COLORADO

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

1997 REFERENCE MANUAL

Alan Weil, Executive Director

January 1997

ERRATA
1997 HCPF Reference Manual

Non-comparable data were used for some charts that appear in both the 1996 HCPF Annual Report and the 1997 HCPF Reference Manual. Primarily, Medicaid expenditures for mental health (MH) and developmental disability (DD) services that are administered through the Department of Human Services were included in Annual Report charts, but were not included in some Reference Manual charts. This difference is most noticeable in regard to the charts showing expenditures by category of client eligibility.

The following Reference Manual charts should be viewed with this correction in mind:

- Figure 27: Medicaid Expenditures by Client Group, FY 87 to 96 (page 74)
- Figure 28: Medicaid Per Capita Costs by Client Group, FY 87 to 96 (page 75)

Versions of these charts with the MH and DD expenditures included are printed on the back of this sheet. These charts contain comparable data as those used for Annual Report Figures 7 and 6, but are presented in the same format as Reference Manual Figures 27 and 28.

In addition, Figure 9 in the Annual Report is an updated and slightly modified version of Figure 14 (page 28) in the Reference Manual. The data sets used are the same, except for the inclusion of an additional six months in the Annual Report version. A larger print of the updated chart is provided below:

Fig. 14: Colorado HMO Medicaid Enrollment by Plan

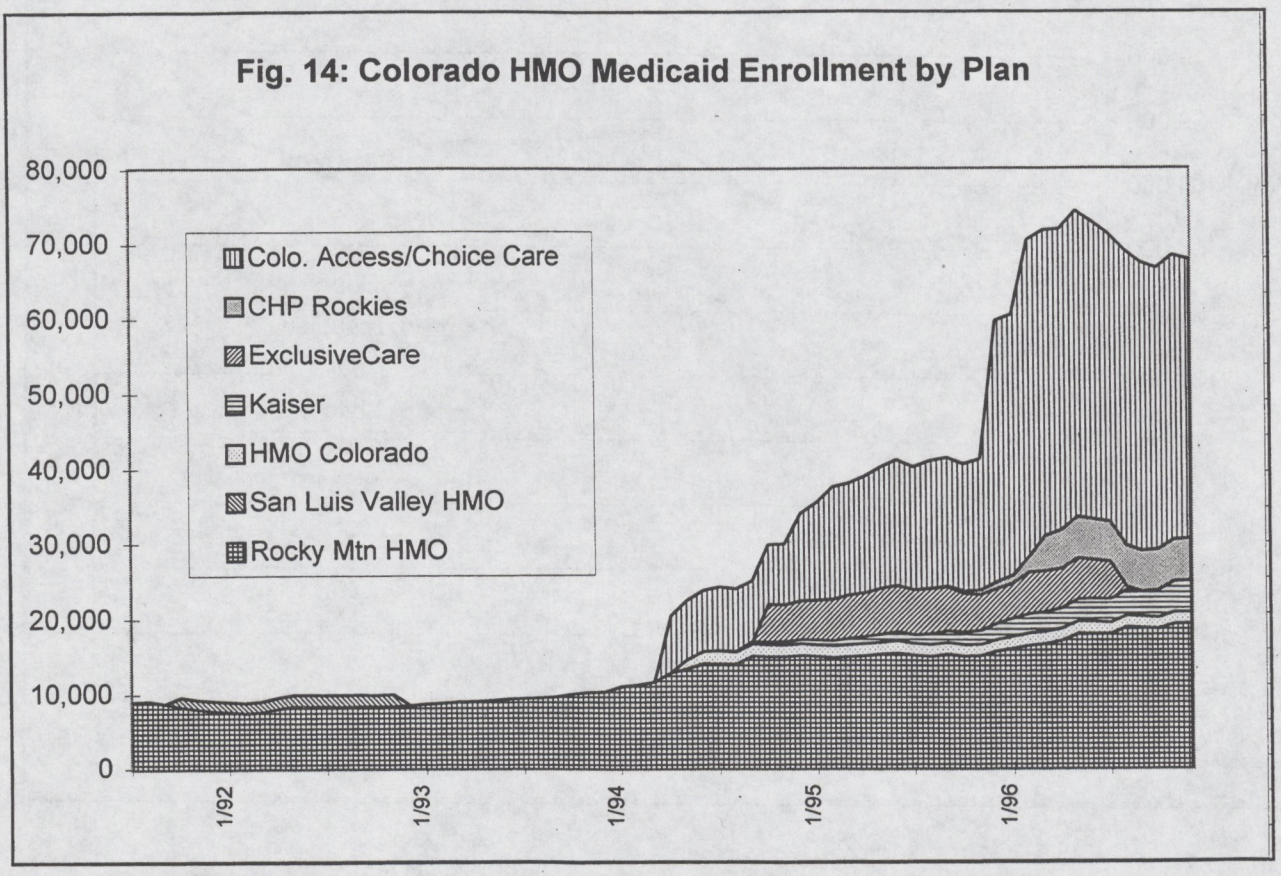


Fig. 27: Medicaid Expenditures by Client Group, FY87-96

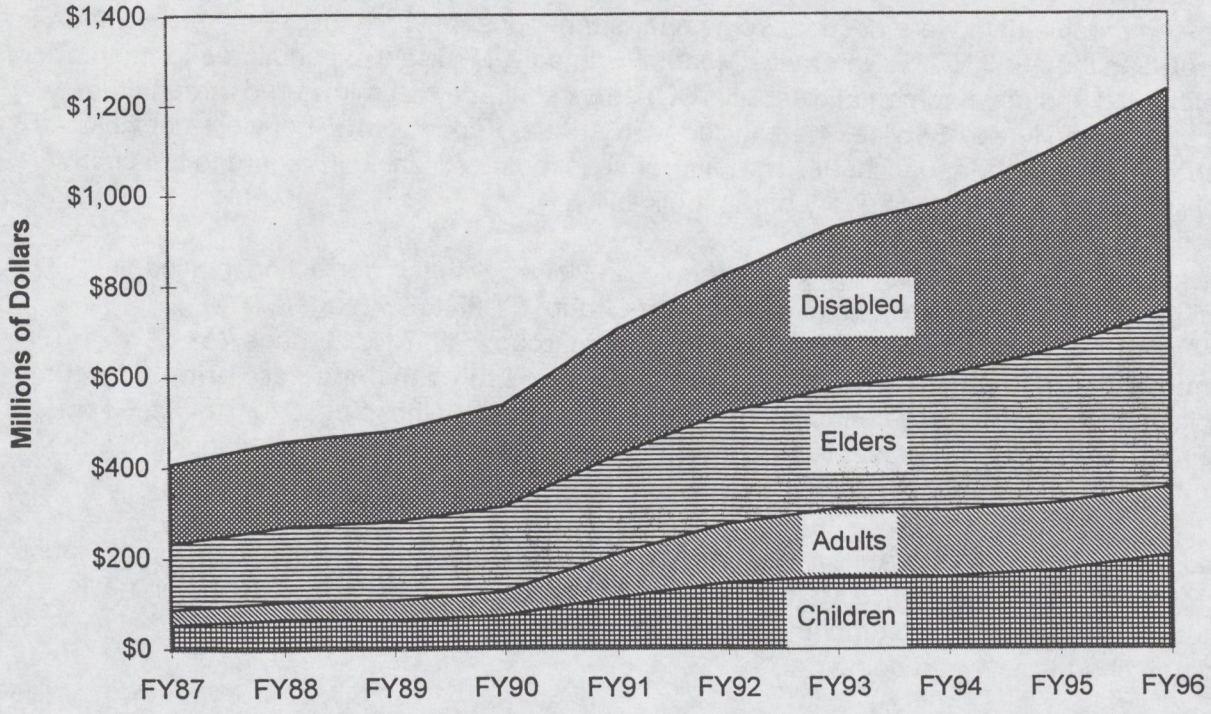
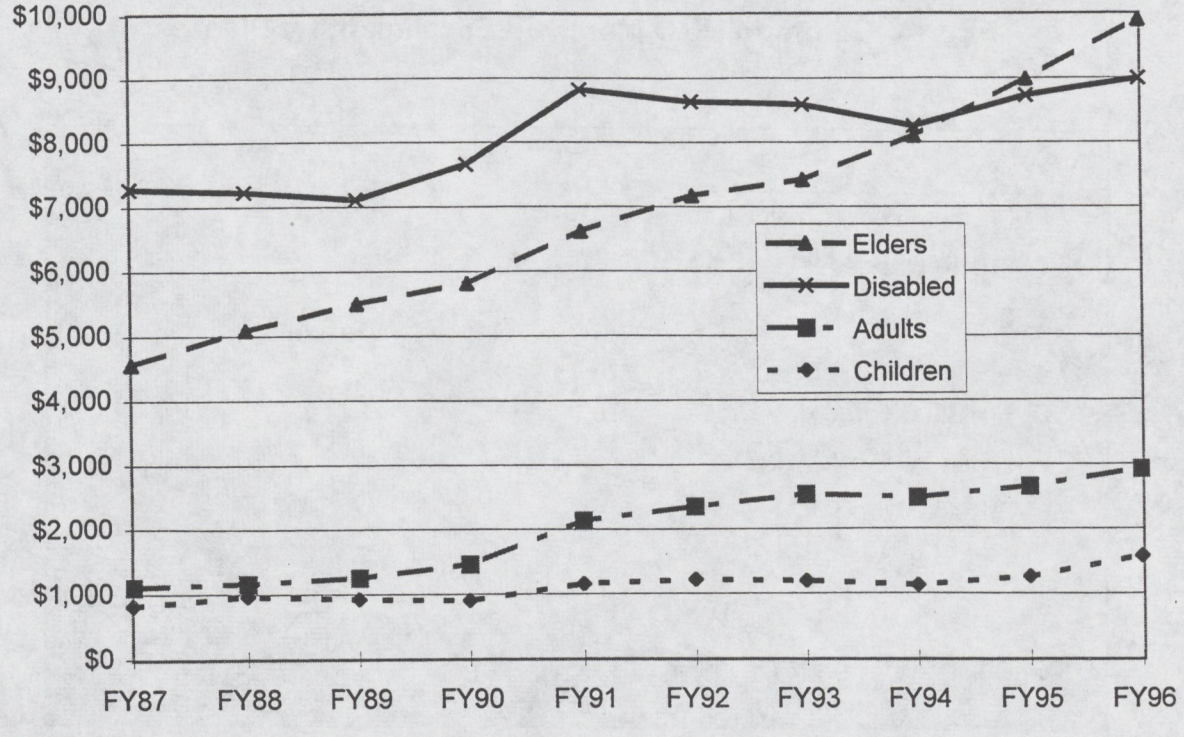


Fig. 28: Medicaid Per Capita Costs by Client Group, FY87-96



DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

1997 REFERENCE MANUAL

Alan Weil, Executive Director

January 1997

STATE OF COLORADO

DEPARTMENT OF HEALTH CARE POLICY & FINANCING

1575 Sherman Street
Denver, CO 80203-1714
(303) 866-2993
(303) 866-4411 FAX

Roy Romer
Governor

Alan Weil
Executive Director

January 1997

Dear Reader:

The 1997 Department of Health Care Policy and Financing Reference Manual is provided as a resource for policy-makers, health care consumers, providers, and all citizens of Colorado. It provides an overview of the Department's work, Colorado Medicaid and other health care programs, and information about important trends in the health care market.

As the Single State Agency responsible for the administration of the Medicaid program, the Department of Health Care Policy and Financing faces many challenges. In a time of fiscal constraints and increasing health care access problems, the Department must find more efficient and effective ways to provide health care for low-income Coloradans.

As one of the largest purchasers of health care in the State of Colorado, the Department has the ability to help shape the overall health care market. The Department's purchasing behavior is designed to improve health plan quality and consumer choice, encourage providers and plans to compete with one another based on price, quality, and accessibility, and reduce risk-skimming behavior.

The Reference Manual describes the Department's efforts to meet these challenges. Our intent is to make the Manual useful for a wide variety of readers. If you would like more detailed information about a particular subject, I encourage you to read the additional source material that is referenced throughout.

Additional copies of the 1997 Reference Manual, the 1997 Annual Report, or any other Department publication are available from the Office of Public and Private Initiatives, Department of HCPF, 1575 Sherman Street, Denver, Colorado 80203. You may also call 303-866-3327, or FAX 303-866-2803.

I welcome your comments and questions.

Sincerely,

Alan Weil

Alan Weil
Executive Director

EQUAL PROTECTION

No person may be excluded from participation in programs administered by the Colorado Department of Health Care Policy and Financing, or denied benefits, or discriminated against, because of: sex, race or color, national origin or citizenship, mental or physical impairment, or religion.

Any person who believes that she or he has been discriminated against for any reason may file a complaint with any of the following agencies:
the local administering agency; HCPF;
the Colorado Civil Rights Commission; or,
the U.S. Department of Health and Human Services.

See the table,
"Who Does What in Colorado Health Care?"
at the front of this Reference Manual for more information.

The 1997 HCPF Reference Manual is produced by
the Colorado Department of Health Care Policy and Financing
Alan Weil, Executive Director
Office of Public and Private Initiatives
Michael Rothman, Director

Tom Kowal - Editor
Reid Reynolds - Statistics and Graphics
Laura Tollen - Analysis and Technical Writing
Dixi Gloystein - Information Technology Services
Theresa Stephens and Bob Syler, General Support Services - Printing

The Department wishes to thank for their contributions:

HCPF staff who provided
program, administrative and statistical information,
and project assistance of many kinds,
and
our **advisors and customers** whose valuable comments and suggestions
help to make possible the constant improvement of the HCPF Reference Manual.

Please send comments on the Reference Manual to: Tom Kowal, Department of Health Care Policy and Financing, 4th Floor, 1575 Sherman St., Denver, CO 80203

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DEPARTMENT OF HEALTH CARE POLICY & FINANCING

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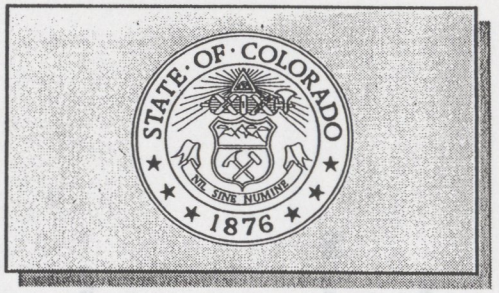


EXECUTIVE DIRECTOR
Alan R. Weil

EXECUTIVE ASSISTANT
Diane Rodriguez-Zepeda

OFFICE OF LEGISLATIVE AFFAIRS
Dean Woodward

OFFICE OF PUBLIC & PRIVATE INITIATIVES
Michael Rothman

DELIVERY SYSTEMS DEVELOPMENT SECTION
Dann Milne

OFFICE OF INFORMATION TECHNOLOGY
Tim Johnson

OFFICE OF MEDICAL ASSISTANCE
Richard Allen

EXECUTIVE ASSISTANT
Cathy McDaniel

MEDICAL SERVICES BOARD
Leah Stresemann

BUDGET OFFICE
Marilyn Golden

OFFICE OF ACCOUNTING & PURCHASING
Jan Frederickson

DIVISION OF HEALTH PLAN MANAGEMENT
Nancy Peters

DIVISION OF MANAGED CARE CONTRACTING
Gary Snider

DIVISION OF HEALTH PLAN OPERATIONS
Marianne Seddon

HEALTH CARE BENEFITS SECTION
Margaret Traudt

FACILITY RATES SECTION
Greg Gruman

PROVIDER RATES SECTION
Bill Mogg

THIRD PARTY RESOURCES SECTION
Roger Gunter

CUSTOMER SERVICE SECTION
Dianne Primavera

ELIGIBILITY & ENROLLMENT SECTION
Colleen Bryan

QUALITY ASSURANCE SECTION
George Main (act.)

INFORMATION SYSTEMS SECTION
Beth Neva

Alan R. Weil, Executive Director

Figure 1: HCPF Organizational Chart

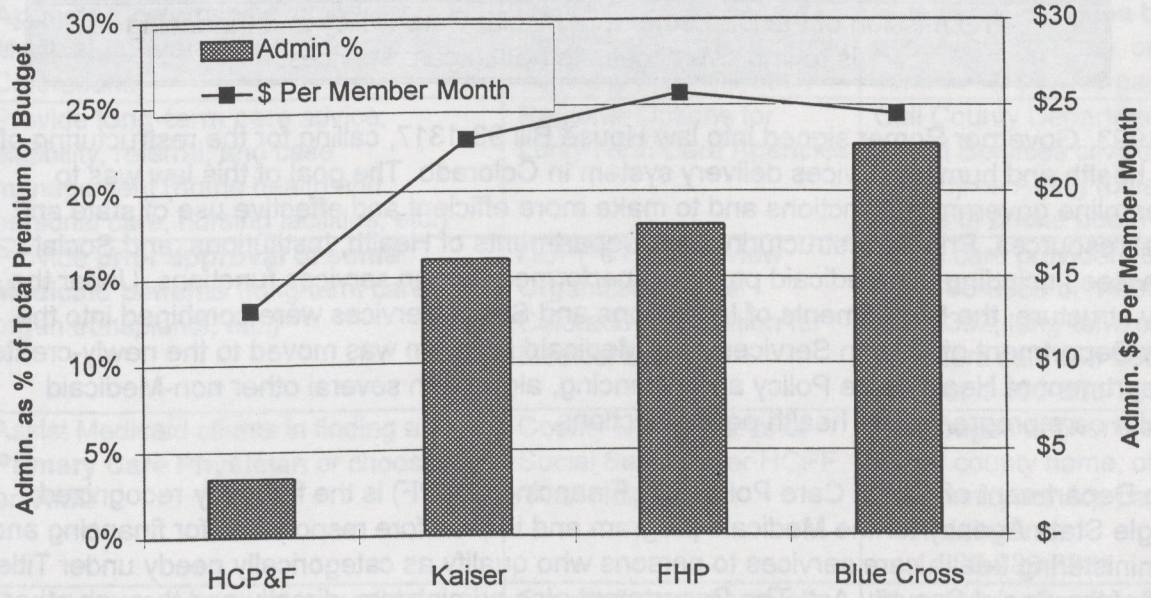
I. Introduction

A. OVERVIEW: DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

The Department of Health Care Policy and Financing (HCPF) was established on July 1, 1994, under the direction of Executive Director Alan Weil. The Department's rule making authority is the Medical Services Board.

In fiscal year 1996 the Department administered a budget of $1.5 billion. Federal funds accounted for over half of this total, with the balance state and grant funds. The Department manages 17% of the state's annual budget but, at a staffing level of 133 full-time equivalent (FTE) personnel, accounts for only one-half of one percent of the state's employees. Total HCPF administrative costs, including public and private sector contracts and eligibility determination at the county level, were 3.4% of the Department's budget during calendar year 1995. As Figure 2 shows HCPF's administrative costs are much lower than private sector insurance companies both as a percent of total budget and per member per month.[1]

Figure 2: HCPF's Administrative Costs Compared to Insurance Companies



The Department is organized into six offices:

- Executive Director
- Medical Assistance
- Public and Private Initiatives
- Information Technology
- Budget
- Accounting and Purchasing

The Office of Medical Assistance administers the state/federal Medicaid program and a number of other state funded health care programs. The Medical Services Board has statutory rule-making responsibility for the Medicaid, Indigent Care, Adult Foster Care and Home Care Allowance programs. Members of the Medical Services Board are appointed to four-year terms by the Governor with the consent of the state Senate.

[1] The Blue Cross figures include HMO Colorado.

The Office of Public and Private Initiatives develops and implements market-oriented health care reforms and Medicaid program improvements. The Offices of Information Technology, Budget, and Accounting and Purchasing are responsible for developing and administering information systems, projecting and administering the Department's annual budget, and operating the Departmental accounting and purchasing systems.

The 1997 Colorado Department of Health Care Policy and Financing (HCPF) Reference Manual provides an overview of the Department's organization, functions, program performance and goals. The Budget Request document (published in November and updated throughout the legislative session) and various reports containing program, planning, financial and statistical data are referenced "Appendix 1: Sources/Publications." Brochures and guides on specific programs (such as Medicaid), designed for use by clients, providers and other agencies, are also available from the Department and from local agencies.

B. HISTORY AND MISSION OF THE DEPARTMENT

The mission of the Department of Health Care Policy and Financing is to improve access to health care services.

In 1993, Governor Romer signed into law House Bill 93-1317, calling for the restructuring of the health and human services delivery system in Colorado. The goal of this law was to streamline government functions and to make more efficient and effective use of state and local resources. Prior to restructuring, the Departments of Health, Institutions, and Social Services (including the Medicaid program) performed human services functions. Under the new structure, the Departments of Institutions and Social Services were combined into the new Department of Human Services. The Medicaid program was moved to the newly-created Department of Health Care Policy and Financing, along with several other non-Medicaid health care programs and health policy functions.

The Department of Health Care Policy and Financing (HCPF) is the federally-recognized Single State Agency for the Medicaid program and is therefore responsible for financing and administering health care services to persons who qualify as categorically needy under Title XIX of the Social Security Act. The Department also administers, directly and through other agencies and contractors, the Colorado Indigent Care Program, the statewide Poison Control Center and a number of state-funded health care programs for elderly and disabled persons.

HCPF staff also provide health data, research, program development and policy support to public and private entities engaged in improving Colorado health care financing, coverage and delivery systems. HCPF's data bases and reports are major Colorado health care information resources.

C. STRUCTURE OF THE HCPF REFERENCE MANUAL

This Manual updates and expands the 1996 HCPF Reference Manual, and replaces what was formerly the narrative section of the Medicaid Program Annual Report. The Manual includes Medicaid program descriptions, accomplishments and future directions.

The body of the Manual is organized according to the Department organizational chart. Each section's functions, goals and objectives, and accomplishments are outlined. Figure 1 displays each section on the Department organizational chart. The Department's Annual

Report, which accompanies this manual, analyzes and interprets current Department program data and discusses the Department's major initiatives. Program and agency abbreviations and technical terms used throughout are listed in Appendix 2.

D. WHO DOES WHAT IN COLORADO HEALTH CARE?

This table outlines the functions of HCPF and other Colorado health care organizations.

Figure 3: Who Does What in Colorado Health Care?

Function	Agency	Phone/Contact
Emergency Services		
Emergency care (if danger to life or health, such as uncontrolled bleeding, auto accident, unconsciousness)	Ambulance or hospital emergency room	**Call 911** or local ambulance service
Poisoning - 24 hour emergency advice and referral	Rocky Mountain Poison Control Center	1-800-629-1123 (Denver Metro); 1-800-332-3073 (outside Metro) or **call 911**
Medicaid-Related Functions		
Apply for, determine eligibility for **Medicaid coverage** (low-income Coloradans)	County Departments of Social Services - Medicaid Eligibility Determination	Blue pages of phone book under county name, or community service pages
Provide **long-term care** advice, eligibility, referral, and case management (home health and personal care, nursing facilities, etc.)	Regional Options for Long-Term Care Agencies	Call County Department of Social Services or Area Agency on Aging (blue pages of phone book)
Provide **prior approval of some Medicaid benefits** (long-term care, organ transplants, etc.)	HCPF's Peer Review Organization - the Colorado Foundation for Medical Care	Acute care providers call: 303-695-3369 or 1-800-333-2362; long-term care providers call: 303-695-3340 or 1-800-888-7053
Assist Medicaid clients in finding a **Primary Care Physician** or choosing an **HMO**	County Departments of Social Services; or HCPF "First Help" Line	Blue pages of phone book under county name, or community service pages. First Help Line: 1-800-283-3221
Provide **transportation** to medical appointments for Medicaid clients	County Departments of Social Services	Blue pages of phone book under county name, or community service pages.
Provide urgent care, **health care**, preventive services (well-baby, pre-natal and delivery care, chronic conditions, immunizations, flu and colds, etc.) for Medicaid clients	For an appointment or for urgent care: HCPF "First Help" Line; or your Primary Care Physician or HMO	First Help Line 1-800-283-3221, or call the Primary Care Physician or HMO listed on your Medicaid card
Pay Medicaid providers, enroll providers, handle claims problems	HCPF's Medicaid fiscal agent: Blue Cross Blue Shield of Colorado	Institutional, pharmacy, and DME providers: 303-831-0214 or 1-800-443-6731. Practitioners (e.g. physicians, clinics, dental, EPSDT), supply, and transportation: 303-831-0504 or 1-800-443-5747

Function	Agency	Phone/Contact
Finding Health Insurance for Individuals and Businesses		
Information about **health insurance for small businesses** (groups of 1 to 50 employees, including self-employed)	Colorado Division of Insurance	303-894-7490
Information about **health care coverage cooperatives** for small businesses	HCPF - Office of Public and Private Initiatives	303-866-3327
Information on private **long-term care insurance**	Colorado Division of Insurance	303-894-7499, x355
Determine eligibility for and provide **Medicare** - health insurance for the elderly (65 years of age and older)	Medicare - U.S. Department of Health and Human Services	For eligibility and other information, call Social Security: 1-800-772-1213 (press "1" then "4")
Provide information on and enroll individuals in **Baby Care - Kids Care** (coverage for pregnant women and children in low-income families)	County Departments of Social Services, and other sites such as Public Health Departments and clinics	Blue pages of phone book under county name. Or call 303-692-2229 or 1-800-688-7777 for the Family Health Line
Provide coverage for **Coloradans who cannot obtain health insurance** because of a pre-existing condition	Colorado Uninsurable Health Insurance Plan	303-863-1960 or 1-800-672-8447
Provide **health care to low-income children** ages 3-19 in school-based health centers (certain schools in Adams County District 14, Denver Public Schools, and Sheridan Schools)	Kaiser-Permanente School Connections, or, call your child's school	Kaiser: 303-344-7425
Provide outpatient **health care for low-income children** under the age of 13 who do not qualify for Medicaid	Child Health Plan	1-800-359-1991
Provide information on **benefits for veterans** (including health care)	U.S. Dept. of Veterans' Affairs	1-800-827-1000
Finding Health Care Services for Individuals		
Provide **financial assistance for hospital or clinic services** (for low-income uninsured Coloradans who are not eligible for Medicaid)	Colorado Indigent Care Program; or local hospitals or community health centers	Colorado Indigent Care Program 303-866-2580; or Billing office at health facility
Provide **dental treatment** to non-Medicaid-eligible, **low-income children** without dental insurance coverage (Denver-metro only)	Kids in Need of Dentistry	303-691-9130
Provide sick and well care for low-income children and sick **care for low-income** adults on a sliding scale. For **residents of Arapahoe, Douglas, and Elbert Counties** only	Doctor's Care	303-730-1313
Provide **health services to American Indians** and Alaskan Natives (eligibility is verified through tribal affiliation)	Indian Health Services	301-443-3024

Function	Agency	Phone/Contact
Finding Health Care Services for Individuals (cont'd)		
Provide children's dental care, services for disabled children, migrant workers, and **children with special health care needs**	Department of Public Health and Environment - Family and Community Health Services	303-692-2310
Provide **health care to low-income, rural, or migrant Coloradans** through Community Health Clinics or the U.S. Public Health Service	Colorado Community Health Network (for locations of local clinics, and referrals)	303-861-5165
Health Care Regulation		
License and regulate **health insurers and HMOs**	Colorado Division of Insurance	303-894-7499, press "0" for operator
Certify and regulate **health care coverage cooperatives**	HCPF - Office of Public and Private Initiatives	303-866-3327
Monitor and regulate compliance with Americans with Disabilities Act; accept complaints on **civil rights** issues	For general questions: U.S. Department of Health and Human Services For employment issues: Equal Employment Opportunity Commission Accessibility of public buildings: U.S. Department of Justice Colorado Civil Rights Commission HCPF Customer Service	Office for Civil Rights 303-844-2024 Equal Employment Opportunity Commission 1-800-669-3362 U.S. Dept. of Justice 1-800-514-0301 Civil Rights Commission 303-894-2997 HCPF 303-866-3513 or 1-800-221-3943
Regulate **Medicaid** and the Colorado Indigent Care Program	HCPF - Medical Services Board	303-866-4416
Monitor **Medicaid quality of care**, Medicaid **fraud and abuse**	HCPF Quality Assurance Section; or Colorado Department of Law - Medicaid Fraud Unit	HCPF: 303-866-2420 Dept. of Law: 303-866-5431
License, and accept **complaints about, health professionals** (doctors, nurses, etc.)	Colorado Department of Regulatory Agencies, Board of (Profession)	303-894-7441
License and **inspect health facilities** (nursing facilities, home health agencies, personal care boarding homes, medical labs, hospitals)	Colorado Department of Public Health and Environment - Health Facilities Division	303-692-2800

Function	Agency	Phone/Contact
Public Health		
Contagious **disease control**	Colorado Department of Public Health and Environment - Epidemiology	303-692-2700
Pollution and **hazardous conditions**	Colorado Department of Public Health and Environment	303-692-3000
Consumer Advocacy		
Handle **Medicaid client complaints regarding HMO** or primary care physician	HCPF Customer Service Line	303-866-3513 or 1-800-221-3943
Assist **Medicaid clients in disenrolling from an HMO**	Disenrollment line at HCPF Peer Review Organization	1-800-854-4563
Handle **non-Medicaid complaints regarding an HMO**	Colorado Division of Insurance; or Colorado Department of Public Health and Environment	Division of Insurance 303-894-7490 Dept. of Public Health and Environment 303-692-2800
Handle **non-Medicaid complaints regarding an insurance company**	Colorado Division of Insurance	Division of Insurance 303-894-7490
Handle **long-term care facility complaints**	Long-Term Care Ombudsman at The Legal Center	303-722-0300
Handle **client appeals on Medicaid** issues	Administrative Law Judges, Department of Law HCPF	Administrative Law Judges 303-866-2500 HCPF Office of Appeals 303-866-5977
Other Public Health Care Issues		
Formulate **state health policy**, including Medicaid and other public health care budgets	Colorado General Assembly (Senate and House) Governor Roy Romer	State Senate: 303-866-4838 or 303-866-3074 State House of Representatives: 303-866-2903 or 303-866-2345 Governor Roy Romer: 303-866-2471
All other questions on health care policy, financing, programs, or services	HCPF Customer Service Information Line	303-866-3513 or 1-800-221-3943

II. Office of Medical Assistance

Overview

The Department's Office of Medical Assistance administers the state's major publicly funded health care programs. The state/federal Medicaid program provides comprehensive health care coverage for about 275,000 low-income Coloradans. State-funded programs such as the Poison Control Center and the Old Age Pension Health and Medical fund, Home Care Allowance, and Adult Foster Care provide services to meet specific health care needs. The state-funded Colorado Indigent Care Program (Resident Discount Program) pays partial reimbursement to providers of clinic and inpatient hospital services for care rendered to low income persons who are not eligible for Medicaid. About 15% of Colorado citizens receive health care services that are financed under these programs. In FY 96 health care providers received $1.4 billion per year in reimbursements for services rendered to those clients.

