5	Digestive System Related Disorders or Procedures	$19,197,497	2,581
6	Bone, Muscle, Joint or Connective Tissue Related Disorders or Procedures	$15,420,645	1,469
7	Renal and/or Urinary System Related Disorders or Procedures	$7,722,161	849
8	Brain Injuries, Brain Disorders and/or Brain Related Procedures	$7,287,207	634
9	Hematology (Blood) Related Disorders or Procedures	$7,285,012	492
10	Pregnancy Related Complications or Procedures	$6,541,463	1,825
	Top Ten Total	**$243,252,961**	**40,295**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to three months after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only.

E4b: FY 05-06 Top 10 Inpatient Hospital Diagnosis Related Groups (DRG) Ranked by Expenditures

Rank	DRG Number	Description	Expenditures	Unduplicated Client Count
1	373	Vaginal Delivery without Complicating Diagnoses	$42,105,526	14,645
2	371	Cesarean Section without Complicating Diagnoses	$17,289,403	3,116
3	370	Cesarean Section with Complicating Diagnoses	$15,854,833	2,131
4	541	Tracheostomy with Mechanical Ventilator	$12,947,714	134
5	372	Vaginal Delivery with Complicating Diagnoses	$10,893,049	2,824
6	801	Neonates Less than 1,000 Grams	$6,891,263	87
7	475	Respiratory System Diagnosis with Ventilator	$5,638,029	244
8	802	Neonates, 1,000 - 1,499 Grams	$4,994,179	167
9	803	Neonates, 1500 - 1,999 Grams	$4,504,203	376
10	542	Tracheostomy with Mechanical Ventilator	$4,215,229	72
		Top Ten Total	**$125,333,429**	**23,796**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to three months after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only.

E4c: FY 05-06 Top 10 Outpatient Hospital Principal Diagnosis Categories Ranked by Expenditures

Rank	Principal Diagnosis Group Number	Description	Expenditures	Unduplicated Client Count
1	789	Other Symptoms Involving Abdomen and Pelvis	$5,211,572	9,050
2	786	Symptoms Involving Respiratory System and Other Chest Symptoms	$3,696,042	9,657
3	780	General Symptoms	$3,346,080	10,036
4	585	Chronic Renal Failure	$3,031,351	191
5	521	Diseases of Hard Tissues of Teeth	$2,534,271	1,870
6	784	Symptoms Involving Head and Neck	$1,819,756	4,224
7	648	Other Current Conditions in the Mother Complicating Pregnancy, Childbirth, and the Puerperium	$1,791,798	5,938
8	V58	Other and Unspecified Aftercare	$1,716,084	1,672
9	787	Symptoms Involving Digestive System	$1,472,528	6,822
10	724	Other and Unspecified Disorders of Back	$1,419,894	4,095
		Top Ten Total	**$26,039,375**	**53,555**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to three months after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only.

E4d: FY 05-06 Top 10 Outpatient Surgical Procedures Ranked by Expenditures

Rank	Surgical Procedure Code	Description	Expenditures	Unduplicated Client Count
1	99.29	Injection or Infusion of Other Therapeutic or Prophylactic Substance	$877,222	936
2	23.41	Application of Crown	$714,332	393
3	66.29	Other Bilateral Endoscopic Destruction or Occlusion of Fallopian Tubes	$594,161	403
4	23.70	Root Canal, Not Otherwise Specified	$507,422	260
5	28.3	Tonsillectomy with Adenoidectomy	$495,061	309
6	89.17	Polysomnogram	$420,589	234
7	51.23	Laparoscopic Cholecystectomy	$359,795	137
8	86.59	Closure of Skin and Subcutaneous Tissue of Other Sites	$350,903	1,525
9	20.01	Myringotomy with Insertion of Tube	$348,243	317
10	23.09	Extraction of Other Tooth	$313,359	154
		Top Ten Total	**$4,981,087**	**4,668**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to three months after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only.

