Department of Health Care Policy and Financing
Program Crosswalks
FY 07-08

Budget Request

NOVEMBER 1, 2006

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PROGRAM CROSSWALK

Summary Section

Program Title: Executive Director's Office

Change Request(s): All

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

Federal/State Statutory and Other Authority

25.5-1-104 (1), C.R.S. (2006):
1) There is hereby created the department of health care policy and financing, the head of which shall be the executive director of the department of health care policy and financing, which office is hereby created. The executive director shall be appointed by the governor, with the consent of the senate, and shall serve at the pleasure of the governor. The reappointment of an executive director after an initial election of a governor shall be subject to the provisions of section 24-20-109, C.R.S. The executive director has those

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

Program Description

Steve Tool was appointed Executive Director effective August 17, 2005. The Executive Director has organized the Department to balance the spans of control and to allow for greater focus on key program and operational areas. Areas of responsibility for the Executive Director include general governance and financial accountability for the Department, communication with partners within and outside of state government, and research and development for current and future refinement of Department operations. Two Offices report directly to the Executive Director:

- Medical Assistance Office; and,
- Operations and Finance Office

In addition, the Privacy and Public Policy Division reports to the Executive Director as well as the Governor's Advocate and Executive Project Coordinator.

FY 07-08 Prioritized Objectives and Performance Measures

All departmental objectives and performance measures are of interest to the Executive Director. They are assigned into sub-units of the Offices in this document (Divisions, Sections, and Units). A complete list of Prioritized Objectives is found in the Strategic Plan, III. Schedule 1-Prioritized Objectives starting on page 9.

Similar or Cooperating Programs and Stakeholders

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

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

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

Privacy and Public Policy Division

Customer Service Section

PROGRAM CROSSWALK

Summary Section

Program Title: Customer Service Section

Change Request(s): None

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

Federal/State Statutory and Other Authority

25.5-1-104 (3), C.R.S. (2006): *The executive director may establish such division, sections and other units...as are necessary for the proper and efficient discharge of the powers, duties and functions of the state department.*

25.5-5-406, (III) (b) C.R.S. (2006): *Complaints and grievances. Each MCO shall utilize a complaint and grievance procedure and a process for expedited reviews that comply with regulations established by the state department. The complaint and grievance procedure shall provide a means by which enrollees may complain about or grieve any action or failure to act that impacts an enrollee's access to, satisfaction with, or the quality of health care services, treatments, or providers. The state department shall establish the position of ombudsman for Medicaid managed care. It is the intent of the general assembly that the ombudsman for*

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

Program Description

The mission of the Customer Service Section is to provide a high level of communication and assistance to all customers who contact the Department of Health Care Policy and Financing. The Section acts as a major focal point for callers that require assistance with questions, and who need help in navigating a complex health care system.

Because each of the customer groups served have different needs and requirements, the Customer Service Section responds to an array of complex concerns and issues. Due to the diversity of the customers served, and the issues that are presented, the development and implementation of standard policies, procedures and responses enhance communications and the quality of information given. The Section has developed an electronic binder to maintain a customer service database that captures such items as the date and time of contact, customer user identification and disposition, type of contact, number of calls received, reason for contacting the Department, and additional notes when necessary.

The Customer Service Contact Center:

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

The Section coordinates activities with Department contractors, other State departments such as the Department of Human Services; Department of Regulatory Agencies, Division of Insurance; and the Department of Public Health and Environment for the resolution and tracking of client, managed care, and provider complaints. Staff refers appropriate calls to each of these departments for information, assistance, and problem resolution; and to community and philanthropic services for assistance with health care benefits and services not available through departmental programs.

Future Directions

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

- Efficiently and effectively meet the high call volume demands;
- Efficiently and effectively ensure high call quality;
- Ensure that consistent and correct information is disseminated;
- Participate in upgrading the automated attendant system;
- Enhance the Customer Service database;
- Monitor and track the Section's performance;
- Improve relations with other areas;
- Provide quality training;
- Reduce staff stress and recognize accomplishments;
- Hold the Ombudsman for Medicaid managed care contractor accountable for an outcome-based results contract; and,
- Focus on employee satisfaction and retention.

FY 07-08 Prioritized Objectives and Performance Measures
3.2 Improve customer satisfaction with programs, services, and care.
Less than 1% of customer calls answered by the customer service staff will receive valid complaints at the Governor's Office.
3.3 Enhance customer service, provider and eligibility personnel's understanding of program requirements, benefits, and responsibilities. To improve the usefulness of communications with clients, constituents, partners, and stakeholders.
The Customer Service Section will maintain the call abandonment rate at the FY 05-06 level of 36.74%.

Similar or Cooperating Programs and Stakeholders

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

Medical Assistance Office

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

Long Term Benefits Division
Community Based Long Term Care Section
Nursing Facilities Section

Client Services Division
Benefits Coordination Section
Eligibility Policy Unit
Program Integrity Section
Pharmacy Section

Child Health Plan Plus Division
Program Evaluation and Contract Operations Section
Delivery Systems Section

PROGRAM CROSSWALK

Summary Section

Program Title: Acute Care Benefits Section

Change Request(s): Increased Funding for Non-Emergency Medical Transportation
Provider Rate Increases

Long Bill Line Item
(1) Executive Director's Office
Personal Services
Health, Life and Dental
Short-term Disability
S.B. 04-257 Amortization Equalization Disbursement
Salary Survey and Senior Executive Service
Workers' Compensation
Operating Expenses
Legal Services and Third Party Recovery Legal Services for 12,684 hours
Administrative Law Judge Services
Purchases of Services from Computer Center
Payment to Risk Management and Property Funds
Capitol Complex Leased Space
Early and Periodic Screening, Diagnosis, and Treatment Program
Non-Emergency Transportation Services
(2) Medical Services Premiums
(5) Other Medical Services
Nurse Home Visitor Program
Enhanced Prenatal Care Training and Technical Assistance
(6) Department of Human Services Medicaid-Funded Programs
(F) Mental Health and Alcohol and Drug Abuse Services-Medicaid Funding
Alcohol and Drug Abuse Division, High Risk Pregnant Women Program

Federal/State Statutory and Other Authority

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

25.5-2-102, C.R.S. (2006): *Subject to the provisions of subsection (2) of this section and section 26-4-104, the program for the categorically needy shall include the following services as mandated and defined by federal law.*

25.5-2-202, C.R.S. (2006): This section outlines the optional services that are provided for the categorically needy.

25.5-5-314, C.R.S. (2006): This section outlines the substance abuse treatment for native Americans -repeal.

25.5-5-308, C.R.S. (2006): *The general assembly hereby finds and declares that breast and cervical cancer are significant health problems for women in this state. The general assembly further finds and declares that these cancers can and should be prevented and treated whenever possible. It is therefore the intent of the general assembly to enact this section to provide for the prevention and treatment of breast and cervical cancer to women where it is not otherwise available for reasons of cost.*

Program Description

Medicaid Benefits

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

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

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

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

- Implements the Medicaid Breast and Cervical Cancer Program for women who have not attained age 65 with a diagnosis of breast or cervical cancer as identified through the Colorado Women's Cancer Control Initiative;
- Monitors and assists with program operations, billing, coding and reimbursement to federally qualified health centers, rural health centers, and Indian Health Services;
- Monitors the Special Connections and Prenatal Plus programs for pregnant women at risk for substance abuse or low birth-weight babies;
- Manages transportation as an administrative service as of July 1, 2004;
- Identifies, researches and analyzes Medicaid recipients for abuse, misuse and over-utilization of medical services;
- Implements Early and Periodic Screening, Diagnosis and Treatment Program; and,
- Initiated an outpatient substance abuse benefit as of July 1, 2006.

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

FY 07-08 Prioritized Objectives and Performance Measures
1.4 To assure delivery of appropriate, high quality care. To design programs that result in improved health status for clients served and to improve health outcomes. To ensure that the Department's programs are responsive to the service needs of enrolled clients in a cost-effective manner.
The Acute Care Benefits Section will address the request of stakeholders by implementing an outpatient substance abuse benefit. The benefit is 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.

Similar or Cooperating Programs and Stakeholders

The Department of Health Care Policy and Financing is the Single State Agency responsible for administration of the Colorado Medical Assistance Program. The Department of Public Health and Environment assists in the administration of several programs. The Department of Public Health and Environment is responsible for the administration of the Infant Immunization Program, the Vaccine for Children program, the Health Care Program for Children with Special Needs including the developmental evaluation clinics, and the Prenatal Plus Program. The Department of Human Services is responsible for the administration of the Special Connections program. The County Departments of Human/Social Services assist with the administration of Non-Emergent Medical Transportation and Early and Periodic Screening, Diagnosis, and Treatment administration.

PROGRAM CROSSWALK

Summary Section

Program Title: Quality Improvement Section

Change Request(s): Move Administrative Contracts in Medical Services Premiums to the Executive Director's Office Long Bill Group

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

Federal/State Statutory and Other Authority

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

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

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

25.5-5-405, C.R.S. (2006): Requires the Department to administer quality measurements for managed care.

25.5-5-406 (1) (b), C.R.S. (2006): Requires the Department to establish a complaint and grievance procedure and a process for expedited reviews for managed care organizations to use.

25.5-5-315, C.R.S (2006): Authorizes the Department to develop and implement disease management programs.

SB 06-165: Authorizes the Department to conduct pilot programs to investigate the feasibility of managing and treating clients with chronic medical conditions using telemedicine.

Program Description

The Quality Improvement Section is responsible for quality assessment and performance improvement endeavors across Medicaid fee-for-service, managed care and home and community based services populations. The Section also manages the disease management program contracts. Quality improvement activities are performed for both the physical health and behavioral health care programs. Specific quality functions include quality measurement and improvement activities, external quality review of managed care and fee-for-service programs, managed care plan contract compliance and monitoring, fee-for-service utilization management, and oversight of the disease management program contracts. The mission of the Quality Improvement Section is to facilitate, monitor and improve access, fiscal accountability, and quality health care for all Medicaid clients. Access to care, the provision of quality

health care services, and the appropriate use of Medicaid resources are facilitated and monitored through a variety of activities performed by the Section.

QUALITY MEASUREMENT AND IMPROVEMENT ACTIVITIES

The Quality Improvement Section generates, collects, compiles, and analyzes data from various sources in order to improve the quality of care and access to services provided to Medicaid clients. This data is used for evaluating the performance of contracting health plans and providers, selecting interventions designed to improve care and services, and evaluating the effectiveness of the overall managed care and fee-for-service programs. The quality and cost effectiveness data analyzed and reported include:

- **Client Satisfaction Surveys:** Satisfaction surveys are conducted for clients in managed care and fee-for-service programs. The physical health plan results are reported to clients to assist them in choosing the best health plan or program to meet their needs. In 2006, the Consumer Assessment of Health Plans Study (CAHPS) client satisfaction survey was completed for the physical health plan managed care organizations, the Primary Care Physician Program, and all fee-for-service. Results are summarized in a Report Card that is mailed to all clients at annual enrollment. The Mental Health Statistics Improvement Program (MHSIP) survey is used to monitor consumer satisfaction for the behavioral health organizations. This data becomes part of the behavioral health organizations' overall quality improvement plan.

- **Quality and Performance Measures:** The Department collects quality and utilization data to enable evaluation of managed care organizations and services provided to clients by fee-for-service providers and Primary Care Physician Program members. For physical health care, these indicators are taken from the nationally recognized Health Plan Employer Data and Information Set (HEDIS). A summary of this data is included in the Report Card and a full report of results is available on the Department's website.

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

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

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

- **Interventions:** The Department conducts limited quality improvement interventions or remeasurements for selected Medicaid populations. The intervention or remeasurement has a single quality focus generally derived from previous quality improvement activities where opportunities for improvement have been identified. In the case of a remeasurement, the Department seeks to evaluate the outcome in a particular aspect of quality to determine if previous interventions have resulted in improved performance.