Figure 4: Number of Clients Served and Payments to Providers, Fiscal Year 96

Program	Number Served	Total Payments
Medicaid (HCPF-Medical Services)	274,536	$991,689,677
Medicaid (DHS-administered MH & DD services)*	NA	$243,697,359
Disproportionate Share & Teaching Hospital payments	NA	$139,718,496
Colorado Indigent Care Program (CICP)	est. 132,000	$34,115,943
Home Care Allowance**	5,796	$14,528,141
Adult Foster Care**	537	$841,934
Poison Control Center	55,456	$1,148,034
TOTAL	**est. 462,000**	**$1.4 billion**

* Department of Human Services administers most Mental Health and Developmental Disability services; MH and DD clients are counted under HCPF Medicaid and receive all Medicaid services

** Client count duplicates Medicaid in most cases

The largest responsibility of the Office of Medical Assistance is the $1.4 billion Medicaid program. Medicaid eligibility, coverage and provider designation policy is established in state law (section 26-4-101 et seq., C.R.S.) and in Title XIX of the federal Social Security Act (42 U.S.C. § 1396 et seq.). The Colorado Department of Health Care Policy and Financing is the designated Single State Agency for the administration of the Medicaid program. Staff of the Department's Office of Medical Assistance units administer (directly or through contracts) the program's financing, cost containment, information and reimbursement systems, coverage and benefits, access and quality of care assurance programs, policy and operations. The Department of Human Services assumes most program administration responsibilities for most Medicaid Mental Health and Developmental Disability services.

A number of citizen boards, with consumer and provider participation, provide essential guidance and facilitate communications among program stakeholders. These boards include the Medical Services Board, the Medicaid Medical Advisory Committee, the Medicaid Advisory Committee for Persons with Disabilities, the Poison Control Board, and a variety of committees that focus on specific service areas such as Home Health or Pharmacy.

Background: Medicaid and Other Publicly Funded Health Programs in Colorado

Medicaid was enacted by Congress in 1964 to fund medically necessary health care services for families and individuals with low incomes. Colorado Medicaid became operational in January, 1969. Medicaid is funded with state and federal dollars, and is administered by the states under federal law and regulations. States have limited flexibility in program design in such dimensions as eligibility, benefits and coverage. By the 1970s it was apparent that Medicaid was falling short of realizing the original goal of financing medically necessary health care for low income, uninsured persons. Problems included:

- cost-shifting to other payers;
- low provider participation because of low Medicaid payment rates;
- lack of private health care providers where low-income individuals lived; and,
- limited ability of the private health care delivery system to provide appropriate health care services to low-income citizens.

Federal, state, and local governments made significant investments to address these problems. To increase access to health care, all levels of government increased funding of health care systems including: the U.S. Public Health Service; the Medicaid program; urban public hospitals; community, migrant and rural health centers; and, public health agencies. In Colorado, Medicaid and the Colorado Indigent Care Program (CICP) are major funding vehicles for the reimbursement of these providers for care rendered to uninsured low-income persons. The Colorado Medicaid program innovated alternative long-term care programs that provide home and community-based care to persons who otherwise would be likely to receive nursing facility care.

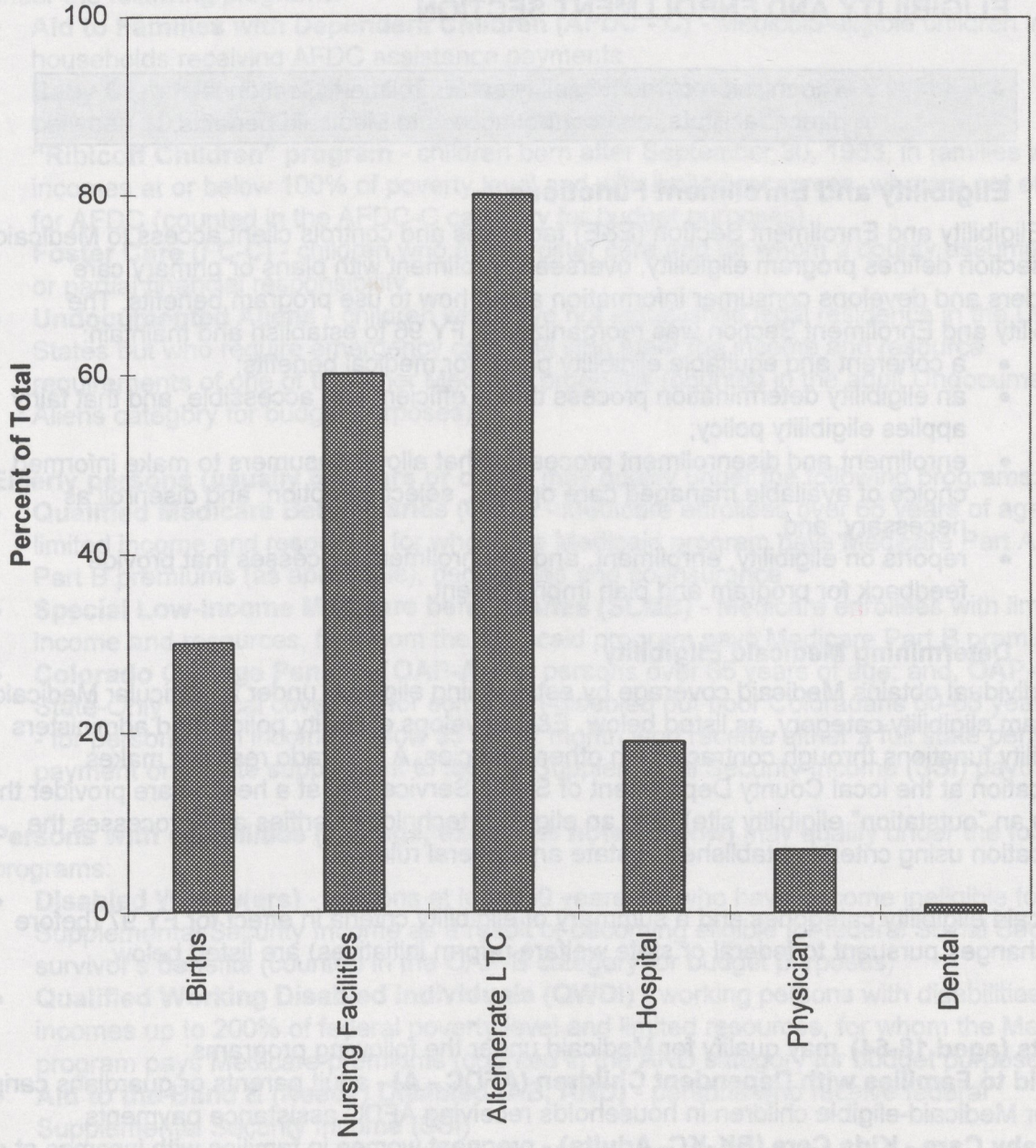
Congressional action and court decisions in recent years have further extended public health care coverage, especially through Medicaid, to groups of individuals such as pregnant women, young children, the elderly, and children and adults with disabilities. Many of these newly-eligible individuals are in need of high-cost care. Public payers, including Medicaid, have also been required to reimburse a number of provider groups such as hospitals, clinics and nursing facilities at substantially higher rates than in the past.

Today, HCPF programs are a major health care payer to hospitals, clinics, home care agencies and nursing facilities in Colorado. The Department's Office of Medical Assistance programs pay for about 30% of all births, 60% of nursing facility and 80% of alternative long-term care services, and provide an important safety net for adults and children with disabilities who may be denied other health care coverage. (See Figure 5 below.) The growth in the number of individuals served by the publicly funded health care system, and the increases in provider rates has extended health care coverage to Coloradans (and reduced cost-shifting to other payers), but has also substantially increased state and federal Medicaid expenditures. The Department now faces new challenges in administering and developing its Medical Assistance programs. Managed care and welfare reform initiatives will result in significant changes to the State's public health care financing, administration and delivery systems over the next few years.

Organization of the Office of Medical Assistance

The Office of Medical Assistance is divided by program function into three divisions and eight sections, as shown on the organizational chart in the front of the Reference Manual. The mission, functions and management plans of each unit are described below.

Figure 5: Medicaid Share of Colorado Health Care Expenditures, 1994



A. ELIGIBILITY AND ENROLLMENT SECTION

The mission of the Eligibility and Enrollment Section is to direct, facilitate, and control access to Medicaid benefits.

1. Eligibility and Enrollment Functions

The Eligibility and Enrollment Section (E&E) facilitates and controls client access to Medicaid. The section defines program eligibility, oversees enrollment with plans or primary care providers and develops consumer information about how to use program benefits. The Eligibility and Enrollment Section was reorganized in FY 96 to establish and maintain:

- a coherent and equitable eligibility policy for medical benefits;
- an eligibility determination process that is efficient and accessible, and that fairly applies eligibility policy;
- enrollment and disenrollment processes that allow consumers to make informed choice of available managed care options, select an option, and disenroll as necessary; and,
- reports on eligibility, enrollment, and disenrollment processes that provide feedback for program and plan improvement.

a) Determining Medicaid Eligibility

An individual obtains Medicaid coverage by establishing eligibility under a particular Medicaid program eligibility category, as listed below. E&E develops eligibility policy, and administers eligibility functions through contracts with other agencies. A Colorado resident makes application at the local County Department of Social Services (or at a health care provider that offers an "outstation" eligibility site), and an eligibility technician verifies and processes the application using criteria established in state and federal rules.

Medicaid eligibility categories and a summary of eligibility criteria in effect for FY 97 (before any changes pursuant to federal or state welfare reform initiatives) are listed below.

Adults (aged 18-64) may qualify for Medicaid under the following programs:

- **Aid to Families with Dependent Children (AFDC - A)** - adult parents or guardians caring for Medicaid-eligible children in households receiving AFDC assistance payments
- **Baby Care - Kids Care (BK-KC, Adults)** - pregnant women in families with incomes at or below 133% of the federal poverty level, who are not eligible for AFDC (133% of poverty = $20,195 for a family of four in 1995)
- **Undocumented aliens program** - adults who have not established legal residence in the United States but who require emergency care, including prenatal and delivery services, and who meet the income and resource requirements of one of the other Medicaid programs

Children (aged 0-18, or to age 19 if still in school, except as noted below) may qualify under the following programs:

- **Aid to Families with Dependent Children (AFDC - C) -** Medicaid-eligible children in households receiving AFDC assistance payments
- **Baby Care Kids Care (BK-KC, Children)** - children from birth to age 6 in families between 101 and 133% of the federal poverty level
- **"Ribicoff Children" program** - children born after September 30, 1983, in families with incomes at or below 100% of poverty level and with limited resources, who are not eligible for AFDC (counted in the AFDC-C category for budget purposes)
- **Foster Care (FC-C)** - children who are in foster care and for whom a county assumes full or partial financial responsibility
- **Undocumented Aliens** - children who have not established legal residence in the United States but who require emergency care and who meet the income and resource requirements of one of the other Medicaid programs (counted in the adult Undocumented Aliens category for budget purposes)

Elderly persons (usually 65 years or older) may qualify under the following programs:

- **Qualified Medicare Beneficiaries (QMB)** - Medicare enrollees over 65 years of age with limited income and resources for whom the Medicaid program pays Medicare Part A and Part B premiums (as applicable), deductibles and co-insurance
- **Special Low-income Medicare beneficiaries (SLMB)** - Medicare enrollees with limited income and resources, for whom the Medicaid program pays Medicare Part B premiums
- **Colorado Old Age Pension: OAP-A** - for persons over 65 years of age; and, **OAP-SO** - State-Only medical coverage for some non-disabled but poor Coloradans 60-65 years old - for persons with incomes below $514 per month who receive either a full state pension payment or a state supplement to federal Supplemental Security Income (SSI) payments

Persons with disabilities (any age, except as noted below) may qualify under the following programs:

- **Disabled Widow(ers)** - persons at least 50 years old who have become ineligible for Supplemental Security Income as a result of becoming eligible for federal Social Security survivor's benefits (counted in the OAP-B category for budget purposes)
- **Qualified Working Disabled Individuals (QWDI)** - working persons with disabilities, with incomes up to 200% of federal poverty level and limited resources, for whom the Medicaid program pays Medicare premiums (counted in the AND category for budget purposes)
- **Aid to the Blind & (Needy) Disabled (AB, AND)** - persons who receive federal Supplemental Security Income (SSI)
- **Colorado Old Age Pension: OAP-B** - for disabled Colorado residents between 60 and 65 years of age with incomes below $520 per month and limited assets
- **Long-Term Care (LTC)** - persons of any age with incomes below 300% of the federal Supplemental Security Income level ($17,424 per year in November 1996) who require long-term care in nursing facilities or through the Home and Community Based Services programs (counted in the OAP-A budget category if over 60 years of age, and in the AND category if below 60)
- **Income Trusts -** persons needing nursing facility care or Home and Community Based Services whose monthly income is over 300% of the Supplemental Security Income payment level, but below the cost of nursing facility care. Income in excess of the 300% level is diverted to a specific type of court-approved income trust, and the person may then qualify for Medicaid. (counted for budget purposes the same as LTC, above)

Figure 6: Medicaid Client Enrollment by Eligibility Category

Category of Eligibility (Budget Category)	# of Clients in FY 95	% in FY 95	# of Clients in FY 96	% in FY 96
Adults				
Aid to Families with Dependent Children - Adults (AFDC - A)	43,311	15.5%	39,344	14.3%
Baby Care - Kids Care - Pregnant Women (BCKC - A)	8,671	3.1%	7,194	2.6%
Undocumented Aliens[2]	3,993	1.4%	4,834	1.8%
Subtotal	**55,975**	**20.0%**	**51,372**	**18.7%**
Children				
Aid to Families with Dependent Children (AFDC - C); and, Ribicoff Children	111,077	39.6%	108,325	39.5%
Baby Care - Kids Care (BCKC - C)	16,886	6.0%	12,735	4.6%
Foster Care Children (FC - C)	7,513	2.7%	8,460	3.1%
Subtotal	**135,476**	**48.4%**	**129,520**	**47.2%**
Elderly				
Qualified Medicare Beneficiaries (QMB) and Special Low-Income Medicare Beneficiaries (SLMB)	3,424	1.2%	3,891	1.4%
Old Age Pension (OAP-A and State-Only OAP Health and Medical Fund)[3]	34,620	12.4%	35,560	13.0%
Subtotal	**38,044**	**13.6%**	**39,451**	**14.4%**
Persons with Disabilities				
Aid to the Blind (AB)	170	0.06%	162	0.06%
Aid to the Needy Disabled (AND)[4]	46,322	16.5%	49,561	18.1%
Old Age Pension (OAP-B)	4,162	1.5%	4,470	1.6%
Subtotal	**50,654**	**18.1%**	**54,193**	**19.7%**
TOTAL	**280,149**	**100.0%**	**274,536**	**100.0%**

Source: HCPF Budget Office - Figures are preliminary for FY 96

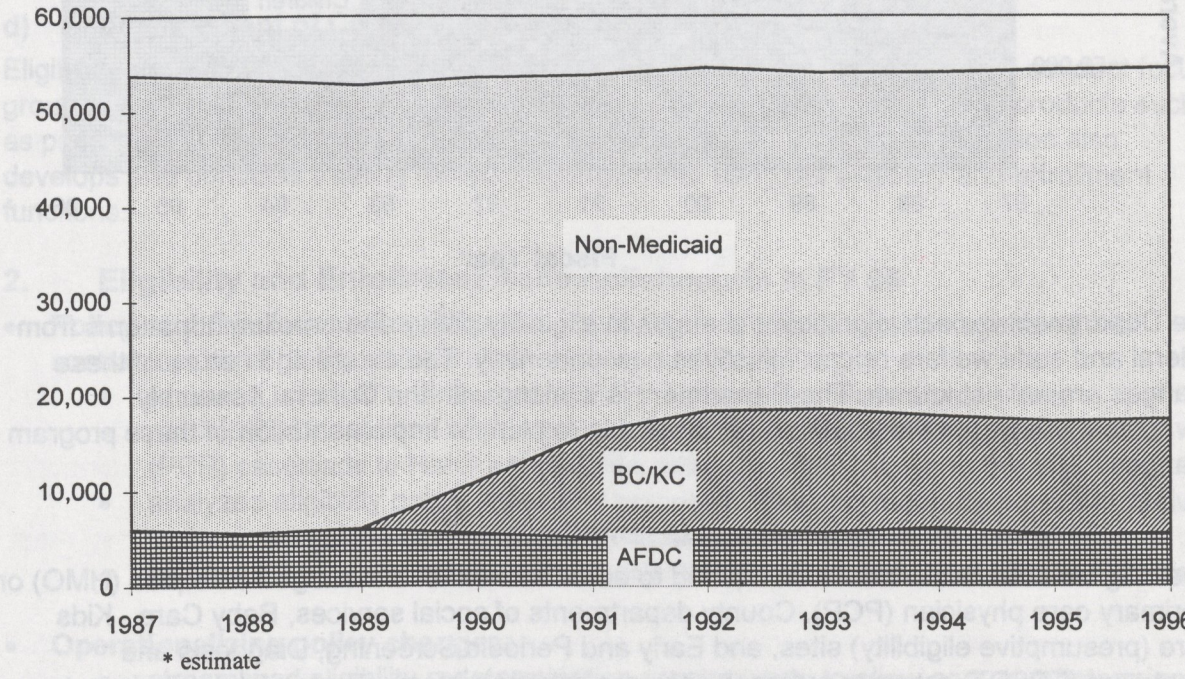
[2] Undocumented Aliens budget category includes both adults and children, although most persons served are adults.

[3] OAP-A budget category includes some Disabled Widow(er)s, Long-Term Care and Income Trust beneficiaries who are 60 years of age or older.

[4] AND budget category also includes Qualified Working Disabled, some Disabled Widow(er)s, Long-Term Care and Income Trust beneficiaries.

Figure 6 above shows the number of persons in each Medicaid eligibility category enrolled in the Colorado Medicaid program as of December, 1995 and 1996. There was a 2% reduction from FY 95 to FY 96 overall in Medicaid client enrollments, with decreases in most eligibility categories. Baby Care - Kids Care (BC/KC) enrollments were down 17% for adults and 25% for children; Aid to Families with Dependent Children (AFDC) enrollments were down 9% for adults and 2.5% for children. Old Age Pension categories had slight enrollment increases. Although enrollments declined in both the AFDC-Adult and Baby Care categories, Figure 7 shows that the number of births to mothers covered by Medicaid has not declined. Medicaid-covered births have remained in the range of 17,300 -18,600 (and between 31% and 34% of total Colorado births) since the Baby Care program extended Medicaid coverage to women in families with incomes to 133% of the federal poverty line. (See Appendix 1, item #30 for more detail on Medicaid's effect on repeat fertility.)

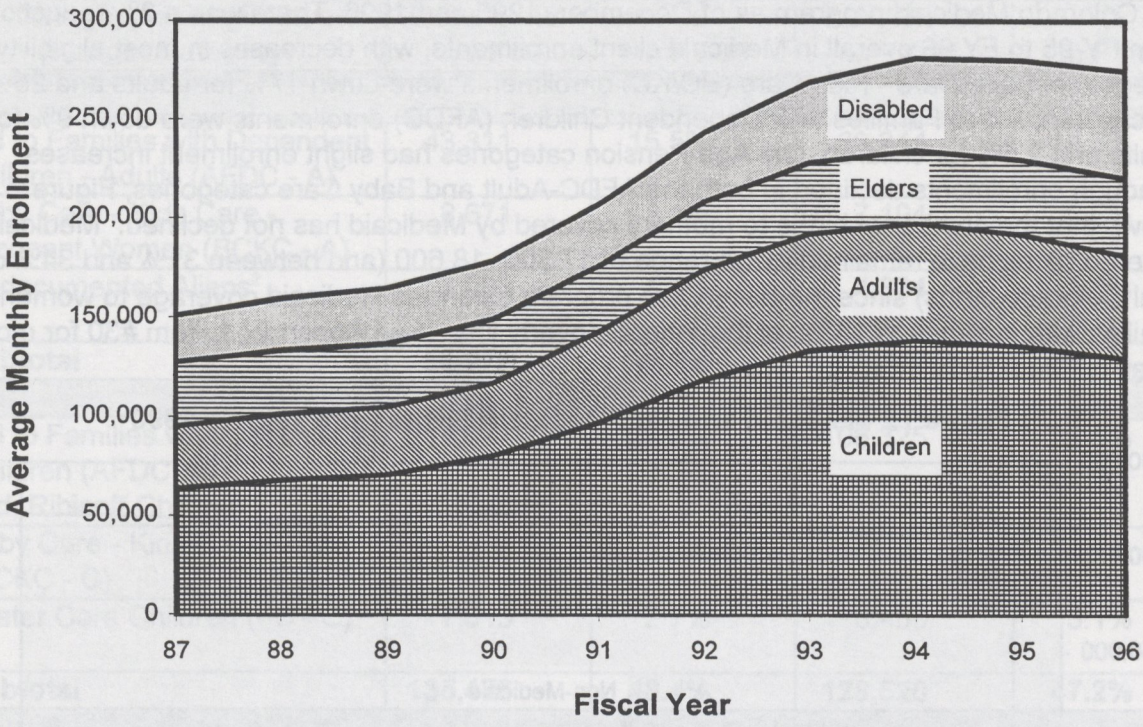
Figure 7: Medicaid and Non-Medicaid Births from 1987 to 1996



* estimate

The state's economy and federal, state and local policies and mandates influence client enrollments in the Department's medical assistance programs. Because program eligibility is based in part upon client household income, enrollment levels are generally counter-cyclical to growth or recession in the state's economy, but are affected by many other factors. Actual enrollment in medical assistance programs often occurs at the time an individual experiences high health care costs, such as during pregnancy or as a result of serious illness or injury. Enrollment in the Department's programs for elderly and disabled persons is influenced by economic factors as well, but may be more subject to demographic influence, as the state's population ages and increasing numbers of disabled persons require assistance. Figure 8 shows the trends in Medicaid enrollment by eligibility group from FY 87 through FY 95 and projected enrollment in FY 96.

Figure 8: Medicaid Enrollment, FY 87-96



The Department expects significant changes in eligibility policy and enrollment patterns from federal and state welfare reform initiatives now underway. The extent and nature of these changes are not yet known. The Department is working with the General Assembly, advocates, clients, providers and other agencies to plan for implementation of these program changes.

b) Managed Care Enrollment and Disenrollment

Most eligible Medicaid clients are required to enroll with either a managed care plan (HMO) or a primary care physician (PCP). County departments of social services, Baby Care - Kids Care (presumptive eligibility) sites, and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program outreach sites are asked to inform clients of their choices, to explain how managed care plans work, and then to enter data on the client's selection. Since these responsibilities for managed care enrollment were assigned to counties and agencies without new staff or system resources, these functions are not adequately implemented. The Department is attempting to support this function by assessing county workloads and procedures, providing enhanced information resources and training, re-designing procedures and systems, and providing information on the need for additional local agency resources.

Clients may disenroll from managed care plans if they are not satisfied with care provision, if circumstances change, or for other reasons. The disenrollment process is handled by the Colorado Foundation for Medical Care (CFMC), under supervision of the Eligibility and Enrollment section. Clients who wish to change their Primary Care Physician are assisted by the Department's Customer Service Information Line.

c) Determining Eligibility for non-Medicaid Health Care Programs

The Eligibility and Enrollment Section coordinates and oversees eligibility determination for the following non-Medicaid programs:

- **Old Age Pension (OAP) Health and Medical Fund** - The Old Age Pension and the Health and Medical Fund are state-funded programs established in the Colorado Constitution. The OAP is a direct cash grant paid to Coloradans age 60 or over who have income below $514 per month and limited resources. The cash grant is accompanied by medical coverage paid through the Old Age Pension Health and Medical Fund. County Departments of Social Services are the eligibility and enrollment sites.

- **Home Care Allowance and Adult Foster Care** - These state-funded long-term care programs provide support to persons who need assistance with activities of daily living, such as housekeeping and mobility. County departments of social services determine financial eligibility, and Options for Long-Term care agencies determine need for care, for over 6000 elderly and disabled persons.

d) Development of Client Information and Staff Training Tools

Eligibility and Enrollment section staff develop client information materials and conduct focus groups with Medicaid clients to review the Department's program information products such as pamphlets, videotapes, eligibility forms, and enrollment materials. The section also develops and conducts training for local agencies that carry out eligibility and enrollment functions.

2. Eligibility and Enrollment Accomplishments in FY 96

- **Policy and Operations Coordination** - Coordinated with other state agencies and contractors on eligibility and enrollment policy and operations:
  - reviewed, charted and revised managed care disenrollment processes
  - participated in revision of procedures for conversion of Primary Care Physician (PCP) caseloads to HMO enrollments, when the PCP moved to the HMO
  - analyzed eligibility policy, roles and responsibilities and recommended alternatives to the existing Medicaid eligibility processes
  - initiated E&E quality assurance projects (with the Department of Human Services)

- **Operationalizing policy changes:**
  - streamlined eligibility redetermination requirements to allow annual redetermination
  - implemented the teen-age pregnancy pilot program which allowed local communities to use Medicaid funds to reduce the incidence of teen pregnancy
  - clarified policy related to Medicaid providers billing clients pursuant to prior year's statutory change and analysis of client complaints

- **Publications** - Developed and distributed educational materials about Medicaid policy and benefits to clients and local agencies, including:
  - managed care information - a videotape for clients, a quarterly Medicaid Managed Care Guide with a directory of providers, a benefit comparison chart listing all Medicaid managed care offerings, agency letters explaining policy and procedures
  - Medicaid home and community based services waiver programs comparison chart
  - disability rights poster campaign and long- term care housing options videotape

- **Managed Care training** - Developed and provided:
  - statewide training for county technicians, Presumptive Eligibility, and EPSDT staff;
  - training for counties on new managed care plans

  - local agency training on environmental assessment of persons with disabilities, and case management for clients with brain injuries
  - internal staff development training in team skills, project management, and customer service
  - client sensitivity training for front-line telephone triage contractors
- **Income Trusts** - Refined policy concerning Medicaid eligibility for persons with income-qualifying trusts, including:
  - trust law to remove unnecessary barriers and costs for Medicaid clients, streamline the distribution formula and eliminate payment of fees from income trusts
  - sample trusts and trustee handbooks; training for local agencies on trust issues
  - review and approval procedures for income trusts, disability and pooled trusts

- **Operations** - Processed assigned caseload efficiently and accurately:
  - managed the Children's Home and Community Based Services Program (HCBS) for 200 clients
  - handled inquiries related to Medicaid dental and vision benefits for adults, and client billing problems

3. Eligibility and Enrollment Management Action Plan FY 97

GOAL 1: Support Medicaid's migration to a managed care delivery environment.
OBJECTIVES

A. Streamline and integrate processes used by clients to enroll in HMOs, convert from PCP to HMO coverage, and to disenroll from HMOs.
B. Research and design alternatives for use of a managed care enrollment facilitator to inform clients of managed care choices and secure more timely selection of a plan.
C. Develop and distribute a managed care newsletter with provider and client information.

