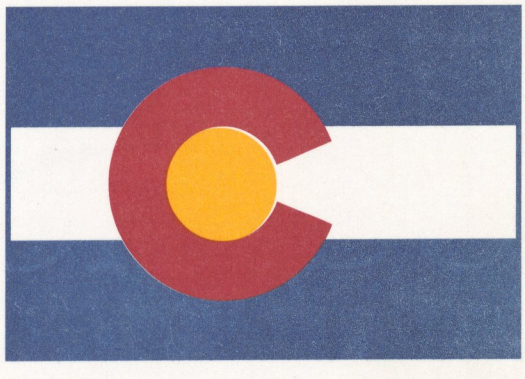
COLORADO

Department of HEALTH CARE POLICY AND FINANCING

1998 REFERENCE MANUAL

Bernard A. Buescher, Acting Executive Director

January 1998



STATE OF COLORADO

DEPARTMENT OF HEALTH CARE POLICY & FINANCING

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Roy Romer
Governor

Bernard A Buescher
Acting Executive Director

January 1998

Dear Reader:

The 1998 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. Along with the Department's Annual Report and Budget documents, the Reference Manual provides an overview of the Department's work, expenditure and utilization data on Colorado Medicaid and other health care programs, and information about important trends in the health care market. The brochures included with the Reference Manual "Managed Care Health Plans" and "Who Does What In Colorado Health Care?" provide specific information on those topics. "Medicaid de Colorado" is included as an example of Spanish-language publications.

As the 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 is finding 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's purchasing methods affect the overall health care market. The Department's purchasing methods are designed to improve access to care and the quality of health services delivered to clients, to offer consumers choice of providers and health plans, and to encourage providers and plans to compete with one another based on price, quality, and accessibility.

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 1998 Reference Manual, the 1997 Annual Report, or any other Department publication listed in the "Sources" Appendix are available from the Office of Public and Private Initiatives, Department of HCPF, 1575 Sherman Street, Denver, Colorado 80203. You may also call the Department's Customer Service line at 303-866-3513, or e-mail: sharon.powers@state.co.us .

I welcome your comments and questions.

Sincerely,

Bernard A. Buescher

Bernard A. Buescher
Acting Executive Director

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Index of Charts and Tables

Who Does What in Colorado Health Care?

Insert to the 1998 HCPF Reference Manual

This table outlines the functions of the Department of Health Care Policy and Financing and other Colorado health care organizations.

For definitions and acronyms, or more detail on HCPF programs and functions, see the HCPF Reference Manual or Annual Report, available on the Internet:http//state.co.us/Executive/Agencies.

HCPF Customer Service:
303-866-3513 (Denver Metro) or
1-800-221-3943 (toll-free statewide)

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: 911**
Medicaid-Related Functions		
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 urgent care or for an appointment: call your Primary Care Physician or HMO; OR, the HCPF "First Help" Line	Call the Primary Care Physician or HMO listed on your Medicaid card, OR: First Help Line 1-800-283-3221
Assist Medicaid clients in finding a **Primary Care Physician** or choosing an **HMO**	County Departments of Social (or Human) Services; local Health Departments; EPSDT sites; OR HCPF Customer Service Line [Beginning in early 1998: Obtain the new Enrollment Facilitator number from HCPF Customer Service]	Blue pages of phone book under county/district name, or community service pages. HCPF Customer Service: 303-866-3513 or 1-800-221-3943
Apply for, determine eligibility for **Medicaid coverage** (low-income Coloradans)	County Departments of Social (or Human) Services' Medicaid Eligibility Determination Unit	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
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.
Pay Medicaid providers, enroll providers, handle claims problems. Note: Providers that serve Medicaid clients under capitated Managed Care contracts do not bill Medicaid directly, but are reimbursed by the HMO or MHASA.	HCPF's Medicaid fiscal agent. Until 6/30/98: Blue Cross/Blue Shield of Colo. From 7/1/98: Consultec (Call HCPF Customer Service for new numbers)	Until 6/30/98: Blue Cross Blue Shield: Denver Metro: 303-831-0214 or Statewide: Practitioners: 1-800-443-5747 Institutional: 1-800-443-6731

Function	Agency	Phone/Contact
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 (CICP); or local hospitals or community health centers	Colorado Indigent Care Program 303-866-2580; or Billing office at health facility
Provide **health care to low-income Coloradans** [sliding fee scale or Medicaid] through Community Health Centers. Also: Migrant or Homeless Health Centers, and the U.S. Public Health Service	Colorado Community Health Network (for the locations of local Health Centers or clinics, and to obtain referrals)	CCHN: Denver: 303-861-5165 Or Statewide Toll-free: 1-800-873-3215 OR: call the local community health center.
Provide **preventive health care** for low income children, pregnant women and infants, including immunizations, prenatal care and family planning and nutrition services	Local public health agencies [District or County **Health Departments**], or Colorado Department of Public Health & Environment (CDPHE) Family Healthline	Blue pages of phone book under county or district name. Or, Family Healthline: 692-2310 (Denver) or 1-800-886-7689
Locating Medicaid and non-Medicaid **health care providers** statewide.	CDPHE Family Healthline (Or the HCPF Customer Service Line - 303-866-3513 or 1-800-221-3943)	Family Healthline: 303-692-2229 or 1-800-688-7777
Provide **health services to American Indians** and Alaskan Natives (eligibility is verified through tribal affiliation)	Indian Health Services	301-443-3024
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	CDPHE: 303-692-2310
Provide **dental treatment** to non-Medicaid-eligible, **low-income children** without dental insurance coverage	Kids in Need of Dentistry (Metro Denver area only) or: Community Health Centers	KIND: 303-691-9130 CCHN: 303-861-5165 , or statewide: 1-800-873-3215
Finding Health Insurance for Individuals and Businesses		
Provide insurance coverage for **health care for low-income children** under the age of 18 who do not qualify for Medicaid [Including new Title XXI Children's Basic Health Plan coverage with sliding-scale, subsidized premiums]	**Child Health Plan** OR [Beginning in mid-1998]: **Children's Basic Health Plan** (CBHP)	303-322-2160 (Metro) or: 1-800-359-1991 (Statewide) CBHP: Call the numbers above, or HCPF Customer Service: 1-800-221-3943
Provide **health care to low-income children** ages 3-19 in school-based health centers (certain schools)	CDPHE School-based Health Program; OR, call your child's school	303-692-2376
Provide information on and enroll individuals in **Baby Care - Kids Care** (Medicaid extended coverage for pregnant women and children in low-income families)	County Departments of Social Services, and other sites such as Community Health Centers, 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 Healthline
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
Information on private **long-term care insurance**	Colorado Division of Insurance	303-894-7499, x355

Function	Agency	Phone/Contact
Finding Health Insurance for Individuals and Businesses (cont'd)		
Determine eligibility for and provide **Medicare** - health insurance for elderly persons (65 years of age and older) and persons with disabilities	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")
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
Provide information on **benefits for veterans** (including health care)	U.S. Dept. of Veterans' Affairs OR the local county veteran's officer	1-800-827-1000
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	1. For general questions: U.S. Department of Health and Human Services 2. For employment issues: Equal Employment Opportunity Commission 3. Accessibility of public buildings: U.S. Dept. Justice 4. Colorado Civil Rights Commission 5. HCPF Customer Service	1. US Dept HHS Office for Civil Rights: 303-844-2024 2. Equal Employment Opportunity Commission: 1-800-669-3362 3. U.S. Dept. of Justice 1-800-514-0301 4. CO Civil Rights Commission: 303-894-2997 5. HCPF: see top of first page
Regulate **Medicaid** and the Colorado Indigent Care Program	HCPF - Medical Services Board	Medical Services Board: 303-866-4416
Monitor **Medicaid quality of care;** prevent, investigate and pursue **fraud and abuse**	HCPF Quality Assurance Section OR: Colorado Department of Law - Medicaid Fraud Unit OR: Colorado Department of General Support Services - Fraud Hotline	HCPF QA: 303-866-2420 Dept. of Law Medicaid Fraud Unit: 303-866-5431 GSS Fraud Hotline: Metro: 303-866-6234 Statewide: 1-888-895-6698
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
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

Function	Agency	Phone/Contact
Consumer Advocacy		
Handle **Medicaid client complaints regarding HMO** or primary care physician	Call the HMO listed on the Medicaid card, or the HCPF Customer Service Line	**Call the HMO,** or HCPF Customer Service: 303-866-3513 or 1-800-221-3943
Assist **Medicaid clients in disenrolling from an HMO**	Disenrollment line at CFMC, or (beginning early 1998) call HCPF Customer Service for the new Enrollment Facilitator number	CFMC: 1-800-854-4563 x3310 HCPF Customer Service: 303-866-3513 or 1-800-221-3943
Handle **non-Medicaid complaints regarding an HMO**	Colorado Division of Insurance; or Colo. 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 Colo. Department of Health Care Policy and Financing	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 State Senate: House of Representatives: Governor Roy Romer State Board of Health	 303-866-4866 (R) or 303-866-4865 (D) 303-866-2904 303-866-2471 303-692-2020
All other questions on health care policy, financing, programs, or services	HCPF Customer Service Information Line OR: Office of the Executive Director, Colorado Department of Health Care Policy and Financing	303-866-3513 (Denver Metro) or 1-800-221-3943 1575 Sherman Street Denver, Colorado 80203 OR: Internet: http//**state.co.us /Executive/Agencies/HCPF**
Who Does What In Colorado Health Care? **Version: 1/98TK**		

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, citizenship, mental or physical impairment, or religion.

Proteción Ante la Ley:

Nadie puede ser excluido de participar en el Medicaid de Colorado o ser privado de los beneficios de la Programa de Medicaid por cuestones de sexo, raza o etnicidad, pais de origen o ciudadanía, impedimento mental o fisico, o su religión.

Se Habla Español

Departmento de Regulación y Financiamiento de Atencion a la Salud **(Medicaid de Colorado)**

Llame al: 866-3513 (en Denver), o 1-800-221-3943 (número gratuito en Colorado)

The 1998 HCPF Reference Manual is produced by
the Colorado Department of Health Care Policy and Financing
Bernard A. Buescher, Acting Executive Director

Tom Kowal - Editor, Project Manager
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Sharon Powers - Assistant Editor

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HCPF office and division directors, section managers and staff
who provided program, administrative and statistical information
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Please send comments on the Reference Manual to:
WWW: tom.kowal@state.co.us
or to the address on the letterhead.

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; the Colorado Department of Health Care Policy and Financing, the Colorado Civil Rights Commission; or the U.S. Department of Health and Human Services.

HCPF Customer Service:

303-866-3513 (Denver Metro) or 1-800-221-3943 (toll-free statewide)

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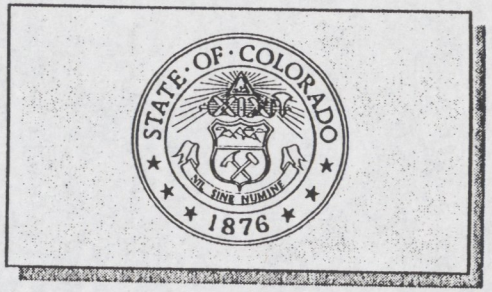
STATE OF COLORADO

DEPARTMENT OF HEALTH CARE POLICY & FINANCING

DECEMBER 1997



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Bernard A. Buescher

Bernard A. Buescher, Acting Executive Director

FIGURE 1: HCPF ORGANIZATIONAL CHART

I. 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.

Effective July 1, 1994 Colorado restructured health and human services delivery systems to streamline government functions and to make more efficient and effective use of state and local resources. The departments of Institutions and Social Services were combined into the new Department of Human Services. Financing and policy implementation functions for publicly funded health care programs, and the direct administration of Colorado's major public health care programs, were moved to the newly-created Department of Health Care Policy and Financing.

The Department of Health Care Policy and Financing (HCPF) is the federally-recognized Single State Agency for the Colorado Medicaid program. HCPF also provides program policy and financial oversight for the Colorado Indigent Care Program, the newly authorized Children's Basic Health Plan, and several other health care programs. The Department contracts with the Department of Human Services (DHS) for Medicaid eligibility determination. The Department also contracts components of major administrative functions such as information and billing systems, and utilization review and quality assurance, to firms that specialize in these areas. HCPF is in the process of competitively procuring contracts for managed care enrollment facilitation and for HMO services.

A. DEPARTMENT OVERVIEW:

The Department is organized into seven offices:

- Office of the Executive Director
- Deputy Director, Office of Legislative Affairs
- Office of Medical Assistance
- Office of Public and Private Initiatives
- Office of Information Technology
- Budget Office
- Office of Accounting and Purchasing

Bernard A. Buescher serves as the Department's Acting Executive Director. The Deputy Director's Office of Legislative Affairs includes the Department's Legislative Liaison and public information functions. The Office of Medical Assistance administers the state/federal Medicaid program and other health care programs that are state-funded. The Office of Public and Private Initiatives administers the Children's Basic Health Plan, and develops and implements other market-oriented health reforms and Medicaid program improvements. The Offices of Information Technology, Budget, and Accounting are responsible for developing and administering information technology systems, requesting and administering the Department's annual budget, and maintaining the departmental accounting system, respectively.

The Medical Services Board has statutory responsibility for promulgation of rules for the Medicaid, Indigent Care (CICP), Adult Foster Care and Home Care Allowance programs. Members of the Medical Services Board are appointed by the Governor and are confirmed by the State Senate. Mr. Richard Walker currently chairs the Medical Services Board. The State Board of Human Services has rule-making authority over the Old Age Pension Health and

Medical Fund. The Children's Basic Health Plan and Poison Control program have advisory boards that advise the HCPF Executive Director and staff.

With 0.5% of the total of State FTEs (Higher Education excluded), HCPF is one of the smallest executive departments in staff size but manages the second largest budget in Colorado government (after K-12 education). HCPF administers more federal funds than any other state agency and manages the State's largest single program: Medicaid. The following table provides an historic summary regarding this budget in relation to the State as a whole and State government in particular.

FIGURE 2: HCPF AND MEDICAID BUDGET SUMMARY, SFYS 81-82 TO 98-99

FISCAL YEAR	MEDICAID ELIGIBLES		% Change	Colorado Population	ELIGIBLES As % Of Colorado Population	FTEs**	HCPF As % of State FTEs*	HCPF As % of Total State Budget	HCPF As % of General Fund State Budget
	NO RETRO* **	RETRO+ OAP STATE ONLY***							
FY 81-82	123,247	NA	NA	NA	NA	49.6	NA	9.5%	8.8%
FY 82-83	127,054	NA	NA	NA	NA	61.6	NA	9.1%	8.9%
FY 83-84	134,124	NA	NA	NA	NA	60.2	NA	9.5%	9.6%
FY 84-85	127,421	NA	NA	3,214,448	NA	83.4	NA	9.4%	9.1%
FY 85-86	129,578	NA	NA	3,243,803	NA	93.5	0.4%	10.2%	9.3%
FY 86-87	141,246	155,196	NA	3,263,354	4.8%	97.2	0.4%	11.6%	10.3%
FY 87-88	148,479	163,560	5.4%	3,271,448	5.0%	102.5	0.4%	10.5%	10.6%
FY 88-89	154,318	168,918	3.3%	3,284,537	5.1%	102.8	0.4%	11.1%	10.7%
FY 89-90	161,323	178,355	5.6%	3,304,042	5.4%	101.4	0.2%	11.9%	11.6%
FY 90-91	NA	206,825	16.0%	3,369,199	6.1%	109.3	0.2%	13.6%	13.4%
FY 91-92	NA	243,688	17.8%	3,464,116	7.0%	111.6	0.3%	19.3%	24.1%
FY 92-93	NA	268,991	10.4%	3,567,727	7.6%	111.3	0.3%	21.3%	21.7%
FY 93-94	NA	281,265	4.6%	3,662,694	7.7%	115.6	0.3%	16.6%	18.0%
FY 94-95	NA	280,578	-0.2%	3,747,561	7.5%	115.9**	0.3%	17.3%	17.5%
FY 95-96	NA	273,800	-2.3%	3,822,677	7.2%	136.7**	0.5%	16.5%	16.7%
FY 96-97 est.	NA	270,050	-1.4%	3,895,753	6.9%	133.0	0.5%	17.2%	16.7%
FY 97-98 base est.	NA	266,563	-1.3%	3,967,572	6.8%	146.0	0.5%	17.3%	17.1%
FY 98-99 base req.	NA	269,717	1.2%	4,035,850	6.8%	NA	NA	NA	NA

Sources: Appropriations Reports, Medicaid Management Information System data, Budget Request and Demographer's Office information.

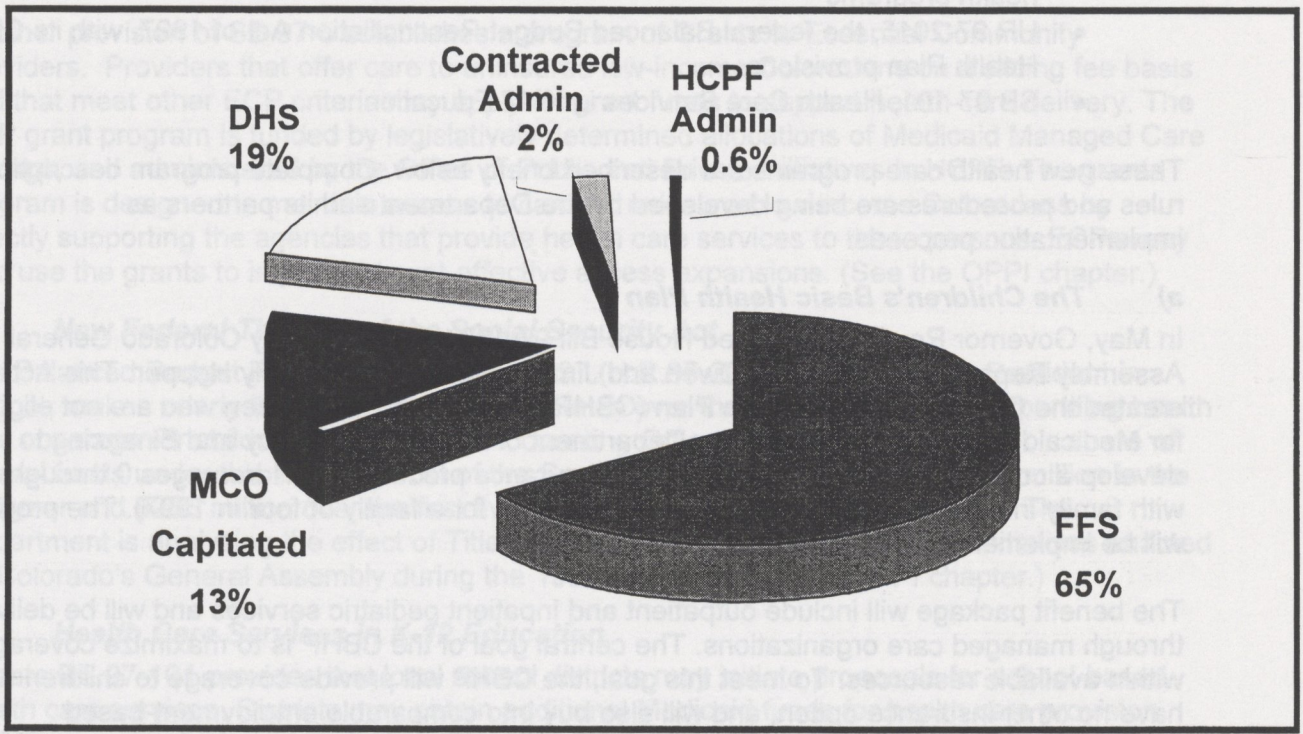
* Wherever the percent of state FTEs exceeds 0.3%, Higher Education FTEs (except central administrative staff, e.g., CCHE) are excluded from the denominator.