E4e: FY 05-06 Top 10 Federally Qualified Health Center (FQHC) Principal Diagnosis Categories Ranked by Expenditures

Rank	Principal Diagnosis Group Number	Description	Expenditures	Unduplicated Client Count
1	V20	Health Supervision of Infant or Child	$12,491,007	44,595
2	V72	Special Investigations and Examinations	$6,770,928	24,217
3	V22	Normal Pregnancy	$5,500,674	6,914
4	465	Acute Upper Respiratory Infections of Multiple or Unspecified Sites	$2,859,002	14,707
5	382	Suppurative and Unspecified Otitis Media	$1,625,992	7,711
6	650	Normal Delivery	$807,530	1,143
7	466	Acute Bronchitis and Bronchiolitis	$803,416	3,595
8	462	Acute Pharyngitis	$795,896	4,726
9	V25	Contraceptive Management	$789,054	3,233
10	079	Viral Infection in Conditions Classified Elsewhere and of Unspecified Site	$759,067	4,270
		Top Ten Total	**$33,202,567**	**115,111**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to three months after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only.

E4f: FY 05-06 Top 10 Rural Health Center (RHC) Principal Diagnosis Categories Ranked by Expenditures

Rank	Principal Diagnosis Group Number	Description	Expenditures	Unduplicated Client Count
1	V20	Health Supervision of Infant or Child	$439,746	2,919
2	382	Suppurative and Unspecified Otitis Media	$255,221	1,476
3	465	Acute Upper Respiratory Infections of Multiple or Unspecified Sites	$237,319	1,569
4	V72	Special Investigations and Examinations	$193,842	569
5	V22	Normal Pregnancy	$135,506	272
6	466	Acute Bronchitis and Bronchiolitis	$125,780	822
7	462	Acute Pharyngitis	$93,748	863
8	461	Acute Sinusitis	$90,696	824
9	780	General Symptoms	$85,092	667
10	250	Diabetes Mellitus	$81,003	241
		Top Ten Total	**$1,737,951**	**10,222**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to three months after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only.

E4g: FY 05-06 Top 10 Physician and Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program Principal Diagnosis Categories Ranked by Expenditures

Rank	Principal Diagnosis Group Number	Description	Expenditures	Unduplicated Client Count
1	V20	Health Supervision of Infant or Child	$7,867,198	63,768
2	650	Normal Delivery	$6,308,271	11,080
3	V22	Normal Pregnancy	$3,498,908	14,486
4	780	General Symptoms	$3,245,917	30,062
5	789	Other Symptoms Involving Abdomen and Pelvis	$3,109,785	20,538
6	786	Symptoms Involving Respiratory System and Other Chest Symptoms	$3,035,628	31,908
7	367	Disorders of Refraction and Accommodation	$2,661,339	26,700
8	V25	Contraceptive Management	$2,636,004	12,690
9	765	Disorders Relating to Short Gestation and Unspecified Low Birth Weight	$2,563,831	2,241
10	654	Abnormality of Organs and Soft Tissues of Pelvis	$2,535,014	3,179
		Top Ten Total	**$37,461,894**	**216,652**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to three months after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only.

E4h: FY 05-06 Top 10 Dental Procedures Ranked by Expenditures

Rank	Procedure Code	Description	Expenditures	Unduplicated Client Count
1	D2930	Prefabricated Stainless Steel Crown - Primary Tooth	$3,804,776	15,828
2	D2391	Resin-Based Composite - One Surface, Posterior	$2,822,745	20,129
3	D1201	Topical Application of Fluoride (include prophylaxis) - Child	$2,398,891	60,823
4	D2140	Amalgam - One Surface, Primary or Permanent	$1,973,813	18,852
5	D3220	Therapeutic Pulpotomy	$1,827,609	12,616
6	D7140	Extraction, Erupted Tooth or Exposed Root	$1,769,666	17,594
7	D8090	Orthodontic Treatment of the Adult Dentition	$1,628,000	543
8	D2392	Resin-Based Composite - Two Surfaces, Posterior	$1,586,291	12,223
9	D7210	Surgical Removal of Erupted Tooth Requiring Elevation and Removal of Bone	$1,570,640	6,614
10	D2150	Amalgam - Two Surfaces, Primary or Permanent	$1,372,414	13,882
		Top Ten Total	**$20,754,846**	**179,104**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to three months after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only.