EXTERNAL QUALITY REVIEW

The Department contracts with an external quality review organization to perform a variety of quality activities. These activities include administration and reporting of the client satisfaction surveys for the fee-for-service population, administration and reporting of the Health Plan Employer Data and Information Set for the fee-for-service population, coordination and reporting of an intervention designed to improve an aspect of care or service, validation of health plan performance improvement projects and performance measures, and administration and reporting of behavioral health organization site reviews. In addition to these activities, the following activities are also performed:

- **Technical Reports**: The external quality review organization produces a technical report for both physical and behavioral health organizations. This report is required by the Centers for Medicare and Medicaid Services and includes an assessment of each health plan's strengths and weaknesses, recommendations for improving the quality of health care services furnished by each health plan, comparative information about all health plans, and an assessment of the degree to which each health plan has addressed the recommendation for quality improvement during the previous year's activities.

- **Focused Studies:** The Department contracts with an external quality review organization to conduct quality of care focused studies that measure an aspect of care or services provided by physical health providers. These studies typically involve medical records review. The FY 05-06 focused studies evaluated the well care provided to adolescents and evaluated aspects of care provided to clients diagnosed with Diabetes. The Department will make the study results available to clients as part of the Report Card and will post the information on the Department's website. The Department will select two new studies for FY 06-07 that will build upon the findings of earlier studies.

- **Physician Profiles:** The Department supplies Primary Care Physician Program members with clinical practice profiles on a routine basis. The profiles are designed to provide physicians with information about the care and services their assigned clients receive, which then can be used to improve care or access to services.

- **Credentialing:** The Department administers a physician credentialing and recredentialing program. This program is a process that evaluates the qualifications of practitioners in the Primary Care Physician Program to deliver health care. The process includes the verification of licensure status, the validity of Drug Enforcement Agency and/or Controlled Dangerous Substances certification, the verification of relevant training and experiences, board certification, and work history.

MANAGED CARE PLAN CONTRACT COMPLIANCE AND MONITORING

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

- **Compliance Monitoring:** Behavioral and physical health plans submit selected reports to the Department on an ongoing basis. These reports focus on areas of contract compliance that are important to client service or can indicate an area of concern, such as the number and geographic distribution of providers or trends in reasons for client grievances and appeals. These reports are reviewed by Department staff and follow-up with the plans occurs when indicated.

UTILIZATION MANAGEMENT

The Department's utilization review contractors support Medicaid's acute care and long term care programs by ensuring that Medicaid services are used appropriately. Using prospective, concurrent and retrospective reviews, utilization review contractors help ensure services provided to Medicaid clients are medically necessary and appropriate. Additional services provided by the utilization review contractors include:

- **Management Reports:** These reports include an analysis of the utilization trends and the results of utilization reviews. Subsequent recommendations for improving the utilization review processes or focus areas are included. The reports are discussed and final decisions on recommendations are made during routine contractor meetings.

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

DISEASE MANAGEMENT PROGRAMS

The Department manages two statewide disease management programs, which began in FY 04-05. The disease management programs provide medical assessment, case management, care coordination, client and provider education and health risk screening, designed to improve the quality of care for clients, reduce utilization of costly services and assist physicians in caring for high-risk clients. The Department's disease management programs include:

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

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

FY 07-08 Prioritized Objectives and Performance Measures
1.4 To assure delivery of appropriate, high quality care. To design programs that result in improved health status for clients served and to improve health outcomes. To ensure that the Department's programs are responsive to the service needs of enrolled clients in a cost-effective manner.
The 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.
3.2 To improve customer satisfaction with programs, services, and care.
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.

Similar or Cooperating Programs and Stakeholders

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

PROGRAM CROSSWALK

Summary Section

Program Title: Managed Care Benefits Section

Change Request(s): Move Administrative Contracts in Medical Services Premiums to the Executive Director's Office Long Bill Group

Long Bill Line Item
(1) Executive Director's Office
Personal Services
Health, Life and Dental
Short-term Disability
S.B. 04-257 Amortization Equalization Disbursement
Salary Survey and Senior Executive Service
Performance-based Pay
Worker's Compensation
Operating Expenses
Legal Services and Third Party Recovery Legal Services for 12,684 hours
Administrative Law Judge Services
Purchases of Services from Computer Center
Payment to Risk Management and Property Funds
Capitol Complex Leased Space
SB 97-05 Enrollment Broker
(2) Medical Services Premiums
(3) Medicaid Mental Health Community Programs
(A) Mental Health Capitation Payments for 410,343 Estimated Medicaid Eligible Clients
(B) Other Medicaid Mental Health Payments
Medicaid Mental Health Fee for Service Payments

Federal/State Statutory and Other Authority

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

Sections 25.5-5-401 through 25.5-4-406 C.R.S. (2006), Statewide System of Managed Care: This statute defines managed care and describes the requirements for the "Statewide Managed Care System."

25.5-5-411, C.R.S, (2006): Requires the Department to administer all Medicaid community mental health services.

Program Description

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

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

Medicaid's Managed Care Programs

- Primary Care Physician Program: Medicaid clients may select a primary care physician who is solely authorized to provide primary care and make referrals to specialty services. That physician, physician group, or health clinic is responsible for coordinating, managing, and authorizing all health care services for the client. Medicaid pays for care delivered on a fee-for-service basis. This program operates as a Primary Care Case Manager program (PCCM) under 42 C.F.R 438.2.

- Managed Care Organizations: Medicaid clients may select a capitated physical health plan which operates under a comprehensive risk contract. Unlike providers participating in the non-capitated managed care programs, the capitated plans have full responsibility, not only for the management of care, but also for the financing and delivery of all necessary and covered health care services. These plans receive a fixed monthly payment from Medicaid for each enrolled Medicaid client. These plans operate as Managed Care Organizations (MCOs) under 42 C.F.R. 438.2.

- Prepaid Inpatient Health Plans: Medicaid clients may select a prepaid inpatient physical health plan that operates under a capitated nonrisk contract. Medicaid clients are assigned to one of five regional capitated behavioral health plans that operate under a risk contract. These plans operate as Prepaid Inpatient Health Plans (PIHPs) under 42 C.F.R. 2.

FY 07-08 Prioritized Objectives and Performance Measures
1.1 To maximize the opportunity to preserve health care services through the purchase of services in the most cost-effective manner possible.
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.

Similar or Cooperating Programs and Stakeholders

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

PROGRAM CROSSWALK

Summary Section

Program Title: Community Based Long Term Care Section

Change Request(s): Provider Rate Increases
Move Administrative Contracts in Medical Services Premiums to the Executive Director's Office Long Bill Group

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

Federal/State Statutory and Other Authority

25.5-4-105, C.R.S. (2006): Authorizes the Department to amend the existing Children's HCBS and Children's Extensive Support Waivers to increase the number of children authorized to be enrolled in the programs.

25.5-5-102 (1), C.R.S. (2006): Home health services are mandated services.

25.5-5-6-1101, C.R.S. (2006): Authorizes the implementation of a consumer-directed service program and makes an appropriation for this program.

25.5-5-302, C.R.S. (2006): Home and community-based services, intermediate care facilities for the mentally retarded, case management, therapies under home health services, private duty nursing services, hospice care, and the Program of All-inclusive Care for the Elderly are optional services.

25.5-6-901, C.R.S (2006): Establishes the children's Home- and Community-Based Services program.

25.5-6-106, C.R.S. (2006): Establishes the single entry point system enabling persons eighteen years of age or older in need of long-term care to access appropriate long-term care services.

25.5-5-306, C.R.S. (2006): Authorizes the Department, in cooperation with the Department of Human Services, to implement a program concerning residential child health care to Medicaid eligible children.

25.5-6-302, C.R.S. (2006): Authorizes the Department to provide, under a federal waiver of statutory requirements, for an array of home- and community-based services to eligible elderly, blind, and disabled individuals as an alternative to nursing facility placement.

25.5-6-401, C.R.S. (2006): Authorizes the Department to seek a federal waiver to provide home and community-based service for persons with developmental disabilities.

25.5-5-412, C.R.S (2006): Authorizes the Department to develop Program of All-Inclusive Care for the Elderly (PACE) sites.

25.5-6-404, C.R.S. (2006): Authorizes the Department and the Department of Human Services to establish a system of reimbursement for home and community-based services for persons with developmental disabilities and to utilize State and federal Medicaid funds.

25.5-6-501, C.R.S. (2006): Authorizes the Department to establish a program to provide home and community-based services for persons with acquired immunodeficiency syndrome.

25.5-6-607, C.R.S. (2006): Authorizes the Department to establish a program to provide home and community-based services to persons with major mental illness.

25.5-6-702, C.R.S. (2006): Authorizes the Department to establish a program to provide home and community-based services to persons with brain injuries.

25.5-6-801, C.R.S. (2006): Authorizes the Department to establish a program to provide home and community-based services to children with autism.

Program Description

State Plan Benefits in Long-term Care

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

Home and Community Based Service Waivers

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

Program of All-Inclusive Care for the Elderly

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

Single Entry Point Agencies

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

Interagency Agreements

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

FY 07-08 Prioritized Objectives and Performance Measures
1.1 To maximize the opportunity to preserve health care services through the purchase of services in the most cost-effective manner possible.
The Community Based Long Term Care Section will enroll, to at least 80% waiver capacity, the Supported Living Services 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.

1.3 To assure payments in support of the programs are accurate and timely, and to procure an effective fiscal agent.
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.
2.2 To assess the need to consolidate federally-funded health care programs within the Single State Agency.
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 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.

Similar or Cooperating Programs and Stakeholders

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

Stakeholders include:

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

PROGRAM CROSSWALK

Summary Section

Program Title: Nursing Facilities Section

Change Request(s): None

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

Federal/State Statutory and Other Authority

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

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

25.5-6-204, C.R.S. (2006): Requires the Department to set rates for nursing facilities and intermediate care facilities for the mentally retarded.

25.5-6-201 through 25.5-6-205, C.R.S. (2006): Instructs the Department on how to set nursing facility rates.

SB 06-131 (2006): Directs the Department to conduct a feasibility study and report to specified committees of the General Assembly by November 1, 2006 on a new reimbursement system for class I nursing facility providers based on a pricing model or pay-for-performance system. 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.

Program Description

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

Nursing Facilities Section functions include:

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

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

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

The Nursing Facilities Section implements rates and monitors the performance of approximately 200 skilled nursing facilities and approximately 255 alternative care facilities. These providers deliver services to approximately 12,500 Medicaid clients at any given time. During FY 04-05, the Department accomplished several policy and operational objectives, including implementation of rule re-writes to clarify, enhance, and assure the appropriateness of the Hospital Back Up Level of Care program and the Nursing Facilities reimbursement process.

SB 06-131, Reimbursement Under Medical Assistance Program for Nursing Facility Providers, directs the Department to conduct a feasibility study and report to specified committees of the General Assembly by November 1, 2006 on a new reimbursement system for class I nursing facility providers based on a pricing model or pay-for-performance system. 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. The bill states that a nursing facility's total reimbursement shall be at least 85% of the statewide average but not exceed 110% of what that facility's total reimbursement would have been without this law.

FY 07-08 Prioritized Objectives and Performance Measures
1.4 To assure delivery of appropriate, high quality care. To design programs that result in improved health status for clients served and to improve health outcomes. To ensure that the Department's programs are responsive to the service needs of enrolled clients in a cost-effective manner.
The 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.
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.
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.