GOAL 2: Collaborate in assuring that clients can readily access Medicaid services that meet their medical needs, and that services provided are of good quality.
OBJECTIVES

A. Integrate, automate and enhance managed care disenrollment processes to expedite access to appropriate care for clients who are unable to get their medical needs met within a given plan, and to give HCPF feedback on quality issues within health plans.
B. Provide clear and usable educational materials about managed care options, and clients' rights and responsibilities. Provide materials usable by non-readers and by non-English-speakers.

GOAL 3: Improve the Medicaid client eligibility processing system by addressing waste, duplication, and delays in processing time.
OBJECTIVES

A. Incorporate Medicaid changes related to federal and state welfare reform initiatives.
B. Lead the Medicaid team in the interdepartmental feasibility study for a new automated eligibility information system (the Colorado Benefits Management System - CBMS).
C. Identify and reduce legal, regulatory, and procedural opportunities for applicants to transfer significant assets in order to qualify for Medicaid.
D. Establish a monitoring process for Model 200 case management agencies and evaluate their operations for opportunities to redirect staff resources.

E. Complete a quality assurance pilot project on adult eligibility intake and investigate feasibility of methods to streamline processes.
F. Fix eligibility and enrollment problems in the COIN (eligibility data base) and MMIS (Medicaid claims database) systems. Provide expert program staff support for system modifications including stabilizing the HMO indicator in COIN, migrating to a permanent ID card, and 6-month guaranteed eligibility.

GOAL 4: Provide support to the creation of client eligibility-related files, features and functions needed to implement the new MMIS.

OBJECTIVES

A. Develop and test specifications for eligibility files in the MMIS.
B. Develop and specify requirements for management reports on eligibility data.
C. Develop and test eligibility-related claims and capitation processing.
D. Participate in design specifications for the decision support sub-system.

GOAL 5: Improve customer access to Medicaid benefits by persons who meet eligibility criteria by improving public information.

OBJECTIVES

A. Gather customer inputs to identify the types of information needed, the appropriate time to give specific information, and the best frequency and media for delivering information.
B. Develop a comprehensive, multi-media Medicaid communications strategy and plan for delivering information to local agencies, clients and advocates, plans, providers, the legislature and industry lobbyists.
C. Develop Internet communications capability for distribution of program information, and research potential for Internet processing of eligibility and enrollment communications.

B. HEALTH CARE BENEFITS SECTION

The mission of the Health Care Benefits Section is to define, implement, coordinate, and promote access to appropriate health care benefits for customers.

1. Health Care Benefits Section Functions

The Health Care Benefits section designs, implements and administers Medicaid and non-Medicaid benefits provided on a fee-for-service basis in institutional, outpatient, community and home care settings. The section:

- defines the scope of services to be provided to eligible clients;
- develops and implements health care policies and benefits in statute, regulations, and procedures;
- assures the provision of cost-effective health care services to eligible individuals in hospitals and nursing facilities, and in outpatient, community and home-based settings;
- coordinates a broad spectrum of programs and services to improve client access and limit duplication and gaps in services;
- monitors utilization, quality and cost-effectiveness of services provided; and,
- administers program change at the federal and state levels including conversion of fee-for-service benefits to managed care benefits.

a) Medicaid Benefits

Colorado Medicaid clients are covered for a comprehensive package of health care services. The Medicaid program reimburses providers for medically necessary services furnished to enrolled Medicaid clients. Covered services include: physician and clinic services, hospital care, prescriptions, home health care, and mental health services. Additional coverage for children includes prosthetics, dental and vision services and immunizations. Other benefits such as transportation to medical appointments, services for technologically dependent and homebound patients, long-term care services (provided in nursing facilities, at the client's home or in community-based settings such as board and care homes), and comprehensive clinic services are provided to Medicaid enrollees to meet the special needs of low-income, elderly, and disabled persons.

The full package of Medicaid benefits is available to clients whether they use the Primary Care Physician (fee-for-service) program or are enrolled in HMOs. Some Medicaid benefits are provided outside of the HMO coverage package - these are called "wrap-around" benefits and are referred by the HMO to other Medicaid providers. A full description of Medicaid benefits, and of the Managed Care program, including provider and HMO listings, is available from HCPF or from local county departments of social services. (Ask for the Managed Care Guide, Document #8 in Appendix 1)

Figure 9 and Figure 10 show FY 96 Medicaid expenditures by service type for each client eligibility group and across all eligibility groups. This chart shows that: elders used the vast majority of the $365 million that the Department spent on long-term care; adults and children used the majority of the $322 million spent on inpatient and ambulatory care; and people with disabilities used the vast majority of the $244 million spent on developmental disability and mental health services provided by the Department of Human Services.

Figure 11 shows different eligibility categories' shares of total enrollment and of total expenditures. People with disabilities and elders, together, are 32% of Medicaid enrollment but account for 71% of total expenditures.

Figure 12 compares the distribution of services purchased by Medicaid in FY 87 and FY 96. The figure shows that Medicaid is now spending a much higher share on HMOs than it was in FY 87. This should cause the share of other individual services covered under the HMO capitation to shrink. However, the inpatient services share has grown slightly since FY 87. This is probably a result of the lawsuit that Medicaid settled in the early 1990s that dramatically increased hospital rates. The figure also shows a large increase in community long-term care that is used as an alternative to nursing facility care.

Figure 9: Medicaid Service Expenditures by Eligibility Category, FY 96 (est.)

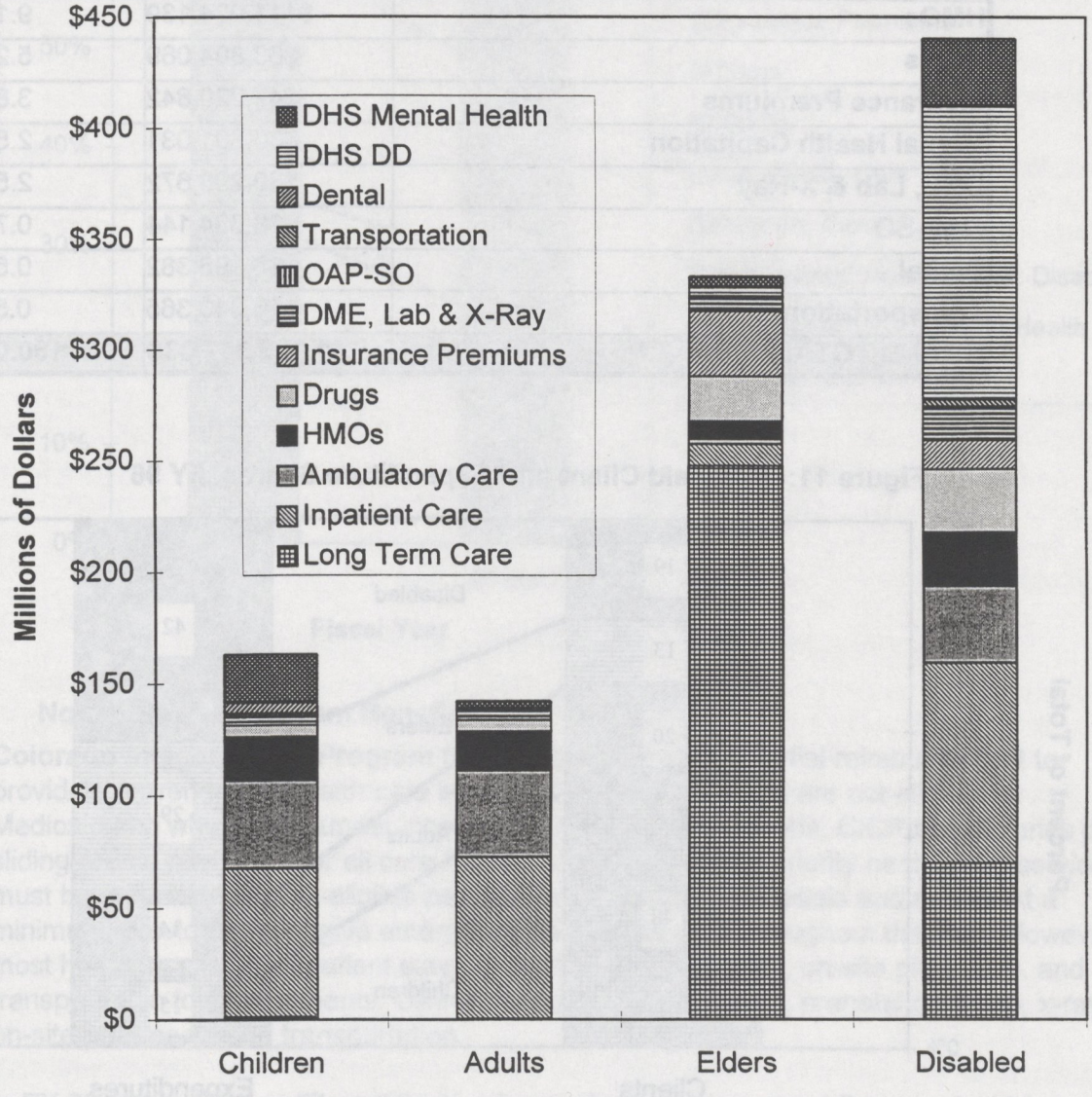


Figure 10: Distribution of Medicaid Expenditures by Service, FY 96

Category of Service	Expenditures	Percent
Long Term Care		
Nursing Facilities	$296,013,600	24.0
Community LTC & Home Health	$68,667,110	5.6
Mental Health & Dev. Disabilities (DHS)	$243,697,359	19.7
Inpatient Care		
Hospital Inpatient	$202,803,940	16.4
Psychiatric Hospitals (age <21)	$1,939,035	0.2
Ambulatory Care		
Physicians	$62,629,367	5.1
Hospital Outpatient	$42,220,417	3.4
Community Clinics	$12,491,564	1.0
HMOs	$111,924,139	9.1
Drugs	$63,804,069	5.2
Insurance Premiums	$47,220,842	3.8
Mental Health Capitation	$30,801,031	2.5
DME, Lab & X-Ray	$30,298,672	2.5
OAP-SO	$8,634,144	0.7
Dental	$6,198,382	0.5
Transportation	$6,043,365	0.5
GRAND TOTAL	**$1,235,387,036**	**100.0**

Figure 11: Medicaid Client and Expenditure Shares, FY 96

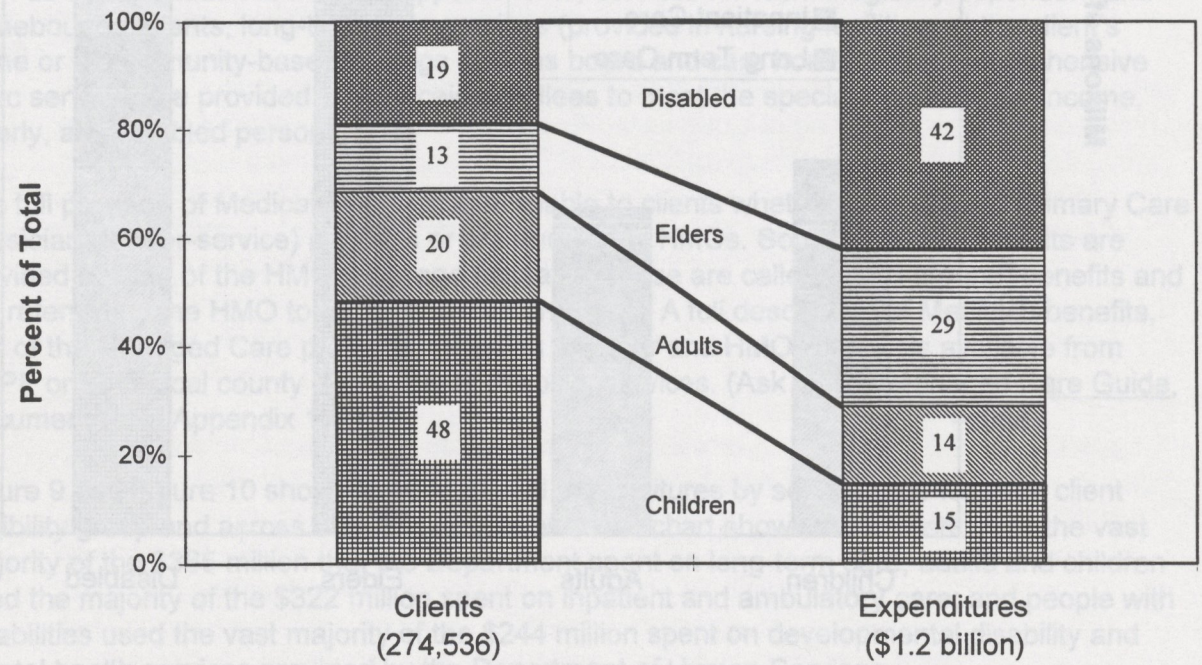
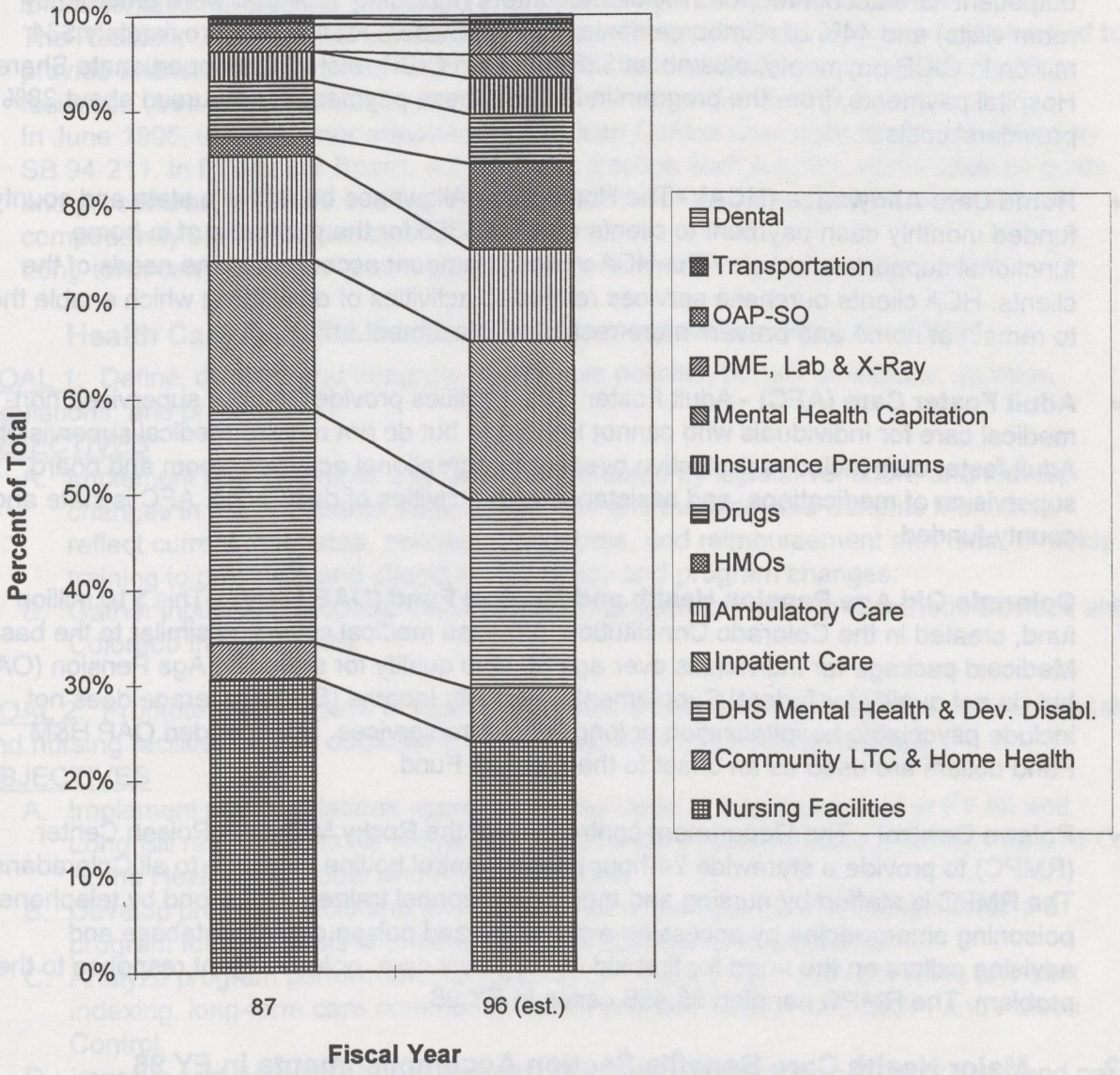


Figure 12: Distribution of Medicaid Expenditures by Service, FY 87 and FY 96



b) Non-Medicaid Program Benefits

- **Colorado Indigent Care Program (CICP)** - CICP provides partial reimbursement to providers for rendering health care services to Coloradans who are not eligible for Medicaid and who qualify under income and need for care criteria. CICP beneficiaries pay sliding-fee co-payments for all care received. By law, specific priority health care services must be provided to CICP-eligible persons by participating hospitals and clinics. At a minimum, providers must give emergency and urgent care throughout the year. However, most hospitals provide inpatient stays, prenatal care, lab, x-ray, on-site pharmacy, and transportation to appointments. Clinics provide preventive care, prenatal care, lab, x-ray, on-site pharmacy, and transportation.

  In FY 96, the CICP had 57 participating hospitals and clinics, providing care in 103 facilities across the state. About 132,000 CICP clients received over 20,500 inpatient admissions and over 503,000 outpatient visits in FY 96. Inpatient hospital services

accounted for 3% of service encounters and 56% of reimbursements; clinics and other outpatient care accounted for 97% of encounters (including 15% that were emergency room visits) and 44% of reimbursements. CICP providers received approximately $34 million in CICP payments, plus about $38 million in CICP-related Disproportionate Share Hospital payments, from the program in FY 96. These payments reimbursed about 28% of providers' costs.

- **Home Care Allowance (HCA) -** The Home Care Allowance benefit is a state and county-funded monthly cash payment to clients of up to $355 for the purchase of in-home functional supports and care. The HCA varies in amount according to the needs of the clients. HCA clients purchase services related to activities of daily living which enable them to remain at home and prevent more restrictive placement.

- **Adult Foster Care (AFC) -** Adult Foster Care facilities provide 24-hour supervised non-medical care for individuals who cannot live alone but do not require medical supervision. Adult foster care includes protective oversight, recreational activities, room and board, supervision of medications, and assistance with activities of daily living. AFC is state and county-funded.

- **Colorado Old Age Pension Health and Medical Fund (OAP H&M) -** This $10 million fund, created in the Colorado Constitution, provides medical coverage similar to the basic Medicaid package for individuals over age 60 who qualify for state Old Age Pension (OAP) but do not qualify for federal Supplemental Security Income (SSI). Coverage does not include psychiatric hospitalization or long-term care services. Unexpended OAP H&M Fund dollars are used as an offset to the General Fund.

- **Poison Control -** The Department contracts with the Rocky Mountain Poison Center (RMPC) to provide a statewide 24-hour poison control hotline available to all Coloradans. The RMPC is staffed by nursing and medical personnel trained to respond by telephone to poisoning emergencies by accessing a computerized poison control database and advising callers on the need for first aid, emergency care, or less urgent response to the problem. The RMPC handled 55,456 cases in FY 96.

2. Major Health Care Benefits Section Accomplishments in FY 96

- In FY 96 the Health Care Benefits Section implemented several new programs and legislative initiatives that were authorized in FY 95, including:
  - The Vaccines for Children Program
  - Payment to certified family planning clinics for prenatal and other medical care services (Senate Bill 95-78)
  - Home visit and case management enhancements to the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Lead Poisoning Prevention Program.
- Regulation clarification and updates, and statewide training for a number of programs including Home Health, home modifications, durable medical equipment, adult day services, and Single Entry Points (also called Options for Long-Term Care agencies).
- Special studies were conducted in the Hospice, Hospital back-up (long-term but acute services), and Private Duty Nursing Programs to evaluate cost-effectiveness and identify areas for improvement. Reports were submitted to the Governor, General Assembly, and the public on the Colorado Indigent Care, Home Health, Home and Community Based

Services, Prenatal Plus, and Poison Control Programs, and on the statewide implementation of Options for Long-Term Care (Single Entry Point) agencies.

- The Resident Quality of Care Incentive Payment Program (ResQUIP) was implemented to provide financial incentives for improvements in the quality of care provided in nursing facilities. (See also: ResQUIP incentive payment method in the Rate section.)
- In June 1995, the Governor appointed the Poison Control Oversight Board mandated by SB 94-211. In FY 96, the Board, with Benefits Section staff support, established its goals and procedures, provided oversight to development of an annual program report, and competitively bid the poison control contract.
- Long-term care utilization review services were competitively bid and contracted.

3. Health Care Benefits Section Management Action Plan for FY 97

GOAL 1: Define, develop and integrate health care policies, benefit definitions, statutes, regulations, and procedures.

OBJECTIVES

A. Implement new programs and benefits mandated by legislative, court, and federal changes in FY 96. Update state regulations and the Medicaid Benefits Manual to reflect current mandates, policies, procedures, and reimbursement methods. Provide training to providers and clients on the policy and program changes.
B. Gather inputs and propose modifications to programs including Prosthetic Devices and Colorado Indigent Care.

GOAL 2: Promote client access to high-quality, cost-effective health care services in hospitals and nursing facilities, and in outpatient, community, and home-based settings.

OBJECTIVES

A. Implement new regulations approved by the Medical Services Board in FY 96 and Long Bill rate changes for Home and Community-Based Services (HCBS), HCA, AFC, Home Health, and Acute and Ambulatory care.
B. Develop programs including an Alternate Care Facilities (ACFs) expansion and a program for individuals with severe organic behavioral impairments.
C. Analyze program performance and report on Primary Care Provider rates and cost indexing, long-term care community-based provider rates, HCA, CICP, and Poison Control.
D. Improve and increase service delivery. Provide training, technical assistance, and on-site review to providers and contractors, including new EPSDT sites, ACFs, Adult Foster Care facilities (AFCs), CICP facilities, and the Poison Control Center.
E. Streamline processes where feasible and cost-effective including Home Health Utilization Control, PRO Utilization Reviews, consolidation of AFC/ACF rules, and the Hospice program's prior approval, reimbursement, and benefit structures.

GOAL 3: Promote coordination among a broad spectrum of programs and agencies to improve client access and to limit duplication and gaps in services.

OBJECTIVES

A. Collaborate with other sections, departments and agencies in the development and implementation of new programs and services.
B. Coordinate and streamline services to children including Home Health, Private Duty Nursing, EPSDT, HCA, HCBS Children's Waivers, and the Handicapped Children's Program.

C. Gather and utilize input of consumers and providers. Provide staffing to advisory groups: Colorado Community Health Network/Medicaid, Durable Medical Equipment, Home Health, Persons with Disabilities, ResQUIP, Long-term Care, HCBS, Home Health, Nursing Facilities, Durable Medical Equipment, CICP, EPSDT, Lead Poisoning Prevention, Dental Services, Pediatric Care, Primary Care Physician (PCP) Program, Electronic Benefit Transfer (EBT) users, the Poison Control Oversight Board, and Hospice.

GOAL 4: Develop and implement improved program accountability systems.

OBJECTIVES

A. Collaborate in the improvement of encounter data, quality management and other reporting requirements in managed care contracts.
B. Improve EPSDT participation rates and Home Health services to clients enrolled in managed care organizations as measured by a lower number of client complaints.
C. Work with the HCPF Quality Assurance Section's Surveillance and Utilization Review System (SURS) staff and the Attorney General's Medicaid Fraud Unit to develop rules and procedures that will assist in taking corrective action against abusive and fraudulent providers.
D. Provide oversight and take appropriate enforcement action related to the Nursing Facility survey and certification program contracted to the Health Facilities Division of the Department of Public Health and Environment.

C. DIVISION OF MANAGED CARE CONTRACTING

The mission of the Division of Managed Care Contracting is to increase Medicaid client enrollment in managed care plans and to develop managed care delivery systems that provide high quality and cost efficient health care.

1. Managed Care Contracting Division Functions

The Division of Managed Care Contracting develops, implements, and monitors contracts with Health Maintenance Organizations (HMOs) and Pre-paid Health Plans (PHPs), and administers the Primary Care Physician (PCP) Program. The Division's purpose is to develop managed care delivery systems to provide high quality and cost-efficient health care and to increase Medicaid client enrollment in managed care plans. The Division:

- negotiates, implements, and manages contracts with managed care organizations and providers to ensure that Medicaid clients receive high quality, cost-effective services;
- provides technical assistance to managed care organizations and providers to help them understand the special needs of the Medicaid population and to support their ability to meet these needs;
- monitors the marketing, enrollment, and subcontracting activities of contracted providers;
- monitors the performance of managed care organizations to ensure that enrolled clients receive high quality care; and,
- analyzes cost, quality, and utilization data to identify areas for improvement.

a) Capitated and Non-Capitated Managed Care Systems

Upon enrollment in the Medicaid program, clients are required to select either a primary care provider or a fully-capitated health plan. These capitated and non-capitated (fee-for-service) managed care programs are supervised by the Division of Managed Care Contracting. The paragraphs below outline the Department's managed care programs. Figure 13 shows the percentage of Medicaid clients enrolled in each type of managed care, and the percentage not enrolled in managed care. Figure 14 shows the history of Colorado Medicaid HMO enrollments, by plan. Figure 15 shows HMO (and other Managed Care Organization - MCO) enrollment levels at the end of FY 96, and the date each plan began enrolling Medicaid clients.

Colorado Medicaid uses two types of managed care programs:

- **Non-capitated "gatekeeper" programs** - Medicaid pays a provider or case manager to coordinate and manage clients' health care needs, but Medicaid continues to pay fees to providers for each service delivered ("fee-for-service"); and,
- **Fully capitated programs** - Medicaid pays an organization a fixed monthly amount to manage and deliver a wide range of health care services for a client.

Medicaid's "gatekeeper" managed care programs are:

- **The Primary Care Physician (PCP) Program:** Medicaid clients may select a primary care physician who is solely authorized to provide primary care and to 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.

- **Options for Long-Term Care (OLTC, also known as Single Entry Point) agencies.** OLTC agencies provide information and referral, assessment, and case management services for long-term care. The agencies meet clients' needs with a combination of community-based care services and nursing facility care. OLTC agencies receive reimbursement as Medicaid providers and also make their services available to other clients on a private pay, fee-for-service basis.

Medicaid's capitated managed care programs include:

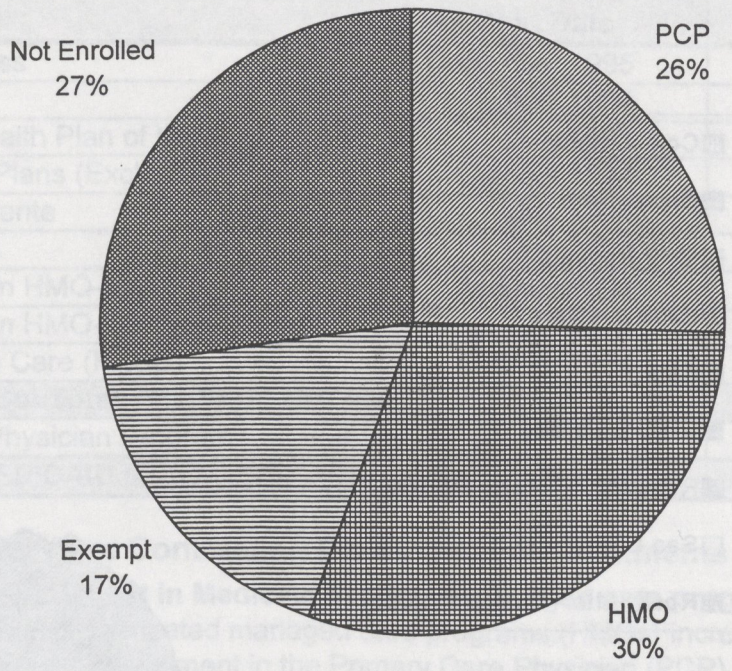
- **Capitated HMOs:** Medicaid clients may select a fully-capitated health plan (an HMO). Unlike providers participating in the non-capitated managed care programs, the capitated plans have full responsibility, not only for the management of care, but also for the financing and delivery of all necessary and covered health care services. These plans receive a fixed monthly fee (premium) payment from Medicaid for each enrolled Medicaid client.