E4i: FY 05-06 Top 10 Laboratory Procedures Ranked by Expenditures

Rank	Procedure Code	Description	Expenditures	Unduplicated Client Count
1	87491	Chlamydia Trachomatis, DNA, Amplified Probe Technique	$1,267,646	21,344
2	87591	Neisseria Gonorrhoeae, DNA, Amplified Probe Technique	$1,044,690	18,099
3	85025	Complete Blood Count with Automated White Blood Cells Differential	$890,966	52,345
4	84443	Thyroid Stimulus Hormone	$634,856	22,842
5	80053	Complete Blood Count with Automated White Blood Cells Differential	$602,105	27,584
6	80101	Drug Screen, Single	$577,745	3,967
7	87086	Urine Culture/Colony Count	$404,673	26,818
8	80048	Basic Metabolic Panel	$394,114	23,424
9	88305	Tissue Exam by Pathologist	$388,346	6,328
10	80061	Lipid Panel	$368,686	16,023
		Top Ten Total	**$6,573,827**	**218,774**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to three months after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only.

E4j: FY 05-06 Top 10 Durable Medicaid Equipment and Supplies Procedures Ranked by Expenditures

Rank	Procedure Code	Description	Expenditures	Unduplicated Client Count
1	S8121	Oxygen Contents Liquid, per Pound	$7,784,505	5,628
2	E1390	Oxygen Concentrator	$6,452,272	8,099
3	E0445	Oximeter Non-Invasive	$1,625,812	993
4	B4160	Enteral Formula for Pediatrics, Calorically Dense	$1,448,478	703
5	E0434	Portable Liquid Oxygen	$1,288,698	4,189
6	K0011	Standard Weight Frame Motorized/Power Wheelchair with Programmable Control	$1,195,098	252
7	T4527	Adult Sized Disposable Incontinence Product	$1,164,113	1,867
8	A9901	Durable Medical Equipment Delivery, Set-up and/or Dispensing Service Component of Another Code	$1,060,001	3,812
9	T4535	Disposable Liner / Shield / Pad for Incontinence	$1,051,219	3,040
10	A4253	Blood Glucose Test or Reagent Strips, per 50 Strips	$1,037,937	4,374
		Top Ten Total	**$24,108,134**	**32,957**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to three months after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only.

E4k: FY 05-06 Top 10 Prescription Drugs Ranked by Expenditures

Rank	Drug Name	Therapeutic Class	Expenditures	Unduplicated Client Count
1	Seroquel	Antipsychotic	$10,370,829	6,797
2	Zyprexa	Antipsychotic	$9,555,152	4,174
3	Risperdal	Antipsychotic	$8,725,632	5,914
4	Abilify	Antipsychotic	$6,281,286	3,074
5	Depakote	Anti-Convulsant	$4,887,746	5,679
6	Lipitor	Lipotropic (lowers cholesterol)	$4,620,783	9,996
7	Synagis	Monoclonal Antibody (prevention/treatment of respiratory virus in infants)	$4,174,938	514
8	Zoloft	Antidepressant	$3,942,150	9,178
9	Advair	Bronchodilator and Corticosteroid	$3,643,973	7,596
10	Lamictal	Anti-Convulsant	$3,579,800	2,260
		Top Ten Total	**$59,782,291**	**55,182**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to three months after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only.

E4l: FY 05-06 Top 10 Prescription Drugs Ranked by the Number of Prescriptions Filled

Rank	Drug Name	Therapeutic Class	Total Prescriptions Filled	Expenditures
1	Hydrocodone	Analgesic	120,044	$1,286,317
2	Albuterol	Bronchodilator	77,176	$959,401
3	Oxycodone	Analgesic	71,950	$3,530,377
4	Amoxicillin	Antibiotic	67,926	$631,075
5	Lisinopril	Hypotensive (angiotensin converting enzyme inhibitor)	58,635	$1,332,756
6	Lipitor	Lipotropic (lowers cholesterol)	48,255	$4,620,783
7	Levothyroxine	Thyroid Hormones	46,699	$455,271
8	Furosemide	Diuretic (used in the treatment of edema and hypertension)	45,266	$270,393
9	Ranitidine	Antacid	45,033	$571,077
10	Seroquel	Antipsychotic	42,249	$10,370,829
		Top Ten Total	**623,233**	**$24,028,278**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and prescriptions filled presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to three months after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only.