Similar or Cooperating Programs and Stakeholders

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

PROGRAM CROSSWALK

Summary Section

Program Title: Benefits Coordination Section

Change Request(s): None

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

Federal/State Statutory and Other Authority

25.5-4-301, C.R.S. (2006): *Recoveries - overpayments - penalties - interest - adjustments - liens: Requires the Department to recover medical assistance benefits paid on behalf of recipients from liable third parties.*

25.5-4-302, C.R.S. (2006): Estate Recovery: Requires the Department to recover the cost of medical assistance paid on behalf of recipients from the estates of recipients.

25.5-4-210, C.R.S. (2006): Purchase of health insurance for recipients: Requires the Department to purchase group health insurance for a medical assistance recipient who is eligible to enroll for such coverage if enrollment of such recipient in the group plan would be cost-effective.

25.5-6-102, C.R.S. (2006): Requires the Department to review trusts created for the purpose of obtaining Medicaid eligibility to ensure compliance with state and federal law.

S. 1932, Deficit Reduction Act of 2005: The Deficit Reduction Act helps restrain Medicaid spending and allows each state flexibility to design Medicaid benefits, and tightens loopholes that allowed people to game the system by transferring assets to their children so they can qualify for Medicaid benefits.

Program Description

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

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

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

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

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

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

In FY 05-06, approximately 7,016 clients were known at any given time to have other sources of health coverage, not including Medicare. When reported, this coverage was verified and loaded into a resource file that the fiscal agent utilized to set denial edits on billed claims, which without third party payment information, would have resulted in Medicaid being billed as the primary payer. These cost avoidance activities saved Colorado over $36.29 million in FY 05-06.

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

To reduce Medicaid costs, the State pays monthly premiums to "buy in" Medicaid clients into Medicare or private health insurance plans. The cost of the premiums is much less than the cost of claims the State would have to pay for health services rendered under Medicaid. During FY 05-06, approximately 61,970 Medicaid clients per month had Medicare Part B coverage purchased by the State, an increase of 429 in Part B "buy-in" clients over FY 04-05. A total of $69,574,499 in Medicare Part B premiums was paid under the buy-in program. Medicaid saved an estimated $158,745,073 in FY 05-06 for health care payments through this purchased coverage. A total of $1,201,105 in Medicare Part A premiums was paid under the buy-in program for an average of 263 clients per month. The Department saved an estimated $136,519,364 in health care expenditures via this cost avoidance action in FY 05-06. The majority of clients who have Medicare receive Part A for free. Therefore, Medicaid achieves cost savings for all Medicaid clients who have Medicare Part A, while only paying the Part A premiums for a small portion of those clients.

Tort/Casualty Recovery

The Medicaid program attempts to recover payments made from third parties who are liable as insurers in the case of auto, accident, homeowner's policies, workers' compensation, or through tort litigation. Benefits Coordination staff manage these recovery activities; however, often there is a need for coordination with the Attorney General's staff in particularly difficult legal cases where there is malpractice litigation. As a result, the program recovered $3,383,297 in FY 05-06.

In addition, the Department utilizes a contractor to pursue tort recoveries previously unknown to the Department, as well as assume the responsibility for the non-reported workers' compensation cases that are listed on a quarterly report. This contract recovered the net amount of $118,857 in FY 05-06.

Trust Recovery and Repayment of Medicaid Expenditures

Income and disability qualifying trusts provide a mechanism for individuals, whose incomes and/or assets would otherwise make them ineligible, to qualify for Medicaid. For income trusts, the client's income is placed in a trust. The Trustee distributes the trust assets according to the rules defining these types of trusts. These disbursements include patient payment to nursing facilities, patient allowances, spousal allowances, and other approved expenditures. The Department is the beneficiary of these trusts. When the trust is no longer required for Medicaid eligibility the balance of the trust is paid to Medicaid. Disability trusts are created from settlement agreements and/or client's assets to provide a resource for the client's use for non-Medicaid covered services. The Medicaid program pays for the client's medical care and is the beneficiary of the trust monies when the trust is no longer required for Medicaid eligibility. The repayments of Medicaid expenditures also include a client's voluntary repayment from excess resources as part of the spend-down to meet eligibility resource requirements to retain Medicaid eligibility. In FY 05-06, $3,036,906 was recovered. The Benefits Coordination Section administers the approval, closing, and accounting for these trusts.

Estate Recovery

The Estate Recovery program, operated by a contractor under supervision of State staff, recovers funds from estates and places TEFRA liens on real property held by Medicaid clients in nursing facilities or client's who were over the age of 55 when benefits were received. The total net estate recoveries for FY 05-06 were $5,740,617.

Retractions/Recoveries:

The State contracts with a contingency-based contractor, to identify recovery opportunities through the use of expanded data matches. The State retracts the value of Medicaid-paid claims if a third party is later identified as a primary payer. This contract recouped a net amount of $12,446,404 in FY 05-06.

Recoveries by Program Areas

Summary of Third Party Cost Avoidance and Post-Payment Recovery	
Program	**FY 05-06**
Cost Avoidance	
Payment by Non-Medicaid Health Care Sources	$36,285,670
Medicare Buy-In	$295,264,437
Private Health Insurance Buy-In	$1,824,295
Subtotal, Cost Avoidance	**$333,374,402**
Cost Recovery	
Tort/Casualty Recovery	$3,383,297
Estate Recovery	$5,740,617
Trust Recovery and Repayment of Medicaid Expenditures	$3,036,906
Subtotal, Cost Recovery	**$12,160,820**
Contractor Recoveries	
Tort/Casualty Recovery	$118,857
Medicare Part A retractions	$3,876,595
Medicare Part B payments	$104,054
Commercial Insurance Payments and Retractions	$7,225,420
Champus	$1,074,761
Other Recoveries (includes adjustments for refunds)	$165,574
Subtotal, Contractor Recovery	**$12,565,261**
Total Avoided And Recovered Costs	**$358,100,483**

FY 07-08 Prioritized Objectives and Performance Measures
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.
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 the Department's 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.

Similar or Cooperating Programs and Stakeholders

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

PROGRAM CROSSWALK

Summary Section

Program Title: Eligibility Policy Unit

Change Request(s): Implementation of HB 06S-1023 and Deficit Reduction Act of 2005

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

Federal/State Statutory and Other Authority

25.5-4-205, C.R.S. (2006): Provides the Department, county departments and medical assistance sites may accept applications for, and determine eligibility for medical assistance.

25.5-4-104, C.R.S. (2006): Requires the Department to establish a medical assistance program in compliance with federal law.

Program Description

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

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

Trends and Other Baseline Information

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

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

Determining Medicaid Eligibility

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

Development of Client Information and Staff Training Tools

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

FY 07-08 Prioritized Objectives and Performance Measures
1.2 To support timely and accurate client eligibility determination.
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.
2.1 To build and manage a high quality team.
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.
3.3 To enhance customer service, providers, clients, stakeholders and eligibility personnel's understanding of program requirements, benefits and responsibilities through effective communication.
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.

Similar or Cooperating Programs and Stakeholders

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

PROGRAM CROSSWALK

Summary Section

Program Title: Program Integrity Section

Change Request(s): None

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

Federal/State Statutory and Other Authority

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

25.5-4-301 C.R.S. (2006): *Year Recoveries - overpayments - penalties - interest - adjustments – liens – review or audit procedures: Identifies the authority for recovery of overpayments, penalties and interest that may be applied, methods of recovery, and expectations when conducting audits or reviews and utilizing a contingency based contractor.*

Program Description

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

Specific Program Integrity activities include:

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

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

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

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

- **Diagnosis Related Group (DRG) Review Contingency Based Contract:** This contract will replace the facility credit balance audit contract. A request for proposals (RFP) was posted June 2, 2006 for DRG, inpatient hospital claims review contract. The contractor will provide data mining techniques and Certified Medical Coder expertise to assist the Department in identifying and recovering DRG overpayments. A contract is in place October 31, 2006.

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

- **The Surveillance Utilization Review System (SURS):** SURS has entered a new stage of analysis. The Medicaid Management Information System provider and client grouping reports are analyzed to identify exceptions to standard deviations. The highest paid providers, procedures and diagnosis are identified for special study and project development.

FY 07-08 Prioritized Objectives and Performance Measures
1.3 To assure payments in support of the programs are accurate and timely, and to procure an effective fiscal agent.
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 wavered services, pharmacies, durable medical equipment/supply providers, hospital providers and physician services.

Similar or Cooperating Programs and Stakeholders

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

PROGRAM CROSSWALK

Summary Section

Program Title: Pharmacy Section

Change Request(s): Decrease Drug Utilization Review Funding

Long Bill Line Item
(1) Executive Director's Office
Personal Services
Health, Life and Dental
Short-term Disability
S.B. 04-257 Amortization Equalization Disbursement
Salary Survey and Senior Executive Service
Workers' Compensation
Operating Expenses
Legal Services and Third Party Recovery Legal Services for 12,684 hours
Administrative Law Judge Services
Purchases of Services from Computer Center
Payment to Risk Management and Property Funds
Capitol Complex Leased Space
Drug Utilization Review
(2) Medical Services Premiums
(3) Medicaid Mental Health Community Programs
(B) Other Medicaid Mental Health Payments
Medicaid Anti-Psychotic Pharmaceuticals
(5) Other Medical Services
Medicare Modernization Act of 2003 State Contribution Payment

Federal/State Statutory and Other Authority

25.5-5-501 through 25.5-5-506, C.R.S. (2006): *Requirements regarding administration of the pharmacy program*

42 U.S.C. § 1396r-8: *Requirements regarding drug rebate program, drug coverage issues and the operation of the drug utilization review board*

42 CFR Part 447 Subpart F: *Allowed payment methods for drug coverage*

42 CFR Part 456 Subpart K: *Requirements regarding drug utilization review board*

42 U.S.C. Chapter 7 Subchapter XVIII Part D: *Medicaid requirements regarding Medicare Part D drug benefit*

42 CFR Part 423: *Medicaid requirements regarding Medicare Part D drug benefit*

Program Description

The mission of the Pharmacy Section is to administer the pharmacy benefit for Medical Assistance Program clients and to establish reimbursement rates for pharmacies to ensure clients have access to quality care, while containing program expenditures and accurately reflecting legislative intent in the most cost-effective manner.

Functions of the Pharmacy Section include:

- Provide pharmacy benefits to eligible Medicaid clients;
- Implement utilization controls such as prior authorizations;
- Establish reimbursement rates for drugs;
- Address client and provide issues related to the pharmacy benefit;
- Review fiscal agent claims processing;
- Maintenance of the drug utilization review board;
- Administering the Pharmacy Unit; and,
- Administering the Drug Rebate Program.

Summary of Activities

Administration of the Pharmacy Benefit: Prescribed drugs within certain limitations are a benefit of the Medical Assistance program. The Pharmacy Section develops and implements pharmacy-related policies regarding the coverage of prescribed drugs. Such policy changes include reviewing and revising the current formulary and implementing any changes to prior authorization criteria. The Pharmacy Section reviews a number of sources of information when developing policies including but not limited to industry trends, manufacturers' drug information, drug studies and reports, government reports, and Colorado Medicaid drug utilization data.

The Pharmacy Section also establishes the reimbursement rate for drugs, which is the lesser of the Medicaid allowable reimbursement charge or the provider's charge plus a dispensing fee minus any applicable copayment. The Medicaid allowable reimbursement charge is the lowest price determined by the following methodologies:

1. Average wholesale price (AWP) minus 13.5% for name-brand drugs
2. Average wholesale price (AWP) minus 35% for generic drugs
3. Direct price plus 18%
4. State maximum allowable cost (M.A.C.)
5. Federal Upper Limit (FUL)

In addition, the Pharmacy Unit addresses and resolves client and provider issues related to the pharmacy benefit. Such issues include drug coverage questions, drug access concerns, billing questions, and appeals related to drug coverage issues.