- **Mental Health Assessment and Services Agencies (MHASAs):** Under this program, mental health services in selected counties are provided through contracted MHASAs that are responsible for all mental health services required by Medicaid clients residing in a given service area. The Division of Mental Health in the Department of Human Services administers this program and manages contracts with the MHASAs, paying them a capitation for each Medicaid client in the service area. A 1996 report on the MHASA program is available from DHS.

- **The Program of All-inclusive Care for the Elderly (PACE):** PACE is available to persons 65 years of age and older who require long-term care services. The program integrates community-based acute and long-term care services, most of which are provided in an Adult Day Health Center in Denver. Care may also be received at home, in the inpatient or outpatient hospital setting, and, when medically necessary, in a skilled nursing facility. PACE receives capitation payments from both Medicaid and Medicare.

- **The Integrated Long-Term Care and Financing (ILTCF) Project.** This demonstration project integrates acute and long-term care services and financial reimbursement mechanisms including both Medicare and Medicaid. The project is being implemented as a pilot program in Mesa County in partnership with Rocky Mountain HMO and the local OLTC agency. The project was under development during FY 96 and is expected to begin enrolling clients in early calendar 1997. Most potential ILTCF enrollees are presently enrolled in Rocky Mountain HMO.

Figure 13: Medicaid Clients by Type of Managed Care, FY 96



Note: MHASA and OLTC clients may be enrolled in any of these Managed Care categories.

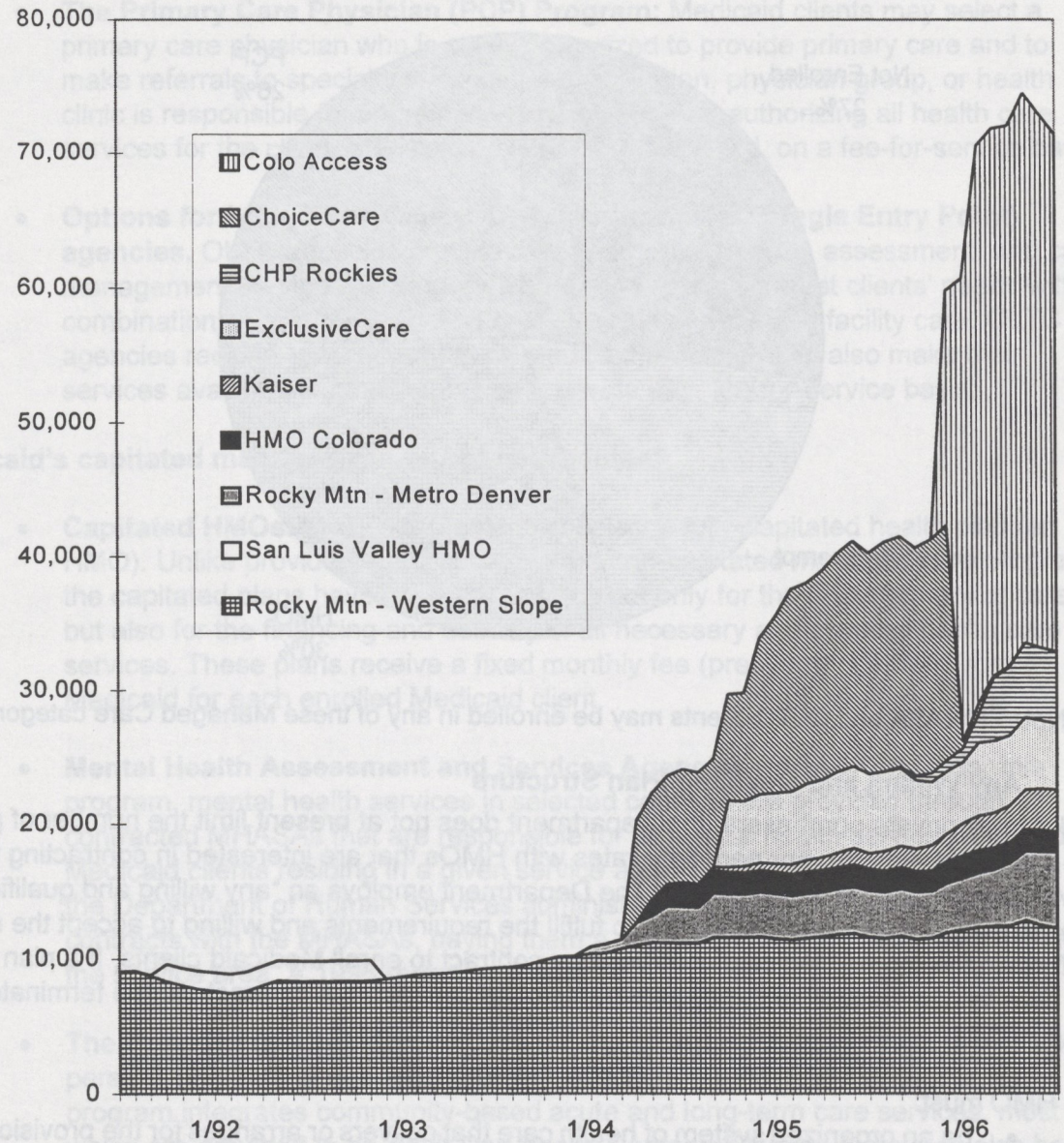
b) Any Willing and Qualified Plan Structure

Unlike most private purchasers, the Department does not at present limit the number of plans that it will contract with, nor negotiate rates with HMOs that are interested in contracting to provide services to Medicaid clients. The Department employs an "any willing and qualified plan" structure. Any HMO that is able to fulfill the requirements and willing to accept the rates set forth in the model Medicaid contract may contract to enroll Medicaid clients. If a plan at any time fails to meet all of the requirements of its contract, the contract can be terminated.

The Department contracts only with HMOs that meet specific criteria, as follows.
The HMO must:

- be an organized system of health care that delivers or arranges for the provision of health care for its members;
- provide comprehensive, continuous health care services with an emphasis on preventive health care, without under-emphasizing acute medical treatment;
- agree to a yearly prepayment contract with fixed monthly payments, under which the HMO is at risk financially to arrange for the provision of a specified package of health services;
- have proven financial stability and be licensed by the Colorado Division of Insurance; and,
- establish and maintain full compliance with the Department's access, quality of care, data collection and reporting, and financial and fraud control systems.

Figure 14: Colorado Medicaid HMO Enrollment by Plan



Notes to Figure 14 and Figure 15:

1) In December 1995, Choice Care became part of a new HMO - Colorado Access. Medicaid clients enrolled in Choice Care were transferred to Colorado Access. This explains the sudden drop in Choice Care enrollment in early 1996.

2) Antero Health Plan (formerly ExclusiveCare) withdrew as a Medicaid HMO in early FY 97.

Figure 15: Medicaid Managed Care - Start Date and Enrollment as of June 96

Health Plan	Medicaid Contract Start Date	Clients Enrolled at end of FY 96
Colorado Access	December 1995	39,787
ChoiceCare[1]	April 1994	0
Community Health Plan of the Rockies	July 1995	5,424
Antero Health Plans (Exclusive Care)[2]	October 1994	5,117
Kaiser Permanente	July 1994	3,070
HMO Colorado	May 1994	1,593
Rocky Mountain HMO-Metro	January 1994	5,465
Rocky Mountain HMO-Western Slope	1974	12,502
Total Longterm Care (PACE)	October 1991	183
SubTotal: Medicaid HMOs		**73,141**
Primary Care Physician Program		63,455
TOTAL MEDICAID MANAGED CARE		**136,596**

2. Managed Care Contracting Division Accomplishments in FY 96

- **Increased enrollment in Medicaid capitated managed care programs** - Enrollment of Medicaid clients in capitated managed care programs (HMOs) increased substantially in FY 96. As a result, enrollment in the Primary Care Physician (PCP) Program decreased.
  - Medicaid HMO enrollments grew by more than 75% from 41,245 enrollees at the end of FY 95 to 73,141 at the end of FY 96. HMOs now serve more than one quarter of Colorado Medicaid clients. (See Figure 13 and Figure 14, above.)
  - The Program for All-Inclusive Care of the Elderly (PACE) grew by 10%, to 220 enrollees.
  - The Mental Health Assessment and Services Agencies (MHASAs) program that began operation in August 1995 now serves 180,711 Medicaid enrollees, or 66% of all Medicaid clients.

- **Risk-adjusted capitated rates** - During FY 96, the Division worked with the Office of Public and Private Initiatives and contractors to develop a diagnosis-based risk-adjusted payment system for Medicaid HMOs. By adjusting capitated rates paid to HMOs according to the diagnoses of their enrolled members, the Department intends to encourage plans to develop networks and systems that will meet the needs of higher-cost Medicaid clients. The Department plans to implement diagnosis-based risk-adjusted rates in FY 98. (See the Office of Public and Private Initiatives chapter for further explanation of the risk-adjusted rates project.)

- **Stronger quality standards for Medicaid HMOs** - During FY 96, the Division, with the Office of Public and Private Initiatives, developed new HMO contract standards. Relying strongly on quality assurance standards developed by the National Committee on Quality Assurance (NCQA - the main national organization that accredits HMOs), but also considering state HMO licensure requirements, the Division incorporated 10 new sections into the Medicaid HMO contract. These sections address HMO standards and performance in areas such as provider network adequacy, access to care, utilization management, quality of care, member rights and responsibilities, grievance procedures and data reporting requirements. In FY 96, a project team was assembled to develop

coordinated HMO monitoring protocols. With Division of Insurance and Department of Public Health and Environment staff, and with involvement of HMO staff and client advocates, HCPF is developing streamlined monitoring processes that will minimize duplication of effort and demands upon plans, while maximizing access to relevant information on plan performance. Monitoring and reporting protocols will use HEDIS 3.0 (Health Plan Employer Data & Information Set) reports, on-site reviews, and evaluation of client satisfaction surveys, complaints, and disenrollment information. Standards and procedures will be routinely revised based on the results of the annual plan examinations.

- **Improving managed care for people with disabilities** -The Medicaid Managed Care Disability Working Group was formed in February of 1996, in response to concerns raised by the disability community and by the General Assembly regarding the rapid increase in enrollment of persons with disabilities in Medicaid HMOs. This group, made up of persons with disabilities, parents of children with special medical needs, and advocates for people with disabilities, provides a forum for persons with disabilities to be involved in the development of policies and procedures to ensure that Medicaid clients with disabilities receive adequate access to quality care in HMOs and other capitated managed care settings. This group proposed about 200 HMO contract modifications. The group continues to work on HMO benefits and quality assurance issues.

3. Managed Care Contracting Division Management Action Plan FY 97

GOAL 1: Negotiate, implement and manage contracts with managed care organizations and providers to ensure that Medicaid clients receive high quality, cost-effective services.

A. Expand the PACE program to new contractors, at metro or non-metro sites.
B. Review Primary Care Physician Program for continued feasibility in its current form; determine size of the program; and consider new reimbursement methods.
C. Review, revise and initiate, continue or resume HMO enrollment processes including: PCP conversion; mailings to unassigned clients for voluntary enrollment; managed care marketing plans; HMO-funded enrollment facilitator; and guaranteed eligibility.
D. Enhance automated support systems including correction of "auto-drop-off"; and direct COIN access for HMOs.

GOAL 2: Provide technical assistance to HMOs and providers to help them understand the special needs of the Medicaid population and to support their ability to meet these needs.
OBJECTIVES

A. Clarify Medicaid HMO benefits package and non-HMO benefits for clients, providers, HMOs and other relevant groups and individuals (wrap-around benefits).
B. Sponsor sensitivity training for staff and HMOs regarding clients with disabilities.
C. Develop managed care contractor requirements and contract language to ensure continuity of care for persons with disabilities.

GOAL 3 Monitor HMO performance to ensure that enrolled clients receive high quality care.
OBJECTIVES

A. Develop and implement consolidated inter-agency monitoring protocols for contract compliance monitoring and health plan evaluation.
B. Conduct evaluations of all contracting health plans prior to contract renewal in the Spring of 1997 using monitoring and evaluation protocols.
C. Revise contract standards based on results of plan evaluations; implement administrative rules consistent with Department policy and contract requirements.

D. CUSTOMER SERVICE

The mission of the Customer Service Section is to assist clients to access appropriate health care and to assist all customers to better understand the services and benefits offered by Health Care Policy and Financing programs.

1. Customer Service Section Functions

The Department is committed to providing excellent service to its customers. Customers include Medicaid clients, Medicaid providers, county-level agents responsible for local HCPF program administration, state and contractor staff, policy makers, and members of the public seeking information about the Department's programs. These groups each have different needs and interests.

The Customer Service section responds to customer questions and complaints, develops and implements policies and procedures to enhance communication and education, collects customer information and directly assists the Department's clients to access appropriate health care. The Customer Service section performs the following functions:

- serve as a focal point for HCPF client inquiries, staff and operate the Customer Service Information Line, and facilitate resolution of customers' problems
- assist clients to enroll with or change Primary Care Physicians or HMOs
- in coordination with the contracted Medicaid Communications unit at the Fiscal Agent, facilitate enrollment of physicians as Medicaid Primary Care Providers and other customer services to providers
- coordinate customer service functions among internal and external customer service units, to ensure that consistent and accurate information is provided
- in cooperation with the Quality Assurance and Eligibility and Enrollment units, coordinate customer service activities with the Peer Review Organization
- in cooperation with the Health Care Information Systems unit, coordinate customer service activities with the Department's fiscal agent (Blue Cross/Blue Shield of Colorado) communications unit
- coordinate Client Advocacy Office services with the Department of Human Services
- coordinate customer services within the Department of Health Care Policy and Financing
- collect, analyze and report customer service needs, suggestions and complaints
- propose, develop and implement policy and systems modifications to improve customer service

a) Department Client Help Lines

The Customer Service section operates three client help lines and coordinates these lines with other help lines operated by contractors and other units of the Department. The following three lines are staffed by the Customer Service section:

- **Customer Service Information Line** - This toll-free telephone service provides immediate response to client and provider questions on the PCP program, other managed care options and general Medicaid and Colorado Indigent Care Program (CICP) issues. An automated "Teletips" function is in development that will provide touch-tone access to recorded messages on the most commonly asked questions. Customer Service representatives also directly assist clients in choosing or changing a primary care physician or enrolling in an HMO. The Information Line number is distributed to all Medicaid clients by county-level eligibility technicians and is printed in Medicaid program brochures. (See Figure 16, "Customer Service Line Calls Per Month," under "Accomplishments" on the next page.)

- **Client Billing Assistance** - Medicaid providers' bills must be submitted as claims to the Medicaid program; providers should not bill clients for any Medicaid-covered benefits or services, other than the nominal client co-payments. When a provider bills a client in error, staff assist clients and providers in resolving the problems.

- **Colorado Indigent Care Program Assistance** - Staff of the Customer Service section respond to ten to fifteen calls per day regarding the Colorado Indigent Care Program. Client inquiries typically concern where to apply for the program, what services and benefits are offered, income eligibility thresholds, and how to appeal cost sharing rates. Provider inquiries concern how to become an Indigent Care provider, how to collect co-payments from patients, and what to do if bills are not paid.

b) Other Client Help Lines and Services

The Customer Service section refers some calls to the Department's Peer Review Organization (PRO) contractor (Colorado Foundation for Medical Care - CFMC), or to other customer service lines. The following help lines and client contact data bases are operated by the PRO, by the Department of Human Services, or by other units in HCPF:

- **HMO Disenrollment Line.** Clients wishing to disenroll from an HMO are referred to the PRO HMO disenrollment line. The PRO conducts an in-depth telephone interview with these clients to determine their reasons for disenrolling, and potentially to assist the plan and the client in resolving any differences. This is an important part of HMO quality control and allows the Department to identify potential problems in HMO customer service, quality of care and access.

- **"First Help" Triage Line.** This medical triage telephone service assists clients who are not enrolled in capitated plans. "First Help" is staffed by registered nurses, backed up by a computerized triage data base and by physicians. The Triage Line assists callers to determine whether their health care problems require immediate care, non-urgent services, or can be resolved with self-care, to select a primary care physician or HMO, and to make health care appointments with providers.

- **Department Front Desk.** The Department maintains a central number that is staffed from 8 a.m. to 5 p.m., Monday through Friday. The receptionist at this number receives calls for all parts of the Department and routes them to other Department support staff so they can be appropriately addressed.

- **Department of Human Services Client Advocacy Line.** Staff in the Department of Human Services Client Advocacy Office answer basic questions regarding HCPF programs, typically Medicaid and Indigent Care Program eligibility and benefits. When callers require more in-depth assistance that cannot be provided in that office, the Client Advocacy Office refers callers to the Customer Service Section for resolution or routing to appropriate staff in the Department of Health Care Policy and Financing.

2. Customer Service Accomplishments in FY 96

- **Customer Service Certification** - All Department staff received customer service training and certification. Customer Service Section staff received additional training and staff development throughout the year

- **Customer Service Information Line Re-Design** - The Customer Service Section collaborated with other Department staff to design a new telephone system and operational procedures. Section staff positions were restructured to provide greatly enhanced telephone information and assistance services to customers. Lost calls, call wait times and customer complaints are all radically reduced by the new system. In its first full month of operation, the redesigned Customer Service Line routed and answered the following calls:

Figure 16: Customer Service Line Calls Per Month - September-October 1996

Call Handling Destination	Number of calls received in 1 month	Average calls handled per working day	Percent of all calls handled
Customer Service Staff Operators	5741	250	65%
Medicaid Program Specialists	864	38	10%
Automated Functions, such as: • Recorded Information Menus • Staff Directories • Voice Mail and FAX	2241	97	25%
TOTAL CALLS	**8847**	**385**	**100%**

3. Customer Service Section Management Action Plan for FY 97

GOAL 1: Assist Medicaid clients to understand PCP and capitated health care options and to make appropriate health care choices based on client need and provider availability.

OBJECTIVES

A. Implement and train staff on new automated telephone customer service system. Address staffing needs for operation of the Customer Service Information Line.

B. Update and maintain PCP, specialist, durable medical equipment, pharmacy, hospital, HMO provider and other provider listings in the Customer Service Information Line (formerly called the PCP Hotline) and in the Managed Care Guide.

C. Collaborate with the fiscal agent, HCPF LAN and other key staff to develop on line provider listings that can be updated by Customer Service staff.

D. Reduce caller complaints about wait time and system access problems.

GOAL 2: Facilitate enrollment of physicians as Medicaid Primary Care Physicians (PCP).
OBJECTIVES

A. Include PCP enrollment information in fiscal agent provider mailings.
B. Add to the PCP lists doctors recruited by the Colorado Department of Public Health and Environment's (DPHE) Outreach Program for care provision to pregnant women.
C. Coordinate staffing responsibilities with the Division of Managed Care Contracting to improve efficiency and eliminate duplication.

GOAL 3: Respond effectively to customer service inquiries from clients and providers.
OBJECTIVES:

A. Maintain current and consistent referral and policy information for use by Access Customer Service Line Operators by: automating key HCPF policy and other referral information; documenting and automating the billing tracking system; collecting, coding, documenting and reporting client comments into an on-line, central database.
B. Create, use and analyze the customer service database and generate reports for management on the inquiries, complaints and comments received and resolved; suggest departmental policy change based on client contacts and issues documented.

GOAL 4: Coordinate internal and external customer service functions at state, county, health plan and provider levels of the Colorado Medicaid and Indigent Care programs.
OBJECTIVES

A. Collaborate with Managed Care Contracting, Eligibility and Enrollment, Colorado Department of Human Services' (DHS) Office of Consumer Relations and Fiscal Agent Communications staffs to clarify and enhance procedures and resolve policy issues. Document job duties of all HCPF staff to facilitate callers' information access.
B. Review, monitor and revise the Joint Service Agreements, contracts and other liaison, coordination and communications arrangements with: DHS Office of Consumer Relations; DHS Aging and Adult Services Eligibility Unit; Managed Care Plans; PRO.
C. Research adding phone system functions to assist non-English speaking or hearing-impaired callers. Provide cultural sensitivity/disability awareness training to Customer Service staff.
D. Collaborate with the Eligibility and Enrollment Section to solicit client input on Customer Service activities. Develop automated Medicaid teletips. Define and operationalize a Customer Service Ombudsman role. Define the managed care assignment protocol and develop client centered approach to assignment process.

E. QUALITY ASSURANCE SECTION

The mission of the Quality Assurance Section is to facilitate and monitor adequate access, fiscal accountability, and quality of Medicaid health care services.

1. Quality Assurance Section Functions

The Quality Assurance section provides quality assurance and utilization management for the Medicaid program and operates systems that detect and pursue fraudulent and abusive use of Medicaid resources. The Quality Assurance section was formed to bring together all of the major systems, staff and contractors that collect and analyze utilization, cost, and quality of care data. The section:

- monitors the cost-effectiveness, access, and quality of services provided to enrollees under both fee-for-service and managed care programs;
- identifies incidents of substandard quality of care, inappropriate billing, and fraudulent or abusive practices by providers or clients and refers for appropriate follow-up;
- facilitates health care quality improvement by identifying "best practice" procedures, working collaboratively with health plans, and by sharing information with providers and consumers; and,
- provides information necessary to evaluate programs and services, supports accountability reporting, and identifies changes that will improve the Medicaid program.

The Quality Assurance section collaborates with the Initiatives Office, the Division of Managed Care Contracting and others in the development and implementation of a Department-wide quality management program using population-based review and oversight of managed care organizations. Monitoring of managed care organizations contracted to serve the Medicaid population is conducted by:

- developing and managing the Department's managed care review contract with the Peer Review Organization (PRO- the Colorado Foundation for Medical Care), including collection of client-reported information on disenrollments and complaints;
- on-site monitoring of HMOs' compliance with standards and contractual requirements
- requiring and analyzing health provision data submitted in standard formats;
- using patient satisfaction surveys to gather consumer concerns and opinions;
- developing encounter data systems for analysis; and by
- implementing quality improvement plans with the HMOs.

The Quality Assurance section operates fee-for-service quality assurance and utilization review programs by:

- developing and managing the Department's acute care and long-term contract with the PRO;
- operating several automated utilization management systems;
- collaborating with other state agencies to ensure that providers and facilities are appropriately licensed or certified,
- prospectively evaluating certain services prescribed by physicians and authorizing appropriate treatment ("prior approval" procedures); and by
- detecting and pursuing fraudulent and abusive practices that misuse Department resources or that result in substandard care for program clients.

Quality Assurance functions are carried out through:

- utilization review;
- detection of fraud and abuse;
- contractual standards; and,
- data collection and analysis.

a) Fee-for-Service Utilization Review Programs

The Department conducts both retrospective and prospective utilization review programs designed to ensure that Medicaid clients receive the most appropriate levels of cost-effective health care services provided on a fee-for-service basis. Prospective utilization programs require providers to request review and authorization of their proposed treatment prior to its delivery. Retrospective review examines treatment already provided to assess its appropriateness in terms of frequency, intensity, cost, and overall benefit to the client. The Quality Assurance Section operates these fee-for-service utilization review systems:

- **Drug Utilization Review (DUR) -** The Department contracts with the University of Colorado Health Sciences Center to operate a retrospective Drug Utilization Review program. This program employs a computerized system to review claims for Medicaid prescriptions and notifies physicians of prescribing patterns that may cause adverse drug interactions. The Colorado Medicaid retrospective DUR program achieved national recognition and has been used as a prototype by other state Medicaid agencies.

- **Uniform Long-Term Care Assessment -** The Colorado Medicaid program has been a leader in the development of a system to ensure the most appropriate and cost-effective use of long-term care (LTC) services. The utilization of high-cost nursing facility services is reduced by assuring appropriate access to community-based care. The Department has developed a Uniform Long-Term Care Assessment instrument, the ULTC-100, and a computerized utilization review and data collection system. Under contract to the Department, the peer review organization (PRO) administers the ULTC-100 to determine the need for various levels of care for individual clients, controls admission to 21 LTC programs, collects and analyzes client and program data, and provides management information, technical assistance and training to the Department and to provider staff.

- **Inpatient Hospital Utilization Review -** Inpatient hospital services are reviewed for appropriateness of care and reimbursement. Some procedures, such as organ transplantation, are subject to prior approval procedures. The state's system for utilization review and control is operated under contract by the PRO. PRO and Department staff designed an enhanced acute and ambulatory care utilization review system, implemented in FY 94 and further developed in FY 95. Major system changes, including automated data transfer, profiling, and sampling, shifted the emphasis of inpatient reviews from prospective to retrospective reviews. Hospitals that previously applied to the PRO on a case-by-case basis for prior approval of admissions and length of stay are now at risk for appropriate utilization decisions using their own internal utilization management programs. Based on retrospective review, payment is recovered if it is determined that unnecessary, excessive or inappropriate quality of care was provided, or if the hospital's claim was improperly submitted.

  The new automated utilization control system is more efficient because it allows review resources to be focused on fee-for-service admissions that have the highest likelihood of inappropriate utilization or charges. In FY 96, the measurable savings attributable to this

PRO review of inpatient utilization was more than $1.6 million. The General Fund measurable savings to cost ratio for the PRO acute care in-patient utilization review program was about 3.5 to 1. Substantial additional but "intangible" savings are attributable to the controls on quality of care, utilization and billing that are employed by hospitals in order to comply with the Department's hospital utilization control requirements.[5]

- **Home Health** - The Quality Assurance Section provides technical assistance to Home Health Agencies to assist them in performing their internal utilization review and control functions, and in complying with external requirements.

- **Durable Medical Equipment (DME) and Transportation Services** - Prior authorizations for some DME and transportation services are processed within the Quality Assurance Section. Prior approval procedures are designed to assure that clients have access to appropriate and cost-effective equipment and services.

b) Detection of Fraud and Abuse of Medicaid Resources

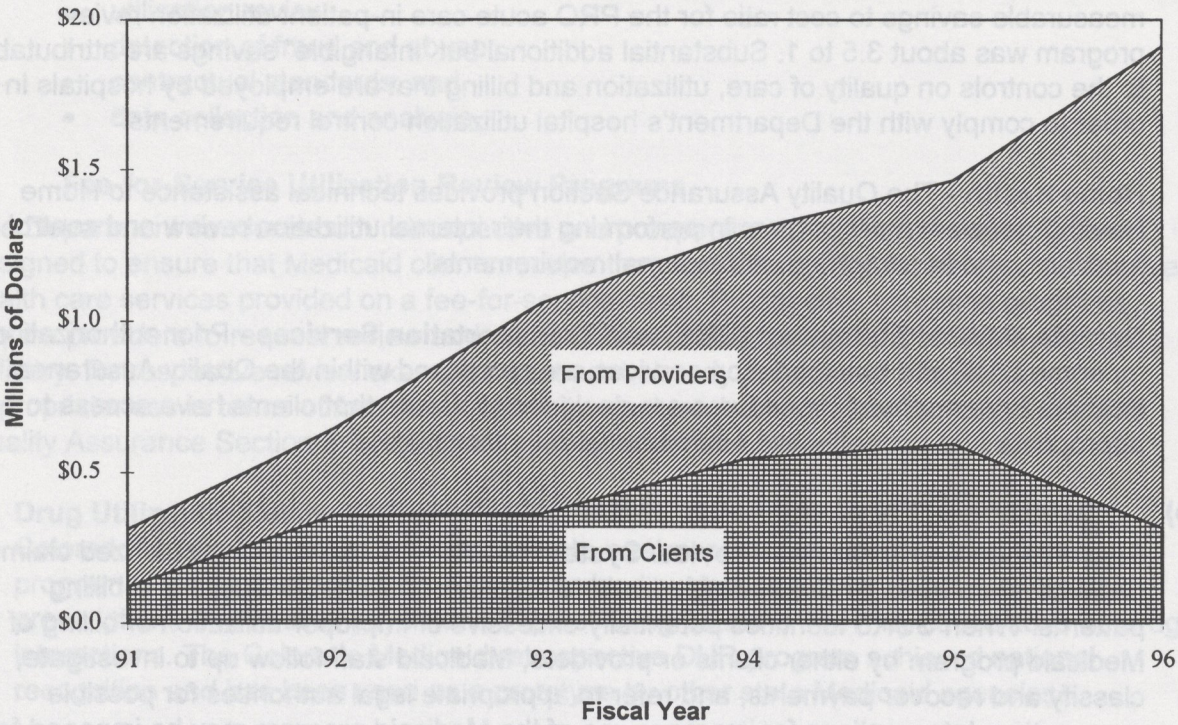
- **Surveillance and Utilization Review System (SURS)** - SURS is a computerized claims review system used by Colorado Medicaid to identify questionable claims and billing patterns. When SURS identifies potentially excessive or improper utilization or billing of the Medicaid program by either clients or providers, Medicaid staff follow up to investigate, classify and recover payments, and refer to appropriate legal authorities for possible prosecution. Interventions for improper use of the Medicaid program may be imposed for fraudulent or abusive practices by clients or providers, and range from education and recovery of over-payments to restriction or exclusion from participation in the program. Civil and criminal sanctions may also be imposed by the State.