** HCPF was formed July 1, 1994. Health Data Commission, Indigent Care, and central development and administrative staff were added to the staff that had managed Medicaid.

*** Retroactive eligibility refers to a method of counting eligible persons that includes all person months for which eligibility has been determined. For example, often in the area of disabled persons a person makes application in one month (e.g., June) but several months are required to complete the process of medical reviews necessary for determination of eligibility. Eligibility covers the period retroactively to the date of application.

In FY 96-97 the Department administered a budget of $1.7 billion. Federal funds accounted for over half of this total, with the balance state and grant funds. Total HCPF administrative costs, including public and private sector contracts and eligibility determination at the county level, are about 3% of the Department's budget. State staff and operating costs account for about 0.6% of the Department's $1.7 billion budget.

FIGURE 3: HCPF BUDGET BY EXPENDITURE CATEGORY



Notes:
DHS = Department of Human Services (Mental Health and Developmental Disability) programs
MCO = Managed Care Organization (such as an HMO)
FFS = Fee-for-Service reimbursements

B. TRENDS AND PROGRAM HIGHLIGHTS

The Department of Health Care Policy and Financing, with its partners in the public and private sectors, is moving rapidly to improve access to health care, quality of health care delivery, and health coverage cost control. Although most of the Department's programs and projects address the health care needs of low-income and uninsured Coloradans, a number of initiatives and purchasing policies benefit the state's broader health care delivery system and market.

Colorado is in the forefront of national efforts to expand children's health care coverage, to move publicly funded health care into Managed Care financing and delivery models, to assure quality of care, to support and enhance the role of public and not-for-profit health care facilities ("Safety Net" or "Essential Community Providers") and to adjust capitation payments to fairly compensate providers who serve clients with extensive health care needs. Some of these initiatives are described on the next pages; others are described elsewhere in the Reference Manual.

1. Improving access to health care for Colorado's children

In 1997, major State and federal initiatives extended health care coverage to children in uninsured low-income families. These initiatives are:

- HB 97-1304, the Colorado Children's Basic Health Plan, and grants to Essential Community Providers
- SB 97-5, Medicaid Managed Care, including investment of savings in children's health programs
- HR 97-2015, the federal Balanced Budget Reconciliation Act of 1997, with its Child Health Plan provisions
- SB 97-101, Health Care Services in K-12 Education

These new health care programs are described briefly below. Complete program descriptions, rules and procedures are being developed by the Department and its partners as implementation proceeds.

a) The Children's Basic Health Plan

In May, Governor Roy Romer signed House Bill 97-1304, sponsored by Colorado General Assembly Representatives David Owen and Jim Dyer and Senator Sally Hopper. This Act created the Children's Basic Health Plan (CBHP), for low-income children who are not eligible for Medicaid coverage. It requires the Department of Health Care Policy and Financing to develop a comprehensive subsidized health insurance product for children ages 0 through 17 with family incomes under 185% of poverty ($29,700 for a family of four in 1997). The program will be implemented as a public-private partnership.

The benefit package will include outpatient and inpatient pediatric services and will be delivered through managed care organizations. The central goal of the CBHP is to maximize coverage within available resources. To meet this goal, the CBHP will provide coverage to children who have no other insurance option, and will also buy into comparable employment-based dependent coverage for children who meet the subsidy criteria and whose parents are offered employment-based dependent coverage. Participants will contribute to program costs through co-payments and sliding-scale premium contributions.

HB1304 authorizes FY 97-98 expansions of the existing Colorado Child Health Plan, from 52 to all 63 Colorado counties, and from serving children age 12 and under to children 17 and under. The Colorado Child Health Plan will sunset on June 30, 1998, with its enrollees transferring to the Children's Basic Health Plan by that time. Enrollment in the CBHP will be limited by available funding. By 2001, under favorable program funding assumptions, CBHP could provide health insurance coverage for almost 1/2 of the approximately 100,000 uninsured children in Colorado families with incomes below 200% of the federal poverty line.

The General Assembly appropriated $2 million General Fund in FY 96-97 for program implementation. The CBHP will rely on partnerships with school districts, local governments, employers, EPSDT and FQHC sites, and other health care providers and not-for-profit organizations for marketing and outreach. Core funding for the CBHP comes from:

- Medicaid managed care savings;
- other savings achieved through health care reforms, consolidation and streamlining;
- new federal Child Health Insurance Program funds; and possibly,
- local foundation grants.

(See the Office of Public and Private Initiatives [OPPI] chapter for details.)

b) Essential Community Provider Grants and Inclusion in HMO Networks

Senate Bill 97-5 recognized and made provisions for the essential role that certain hospitals, health centers and other community providers play in delivering care to Medicaid clients and uninsured Coloradans. The statute affords Essential Community Providers (ECPs) an opportunity to be included in the HMO service delivery networks that serve Medicaid clients. This inclusive policy is designed to promote access to care for low-income Coloradans, as well as continuity of care and the financial viability of ECPs.

Another provision of SB 97-5 establishes a program of Grants to Essential Community Providers. Providers that offer care to uninsured low-income Coloradans on a sliding fee basis and that meet other ECP criteria may apply for grant funds to support health care delivery. The ECP grant program is funded by legislatively determined allocations of Medicaid Managed Care savings, and administered by the Office of Public and Private Initiatives in HCPF. The grants program is designed to maintain access to care for uninsured low-income Coloradans by directly supporting the agencies that provide health care services to these persons. ECPs may also use the grants to implement cost-effective access expansions. (See the OPPI chapter.)

c) New Federal Title XXI of the Social Security Act

The Balanced Budget Reconciliation Act of 1997 (H.R.97-2015), signed by the President in August, makes nearly $24 billion available to states over the next ten years for expanding health care coverage for children. The General Accounting Office estimates that Colorado's share of federal funds under this new Title XXI of the Social Security Act will be about $42 million in the first year and $206 million over the first five years. A state match is also required. The Department is analyzing the effect of Title XXI upon the children's health care initiatives enacted by Colorado's General Assembly during the 1997 Session. (See the OPPI chapter.)

d) Health Care Services in K-12 Education

Senate Bill 97-101 provides that local school districts may initiate proposals for school-based health care services. Districts may obtain additional Medicaid funds for health care provision and also receive technical assistance from the Department in implementing and expanding these services to school children. (See the OPPI chapter.)

2. Welfare Reform Changes to Medicaid Eligibility - Colorado Works

Welfare reform in Colorado, called "Colorado Works," is established by SB 97-120. Colorado Works is the state's version of the Temporary Assistance to Needy Families (TANF) program that was created under federal Welfare Reform efforts. TANF reforms and replaces the Aid to Families with Dependent Children [AFDC] program. Federal and state law changes have significantly altered the basis for Medicaid eligibility, as well.

Senate Bill 97-120 also created "Transitional Plus," a subsidized health care insurance program for Colorado families transitioning off public assistance. In order to draw federal funds to help finance the Transitional Plus program the Department will submit an 1115 Research and Demonstration waiver request to the federal Department of Health and Human Services.

Please see the Enrollment and Eligibility Section chapter and the Office of Public and Private Initiatives chapter of the Reference Manual for details on changes to the Colorado Medicaid Program that support and augment the Colorado Works program goal of assisting clients to move from welfare to work.

3. Managed Care program expansions

The Department continues to design and implement program modifications in pursuit of its mandates to increase the percentage of Medicaid clients who are enrolled in managed care programs. Senate Bill 97-5 requires that 75% of Medicaid clients be enrolled in managed care by the year 2000. A number of initiatives underway are listed below. Managed Care objectives and accomplishments are also detailed in the section narratives in the main body of this Manual.

a) Managed Care Enrollment Facilitator

In pursuing the goal of enrolling 75% of Medicaid clients in managed care programs by July 1, 2000, the Department intends that clients have clear, unbiased, current and relevant information about choice of providers and health plans. HCPF and its partners are developing policies and systems that will provide clients with more complete information about managed care and how to use it, and that will assist them to negotiate the managed care system in a way that preserves or establishes stable and adequate health care delivery.

A Request for Proposals (RFP) was issued for Enrollment Facilitator services in August, 1997. Enrollment Facilitator services are scheduled to begin statewide in early 1998.The Enrollment Facilitator will perform a broad range of managed care enrollment and disenrollment functions leading to increased voluntary selection of a Health Maintenance Organization or Primary Care Physician by Medicaid clients.

During the first year of Enrollment Facilitator operation it is anticipated the contractor will enroll at least 63,000 Medicaid clients into managed care. Beginning July 1998, all clients who are newly eligible for Medicaid will be enrolled in managed care organizations within 90 days of eligibility notification. (See the Eligibility and Enrollment Section chapter for detail on the Enrollment Facilitator project.)

b) HMO Competitive Bidding

Also pursuant to SB 97-5 authorization, the Department may competitively bid Medicaid managed care contracts. Under competitive bidding, managed care organizations will compete with one another to provide the best quality product at the lowest price.

The Department is preparing a Request for Proposals (RFP) or other procurement tool that will define the parameters under which the plans will compete. During FY 97-98, a departmental team is examining options for structuring the competitive bidding process. The Department researched and developed competitive HMO procurement models, and then solicited statewide inputs from consumers, providers, plans and other interested parties. (See the OPPI chapter.)

c) Risk Adjustment of HMO Rates

The Department is developing a system to adjust capitation payments to HMOs according to the expected health care resource utilization of clients enrolled in the plan. Risk adjustment allows the Department to pay plans more for sicker individuals who tend to use more resources and pay less for healthy individuals who consume fewer resources, and thus to improve both access for clients with health problems, and reimbursement equity for plans. (See the OPPI chapter.)

d) Managed Care Program Growth

With the implementation of the managed care Enrollment Facilitator, HMO enrollment is projected to increase 10% for FY 97-98 -- from 71,000 HMO enrollees to 78,000 enrollees. As the Facilitator function develops, HMO enrollments are expected to increase another 49%, from 78,000 to 116,000 enrollees. Enrollment in the Primary Care Physician Program (PCPP) is

expected to remain stable for the balance of FY 97-98. Although Medicaid clients who are required to choose a managed care option may select a PCP, the capacity of the PCPP for new clients is estimated at only 5,000 clients. As HMOs recruit physicians from the PCPP, the possibility of PCPP program growth diminishes. (See the Managed Care chapter.)

e) Quality Assurance

As managed care is expanded to enroll more Medicaid clients, the Department is designing and implementing a more comprehensive and well-coordinated managed care quality monitoring program. Whereas in the fee-for-service environment the quality assurance focus is on preventing over-utilization and encouraging better coordination of care, in managed care the focus is on assuring that clients have adequate access to necessary services, and that the quality of care is satisfactory. Key elements of this program are listed below: (See also the Quality Assurance Section chapter.)

Continuity of Care - Continuity of client access to appropriate care is assured by means of specific contract terms and conditions that each managed care organization must adhere to. The managed care contract specifications for continuity of care are updated annually as useful improvements are identified.

Client Surveys- Client satisfaction with Medicaid managed health care providers is measured using the Consumer Assessment of Health Plans Study (CAHPS), an instrument developed by the U.S. Public Health Service.

Health Plan Employer Data Information Set (HEDIS) - HMOs report to HCPF using a variety of utilization, access, quality of care measures from the Health Plan Employer Data Information Set (HEDIS). The measures are used to compare HMOs, determine potential areas for improvement, note strengths, and identify trends in services provided to Medicaid clients.

Site Reviews - Department staff conduct yearly site reviews of HMOs to ensure compliance with contractual standards. During 1997, a pilot site review was conducted that focused on the complaints and appeals systems. In 1998 and annually thereafter, these reviews will address an extensive list of service, access, quality of care, and administrative issues specified in the contract.

External Quality Review - The Department is bidding out several managed care review activities to an External Quality Review Organization (EQRO). These reviews will include medical record reviews, quality of care case review, and encounter data validation. EQRO activities will focus strongly on the aspect of quality of care as documented in medical records. HMOs must take specific action to address any areas for improvement that are identified.

Complaints, Grievances, and Disenrollments - The Department analyzes complaints received directly from clients, complaints reported by HMOs, and the reasons given by clients for disenrolling from plans. Complaint patterns and trends identified are prioritized for more intensive review and action.

Profiling - HCPF is developing a profiling program that will provide indicators of high quality HMO health care. Using the full range of data available, profiling will provide information to assist Medicaid enrollees in choosing the best health program for them. Profiling system development is being coordinated with HMOs, providers, and consumers to assure that profiling information is valid and useful.

4. Changes in Long-Term Care:

a) Revisions to Nursing Facility Rates

The Department implemented reimbursement system changes and a case mix rate methodology study as authorized by SB 97-42.

Nursing Facility Rate Ceilings - Senate Bill 97-42 substantially altered the methodology for nursing facility rate-setting. The new law sets rate increase ceilings of 8% growth for health care costs and 6% for administrative costs. This change will substantially reduce the rate of growth in nursing facility rates and save the state over $15 million annually.

Case Mix Reimbursement - The Department is also required to research the potential for basing nursing facility rates on case mix, and to provide a case mix report and recommendations to the General Assembly. An advisory board was convened to review and comment upon HCPF staff work. Staff have surveyed states that currently utilize Case Mix reimbursement systems, reviewed existing Colorado Case Mix components and are preparing a Request for Proposals (RFP) for a contractor to assist in conducting an in-depth analysis of Case Mix options. (See Rate Setting Sections' chapter.)

b) Utilization Trends

The Department's Long-Term Care programs continue to increase utilization of community-based care, and to decrease the use of institutional settings such as Nursing Facilities. Over the last five years, the number of HCPF clients requiring long-term care services has risen with the increase in the number of elderly and disabled Coloradans, but the number of clients receiving care in Nursing Facility has remained steady. More clients, and a higher percentage of clients, are being served in community-based settings such as Home Health and Home and the Community-Based Services - Elderly Blind and Disabled (HCBS-EBD) program. Another trend noted within the community based programs is a slowing of the growth in the Home Care Allowance program. This also correlates with increased growth in the HCBS-EBD programs. (See the Medical Assistance, Eligibility and Enrollment, and Health Care Benefits chapters.)

c) The Integrated Care and Financing Project

This pilot program integrates acute and long-term care, Medicare and Medicaid services for individuals with disabilities and/or chronic conditions. The ICF project will demonstrate improved health care coordination and reduced cost-shifting among providers and payors. Improved health care outcomes are expected to result. HCPF, Mesa County DSS, Rocky Mountain HMO, HCFA and the Robert Wood Johnson Foundation will implement the project in Mesa County. (See the OPPI chapter.)

5. Systems Readiness

The Department continues rapid information systems development in response to the needs of Colorado's changing programs of publicly funded health care.

a) Colorado Benefits Management System

Pursuant to legislative direction (CRS 26-4-403(1) et seq) , HCPF and the Department of Human Services, with their partners in local government and health and social service agencies, are developing a new automated information system to support eligibility determination and benefits management functions for public assistance and health coverage programs. The Colorado Benefits Management System (CBMS) is designed as an integrated client database

and system platform that will efficiently serve the state's major public benefit programs and clients. Design features include:

- Clients will provide only one time the information that is required to determine eligibility and track their benefits. CBMS will use the information to qualify the client for the full range of public and medical assistance benefits.
- Clients will make program applications at Community Health Centers, Public Health Departments, schools, hospitals, long-term care single entry points and other community service agencies, as well as at County Departments of Social (or Human) Services.
- CBMS will make eligibility determinations on-line, using an automated rule database. Clients and eligibility staff can complete enrollments to all appropriate programs at the time of application.
- By streamlining the eligibility determination process and creating an integrated client database, CBMS will enhance access to needed services, reduce administrative costs, and improve continuity of coverage and care.

A recently completed CBMS feasibility study estimated development and implementation costs at $39.5 million. The medical assistance modules could be implemented in early 2000. (See the Office of Information Technology chapter.)

b) Medicaid Management Information System (MMIS) Transition

The implementation of the redesigned MMIS is proceeding on schedule, except for some new requirements resulting from FY 96-97 legislation. The new MMIS will provide significant improvements in processing Medicaid claims and accessing Medicaid data. The new system and database will also accommodate processing and reporting needs for other HCPF programs. The new fiscal agent contractor, Consultec, has assigned over 100 staff to the development effort. Planning for the pilot test to be conducted May through June of 1998 has begun. The Department anticipates that the new MMIS will be operational on July 1, 1998. (See the Information Systems Section chapter.)

c) Systems Changes Implementing the Personal Responsibility and Work Opportunity Reconciliation Act

The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), Public Law 104-193 enacted August 22, 1996 provides 75%-90% federal funding of Medicaid systems changes and other costs of implementing Welfare Reform. Department staff are determining priorities for use of Colorado's allocation of $5.166 million for expenditures related to outreach, client education, training, identification of "at risk" TANF clients and eligibility systems changes.

6. Award-Winning Customer Service -

The Customer Service Section's excellent performance was recognized in 1997 with the Department's Outstanding Performance Award, and the Governor's Award for Peak Performance for Citizen Satisfaction. The Department continues to improve customer services. Over 150 pre-recorded messages in both English and Spanish about Medicaid benefits and programs have been added to the Department's 24-hour automated phone system. A Spanish-speaking operator and a TTD/TTY unit were added in 1997. Staff responded to more than 60,000 phone inquiries in the past year. Further increases in calls are anticipated, pursuant to recent legislative changes especially regarding children's health care expansions, client liability for out-of-network provider billings, and increasing managed care enrollments. (See the Customer Service Section chapter.)

II. OFFICE OF THE EXECUTIVE DIRECTOR

A. OVERVIEW OF THE OFFICE OF THE EXECUTIVE DIRECTOR

The Department's Executive Director is appointed by the Governor and confirmed by the Senate. She or he serves as a member of the Governor's cabinet and is responsible to the Medical Services Board which is the principal rule-making authority for the Department's programs. Bernard A. Buescher was appointed Acting Executive Director of HCPF in 1997.

Six offices report to the Executive Director of the Department:

- Deputy Director - Legislative Affairs
- Public and Private Initiatives
- Medical Assistance
- Budget
- Accounting and Purchasing
- Information Technology

The functions of these organizational units are described in the chapters that follow, in the order that they appear from left to right on the organizational chart at the front of this Manual.