The Pharmacy Section also reviews claims processed by the fiscal agent to oversee quality assurance practices. The Pharmacy Section also ensures that the fiscal agent has appropriate prospective drug utilization review edits in place.

In addition, the Pharmacy Section is responsible for the maintenance of the drug utilization review board and the Section's personnel serve as the liaison between the board and the Department. As part of its duties, the board engages in a retrospective drug utilization review program designed to improve clinical outcomes and reduce drug expenditures by eliminating inappropriate drug use and dosing.

Drug Rebate Program: In exchange for the coverage of drugs, manufacturers agree to rebate an amount of funds based on utilization data for each drug covered under the Medicaid program. The Pharmacy Section researches pharmaceutical claims data, reconciles data with manufacturer invoices, submits the results to manufacturers to obtain rebate payments, conducts follow-up on non-payment, and settles dispute differences.

Dual Eligible Part D Eligibility Issues: Effective July 1, 2006, the Pharmacy Section addresses policy issues related to the dual eligibles' eligibility. Although Medicare is responsible for the Part D drug program, eligibility coordination issues arise between Medicaid and Medicare. The Pharmacy Section will be responsible for addressing the Medicaid portion of these issues. The Pharmacy Section will work with CMS and the counties to resolve any such issues.

FY 07-08 Prioritized Objectives and Performance Measures
1.1 To maximize the opportunity to preserve health care services through the purchase of services in the most cost-effective manner possible.
Based on identifying opportunities within the pharmacy program and utilizing the Drug Utilization Review Board recommendations, the Pharmacy Section will provide recommendations on a quarterly basis for prior authorizations, limits and controls to effectively manage the prescription drug expenditures.
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.

Similar or Cooperating Programs and Stakeholders

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

PROGRAM CROSSWALK

Summary Section

Program Title: Delivery Systems Section

Change Request(s): Children's Basic Health Plan Caseload and Rates

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

Federal/State Statutory and Other Authority

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

25.5-8-101, C.R.S. (2006) et seq.: *"This article shall be known and may be cited as the 'Children's Basic Health Plan Act'."*

Program Description

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

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

Accomplishments

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

Administration

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

Health Care Service Delivery

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

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

State Managed Care Network: The Department offers a self-funded managed care network. The State contracts directly with health care providers in counties where health maintenance organizations have been unable to offer coverage. In addition, Children's Basic Health Plan enrolled children in counties served by health maintenance organizations can receive services through the State managed care network while they are waiting for enrollment in a health maintenance organization. The Department contracts directly with over 2,650 providers: 1,551 primary care physicians; 1,095 specialists; 21 hospitals systems in 44 locations; and, a number of ancillary service providers, which include essential community providers, to create a State-run managed care network. Anthem Blue Cross Blue Shield manages the network.

Dental Program

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

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

FY 07-08 Prioritized Objectives and Performance Measures
1.4 To assure delivery of appropriate, high quality care. To design programs that result in improved health status for clients served and to improve health outcomes. To ensure that the Department's programs are responsive to the service needs of enrolled clients in a cost-effective manner.
The 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 Employer 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 the results to implement appropriate policy changes that assure the delivery of appropriate, high quality care.
3.4 To streamline health care services for children and families.
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.

Similar or Cooperating Programs and Stakeholders

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

PROGRAM CROSSWALK

Summary Section

Program Title: Program Evaluation and Contract Operations Section

Change Request(s): Children's Basic Health Plan Caseload and Rates

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

Federal/State Statutory and Other Authority

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

25.5-8-101, C.R.S. (2006) et seq.: *"This article shall be known and may be cited as the 'Children's Basic Health Plan Act'."*

Program Description

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

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

Accomplishments

SB 05-221 implemented a process for the Department to seek state and federal approval for a Health Insurance Flexibility and Accountability waiver. The Department submitted a proposal to the Health and Human Services Committees of the Colorado State Legislature in July 2004. The proposal was aimed at creating a streamlined health care delivery system called the Colorado Family Care program for low-income children and families in the Children's Basic Health Plan and Medicaid. The proposal was not approved by the Health and Human Services Committees and therefore did not go forward to the Joint Budget Committee or the Centers for Medicare and Medicaid Services for approval. However, after reviewing the Department's proposal, members of the Health and Human Services Committees expressed interest to further explore this initiative. The Department is working on proposing strategies to streamline the Children's Basic Health Plan and Medicaid within existing statutes and regulations to the Executive Director by December 2007. If the proposed strategies are approved, the Department will implement appropriate changes.

Prenatal Program

Pregnant women of any age with incomes at or below 200% of the federal poverty level, who are not eligible for Medicaid, are eligible for the Children's Basic Health Plan Prenatal Program. These women receive prenatal, delivery, and post-partum medical

care. There are no co-pays or enrollment fees for these clients. Enrollment into the prenatal program was temporarily suspended in May 2003 but was reinstated July 1, 2004.

Outreach

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

Enrollment and Disenrollment

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

FY 07-08 Prioritized Objectives and Performance Measures
1.4 To assure delivery of appropriate, high quality care. To design programs that result in improved health status for clients served and to improve health outcomes. To ensure that the Department's programs are responsive to the service needs of enrolled clients in a cost-effective manner.
The 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.
3.2 To improve customer satisfaction with programs, services, and care.
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 Prioritized Objectives and Performance Measures
4.3 To seek grants as applicable to improve the administration of programs.
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.

Similar or Cooperating Programs and Stakeholders

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

Operations and Finance Office

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

Eligibility Operations Section

Audits Section

Controller and Operations Division
Accounting Section
Contracts and Purchasing Section
Human Resources Section

Finance Division
Safety Net Financing Section
Rates Section
Data Section

Budget Division
Budget and Financing Section

PROGRAM CROSSWALK

Summary Section

Program Title: Information Technology Contracts and Monitoring Section

Change Request(s): None

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

Federal/State Statutory and Other Authority

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

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

25.5-4-204, C.R.S. (2006): *Automated medical assistance administration.*
(1) The general assembly hereby finds and declares that the agency responsible for the administration of the state's medical assistance program would be more effective in its ability to streamline administrative functions of program administrators and providers under the program through the implementation of an automated system that will provide for the following: (a) Electronic claim submittals; (b) On-line eligibility determinations; (c) Electronic remittance statements; (d) Electronic fund transfers; and (e) Automation of other administrative functions associated with the medical assistance program.

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

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

Program Description

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

The Section assures compliance with State and federal regulations which affect Medicaid Management Information System operations and contract management for information technology (IT) contracts. These activities include timely submission of Advance Planning Documents to the Centers for Medicare and Medicaid Services, timely execution of contracts, monitoring of legislation that may impact systems, and operational changes at the fiscal agent vendor. In addition, this section is responsible for monitoring Federal rule changes related to Health Insurance Portability and Accountability Act (HIPAA) regulations.

The Information Technology Contracts and Monitoring Section directs the support of the fiscal agent contract for Medicaid Management Information System services. Medicaid is the primary payment source for health care services for 403,000 of Colorado’s low-income citizens each month and 9,000 for State-only participants. The Children’s Basic Health Plan covers services for about 49,000 children and pregnant women each month.

HIPAA Compliance

The Section also coordinates work related to the Health Insurance Portability and Accountability Act (HIPAA). HIPAA affects many State agencies, as well as all health care providers, plans, and payers across the country. HIPAA is an effort to standardize health care transactions and assure privacy/security of the health information. For these reasons, coordination with other affected entities is important to the success with any HIPAA effort.

HIPAA requires change throughout the Department's systems and across many business processes. HIPAA implementation efforts in the last few years include standardizing the electronic claim submission process for both batch and interactive claims. National standard coding is now used on all transactions. Privacy and security rules have been fully implemented in the Department. The next rule to be implemented is the National Provider Identifier with a compliance date of May 23, 2007.

Contract Management, Budget Development and Administration

The contracts that this Section is responsible for include: the Web Portal, the Medicaid Management Information System, the Medical Identification Card contract, the Colorado Benefits Management System (CBMS) vendor contract with EDS, and a variety of agreements with the Office of Information Technology (OIT), the Department of Human Services and Office of CBMS. The Medicaid Management Information System contract is a fixed price contract that encompasses the day-to-day operations of the system. When new initiatives are developed either through legislation or policy change, there are usually system and/or operational changes to the Medicaid Management Information System. New work requires new contract language, which is an integral part of the work this Section does. To address changes adequately, a information technology project process is initiated to identify any and all impacts to any and all information technology systems, including the web environment, the Colorado Benefit Management System, and infrastructure. By monitoring policy changes with potential system changes, budget impacts are identified early in order to establish a funding source and federal approval. Given the complexity of the systems it drives a high degree of contracting and budget activity.

Major Accomplishments

The major accomplishment over the last year was the implementation of changes for the Medicare Part D pharmacy benefit for Medicare/Medicaid dually eligible clients. These changes prevent Medicaid from paying for Medicare covered drugs while paying for Medicare excluded drugs and supplies. Other accomplishments were the inclusion of the clients' primary spoken language from the Colorado Benefit Management System into the Medicaid Management Information System. The clients' language is sent to managed care plans in order to better match managed care network providers with the clients' needs.

The following are additional accomplishments for FY 05-06:

- Updated billing manuals so providers may bill Medicaid with minimal amounts of confusion.
- Provider enrollment forms, including information on doing business electronically, are now delivered via the Provider Services portion of the web site.
- Began web delivery of monthly provider bulletins by sending email notifications to providers. This has decreased the amount of postage and paper used each month.
- All claims transactions can now be submitted via the Department's Web Portal. The outdated electronic system, WINASAP, has been fully retired.
- Automated the updating of license information for many provider types using the Department of Regulatory Agencies' electronic files. This automates approximately 85% of all license updates rather than relying on 100% manual updates.
- Enrolled providers for the new substance abuse benefit, the new Therapeutic Residential Child Care Facilities (TRCCFs), and Developmental Disabilities direct services.

From the Section's administrative report in FY 05-06, it is estimated that the fiscal agent processed 19.8 million claims, 4.5% more than the previous fiscal year. These claims amounted to roughly $2.6 billion processed through the Medicaid Management Information System, 5% higher than in FY 04-05. It should be noted that not all payments or adjustments to expenditures are recorded through the Medicaid Management Information System and therefore this figure is for comparison purposes only. Caseload growth and declining enrollment in health maintenance organizations are the primary causes for the increase in claim counts.

Critical Issues

For FY 06-07, the most critical issue is the reprocurement of the Medicaid Management Information System contract. The Centers for Medicare and Medicaid Services require Medicaid Management Information System fiscal agent contracts to be competitively bid every eight years. The current contract with the State's fiscal agent, Affiliated Computer Services, will expire in FY 06-07. The Department issued a request for proposals to transfer operations of our current Medicaid Management Information System to a new fiscal agent. The new contractor was announced on August 31, 2006 and the incumbent, ACS, was the only bidder and won the contract. The new contract will be in place on November 15, 2006. The system and operations will be in place by July 1, 2007.

As mentioned above, there is a new HIPAA rule further applying administrative simplification. The final rule for the National Provider Identifier for HIPAA was published by the federal government on January 23, 2004, with a compliance date of May 23, 2007. This rule is unique in that the normal two-year implementation time line does not apply. The centralized data bank began operations May 23, 2005, at which time the two-year time clock started. The impact of this rule will be in the Medicaid Management

Information System, run by the fiscal agent and the Department's Web site provider applications. Mandatory remediation work will be completed by May 23, 2007.

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

The Deficit Reduction Act of 2005 has provisions for Medicaid reform in terms of benefits and eligibility criteria. The Department continues to assess the impact of the Deficit Reduction Act to assure that appropriate system changes are implemented to support any changes in policy. At this point, the impacts are unknown. Changes will affect both the Colorado Benefit Management System and the Medicaid Management Information System.