  The Quality Assurance section coordinates recovery and sanction activities with the U.S. Department of Health and Human Services Office of the Inspector General and the Medicaid Fraud Control Unit located in the Colorado Attorney General's Office. Recoveries resulting from SURS operations are substantial, as shown in Figure 17. The deterrence of fraudulent or abusive use of Medicaid funds resulting from the presence of the utilization and cost control systems are generally assumed to result in even greater cost avoidance effects than the actual measurable cost recoveries shown.

- **Nursing Facility Audits** - The Section audits nursing facilities' per diem cost reporting and handling of patients' needs trust funds. Nursing facilities report and claim reimbursement for daily patient care on a per diem basis. Auditing helps to ensure that the nursing facilities are reimbursed only for those days that were actually rendered. Nursing facilities are also required to establish trust funds for the patients who desire them. The trust funds permit patients to have access to funds for personal needs not provided by the nursing facility. The audits are conducted to prevent or identify and correct any fraud or mismanagement of trust funds.

[5]Colorado Foundation for Medical Care - Acute Care Annual Report for the Department of Health Care Policy and Financing, 1995.

Figure 17: Recoveries of Inappropriate Payments, FY 91 through FY 96



Notes to Figure 17: The large increase in "Recoveries from Providers" in FY 96 is attributable to global settlements coordinated by the National Association of Medicaid Fraud Control Units.

c) Contract Standards For Medicaid Providers and Health Plans

Qualification standards for providers and contracting health plans are a critical component of the Department's quality assurance program. These standards are necessary to exclude substandard providers from the Medicaid delivery system and enable the Department to measure performance and identify opportunities for quality improvement. The Department requires that all Medicaid providers and facilities hold appropriate state licenses and/or certifications in their area of practice and service delivery and that they remain in good standing with their appropriate licensing entities.

- **Standards for Medicaid providers** - Physicians, nurses, health aides, and therapists who are enrolled as Medicaid providers must be licensed or certified by the Colorado Department of Regulatory Agencies. The Medicaid program fiscal agent routinely assures that such providers have the necessary licenses in good standing before payment for services is made under the fee-for-service and Primary Care Physician programs. Activities to ensure that providers who serve Medicaid clients meet particular program standards are now consolidated in the Quality Assurance section. Contracting managed care plans are held responsible for credentialing of their provider networks. The Department is working to enhance standards for managed care plan provider networks to ensure their qualifications and capacity to serve Medicaid populations.

- **Provider Enrollment and Certification** - This section enrolls providers of Home Health, Alternative Care Facilities, Adult Day Services, Personal Care, and Homemaker services by receiving and reviewing certification recommendations from the Colorado Department

of Public Health and Environment. Providers of Electronic Monitoring, Home Modification, and Non-Medical Transportation services are certified by this Section.

- **Contract Standards for Health Plans -** The Quality Assurance Section participates in the development of contractual standards for Health Maintenance Organizations (HMOs) and, in coordination with the Division of Managed Care Contracting monitors Medicaid-contracting HMOs' compliance with these standards.

d) Collection Of Data About Quality and Access to Care

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

- **Complaint data and patient satisfaction surveys -** The Customer Service and Eligibility and Enrollment sections will coordinate the Department's system to collect data about complaints. Quality Assurance Section staff will contribute to the design and production of reports to be used by program staff to monitor plan and provider performance, and to the design and execution of surveys of enrollee satisfaction with access and quality of care.

- **Quality indicators for managed care -** The Department is currently involved in an effort to identify and collect quality indicators that will enable evaluation of the performance of contracting managed care health plans and Primary Care Physician program providers, and that will supplement assessment of the overall quality of care provided to Medicaid clients. This HEDIS 3.0 project is further described in the section entitled "Office of Public and Private Initiatives."

- **Encounter data -** The Department is developing the capacity to collect and analyze encounter data from all providers and health plans that serve Medicaid clients. Encounter data is the record of patient-specific treatment episodes of care. Currently, the Department collects claims data from fee-for-service providers and calculates utilization rates and costs by eligibility category and service codes. The Quality Assurance Section is involved, with other sections and with the new fiscal agent, in the development of Department and HMO capacity to collect and analyze encounter records. The new fiscal agent will begin collecting encounter data on July 1, 1998.

2. Quality Assurance Accomplishments in FY 96

As evidenced by creation of the Quality Assurance section, the Department is developing and implementing an enhanced quality management program. Traditional quality assurance methods that focus on identifying and eliminating the most substandard or outlier providers or practices are being replaced by a focus on ongoing quality improvement. This includes:

- defining measurable quality and access standards;
- measuring performance against these standards using standardized quality indicators and other measures; and,
- implementing activities to improve quality and access to health care services.

The FY 97 HMO contracts increased accountability of Department contractors. Medicaid HMOs are now required to report data to enable evaluation of performance and identification of targeted quality improvement goals and projects. The Quality Assurance section in FY 96 prepared to implement projects to:

- identify and design a limited number of focused studies and data collection efforts that will evaluate key areas of concern and may lead to development of practice guidelines;
- improve Department data system capacity to enable collection, verification and monitoring of quality and access to services using quality indicators;
- develop an encounter data system that will enable risk adjustment, calculations of indicators and comparisons of managed care with fee-for-service; and,
- collect, analyze and disseminate data needed by the Department to evaluate the cost-effectiveness and improvements in quality of Medicaid managed care.

3. Quality Assurance Management Action Plan FY 97

GOAL 1: Develop a long-range, comprehensive quality monitoring plan.

OBJECTIVES:

A. Develop an efficient, integrated Quality Assurance system for both managed care and fee-for-service delivery systems.
B. Implement an accountable continuous quality improvement philosophy to positively impact the managed care environment and the care it provides to Medicaid members.
C. Propose a more effective role for the PRO based upon a broad study of current activities and Medicaid program needs.
D. Analyze data gathered using a standard format (Health Plan Employer Data Information Set - HEDIS 3.0).
E. Plan, develop, and test an encounter data system for use beginning in FY 98.

GOAL 2: Perform a complete review of all current Prior Authorization processes, examining the efficacy of such activities.

OBJECTIVES:

A. Deliver recommendations for modification or elimination of inappropriate or excessive portions of the Department's utilization review systems.
B. Plan for the expanded use of the fiscal agent and PRO in activities where prior authorizations are warranted.

F. RATE SETTING SECTIONS

The mission of the Provider Rates and Facility Rates Sections is to reimburse health care providers appropriately to ensure that clients have access to quality care, to comply with federal and state law, and to contain program expenditures.

1. Rate-Setting Functions

Two sections within the Department are responsible for rate-setting. The Provider Rates section sets and administers rates for physicians, clinic services, federally qualified health centers, HMOs, medical equipment and supplies, transportation, prescription drugs, reproductive health clinic services, home health agencies, community-based long-term care services providers, and single entry point agencies. The Facility Rates section sets rates for hospitals and nursing facilities.

In setting reimbursement or capitation rates for both institutional and non-institutional providers, the Department aims to:

- reimburse providers sufficiently to allow Medicaid clients appropriate access to necessary services;
- compensate providers in a manner that minimizes cost-shifting onto other payers in the market;
- comply with federal and state law;
- control program expenditures; and,
- increase incentives for providers to furnish high-quality care to high-risk Medicaid clients.

Provider Rates section functions include:

- setting ambulatory care and outpatient provider rates;
- administering the drug rebate program;
- administering the Disproportionate Share Hospital (DSH) program;
- setting HMO rates and performing financial review of HMOs;
- tracking expenditure trends for acute care services and analyzing effects upon costs and rates caused by utilization patterns and changes in the Consumer Price Index; and,
- administering the finances of the Single Entry Point Program.

Facility Rate Section functions include:

- setting inpatient hospital and nursing facility rates;
- responding to facility rate appeals and representing the Department in litigation;
- administering rate adjustments, cost settlements, and billing reconciliations;
- administering contracts for facilities auditing and appraisal services;
- determining emergency care rates; and,
- assisting in and monitoring facility change-of-ownership processes to ensure that the new owners are financially viable and can meet Medicaid quality standards and administrative procedures.

Specific reimbursement methods vary by type of provider, due to variations in the law, customs, and the health care delivery environment. A detailed description of how rates are set can be found in Document #14 in Appendix 1. A summary of rate-setting methods for the major service categories is presented below.

Provider reimbursement functions are designed and carried out as follows:

a) Cost-Based and Non-Cost Based Reimbursement

Provider payment rates are either cost-based or non-cost-based. Cost-based rates are based on the facility's or provider's cost of providing care, and not on the provider's charges for that care. In most cases where private payers are involved, a facility's charges will be higher than its costs. However, large public payers such as Medicaid and Medicare have both the market power and the legislative mandate to pay no higher than cost in certain instances.

Cost-based rates were designed as a cost-saving device. However, there are drawbacks to cost-based reimbursement. Cost-based payment systems usually do not permit the Medicaid program to pay facilities or providers below their claimed costs, nor do they create incentives to lower costs, although such systems do ensure that rates are at least adequate to cover expenses. In addition, cost-based payment methodologies place an extra burden on the Medicaid program of determining whether claimed costs are in fact "reasonable." Federal law is the driving force behind most cost-based reimbursement in the Medicaid program in Colorado, affecting the rates for hospitals, nursing facilities, and federally qualified health centers (FQHCs). Under provisions of the federal Boren amendment, the Department must ensure that it is paying rates to inpatient hospitals and nursing facilities that cover the "reasonable costs of an economic and efficiently-operated facility" (42 U.S.C. 1396(a)(13)(A)). Facilities submit annual cost reports showing facility costs and some measures of utilization (e.g., the number of patients seen per year).

The Department sets non-cost-based rates by taking into consideration not only the costs of products and services, but also other payers' rates, negotiations with providers, and available appropriations. In some instances, the Department uses Medicare fee schedules as a standard to gauge levels of non-cost-based reimbursement. Medicare bases its non-cost-based rates on national, provider-specific data, adjusted for geographic factors such as differential inflation rates. Prior to 1981, federal regulations required that non-cost-based Medicaid payments be equal to or less than Medicare payments for the same services. Since 1981, the only limitation on non-cost-based payments is the assurance that payments for these services are sufficient to enlist enough providers so that Medicaid services are available to clients, at least to the extent that those services are available to the general population (42 CFR 447.204).

b) Rate Study Results

In November, 1994, the Department conducted a study of Medicaid provider payment rates, comparing them to other payers' rates for the same services.[6] The study found that, in several categories of service, an increase in Medicaid's rates would encourage greater provider participation, improve equity across providers, and improve Medicaid clients' access to care. Figure 18 below provides a summary of some of the major types of services covered by Medicaid and indicates whether they are covered under a cost-based or non-cost-based

[6]Medicaid Rate Study - Footnote #26, FY 95 Long Bill, Department of Health Care Policy and Financing, November 1994.

reimbursement mechanism, and includes key findings from the Department's 1994 Rate Study. The table is followed by a more detailed description of the rate-setting methodology for each of the major categories of services.

Figure 18: Reimbursement Methods for Selected Services

Service Type	Type of Reimbursement	Federal or State Mandated?	Key Results of 1994 Rate Study
Outpatient Hospital	Cost-based (72% of audited costs)	State	Outpatient rates are a lower percentage of cost than are inpatient rates. This may discourage the appropriate use of outpatient services.
Physicians Office and other Practitioners	Non-cost-based, set by Department within limits set by the Legislature (RVU - related)[7]	State	Low rates are cited as a barrier to physician participation in Medicaid.
Outpatient Federally-Qualified Health Clinics	Cost-based (100%)	Federal	Rates meet federal standard to pay 100% of reasonable cost.
Community-Based Services	Both Cost-Based and Non-Cost-Based (depends on type of service)	State	In most cases, Medicaid pays between 74% and 90% of private-pay rates
Inpatient Hospital	Cost-based	Federal - Boren	Rates meet federal guidelines for "reasonableness of cost"
Nursing Facility	Cost-based (100%)	Federal - Boren *and* State - State legislative requirements are more prescriptive than Boren.	Rates meet federal guidelines for "reasonableness of cost" and are generally slightly lower than private pay rates
Prescription Drugs	Non-cost-based	Federal *and* State	Rates cover 94% of pharmacists' costs[8]
Colorado Indigent Care Program	Non-cost-based	State	Not discussed in Rate Study

c) Outpatient Hospital Services

Outpatient hospital services are reimbursed at the lower of 72% of cost or charges.[9] This percentage rate is determined by the state. The payment is based upon an estimate of costs, reconciled two to three years later when audited cost reports are available.

[7] Relative Value Units (RVU) are described more fully under the sub-section "Physician and Other Practitioner Office Visits."

[8] "Pharmacy Reimbursement Rates: Their Adequacy and Impact on Medicaid Beneficiaries." Report to Congress, 1994, U.S. Department of Health and Human Services, Health Care Financing Administration, Office of Research and Demonstration. HCFA Publication #03353.

[9] Examples of outpatient hospital services include routine cataract removal or arthroscopic surgery.

d) Physician and Other Practitioner Office Visits

Most physicians' and other practitioners' services are reimbursed using Relative Value Units (RVU) 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. These relative values are multiplied by a conversion factor, which turns them into dollar amounts per procedure. State policy sets the conversion factor.

e) Outpatient Care Provided at Federally Qualified Health Centers

Outpatient care provided at a Federally Qualified Health Center (FQHC) is reimbursed according to federal guidelines. An FQHC is a community-based clinic which receives funding from the U.S. Department of Health and Human Services to serve low-income and indigent patients. The federal government requires Medicaid to reimburse FQHCs at 100% of their "reasonable costs." Federally-Qualified Health Centers receive this level of reimbursement in order to preserve access to health care in medically underserved areas.

f) Community-Based Services

All long-term care services that are not provided in a nursing facility or hospital are called "community-based services." These include services provided in patients' homes, as well as in residential care settings of various types.

The only community-based service that is reimbursed with a cost-based methodology is Adult Day Services. Hospice rates, while not cost-based, are set by federal regulation. The rates for all other services are based on historical rates and available appropriations. The historical rates reflected provider costs at the time they were originally set in the late 1970s to early 1980s, but the link between costs and rates has diminished over time.

Community-based services are reimbursed on a per-hour, per-month, per-mile, per-service, or per-day basis, depending on the type of service. During the period 1983 to 1991, there were no rate increases for most services, and for others, the increases did not meet the costs of providing care. Since that period, rates for various service categories have been raised periodically for inflation and to move towards covering providers' costs.

g) Inpatient Hospital Services

The Department reimburses hospitals for inpatient care using a cost-based methodology, as required by the Boren amendment. Boren requires Medicaid to pay 100% of the "reasonable costs of an economic and efficiently-operated facility." The Department determines, within federal law, "reasonable" costs and "economic and efficiently-operated facility" definitions.

The Department reimburses inpatient hospitals using one of two methods: the prospective payment system (PPS - also known as the Diagnostic-Related Grouping, or DRG method), or a daily rate, which is also referred to as non-PPS. Almost all acute care hospitals are reimbursed under the PPS. Daily rate hospitals are those providing psychiatric care for persons under 21 years of age, rehabilitation, long-term stay, or specialty pediatric care.

h) Nursing Facility Services

The Department reimburses nursing facilities using a cost-based methodology that is set and described in state statute. The federal Boren amendment requires that nursing facilities be reimbursed their reasonable costs of providing care. The state statute produces rates that are probably higher than those required under the Boren amendment.

The Department contracts with the following three types of nursing facilities:

- Class 1: skilled nursing facilities (185 facilities)
- Classes 2 and 4: intermediate care facilities for the mentally retarded (5 facilities)
- Class 5: rehabilitation facilities (1 facility)

For each class, the Department establishes a maximum reasonable payment of each of three categories of cost:

- Direct health care costs (food, medical supplies, etc.)
- Administrative costs
- Fair rental allowance for capital-related assets (physical plant costs)

The Department also made $2.9 million in quality incentive payments to nursing facilities in FY 96. The Resident Quality of Care Incentive Payment Program (ResQUIP) is described further in the Health Care Benefits section.

i) Prescription Drugs

Rate-setting for prescription drugs is regulated at both the state and federal level. By state regulation, rates for prescription drugs are 90% of the Average Wholesale Price (AWP), not to exceed the federal maximum allowable charge, plus a dispensing fee of $4.08 per prescription. The Average Wholesale Price, a national average published by the non-profit company Medical Economics, is the recognized standard upon which drug prices are built. The federal maximum allowable charge is an amount determined by the Health Care Financing Administration for every type of drug for which a multi-source generic substitute exists. There are no federally-defined maximum charges for drugs for which there are no generic substitutes.

Since 1991, Medicaid programs in the United States have participated in the Drug Rebate Program. Prior to 1991, state Medicaid programs were permitted to define a limited list of drugs, known as a drug formulary, for which Medicaid would reimburse pharmacies. Drugs not on the state-approved formulary would not be covered. A 1991 federal law changed this. Medicaid is now required to cover any drug made by any drug manufacturer that contracts with the Health Care Financing Administration. In exchange, those manufacturers agree to rebate an amount based on utilization data for each drug covered under the Medicaid program. In FY 95, the total drug rebate to Colorado Medicaid was $18.2 million.

j) Health Maintenance Organization Rates

Current Department HMO rate-setting methods are based on fee-for-service data and are set individually for each Medicaid eligibility category. Capitation is set at 95% of the average historical per-capita fee-for-service cost of services for each client eligibility category. The 95% cap is required by Department policy, rather than by federal or state mandate. Per capita fee-for-service expenditures by demographic grouping are calculated by dividing the fee-for-service expenditures by the number of fee-for-service eligibles. Costs for services not included in the HMO benefit package (such as nursing facility care and transportation) are excluded

from calculation of the capitation rate. Each year, the Department examines its fee-for-service expenditures to determine capitation rates for the upcoming year.

k) Payments not Directly Related to the Provision of Care to Medicaid Clients

Traditionally, the Medicaid program has been a means not only of providing health care to enrollees, but also of channeling state and federal dollars toward health care programs that serve other low-income people. The Colorado legislature has elected to provide funds to various programs and, in some cases, has channeled those funds through the Medicaid program. This allows the state to draw down federal matching funds for these programs.

- **Family Medicine Residency Training Program Payments -** The primary mission of the Family Medicine Residency Training Programs is to train family physicians and to increase access to care in rural or medically under-served areas. Under this program, run by the University of Colorado Health Sciences Center, all medical residents must complete a one-month rotation in a rural or medically under-served area of Colorado. On July 1, 1994, the state refinanced funds for this program through Medicaid and was thus able to obtain federal matching funds. The General Assembly appropriated about $1.5 million to the program in FY 96. This was matched by federal dollars.

- **Major Teaching Hospital Payments -** The State of Colorado makes payments to University Hospital and Denver General Hospital, both of which serve a high proportion of indigent and Medicaid patients, to defray the cost of training interns and residents. In FY 96, these payments to University Hospital and Denver General, including state General Fund dollars and federal funds, totaled $10.7 and $9.7 million, respectively.

- **Disproportionate Share Hospital (DSH) Payments -** The state makes disproportionate share payments to hospitals that have a high number of Medicaid indigent care clients compared to other hospitals in the state. The payments help defray the cost of treating uninsured, low income patients, thereby supporting the hospitals' financial viability, preserving access to care for Medicaid clients, and reducing cost-shifting onto private payers. Figure 19 below shows total disproportionate share payments made to inpatient hospital providers from FY 92 to FY 96, and projected to be made in the current fiscal year.

Figure 19: Disproportionate Share Payments to Hospitals

($ millions)

FY 92	FY 93	FY 94	FY 95	FY 96	FY 97 (projected)	Total FY 92 - FY 97
$122.7	$358.0	$290.4	$178.0	$105.0	$121.7	$1,176.0

- **Colorado Indigent Care Program (CICP) -** The CICP is designed to reimburse providers of primary and emergency care to low-income Coloradans who do not qualify for Medicaid. Some Indigent Care providers receive Disproportionate Share funds and are reimbursed according to the methodology described above for that program. Non-Disproportionate Share providers can also participate in the Indigent Care Program. These providers are

referred to as "outstate" providers. Annually, the General Assembly appropriates funds for Indigent Care Outstate providers.

2. Rate Setting Accomplishments FY 96

The Facility Reimbursement section implemented the following projects in FY 96:

- An automated nursing facility rate-setting process and more streamlined rules and regulations for administering rates for nursing facilities and hospitals. These changes allow the unit to improve efficiency and contain Medicaid costs. The unit also increased the proportion of rate appeals that are settled informally.

- A major DRG Re-Scaling project. Previous relative weights assigned to the DRGs came from a 1987 study. Changes in technology and improvements in treatment techniques have altered the relative costs of the DRGs. During the 1995 legislative session, the General Assembly appropriated $100,000 to the Department to re-scale or re-weight the DRGs using Medicaid cost data from Colorado. This project was successfully completed by Department and contractor staff. The new system will allow the Department to distribute payments more equitably across hospitals.

- Rate adjustments were made to FY 97 HMO contracts, based upon a study of prior care costs of Medicaid clients. See "Medicaid Risk Adjustment," in the Office of Public and Private Initiatives project descriptions.

- Contracts were let and work begun on a risk-adjusted payment system for HMOs, based on a marker-diagnosis approach. The Department plans to have the diagnosis-based rate system operational for HMO payments in FY 98. The risk adjustment project is described in more detail in the "Office of Public and Private Initiatives" section.

3. Rate Setting Sections' Management Action Plans for FY 97

a) Provider Rates Section

GOAL 1: Effectively administer managed care organization (HMO) rates.

OBJECTIVES

A. Assure that managed care rates comply with federal and state regulations and support access to care and quality of care.
B. Develop data base and reporting system for calculation of managed care acute rates. Obtain and process client specific HMO and FFS utilization and cost data, separate covered capitated and non-capitated services, and recalculate rates.
C. Collaborate with other Department units in developing competitive procurement methods for HMO services.
D. Provide oversight of rate calculations and obtain annual actuarial reviews as required for: PACE program, Mental Health Capitation, Integrated Care & Financing Project and Single Entry Point program.
E. Assure that the various capitated and fee-for-service rate structures are internally consistent and that reimbursements do not overlap.
F. Respond to financial stability issues regarding Managed Care contractors.
G. Assure compliance with the federal requirement for Medicaid to reimburse 100% of reasonable costs to Federally Qualified Health Centers, whether through fee-for-

service or managed care organization rate structures, unless the requirement is waived by the FQHC.

GOAL 2: Administer the Drug Rebate Program.
OBJECTIVES

A. Monitor proposed federal Drug Rebate regulations and implement as required. Modify financial reporting, respond to drug claims audits, develop an administrative appeal process for drug manufactures and meet dispute resolution requirements. Increase staffing and upgrade equipment as necessary.
B. Streamline drug rebate transactions including automating systems, installing "lockbox" deposits, improving check security, expediting routing and expediting deposits. Institute more effective procedures for dispute resolution, receivables and interest billing.

GOAL 3: Develop Options for Long-Term Care (OLTC - also known as Single Entry Point) agency reimbursement systems.
OBJECTIVES

A. Develop fee systems to support screening and deinstitutionalization capacities at Single Entry Point Agencies for Medicaid-eligible and potentially eligible clients.
B. Streamline, integrate and improve community-based care reimbursement systems including: rate structure incentives for care resource development; assumption of commercial LTC insurance premiums for families at risk of default; accurate OLTC/community care client counts; OLTC inflationary rate adjustments.

GOAL 4: Administer Disproportionate Share Hospital (DSH) payment system.
OBJECTIVES

A. Develop and coordinate an advisory committee to analyze the current DSH payment methods and processes and recommend improvements.
B. Identify DSH reimbursement components in HMO rate payments; develop and implement methods to exclude DSH from HMO rates and pay separately.
C. Identify and explore efficient and effective methods for continuing DSH payment support to provision of care for low income Coloradans.

GOAL 5: Administer and monitor provider rates and expenditures.
OBJECTIVES

A. Develop rate adjustments within available appropriations to meet competing requirements of programs and to maintain or improve access to and quality of care.
B. Consult with stakeholders, and develop and apply cost containment measures for Federally Qualified Health Centers (FQHC).
C. Inventory and develop cost containment measures available to meet budget constraints.

b) Facility Rates Section

GOAL 1: Set rates for Hospitals and Nursing Facilities that reimburse the costs of efficiently and economically operated facilities in accordance with the provisions of the state statutes, federal Medicaid requirements, and Department regulations.

OBJECTIVES

A. Review rate setting methodologies to determine if rates are sufficient to satisfy Boren amendment requirements, and to ensure that only those costs that are reasonable, necessary and patient-related are reimbursed.

B. Let and manage audit, appraisal and data management contract components including: hospital and nursing facility costs; property appraisals of nursing facilities; fiscal agent retroactive rate adjustments and recoveries of overpayments.

C. Analyze alternative rate setting options, proposed and implemented changes in federal and state reimbursement laws and regulations and their effects on the state, providers, and the public. Conduct surveys of census information, private pay, and owner-administrator salaries for use in auditing, rate setting, and cost ceiling calculations.

D. Manage hospital reimbursement system components including: allowable costs and rate setting methodologies for facilities and medically indigent program; hospital rate rebasing and DRG reweighting; conversion of specialty, teaching, and rehabilitation hospitals to prospective payment system and DRG payment methodology. Improve timeliness and efficiency of hospital rate setting and contracting processes.

GOAL 2: Respond to provider appeals and conduct informal reconsideration process.

OBJECTIVES

A. Staff the provider appeal litigation process by providing documents, tracking litigation, negotiating with attorneys, and serving as witnesses in rate appeals.

B. Review rate appeals, research cases with auditors, adjust rates by stipulation, and negotiate settlements to avoid unnecessary litigation. Determine and convey the Department's policy, positions and decisions.

GOAL 3: Improve effectiveness and efficiency of rate setting and public information functions.

OBJECTIVES

A. Provide accurate and timely information to providers, consumers, agencies and other interested parties about HCPF's facility rates and rate setting methodology, in meetings, by telephone and written instructions to providers, agencies, outside research groups and the public. Develop response systems to improve customer support, response time and quality of information products.

B. Identify and employ new technology and computer networks with contractors, auditors and the fiscal agent to increase efficiency of rate setting, reimbursement processing, retroactive adjustments and office functions. Train staff and agents.

C. Provide expert support to new fiscal agent and Medicaid Management Information System (MMIS) conversion; identify section claims processing needs and requirements to fiscal agent and management.

G. THIRD PARTY RESOURCES

The mission of the Third Party Resource Section is to extend public purchasing power by pursuing third party payment of medical costs for Medicaid eligible persons.

1. Third Party Resources Functions

The Third Party Resources Section pursues alternate payment sources to "recover" costs for services for which Medicaid is not liable. As the "payer of last resort," Medicaid will not pay for health care services for which any other entity is responsible (10 CCR 2505-10). Applicants for Medicaid coverage are required to provide information on any resources they have which may pay for health care services.

Other payer sources that are liable for payment prior to Medicaid include, but are not limited to, Medicare, commercial health insurance policies or HMO plans that are a benefit of employment or retirement, and 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, and the Department of Labor and Employment.

Third Party cost avoidance and post-payment programs administered by the Third Party Resources section include:

- cost avoidance through obtaining payment by non-Medicaid sources;
- the health insurance buy-in program;
- tort/casualty recovery;
- estate recovery;
- prescription drug and federally required recoveries; and,
- credits of Medicaid payments made to providers when another third party is identified as the primary payer.