B. GUIDING PRINCIPLES

The following Guiding Principles serve as a framework for the Department's policy development, operations and program administration:

1. The Department will treat all clients and potential clients with respect and consideration.
2. The Department regards our providers, clients, advocacy groups, counties and other local government units, the Governor's Office and the General Assembly as our partners. Each is integral to our success.
3. The Department will be scrupulously honest in all of our relationships: with each other, with our all of our partners and with the public.
4. The Department will be a focused, accountable, efficient organization.
5. The Department will work to expand coverage of and access to health care for low-income, needy individuals.
6. The Department will be a cost-effective purchaser of health care.
7. The Department will constantly evaluate the success of our efforts by using client input, outreach efforts, and surveys. We will continually search for methods to improve quality, accessibility and cost effectiveness.

C. HCPF DIVERSITY COUNCIL AND PLAN

The employees of the Department of Health Care Policy and Financing believe that diversity is the celebration and utilization of all people in a climate of mutual understanding and respect of differences and similarities. The work of the Department's Diversity Council was recognized in 1997 with the Governor's Peak Performance Award. HCPF diversity plans and activities are used by other agencies as a model for achieving, appreciating and maximizing the benefits of a diverse workforce. The following HCPF diversity goals are addressed through a detailed workplan and through the active participation of staff at all levels:

1. To increase the recruiting, hiring, training and promotion of a diverse workforce.
2. To create an employee career development plan.
3. To improve understanding of cultural diversity through Departmental training.
4. To improve understanding of different cultures, histories, and experiences.

III. OFFICE OF PUBLIC AND PRIVATE INITIATIVES

The mission of the Office of Public and Private Initiatives (OPPI) is to analyze, develop, and implement health care system innovations that improve access, quality and effectiveness of health care services for all Coloradans by working in partnership and sharing information with private sector and other public sector individuals and entities.

1. Purpose and Goals of the Office of Public and Private Initiatives

Initiatives Office projects focus on the following areas:

- Development of new health care delivery systems to reduce cost and/or improve accessibility and quality.
- Increasing access to insurance and health care services
- Purchasing reform in the public and private sectors
- Analyzing and informing Coloradans about the status of the health care system
- Evaluating programs implemented by the Department to improve access, quality or costs of health care services

Projects and initiatives in each of these areas are described below.

2. OPPI Projects and Initiatives

a) Health Care Delivery Systems Development

In addition to providing research and policy support to the Department, OPPI staff develop, administer, or facilitate health care delivery system improvements. These new methods and systems often serve as pilots for Medicaid and other public health care program innovations. Current projects are outlined below.

Integrated Care and Financing Project - The ICF project 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 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 Options for 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. A federal waiver for this project was approved on July 1, 1997. The demonstration project, funded under a Robert Wood Johnson Foundation grant, will begin in the spring of 1998.

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 to reduce the long-term social and economic impact of the injury. The HCBS-BI program has served 151 individuals statewide since its inception July 1, 1995.

Managed Care Safety Net Project - In the spring of 1997, the Office of Public and Private Initiatives received a one-year planning grant from the Robert Wood Johnson Foundation to improve service delivery to children with special needs enrolled in Medicaid HMOs. The goal of the "Safety Net" Project is to develop methods to assess client needs and identify appropriate services. The project will also create links between HMOs and community-based providers and service agencies. The project has applied for two years of additional funding for implementation. The Safety Net Project objectives are to:

- Identify and describe models of effective client screening and assessment instruments and successful contracting relationships between HMOs and community-based organizations (CBOs) serving vulnerable Medicaid populations;
- Develop a screening instrument and assessment process that will permit HMOs to identify children with special needs enrolled in Medicaid, create individualized care plans, and develop an infrastructure for care coordination for Medicaid clients; and
- Develop HMO/CBO model referral forms and model contracts to increase communication of patient treatment, referrals, and/or contracting between HMOs and traditional safety net providers, identify services that may be moved into capitated plans, and increase client receipt of psycho-social services that HMOs often do not provide to Medicaid clients.

Home Health Aide Pilot Program - This project will use federal waiver authority and a state law change in order to improve access to home health care. The waiver of federal Medicaid regulations will permit home health services to be provided to some active disabled clients at sites other than the client's home, such as at school or work. Additional costs of out-of-home services will be offset by the use of nurse-supervised home health aides for delegated tasks, rather than the use of nurses, as permitted by recent changes to state law. The Initiatives Office expects to begin implementing the program in 1998.

Consumer-Directed Attendant Support Program - In 1996, the General Assembly authorized a pilot program to test improved methods 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. OPPI submitted 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. A staff person to implement the program will be hired in early 1998.

b) Increasing Access to Insurance and Health Care Services

The Initiatives Office staffs the following health care access projects in cooperation with other HCPF units and with the Department's public and private partners:

Children's Basic Health Plan - House Bill 97-1304, the Children's Basic Health Plan (CBHP) creates a non-Medicaid, non-entitlement subsidized health insurance program for low-income children ages 0-17 with family incomes at or below 185% of the federal poverty level. Based upon U.S. Census Bureau estimates, there are approximately 100,000 children without health insurance coverage in Colorado families with incomes below 200% of the poverty level.

In August 1997, the President signed the federal Budget Reconciliation Act that also provides funding for expanding health care coverage for low-income children. The federal statute adds a new section to the Social Security Act, Title XXI, creating the State Children's Health Insurance Program. Under this new law, Colorado has access to approximately $42 million in federal matching funds each year for the next ten years for a subsidized insurance program for low-income children.

On October 13, 1997, Colorado submitted its required Title XXI State Plan to the U.S. Health Care Financing Administration. Colorado's Title XXI program, Child Health Plan Plus (CHP+), could begin enrolling children as early as March 1998. As required by state legislation, the benefits package is based on the Standard Plan as defined in Colorado's small group insurance reform law. Services for this non-entitlement program are to be delivered through HMOs that are willing to contract with Medicaid. Premiums are set on a sliding fee scale for families below 185% of poverty. Families with incomes above 185% of poverty can buy in to CHP+ at full cost.

Design and implementation of House Bill 1304, which forms the framework of the CHP+, was a collaborative process, with input from broad-based constituency representatives, including advocates for low-income families and children, employers, business leaders, health care providers and government agencies. The Department of Health Care Policy and Financing administers the Child Health Plan Plus through subcontracts with the Colorado Child Health Plan and the Colorado Foundation for Families and Children.

A Policy Board of leaders in the business, provider, health plan and advocacy fields assists the CBHP. Five advisory teams were organized to recommend plans and methods based on the state and federal legislation. The five teams are:

- benefit design and pricing;
- eligibility, enrollment and management information system design;
- subsidized employment-based coverage;
- marketing of the product; and,
- HMO contracting and oversight.

Team members include representatives of the business, provider, insurance and consumer communities, as well as Health Care Policy and Financing and other government agency staff.

The Essential Community Provider Grants Program - Senate Bill 97-5 authorized a new essential community provider (ECP) grants program. The ECP grants are designed to increase access to care for low-income Coloradans by directly supporting the provision of health care services to medically indigent Coloradans. Grants may also be used by ECPs to implement additional cost-effective options to expand access to services.

ECPs are defined by the Department as health care providers that have historically served a high proportion of medically needy or medically indigent patients, that demonstrate a ongoing commitment to serve these populations, and that waive charges for services or charge on a sliding scale based on income, not restricting health care access based upon ability to pay.

Medicaid Managed Care Savings - Senate Bill 97-5, the Medicaid managed care bill, provides that managed care savings will be directed to children's health insurance coverage and to ECP grants. Each year HCPF will report on managed care savings to the Governor's Office and to the General Assembly and make recommendations on the distribution of managed care savings to ECP grants and/or to the CBHP. The report will include analysis of CBHP effects upon providers' uncompensated care burdens, and an assessment of the financial viability of ECPs.

School-Based Health Centers - Senate Bill 97-101 provides that local school districts may initiate proposals to obtain additional financial support from the Medicaid program for School-Based health care services. HCPF staff will review each district's proposed plan for conformance to Medicaid requirements and consistency with legislative intent. Approved district plans will receive state and federal Medicaid funds. HCPF staff are also working In coordination with representatives from the Department of Public Health and Environment, the Department of Education and from School-Based Health Centers (SBHCs) to coordinate enrollment in the Children's Basic Health Plan (CBHP).

Work Incentives Program for People with Disabilities - Senate Bill 97-147 creates a pilot program to assist people with disabilities in returning to work. The new law is intended to remove a barrier that keeps many disabled individuals out of the workplace – the fear of losing Medicaid benefits because of increased income. OPPI is responsible for developing and implementing a pilot program to encourage low-income, permanently-disabled Medicaid clients who receive Supplemental Security Income (SSI) or Supplemental Security Disability Income (SSDI) to enter the work force by allowing them to buy into Medicaid, even when their incomes exceed the Medicaid eligibility threshold. The pilot program is capped at 150 participants. There is no implementation timeline yet for this program because there is no appropriation in the current year's budget for administrative costs. The Department is requesting an administrative budget for the program for FY 99.

Welfare to Work Transition- "Transitional Plus," a subsidized health care insurance program for Colorado families transitioning off public assistance, was authorized by the Colorado Legislature in 1997. Families would become eligible for Transitional Plus when they are no longer eligible for TANF cash benefits and have exhausted Transitional Medicaid benefits. Families will contribute to the cost of their health care through sliding scale premiums based on income and minimal co-payments. OPPI staff are working on an application for a federal waiver of Medicaid regulations to permit implementation of the program in 1999.

c) 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 that attempt to capitalize on the benefits of large-group purchasing.

Competitive Procurement and Selective Contracting Projects - 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, and supplemental oxygen in metro-area nursing homes.

HMO Competitive Bidding - The Department is preparing to competitively bid Medicaid HMO contracts. This is a significant change to current rate setting and contracting procedures. Managed care organizations will compete with one another to provide the best quality product at the lowest price. Consumers, providers, plans and consultants are providing valuable inputs on

the procurement design. In October and November of 1997, the Colorado Department of Health Care Policy and Financing held a series of meetings with HMOs, providers, clients, and others to share its preliminary thinking about HMO competitive bidding and to take input on the design of a procurement tool that is appropriate for the Colorado HMO marketplace and health care service delivery system. The goals of the competitive bidding project are to improve access to care, quality of care, and cost-effectiveness of HMO service delivery to Medicaid clients statewide.

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.

In FY 98, the Department implemented a risk adjustment methodology that adjusts payments to health plans based on the diagnoses of the plans' enrollees. The Department's chosen risk adjuster, the Disability Payment System (DPS), groups 2,400 ICD-9 diagnosis codes that are associated with elevated future costs into some 40 categories. 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.

Private Health Care Coverage Cooperatives - In June 1994, Governor Romer signed into law House Bill 1193, authorizing the creation of 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 larger employers as well. The Initiatives Office is responsible for certifying and monitoring health care coverage cooperatives, and for providing technical assistance to certified or emerging cooperatives.. The goal of such certification is to protect consumers against risk skimming and cost shifting on the part of the cooperative.

In August of 1995, the Department awarded a certificate of authority to the first health care coverage cooperative, the Cooperative for Health Insurance Purchasing (CHIP), which offers a choice of four HMOs to employers of all sizes throughout the state. In August 1997, the CHIP covered 8,594 subscribers and 17,112 lives. In July of 1997, Colorado became the first state in the country to license two, competing, private-sector health care cooperatives in the same geographic region. Colorado Options, a new cooperative developed by the Colorado Bar Association, will also serve all 63 counties in Colorado and will offer a choice among 3 carriers and several benefit plans (HMO and PPO).

d) Analyzing and informing Coloradans about the health care system

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. OPPI staff issue reports and newsletters on health care issues, present briefings and presentations, participate on health care task forces and committees, staff health data collection projects, analyze and disseminate initiatives and answer information requests.

For publication citations and distribution, please see Appendix 1. Initiatives Office information gathering and dissemination activities include the following projects:

State Health Expenditure Account (SHEA) – In 1997 OPPI released the first edition of Colorado's State Health Expenditures Account (SHEA). SHEA tracks the flow of funds in the Colorado health care market by payer (fully-insured employer, self-insured employer, Medicare, Medicaid, other government, and out-of-pocket) and by direct health care service (hospital inpatient/outpatient, physician inpatient/outpatient, prescription drugs, long-term care, dental care, and other medical professionals). The initial SHEA reports data from 1994.

An updated report using 1995 data is scheduled for release in January, 1998. For this report, staff focused on improved data collection and analysis. In addition to tracking expenditures, the report addresses the following questions:

- What was the percentage growth in health care spending from 1994 to 1995?
- How has public health spending changed?
- What areas may need future reform or legislation?
- What impact did the growth of managed care have on health care expenditures?

Data Analysis on the Uninsured and Under-insured - Initiatives Office staff continue to develop 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 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) Evaluating programs Implemented by the Department to Improve Access, Quality or Cost-Efficiency of Health Care Services.

The Initiatives Office evaluates and reports on waiver, grant and pilot programs. OPPI and Medicaid staff cooperatively assess the efficiency and effectiveness of existing program methodologies and develop options for improvement. Evaluation efforts focus upon measures of cost effectiveness, effects upon the health care market and delivery systems, and upon access and quality of care. (See Management Action Plan, Goal # 5, below.)

3. OPPI Management Action Plan FY 98

GOAL 1:

To collaboratively develop and implement policies, programs and delivery systems to reduce cost and/or improve accessibility and quality.

FY 98 OBJECTIVES and PERFORMANCE MEASURES PROGRAM GOAL 1:

Continue to implement and monitor the Integrated Care and Financing Project.	**FY 96-97**	**FY 97-98**
Promulgate Regulations		October 1997
Amend RMHMO Contract		January 1998
Complete client and public communications		March-May 1998
Complete conversions and dual enrollments		March-May 1998
Continue to Implement the Brain Injury Program		
Consultation and site certification of providers		Ongoing
Conduct annual training conference		Spring 1998
Provide technical assistance to DHS		Ongoing
Submit HCFA reports and apply for waiver renewal		December 1997
Implement Medicaid Managed Care Safety Net Project		
Develop RWJ Foundation grant renewal proposal		November 1997
Develop forms, protocols and resource guide		December-April 1997
Hire independent evaluator		December 1997
Develop model contracts for HMOs and CBPs		March 1998
Design and develop Home Health Aide Pilot Project		
Obtain waiver approval from HCFA	October 1997	
Develop agency checklist and proposed rules		January 1998
Proposed rules completed		January 1998
RFP and contracting Home Health Agencies		March-June 1998
Train OLTC agencies		June 1998
Design and Develop Consumer-Directed Attendant Support Program		
Hire staff to develop/administer program		June 1998

FY 98-99 PERFORMANCE MEASURES PROGRAM GOAL 1:

Continue to implement and monitor the Integrated Care and Financing Project.	**FY 98-99**
Monitor QA performance and provide technical assistance	Ongoing
Revise program rules	January 1999
Conduct joint monitoring with HCFA	March 1999
Identify potential expansion sites	July – November, 1999
[Pending 1915b Waiver] Implement Brain Injury Program	
Consultation, site certification/annual monitoring of providers	Ongoing
Conduct annual training conference	Spring 1999
Submit annual HCFA 372 Report and any waiver amendments	December 1998
Home Health Aide Pilot Project	
Contingent upon funding, implement program	August 1998
Design and Implement Consumer-Directed Attendant Support Program	
Design project and submit waiver request	August-September 1998
Obtain Waiver Approval	March 1999
Promulgate rules	June 1999
Enroll Clients	July 1999

FY 97-98 and 98-99 GOAL 2:

To increase access to insurance and health care services through design and implementation of the Children's Basic Health Plan, the Essential Community Provider Grants Program, the Annual Managed Care Savings Reports, and incentives programs for persons with disabilities and persons transitioning from welfare to work.

FY 97-98 OBJECTIVES PROGRAM GOAL 2:

1. Design and Implement the Children's Basic Heath Plan
   - Manage CBHP Budget and Track Financing. Design eligibility determination, enrollment and management information systems. Create a marketing and communications plan. Design coordinating plan for employer-based coverage and CBHP.
   - Submit Title XXI State Plan to the Health Care Financing Administration.
   - Implement phase one, Child Health Plan Plus, of the CBHP.
2. Design and Implement the Essential Community Provider Grants Program
   - Ascertain Department priorities for the program. Develop series of recommendations from ECPs and their representatives on intent and goals of program and criteria for obtaining funding.
   - Develop and distribute application for grants, make grant awards.
   - Publish Managed Care Savings Reports
   - Submit an annual savings report to the Joint Budget Committee and to the Office of State Planning and Budgeting.
3. Design Work Incentives Program for People With Disabilities
   - Submit federal waiver to allow SSI/SSDI recipients to buy-into Medicaid.
   - Work with Division of Vocational Rehabilitation in the Department of Human Services to design client selection process, program marketing materials, and interface with Social Security work incentive programs.
4. Design and Implement Medicaid Plus Program for People Transition from Welfare to Work
   - Design a subsidized insurance program for families transitioning off public assistance, including benefit structure, client cost-sharing, eligibility and enrollment systems.
   - Submit and defend waiver application, implement as feasible.

FY 98-99 OBJECTIVES PROGRAM GOAL 2:

1. Continue to Implement the Children's Basic Heath Plan
   - Develop and implement an accounting system for using federal Medicaid funds to support the Children's Basic Health Plan by November 30, 1998
2. Design and Implement the Essential Community Provider Grants Program
   - Evaluate process followed in first year of grants program by October 1998.
   - Grant applications distributed March 99; awards made in July 1999.
3. Publish Managed Care Savings Reports
   - Submit an annual savings report to the Joint Budget Committee and to the Office of State Planning and Budgeting by September 1, 1999.
4. Implement Incentives Program for People With Disabilities
   - Implement Medicaid buy-in program for 150 SSI/SSDI recipients as authorized by Disability Work Incentive Program and federal waiver.
   - Collect and monitor health care service utilization data. Assist the Division of Vocational Rehabilitation in the Department of Human Services with selecting and informing clients of program guidelines. Collect premium contributions from individuals .
   - Continue to Implement Medicaid Plus

FY 97-98 PERFORMANCE MEASURES PROGRAM GOAL 2:

Design and implement the Children's Basic Health Plan	**FY 96-97**	**FY 97-98**
Select Policy Board and working team members	July-Oct. 97	
Submit Title XXI State Plan to HCFA	Oct. 1997	
Design eligibility, enrollment & MIS systems		Ongoing
Create marketing & communications plan		Ongoing
Design coordinating plan for employer-based coverage		Ongoing
Implement Child Health Plan Plus		January 1998
Design, Implement ECP Grants Program		
Develop criteria for funding		December 1997
Promulgate rules		February 1998
Distribute application form for grant funding		March 1998
Funding Applications Due		April 1998
Grant Awards Made		July 1998
Managed Care Savings Reports		
Submit report to Joint Budget Committee	Oct. 1997	September 1998
Work Incentives Program for People with Disabilities		
Submit federal waiver for SSI/SSDI buy-into Medicaid		December 1997
Design programs, client selection process, marketing		June 1998
Transitional Plus Program–Welfare to Work		
Design program/submit 1115 waiver request		December 1997
Implement program		July 1998

FY 98-99 PERFORMANCE MEASURES PROGRAM GOAL 2:

Implement the Children's Basic Health Plan	**FY 98-99**
Implement Children's Basic Health Plan	July 1998
Develop/implement accounting system for Medicaid fund use	November 1998
Continue to Implement ECP Grants Program	
Evaluate process used in first year	October 1998
Distribute grant application forms	March 1999
Funding Applications Due	April 1999
Grant Awards Made	July 1999
Managed Care Savings Reports	
Submit report to Joint Budget Committee	September 1999

FY 97-98 and 98-99 GOAL 3

To facilitate effective value-based purchasing of health care by the Department and by other public and private purchasers.