The current contract for on-going maintenance and support of the Colorado Benefits Management System will expire in July 2008. Activities have commenced to prepare a Request for Proposal to re-procure these services. The new contractor is expected to commence activities by July 1, 2007, with transition to be complete by June 30, 2008.

The current CGI contract for on-going maintenance and support of the Department's Web Portal will expire in June 2008. The Department is evaluating the option of extending the contract or preparing a request for proposals.

FY 07-08 Prioritized Objectives and Performance Measures
1.3 To assure payments in support of the programs are accurate and timely, and to procure an effective fiscal agent.
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%.
2.4 To maintain efficient management of the Department's information systems technology.
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 Prioritized Objectives and Performance Measures
2.5 To hold accountable the Department's administrative contractors, including other State and local agencies, through outcome-based contracting and dedicated contract management.
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.
3.3 To enhance customer service, providers, clients, stakeholders and eligibility personnel's understanding of program requirements, benefits and responsibilities through effective communication.
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.

Similar or Cooperating Programs and Stakeholders

Other states operate Medicaid Management Information Systems and eligibility systems, but there are no other systems in Colorado that provide similar functionality for Medicaid or Children's Basic Health Plan clients. The following is a list of some of the departments and major stakeholders involved in successful implementation of the federal rules and State laws related to the claims payment systems:

Governor's Office of State Planning and Budgeting
Governor's Office of Information Technology
Attorney General's Office
Governor's Office of Colorado Benefits Management System
Colorado Department of Human Services
Centers for Medicare and Medicaid Services
All clients, health plans and providers, and certain business associates participating in the Colorado Medicaid or Child Health Plan Plus programs whose continuity of services depends on timely and effectively implementation
Health care providers and managed care organizations (medical, behavioral, and dental care)

PROGRAM CROSSWALK

Summary Section

Program Title: Claims Systems Section

Change Request(s): Implementation of HB 06S-1023 and Deficit Reduction Act of 2005
Provider Rate Increases

Long Bill Line Item
(1) Executive Director's Office
Personal Services
Health, Life and Dental
Short-term Disability
S.B. 04-257 Amortization Equalization Disbursement
Salary Survey and Senior Executive Service
Workers' Compensation
Operating Expenses
Legal Services and Third Party Recovery Legal Services for 12,684 hours
Administrative Law Judge Services
Purchases of Services from Computer Center
Payment to Risk Management and Property Funds
Capitol Complex Leased Space
Medicaid Management Information System Contract
Medicaid Management Information System Reprocurement
Health Insurance Portability and Accountability Act of 1996 (HIPAA) Web Portal Maintenance
Health Insurance Portability and Accountability Act of 1996 (HIPAA) National Provider Identification Assessment and Implementation
Medicaid Identification Authorization Cards
(2) Medical Services Premiums
(5) Other Medical Services
Medicare Modernization Act of 2003 State Contribution Payment

Federal/State Statutory and Other Authority

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

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

25.5-4-204, C.R.S. (2006): *Automated medical assistance administration.*
(1) The general assembly hereby finds and declares that the agency responsible for the administration of the state's medical assistance program would be more effective in its ability to streamline administrative functions of program administrators and providers under the program through the implementation of an automated system that will provide for the following: (a) Electronic claim submittals; (b) On-line eligibility determinations; (c) Electronic remittance statements; (d) Electronic fund transfers; and (e) Automation of other administrative functions associated with the medical assistance program.

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

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

Program Description

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

The Section oversees the technical administration of the Medicaid Management Information System. This system receives eligibility information from the Colorado Benefits Management System. The information system processes claims and submits payment requests to the Colorado Financial Reporting System for actual warrants or electronic funds transfers. In addition to the Medicaid Management Information System, the Section also manages the Medicaid Management Information System Decision Support System that provides

the data and analysis tools to research and manage Medicaid and the Children's Basic Health Plan programs. Enhancements to the system are developed with the fiscal agent and are implemented after State approval.

The Claims Systems Section directs the support of the fiscal agent contract for Medicaid Management Information System services. Medicaid is the primary payment source for health care services for over 420,000 of Colorado's low-income citizens each month and 9,000 for State-only participants. The Children's Basic Health Plan covers services for about 49,000 children and pregnant women each month.

Major Accomplishments

The major accomplishment over the last year was the implementation of the changes for Medicare Part D pharmacy benefit for Medicare/Medicaid dually eligible clients. These changes prevent Medicaid from paying for Medicare covered drugs while paying for Medicare excluded drugs and supplies. Other accomplishments were the inclusion of the client's primary spoken language from the Colorado Benefit Management System into the Medicaid Management Information System. The client's language is sent to managed care plans in order to better match managed care network providers with the clients' needs.

The following are additional accomplishments for FY 05-06:

- System changes done to bring in Colorado Benefit Management System (CBMS) data for clients covered by the new provisions of HB 05-1262, Tobacco Taxes for Health Related Purposes.
- Updated Old Age Pension Health and Medical Care Fund and Child Health Plan Plus eligibility verification messages so that providers will clearly know the client is or is not covered by Medicaid, Old Age Pension, or the Child Health Plan Plus Program.
- Several updates were made to the pharmacy system to add drugs, add prior authorization, and limit distribution to the approved unit dose.
- Installed system changes to bring the substance abuse benefit to reality (HB 05-1015).
- Installed Diagnostic Related Groupings (DRG) version 23 to assure inpatient hospital claims pay the appropriate rates.
- Installed system changes to allow the payment of Therapeutic Residential Child Care Facilities (HB 06-1395).
- Completed development and testing of Medicare crossover claims via the new Coordination of Benefits Contractor (COBC). With this change, all electronic claims are compliant with the Transactions and Code Sets provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- Implemented the rule allowing adult dental services.

Critical Issues

For FY 06-07, the most critical issue will be the implementation of the newly reprocured Medicaid Management Information System contract. The Centers for Medicare and Medicaid Services require Medicaid Management Information System fiscal agent contracts to be competitively bid every eight years. The current contract with the State's fiscal agent, Affiliated Computer Services, will expire in FY 06-07. The Department issued a request for proposals to transfer operations of our current Medicaid Management Information System to a new fiscal agent but a new vendor was not selected. The new contract will be in place November 15, 2006 with the system and operations estimated to be operational by July 1, 2007.

As mentioned above, there is a new HIPAA rule further applying administrative simplification. The final rule for the National Provider Identifier for HIPAA was published by the federal government on January 23, 2004, with a compliance date of May 23, 2007. This rule is unique in that the normal two-year implementation time line does not apply. The centralized data bank began operations May 23, 2005, at which time the two-year time clock started. The impact of this rule will be in the Medicaid Management Information System, run by our fiscal agent and the Department's web site provider applications, with remediation work completed by May 23, 2007.

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

The Deficit Reduction Act of 2005 has provisions for Medicaid reform in terms of benefits and eligibility criteria. The Department continues to assess the impact of the Deficit Reduction Act to assure that appropriate system changes are completed to support any changes in policy. At this point, the full impacts are unknown. Changes will affect both the Colorado Benefit Management System and the Medicaid Management Information System.

FY 07-08 Prioritized Objectives and Performance Measures
1.3 To assure payments in support of the programs are accurate and timely, and to procure an effective fiscal agent.
The Claims Systems Section will assist in assuring that over 95% of claims are paid and/or denied within 10 business days and that 97% of all claims are submitted electronically.
The Claims Systems Section will facilitate the new fiscal agent contract transition by assuring that the new prescription drug system is operating per requirements and in production by July 1, 2007.

FY 07-08 Prioritized Objectives and Performance Measures
4.1 To increase the use and consistency of data analysis to drive Department program decisions.
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.

Similar or Cooperating Programs and Stakeholders

Other states operate Medicaid Management Information Systems and eligibility systems, but there are no other systems in Colorado that provide similar functionality for Medicaid or Children's Basic Health Plan clients. The following is a list of some of the departments and major stakeholders involved in successful implementation of the federal rules and State laws related to the claims payment systems:

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

PROGRAM CROSSWALK

Summary Section

Program Title: Eligibility Systems Section

Change Request(s): Implementation of HB 06S-1023 and Deficit Reduction Act of 2005

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

Federal/State Statutory and Other Authority

25.5-4-205 (1) (a), (2006): *Determination of eligibility for medical benefits shall be made by the county department in which the applicant resides, except as otherwise specified in this section. Local social security offices also determine eligibility for Medicaid benefits at the same time they determine eligibility for supplemental security income. The state department may accept medical assistance applications and determine medical assistance eligibility and may designate the private contractor that administers the children's basic health plan, Denver health and hospitals, and a hospital that is designated as a regional pediatric trauma center, as defined in section 25-3.5-703 (4) (f), C.R.S. to accept medical assistance applications and to determine medical assistance eligibility.*

Any person who is determined to be eligible pursuant to the requirements of this article and articles 5 and 6 of this title shall be eligible for benefits until such person is determined to be ineligible. Upon determination that any person is ineligible for medical benefits, the county department, the state department, or other entity designated by the state department shall notify the applicant in writing of its decision and the reason therefore. Separate determination of eligibility and formal application for benefits under this article and articles 5 and 6 of this title for persons eligible as provided in sections 25.5-5-101 and 25.5-5-201shall be made in accordance with the rules of the state department.

Program Description

Per executive order, the Governor's Office of Colorado Benefits Management System (CBMS) was established to serve as the central development organization for the on-going maintenance and delivery of CBMS. This order transitioned all system development responsibilities to CBMS and established communication and procedures to assure the Department's system needs are met.

The Colorado Benefits Management System is an information technology system which implements a single automated system to support application, eligibility determination, benefits issuance, and reporting for medical, food, and public assistance programs. The Colorado Benefits Management System project development and implementation officially started with the signing of the design vendor contract with Electronic Data Systems on July 17, 2000. The budget for development began in 1996. The Colorado Benefits Management System was accepted June 30, 2006.

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

- Governor's Office of Colorado Benefits Management System;
- Colorado Department of Human Services;
- Colorado Department of Health Care Policy and Financing;
- County Departments of Social Services (64 counties); and,
- Non-county Medical Assistance sites.

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

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

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

- Requests for programming changes to support legislative and policy changes;
- Coordinates changes to rules-based decision tables that implement eligibility rules in the system; and,
- Coordinates the maintenance and support of the Colorado Benefits Management System Decision Support System.
- Oversees the Office of CBMS in regards to ensuring State and federal compliance.

Accomplishments

- Established procedures to control the CBMS Decision Table change process, including the capture of more comprehensive information about changes to be made along with federal or State regulations to support the changes as well as more rigorous review of proposed changes by the Department's Operations and Policy sections.
- Implemented the Medicare Part D low-income subsidy program and established an interface between CBMS and the federal system to deliver information about dual-eligible clients and low-income subsidy applicants to the Centers for Medicare and Medicaid Services.
- Re-engineered the SDX and BENDEX interfaces with federal systems to assure proper processing of Social Security Income and Medicare data in CBMS.
- Implemented the home and community based services Consumer-Directed Care for the Elderly waiver program.
- Implemented new programs in support of tobacco tax legislation.
- Implemented numerous eligibility determination rule enhancements to improve determination accuracy.

Critical Issues

- The current contract for on-going maintenance and support of CBMS will expire in July 2008. Activities have commenced to prepare a request for proposals to re-procure these services. The new contractor is expected to commence activities by July 1, 2007, with transition to be completed by June 30, 2008.

- New eligibility and documentation requirements have been established by the Centers for Medicare and Medicaid Services as part of the Deficit Reduction Act of 2005. A number of changes must be made to CBMS to come into compliance with these new rules.