E4m: FY 05-06 Top 10 Prescription Drugs Prior to Medicare Part D (Effective January 1, 2006) Ranked by Expenditures

Rank	Drug Name	Therapeutic Class	Expenditures	Unduplicated Client Count
1	Zyprexa	Antipsychotic	$6,885,226	3,751
2	Seroquel	Antipsychotic	$6,357,821	5,577
3	Risperdal	Antipsychotic	$5,457,138	4,997
4	Abilify	Antipsychotic	$3,491,446	2,404
5	Lipitor	Lipotropic (lowers cholesterol)	$3,467,823	8,951
6	Depakote	Anti-Convulsant	$3,228,655	4,862
7	Zoloft	Antidepressant	$2,614,274	7,194
8	Oxycodone	Analgesic	$2,258,870	13,338
9	Advair	Bronchodilator and Corticosteroid	$2,241,649	5,766
10	Lamictal	Anti-Convulsant	$2,163,469	1,788
		Top Ten Total	**$38,166,371**	**58,628**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to three months after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only.

E4n: FY 05-06 Top 10 Prescription Drugs Prior to Medicare Part D (Effective January 1, 2006) Ranked by the Number of Prescriptions Filled

Rank	Drug Name	Therapeutic Class	Total Prescriptions Filled	Expenditures
1	Hydrocodone	Analgesic	74,354	$810,540
2	Lisinopril	Hypotensive (angiotensin converting enzyme inhibitor)	44,790	$1,025,875
3	Oxycodone	Analgesic	44,242	$2,258,870
4	Albuterol	Bronchodilator	41,640	$501,376
5	Furosemide	Diuretic (used in the treatment of edema and hypertension)	37,832	$225,066
6	Lipitor	Lipotropic (lowers cholesterol)	36,781	$3,467,823
7	Levothyroxine	Thyroid Hormones	33,842	$328,237
8	Ranitidine	Antacid	33,079	$415,178
9	Warfarin Sodium	Anticoagulant	30,487	$391,573
10	Amoxicillin	Antibiotic	28,729	$256,606
		Top Ten Total	**405,776**	**$9,681,144**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and prescriptions filled presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to three months after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only.

E4o: FY 05-06 Top 10 Prescription Drugs After Medicare Part D (Effective January 1, 2006) Ranked by Expenditures

Rank	Drug Name	Therapeutic Class	Expenditures	Unduplicated Client Count
1	Seroquel	Antipsychotic	$4,013,008	3,474
2	Risperdal	Antipsychotic	$3,268,494	3,079
3	Abilify	Antipsychotic	$2,789,840	1,903
4	Synagis	Monoclonal Antibody (prevention/treatment of respiratory virus in infants)	$2,696,733	481
5	Zyprexa	Antipsychotic	$2,669,927	1,454
6	Depakote	Anti-Convulsant	$1,659,091	2,750
7	Lamictal	Anti-Convulsant	$1,416,331	1,350
8	Advair	Bronchodilator and Corticosteroid	$1,402,325	3,986
9	Zoloft	Antidepressant	$1,327,876	4,437
10	Topamax	Anti-Convulsant	$1,323,823	1,442
		Top Ten Total	**$22,567,448**	**24,356**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to three months after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only.

E4p: FY 05-06 Top 10 Prescription Drugs After Medicare Part D (Effective January 1, 2006) Ranked by the Number of Prescriptions Filled

Rank	Drug Name	Therapeutic Class	Total Prescriptions Filled	Expenditures
1	Hydrocodone	Analgesic	45,690	$475,777
2	Amoxicillin	Antibiotic	39,197	$374,469
3	Albuterol	Bronchodilator	35,536	$458,025
4	Oxycodone	Analgesic	27,708	$1,271,507
5	Lorazepam	Anti-Anxiety Drug (benzodiazepine)	18,872	$481,261
6	Zyrtec	Antihistamine	17,206	$984,355
7	Seroquel	Antipsychotic	15,379	$4,013,008
8	Ibuprofen	Analgesic / Non-Steroidal Anti-Inflammatory Drug	14,448	$94,938
9	Clonazepam	Anti-Convulsant	14,310	$277,138
10	Risperdal	Antipsychotic	14,279	$3,268,494
		Top Ten Total	**242,625**	**$11,698,971**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and prescriptions filled presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to three months after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only.