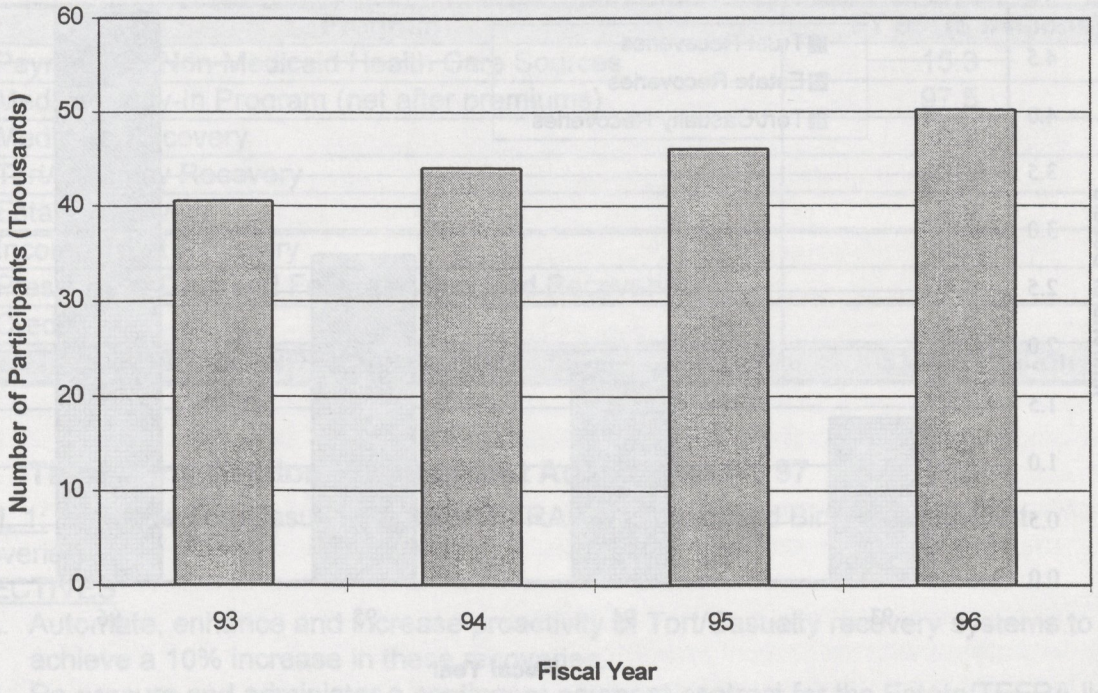
a) Cost Avoidance Through Payment by Non-Medicaid Health Care Sources

An average of 13,178 clients per month have their claims paid by other sources of health coverage, such as private health care insurance, that were identified and pursued by the Third Party Resource Section systems and staff work. These cost avoidance activities saved Colorado over $15.25 million in FY 96.

b) Health Insurance Buy-In Program

In order to reduce Medicaid costs for covered persons with health insurance eligibility, the State pays monthly premiums to enroll (or "buy in") Medicaid clients in Medicare or in 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. As shown in Figure 20, during FY 96, approximately 50,000 Medicaid clients per month had Medicare or private health insurance coverage purchased by the State. This is an 8% increase in buy-in clients over FY 95. In FY 96, $228,124 in health insurance buy-in premiums were paid for Medicaid clients, and $125.6 million in health care costs were paid under the purchased coverage that would otherwise have been a Medicaid program liability. In addition, $165,394 was recovered from Medicare after Medicaid had paid but Medicare was found to be the primary insurer.

Figure 20: Medicare/Health Insurance Buy-In Program



c) Tort/Casualty Recovery

The Medicaid program attempts recovery of payment from third party insurers in the case of auto, accident, or homeowners policies, or other tort litigation. State staff manage tort/casualty recovery activities. These include recoveries related to accidents or wrongful injury settlements. System enhancements made during FY 96 helped boost recoveries to $2.3 million dollars, up 19.6% over FY 95. Figure 21 shows tort/casualty recoveries in fiscal years 93 through 96.

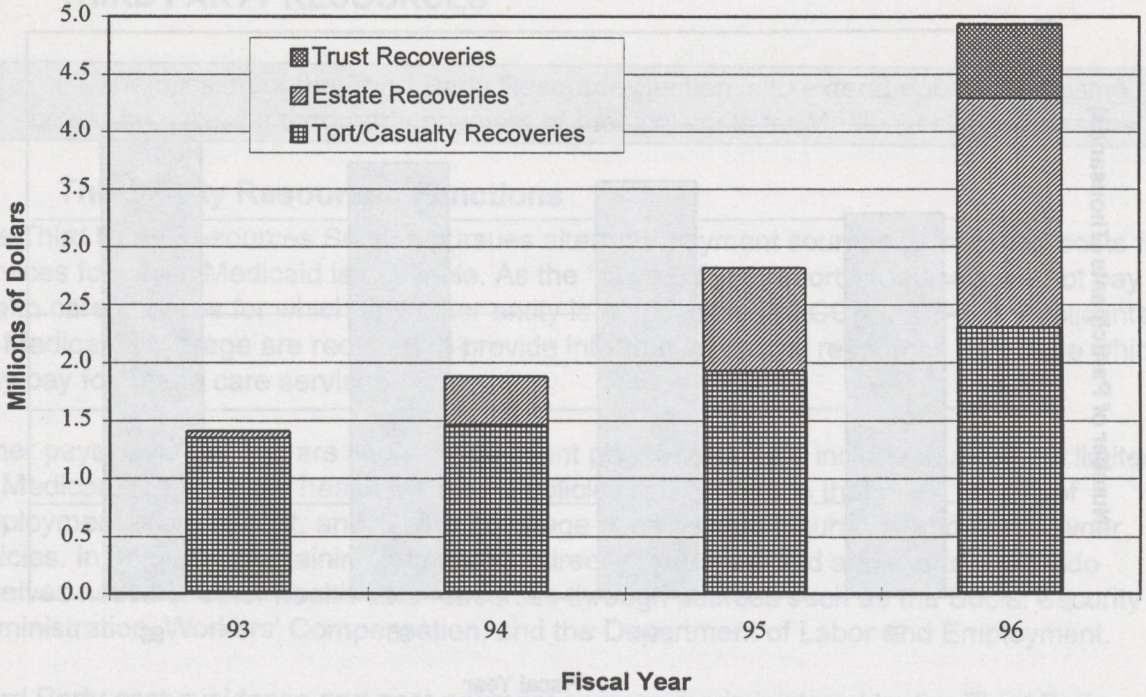
d) Estate Recovery

The Estate Recovery program, operated by a contractor under supervision of the Medicaid program, recovers funds from estates and places Tax Equity and Financial Responsibility Act of 1992 (TEFRA) liens on real property held by Medicaid clients in nursing facilities. As shown in Figure 21, total estate recoveries during the third full year of operations were $1,989,421, up 125% compared to FY 95 recoveries.

e) Income Trust Recovery

Income trusts provide a mechanism for individuals to pay a portion of their nursing home costs, while the Medicaid program assumes remaining costs and the state is beneficiary of those trust monies when the trust closes. As shows in Figure 21, $648,821 was recovered in FY 96. Changes to the Department's trust rules were made to collect more care costs from trusts during the time that care is being provided, which will result in earlier recoveries of Medicaid-paid care costs (and less recovery after trust closure). The Third Party Resources Section assumed administration of closing and performing accounting for these trusts from the Quality Assurance Section, in FY 96. Historical data on income trust recovery is not available.

Figure 21: Tort/Casualty, Estate and Trust Recoveries



f) Prescription Drug and Federally Required Recoveries

The Third Party Resources Section coordinates the Medicaid Fiscal Agent (currently, Blue Cross-Blue Shield of Colorado) post-payment recovery activities for prescription drug coverage and manages federally required recoveries of medical coverage including prenatal care and court ordered medical support. The prescription drug recovery efforts by the fiscal agent ended in February 1996 and were replaced with the more cost effective method of Cost-Avoidance. This makes prescription benefits consistent with all other medical benefits. Recoveries collected by the Fiscal Agent for FY 96 amounted to $0.5 million dollars.

g) Credits

The State retracts the value of Medicaid-paid claims if a third party is later identified as a primary payer. These recoveries, known as credits, are collected from providers when other health coverage is discovered subsequent to payment by the Medicaid program. In FY 96, credits saved the state $1.58 million.

2. Third Party Resources Section FY 96 Accomplishments

- **Recoveries** - Third Party Resources operated and expanded resource recovery programs that recovered $119.91 million in FY 96. Figure 22 shows that cost-avoidance activities saved the state $112.7 million in FY 96. Recoveries and credits yielded $7.2 million.

- **Birth-Related Cost Recovery Program** - This new resource recovery program will collect from non-custodial parents repayment of public monies expended for birth-related medical costs. The Section obtained federal waivers and developed regulations and program procedures to implement this legislation.

Figure 22: Summary: Third Party Cost Avoidance and Post-Payment Recovery

Program	FY 96 ($ millions)
Payment by Non-Medicaid Health Care Sources	15.3
Medicaid Buy-In Program (net after premiums)	97.5
Medicare Recovery	0.2
Tort/Casualty Recovery	2.3
Estate Recovery	2.0
Income Trust Recovery	0.7
Prescription Drug and Federally Required Recoveries	0.5
Credits	1.6
TOTAL AVOIDED AND RECOVERED COSTS	**$119.9 million**

3. Third Party Section Management Action Plan FY 97

GOAL 1: Increase Tort/Casualty, Estate/TEFRA Lien, Trust, and Birth Related Cost Recoveries.

OBJECTIVES

A. Automate, enhance and increase proactivity of Tort/Casualty recovery systems to achieve a 10% increase in these recoveries.
B. Re-procure and administer a contingent payment contract for the Estate/TEFRA lien program to recover over $2 million per year.
C. Audit and track (LTC) Income Trust recoveries, pursuant to regulatory changes that cause increased monthly Medicaid revenues and reduced trust balances. Streamline and speed up trust closure recoveries.
D. In collaboration with Child Support Enforcement units, initiate collections from non-custodial parents for repayment of public monies expended for birth related medical costs, and more promptly identify non-custodial parents.

GOAL 2: Administer and enhance Health Insurance cost avoidance activities.

OBJECTIVES

A. Automate a Third Party Liability (TPL) subsystem to link County Social Services, Medicaid Fiscal Agent and State TPR units through the Client Oriented Information Network (COIN) for reporting and verification of health insurance coverage.
B. Research cost avoidance through recoveries of long term care insurance benefits.
C. Develop mechanisms for avoiding costs of care available to Medicaid clients under third party managed care plans, and for assuming client copayments to those plans.
D. Maintain, enhance and streamline methods of identifying and processing potential Health Insurance Buy In (HIBI) clients.
E. Procure contract data matching and other cost avoidance and recovery services.
F. Research the potential of reinsuring Medicaid fee for service and managed care.
G. Determine the feasibility of group purchase of Medicare supplemental insurance for dual eligible (Medicare-Medicaid) clients, and associated reductions in pharmacy and other costs.
H. Recommend legislation to make Medicaid clients financially responsible for third party reimbursements rendered uncollectible by Medicaid because of failure of the client to meet applicable third party insurance requirements.

H. INFORMATION SYSTEMS SECTION

The mission of the Information System Section is to ensure access to Medicaid services by supplying timely and accurate eligibility information and reimbursements to Medicaid Providers, and by ensuring that state and federal regulatory and fiscal requirements are met.

1. Information Systems Section Functions

The Information Systems section administers the Department's fiscal agent contract for health care claims processing. The section manages health care program information and oversees systems operations and development by the fiscal agent. The section applies total quality management in the evaluation, design, implementation and monitoring of electronic data processing systems and administrative processes.

The Information Systems section functions are to:

- maintain and enhance the Medicaid Management Information System (MMIS);
- maintain and enhance the Client Oriented Information Network (COIN) system components that support Office of Medical Assistance programs;
- ensure administrative and operational integrity of the MMIS;
- ensure the systems integrity of the MMIS;
- maintain oversight of COIN system integrity;
- ensure continuity of maximum federal financial participation; and,
- support federal and other state agency mandates and system requirements.

The Information Systems section:

- initiates, reviews and approves HCPF modifications to the MMIS;
- Initiates, reviews and approves HCPF modifications to COIN;
- oversees fiscal agent administrative operation of the MMIS to ensure State Plan and contract compliance;
- coordinates HCPF direction of fiscal agent administrative activities to ensure continuity of contract requirements;
- develops advanced planning document (APD) requests for ninety percent federal funding for MMIS enhancement efforts;
- manages MMIS Reprocurement including developing Request for Proposals, evaluating submitted proposals, and implementing selected vendor's systems, and,
- implements HCPF business systems changes needed to comply with federal and state agency requirements.

The Information Systems section manages the current fiscal agent contract with Blue Cross Blue Shield of Colorado that includes operation and development of the Medicaid Management Information System (MMIS). The section oversees the Medicaid fiscal agent's performance in the following service areas:

- operation, enhancement and maintenance of the automated claims processing system (MMIS);
- provider enrollment, training and communications;
- claims resolution and reimbursement; and,
- communications, coordination and problem resolution with program and financing co-operators including:

- Colorado Financial Reporting System (COFRS)
- Social Security Administration (SSA)
- U.S. Department of Health and Human Services, Health Care Financing Administration (Medicare and Medicaid programs)
- Colorado Department of Public Health and Environment
- Colorado Department of Labor and Employment
- Colorado Department of Human Services
- University of Colorado Health Sciences Center.

2. Information Systems Section Accomplishments in FY 96

- **MMIS Reprocurement** - HCFA requires the state to reprocure (solicit competitive bids for) the fiscal agent contract periodically. In FY 96, the Information Systems Section issued a Request for Proposals (RFP) for replacement, enhancement and operation of a new MMIS by July 1,1998. The Section obtained 90% federal funding for the implementation costs ($15.4 million) for the new MMIS. The new MMIS will support multiple programs including managed care and fee-for-service Medicaid, CICP, and any new programs of coverage expansion to uninsured or underinsured Coloradans.

- **MMIS Operations and Development** - MMIS paid 9,030,458 Medicaid claims for 274,536 Medicaid clients in FY 96. The Health Care Information Systems section monitors ongoing claims processing functions to ensure that claims are paid according to the Medicaid State Plan. The section also developed and oversaw the fiscal agent's implementation of over 12,000 hours of MMIS system enhancements (changes and improvements), including:
  - HMO Expansion and Mental Health Capitation - Plan-specific rates and reporting systems were automated for future HMO expansion. Enrollments in Medicaid physical health programs expanded to over 73,000. 1,966,578 Mental health capitation payments were processed in FY 96.
  - Automated Medical Payment System (AMPS) - 7,215,037 transactions were processed through AMPS in FY 96, with a reduction in the rejected claim percentage (denial/ error rate) from 14.25% in FY 95 with the old paper claims system to 5.4% in FY 96 with the new electronic claims. Initial claims rejections (errors) were also down, to only 17.1% of claims.
  - Electronic Funds Transfer (EFT) - Approximately 2,000 providers used EFT as of June 1996. For these providers, EFT and AMP systems changes reduced the time from provider claim filing to reimbursement from 20-30 days to 7-12 days.
  - Colorado Medicaid Eligibility Response System (CMERS) - CMERS provides instant automated eligibility verification to any Medicaid provider.
  - Home Health Reporting to allow distinguishing regular home health expenditures from waiver program home health service expenditures.
  - Children's Habilitation Services Program implemented as a separate program for expenditure tracking.
  - These system modifications were designed in FY 96 to be installed in FY 97:
    - Diagnostic Related Grouping (DRG) expansion for specialty services
    - Prospective Drug Utilization Review (ProDUR) enhancements
    - Minimum Support Waiver enhancements to allow extension of HCBS services to persons with Developmental Disabilities

3. Information Systems Section Management Action Plan FY 97

GOAL 1: Manage the implementation of a new Medicaid Management Information System (MMIS).

OBJECTIVES

A. Complete analysis of Medicaid Program requirements to be met by the new system.
B. Complete detailed systems specifications for the modification of the new system to reflect Colorado Medicaid and Indigent Care Program requirements.
C. Design and complete acceptance testing to ensure that all Colorado requirements have been incorporated in the new MMIS.
D. Complete conversion specifications for all files.
E. Manage conversion projects, contracts, staffing and budgets.

GOAL 2: Provide automated data support for quality assurance.

OBJECTIVES

A. Develop encounter data specifications to measure quality of managed care.
B. Develop prior authorization requirements for the MMIS.

GOAL 3: Support access to Managed Care.

OBJECTIVES

A. Ensure COIN processes and MMIS HMO assignment processes are operational.
B. Provide data on SSI, Presumptively Eligible, and Informed Access clients for managed care options.
C. Implement automated HMO assignment and ability to generate partial capitation for mid-month eligibility changes.
D. Process voluntary PCP conversions associated with new HMO contracts.
E. Provide PCP reporting over the Internet.

GOAL 4: Ensure continuity of service in the current MMIS and complete all system enhancements scheduled by the end of FY 97.

OBJECTIVES

A. Ensure timely and accurate Medicaid eligibility identification for Medicaid providers.
B. Complete installation of daily eligibility update capability.
C. Collaborate with DHS and systems contractors to implement plastic Medicaid eligibility cards (MAC/EBT).
D. Coordinate systems interfaces among CFMC, Foster Care, Single Entry Point, Presumptive Eligibility, Informed Access and the MMIS.
E. Install DRG rebasing and expansion for all inpatient services.
F. Incorporate encounter data into MMIS that can support comparison of fee-for-service and managed care data.
G. Bring CICP data into the MMIS claims data base in preparation for assumption of CICP claims processing by the start of the new MMIS in July 1998.

III. Office of Public and Private Initiatives

The mission of the Office of Public and Private Initiatives is to facilitate innovations in Colorado's health care system that improve the access, quality and cost-effectiveness of health care services for all Coloradans.

1. Initiatives Office Functions

The Office of Public and Private Initiatives analyzes, develops, and implements health care system innovations that improve access, quality and effectiveness of health care services for all Coloradans. The Initiatives Office works in partnership and shares information with private and public sector individuals and entities.

The projects of the Initiatives Office are in five areas:

- insurance coverage expansion;
- purchasing reform in the public and private sectors;
- improvements in health system accountability;
- health care information and data dissemination; and,
- development of new health care delivery systems to reduce cost and/or improve accessibility and quality.

a) Insurance Coverage Expansion

According to a 1995 report from the Office of Public and Private Initiatives, about 540,000 Coloradans (16%) were uninsured in the fall of 1993. (See Figure 23.) Nearly one in four Coloradans (22%) did not have health insurance for some time during the year prior to the survey. More than one quarter (28%) of the uninsured in Colorado were children under the age of 18.

The overwhelming majority of uninsured Coloradans are members of working families, most of whom have incomes below 200 percent of the federal poverty level ($30,300 for a family of four in 1995). (See Figure 24.) Nearly three-quarters of Colorado's uninsured adults are employed (74%), and more than half of uninsured working adults (58%) have family incomes under 200 percent of poverty. Ninety-one percent of the uninsured children in the state are in families with at least one working parent, and sixty-one percent are in working families with incomes under 200 percent of poverty.

Initiatives Office staff conduct a variety of projects designed to reduce the number of uninsured Coloradans. These activities are described below in this sub-section, and under "Initiatives Office Accomplishments FY 96," and "Management Action Plan 97."

Figure 23: Sources of Insurance Coverage Among Colorado's Non-Institutionalized Population, 1993 N= 3,481,551

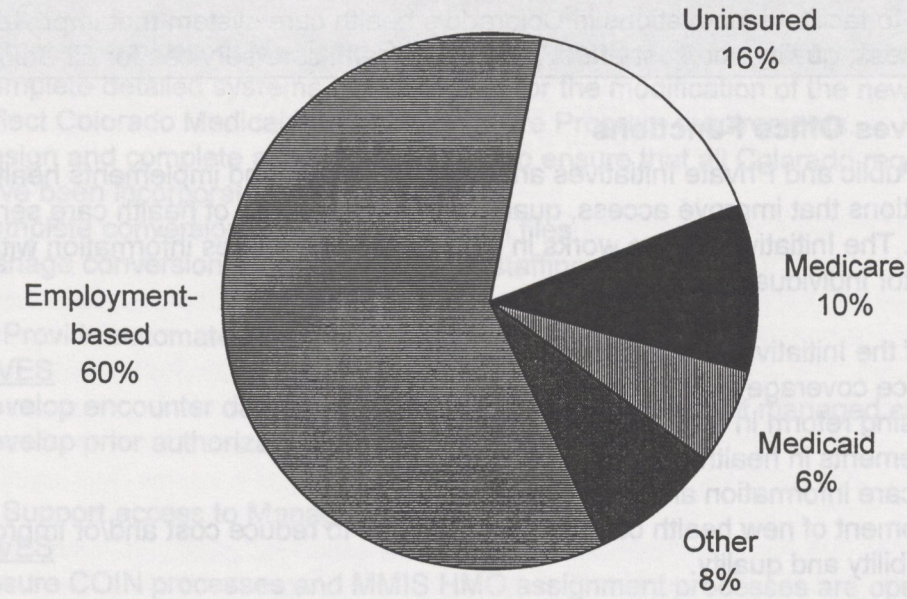
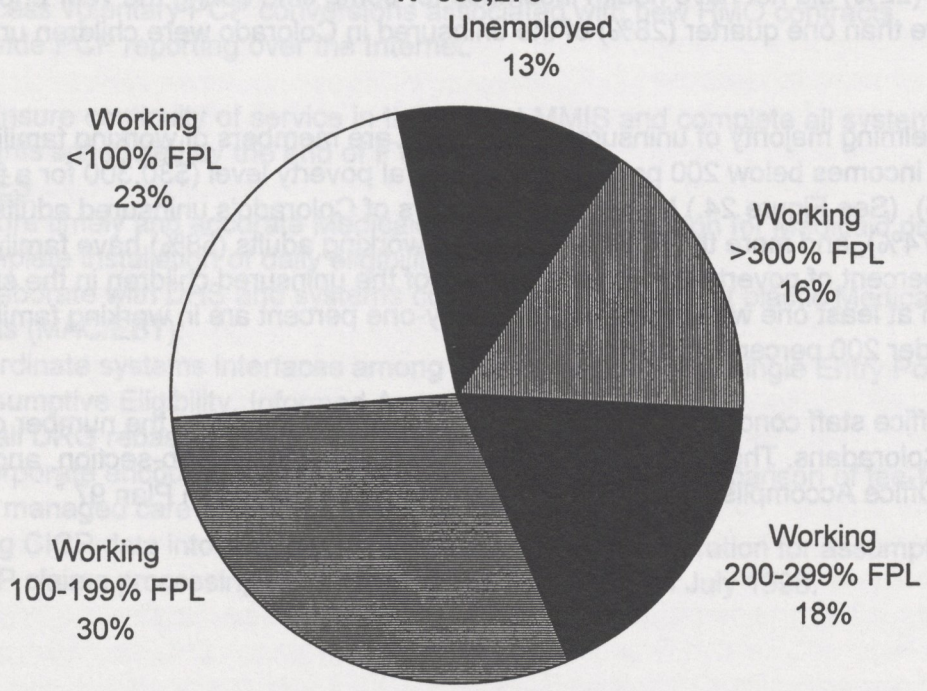


Figure 24: Uninsured Under Age 65 by their Family's Employment Status and Income, 1993 N=538,275



Source [both charts]: RAND Corporation Survey funded by the Robert Wood Johnson Foundation

b) Purchasing Reform in the Public and Private Sectors

During the past several years, the health care reform debate in the United States has focused on large-group insurance purchasing strategies. Economic theory and the experience of large purchasing pools suggest that there are substantial benefits to large-group purchasing of health insurance in the areas of administrative savings, enrollee choice of plans, greater bargaining leverage, and improved data-collection capacities. The Initiatives Office participates in several projects that address both public and private sector insurance purchasing strategies and attempt to capitalize on the benefits of large-group purchasing.

- **Private Sector Health Care Coverage Cooperatives.** In June of 1994, Governor Romer signed into law House Bill 94-1193, creating health care coverage cooperatives in the private sector. The law, backed by a broad coalition of employers and consumers, allows employers to achieve economies of scale and to increase their negotiating power with health plans by joining together to purchase insurance coverage. The law is primarily designed to give small employers increased access to competitive premium rates, although cooperatives have the option of opening membership to employers of all sizes.

  The Initiatives Office is responsible for certifying health care coverage cooperatives to protect consumers against risk skimming and cost shifting. The Initiatives Office also provides technical assistance to certified or emerging cooperatives. In August 1995, the Department awarded a certificate of authority to the first health care coverage cooperative, The Alliance, which offers a choice of four HMOs to employers of all sizes throughout the state. As of July 1996, The Alliance covered more than 11,000 lives.

- **The Public Employers Insurance Purchasing Project.** In House Bill 94-1317, the General Assembly requested a report from the Department regarding health benefits purchasing for state employees. The January, 1995 report examined the health benefits purchasing functions of six state purchasers: the University of Colorado, the State Colleges Insurance Consortium, the Colorado Community College and Occupational Education System, Colorado State University, the Colorado Department of Personnel, and the Public Employees' Retirement Association. The report found that these purchasers perform many of the same functions in providing health benefits to employees and retirees and that the state could achieve savings and greater enrollee choice through consolidated purchasing. As a result of the report, the Initiatives Office created the Public Employers Insurance Purchasing Project to develop options for voluntary coordination or consolidation of health benefits purchasing among interested public employers.

- **Medicaid HMO Risk Adjustment.** Historically, Medicaid has paid HMOs the same amount per month for each person in a given eligibility category. These payments were based on the average fee-for-service claims for persons in that category. In reality, there is a great deal of variation in the utilization of services among individuals within each category. Health plans know that this variation exists and may attempt to attract those individuals they believe will use fewer than average resources. "Risk adjustment" allows the Department to pay plans more for individuals who are likely to consume a great deal of resources and less for individuals likely to consume few resources.

  The Department is now contracting with Dr. Richard Kronick, a consultant who is working with five other states, to develop risk-adjusted Medicaid capitated rates. Dr. Kronick's system, the Disability Payment System, groups 2,400 ICD-9 diagnosis codes that are

associated with elevated future costs into 18 major categories. These categories are associated with either major body systems, such as cardiovascular, skeletal, or central nervous, or specific types of illness or disability such as diabetes, cancer or mental retardation. By adjusting capitated rates paid to HMOs according to diagnoses of their enrolled members, the Department is encouraging plans to develop networks and systems that meet the needs of higher-cost Medicaid clients. If this project is successful, the techniques developed for Medicaid could be applied to other group purchasing environments.

- **Competitive Procurement and Selective Contracting.** The Department is developing and pilot-testing various market-based models and methods of assuring accountability for costs, access, and quality of care by competitively setting rates, establishing provider qualifications, awarding and managing contracts, and measuring performance. Current projects include competitive procurement of organ transplant services, oxygen in metro-area nursing homes, and drugs in nursing homes. These techniques are being evaluated and developed for use in competitive procurement of HMO services.

c) Improvements in Health System Accountability

As innovative purchasing strategies make Colorado's health care market more price-competitive, consumers and purchasers want to ensure that price competition does not come at the expense of quality and accessibility. The Department of Health Care Policy and Financing (Initiatives Office and other HCPF staff), the Division of Insurance, and the Department of Public Health and Environment are working together to design coordinated quality of care standards, performance measures, and monitoring for health plans. The goals of this effort are:

- to eliminate redundancy in state agency regulatory efforts;
- to maximize the use of state resources;
- to build on prevailing private sector structures;
- to reduce health plan compliance costs by streamlining quality reporting requirements; and,
- to incorporate efficient and effective quality monitoring methods to ensure consumer protection.

These goals will be met through revision of HMO licensure regulations, enhanced Medicaid managed care contract standards, data collection, and coordinated monitoring efforts.

d) Health Care Information and Data Dissemination

The Initiatives Office informs the public about health care reform proposals and initiatives. The public includes employers, consumers, health carriers and plans, providers, research groups, policy-makers in other states, the General Assembly, the Governor, and other state and federal agencies. Among the techniques used to keep the public informed about health care proposals and initiatives are:

- reports and a semi-annual newsletter on health care issues;
- briefings and presentations to various public and private groups;
- participation on health care task forces and committees;
- staffing health data collection, analysis and dissemination initiatives; and,
- answering information requests.

Initiatives Office information dissemination activities include the following projects: (For publication citations see Appendix 1.)

- **State Health Expenditure Account** - The State Health Expenditure Account tracks the flow of funds in the health care market from payers to providers, to enable assessment of the market share of various delivery systems, the source of payment for medical services, and the fluctuations in expenditure growth in various sectors of the health care industry.