OBJECTIVES PROGRAM GOAL 3:

1. Develop and implement methods to competitively procure select services in the Medicaid fee-for-services program, with enhanced access, quality, and cost-effectiveness.
   - Implement a case rate for organ transplant services, with competitively bid rates as feasible.
   - Implement a daily rate for Supplemental Oxygen services provided in Metro nursing facilities by January 1, 1999. Determine feasibility of improving access, quality, and

cost-effectiveness of these services through competitive bidding by June 30, 1999. If directed legislatively, evaluate the option of including supplemental oxygen services in the nursing facility daily rate.

- Based upon improved information on utilization and costs available from the new MMIS by January 1, 1999, determine by June 30, 1999 the feasibility of competitively procuring, unit dose pricing, inclusion in nursing facility daily rates, and other procurement innovations for prescription drugs delivered in Metro nursing facilities.
- Continue to propose, investigate and implement as feasible alternative procurement and contracting methods for Medicaid's fee-for-service programs.

2. Implement risk adjustment for the 1998 contract year and plan for the 1999 contract year.
   - Refine diagnoses list with input from providers and consumers for 1999 contracts.
   - With the Encounter Data Working Group, support the health plans to submit encounter data to the MMIS. Analyze and produce risk adjusted rates for the 1999 contract year.
   - Implement risk adjusted rates January 1999.
3. Develop and implement competitively procured Medicaid HMO contracts with improved accountability for access, quality, and cost.
   - Incorporate the Department's developing access/enrollment, quality assurance and rate methodologies (including risk adjustment) into competitive procurement instruments, and coordinate the use of these tools to competitively procure HMO contracts.
   - Solicit and incorporate inputs from consumers, advocates, providers, plans and other stakeholders in developing models for competitive procurement of HMO contracts.
4. Regulate and provide technical assistance to health care coverage cooperatives.
   - Comply with statutory and regulatory obligations to act on applications for a cooperative certificate of authority, cooperative annual reports, and requests for waivers pursuant to HB 96-1264 within 30 days of receipt.

FY 97-98 PERFORMANCE MEASURES PROGRAM GOAL 3:

Item	FY 97-98
Implement selective contracting for organ transplant services	July 1, 1998
Investigate as feasible selective contracting for other FFS services	Ongoing
Develop HMO procurement model	July 1, 1998
Implement risk adjustment	October 1, 1997
With health plans, prepare encounter data specifications for new MMIS	Entire fiscal year
Health plans submit encounter data for risk adjustment	April, 1998
Review applications and reports from health care co-ops within 30 days	Ongoing

FY 98-99 PERFORMANCE MEASURES PROGRAM GOAL 3:

Item	FY 98-99
Implement daily rate for oxygen services in nursing homes	January 1, 1999
Determine feasibility of competitively procuring or unit dose pricing for prescription drugs in metro nursing facilities	June 30, 1999
Investigate as feasible selective contracting for other FFS services	Ongoing
Competitively procured HMO contracts effective	January 1, 1999
Develop risk adjusted HMO rates for calendar year 1999	July 1, 1998
Implement risk adjusted HMO rates for calendar year 1999	January 1, 1999
HMOs submit encounter data for risk adjustment in calendar year 2000	April 1999

FY 97-98 and FY 98-99 PROGRAM GOAL 4:

Analyze and inform Coloradans about the status of the health care system.

OBJECTIVES PROGRAM GOAL 4:

1. Publish and distribute annually to interested legislators, agencies and persons the Department of Health Care Policy and Financing Reference Manual and Annual Report.
2. Distribute the Reference Manual and Annual Report, with access information for other Department publications, on the Department's LAN to be used for staff training, and on the Department's Internet Home Page for general distribution.
3. Continue to integrate program descriptions, performance measures and data files used in Department's budget documents with the Reference Manual and Annual Report.
4. Produce a companion document and presentation set to the Annual Report and Reference Manual that serves as a centralized source of data, including tables and charts illustrating key Department program descriptions and performance measures.
5. Produce a report investigating the cost and volume of uncompensated care in Colorado and present recommendations for coordination or consolidations of current programs.
6. Publish an annual report on competition in the health care market in Colorado.
7. Brief constituents on the findings of the 1995 State Health Expenditure Account (SHEA) between November 1997 – January 1998. Data collection for the 1996 SHEA will begin in the fall of 1998, and a report on the findings released in December, 1998.
8. Produce report analyzing recent trends in health insurance coverage in Colorado based on data from the Current Population Survey.

PERFORMANCE MEASURES PROGRAM GOAL 3:

Reference Manual Publication Date				
Item	**FY 95-96**	**FY 96-**	**FY 97-98**	**FY 98-99**
Target			1/1/98	1/1/99
Actual	3/1/96	1/1/97		
Reference Manual Copies Distributed				
Target			700	700
Actual	600	700		
Annual Report Publication Date				
Target		1/1/97	1/1/98	1/1/99
Actual	(not published)	1/1/97		
Annual Report Copies Distributed				
Item	**FY 95-96**	**FY 96-97**	**FY 97-98**	**FY 98-99**
Target			1,100	1,100
Actual		1,100		
Data Book Completion Date				
Target	6/1/96	6/1/97	4/15/98	3/1/99
Actual	8/1/96	Annual Report Substituted		
Annual Report and Publication List Posted on Home Page				
Target			1/15/98	1/15/99
Actual		4/15/97		
Uncompensated care and consolidation report Target				8/98
Brief State Health Expenditures report Target				1/99-3/99
Report on uninsured data Target				6/99

FY 98-99 PROGRAM GOAL 5:

Evaluate programs implemented by the Department to improve access, quality or costs of health care services.

FY 97-98 OBJECTIVES PROGRAM GOAL 5:]

1. Evaluate the Integrated Care and Financing Project. Design data collection; develop instruments; collect data.
2. Evaluate the Brain Injury Program. Review recommendation of the HCFA compliance review site visit in October. Consult with advisory committee on outcome and recommendations.
3. Research approaches other states have taken to quality assurance and outcome measurement in home based services.
4. Evaluate or revise the State's 1115 federal waiver (of freedom of choice and inpatient reimbursements) for the competitive procurement of Medicaid organ transplant services. Maintain waiver authority according to federal and state requirements; extend or renew. Provide to HCFA and the legislature an evaluation of the effects upon access, quality and cost effectiveness, after 2 years of program operation requirements; extend or renew the waiver as appropriate.
5. Evaluate the Medicaid HMO competitive procurement project. By 7/1/98, establish accountability measures for evaluating effects of the initiative to competitively procure Medicaid HMO contracts upon access, quality and cost-effectiveness. Publish an annual evaluation of the program for competitive procurement of HMO services, by August 1 of each year following the first full year of operation.
6. Provide to HCFA and the legislature an evaluation of the effects upon access, quality and cost effectiveness of the waiver program for the competitive procurement of organ transplant services, after 2 years of program operation.

FY 98-99 PERFORMANCE MEASURES PROGRAM GOAL 5:

Evaluate the HMO competitive bid project	**FY 96-97**	**FY 97-98**
Establish accountability measures	June 30, 1997	
Publish annual evaluation		Start: August 1999
Evaluate the Brain Injury Program		**FY 97-98**
Develop format for program evaluation		July – Sept, 1997
Design format for client and provider satisfaction surveys		October, 1997
Conduct client and provider satisfaction surveys		January, 1998
Collaborate with CHA on hospital discharge LOS		January – June, 1998
Design outcome measurement tool		March, 1998
Issue report to Legislature		September, 1998
Evaluate the Integrated Care and Financing Project		**FY 97-98**
Conduct client and provider satisfaction surveys		January 1999
Conduct health status survey		Jan.-Feb. 1999
Produce final evaluation report		July 1999
Make expansion recommendations		July 1999
Evaluate Organ Transplant Waiver		**FY 97-98**
Maintain waiver authority		Ongoing
Produce evaluation report to HCFA and the General Assembly		Start date +2 years
Evaluate the HMO competitive bid project.	**FY 96-97**	**FY 97-98**
Establish accountability measures	June 30, 1997	
Publish annual evaluation report		Begin August, 1999

4. Recent Accomplishments of the Initiatives Office and its Partners

- ***Integrated Care and Financing Project -*** Completed project design and rate methodology, in consultation with local project staff on the care coordination model. Identified quality assurance indicators to be measured in the pilot. A federal waiver was approved on July 1, 1997, allowing the demonstration to begin in early 1998. Staff, providers and consumers developed a communications plan to explain the new program to eligible recipients.

- ***Brain Injury Program*** - During the initial two years of operation, the program served 151 persons between the ages of 16 and 64 with traumatic or acquired brain injury. 64% were traumatic and 35% were acquired brain injuries. Sixty percent of the clients in this program came from the Denver metro area. Initiatives staff certified 53 HCBS-BI providers, representing a continuum of provider types from individual practitioners to agencies.

- ***Home Health Aide Pilot Program -*** OPPI conducted a survey of home health agency costs and practices and included this information in a waiver request to HCFA in May of 1995. Final waiver approval was received on October 15, 1997. It is projected that clients will begin enrolling in the program in July 1998.

- ***Consumer-directed Attendant Support Program -*** Since June of 1996, OPPI 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.

- ***Residential Treatment Center Program*** – OPPI staff assisted in moving the RTC program from HCPF to the Department of Human Services effective July 1, 1997. The RTC program experienced rapid growth between 1994 and 1997, to a capacity of approximately 1350 children with a psychiatric diagnosis in 47 participating facilities throughout the state. Fiscal management for the program was transferred to county governments, along with control of access and utilization of RTCs. HCPF will continue to monitor RTC use of Medicaid funds.

- ***Children's Basic Health Plan*** - In October, 1997, Colorado submitted its Title XXI State Plan to the Health Care Financing Authority for a children's health insurance program.

- ***School-Based Health Centers*** – In coordination with representatives from the Department of Public Health and Environment and the Department of Education, OPPI staff assisted SBHCs in preparing for managed care contracting, including establishing health insurance profiles of students, fee schedules, quality and access standards, a network of SBHC administrators, and facilitating meetings with managed care representatives.

- ***Competitive Procurement and Selective Contracting*** – A federal waiver to permit competitive procurement and improved access and quality of Organ Transplant services was obtained in early 1997. This was followed by an Invitation for Bids in July 1997. An insufficient number of viable bids was received in the first round of bidding; the utilization/cost database, contract and waiver specifications are under revision for a second bid offering in early 1998. Improved reimbursement and contracting methods for

Supplemental Oxygen Services in metro Nursing Facilities were developed by the Competitive Procurement Project and approved by the Medicaid program in 1997 for implementation in late 1998. The "uniform daily rate to any willing and qualified provider" methodology is expected to provide improved access to more cost-efficient oxygen services.

- ***HMO Competitive Bidding*** – During the second half of FY 97, the HMO Bidding Team, led by Initiatives Office staff, reviewed the experience of other state Medicaid programs that have implemented competitive bidding. Based on other states' and payors' models and the Colorado markets and delivery systems, staff developed options for methods of competitively procuring Medicaid managed care. The options were presented for review and comment at community and plan input meetings in October and November 1997.

- ***Medicaid HMO Risk Adjustment*** – In FY 96-97, Initiatives Office staff convened and staffed health plan working groups to develop guidelines and methodology policy for HMO rate risk adjustment. HMOs first submitted test encounter data and then a full year of data for the FY 98 risk adjustment. As a result of this collaborative work between the Department, the health plans, and the consultant, the first round of risk adjustment factors was released in July, 1997.

- ***Private Sector Health Care Coverage Cooperatives*** – In FY 97, Initiatives Office staff issued the first "House Bill 1264" waiver to a certified health care coverage cooperative. House Bill 1264, passed by the General Assembly in 1996, provides qualified health care coverage cooperatives with an exemption from provisions of the Small Group Insurance Reform law; exemptions allow qualified cooperatives to negotiate different prices with health plans. Initiatives Office staff developed regulations to implement the act, which were adopted by the Executive Director in October 1996. The first waiver was awarded to the Cooperative for Health Insurance Purchasing (CHIP) on June 30, 1997.

- ***Public Employers Insurance Purchasing Project*** – The Initiatives Office provided technical assistance and regulatory guidance to the Public Employers Group Insurance Authority (PEGI) Transition Team. This group, established by the Public Employees' Retirement Association (PERA), the State Department of Personnel, and the Colorado Municipal League, sought to develop legislation that would create a state authority to purchase health insurance for state and public employees in Colorado. Senator Rizzuto and Representative Owen introduced House Bill 97-1092, creating the Public Employers Group Insurance Authority, which passed the House of Representatives but failed in the Senate.

- ***Department of Health Care Policy and Financing Reference Manual and Annual Report*** - In 1996 and 1997 the Office produced and distributed more than 600 copies annually of the comprehensive Department Reference Manual, and 1100 copies of the summary 1996 HCPF Annual Report. Legislators, providers, consumers, health plans, Medicaid clients, state and local agencies, and other interested parties utilize the Manual and Report to obtain information on HCPF programs, goals and objectives, budget and products. The Annual Report and an abridged version of the Reference Manual were also made available in 1997on the State of Colorado-HCPF Internet site.

- ***Insurance Coverage Expansion*** - In August of 1995, Governor Romer released an OPPI report, "Survey Data on Family and Employer Health Insurance: Implications for

Colorado," and appointed a Task Force on Coloradans Without Health Insurance. For the 1996 legislative session, the Task Force developed an unsuccessful legislative proposal for tax credit financing of community health initiatives. Since then, OPPI 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. The information provided by OPPI was helpful in securing passage of House Bill 97-1304, the Children's Basic Health Plan.

- ***Interagency Working Group on Health System Accountability*** - During FY 95-96, 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 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 that were promulgated by the Division of Insurance in early 1997, regarding consistent processes for utilization review across carriers.

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 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 is engineering an information technology foundation to meet the customers' diverse computing requirements, and providing training and methods for its use.

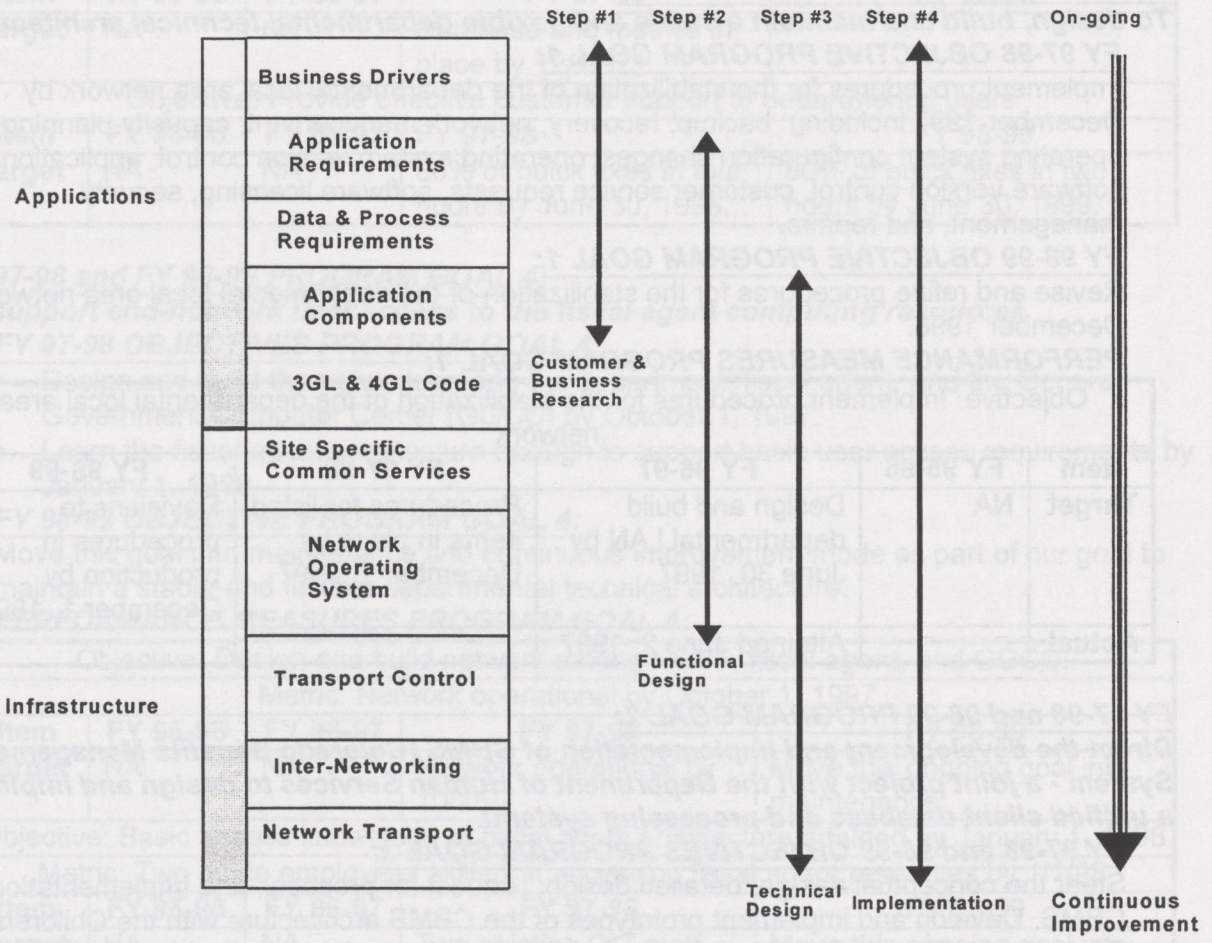
The departmental business functions and responsibilities continue to grow. With each business unit expansion and functional review, the Office of Information Technology (OIT) seeks to guide the technology components toward a common enterprise systems architecture. The OIT staff members continually review the technical processes of the department's business units and its external partners in order to guide design and implementation efforts toward interoperable, flexible, and standard technical platforms.

The goals of the Office of Information Technology are to:

- design and build a stable and flexible technology architecture for the department;
- provide effective customer support to departmental users of information technology;
- support network access to the fiscal agent computing resources;
- in coordination with the Department of Human Services, direct the development and implementation of the Colorado Benefit Management System (CBMS);
- develop sound financial controls and planning methods for managing the department's investment in information technology;
- sustain and enhance an Information Technology education and training program for the department;
- leverage our information technology infrastructure as a departmental communications and research tool; and,
- coordinate Departmental Information Technology planning.

The schematic figure on the next page illustrates the Department's information system structure and standards. The figure shows the 10-layer model used by OIT in analyzing, designing and implementing the department's technology solutions to its business problems.

FIGURE 4: OFFICE OF INFORMATION TECHNOLOGY STRUCTURE AND STANDARDS, LAYERS OF FOCUS



Business Drivers - Business requirements, New business opportunities, Customer Support, Stabilize IT Environment, Priorities, User Profiles, Strategic Planning, Tactical Planning, Technical Architecture, Organizational Structure, Scheduling, Contracts, Evaluations, Staffing, Budgeting, Project Management, Office Space, etc.