FY 07-08 Prioritized Objectives and Performance Measures
1.2 To support timely and accurate client eligibility determination**.**
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.
2.4 To maintain efficient management of the Department's information systems technology.
The Information Technology Division, Eligibility Systems Section will work with the Office of CBMS and Department of Human Services to 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.
3.5 To develop a more direct relationship with counties and improve two-way communication.
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.
The Information Technology Division, Eligibility Systems Section will provide quarterly communications to counties and medical assistance sites detailing Colorado Benefits Management System changes.
4.1 To increase the use and consistency of data analysis to drive Department program decisions.
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.

Similar or Cooperating Programs and Stakeholders

The General Assembly
Governor's Office of Information Technology
Governor's Office of CBMS
Colorado Department of Human Services
Colorado Social Services Directors Association
County departments of social services
Non-county medical application sites
Centers for Medicare and Medicaid Services

PROGRAM CROSSWALK

Summary Section

Program Title: Information Technology Support Section

Change Request(s): Increased Funding for Commercial Leased Space

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

Federal/State Statutory and Other Authority

25.5-1-104 (3), C.R.S. (2006): *The executive director may establish such divisions, sections, and other units within the state department as are necessary for the proper and efficient discharge of the powers, duties, and functions of the state department.*

Program Description

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

The Information Technology Support Section guides and supports the information technology requirements for initiatives sponsored by business units. In doing so, the Information Technology Support Section supports the technical local area network infrastructure, access to vendor resources including EDS/Office of Colorado Benefits Management Systems, fiscal agent, and web host, fiscal agent resources, customer support services, inventory management, and planning and consulting services. This Section establishes the standards for business applications, telecommunications architecture, and technology infrastructure to be used internally by the Department. Along with other information technology sections in the Information Technology Division, this Section provides technical consulting to business units in preparing to outsource business functions. The Section also provides user security administration functions for the various systems to which Department users have access.

Major accomplishments:

- Departmental firewall implemented, providing additional granular control over configuration of network access rules applying to incoming and outgoing traffic.
- Placed Department network on a private IP address scheme, permitting additional security isolation from Internet intrusions.
- Installed Intrusion Detection System (IDS) to monitor the Department's network for possible outside attack, and monitor the Department's systems to detect possible compromise from such things as viruses, worms, and trojans.
- Upgraded workstation infrastructure, removing older, less capable systems from our workstation inventory.
- Provided Department users with additional system training through a series of brown-bag training sessions, and printed documents providing instruction in specific skills.
- Created emergency call center database application in support of tracking and reporting necessary for demonstrating court order compliance.
- Performed internal security self audits to verify and document effectiveness of internal security policies and practices.

FY 07-08 Prioritized Objectives and Performance Measures
2.4 To maintain efficient management of the Department's information systems technology.
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.

Similar or Cooperating Programs and Stakeholders

Governor's Office of State Planning and Budgeting
Governor's Office of Information Technology
Colorado Department of Human Services
All Department employees and contractors

PROGRAM CROSSWALK

Summary Section

Program Title: Audits Section

Change Request(s): Internal Audit of Primary Care Fund

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

Federal/State Statutory and Other Authority

25.5-4-205, C.R.S. (2006): Provides the Department, county departments and medical assistance sites may accept applications for, and determine eligibility for medical assistance. This includes a demonstration project authorizing qualified personnel to make eligibility determinations for medical assistance and CHP for students enrolled in public schools.

42 CFR Section 431.800-431.865: *"Establishes State Plan requirements for a Medicaid eligibility quality control (MEQC) program"*.

25.5-1-114 (3), C.R.S. (2006): "*The State Department, under the supervision of the Executive Director, shall provide supervision of county departments for the effective administration of medical assistance as set out in the rules of the Executive Director and the Rules of the State Board pursuant to Section 25.5-1-301*".

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

42 CFR Part 431.950- 431.1002: "*Requires states to submit information necessary to enable the Secretary to produce a national improper payment estimate for Medicaid and the State Children's Health Insurance Program*".

Office of Management & Budget (OMB) Circular A-133 (Revised June 24, 1997) Audits of States, Local Governments, and Non-Profit Organizations, Subpart D-Federal Agencies and Pass Through Entities, Section 405 Management Decision. "*The Single Audit Act of 1984 established requirements for audits of States, local governments, and Indian tribal governments that administer Federal financial assistance programs.*"

Program Description

The Audits Section is a new section within the Department. It was formed to consolidate many of the auditing functions throughout the Department as well as consolidate the responsibility of medical assistance sites oversight. Responsibilities for this Section include:

Department Audit Coordination
The Department is routinely audited by the State Auditor's Office, the U.S. Office of the Inspector General, and the federal Centers for Medicare and Medicaid Services. The Department is committed to work on all audit findings and continually improve processes and policies. The Audits Section actively monitors the implementation of all audit findings and is responsive to all information requests from auditors.

Medicaid Eligibility Quality Control Unit
The Medicaid Eligibility Quality Control (MEQC) unit assesses eligibility determinations to assure accuracy and timeliness of the eligibility determination to avoid inappropriate payments and client determination delays.

County Audits
This function was transferred from the Department of Human Service with the passage of SB 06-219. This ensures that the Department is able to issue management decisions on all county single audits, follow-up on county audit findings and review county financial statements.

Medical Assistance Sites

25.5-4-205, C.R.S. (2006) allows for medical assistance sites to accept medical assistance applications to determine medical assistance eligibility. Establishment of policy, contract negotiation and monitoring of medical assistance sites exists within the Audits Section. In addition, HB 06-1270 requires a demonstration project to allow qualified personnel to make eligibility determinations for medical benefits under the State Medical Assistance Program and Children's Basic Health Plan for students enrolled in a public school. The demonstration project allows for no fewer than three school districts in both rural and urban areas to participate in the demonstration project. The Audits Section is responsible for timely and accurate implementation of this project.

Payment Error Rate Measurement Program

The Payment Error Rate Measurement program is required by the federal Centers for Medicare and Medicaid Services (CMS) to comply with the Improper Payments Information Act of 2002. The purpose of the program is to examine the accuracy of eligibility determinations and claim payments to ensure that the Department only pays for appropriate expenditures.

FY 07-08 Prioritized Objectives and Performance Measures
1.2 To support timely and accurate client eligibility determination.
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.
The Audits Section will implement three pilot medical assistance sites within school districts as required by HB 06-1270.
1.3 To assure payments in support of the programs are accurate and timely.
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 the highest audit concerns.
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.
The Medicaid Eligibility Quality Control Unit will review timelines and accuracy of Medicaid and Child Health Plan Plus Applications twice during the FY 07-08.
3.2 To improve customer satisfaction with programs, services, and care.
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.

Similar or Cooperating Programs and Stakeholders

The Department works closely with the county departments of social services and the medical assistance sites to ensure that eligibility determinations are completed correctly. The Department also works with the Department of Human Services (DHS) who also conducts reviews of the counties and monitors the single audit reports for programs administered by DHS. The Department

coordinates with the Department of Education, the Department of Public Health and Environment, the Centers for Medicare and Medicaid Services, the State Auditor's Office and other stakeholders to ensure proper implementation of the school based medical assistance sites.

PROGRAM CROSSWALK

Summary Section

Program Title: Eligibility Operations Section

Change Request(s): Court Compliance for Cases Exceeding Processing Guidelines
Implementation of HB 06S-1023 and Deficit Reduction Act of 2005

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

Federal/State Statutory and Other Authority

25.5-4-205, C.R.S. (2006): Provides the Department, county departments and medical assistance sites may accept applications for, and determine eligibility for medical assistance.

25.5-4-205, C.R.S. (2006): Requires the Department to establish a medical assistance program in compliance with federal law.

Program Description

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

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

Trends and Other Baseline Information

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

- Implement and oversee eligibility policy for Colorado Medicaid and CHP+ programs in response to state and federal statutory change as directed by the Eligibility Policy Unit;
- Develop eligibility processes for Colorado Medicaid and CHP+ in CBMS;
- Develop and disseminate program information to Medicaid clients and CHP+ regarding newly released rules and revisions; and,
- Develop training on Medicaid and CHP+ CBMS functionality for field agents (county departments of social services, medical assistance sites, Single Entry Point agencies, presumptive eligibility sites, and outreach workers).

Determining Medicaid and CHP+ Eligibility

An individual obtains Medicaid or CHP+ coverage by meeting the eligibility criteria under a particular Medicaid or CHP+ category. The Eligibility Operations Section interprets and implements eligibility policy rules in CBMS and administers eligibility functions through contracts with other agencies. A Colorado resident submits an application to his/her county department of human/social services or to a medical assistance site, who enters the information provided into CBMS. CBMS will determine the applicant's

Medicaid or CHP+ eligibility based on the data entered into the system. The Section also oversees the contract with CEL, the company that determines State disability. Clients who are categorically eligible by disability must meet financial and disability criteria.

Eligibility Operations Section staff initiates and implements training pertaining to changes in CBMS as a result of a policy or rule change, assist and provide material being disseminated by the Eligibility Policy Unit regarding training for local agencies that carry out eligibility determination functions.

FY 07-08 Prioritized Objectives and Performance Measures
1.2 To support timely and accurate client eligibility determination.
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.
3.2 To improve customer satisfaction with programs, services, and care.
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.
3.3 To enhance customer service, providers, clients, stakeholders and eligibility personnel's understanding of program requirements, benefits and responsibilities through effective communication.
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.
3.5 To develop a more direct relationship with counties and improve two-way communication.
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.

Similar or Cooperating Programs and Stakeholders

The federal Centers for Medicare and Medicaid Services administer the federal Medicare program, which does provide a range of health care benefits to elders and some disabled individuals. The Social Security Administration (SSA) will continue to provide updates and new records for clients who receive Social Security Income (SSI) benefits. SSA records are sent to CBMS as inbound

records that either updates or creates new records in CBMS that may have an impact on applicant/client eligibility. The Child Health Plan Plus also provides medical coverage through the State selected vendor for children up to 200% of poverty who are not Medicaid eligible. This Section also works closely with counties, medical assistance sites and the Department of Human Services in eligibility operations functions.

PROGRAM CROSSWALK

Summary Section

Program Title: Safety Net Financing Section

Change Request(s): Technical Adjustment to Old Age Pension State Medical Program
Internal Audit of the Primary Care Fund
Implementation of HB 06S-1023 and Deficit Reduction Act of 2005

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

Long Bill Line Item
University of Colorado Family Medicine Residency Training Programs

Federal/State Statutory and Other Authority

25.5-3-101, C.R.S. (2006), et seq.: Reform Act for the Provision of Health Care for the Medically Indigent.

25.5-3-1001, C.R.S. (2006), et seq.: Comprehensive Primary and Preventive Care Grant Program Act.

Article XXIV of the Colorado Constitution and 25.5-2-101, C.R.S. (2006): *Establishment of the Old Age Pension Health and Medical Care Fund and Supplemental Old Age Pension Health and Medical Care Fund.*

Section 21 of Article X of the Colorado Constitution and 25.5-3-201 (2006), et. seq.: *Comprehensive Primary and Preventive Care Grant Program*

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

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

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

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

Program Description

Colorado Indigent Care Program

The Colorado Indigent Care Program distributes federal and State funds to partially compensate qualified health care providers for uncompensated costs associated with services rendered to the indigent population. Qualified health care providers who receive this funding render discounted health care services to Colorado citizens, migrant workers, and legal immigrants with limited financial resources who are uninsured or underinsured and not eligible for benefits under the Medicaid Program or the Children's Basic Health

Plan. Clients can have third party insurance, but this resource must be exhausted prior to the Colorado Indigent Care Program reimbursing providers. There are no age limitations for clients who receive services through the Colorado Indigent Care Program.