- **Public/Private Partnership for Health Data** - The Department, led by the Initiatives Office, is working with the Colorado Business Group on Health (a large-employer coalition), The Alliance (a small-employer coalition), and the National Committee on Quality Assurance to implement a collaborative project to collect, analyze, and report on comparative health plan quality data. As its first project, this Data Partnership will collect HEDIS 3.0 measures, producing an initial report by the summer of 1997.[10] The Department plans to use information produced by the Partnership to make purchasing and contracting decisions, inform Medicaid clients, and foster market-wide quality improvement.

- **Data Analysis on the Uninsured and Under-insured** - Initiatives Office staff are developing a variety of mechanisms for tracking the impact of lack of insurance and under-insurance on Colorado's health care market. Staff use data from the U.S. Bureau of the Census - Current Population Survey, the 1993 RAND survey of family and employer health insurance (see "Insurance Coverage Expansion" above) and other sources to produce estimates of the number of uninsured and under-insured Coloradans, the sources of care for such individuals, and the magnitude of the cost-shifting burden borne by privately-insured groups and government programs. Such estimates can assist policy-makers in evaluating proposals to expand coverage to the uninsured or to introduce various insurance reform measures.

e) Development of New Health Care Delivery Systems

In addition to providing research and policy support to the Department, Initiatives Office staff develop, administer, or facilitate improvements in the health care delivery system. These new methods and systems often serve as pilots for wider Medicaid program innovations.

- **Integrated Care and Financing Project.** The Integrated Care and Financing Project, funded under a Robert Wood Johnson Foundation grant, integrates acute and long-term care services and the financial reimbursement mechanisms for those services for individuals eligible for both Medicaid and Medicare. Under the project, acute and long-term

[10] "HEDIS" refers to the Healthplan Employer Data and Information Set developed by the National Committee on Quality Assurance. It is a standardized set of quality and access measurements that purchasers can use to compare health plans to one another. An increasing number of health care payers are requiring HEDIS measures from health plans.

care services in Mesa County will be financed through, managed, and provided by Rocky Mountain HMO, in cooperation with the Integrated Care Project and the local long-term care Single Entry Point agency. Expansion of the model to other parts of the state will be dependent on evaluation of the initial demonstration site experience.

- **Brain Injury Program.** The Brain Injury program offers an intensive, cost-effective, community-based care alternative to individuals with acquired and traumatic brain injuries who would otherwise remain hospitalized. This Medicaid waiver program is a blend of traditional medical model rehabilitation and non-medical community-based care focused on functional rehabilitation. The goal of the program is to return individuals to more productive, independent lifestyles in the community and reduce the long-term social and economic impact of the injury.

- **Residential Treatment Centers.** In the early 1990s, out-of-home placement child care providers and child advocates approached the state with concerns regarding the limited availability of Residential Child Care Facility beds for Colorado's foster-care children. The lack of beds was attributed to low reimbursement rates for these services. Prior to FY 95, these services were a General Fund, state-only benefit and did not receive federal matching funds through the Medicaid program. The Residential Treatment Center project brings Medicaid funds, including federal matching dollars, into the system to pay for mental health treatment for children in these facilities. Since FY 95, 43 facilities with 885 foster care children were refinanced by the project.

- **Home Health Aide Pilot Program.** Because current federal Medicaid regulations require home health services to be provided in a client's home, some active disabled clients are prevented from leaving their homes for school, work, or other activities. In addition, state law concerning delegation of specific tasks from nurses to home health aides has changed. Medicaid has also changed its payment incentives to facilitate this delegation. Under the Home Health Aide Pilot program, home health aides, rather than registered nurses, will provide care in alternative settings, permitting disabled clients to move about the community without foregoing necessary care. Although it can be more costly to provide care in settings outside the home, costs will be offset by the use of nurse-supervised home health aides for delegated tasks, rather than the use of nurses. The Initiatives Office hopes to begin implementation of the program in the Spring of 1997, once the Health Care Financing Administration has granted the necessary waiver of Medicaid regulations.

- **Consumer-Directed Attendant Support Program.** In 1996, the General Assembly passed a law calling for the development of a pilot program to test more effective and efficient ways of delivering attendant support services to disabled individuals. The pilot program will allow Medicaid clients to employ, train, and directly pay personal care providers of their choosing and to receive care in locations other than the home. The Initiatives Office plans to submit a waiver request to the federal Health Care Financing Administration (HCFA) in February, 1997, to permit enrollment of an estimated 150 clients in the program. The earliest projected enrollment date is July 1, 1997. The pilot is expected to run for three years.

- **School-Based Health Centers.** In coordination with representatives from the Department of Public Health and Environment, managed care organizations, and School-Based Health Centers (SBHCs), Initiatives Office staff are developing long-term financing strategies for SBHCs. School-Based Health Centers are a model of health service delivery in which primary care providers deliver primary, preventive, and mental health care services to students in the school setting. At present, the majority of the 26 SBHCs in Colorado are funded through time-limited federal, local, and private grants and do not charge or bill for services provided. The SBHC task force is formulating a variety of financing strategies, including charging students for services, billing Medicaid and private insurers, and contracting with managed care organizations.

- **Cooperative Health Care Agreements Board.** In 1993, the General Assembly passed the Hospital Efficiency and Cooperation Act, designed to encourage innovation in health care delivery. This law created the Cooperative Health Care Agreements Board to evaluate hospital joint ventures and to provide approved ventures with immunity from federal antitrust regulation. Under the doctrine of state action immunity, arrangements that might otherwise violate federal antitrust laws may be deemed acceptable if they are supervised by the state and can be shown to fulfill a state-recognized public policy goal. The Initiatives Office staffs the Cooperative Health Care Agreements Board and provides technical assistance in the analysis of cooperative agreement applications. However, since the creation of the Board, the Federal Trade Commission and the Department of Justice have promulgated new guidelines for hospital joint ventures and mergers. This new information may provide hospitals with greater clarity about permitted or lawful activities, thus eliminating the need to seek protection through state action immunity. To date, the Cooperative Health Care Agreements Board has received no applications for immunity. This experience is consistent with the experience of similar boards in other states.

2. Initiatives Office Accomplishments in FY 96

- **Insurance Coverage Expansion** - In August of 1995, Governor Romer released the Initiatives Office report, "Survey Data on Family and Employer Health Insurance: Implications for Colorado," and appointed a Task Force on Coloradans Without Health Insurance. The Task Force developed an unsuccessful legislative proposal for tax credit financing of community health initiatives. Since the 1996 legislative session, Initiatives Office staff have assisted advocacy groups interested in expanding insurance coverage to children by researching other states' child health programs and building a model to estimate the costs of various expansion proposals.
- **Private Sector Health Care Coverage Cooperatives** - During the 1996 legislative session, Initiatives Office staff provided policy support to employer coalitions around House Bill 96-1264, a bill designed to provide qualified health care coverage cooperatives with an exemption from certain provisions of the Small Group Insurance Reform law. This act, which was passed in May of 1996, enables qualified cooperatives to negotiate with health plans for prices that are different than would otherwise be permitted under the Small Group Reform law. Initiatives Office staff developed regulations to implement the act, which were adopted by the Executive Director in October 1996.
- **Public Employers Insurance Purchasing Project** - The Initiatives Office provided staff assistance to the Public Employers' Working Group to develop a proposal for combined insurance purchasing between the Public Employees' Retirement Association (PERA) and the Department of Personnel. In June of 1996, the Governor and the PERA Board of

Trustees agreed to pursue pooled purchasing. The two purchasers formed a Transition Team to develop 1997 legislation to create a joint purchasing entity. Initiatives Office staff provided technical assistance to this Transition Team to ensure that draft legislation is consistent with the health care coverage cooperative law.

- **Medicaid HMO Risk Adjustment** - Initiatives Office staff negotiated with Medicaid HMO representatives to develop risk adjustment methodologies and contract language. Plans agreed to initial risk adjustment based on prior costs for the FY 97 contracts. Plans will also submit diagnostic data during FY 97 to support diagnosis-based risk adjustment in FY 98. A study by Dr. Rick Kronick, containing an analysis of medical costs of individuals remaining in Medicaid fee-for-service versus those switching to HMOs, was used as the basis for the FY 97 prior-cost rate adjustments.
- **Competitive Procurement and Selective Contracting** - In early 1995, the Initiatives Office sent out over 400 Requests for Information on oxygen and prescription drugs provided in nursing facilities, and on services to persons with severe organic behavioral impairments, and analyzed more than 100 responses. More than 20 consumer, provider and advisory groups provided additional inputs in Competitive Procurement Initiatives forums. Program development projects are utilizing these inputs. A preliminary summary of competitive procurement project findings and plans was distributed to more than 600 interested parties in May 1996. A project to develop competitive procurement methods for Managed Care (HMO) services will be initiated in January 1997.
- **Interagency Working Group on Health System Accountability** - During FY 96, the Interagency Working Group targeted managed care consumer complaints and grievances as a key area of concern. The Working Group released a report in October 1996, describing the current status of consumer complaints and appeals under managed care and making recommendations for enhancing consumer protections in the grievance process. The Working Group also developed new managed care regulations, to be promulgated by the Division of Insurance in early 1997, regarding consistent processes for utilization review across carriers. In addition, the group continues to identify additional regulatory and statutory changes that may be needed in order to enhance consume protection.
- **Enhanced Medicaid Managed Care Quality and Access Standards** - In November 1995, the Interagency Working Group (see above) agreed on common standards to use in HMO regulation, purchasing, and monitoring. Initiatives Office staff led a Department project that incorporates these standards into the FY 97 Medicaid HMO contracts.
- **Public/Private Partnership for Health Data** - During FY 96, Initiatives Office staff convened and facilitated meetings among purchasers and health plans, resulting in an agreement to collect and audit HEDIS 3.0 measures across purchasers in 1997. Initiatives Office staff have also secured a contract with the National Committee on Quality Assurance to train Colorado's managed care plans in HEDIS reporting protocols. This training will take place in January, 1997.
- **State Health Expenditure Account** - Initiatives Office staff researched other states' analyses of health care expenditures and worked with other state agencies to agree on priorities in developing comparable expenditure data. Staff also developed a methodology for estimating 1994 health care expenditures in Colorado by payer and service. Using this methodology, staff analyzed data from federal and state sources to produce a report on 1994 health care expenditures. The report was released in December 1996.

- **Health Care Reform Public Hearings Survey and Report -** After the release of the ColoradoCare feasibility study in September 1993, thirty-two public hearings were conducted to determine Coloradans' priorities for health care reform. During these hearings, participants completed a one-page survey about health care issues. Initiatives Office staff analyzed 2,600 surveys from these hearings and produced a report in August of 1995, which was distributed to approximately 300 individuals and organizations throughout Colorado.
- **Health Care Policy and Financing Reference Manual -** In 1996 the Initiatives Office produced and distributed more than 600 copies of the Department Reference Manual to legislators, providers, consumers, health plans, Medicaid clients, state and local agencies, and other interested parties. A customer satisfaction survey produced more than 50 responses that are being used to improve the utility and quality of the Manual.
- **Integrated Care and Financing Project -** The Department developed the project design and rate methodology, consulted with local project staff on the care coordination model, and identified quality assurance indicators to be measured in the pilot. In September of 1995, the Department submitted a request to the federal Health Care Financing Administration (HCFA) to waive certain federal requirements and allow implementation of the project. Throughout 1996, the Department has worked with HCFA to answer questions raised by the waiver application. Approval of the waiver is expected in January or February of 1997. Staff have also worked extensively with provider and consumer groups to develop a communications plan to explain the new program to eligible recipients.
- **Brain Injury Program -** July 1, 1996, marked the end of the first year of operation of the Brain Injury Program. During that year, the program served 40 individuals between the ages of 16 and 64 with traumatic or acquired brain injury. Initiatives Office staff have certified 35 providers to participate in the program, representing a continuum of provider types from individual practitioners to agencies.
- **Residential Treatment Center Program -** In FY 96, staff brought an additional 18 facilities into the Residential Treatment Center Program, adding these to the 25 facilities already participating. This brought the number of covered children from 546 to 885. Staff also provided billing training and technical assistance to new and participating facilities.
- **Home Health Aide Pilot Program -** The Initiatives Office conducted a survey of home health agency costs and practices and included this information in a waiver request to HCFA in May of 1995. Staff are currently working to resolve HCFA's questions. Final waiver approval is expected in December 1996, with the first clients enrolling in the program in February 1997.
- **Consumer-directed Attendant Support Program -** Since June of 1996, the Initiatives Office has staffed an advisory committee of consumers and providers to give input into the design of the program. The advisory committee meets once a month to discuss issues such as the program's governing rules, eligibility criteria, the training curriculum for participating Medicaid clients, and the hiring of staff to administer the pilot program.
- **School-Based Health Centers** - Staff have helped School-Based Health Centers (SBHCs) complete a number of steps necessary to secure managed care contracts, including creating health insurance profiles of students enrolled in SBHCs, developing a fee schedule, shaping quality and access standards for SBHCs, creating a network of SBHC administrators, and facilitating meetings with managed care representatives. To date, staff have facilitated contracts between three SBHCs and two health plans.

- **Cooperative Health Care Agreement Board** - In accordance with legislative requirements, the Initiatives Office issued a report to the General Assembly regarding the activities of the Cooperative Health Care Agreement Board. The report was released in November, 1996.

3. Office of Public and Private Initiatives Management Action Plan 97

GOAL 1: Facilitate effective value-based purchasing of health care by the Department and by other public and private purchasers.

OBJECTIVES

A. Implement competitively bid contracts for global organ transplant services and competitive rate setting on a daily rate basis for oxygen delivered to clients in Denver Metro Nursing Facilities.
B. Complete an instrument for competitively procuring HMO services in collaboration with stakeholders. Prepare to implement by 7/98.
C. Complete first round of diagnosis-based risk adjustment by 7/1/97.
D. Complete contract compliance reviews of Medicaid HMOs in collaboration with other agencies.
E. Collect HEDIS 3.0 data for calendar year 1996 in collaboration with other purchasers.
F. Work with other purchasers to develop and implement future joint data projects, such as customer satisfaction surveys or focused studies.
G. Develop a long-term plan for coordinated monitoring of managed care among state agencies and the federal government.
H. Collaborate with the Division of Insurance, the Department of Public Health and Environment, providers, health plans, and consumers to develop and implement health care regulations increasing accountability of health carriers for standards of care and service delivery. Report and recommend to the General Assembly on effects of 1996 legislation regarding health plan quality, access, and financial standards.
I. If funded as part of a pending grant application to the Robert Wood Johnson Foundation, lead a project to enhance or develop consumer information and advocacy resources within the health care system.
J. Promptly respond to applications for health care coverage cooperative certificates of authority, request for technical assistance, waiver requests, and cooperatives' annual reports.

GOAL 2: Collaboratively develop and implement improvements to health care programs and delivery systems.

OBJECTIVES

A. Implement the Integrated Care and Financing project and monitor and evaluate effects on cost, quality and access.
B. Implement, expand, and coordinate Home and Community-Based Services for Brain Injury clients and the Home Health Aide Pilot Program. Provide training and technical assistance to providers, agencies, hospital personnel, and clients; obtain waiver authority; procure pilot agencies; monitor and evaluate.
C. Assist in securing contracts from two new health plans with School-Based Health Centers.
D. Implement a Medicaid Managed Care Safety Net grant to develop care coordination standards and models, contracting models for managed care organizations and community based providers, and data collection and analysis protocols.

E. Continue to recruit providers into the Brain Injury Program, particularly in more rural areas of the state. By the end of FY 97, serve 120 individuals in the Program.
F. Administer the Residential Treatment Center (RTC) program; establish rates; certify facilities; coordinate with the Department of Human Services in monitoring provision of appropriate, cost-effective services to Medicaid-enrolled children.

GOAL 3: Analyze and inform Coloradans about the status of the health care system.
OBJECTIVES

A. Update the methodology for the State Health Expenditure Account and publish the 1996 account by December 1997.
B. Analyze the 1993 RAND survey data and the 1994 through 1996 Current Population Surveys to publish a report that shows how many Coloradans are uninsured, how the uninsured use health care, and the demographic characteristics of the uninsured.
C. Produce a report analyzing the level of competition in Colorado's regional health care markets and assessing the effect on Colorado consumers.
D. Provide information, research and policy analysis to the Governor's Office, General Assembly, other Departments and agencies, consumers, providers and other health care stakeholders on issues including: small group insurance; consumer health care options, such as new or improved consumer protection and advocacy mechanisms; and, constituent questions and concerns.
E. Disseminate health care issue information through newsletters and other publications, presentations, and meetings of interested health care stakeholders.

GOAL 4: Evaluate Department programs to improve access, quality and costs of health care services.
OBJECTIVES

A. Evaluate the Medicaid Mental Health Assessment and Services Agency (MHASA) capitation program effects upon Residential Treatment Center costs and scope of services.
B. Evaluate the activities of the Cooperative Health Care Agreements Board and provide the General Assembly with recommendations on sunset review.
C. Produce the first annual evaluation of effectiveness and efficiency of the Home and Community-Based Services Brain Injury (HCBS BI) program. Collaborate with the Home Health Pilot advisory committee to design and produce the HCBS BI report on cost-effectiveness, quality and access.

IV. Office of Information Technology

The mission of the Office of Information Technology is to design, develop and maintain information systems that support the Department's mission and goals.

1. Information Technology Office Functions

The Office of Information Technology (OIT) was formed to meet the Department's expanding needs for a departmental local area network, access to decision support, and information system development. The OIT staff assist Department and external agencies in accessing appropriate health care and program information from a variety of sources by extracting data from all available sources and systems, integrating that data and providing training and methods for its use. Figure 25 illustrates these Information Technology functions.

The goals of the Office of Information Technology are to:

- design and build a stable and flexible technology architecture for the department;
- deliver basic local area network hardware and software services;
- assist in the integration of data resources;
- expand cost-effective use of Information Technology; and,
- coordinate Departmental Information Technology planning.

To accomplish these goals, OIT staff perform the following functions:

a) Design, build and maintain a stable and flexible departmental technical architecture:

- Build a departmental local area network and access to alternative computing resources, using products and vendors that enable our long-term business strategies to be realized.
- Maintain a technical environment that can grow with the business and deliver basic local area network hardware and software services.
- Implement standard hardware and software in the support of the primary business functions of the department.

b) Assist in the integration of data resources:

- Extract and make available in ad-hoc reports information from the Department's three mission-critical mainframe computer systems:
  - Medicaid Management Information System (MMIS);
  - Client-Oriented Information Network (COIN);
  - Colorado Financial Reporting System (COFRS);
- Obtain data from external sources such as demographics and health care normative data and facilitate its use in the Department.

c) Expand cost-effective use of Information Technology:

- Make appropriate information technology tools available to staff.
- Train and support staff to leverage the diverse user skill sets; assist staff in resolving information technology problems.

d) Coordinate Departmental Information Technology planning:

- Consult with Department managers in planning their information technology strategies, methods, and systems development.

- Provide staff support to cross-functional teams for projects with information technology components.
- Prepare, present, defend, develop and implement the Department's five-year and yearly Information Management Action Plan (IMAP), as required by the state's Information Management Commission.

2. Information Technology Accomplishments in FY 96

- Continued to support the deployment of better tools for data integration and analysis. The Medicaid Automated Data Extract System (MAUDE) continued to provide valuable information from both COIN and MMIS. Staff was dedicated to provide additional mainframe ad-hoc reports from eligibility, capitation, and COFRS data bases.
- Continued to analyze and develop strategies related to the data needs of the department.
- Played a major role in the proposal and review of the new fiscal manager contract.
- Absorbed the loss of key staff and rebuilt the OIT team with new staff possessing the necessary diversity and skill sets.
- Selected and purchased hardware and software for the new departmental local area network.

3. Office of Information Technology Management Action Plan for 97

GOAL 1 Stabilize the existing information technology environment.

A. Develop an Office of Information Technology working environment based on respect, integrity, accountability, and trust.
B. Develop an information technology vision.
C. Build a reliable departmental technology architecture.
D. Design, develop, and implement a departmental local area network using Microsoft Windows NT Server and the Microsoft Office and Backoffice suites of software.
E. Train Office of Information Technology staff to effectively support the new departmental technology.

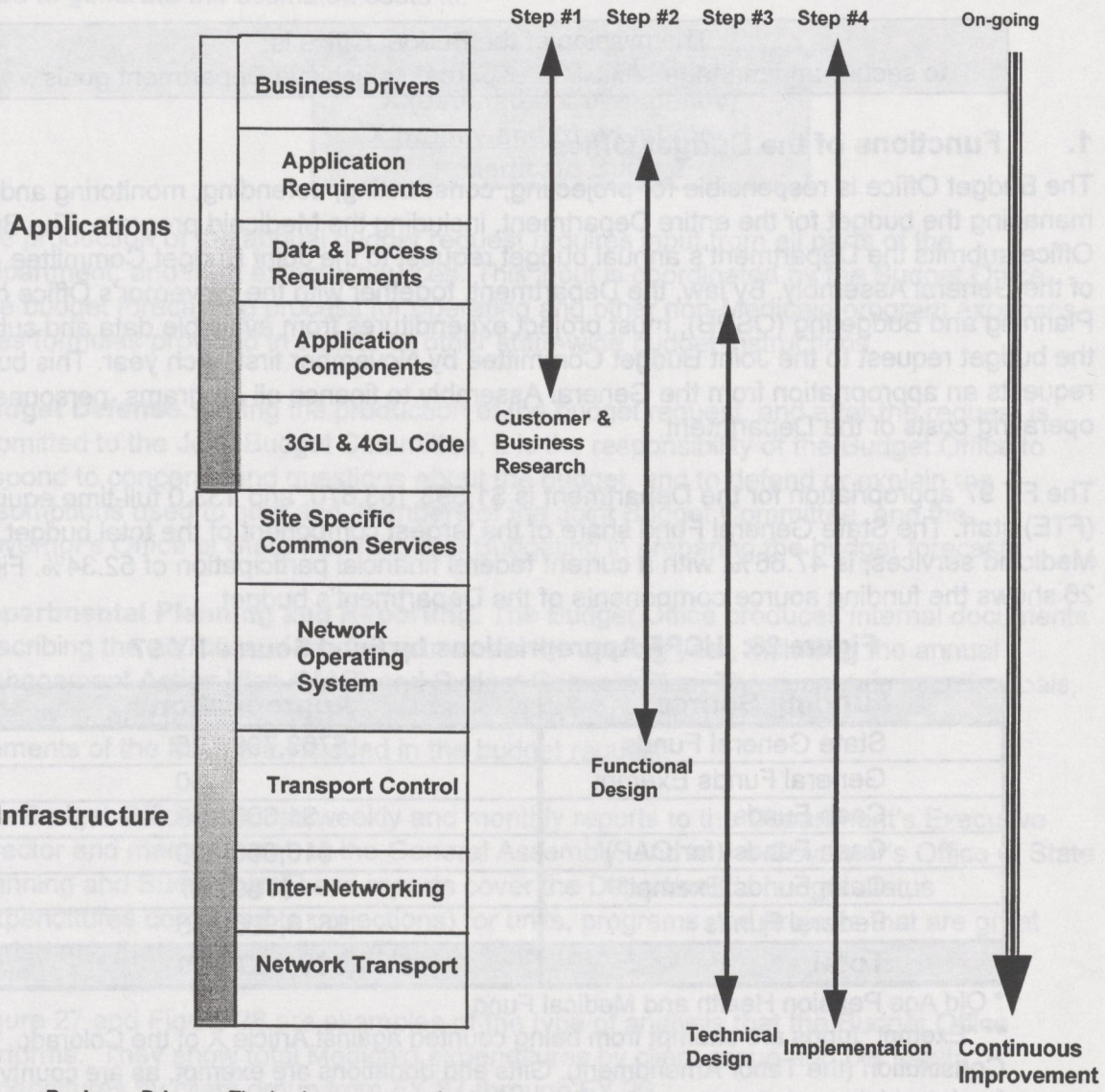
GOAL 2: Support end user access to the fiscal agent computing resources.

A. Assist staff in the design and production of ad hoc reports from the paid claims database.
B. Maintain and assist staff in the use of the MAUDE data extraction software application.
C. Provide consultant support in design and development of the new MMIS.

GOAL 3: Expand Managed Care systems support.

A. Support rate setting data bases, spreadsheets and systems methods.
B. Assist Managed Care staff in the design and development of decision support systems.
C. Assist Managed Care staff in the design and development of operations systems including procurement and contract management tools, encounter data systems, and Quality Assurance information collection and reporting.

Figure 25: Office of Information Technology - Layers of Focus



Business Drivers - The business reasons for deploying information technology
Application Requirements - The research and systems analysis work required to determine user requirements and scope business processes in technology terms
Data & Process Requirements - The systems design work required to map out work flow, data flow, and technology usage scenarios
Application Components - The software packages and services required to do every day work
3GL & 4GL Code - The computer programming languages used to build applications
Site Specific Common Services - The software packages and services that are often functioning in the background to make every day work operate
Network Operating System - The operating system software required to make the local area network workstations and servers function
Transport Control - The networking software that supervises the data transportation from end processor to end processor
Inter-Networking - The networking software that governs the transport of the information over multiple networks
Network Transport - The networking hardware and low-level software for equipment

*** Customer Support Service and Research & Development required across all layers of the model**

V. Budget Office

The mission of the Budget Office is
to secure and manage sufficient resources to achieve Department goals.

1. Functions of the Budget Office

The Budget Office is responsible for projecting, constructing, defending, monitoring and managing the budget for the entire Department, including the Medicaid program. The Budget Office submits the Department's annual budget request to the Joint Budget Committee (JBC) of the General Assembly. By law, the Department, together with the Governor's Office of State Planning and Budgeting (OSPB), must project expenditures from available data and submit the budget request to the Joint Budget Committee by November first each year. This budget requests an appropriation from the General Assembly to finance all programs, personnel, and operating costs of the Department.

The FY 97 appropriation for the Department is $1,593,163,670, and 133.0 full-time equivalent (FTE) staff. The State General Fund share of the largest component of the total budget, Medicaid services, is 47.66%, with a current federal financial participation of 52.34%. Figure 26 shows the funding source components of the Department's budget.

Figure 26: HCPF Appropriations by Fund Source FY 97

Funding Source	Appropriation
State General Funds	$763,799,775
General Funds Exempt	$0
Cash Funds	$1,608,173
Cash Funds (for OAP)*	$10,000,000
Cash Funds Exempt**	$759,067
Federal Funds	$816,996,655
Total	**$1,593,163,670**

* Old Age Pension Health and Medical Fund

** "Exempt" funds are exempt from being counted against Article X of the Colorado Constitution (the Tabor Amendment). Gifts and donations are exempt, as are county cash funds paid through the state, as these are already counted at the local level.

The Budget Office functions are to:

- accurately project each year's expenditures to permit the Department to pay for all medically-necessary and appropriate care provided to eligible clients;
- obtain a state appropriation that is sufficient to draw down the appropriate amount of federal resources and to obtain the authority to spend those resources;
- obtain funding for the Department's personnel and operating costs; and,
- obtain funding for all other programs and responsibilities of the Department.

These functions are carried out as follows:

- **Budget Forecasting and Preparation:** To prepare the annual budget request, the Budget Office must estimate Medicaid and other expenses in the coming year. The estimate of

Medicaid expenses is based on trends in enrollment and utilization. The general formula used to generate the estimated costs is:

(estimated cost/eligible)
X (estimated # of eligibles)
X (policy and trend inflators)
= Medicaid Budget

The production of the annual budget request requires input from all parts of the Department, and from external sources. This input is coordinated by the Budget Office. The budget forecasting process for operating and other non-Medicaid program expenses uses formulas provided in statute or other state-wide budget instructions.

- **Budget Defense.** During the production of the budget request, and after the request is submitted to the Joint Budget Committee, it is the responsibility of the Budget Office to respond to concerns and questions about the budget, and to defend or explain the assumptions used to staff and members of the Joint Budget Committee, and the Governor's Office of State Planning and Budgeting in preparing the budget forecasts.

- **Departmental Planning and Reporting.** The Budget Office produces internal documents describing the activities of the Department in the coming year, including the annual Management Action Plan (MAP) and Budget Request Plan. These contain specific goals, objectives, and performance measures for each unit of the Department. Pertinent elements of the MAP are included in the budget request.

  The Budget Office provides weekly and monthly reports to the Department's Executive Director and management, to the General Assembly, and to the Governor's Office of State Planning and Budgeting. These reports cover the Department's budget status (expenditures compared to projections) for units, programs and projects that are grant funded and those that are federal and/or state funded.