Application Requirements - User Requirements, Decomposition Diagrams, Systems Analysis, Quantitative Research, Qualitative Research

Data & Process Requirements - Data Model, Work Flow, DBMS Design, Use-Case Scenarios, Systems Design

Application Components - Office 97, Decision Support, Rules Processors

3GL & 4GL - Ad Hocs, Cobol, JCL, SQL Procedures, TSO, Visual Basic

Site Specific Common Services - Exchange (Email), SNA Gateway, Decision Support Interface, Net Mgt. Software, Internet Access, Help Desk Software, DBMS, SMS, Security, Transaction Processors

Network Operating System - Server Configuration, Workstation Configuration, File Management, Disk-CPU-Memory Management, Print services, Capacity planning, Backup-Restore Procedures, Archiving Plan, Hardware Architecture Planning, Disaster Recovery/Business Resumption Planning, Research & Development

Transport Control - TCP, FTP, Telnet, SNMP, HTTP, RAS, DHCP

Inter-Networking - IP Addressing, Router Configurations, Hub Configurations, Net Management Ports, WAN Interface

Network Transport - Wiring, NIC cards, IEEE 802.3, Power, Patch Panels, Cubicle Ports

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

2. OIT PROGRAM GOALS, OBJECTIVES AND PERFORMANCE MEASURES

FY 97-98 and 98-99 PROGRAM GOAL 1:

To design, build and maintain a stable and flexible departmental technical architecture.

FY 97-98 OBJECTIVE PROGRAM GOAL 1:

Implement procedures for the stabilization of the departmental local area network by December 1997 including: backup, recovery, network management, capacity planning, operating system configuration changes, operating system version control, application software version control, customer service requests, software licensing, security management, and repairs.

FY 98-99 OBJECTIVE PROGRAM GOAL 1:

Revise and refine procedures for the stabilization of the departmental local area network by December 1998.

PERFORMANCE MEASURES PROGRAM GOAL 1:

Objective: Implement procedures for the stabilization of the departmental local area network				
Item	**FY 95-96**	**FY 96-97**	**FY 97-98**	**FY 98-99**
Target	NA	Design and build departmental LAN by June 30, 1997.	Procedures for listed items in place by December 1, 1997	Revisions to procedures in production by December 1, 1998
Actual		Attained June 2, 1997		

FY 97-98 and 98-99 PROGRAM GOAL 2:

Direct the development and implementation of CBMS [Colorado Benefits Management System - a joint project with the Department of Human Services to design and implement a unified client database and processing system].

FY 97-98 and 98-99 OBJECTIVES PROGRAM GOAL 2:

Steer the conceptual design, detailed design, request for proposal, and implementation of CBMS. Develop and implement prototypes of the CBMS architecture with the Children's Basic Health Plan requirements and a standalone subset of the Medicaid rules. Build and operate organizational structure and budget for CBMS. Begin system development.

PERFORMANCE MEASURES PROGRAM GOAL 2:

Item	**FY 97-98**	**FY 98-99**
Target	Conceptual design, detailed design, RFP, and pilots done by June 30, 1998	Development vendor secured and implementation underway.

FY 97-98 & FY 98-99 PROGRAM GOAL 3:

To provide effective customer support to departmental users of information technology.

FY 97-98 OBJECTIVES PROGRAM GOAL 3:

Develop an informal and comfortable interface with customers while formally capturing request and requirements data. Establish a database of customer requests, requirements, and service metrics by December 1, 1997. Summarize the effectiveness of customer interactions. Deliver solutions to 80% of the "quick fix" requests within four hours by June 30, 1998.

FY 98-99 OBJECTIVE PROGRAM GOAL 3:

Summarize the effectiveness of customer interactions. Deliver solutions to 80% of the "quick fix" requests within two hours by June 30, 1999.

PERFORMANCE MEASURES PROGRAM GOAL 3:

Establish a database of customer requests, requirements, and service metrics by 12/1/97				
Item	**FY 95-96**	**FY 96-97**	**FY 97-98**	**FY 98-99**
Target	NA	NA	Database and metrics in place by 12/1/97.	
Objective: Provide effective customer support to departmental users				
Item	**FY 95-96**	**FY 96-97**	FY 97-98	**FY 98-99**
Target	NA	NA	80% of quick fixes in four hours by June 30, 1998.	80% of quick fixes in two hours by June 30, 1999.

FY 97-98 and FY 98-99 PROGRAM GOAL 4:

To support end-network user access to the fiscal agent computing resources.

FY 97-98 OBJECTIVES PROGRAM GOAL 4:

- Design and build the network among the department, fiscal agent, and the General Government Computer Center (GGCC) by October 1, 1997.
- Learn the fiscal agent architecture enough to support basic user access requirements by January 1, 1998.

FY 98-99 OBJECTIVE PROGRAM GOAL 4:

Move this goal into maintenance and continuous improvement mode as part of our goal to maintain a stable and flexible departmental technical architecture.

PERFORMANCE MEASURES PROGRAM GOAL 4:

Objective: Design and build network among HCPF, fiscal agent, and GGCC.				
Metric: Network operational by October 1, 1997.				
Item	**FY 95-96**	**FY 96-97**	**FY 97-98**	**FY 98-99**
Target	NA	NA	Network operational by 10/1/97	Move this ongoing goal into maintenance
Objective: Basic access knowledge of fiscal agent architecture attained by January 1, 1998				
Metric: Two office employees skilled at accessing fiscal agent resources by 1/1/98				
Item	**FY 95-96**	**FY 96-97**	**FY 97-98**	**FY 98-99**
Target	NA	NA	Two existing OIT staff skilled at accessing resources by 1/1/98	Move this ongoing goal into maintenance

FY 97-98 and FY 98-99 PROGRAM GOAL 5:

To develop sound financial controls and planning methods for managing the Department's investment in information technology.

FY 97-98 OBJECTIVES PROGRAM GOAL 5:

- Design and build a centralized inventory control database for hardware and software purchased by this office by November 1, 1997.
- Develop financial statements, tracking databases, and control procedures for budget appropriations, budget forecasts, and office expenses by October 1, 1997.

FY 98-99 OBJECTIVE PROGRAM GOAL 5:

Enhance and maintain the centralized inventory control and financial control.

PERFORMANCE MEASURES PROGRAM GOAL 5:

Objective: Design and build a centralized inventory control database				
Metric: Inventory control database in production by November 1, 1997				
Item	**FY 95-96**	**FY 96-97**	**FY 97-98**	**FY 98-99**
Target	NA	NA	Inventory control database by 11/1/97	Enhance and maintain by 6/30/99
Objective: Develop financial controls and databases.				
Metric: Financial controls and databases in production by October 1, 1997.				
Item	**FY 95-96**	**FY 96-97**	**FY 97-98**	**FY 98-99**
Target	NA	NA	Financial controls and databases by 10/1/97	Enhance and maintain by 6/30/99

FY 97-98 and 98-99 PROGRAM GOAL 6:

To develop a Departmental Information Technology education and training program.

FY 97-98 OBJECTIVES PROGRAM GOAL 6:

- Deliver 100 hours of hands-on in-house training and education to departmental users by June 30, 1998. Specify ongoing requirements for in-house training for subsequent years.
- Research the feasibility of a structured education and training program for the department. If feasible, implement by January 1, 1998.

FY 98-99 OBJECTIVE PROGRAM GOAL 6:

- Revise education and training approach to meet new departmental requirements.

PERFORMANCE MEASURES PROGRAM GOAL 6:

Objective: Deliver 100 hours of hands-on in-house training and education to users				
Metric: 100 hours of training delivered by June 30, 1998				
Item	**FY 95-96**	**FY 96-97**	**FY 97-98**	**FY 98-99**
Target	NA	NA	100 hours of training delivered by 6/30/98	Revise to meet new departmental requirements
Objective: Determine feasibility of structured education and training program.				
Metric: Feasibility determined and begin implementation by January 1, 1998.				
Item	**FY 95-96**	**FY 96-97**	**FY 97-98**	**FY 98-99**
Target	NA	NA	Feasibility and alternatives researched by 1/1/98	If feasible, implement education and training program.

FY 97-98 and FY 98-99 PROGRAM GOAL 7:

To leverage the Department's information technology infrastructure as a research and communications tool.

FY 97-98 OBJECTIVE PROGRAM GOAL 7:

- Develop our State of Colorado Internet web site to include departmental reference material, publications, research findings, frequently asked questions, and current health care policy news by January 1, 1998.
- Develop our departmental Intranet capabilities to include an index server and search engine for internal reference documents, standard operating procedures, team reports, research findings, and current health policy news by March 1, 1998.

FY 98-99 OBJECTIVE PROGRAM GOAL 7:

Move this goal into maintenance and continuous improvement mode as part of our goal to maintain a stable and flexible departmental technical architecture.

PERFORMANCE MEASURES PROGRAM GOAL 7:

Objective: Develop our State of Colorado Internet web site				
Metric: Additional web site features researched, designed, programmed, and implemented by January 1, 1998				
Item	**FY 95-96**	**FY 96-97**	**FY 97-98**	**FY 98-99**
Target	NA	NA	Features added by 1/1/98	Move into maintenance
Objective: Develop Departmental intranet capabilities				
Item	**FY 95-96**	**FY 96-97**	**FY 97-98**	**FY 98-99**
Target	NA	NA	Features added by 3/1/98	Move into maintenance

FY 97-98 and FY 98-99 PROGRAM GOAL 8:

To coordinate departmental information technology planning.

FY 97-98 and FY 98-99 OBJECTIVES PROGRAM GOAL 8:

- Consult 200 hours with department managers in planning their information technology strategies, methods, and systems development by June 30, 1999.
- Prepare, present, defend, develop and implement the Department's five-year and yearly Information Management Annual Plan (IMAP) as required by the state's Information Management Commission.

PERFORMANCE MEASURES PROGRAM GOAL 8:

Objective: Consult 200 hours with Department managers				
Item	**FY 95-96**	**FY 96-97**	**FY 97-98**	**FY 98-99**
Target/ Actual	NA	NA	Consulting completed by 6/30/98	Consulting completed by 6/30/99
Objective: Prepare, present, defend, develop and implement the Department's five-year and yearly Information Management Annual Plan (IMAP)				
Item	**FY 95-96I**	**FY 96-97**	**FY 97-98**	**FY 98-99**
Target/ Actual	NA	IMAP completed by 8/1/97	IMAP completed and defended by 12/1/98	IMAP completed and defended by 12/1/99

3. Recent Office of Information Technology Accomplishments

- Designed, developed and installed a new information technology architecture for all departmental users. The architecture is based on Microsoft NT 4.0 clients and servers, Microsoft Office 97, TCP/IP, and Ethernet (see Figure 5 for details).
- Developed a vision and conceptual design template for the integration of medical insurance eligibility processes into the Colorado Benefits Management System (CBMS). CBMS is a joint effort with the Colorado Department of Human Services.
- Played a major role in the proposal and review of the new fiscal manager technical architecture.
- Continued to support the Medicaid Automated Data Extract System (MAUDE).
- Supported the accounting and purchasing elements of the COFRS system.
- Developed a help desk structure for LAN-based technology support.
- Developed and instituted departmental LAN standards.

V. OFFICE OF MEDICAL ASSISTANCE

A. 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 a quarter-million 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 Colorado Indigent Care 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 96-97 health care providers received over $1.5 billion per year in reimbursements for services rendered to those clients.

FIGURE 5: NUMBER OF CLIENTS SERVED AND PAYMENTS TO PROVIDERS, FISCAL YEAR 96-97

Program	Number Served	Total Payments
Medicaid (HCPF-Medical Services)	270,000	$1065.6 million
Medicaid (DHS-administered MH & DD services)*	NA	$291.4 million
Disproportionate Share Hospital payments**	NA	$121.7 million
Colorado Indigent Care Program (CICP)	est. 135,000	$38.5 million
Home Care Allowance***	5,900	$15.0 million
Adult Foster Care***	300	$ 0.8 million
Poison Control Center	55,500	$1.1 million
TOTAL	**est. 460,000**	**$1,534 million [$1.5 billion]**

NOTES:
* 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.
** DSH amounts are calculated on an accrual basis (tied to the fiscal year for which the plan was approved) rather than a cash basis (the year of the actual payment) and therefore will not tie to COFRS-based budget reports.
*** 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 Mental Health and Developmental Disability services, although these are largely funded by the Medicaid program.

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.

1. Background: Medicaid and Other Public Health Programs

Congress enacted Medicaid 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 culturally and linguistically competent health care services to low-income citizens.

Federal, state, and local governments made significant investments in the following decades to address these problems. To improve 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 (local health departments). 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. Also beginning in the 1980's, 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.

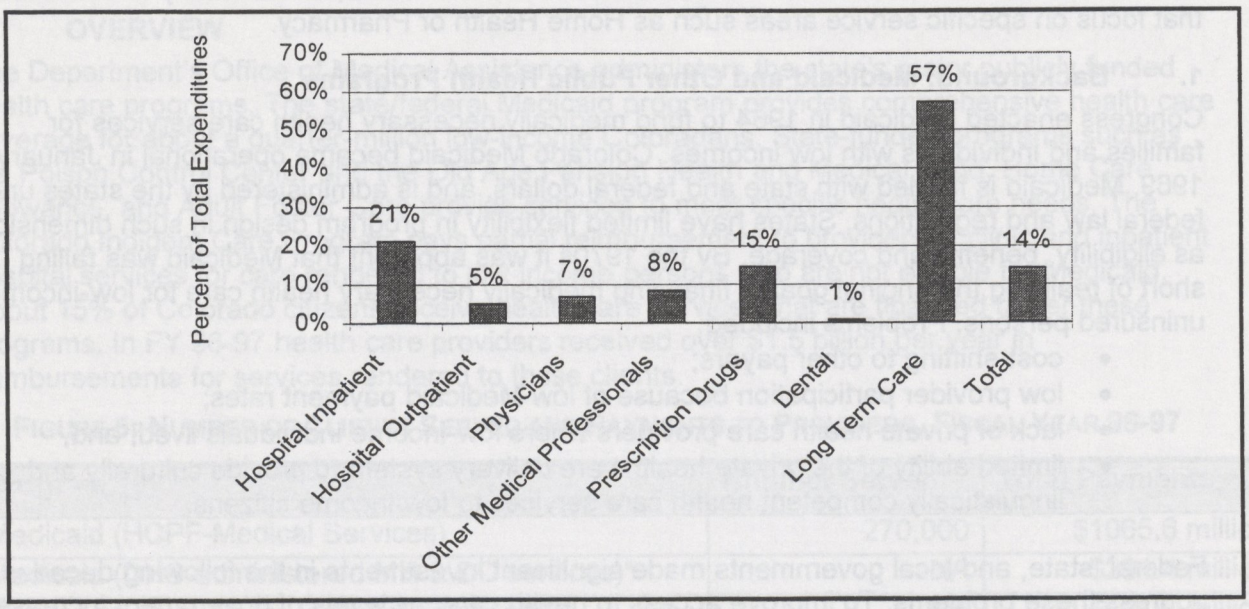
Congressional action and court decisions in recent years have further extended public health care coverage, especially through Medicaid, to groups of individuals such as pregnant women, young children, the elderly, and children and adults with disabilities. Many of these newly-eligible individuals are in need of high-cost care. Public payers, including Medicaid, were also required to reimburse a number of provider groups such as hospitals, community health centers and nursing facilities at substantially higher rates. Federal budget legislation in 1997 created a major coverage expansion program for children that will further improve health care access for low-income families, and further expand publicly funded health care programming.

Today, HCPF programs are a major health care payer to health plans, 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 chart on next page.) 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 roles as health care payors.

The Department now faces new challenges in administering and developing its Medical Assistance programs. Managed care, coverage expansions and welfare reform initiatives are resulting in significant changes to the State's public health care financing, administration and

delivery systems. The Office of Medical Services staff are engaged in major restructuring of programs and operations to meet these challenges.

FIGURE 6: MEDICAID SHARE OF COLORADO HEALTH CARE EXPENDITURES, 1995



2. Organization of the Office of Medical Assistance

The Office of Medical Assistance is divided by program function into three Divisions. These Divisions are organized into a total of eight Sections. There is also a Managed Care Transition Project that coordinates a number of department-wide teams. The three Divisions are as shown on the organizational chart in the front of the Reference Manual: Health Plan Management, Health Plan Operations, and Managed Care Contracting.

The mission, functions and management plans of each unit are described on the following pages. The order of listing of the Sections (the organizational units within the Divisions) in this Manual does not follow the organizational chart. Instead, the order below approximates the pathway that a client would take in accessing services, and then the path that health providers or HMOs would use in obtaining and processing their contracts and reimbursements:

- Customer Service
- Eligibility and Enrollment
- Health Care Benefits
- Managed Care Contracting [The Managed Care Project description follows]
- Quality Assurance
- Facility and Provider Rates (2 sections)
- Information Systems
- Third Party Resources

NOTE: In order to present program information coherently in this Manual, all Eligibility and Enrollment, Health Benefits, and Managed Care programs and procedures are explained fully under those Section headings, whether or not a specific program component is actually managed in that Section. For example, although staff administering Poison Control and Colorado Indigent Care (CICP) programs are assigned to the Facility Rates section (and the rate setting methods are in fact explained under Facility Rates), the benefits provided under those programs are explained under the Health Benefits Section. There are notes in the text below where this convention is followed.]

B. 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.

The Customer Service Section's staff and Section Manager were recognized in 1997 with two awards for excellence:

- **the Department's Outstanding Performance Award, and**
- **the Governor's Award for Peak Performance for Citizen Satisfaction.**

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:

- Staff and operate the Customer Service Information Line, and facilitate resolution of customers' problems.
- Assist clients to enroll with or change Primary Care Physicians, and to enroll into HMOs. (See also the FirstHelp line function described in the Managed Care Division chapter, and the proposed Enrollment Facilitator function described in the Eligibility and Enrollment Section chapter.)
- Refer providers to the contracted Medicaid Communications unit at the Fiscal Agent, to facilitate enrollment of physicians as Medicaid Primary Care Providers and other providers.
- Coordinate customer service functions among internal and external customer service units, to ensure that consistent and accurate information is provided and problems are resolved including:
  - Coordinate customer service functions with the Quality Assurance and Eligibility and Enrollment Sections, and the Peer Review Organization.
  - Cooperate with the Information Systems Section to coordinate customer service functions with the Department's fiscal agent contractor's communications units.
  - Coordinate resolution of problems with the contracted Client Advocacy Office of the Department of Human Services.
- Propose, develop and implement policies, procedures and systems modifications to improve customer service.
- Beginning in 1998, procure and manage a contract to operate a Managed Care Ombudsman program.

a) Client Help Lines and Services

- The Customer Service section operates the **Customer Service Information Line** - This toll-free telephone service provides immediate response to client and provider questions regarding: the PCP program, other managed care options and general Medicaid and Colorado Indigent Care Program (CICP) information. An automated "Teletips" function provides touch-tone access to recorded messages on the most commonly asked questions. This is available to the general public 24 hours per day in both English and Spanish. Customer Service representatives also directly assist clients in choosing or changing a primary care physician or enrolling into an HMO. The Information Line number is distributed to all Medicaid clients by county-level eligibility technicians and is printed in Medicaid program brochures and publications.