This program primarily compensates providers that have contracted with the program to provide health care services to persons with income and assets at or below 250% of the federal poverty level. The program directly contracts with hospitals and community health clinics. By statute, Colorado Indigent Care Program providers are required to prioritize care in the following order:

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

The Children's Hospital, Clinic Based Indigent Care

The Children's Hospital, Clinic Based Indigent Care Program provides outpatient care to Colorado Indigent Care Program clients. The Children's Hospital receives an administration fee to cover expenses associated with operating the program while care is provided by Colorado Indigent Care Program clinics (outpatient facilities) .

Pediatric Specialty Hospital

The Pediatric Specialty Hospital provides funding to pediatric specialty hospitals to help offset the costs of providing care to a large number of Medicaid and indigent care clients. The Children's Hospital is the only provider.

Comprehensive Primary and Preventive Care Grant Program

The Comprehensive Primary and Preventive Care Grant Program was established to provide grants to health care providers in order to expand primary and preventive health care services to Colorado's low-income residents. Because primary and preventive care are two of the most cost effective means of keeping people healthy, the Comprehensive Primary and Preventive Care Grant Program is intended to expand these services to Colorado's uninsured or medically indigent populations. However, it is not intended to supplant or expand Medicaid, the Children's Basic Health Plan, or the Colorado Indigent Care Program. Comprehensive Primary and Preventive Care grants are to be used to:

- Increase access for comprehensive primary care services for uninsured or medically indigent patients who are served by qualified providers;
- Create new services or augment existing services provided to uninsured or medically indigent patients; or

- Establish new sites that offer comprehensive primary care services in medically underserved areas of the state or to medically underserved populations.

In FY 05-06, grants were awarded in the amount of $2,583,357 to the following facilities:

Provider	Amount
Catholic Health Initiative, St. Mary-Corwin Foundation	$132,967
Colorado Coalition for the Homeless	$250,000
Clinica Campesina	$237,755
High Plains Community Health Center	$75,108
Dolores County Health Associatrion	$25,850
Marillac Clinic	$200,000
Metro Community Provider Network	$500,000
Valley Wide Systems	$75,000
Salud Family Health Centers	$89,581
Peak Vista	$500,000
Subtotal FY 05-06 Grants	**$2,086,261**
Carryover Grants from Prior Years	
Colorado Coalition for the Homeless	$150,000
High Plains Community Health Center	$26,483
Marillac Clinic	$220,613
Pueblo Community Health Center	$100,000
Subtotal Carryover Grants	**$497,096**
Total	**$2,583,357**

Old Age Pension State Medical Program

The Old Age Pension State Medical Program provides limited medical care for individuals receiving Old Age Pension grants. Those eligible for this program are over age 60, but may not meet Supplemental Security Income criteria or residence requirements, and are therefore ineligible for Medicaid. This population could be disabled to some degree, but not sufficiently to qualify for Supplemental Security Income.

Primary Care Fund

Effective July 1, 2005, H.B. 05-1262 established the Primary Care Fund which allocates money to all qualified providers in the State who serve uninsured or medically indigent patients. In FY 05-06, twenty-five healthcare providers including federal qualified health centers, clinics, and medical centers qualified to receive funding from the Primary Care Fund, which allocates funds based on the proportionate share of uninsured or medically indigent patients served.

In FY 05-06 funding was provided in the amount of $44,000,000 to the following facilities:

Provider	Amount
Catholic Health Initiative, St. Anthony Family Med Residency	$378,324
Catholic Health Initiative, St. Mary- Corwin Foundation	$457,508
Christian Healing Network	$65,987
Clinica Campesina Family Health Services	$2,912,217
Colorado Coalition for the Homeless	$1,640,872
Commerce City Community Health Services	$92,382
Denver Health & Hospital Authority	$10,518,296
Doctors Care	$70,386
Dolores County Health Association	$127,574
High Plains Community Health Center	$624,675
Inner City Health Center	$1,007,399
Limon Doctor’s Committee	$87,982
Marillac Clinic	$1,143,771
Metro Community Provider Network	$3,770,046
Mountain Family Health Centers	$686,263
North Colorado Family Residency	$131,974
Peak Vista Community Health Centers	$3,708,458
People’s Clinic	$1,165,767
Plan de Salud Del Valle Inc.	$7,144,171
Pueblo Community Health Center	$1,684,863
Rocky Mountain Youth & Nursing	$862,228
Summit Community Care Clinic	$642,272
Sunrise Community Health Center	$2,960,608

Provider	Amount
Uncompahgre Combined Clinics	$101,180
Valley-Wide Health Systems	$2,014,797

University of Colorado Family Medicine Residency Training Programs

The University of Colorado Family Medicine Residency Training Program line item provides payments to hospitals to help offset their costs of participating in the Colorado Family Medicine Residency Training Program. The Advisory Commission on Family Medicine at the Department of Higher Education, Health Sciences Center administers the program. Currently, there is one clinic and nine hospitals participating in the program.

Colorado Health Care Services Fund

Effective July 1, 2006, S.B. 06-044 established the Colorado Health Care Services Fund which allocates money to Denver Health and Hospitals, community health clinics, and primary care clinics operated by a licensed or certified health care facility to provide primary care services to low-income adults. In addition, SB 06-044 increased the federal poverty level (FPL) from 200% to 250% of the FPL for the Colorado Indigent Care Program.

Financing Opportunities

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

Major Accomplishments

In FY 05-06, the Safety Net Financing Section implemented a financing initiative for an enhanced outstationing payment to Denver Health Medical Center. This financing initiative allowed the Department to provide additional federal funds to this provider without utilizing General Fund.

In addition, the Section produced its Medically Indigent and Colorado Indigent Care Program FY 04-05 Annual Report and submitted this report to the Senate and House Health and Human Services Committees.

FY 07-08 Prioritized Objectives and Performance Measures
1.1 To maximize the opportunity to preserve health care services through the purchase of services in the most cost-effective manner possible.
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.
1.3 To assure payments in support of the programs are accurate and timely, and to procure an effective fiscal agent.
Quarterly payments to providers who qualify for the Primary Care Fund will be made according to schedule for disbursement per regulation 8.950.5.C.
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.
1.5 To accurately project, report, and manage budgetary requirements to affect Executive and Legislative intent with program and budget development and operations. To accurately record and monitor expenditures for programs managed by the Department so there may be accurate financial reporting at all times.
The Safety Net Financing Section will submit a report to the Finance Division Director and Office of Operations and Finance Director by November 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.
2.4 To maintain efficient management of the Department's information systems technology.
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.
2.5 To hold accountable the Department's administrative contractors, including other State and local agencies, through outcome-based contracting and dedicated contract management.
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 could include issuing an amendment to the original contract or adjusting payment to the contractor.
3.2 To improve customer satisfaction with programs, services, and care.
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.

FY 07-08 Prioritized Objectives and Performance Measures
3.2 To improve customer satisfaction with programs, services, and care.
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.

Similar or Cooperating Programs and Stakeholders

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

PROGRAM CROSSWALK

Summary Section

Program Title: Rates Section

Change Request(s): Public School Health Services Corrections
Funding for Additional Hospital and Federally Qualified Health Center Audits
Provider Rate Increases

Long Bill Line Item
(1) Executive Director's Office
Personal Services
Health, Life and Dental
Short-term Disability
S.B. 04-257 Amortization Equalization Disbursement
Salary Survey and Senior Executive Service
Workers' Compensation
Operating Expenses
Legal Services and Third Party Recovery Legal Services for 12,684 hours
Administrative Law Judge Services
Purchases of Services from Computer Center
Payment to Risk Management and Property Funds
Capitol Complex Leased Space
Hospital and Federally Qualified Health Clinic Audits
Primary Care Provider Rate Task Force and Study
(2) Medical Services Premiums
(3) Medicaid Mental Health Community Programs
(A) Mental Health Capitation Payments for 410,171 Estimated Medicaid Eligible Clients
(B) Other Medicaid Mental Health Payments
Medicaid Anti-Psychotic Pharmaceuticals

Long Bill Line Item
(5) Other Medical Services
Public School Health Services

Federal/State Statutory and Other Authority

25.5-5-508, C.R.S. (2006): *Capitation Payments: Requirements regarding rate setting for managed care organizations, including health maintenance organizations and behavioral health organizations.*

25.5-5-412, C.R.S. (2006): *Program of all-inclusive care for the elderly - services – eligibility: This section provides for the creation and implementation of the Program of All-inclusive Care for the Elderly*

25.5-4-402, C.R.S. (2006): *Providers – hospital reimbursement: Requirements regarding rate setting for hospitals.*

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

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

Program Description

The Rates Section serves as an internal service organization within the Department, working with program management to calculate payment rates for medical services that are clear, defensible, and appropriate.

Functions of the Rates Section include:

- Setting and administering rates for federally qualified health centers, rural health clinics, and hospitals;
- Setting rates for managed care organizations including health maintenance organizations and behavioral health organizations;
- Setting rates for Programs of All-Inclusive Care for the Elderly; and,
- Setting rates for home and community based waiver services.

Summary of Activities

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

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

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

Behavioral Health Organizations: Capitation rates are calculated for behavioral health organizations, formerly known as mental health assessment and services agencies. This rate calculation relies on encounter data and plan financials to develop an experience rate. Rates are separately priced for State Plan services and non-State Plan waivered services for the regions using the behavioral health organization’s experience.

Program for All-Inclusive Care for the Elderly Rate Setting: The Rates Section calculates blended premiums for the Program for All-Inclusive Care for the Elderly. The Program for All-Inclusive Care for the Elderly is a joint Medicare and Medicaid program that includes all of the health care costs to meet the need for acute care and long-term care for clients who qualify for long-term care services. The program premium includes a blend of rates for geographic location and for two different long-term care programs: nursing home facilities and home and community based waiver programs.

Home and Community Based Services Rate Setting: Formal responsibility for setting these rates has shifted to the Rates Section. There are a broad and diverse set of services available under the Department's home and community based services waiver programs. The Rates Section is responsible for determining appropriate rates of payment for these services.

FY 07-08 Prioritized Objectives and Performance Measures
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.
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 than twice a year. The second of the two will be completed and sent to the managed care plans no later than April 30, 2008.
4.1 To increase the use and consistency of data analysis to drive Department program decisions.
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.

Similar or Cooperating Programs and Stakeholders

Behavioral Health Organizations
Community Centered Board Partners
Child Health Plan Plus
Colorado Association of Homes and Services for the Aging
Colorado Community Health Network
Colorado Department of Public Health and Environment
Colorado Health and Hospital Association
Colorado Healthcare Association
Colorado Rural Health Centers
Community Centered Boards
Community Mental Health Centers
Colorado Behavioral Healthcare Council

Division for Developmental Disabilities, Colorado Department of Human Services
Division of Mental Health, Colorado Department of Human Services
Federally Qualified Health Centers
Healthcare Financial Management Association Reimbursement Committee
Health Maintenance Organizations
Home Care Association of Colorado
Program for All-Inclusive Care for the Elderly

PROGRAM CROSSWALK

Summary Section

Program Title: Data Section

Change Request(s): None

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

Federal/State Statutory and Other Authority

25.5-1-104 (3), C.R.S. (2006): *The executive director may establish such divisions, sections, and other units within the state department as are necessary for the proper and efficient discharge of the powers, duties, and functions of the state department.*

Program Description

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

Functions of the Data Analysis Section

The Section provides services that:

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

Summary of Activities

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

- Assist in calculating the fiscal impact of new legislation;
- Acquire and organize data from various information systems;
- Meet the Department's mandate to report quantitatively to the General Assembly, the federal government and others;

- Determine trends and projections on eligibility data, costs, and benefit services;
- Provide samples and alternatives demonstrating the implications of various policy decisions; and,
- Measure provider performance via peer benchmarking.