  Figure 27 and Figure 28 are examples of the type of analysis that the Budget Office performs. They show total Medicaid expenditures by client group and per capita expenditures by client group from FY 87 through FY 96.

- **Fiscal Note Preparation.** During the legislative session, all bills that affect either the Medicaid program specifically or the health care market in general are sent to the Department from the General Assembly for preparation of a fiscal note. A fiscal note is an estimate of the fiscal impact of a bill on the Department and its programs. A fiscal note may also contain narrative about possible fiscal impacts on other participants in the health care market. The Budget Office coordinates preparation of all fiscal notes in the Department.

- **Management of the Operational Budget.** The Budget Office manages the Department's operational budget. The office collects and reports data on personal services, operating and other administrative expenses, grants and programmatic expenditures.

- **Special Projects.** From time to time, the Budget Office conducts special projects assigned by the Executive Director.

2. Budget Office Accomplishments FY 96

The Budget Office in FY 96:

- Produced a report in November 1995 (as requested by Footnote 31 of the FY 96 Long Bill and Senate Bill 95-214), evaluating the Medicaid budget forecasting techniques and making recommendations for future improvements in those techniques. The Budget Office will proceed to implement all improvements possible within its authority.
- Created a detailed data base in Excel on Medicaid expenditures, caseload per capita costs by eligibility category and service category from FY 87 to FY 96.
- Created strong linkage between HMO rates and budget and verified the relationship.
- Prepared extensive analyses and briefing materials on the impact of managed care expansions and impacts of proposed federal changes.
- Prepared analysis of eligibility criteria used to drive various Medicaid Management Information System (MMIS) reports to prepare for MMIS transition.
- Prepared, submitted on time and defended budget requests, supplemental requests.
- Reviewed and verified fiscal notes to proposed legislation prepared by program staff.
- Developed and implemented improved reporting and management of administrative budget.
- Participated in budgeting for and transacting disproportionate share hospital payments that yielded a net General Fund gain to the state.

Figure 27: Medicaid Expenditures by Client Group, FY 87 to 96

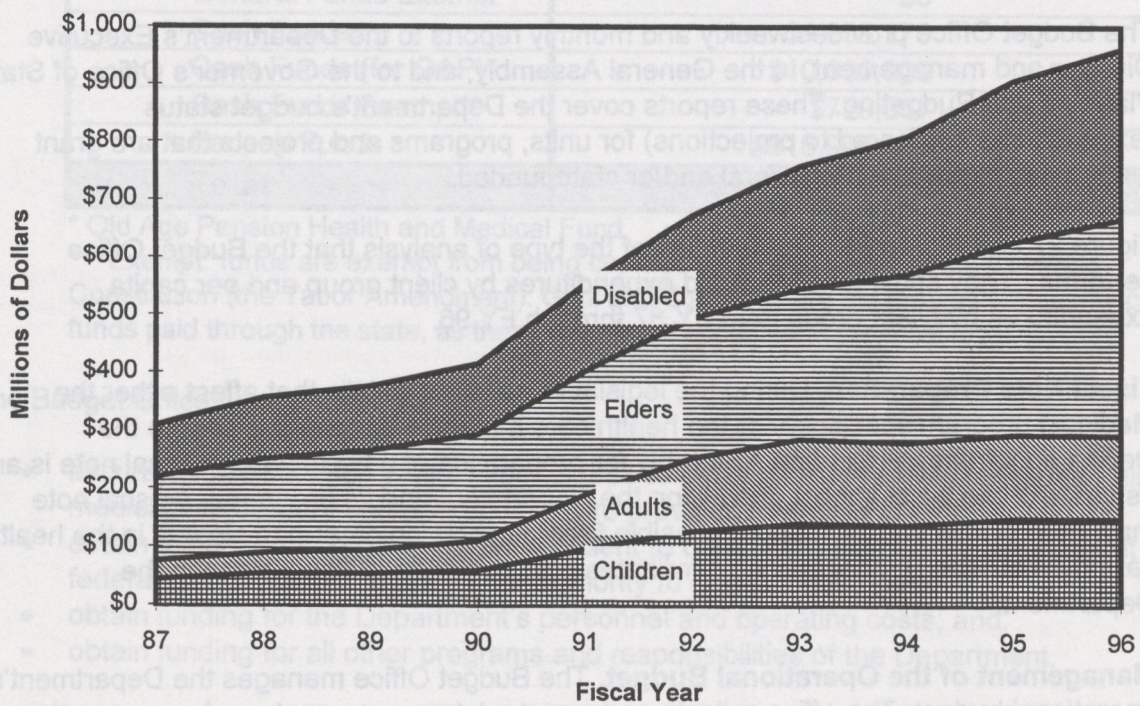
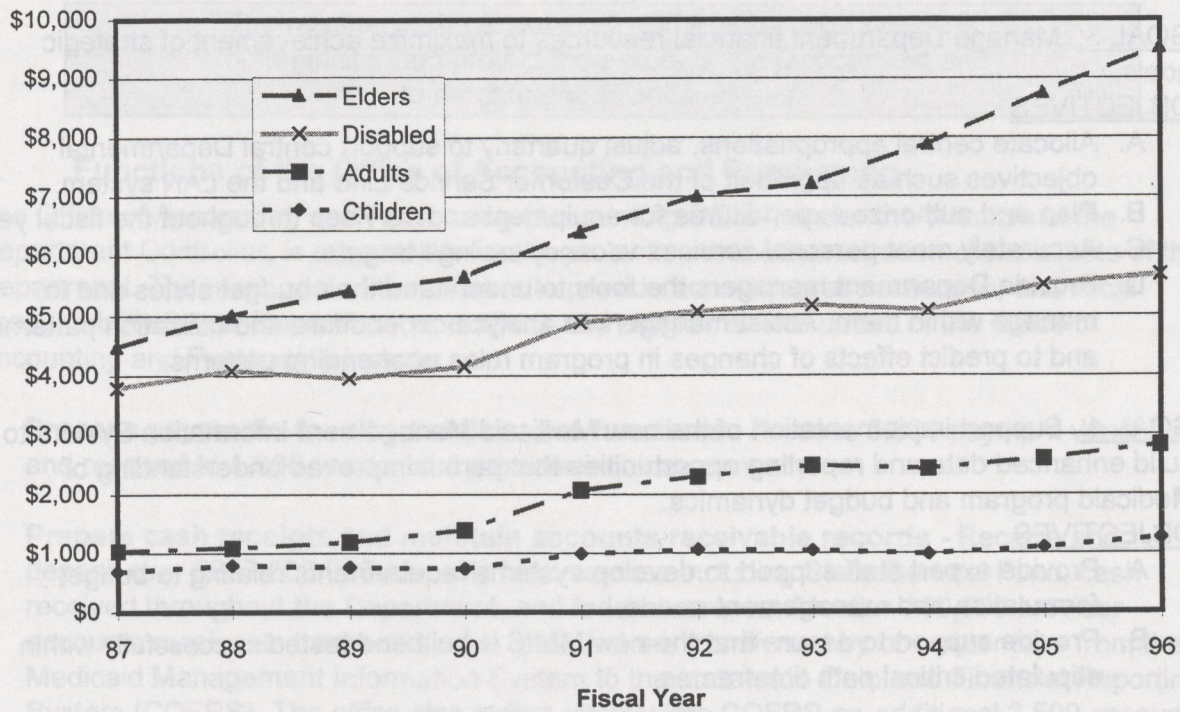


Figure 28: Medicaid Per Capita Costs by Client Group, FY 87 to 96



3. Budget Office Management Action Plans FY 97

GOAL 1: Accurately project the Department's budgetary needs

OBJECTIVES

A. Project Medicaid premiums within +/- 2% of final actual costs for the fiscal year.
B. Continuously improve caseload and expenditure projection, including a focus on effects of mental health capitation and health maintenance organization expansions on the base.
C. Accurately construct continuation funding levels for both entitlement and non-entitlement programs in conformance with published guidelines.
D. Identify policy changes (such as federal changes) and forecast for inclusion in the appropriate request documents.

GOAL 2: Obtain sufficient state and federal spending authority to allow the Department to perform its responsibilities and to effectively address its goals.

OBJECTIVES

A. Prepare Budget Request (November 1), Supplemental Requests and Budget Request Amendments that accurately and persuasively reflect the Department's need for funding to serve the populations eligible for care.
B. Respond to Office of State Planning and Budgeting and Joint Budget Committee staffs' questions and requests for data fully, effectively and on time.
C. Assure budget document accuracy, tying all schedules to source documents (such as COFRS, actual appropriations bills, etc.). Utilize quality assurance methodologies to minimize errors.
D. Prepare and defend fiscal notes for new bills within allotted timeframes; assure that these are sustained by Legislative Council/Joint Budget Committee staffs and are accurate reflections of budgetary need.

E. Assure that federal funds are available each quarter in amounts that reflect the quarter's cash management environment.

GOAL 3: Manage Department financial resources to maximize achievement of strategic goals.

OBJECTIVES

A. Allocate central appropriations, adjust quarterly to support central Departmental objectives such as upgrades of the Customer Service Line and the LAN system.
B. Plan and authorize expenditures for equipment and services throughout the fiscal year.
C. Accurately meet personal services vacancy savings targets.
D. Provide Department managers the tools to understand their budget status and to manage within them. Assist managers to analyze expenditure and utilization patterns and to predict effects of changes in program rules or spending patterns.

GOAL 4: Support implementation of the new Medicaid Management Information System to build enhanced data and reporting opportunities that permit improved understanding of Medicaid program and budget dynamics.

OBJECTIVES

A. Provide expert staff support to develop systems requirements relating to budget formulation and management needs.
B. Provide support to assure that the new MMIS is built and tested successfully within stipulated critical path timeframes.

VI. Office of Accounting and Purchasing

The mission of the Accounting and Purchasing Division is to administer and protect the assets of the Department and to procure goods and services.

1. Functions of the Office of Accounting and Purchasing

The Office of Accounting and Purchasing (Accounting Office), under the direction of the Department Controller, is responsible for the protection and administration of the assets of the Department. The main goal of the office is to provide accounting assistance to, and fiscal accountability for, all Department operations and programs. The duties of the Office of Accounting and Purchasing include:

- **Process payments for all administrative functions** - Process 5,300 payment vouchers and respond to 1,300 vendor and provider inquiries annually.

- **Prepare cash receipts and maintain accounts receivable records** - Receive and deposit over $887,000,000 annually from sources including State General Fund, cash received throughout the Department, and federal revenue. Monitor 250,000 provider accounts receivable transactions per year that are transferred by computer tape from the Medicaid Management Information System to the state-wide Colorado Financial Reporting System (COFRS). The office also enters directly into COFRS an additional 3,500 accounts receivable transactions for the Drug Rebate program.

- **Liaison for Payroll and Personnel Actions** - Under an interagency agreement with General Support Services, coordinate HCPF personnel and payroll actions. Maintain and administer leave tracking for Department employees.

- **Coordinate Departmental account activities with the statewide Colorado Financial Reporting System (COFRS)** - The Medicaid Management Information System feeds 4,500 payment vouchers, invoices, and journal vouchers into the COFRS system each week. It also feeds vendor information to update the vendor file for every new Medicaid provider and makes changes to current providers' files. The Accounting Office monitors this process and acts as a liaison among the program areas, the fiscal agent, and the COFRS staff.

- **Ensure internal control and fiscal compliance** - Monitor financial transactions to ensure compliance with all statutes and fiscal rules as promulgated by the General Assembly, the State Controller, and the federal government. Ensure that the Department follows generally-accepted accounting principles.

- **Prepare Departmental financial and management reports** - The accounting staff has twelve accounting period closings and one year-end closing in which accruals are posted. These accounting period closings generate the Department's financial and management reports. The Department prepares quarterly expenditure reports for both the Health Care Financing Administration and the State Controller's Office.

- **Develop and maintain fixed asset records and related fiscal reporting -** Reconcile Department equipment records with the COFRS database monthly and conduct Departmental physical inventory annually.

- **Process all procurement documents for the Department under the direction of the State Purchasing Director -** Process 110 purchase orders and 8 to 10 Requests for Proposals or Invitations for Bids annually and ensure compliance with the state procurement code.

- **Review and process Department contracts -** Ensure that all constitutional and statutory requirements have been met prior to execution of 500 contracts and 20 Memoranda of Understanding annually.

2. Accounting and Purchasing Accomplishments in FY 96

- **COFRS/CD-ROM system** - During fiscal year 96 staff developed the capability to download COFRS expenditure data to CD ROM which enables them to access information more efficiently, produce ad hoc reports, and save computer disk storage space.

- **Automated Contract Tracking system** - Paper contract routing slips were replaced with an electronic version (on COFRS) named CLIN (Contract Logging INquiry table). The CLIN allows the user to track the progress of their contract in external clearance through state personnel, state purchasing, attorney general, and/or the state controller's office.

- **Leave tracking system** - The KRONOS leave tracking system purchased from Gerber systems was installed and staff trained. Department employee leave balances were transferred from the Department of Human Services system to KRONOS effective July 1, 1996. Leave balances for HCPF employees will be tracked and reported on this system.

3. Accounting and Purchasing Management Action Plan for FY 97

GOAL 1: Facilitate accounting and purchasing functions, and working relationships among all organizational units of the Department, by communicating Accounting and Purchasing systems and rules to staff.

OBJECTIVES

A. Strengthen and improve accounting and purchasing processes by training Department staff on accounting, purchasing and contracting issues.
B. Implement Colorado Financial Reporting System (COFRS) Extended Purchasing (EPS) and other accounting and purchasing systems by training Department staff.

GOAL 2: Collaborate in the development and operation of automated data processing systems.

OBJECTIVES

A. Provide expert staff support to design and implement accounting and purchasing functions of the new MMIS such as: accounts receivable, drug rebate, and encumbrance/liquidation.
B. Maintain and enhance accounting staff's ADP and LAN capabilities. Update skills and equipment as necessary to maximize the effective use of automated data handling.
C. Further automate accounting data handling and reporting systems, including CD-ROM systems, in collaboration with Office of Information Technology.

VII. Appendix 1: Sources/Publications

The following reports are produced by the Department of Health Care Policy and Financing (HCPF) and can be obtained from:

Office of Public and Private Initiatives
Colorado Department of Health Care Policy and Financing
1575 Sherman St., Denver, CO 80203
Phone # 303-866-3327 - FAX # 303-866-2803

Source documents and publications are listed below alphabetically by title, within the following categories:

- Budget and Program Reports
- Access to Health Care Coverage
- Health Care Research and Data
- Health Care Regulation
- Demonstration Projects and Feasibility Studies

All publications are written by staff of the Colorado Department of Health Care Policy and Financing (HCPF), unless otherwise noted.

- **Budget and Program Reports**
- *Budget Reports*

1. Department of Health Care Policy and Financing Reference Manual, 1996, and 1997 (this document).
2. Budget Request, Fiscal Year 97-98, 1996.
3. Report to the General Assembly Pursuant to House Bill 94-1029, 1996.
4. Budget Request, Fiscal Year 96-97, 1995.
5. Improvements and Considerations in Forecasting Medicaid Caseload and Expenditures, SB 95-214 - Footnote #31, 1995.

- *Program Reports*

6. Colorado Indigent Care Program FY 1995 Annual Report, 1996.
7. Colorado Indigent Care Program Uniform Data Reporting Manual, 1996.
8. Managed Care Guide; Directory of Colorado Medicaid Managed Care Health Plans and Providers (Updated Quarterly), (available from HCPF Eligibility and Enrollment Section) 1996.
9. Colorado Medicaid Report on Community Health Programs: HCBS-EBD, HCBS-PLWA, and Home Health, 1996.
10. Long-Term Care Single Entry Point Access System Annual Evaluation and Status Reports: 1993, 1994, 1995 and 1996.
11. Colorado Medicaid Program Annual Report, 1994 (SFY 92-93), and 1995.
12. Acute Care Annual Report for (HCPF), Colorado Foundation for Medical Care, 1995.
13. Poison Control Services Annual Report, Fiscal Year Ending 6/30/95, 1995.
14. Medicaid Rate Study - Footnote #26, FY 95 Long Bill, 1994.
15. An Integrated Quality Assurance System for Home Based Services, 1992.

- **Access to Health Care Coverage**

16. The Health Care Reform Initiative: Increasing Efficiency and Equity in Colorado's Health Care Market. Proposal for funding to the Robert Wood Johnson Foundation, 1996.

17. (Report from the) Governor's Task Force on Coloradans Without Health Insurance, 1996.
18. Who is Uninsured in Colorado? What Should We Do About It?, 1996.
19. Health Care Reform Initiatives Project: Proposal to the Robert Wood Johnson Foundation, 1995.
20. Is Lack of Health Insurance an Affordability Issue?, 1995.
21. Options for a Health Insurance Voucher Program for Uninsured Coloradans, 1995.
22. The Rationale for Making Health Insurance More Affordable for Coloradans, 1995.
23. Selected State Programs to Decrease the Uninsured, 1995.
24. Selecting a Population and a Strategy for Decreasing Uninsurance in Colorado, 1995.
25. Findings from the Health Care Reform Public Hearings Survey, Office of Public and Private Initiatives, 1995.
26. ColoradoCare Public Hearing Results: Report to the Colorado General Assembly, 1994.
27. ColoradoCare Preliminary Feasibility Study: Report to the Colorado General Assembly, 1993.
28. ColoradoCare Preliminary Feasibility Study: Appendix to the Report to the Colorado General Assembly, 1993.

- **Health Care Research and Data**

29. Colorado Hospital Outcomes, 1993-1994. Health Data Commission, Forthcoming (1997).
30. Repeat Fertility and Contraceptive Implant Use Among Medicaid Recipients in Colorado, by Sue Austin Ricketts, published in *Family Planning Perspectives* , Volume 28, #6, Nov-Dec 1996 - available from CDPH&E.
31. Colorado State Health Expenditure Account, 1996.
32. Survey Data on Family and Employer Health Insurance: Implications for Colorado, Office of Public and Private Initiatives, 1995.
33. Colorado Medicaid's Primary Care Physician Initiative and Ambulatory Care Sensitive Hospitalizations: General Report, Health Data Commission, 1995.
34. Colorado Medicaid's Primary Care Physician Initiative and Ambulatory Care Sensitive Hospitalizations: Technical Report, Health Data Commission, 1995.

- **Health Care Regulation**
- *Health Care Coverage Cooperatives*

35. Guide to Health Plan Ground Rules and Cooperative Infrastructure Elements, 1995.
36. Sample Application for a Certificate of Authority to Operate as a Health Care Coverage Cooperative, 1995.
37. Sample Health Plan Request for Application, 1995.
38. Strength in Numbers: What Colorado Employers Should Know About Health Care Coverage Cooperatives (Brochure), 1995.

- *Antitrust Issues*

39. Antitrust Issues in Colorado Health Care: Recommendations for the Future of the Cooperative Health Care Agreements Board, 1996.

- **Demonstration Projects, Partnerships, and Feasibility Studies**
- *Consolidation of Colorado Government Agency Purchasing*

40. The Public Employers' Health Care Purchasing Project: Progress Report to the General Assembly, 1996.
41. Colorado Government Agency Purchasing Pool: Pricing of Standard Benefits for HMO and POS Plans for Active Employees and Early Retirees. Coopers & Lybrand for HCPF, 1996.
42. Options for the Governance of a State Employer Health Insurance Purchasing Pool, 1996.

43. Options for the Consolidation of Health Benefits Purchasing for State Employees, 1995.
44. The Feasibility of Consolidating Health Benefits Purchasing for Medicaid Recipients and State Employees, 1995.

- *Integrated Care and Financing*

45. Integrated Long-Term Care and Financing Project: Reforming Long-Term Care Financing and Delivery in Colorado, Annual Progress Report, 1996.

- *Worker's Compensation*

46. Workers' Compensation Feasibility Study, 1995.

- *Risk Adjustment*

47. Calculation of Risk Adjustment Factors for FY 96-97 for HMOs under Contract to Colorado Medicaid: Results of the Switcher Study, Dr. Richard Kronick and Lora Lee, University of California at San Diego for HCPF, 1996.

- *Health Plan Accountability*

48. Review of Public and Private Efforts to Ensure Health Plan Accountability, Office of Public and Private Initiatives, 1995.
49. Options for a Medicaid Quality Assurance Program, 1995.

- *School-Based Health Centers*

50. Policy Options to Increase Medicaid Reimbursement of School-Based Health Center Services, 1996.

- *Prescription Drugs*

51. (Report on) Consumer Access to Prescription Drugs, HCPF staff and the Task Force on Consumer Access to Prescription Drugs, 1994.

- *Competitive Procurement*

52. Competitive Procurement and Selective Contracting Project Report and Plans, draft 1996 (update forthcoming, 1997).

CITATIONS

State and Federal Statutory and Regulatory Citations relevant to HCPF programs:

Colorado Statute

- Health Care Coverage Cooperatives, § 6-18-101, *et seq.*, Colorado Revised Statute (C.R.S.).
- Department of Health Care Policy and Financing, § 25.5-1-101, *et seq.*, C.R.S.
- Cooperative Health Care Agreements Board, § 25.5-1-501, *et seq.*, C.R.S.
- Adult Foster Care, §§ 26-2-119 and 26-2-114, C.R.S.
- Home Care Allowance, §§ 26-2-114, 26-2-203, and 26-2-119, C.R.S.
- Medical Assistance Act, § 26-4-100, *et seq.*, and § 26-4-704, *et seq.*, C.R.S.

Colorado Regulation

- "Staff Manuals" of the Colorado Department of Human Services and the Colorado Department of Health Care Policy and Financing (Volumes 3, 7, and 8), Colorado Code of Regulations 10 CCR-2505-10.
- Health Care Coverage Cooperative Regulations, 10 CCR 2505-2 (OPPI-96-1, as amended).
- Cooperative Health Care Agreements Board Regulations, 10 CCR 2505-1 (CHCAB-95-1).

Federal Statute

- Titles XVIII and XIX, Social Security Act.

Federal Regulation

- 42 Code of Federal Regulations, Part 400-429 and Part 430 to End.

VIII. Appendix 2: HCPF Acronyms and Terms

Acronym	Explanation
AB	Aid to the Blind
ACF	Alternative Care Facility
ADL	Activities of Daily Living
AFC	Adult Foster Care
AFDC	Aid to Families with Dependent Children
AG	Attorney General
AMPS	Automated Medicaid Payment System - electronic claims system
AND	Aid to the Needy Disabled
BC/BS	Medicaid's Fiscal Agent, Blue Cross/Blue Shield of Colorado
BC - KC	Baby Care - Kids Care program
CARVE-OUT	A benefit or service that is not included under an otherwise global services agreement, such as a Medicaid HMO contract
CCB	Community-Centered Board (for DD)
CDHS	Colorado Department of Human Services
CDPH&E	Colorado Department of Public Health and Environment
CFMC	Colorado Foundation for Medical Care - HCPF's PRO contractor
CFR	Code of Federal Regulations
CICP	Colorado Indigent Care Program
COIN	Client Oriented Information System (CDHS/HCPF eligibility database)
CPT-6	Current Procedural Terminology (Physician Reimbursement Guide)
CRS	Colorado Revised Statutes
CSPR	Control System for Proposed Rules (state regulations)
CWEST	Child Welfare Eligibility and Services Tracking (system)
DD	Developmentally Disabled
DH&H	Denver Health and Hospitals
DME	Durable Medical Equipment
DoI	(Colorado) Division of Insurance
DRG	Diagnosis Related Group
DSH	Disproportionate Share Hospital - a facility receiving additional Medicaid funds in consideration of providing a high volume of care to low-income persons
EBT/EFT	Electronic Benefit/Funds Transfer - alternative to paper checks
EOMB	Explanation of Medicare Benefits
EPSDT	Early and Periodic Screening, Diagnosis and Treatment (preventive health care program for Medicaid clients up to age 21)
FA	Fiscal Agent (Blue Cross/Blue Shield of Colorado) - Medicaid's fiscal intermediary; operates the provider claims system and MMIS database
FFP	Federal Financial Participation
FFS	Fee-for-service (non-capitated health care payment system)
FQHC	Federally Qualified Health Clinic (or Center) - health service facility for low-income persons in a medically underserved area
FY	(State) Fiscal Year, July 1-June 30
GSS	(Colorado Department of) General Support Services
HCA	Home Care Allowance
HCBS	Home and Community Based Services (Programs) - long-term care at home or in community-based facilities (alternatives to Nursing Facility services)
CHILDREN'S HCBS	(Formerly Katie Beckett, aka Model 200 Waiver) HCBS for children with physical disabilities
HCBS/BI	HCBS for persons with brain injury
HCBS/CES	Children's Extensive Support-services for children with intensive behavioral or medical needs
HCBS/CMW	HCBS Children's Medical Waiver for children with developmental disabilities
HCBS/DD	persons with developmental disabilities, includes day program, transportation, residential care
HCBS/EBD	Elderly, Blind & Disabled
HCBS/MI	HCBS for the Mentally Ill
HCBS/PLWA	HCBS for Persons Living with AIDS
HCBS/SLS	Supported living for persons with developmental disabilities
HCFA	(federal) Health Care Financing Administration
HCPF	(Colorado Department of) Health Care Policy & Financing

HEDIS	Healthplan Employer Data and Information Set - NCQA's measurement system for health care quality and performance
HH	Home Health
HIBI	Health Insurance Buy-In (Program)
HHS	(federal) Health and Human Services Department
HMO	Health Maintenance Organization
IADL	Independent Activity of Daily Living - a measure of need for long-term care (see ULTC-100)
ICF	Intermediate Care Facility
ICD-9-CM	International Classification of Diseases, version 9, Clinical Modification
JBC	Joint Budget Committee
LTC	Long-Term Care
MAC	1. Medicaid Authorization Card 2. Medical Assistance Advisory Council 3. Maximum Allowable Cost--a federally-designated list of non-sole-source drugs; presently Colorado Medicaid's basis for differentiating drugs with a $.50 co-payment (MAC drugs) from those with a $2.00 co-payment (non-MAC drugs)
MCPI	Medical Consumer Price Index (US Dept of Labor statistics)
MCR or M18	Medicare
MHASA	Mental Health Assessment & Services Agency
MI	Medically Indigent - the Colorado Indigent Care Program
MK or M19	Medicaid
MMIS	Medicaid Management Information System - Medicaid database and claims payment system operated by the FA
NCQA	National Commission on Quality Assurance - HMO accrediting body
NF	Nursing Facility
NON-PPS	Non-prospective Payment System- daily rate reimbursement for inpatient hospital services
OAP-A	Old Age Pension/ 65 years or older
OAP-B	Old Age Pension/60 to 64 years
OAP-SO	Old Age Pension - State Only health and medical benefits
OASDI	Old Age Survivors Disability Insurance (an SSI program)
OLTC	Options for Long Term Care (Single Entry Point agencies)
OSPB	Office of State Planning and Budget (Governor's Office)
OTC	Over the Counter (Drugs)
PACE	Program of All-Inclusive Care for the Elderly (Prepaid health plan for frail elders age 65 and over)
PCBH	Personal Care Boarding Home
PCP/PCPP	Primary Care Physician/Primary Care Physician Program
PDN	Private Duty Nursing
PERA	Public Employees' Retirement Association - a health care payer
PHP	Prepaid Health Plan; like an HMO
POC	Plan of Care (HH, HCBS)
PPS	Prospective Payment System (for inpatient hospitals)
POS	Point of Service- clinic-based HMO
PPO	Preferred Provider Organization - a type of MCO
PRO	Peer Review Organization -- presently contracted to CFMC
QDWI	Qualified Disabled & Working Individuals (Medicaid/SSI program)
QMB	Qualified Medicare Beneficiary (MK/MCR program)
RTC	Residential Treatment Center (for children with behavioral problems)
SEP	Single Entry Point
SLMB	Special Low-Income Medicare Beneficiaries (MK/MCR program)
SMIB	Supplementary Medical Insurance Benefits (MK/MCR program)
SNF	Skilled Nursing Facility
SSA	Social Security Administration
SSI	Supplemental Security Income
SSI-CS	Supplemental Security Income - Colorado Supplement (OAP)
Title XVIII	(Social Security Act) - Medicare
Title XIX	(Social Security Act) - Medicaid
TPL	Third Party Liability
ULTC-100	Uniform Long Term Care (client needs assessment tool) form
WRAP AROUND SERVICES	Medicaid services that are not covered by HMOs, but that are covered for Medicaid clients enrolled in HMOs by referral or direct access to fee-for-service Medicaid providers.