- **Client Billing Assistance** is also available by calling the Customer Service Information Line - 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. Staff also advocate on the client's behalf with collection agencies and upon request, assist clients who have been erroneously taken to court because of Medicaid bills.

- Staff coordinate with the **Colorado Indigent Care Program** staff to resolve client issues. Oftentimes, people who are not eligible for Medicaid may qualify for assistance through this program. Staff in the Customer Service Section are trained to answer basic questions about the CICP.

- **Other Client Help Lines and Services** - The Customer Service section refers some questions to other help lines. The following help lines and client contact databases are currently operated by the CFMC (the Department's Peer Review Organization contractor), 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 CFMC-operated 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.

  - **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 that 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. PROGRAM GOALS, OBJECTIVES AND PERFORMANCE MEASURES

FY 97-98 and FY 98-99 PROGRAM GOAL 1:

To assist Medicaid clients to make quality health care choices, to coordinate this function with the enrollment facilitator.

OBJECTIVES PROGRAM GOAL 1:

1. Explain managed care to callers and provide them with available managed care choices.
2. Enter managed care choice data in COIN and Access Database
3. Coordinate with Eligibility and Enrollment, Managed Care Contracting and other HCPF units to maintain current information on HMO and PCPP providers and networks, and managed care information, on the pre-recorded VERBATIM Teletip system

FY 97-98 and FY 98-99 PROGRAM GOAL 2:

To provide accurate, timely information to customers.

FY 97-98 OBJECTIVES PROGRAM GOAL 2:

1. Increase Customer Service Representatives from 3 FTE to 5 FTE
2. Increase hours of operation from 7:00AM to 6:00 PM
3. Develop file of necessary information for CS Line Representatives and coordinate with OIT to automate this information On-Line for easy access by operators
4. Create reports for management to quantify inquiries/problems/resolutions
5. Implement and maintain current information on VERBATIM Teletips
6. Establish full service availability in Spanish
7. Develop one-stop-shop capability of staff
8. Contract to upgrade software to generate call tracking reports from VERBATIM system
9. Reduce average caller wait time to less than 300 seconds; respond to written inquiries within 10 working days
10. Create an information library which centralizes and maintains a copy of all HCPF brochures, publications, rules and policy; develop listing of Community Resources which may be able to assist clients if services needed are not a Medicaid Benefit
11. Purchase Language Line services to serve non-English/non-Spanish-speaking callers
12. Ensure that State Plan Amendments are accurate, timely and consistent

FY 97-98 and FY 98-99 PROGRAM GOAL 3:

To provide superior interactions with the general public and internal customers.

OBJECTIVES PROGRAM GOAL 3:

1. Develop a form to track staff compliments/complaints (12/97)
2. Develop procedures to reward staff for excellence in customer service (9/97)
3. Develop a schedule and tracking form for Manager to monitor 4 calls/week for each customer service representative 12/97
4. Anticipate and prevent problems for clients by suggesting policy change and developing customer-centered policies, rules and procedures
5. Provide training to improve Customer Service Skills of each customer service staff member
6. Develop and implement a Customer Call Back procedure and tracking form to determine customer satisfaction with Customer Service Representatives12/97
7. Implement voice mail customer satisfaction surveying and document comments to be used to continually improve the understandability of the Teletips feature

8. Post weekly Customer Service Tips as the goal for the week 1/98
9. Develop rules for reimbursement to clients who have retroactive eligibility (i.e. rules to allow provider to submit a claim or reimburse the client, sanction the provider or reimburse the client directly from Medicaid, make failure to issue reimbursement to a client a basis for decertification of the provider)
10. Ensure that all policy interpretations are consistent with Medicaid rules and regulations
11. Provide input to the Welfare Reform Committee to try and reduce negative effects on legal immigrants, delayed Medicaid coverage of persons with disabilities and the elderly
12. Participate in departmental teams and provide input into team decisions and products, which are citizen centered, high quality, convenient and inexpensive
13. Gather input from the Medicaid Disability Advisory Group, Diversity Council and other sources
14. Coordinate with Citizen Advocacy Corps, Fiscal Agent (Medicaid Communications) and Front Desk to assure that clients issues are resolved
15. Maintain a Customer Friendly Staff with an attitude of helpfulness to the rest of HCPF

FY 97-98 PROGRAM GOAL 4:

To improve ability to assist certain client populations.

FY 97-98 Objectives:

1. At least 1 of 2 new Customer Service Representatives will speak Spanish
2. Translate Teletips into Spanish and activate Spanish capabilities of the Verbatim system

OVERALL CUSTOMER SERVICE PERFORMANCE MEASURES

Item	FY 94-95	FY 95-96	FY 96-97	FY 97-98
Customers served per month				
TARGET	Unknown	4,160	4,620	4,620
ACTUAL	Unknown	4,160	3,938	4333
Average wait time per call				
TARGET	Unknown	10 minutes	15-20 minutes	Less than 3
ACTUAL	Unknown	15+ minutes	Less than 5	Less than 3
Average # of complaints/mo				
TARGET	Unknown	5-10	65	4*
ACTUAL	Unknown	65	74	6

* Starting in FY 97-98, only complaints about Customer Service line problems will be logged, such as staff responses or wait times. Previously, all complaints received were logged; most concerned client problems with eligibility, benefits or treatment by other agencies.

3. **Recent Customer Service Accomplishments**

- **Customer Service Information line staff responded to 47,264 calls in FY 96-97.**
  - Of these calls the Information line operators resolved 84%, and 16% were referred to subject matter experts within the department or to outside entities.
  - Average **wait time** per call was reduced by more than 80%.
- Customer Service Specialists responded to resolve inquiries from legislators on behalf of constituents and requests by citizens to the Governor's Office.
- **Performance Awards -** The Customer Service Section received the first Annual HCPF Recognition for Outstanding Performance Award. The Section Manager received the 1997 Governor's Peak Performance Award for Citizen Satisfaction.
- **Customer Service Certification** - All Department staff received customer service training and certification during FY 96-97. 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. Call wait times and customer complaints are all radically reduced by the new system. From July 1, 1996-June 20, 1997 the redesigned Customer Service Line routed and answered over 60,000 calls from clients, providers, legislative constituents, and other persons needing information about HCPF programs.

C. ELIGIBILITY AND ENROLLMENT SECTION

The mission of the Eligibility and Enrollment Section is to provide a gateway to benefits for eligible clients.

1. Program Description

The Eligibility and Enrollment Section (E&E) facilitates and controls client access to Medicaid benefits by developing and administering eligibility policy and enrollment procedures, and by administering eligibility determination for several programs. The section defines Medicaid program eligibility, oversees enrollment with managed care 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.

The section's major responsibilities are detailed below:

a) Eligibility and enrollment policy dissemination:

- Determine eligibility policy for Colorado Medicaid in response to state and federal law and regulations
- Develop and implement procedures and systems for Medicaid managed care enrollment and disenrollment
- Develop and disseminate program information to Medicaid clients
- Develop and deliver training on Medicaid eligibility and managed care enrollment for county departments of social services, single entry points, presumptive eligibility sites, EPSDT outreach workers, and other eligibility and enrollment staff

b) Medicaid application process oversight for:

- County departments of social services and their outreach sites (through interagency agreement with Colorado Department of Human Services)
- Presumptive Eligibility (through interagency agreement with Colorado Department of Human Services)
- Baby Care Kids Care (through interagency agreement with DHS)
- Review of trusts for their potential impact on Medicaid eligibility
- Model 200 Children's HCBS waiver (expanded eligibility for severely disabled children

c) Managed Care Enrollment and Disenrollment:

- Design, publication and dissemination to Medicaid clients of Managed Care choice information
- Training and oversight for eligibility and provider site Managed Care enrollment processes
  - Managed Care Enrollment Facilitator contract procurement and management
  - Disenrollment process design and contractor oversight

d) Direct Administration of Medicaid Programs and Benefits:

- Prenatal Plus Program (in cooperation with the Department of Public Health and Environment)
- Teen Pregnancy Prevention Program
- Special Connections (high-risk pregnancy program, in cooperation with the Department of Human Services)
- Benefits to undocumented aliens
- Medicaid abortions

2. Welfare Reform Changes to Medicaid Eligibility

Federal and state Welfare Reform initiatives caused a major change in the basis for Medicaid eligibility, but very few Coloradans lost Medicaid eligibility as a result. In fact, additional Colorado residents became eligible for Medicaid coverage under the TANF and Colorado Works provisions and the related implementing legislation. Medicaid clients continue to be eligible for Medicaid if they meet the AFDC eligibility criteria that were in place on or prior to July 16, 1996, even though they will no longer be eligible for AFDC. They need not be receiving assistance under Colorado Works and there is no time limit for Medicaid eligibility. These and other changes are detailed below:

a) Services to Families and Children

TANF (Temporary Assistance to Needy Families)-- The "Colorado Works" program is the state's version of the federal TANF program. TANF reforms and replaces the Aid to Families with Dependent Children [AFDC] program. To be eligible, individuals must meet the eligibility standards of the AFDC program of July 16, 1996, except that Colorado Works will also be available to two parent families and to those with additional resources (a car and up to $2000). Medicaid benefits continue at least as long as individuals remain in the Colorado Works Program. However, the five-year lifetime limitation on receipt of TANF benefits does not apply to Medicaid. Medicaid coverage continues as long as families and individuals meet program income and resource guidelines. Transitional Medicaid benefits are also available.

Senate Bill 97-120 authorized "Transitional Plus" a subsidized health care insurance program for Colorado families transitioning off public assistance. Families become eligible for Transitional Plus when they are no longer eligible for TANF cash benefits and have exhausted Transitional Medicaid benefits. The benefit package will include both inpatient and outpatient care, but will not be as comprehensive as the Medicaid benefit package. Families will contribute to the cost of their health care through sliding scale premiums based on income and minimal co-payments. The subsidy can also be used to help families purchase employer-based family coverage. The Department will in 1998 apply for a federal waiver of Medicaid regulations to permit implementation of the "Transitional Plus" program in 1999.

AFDC (Aid to Families with Dependent Children) -- Medicaid eligibility continues for individuals and families who would be eligible for AFDC according to the eligibility standards of July 16, 1996, regardless of participation or non-participation in Colorado Works. There is no time limit for this continuing Medicaid eligibility.

b) Services for Immigrants

Legal immigrants -- Those legal immigrants in the following categories who were present in the U.S. prior to August 22, 1996, if otherwise eligible, will retain eligibility for Medicaid coverage:

- Legal permanent residents
- Refugees and Asylees

- Veterans and active duty military, their spouses and dependent children, unremarried surviving spouses of veterans, and Hmong and Highland Lao veterans
- Parolees who are paroled for at least one year
- Conditional entrants and individuals whose deportation is being withheld
- Battered immigrants
- Certain Cuban and Haitian entrants, Amerasians, and certain American Indians

Individuals qualifying under the above categories comprise about 95% of the legal immigrants in this country who were eligible prior to welfare reform. They are referred to in the federal law as "qualified" immigrants.

There are other categories of immigrants who may qualify for Medicaid coverage. The Balanced Budget Act of 1997 continued SSI coverage for disabled immigrants who were in the U.S. on 8-22-96. Also, an immigrant could be terminated from SSI or be denied SSI due to her/his immigrant status and still be eligible for Medicaid. Those individuals should contact their county departments of social services to insure their continued coverage.

Legal immigrants who arrive in the U.S. on or after August 22, 1996, if otherwise eligible, are eligible for Medicaid coverage if they are in one of the following categories:

- Veterans and active military, their spouses and dependent children, unmarried surviving spouses of veterans, and Hmong and Highland Lao veterans
- Refugees and Asylees
- Individuals granted withholding of deportation
- Certain Cuban and Haitian entrants, Amerasians, and certain American Indians

Other categories of legal qualified immigrants will be barred from Medicaid coverage for the first five years after entry into the U.S.

Emergency services -- all immigrants, if otherwise eligible, regardless of their immigrant status or date of entry, are eligible for emergency services. Emergency services includes labor and delivery.

Confidentiality -- Medicaid providers and the Medicaid program must maintain clients' medical confidentiality. Federal law therefore forbids reporting on the immigration status of clients by Medicaid staff or providers.

c) SSI-Children

It is estimated that between 2,000 to 3,000 children in Colorado may lose SSI income due to the Social Security Administration's new definition of disability for children. SSA must discontinue the individualized functional assessment and eliminate maladaptive behavior in determining whether a child is disabled. These children, however, will continue to be covered by Medicaid according to provisions of the Balanced Budget Act of 1997.

d) Eligibility for State-Only Programs

The General Assembly took action to assure that legal immigrants continue to be eligible for State-funded programs including Home Care Allowance, Adult Foster Care and the Colorado Indigent Care Program, if the other eligibility standards are met. In addition, there are two new state-funded programs for legal immigrants that restore coverage that was removed by the federal changes:

- Prenatal care will be reimbursed for any legal immigrant if otherwise eligible.
- Long-term care services are reimbursable for persons who were receiving Medicaid-reimbursed Nursing Facility or HCBS-EBD (elderly, blind, or disabled) services on 7-1-97 and who are no longer eligible for Medicaid.

3. 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 97-98 are listed below. Although the AFDC program no longer exists as a category of financial assistance (it was replaced under Welfare Reform initiatives by TANF and Colorado Works), the pre-existing eligibility criteria remain the basis for Medicaid eligibility. For the purposes of this table, the Colorado Works and Transitional Medicaid categories of eligibility are assumed under the AFDC category, since the eligibility criteria, with the exceptions noted above, remain the same.

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

- **Colorado Works/ TANF/Aid to Families with Dependent Children (AFDC - A)** - adult parents or guardians caring for Medicaid-eligible children in households whose incomes and resources meet the AFDC standards existing on July 16, 1996. These families may or may not be enrolled in the Colorado Works program.
- **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 = $21,348 for a family of four in 1997).
- **Undocumented Aliens** - 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 whose incomes and resources meet the AFDC standards existing on July 16, 1996. These families may or may not be enrolled in the Colorado Works program.
- **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 (these children are 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 & Aid to the Needy Disabled (AB, AND) -** persons who receive federal Supplemental Security Income (SSI), and children who were eligible to receive SSI payments prior to changes in SSA eligibility rules (see above)
- **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 either to the cost of care (if the person receives care in a nursing facility) or to a specific type of court-approved income trust (for HCBS clients). This arrangement allows the person to qualify for Medicaid coverage, and allows the Medicaid program to recover to the extent available the costs of care. (Counted for budget purposes the same as LTC, above)

Medicaid enrollment statistics

The figures on the next pages show Medicaid enrollment statistics and trends.

FIGURE 7: MEDICAID CLIENT ENROLLMENT BY ELIGIBILITY CATEGORY

Category of Eligibility (Budget Category)	# of Clients in FY 95-96	% in FY 95-96	# of Clients in FY 96-97	% in FY 96-97
Adults				
Colorado Works / TANF / AFDC - A	39,344	14.3%	35,865	14.6%
Baby Care - Kids Care - Pregnant Women (BCKC - A)	7,194	2.6%	5,419	2.0%
Undocumented Aliens[1]	4,834	1.8%	5,384	2.0%
Subtotal	**51,372**	**18.7%**	**46,668**	**17.3%**
Children				
Colorado Works / TANF / AFDC - C; Ribicoff Children	108,325	39.5%	110,591	41.0%
Baby Care - Kids Care (BCKC - C)	12,735	4.6%	7,478	2.8%
Foster Care Children (FC - C)	8,460	3.1%	9,387	3.5%
Subtotal	**129,520**	**47.2%**	**127,456**	**47.2%**
Elderly				
Qualified Medicare Beneficiaries (QMB) and Special Low-Income Medicare Beneficiaries (SLMB)	3,891	1.4%	4,240	1.6%
Old Age Pension (OAP-A and State-Only OAP Health and Medical Fund)[2]	35,560	13.0%	36,365	13.5%
Subtotal	**39,451**	**14.4%**	**40,605**	**15.0%**
Persons with Disabilities				
Aid to the Blind (AB)	162	0.06%	154	<0.1%
Aid to the Needy Disabled (AND)[3]	49,561	18.1%	50,523	18.7%
Old Age Pension (OAP-B)	4,470	1.6%	4,644	1.7%
Subtotal	**54,193**	**19.7%**	**55,321**	20.5%
TOTAL	**274,536**	**100.0%**	**270,050**	**100.0%**

Source: HCPF Budget Office - Figures are preliminary for FY 96-97

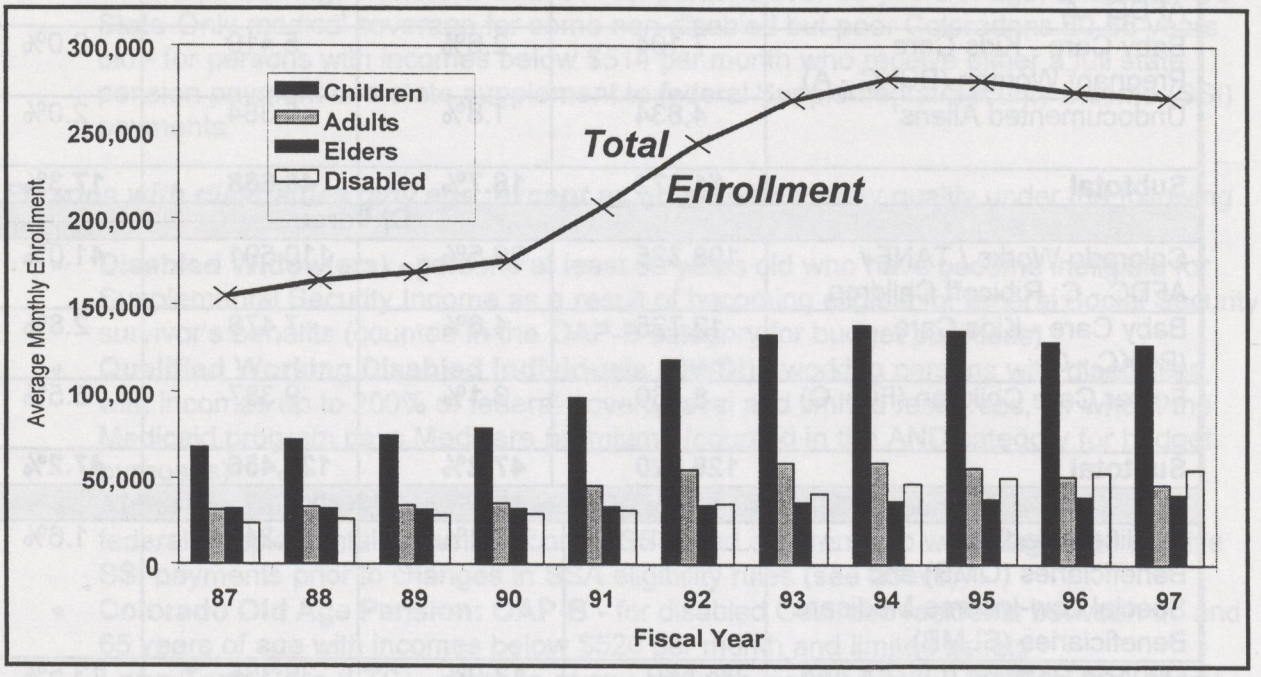
Medicaid Enrollment Trends

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

[1] Undocumented Aliens budget category includes both adults and children, although most persons served are adults.
[2] OAP-A budget category includes some SSI Disabled Widow(er)s, Long-Term Care and Income Trust beneficiaries who are 60 years of age or older.
[3] AND budget category also includes SSI Qualified Working Disabled, some Disabled Widow(er)s, Long-Term Care and Income Trust beneficiaries.