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

In addition to data analysis, this Section has the responsibility of assisting rate setting and benefits staff in ensuring correct payment to the managed care organizations.

FY 07-08 Prioritized Objectives and Performance Measures
1.5 To accurately project, report, and manage budgetary requirements to affect 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.
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.
4.1 To increase the use and consistency of data analysis to drive Department program decisions.
The Data Section will establish standardized reports, when feasible, to assist in programmatic decisions and to ensure reporting consistency by July 31, 2007.

Similar or Cooperating Programs and Stakeholders

Affiliated Computer Services, Inc. (fiscal agent)
Colorado Department of Public Health and Environment
Colorado Department of Human Services
Colorado Residential Care Association
Home Care Association of Colorado
Colorado Health Institute
Colorado Assisted Living Association (CALA)
Colorado Association of Homes and Services for the Aging (CAHSA)
Health Services Advisory Group
McKesson Health Solutions
National Jewish Center, Alere and University of Arizona

PROGRAM CROSSWALK

Summary Section

Program Title: Accounting Section

Change Request(s): Move Administrative Contracts in Medical Service Premiums to the Executive Director's Office Long Bill Group

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

Federal/State Statutory and Other Authority

25.5-1-104 (2) and (3), C.R.S. (2006): *"The Department of health care policy and financing shall consist of an executive director of the Department of health care policy and financing…and other units as shall be established by the executive director pursuant to the provisions of subsection (3) of this section." "(3) The executive director may establish such divisions, section, and other units...as are necessary for the proper and efficient discharge of the powers, duties, and functions of the state department..."*

SB 06-129 (2006): Allows the Department to utilize the cash system of accounting for any nonadministrative expenditure that qualifies for Title XIX federal financial participation except for expenditures under the program for the medically indigent. The bill allows the Department to promulgate rules to identify programs using cash accounting.

Program Description

The purpose of the Accounting Section is to ensure the proper recording and reporting of economic events that occur in the Department are in compliance with generally accepted accounting principles and State and federal rules and regulations. The function of this Section is to record and report expenditures, revenues, cash, accounts receivable, accounts payable and all other financial statement balances.

Major Functions:

The Accounting Section is responsible for all financial accounting and financial control functions of the Department, and many of the critical financial reporting functions. This includes quarterly financial reports of expenditures and revenues to the federal government for the Medicaid and Child Health Plan Plus programs, and any other federal grant funds received by the Department. The section is responsible for conducting the financial closing processes (monthly, quarterly and annually), which are the basis for all financial reports and the financial portions of the Department's budget. It also includes accurate and timely processing of Medicaid provider and administrative payments, cash receipt processes for $1.2 billion worth of annual cash received by the Department, internal accounting and financial control systems, tax reporting through IRS forms 1099 and W2, and employee payroll processing.

Accomplishments:

The Section played a significant role in the implementation of the tobacco tax bill, HB 05-1262, which affected many programs internally in COFRS. The Section completed the State's benchmarking project that was conducted by the State Controllers Office to identify current COFRS system needs and best practices between Colorado State departments and other States. Accounting has also been actively involved with current year audits that are being performed by different agencies and working on implementation of a new automated reconciliation process between receivables that are being tracked in the Medicaid Management Information System and those that are recorded in COFRS. In addition, the Section has been effectively reviewing other audit recommendations for implementation of additional procedures or modification of existing procedures to make the Section more effective. This will help identify reconciling items in a time efficient manner and will allow the Section to spend more time resolving reconciling items on a monthly basis. Lastly, the Section finalized its review of the federal 60 Day Repayment Rule for provider overpayments and implemented additional procedures to bring the Department into full compliance.

FY 07-08 Prioritized Objectives and Performance Measures
1.3 To assure payments in support of the programs are accurate and timely, and to procure an effective fiscal agent.
The Accounting Section will work with other sections within the Department and with outside agencies to complete the implementation of SB 05-219 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.
FY 07-08 Prioritized Objectives and Performance Measures
1.5 To accurately project, report, and manage budgetary requirements to affect Executive and Legislative intent with program and budget development and operations. To accurately record and monitor expenditures for programs managed by the Department so there may be accurate financial reporting at all times.
The Accounting Section 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.

Similar or Cooperating Programs and Stakeholders

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

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

PROGRAM CROSSWALK

Summary Section

Program Title: Contracts and Purchasing Section

Change Request(s): None

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

Federal/State Statutory and Other Authority

25.5-1-104 (2) and (3), C.R.S. (2006): *"The Department of health care policy and financing shall consists of an executive director of the Department of health care policy and financing…and other units as shall be established by the executive director pursuant to the provisions of subsection (3) of this section." "(3) The executive director may establish such divisions, section, and other units...as are necessary for the proper and efficient discharge of the powers, duties, and functions of the state department..."*

24-102-202 (2), C.R.S. (2006): *"Except as otherwise specifically provided in this code, the executive director* [of the department of personnel] *shall, pursuant to rules: (a) Procure or supervise the procurement of all supplies and services needed by the state."*

24-102-204, C.R.S. (2006): *"Subject to rules, the executive director* [of the department of personnel] *may delegate purchasing authority to designees or to any department, agency, or official."*

Program Description

The purpose of the Contracts and Purchasing Section is to provide all aspects of procurement for the Department under State and federal procurement laws, rules, policies, procedures and guidelines.

Major Functions:

The Contracts and Purchasing Section is responsible for over 2,000 contracts and provides all aspects of procurement for the Department under State and federal procurement laws, rules, policies, procedures and guidelines. These services are provided under Group II purchasing delegation from the State's Department of Personnel and Administration. These are full service State procurement responsibilities and include among others reviewing and approving contracts, issuing and awarding requests for proposals (RFPs), and approving procurement methodologies.

Accomplishments:

The Contracts and Purchasing Section has developed a template contract for use throughout the Department. It complies with the State's contract language requirements, as established by the State Controller's and Attorney General's Offices. During FY 04-05, the Department submitted 32 contracts to the State Controller that were statutory violations. During the first 5 months of FY05-06, the Department submitted 22 such violations to the State Controller. In the final 7 months of FY 05-06, the number of statutory violation contracts was reduced to 8 due to a concerted Department-wide effort.

Critical Issues:

The 2006 legislative session, and the subsequent Special Session, enacted new legislation regarding illegal immigration which will have a significant impact on all types of contracts, including purchase orders. The impact will begin to be felt in FY 06-07.

FY 07-08 Prioritized Objectives and Performance Measures
2.5 To hold accountable the Department's administrative contractors, including other State and local agencies, through outcome-based contracting and dedicated contract management.
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.

Similar or Cooperating Programs and Stakeholders

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

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

PROGRAM CROSSWALK

Summary Section

Program Title: Human Resources Section

Change Request(s): Increased Funding for Commercial Leased Space
Funding to Continue Efforts on Cases Exceeding Processing Guidelines
Adjust FTE Count

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

Federal/State Statutory and Other Authority

25.5-1-104 (2) and (3), C.R.S. (2006): *"The Department of health care policy and financing shall consists of an executive director of the Department of health care policy and financing…and other units as shall be established by the executive director pursuant to the provisions of subsection (3) of this section." "(3) The executive director may establish such divisions, section, and other units...as are necessary for the proper and efficient discharge of the powers, duties, and functions of the state department."*

Program Description

This Section provides the full range of Human Resource Services to all the employees of the Department of Health Care Policy and Financing. This is a decentralized personnel function, which includes recruitment, testing, selection, classification, salary administration, diversity, training, rules interpretation, work force development, employee/manager counseling, corrective and disciplinary actions, separation analysis, dispute resolution and maintaining personnel records within the confines of the State Personnel Rules. Also this Section provides advice, guidance, counseling and technical assistance to department managers and staff on the workings of the State personnel system.

Major Functions:

The Human Resources Section is responsible for all functions necessary to properly classify Department staff positions and to fill those positions in accordance with the State constitution and the State personnel rules and procedures. This includes proper classification of positions, announcing job openings, reviewing applications, testing candidates, and referring qualified candidates to departmental appointing authorities. Human Resources staff participates in corrective action meetings, disciplinary hearings, and any appeals related to the results of those functions.

Accomplishments:

In FY 05-06 the Department allocated 2 new FTE in the Human Resources section. The Section has conducted numerous trainings for all department staff, which were Violence in the Workplace and Sexual Harassment, and the Section manager was awarded the manager of the year award. The Section is now responsible and fully delegated the authority to review and approve all personal service contracts and has hired a Personal Service Specialist to perform that assignment.

FY 07-08 Prioritized Objectives and Performance Measures
4.2 To develop enhanced training and retention strategies for Departmental staff.
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.

Similar or Cooperating Programs and Stakeholders

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

PROGRAM CROSSWALK

Summary Section

Program Title: Budget Division (includes Budget and Financing Section)

Change Request(s): Move Administrative Contracts in Medical Services Premiums to the Executive Director's Office Long Bill Group
Technical Adjustment to Old Age Pension State Medical Program
Public School Health Services Corrections
Adjust FTE Count

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

Federal/State Statutory and Other Authority

25.5-1-104 (3), C.R.S. (2006): "*The executive director may establish such divisions, sections, and other units within the state department as are necessary for the proper and efficient discharge of the powers, duties, and functions of the state department.*"

Program Description

Budget Division Key Responsibilities:

The Department's budget is approximately $3.39 billion. The Budget Division's five key responsibilities are to project, construct, present, monitor, and manage the departmental budgets, acting as a conduit for the Department to the Executive and Legislative branches, translating the Department's policy needs and objectives into monetary terms.

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

- Coordinates the development of the Department's Strategic Plan and Program Crosswalks, which encompasses all areas of departmental activity for each individual office, division, section, etc. The Strategic Plan is both an operational and long-range plan, integrated with short-range planning and is the basis for the Department's Budget Request;

- Estimates, requests, presents, and defends program and operations budgetary needs to the Executive and Legislative authorities. Directs preparation of each phase of the budget request process deliverables, including preparation of requisite statistical forecasting of caseload and premiums and health care services pricing;
- Monitors, projects, and as appropriate, manages Department appropriations. This includes ensuring that expenditures meet legal requirements and that they support departmental requirements and objectives;
- Coordinates and reviews the preparation of fiscal notes for proposed legislation;
- Monitors caseload and expenditures throughout the fiscal year;
- Ensures the proper spending of Medicaid funds for departments that are financed through this budget;
- Assists Accounting in closing the financial records for the Department each year;
- Performs special studies and projects throughout the year, including research into possible areas for cost containment; and
- Provides ongoing department-wide budget training. Topics include the budget process and planning, Change Request development, and fiscal note preparation.

The Budget Division recently underwent a reorganization to divide responsibilities in this demanding area, and created the Budget and Financing Section. This new Section is responsible for nearly all administrative line items in the Department's Executive Director's Officer Long Bill group, plus oversees tobacco tax projections, the Indigent Care Program funding, and all transfer appropriations to sister State agencies.

FY 07-08 Prioritized Objectives and Performance Measures
1.5 To accurately project, report, and manage budgetary requirements to affect Executive and Legislative intent with program and budget development and operations. To accurately record and monitor expenditures for programs managed by the Department so there may be accurate financial reporting at all times.
The Budget Division will provide the Office of State Planning and Budgeting with 100% budget requests (Supplementals, Budget Amendments, Decision Items, FY 07-08 Budget Request) by the requested Executive and Legislative branches due dates.
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 of the end of the month.

FY 07-08 Prioritized Objectives and Performance Measures
2.5 To hold accountable the Department's administrative contractors, including other State and local agencies, through outcome-based contracting and dedicated contract management.
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.
4.2 To develop enhanced training and retention strategies for Departmental staff.
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).
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.
4.5 To increase communication with our county partners.
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.

Similar or Cooperating Programs and Stakeholders

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