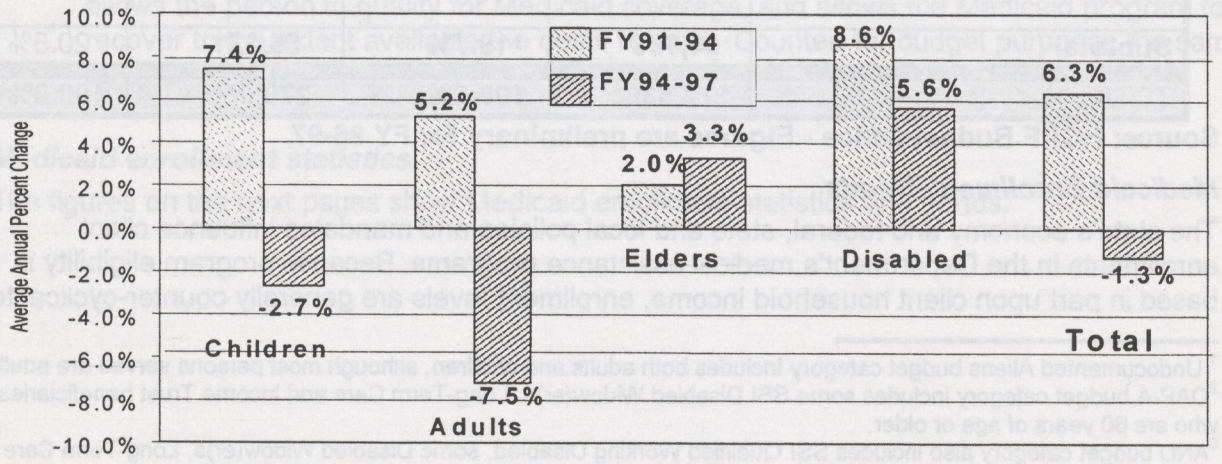
growth or recession in the state's economy, but are affected by many other factors. For example, enrollment in the Department's programs for elderly and disabled persons is influenced by economic factors, but may be more subject to demographic influence, as the state's population ages and increasing numbers of disabled persons require assistance.

FIGURE 8: MEDICAID ENROLLMENT, FY 86-87 THROUGH 96-97



Welfare Reform (TANF/Colorado Works) initiatives and children's health care coverage expansions may cause significant changes in Medicaid enrollments in FY 97-98 and subsequent years, but the nature and extent of these effects are unknown at the Reference Manual publication date. The figure below shows the change in Medicaid enrollment growth during FYs 91-94 compared to FYs 94-97. Although there are large variances by eligibility group, overall enrollment decline in recent years exceeded the increase of the early 90's.

FIGURE 9: MEDICAID ENROLLMENT CHANGE, FYS 91-94 COMPARED TO FYS 94-97



Medicaid-covered Births

Although enrollment continues to decline in both the AFDC-Adult and Baby Care-Kids Care (BK-KC) categories, the figures below show that the number of births to mothers covered by Medicaid has not significantly declined. Medicaid-covered births have remained in the range of 17,000 -18,600 (and between 31% and 34% of total Colorado births) since the Baby Care program (starting in April, 1990) extended Medicaid coverage to women in families with incomes to 133% of the federal poverty line. (See Appendix 1 [under Health Care Research and Data, article:"Repeat Fertility..."] for more detail on Medicaid program effects upon births in Colorado.)

FIGURE 10: MEDICAID AND NON-MEDICAID BIRTHS FROM 1987 TO 1997

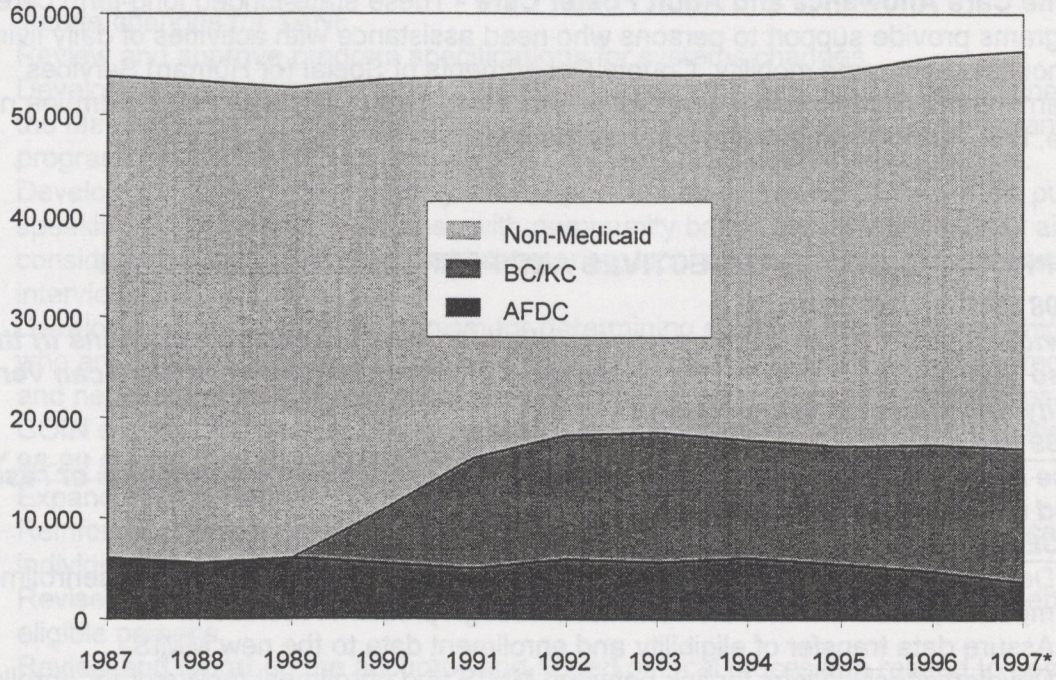


FIGURE 11: MEDICAID AND NON-MEDICAID BIRTHS FROM 1987 TO 1996

Calendar Year	AFDC Births	BabyCare/ KidsCare Births	Total CO Medicaid Births	Total CO Births	% of CO Births Covered By Medicaid
1987	6,038		6,038	53,803	11.22%
1988	5,517		5,517	53,346	10.34%
1989	6,019		6,019	52,697	11.42%
1990	5,500	5,387	10,887	53,491	20.35%
1991	5,002	11,032	16,034	53,786	29.81%
1992	5,963	12,365	18,328	54,525	33.61%
1993	5,656	12,932	18,588	54,013	34.41%
1994	6,088	11,773	17,861	54,050	33.05%
1995	5,441	11,836	17,277	54,310	31.81%
1996	4,769	12,616	17,385		
1997 (est.)	3,700	13,300	17,000		

Source: Sue Rickets, Colorado Department of Public Health and Environment

4. 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 (or Human) 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 (or Human) Services determine financial eligibility, and Options for Long-Term Care agencies determine need for care, for over 6000 elderly and disabled persons.

5. PROGRAM GOALS, OBJECTIVES AND PERFORMANCE MEASURES

FY 97-98 PROGRAM GOAL 1:

To provide support to the development of eligibility and enrollment functions in the new MMIS so that Medicaid clients can be enrolled in managed care, providers can verify eligibility and claim accurate reimbursement.

FY 98-99 PROGRAM GOAL 1

Resume normal claims processing in the new system without further focus or resources devoted to the system from this section.)

OBJECTIVES and PERFORMANCE MEASURES PROGRAM GOAL 1:

1. Develop non-standard test requirements for eligibility, enrollment, and disenrollment modules, and work with the contractor through problem resolution.
2. Assure data transfer of eligibility and enrollment data to the new MMIS.
3. Develop specifications for link between MMIS and enrollment facilitator for enrollment and disenrollment functions.
4. MMIS eligibility and enrollment functions will perform to specification at July 1, 1998.
5. MMIS-based system will support Enrollment Facilitator enrollment of eligible individuals in Colorado Basic Health Plan as of August 1998.

FY 97-98 and FY 98-99 PROGRAM GOAL 2:

To support Medicaid's migration to a managed care delivery environment to improve access to and lower the cost of medical care for Medicaid clients.

OBJECTIVES and PERFORMANCE MEASURES PROGRAM GOAL 2:

1. Implement the enrollment facilitator as appropriated in SB 97-05, to improve the choice counseling and customer service aspects of enrollment and disenrollment processes.
2. Monitor marketing and outreach activities of HMOs until the facilitator is activated.
3. Participate on a Department team to implement six-month eligibility.
4. Provide eligibility and enrollment policy input to various departmental teams on various managed care issues such as policy clarification, competitive HMO bidding, and extending managed care to LTC populations.
5. Ease the process of client disenrollment from managed care plans by completing the transfer of all retroactive disenrollments to the disenrollment contractor.

6. Manage a contractor to complete 4 PCP conversions and 1 unassigned enrollment projects (36,000 clients) in efforts to increase the numbers of managed care enrollees.
7. Identify and resolve Enrollment Facilitator implementation problems.
8. Expand Enrollment Facilitator outreach to Aid to Needy Disabled population.
9. Conduct client satisfaction survey related to function of Enrollment Facilitator.
10. In FY 98-99, increase voluntary Managed Care enrollment rate to 70% of eligible clients.

FY 97-98 and FY 98-99 PROGRAM GOAL 3:

To implement the medical assistance aspects of welfare reform pursuant to changes in state and federal law.

FY 97-98 OBJECTIVES PROGRAM GOAL 3:

1. Submit and obtain approval of a state plan amendment that accurately reflects state statute changes for TANF.
2. Review and approve program specifications for systems changes.
3. Develop and submit regulations for emergency passage (upon Governor's signature) by the Medical Services Board to implement statutory changes regarding immigrants, state programs, AFDC/TANF/Colorado Works, and the DDS determination process.
4. Develop and disseminate: agency letters, provider bulletins and COIN e-mail; public speaking script for HCPF staff use with community based organizations; desk aids for consideration of alternate Medicaid categories; local agency training; press releases and interviews, public information.
5. Develop and establish a mechanism for determining eligibility for disabled immigrants who are not evaluated by SSI but who may be eligible for Medicaid. Develop request and negotiate with DDS and county PACs. Develop and distribute agency letter and COIN e-mail. Distribute public information through advocacy community, providers etc.

FY 98-99 OBJECTIVES PROGRAM GOAL 3:

1. Expand public information related to welfare reform.
2. Reinforce local processes for evaluating eligibility for other categories of Medicaid when individual eligibility for a given category is discontinued.
3. Revise and improve local systems as needed to assure accurate delivery of benefits to eligible persons.
4. Review and report on the accuracy and speed of local processing related to populations changed by welfare reform.

PERFORMANCE MEASURES PROGRAM GOAL 3:

1. All objectives above will be achieved in a timely fashion using available resources.
2. County agency training and reference materials will be delivered on schedule.

FY 97-98 and FY 98-99 PROGRAM GOAL 4:

To contribute to the Governor's goal of improving customer service in Colorado State Government.

OBJECTIVE PROGRAM GOAL 4:

Increase Medicaid client awareness of and access to Medicaid information.

FY 97-98 and FY 98-99 PROGRAM GOAL 5:

To develop an eligibility strategy to support the medical assistance programs administered by the Department.

FY 97-98 OBJECTIVES PROGRAM GOAL 5:

1. Participate on a departmental team to develop waiver requirements for a new 1115 waiver, and take the lead to identify opportunities for streamlining Medicaid eligibility criteria and implement a variety of newly legislated eligibility categories, including:
   - Medicaid Transitional Plus Buy-in for persons leaving Colorado Works (HB 97-1166)

- Extended Medicaid for Working Disabled Persons Pilot Buy-in Program (SB 97-147)
- Combining Model 200 waivers under central waiver and administration, or application for 400 more waiver slots for children
- Uninsured buy-in program (SB 97-5)

2. Participate on departmental team to develop a new automated eligibility system for a variety of non-Title XIX medical assistance programs, including several created by new legislation.
   - non-entitlement health care buy-in for low-income uninsured persons
   - non-entitlement Children's Basic Health Plan
   - state-only programs for non-Medicaid qualifying immigrants
3. Participate on an interdepartmental team to design and procure a new eligibility system for Medicaid and other public assistance programs. Develop and implement action plan to speed eligibility processing, based on recommendations of FY 95-96-97 Medicaid Mapping Project, Quality Control study on Eligibility Processing in Adult Categories, Colorado Benefits Management System Business Process Review study, etc..
4. Develop and implement training on current systems, particularly welfare reform changes.

FY 98-99 OBJECTIVES PROGRAM GOAL 5:

1. Implement the 1115 eligibility waivers approved by the federal Health Care Financing Administration: write and implement regulations; develop processes and forms; write agency and provider letters; develop public information materials; provide local training
2. Extend medical assistance to new categories of non-Title XIX eligibles. (Same process as Objective #1)
3. Participate in systems design phase for new Medicaid eligibility system.
4. Continue training on current systems, particularly on welfare reform changes.

FY 98-99 PERFORMANCE MEASURES PROGRAM GOAL 5:

1. Produce eligibility Guide for Department and counties to include Children's Basic Health Plan requirements.
2. Develop monitoring system to track eligibility application process and approval rate.

FY 97-98 and FY 98-99 PROGRAM GOAL 6:

To administer the Medicaid benefits assigned to the section.

OBJECTIVES PROGRAM GOAL 6:

1. Trusts: Review trust documents within 10 days of receipt and respond to County Department of Social Services regarding the trusts' effect on Medicaid eligibility. Attend hearings, review Administrative Law Judge decisions, draft exceptions. Provide monthly reports. Identify policy needs related to trusts and transfers of assets. Develop policy option papers, legislative language and regulations.
2. Model 200 Children's' HCBS Waiver: Review and approve applications for the waiver. Respond to requests within 15 days of receipt. Maintain the waiting list for the waiver. Provide monthly reports to management on status of waiting list, number of requests for expedited placement on the waiting list, waiver costs, etc. Study alternatives for setting upper income limit on eligibility, etc. as directed in SB 97-147 and report to Legislature by November 1. Develop and submit for departmental approval a budget initiative for FY 97-98-99 to request federal approval of two additional Model 200 programs for disabled children. Work with DHS to transition monitoring responsibilities and new monitoring tool for this program to Department of Human Services Single Entry Point monitors. Develop and implement corrective action plans for problems discovered in local agency monitoring efforts.
3. Prenatal Plus Program: Provide a "sounding board" to Department of Public Health and Environment (DPHE) in their administration of the program. Review program legislative

reports and respond to management inquiries. Work cooperatively with DPHE in development of Colorado specific figures on costs related to low birth weight babies. Provide quarterly MAUDE reports on service utilization. Evaluate and implement new service codes.

4. Teen Pregnancy Prevention Project: Distribute information annually to communities to solicit potential sites one time through the year. Accept inquiries, review and approve requests, and certify sites as requested. Work with fiscal agent to establish provider numbers. Work with CDPHE and fiscal agent to resolve claims processing problems. Review annual report and respond to management and legislative inquires. Ensure 10% local match is appropriately collected and tracked through the accounting system.
5. Special Connections: Provide a "sounding board" to Alcohol and Drug Abuse Division in administration of the program. Respond to management inquiries. Provide quarterly Maude reports on service utilization. Evaluate and implement necessary service code changes.
6. Undocumented Aliens: Act as final authority on issues involving this category. Respond to inquiries as appropriate.
7. Abortions: Respond to inquiries as appropriate. Act as final authority on issues.
8. State Plan Amendment on OB/Pediatric Access: Develop and analyze provider/claims data to ensure Colorado's compliance with federal mandates. Develop and analyze pricing data required in amendment submittal. Submit and respond to any federal inquiries related to required annual submittal.

Additional FY 98-99 OBJECTIVES PROGRAM GOAL 6:

1. Develop and implement action plan to aggressively address areas of most egregious transfer and trust activity that results in funds not being available for clients' care or estate recovery.
2. Implement and publicize new Model 200 waiver slots for waiting list.

FY 98-99 PERFORMANCE MEASURE PROGRAM GOAL 6:

Create annual report for each program listed above with recommendations for change, number of clients served and trends.

6. Eligibility and Enrollment Accomplishments in FY 96-97

- **Policy and Operations Coordination**
  - collaborated within HCPF and with health plans and advocates in revision of managed care disenrollment processes
  - centralized and implemented revision of procedures for conversion of Primary Care Physician (PCP) caseloads to HMO enrollments
  - successfully managed first PCP to HMO conversion
  - 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)
  - led the Medicaid team in the interdepartmental feasibility study for a new automated eligibility information system (the Colorado Benefits Management System - CBMS).
  - identified and reduced legal, regulatory, and procedural opportunities for applicants to transfer significant assets in order to qualify for Medicaid.
  - completed a quality assurance pilot project on adult eligibility intake and investigate feasibility of methods to streamline processes
  - fixed eligibility and enrollment problems in the COIN (eligibility database) and MMIS (Medicaid claims database) systems

  - provided 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
- **Operationalizing policy changes:**
  - extended the teen-age pregnancy pilot program which allows local communities to use Medicaid funds to reduce the incidence of teen pregnancy
  - supported Medicaid's migration to a managed care delivery environment with Enrollment Facilitator RFP and rules
  - streamlined and integrated processes used by clients to enroll in HMOs, convert from PCP to HMO coverage, and to disenroll from HMOs
- **Publications - Developed and distributed educational materials about Medicaid policy and benefits to clients and local agencies, including:**
  - managed care information - 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
  - county specific managed care option brochures for 3 areas of the state
  - clear and usable educational materials about managed care options, and clients' rights and responsibilities, including materials usable by non-readers and by non-English-speakers
  - rules and agency letters conveying Medicaid changes related to federal and state welfare reform initiatives
- **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
  - managed care updates
- **Income Trusts - Refined policy on Medicaid eligibility for persons with income trusts:**
  - trust law amended to remove unnecessary barriers and costs for Medicaid clients, streamline the distribution formula and eliminate payment of fees from income trusts
  - sample trusts developed for use in training for local agencies on trust issues
  - amended review and approval procedures for income, disability and pooled trusts
  - developed spousal impoverishment rule for PACE program
- **Operations - Processed assigned caseload efficiently and accurately:**
  - managed the Children's Home and Community Based Services Program (HCBS) for 200 clients
  - established a monitoring process for Model 200 case management agencies and evaluated their operations for opportunities to redirect staff resources
  - handled inquiries related to Medicaid dental and vision benefits for adults, and client billing problems
  - developed and specified requirements for management reports on eligibility data

D. 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 eligiblity sites. (Ask for the Managed Care Guide, listed in "Sources," Appendix 1)

b) Medicaid Benefit Utilization by Eligibility Category

The figures below, "Medicaid Service Expenditures by Eligibility Category," "Distribution of Medicaid Expenditures by Service and Eligibility" and "Expenditures by Type of Service by Eligibility Category," show Medicaid expenditures by service type for each client eligibility group and across all eligibility groups. These figures demonstrate the wide variation in benefit use among client eligibility types.

It can be seen that:

- elders used the vast majority of long-term care services;
- adults and children used the majority of inpatient and ambulatory care; and,
- people with disabilities used the vast majority of the Medicaid-reimbursed developmental disability and mental health services provided by Department of Human Services programs.

It can also be seen that although persons with disabilities and elders, together, are 35% of Medicaid enrollment but account for 73% of total expenditures.

FIGURE 12: MEDICAID SERVICE EXPENDITURES BY ELIGIBILITY CATEGORY, FYS 87-97

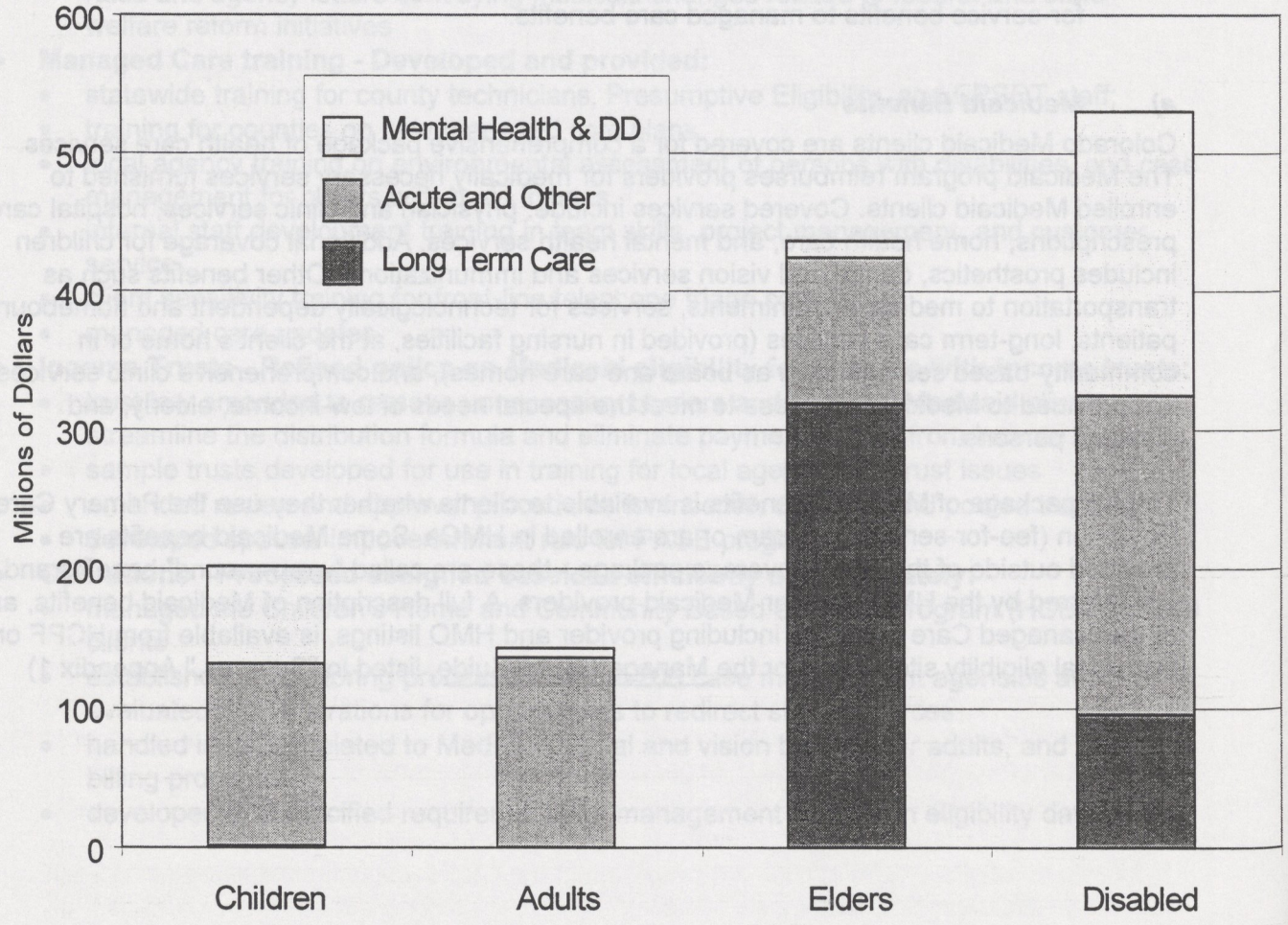


FIGURE 13: DISTRIBUTION OF MEDICAID EXPENDITURES BY SERVICE AND ELIGIBILITY, FY 96-97

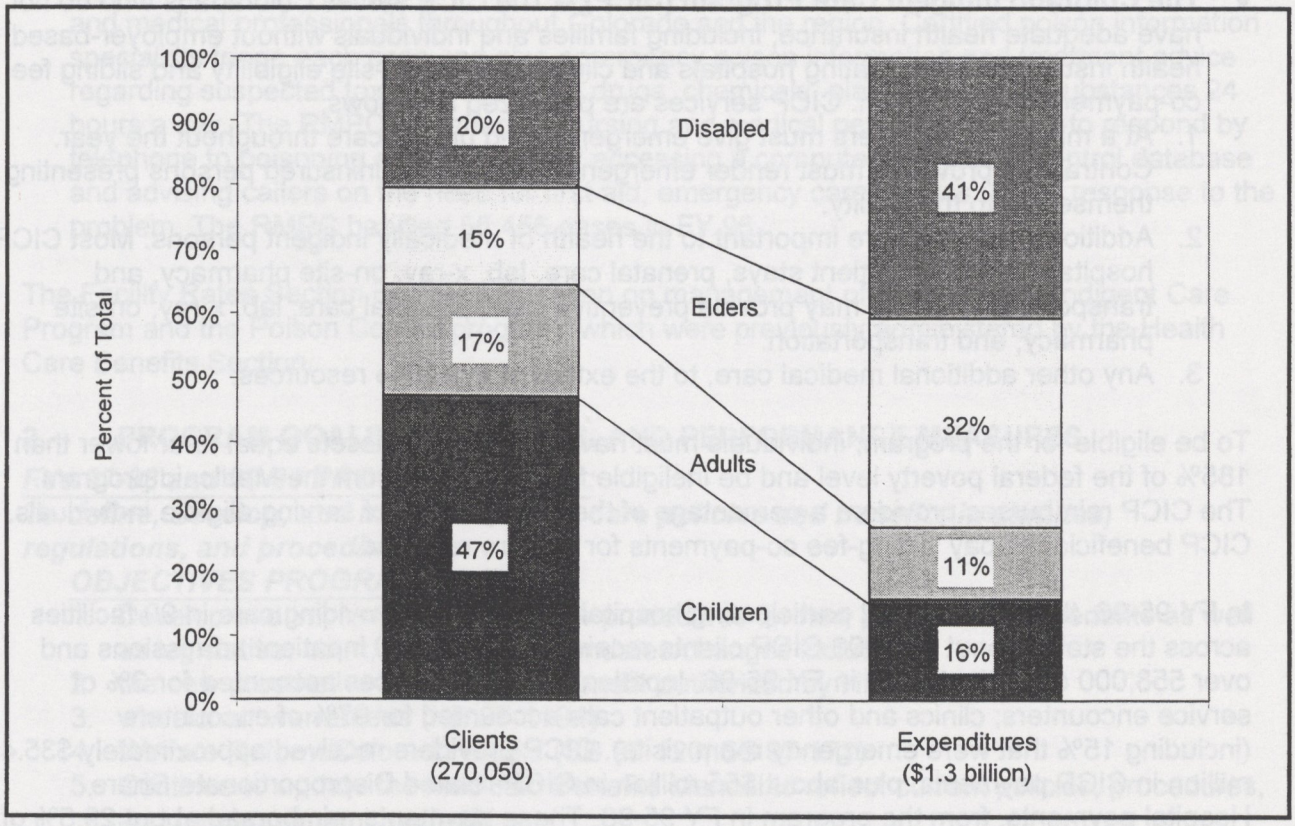


FIGURE 14: EXPENDITURES BY TYPE OF SERVICE BY ELIGIBILITY CATEGORY, FY 96-97

Type of Service	Children	Adults	Elders	Disabled	Total
Mental Health & DD	*Thousands of Dollars*				
Mental Health Capitation	18,943	1,867	1,480	15,926	38,216
Dept. of Human Services	50,857	4,588	10,764	189,857	256,066
Subtotal	*69,800*	*6,455*	*12,244*	*205,783*	*294,282*
Acute & Other					
Inpatient Care	40,517	60,845	8,846	69,235	179,443
Ambulatory Care	31,569	29,965	3,164	34,944	99,642
Community Clinics	4,791	4,081	53	1,661	10,585
HMOs	41,308	36,614	12,772	49,235	139,929
Drugs	5,582	4,451	26,816	39,789	76,639
Insurance Premiums	17	105	19,663	15,020	34,806
DME, Lab & X-Ray	3,612	3,176	8,087	16,374	31,250
OAP-SO	0	0	9,470	0	9,470
Transportation	1,279	386	1,510	3,662	6,838
Dental	6,240	369	0	561	7,170
Subtotal	*134,916*	*139,992*	*90,383*	*230,481*	*595,772*
Long Term Care					
Nursing Facilities	0	9	273,444	49,979	323,432
Home & Comm. Based Care	1,630	152	34,680	42,686	79,148
Hospice	35	7	3,161	1,649	4,852
SEP	0	0	7,399	1,559	8,958
Subtotal	*1,665*	*168*	*318,684*	*95,873*	*416,390*
Grand Total	***206,381***	***146,615***	***421,311***	***532,137***	*1,306,444*

c) Non-Medicaid Program Benefits

- **The Colorado Indigent Care Program (CICP)** -- The CICP serves Coloradans who do not have adequate health insurance, including families and individuals without employer-based health insurance. Participating hospitals and clinics provide on-site eligibility and sliding fee co-payment determination. CICP services are prioritized as follows:
  1. At a minimum, providers must give emergency and urgent care throughout the year. Contracting providers must render emergency services to uninsured persons presenting themselves to the facility.
  2. Additional medical care important to the health of medically indigent persons. Most CICP hospitals provide inpatient stays, prenatal care, lab, x-ray, on-site pharmacy, and transportation. Clinics may provide preventive care, prenatal care, lab, x-ray, on-site pharmacy, and transportation.
  3. Any other additional medical care, to the extent of available resources.

To be eligible for the program, individuals must have income and assets equal to or lower than 185% of the federal poverty level and be ineligible for assistance from the Medicaid program. The CICP reimburses providers a percentage of the facility's cost of serving eligible individuals. CICP beneficiaries pay sliding-fee co-payments for all care received.

In FY 95-96, the CICP had 62 participating hospitals and clinics, providing care in 90 facilities across the state. About 134,000 CICP clients received over 15,000 inpatient admissions and over 558,000 outpatient visits in FY 95-96. Inpatient hospital services accounted for 3% of service encounters; clinics and other outpatient care accounted for 97% of encounters (including 15% that were emergency room visits). CICP providers received approximately $35.4 million in CICP payments, plus about $55 million in CICP-related Disproportionate Share Hospital payments, from the program in FY 95-96. These payments reimbursed about 29.5% of providers' costs. The CICP utilization and reimbursement figures for FY 96-97 will be reported in the CICP Annual Report, to be released in February 1998.

- **Home Care Allowance (HCA)** - The Home Care Allowance benefit is a state and county-funded monthly cash payment to clients of up to $385 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 has a five-year contract with Rocky Mountain Poison and Drug Center (RMPDC) to act as the state's poison control service provider. RMPDC is a

certified regional poison control center affiliated with the Denver Health Medical Center. The Poison Control Center provides toll-free telephone consultation for poisonings to citizens and medical professionals throughout Colorado and the region. Certified poison information specialists triage each case and give emergency poison information and treatment advice regarding suspected toxic exposures to drugs, chemicals, plants and other substances 24 hours a day. 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.

The Facility Rates Section has recently taken on management of the Colorado Indigent Care Program and the Poison Control program, which were previously administered by the Health Care Benefits Section.

2. PROGRAM GOALS, OBJECTIVES, AND PERFORMANCE MEASURES

FYs 97-98 and 98-99 PROGRAM GOAL 1:

To define, develop, and integrate health care policies and benefits in statutes, regulations, and procedures.

OBJECTIVES PROGRAM GOAL 1:

1. Develop and implement rules and/or procedures for new programs and benefits as well as legislative, court, and federal mandates/changes including:
2. the new prosthetics and orthotics benefit authorized by HB 97-1063
3. wheelchair warrantees (HB 97-1194)
4. Welfare Reform/Colorado Works (SB 97-120, SB 97-171)
5. Continue to update the Medicaid Benefits Manual to reflect current policies, procedures, and reimbursement methods.
6. Provide training to providers and local agencies on the policy changes described above.

PERFORMANCE MEASURES PROGRAM GOAL 1:

- Objective 1: Rules will be presented to the State Board by June 1998 and June 1999.
- Objective 2: The Medicaid Benefits Manual will continue to be updated each year.
- Objective 3: Training/orientation sessions on rule changes will be held as needed.

FYs 97-98 and 98-99 PROGRAM GOAL 2:

To promote access to high-quality, cost-effective health care services to clients in hospitals, clinics, and nursing facilities, and in outpatient, community, and home-based settings.

OBJECTIVES PROGRAM GOAL 2:

1. Implement rate increases in accordance with the Long Bill for Home and Community Based Services, Home Care Allowance, Adult Foster Care, Private Duty Nursing, Home Health, and Acute and Ambulatory care.
2. Implement a pilot initiative in three or more areas of the State to allow nursing facility residents to receive LTC services at home or in the community in FY 97-98. Expand the pilot initiative to two or more additional areas of the state in FY 98-99.
3. Conduct studies and prepare reports to the Legislature, the Governor, HCFA, and other departments/agencies as mandated to provide information and identify areas for improvement.
4. Provide training, technical assistance and on-site reviews to providers and contractors to promote the delivery of high-quality, cost-effective services.

5. Monitor and project caseloads and expenditures relating to the HCB section's programs. This includes preparing monthly budget update reports, developing projections, and conducting analyses as needed.
6. Review and authorize two Quality of Care incentive payments per year to Nursing Facilities that participate in the Resident-Centered Quality Improvement Program.
7. Work with Department of Human Services and other contractors to produce Medicaid Authorization Cards if funding becomes available.
8. Apply to the HCFA for renewal of the HCBS-EBD waiver.
9. Actively participate in developing and designing a new data system for client eligibility (cash and medical services benefits). The new Colorado Benefit Management System (CBMS) should operationalize medical services policies, improve the integration of systems, and increase the ease of use for both internal and external customers. Actively participate in the drafting of an RFP for the CBMS project. Assist in implementing and in receiving Federal Certification of the new Medicaid management Information System (MMIS) and continue to improve the effectiveness of the production system. Continue implementing the SEP data system.

PERFORMANCE MEASURES PROGRAM GOAL 2:

- Rate changes will be calculated, approved, and applied effective July 1 of each year.
- The deinstitutionalization project will be implemented in three areas of the state by January, 1998 and will be expanded to two or more additional areas of the State by January 1999.
- Reports/studies will be completed in accordance with mandated deadlines.
- Training, orientation, and technical assistance will be provided each year as needed to promote the delivery of quality services.
- Budget updates and requested analyses will be completed in an accurate and timely manner. Budget Office deadlines will be met with documents needing little revision.
- The ResQUIP plans will be reflective of patient input and the two incentive payments will be made in December 1997 and 1998 and June 1998 and 1999.
- Production of Medicaid Authorization Cards will be continued if funding is made available.
- HCBS-EBD waiver applications will be sent to the HCFA by March 1998, for renewal effective July 1998.
- Implementation of the new Medicaid Management Information System will be monitored, and the Certification of the MMIS (July through October, 1998) will be approved.
- RFP responses for the CBMS will be evaluated.

FYs 97-98 and 98-99 PROGRAM GOAL 3:

To promote coordination among a broad spectrum of programs and services to improve client access and limit duplication and gaps in services; to integrate team efforts with the Section's objectives.

OBJECTIVES PROGRAM GOAL 3:

1. Coordinate with other Sections in the Department including Quality Assurance, Facility and Provider Rates, Customer Service, Eligibility and Enrollment, Division of Managed Care, and the Office of Public and Private Initiatives to ensure clients and providers receive consistent, high-quality services.
2. Actively participate and work in teams with other sections, departments, and agencies to develop and implement new programs and services to clients including Long-term Care Insurance, Home Health Aide Pilot, Integrated Care and Financing Project, Consumer-Directed Attendant Support Program, Competitive Procurement, new programs and services to MH and DD clients, School-Based Refinancing, Nursing Facility Case Mix

Reimbursement, Children's Basic Health Plan, Safety Net Grant and the Home Health Pilot Program.

3. Actively participate in efforts to coordinate and streamline services to children including Home Health, Private Duty Nursing, EPSDT, HCBS Children's Waivers, Health Care Program for Children with Special Needs (HCP), and Part H of the Individuals with Disabilities Education Act.
4. Actively participate in advisory committees including those for Persons with Disabilities, ResQUIP, Long-term Care, HCBS, Home Health, Nursing Facilities, Durable Medical Equipment, EPSDT, Lead Poisoning Prevention, Dental Services, Pediatric Care, Primary Care Physician Program, Personal Care Boarding Homes, Hospice, and the Colorado Interagency Coordinating Council.

PERFORMANCE MEASURES PROGRAM GOAL 3:

- Staff will actively coordinate and work with teams and staff from other sections in developing rates: resolving provider and client issues, providing information and training, and quality assurance mechanisms to promote access to quality services for clients.
- New programs and services to clients will be developed and implemented effectively and efficiently with the least disruption to clients, providers, and case managers, and with input from and coordination with other sections, departments and agencies as appropriate.
- Services to children will be more accessible and user friendly; duplication and gaps between children's programs will be minimized; EPSDT referrals for services related to the HCB Section's programs will be handled promptly and appropriately.
- Input of consumers, providers, advocates, local agencies, and case managers will be obtained and given full consideration in the development and implementation of new services, policies, rules, etc.

FYs 97-98 and 98-99 PROGRAM GOAL 4:

To oversee the provision of program benefits within the developing and established health care systems, including managed care services. To monitor the implementation of client education, and assure the availability of provider education on program benefits.

OBJECTIVES PROGRAM GOAL 4:

1. Actively participate in implementing new managed care contracts and other managed care requirements, including improved encounter data and other reporting requirements.
2. Provide training to managed care organizations as needed or requested in Home Health, EPSDT, and other medical assistance programs to improve EPSDT participation rates and Home Health services to clients enrolled in managed care organizations.
3. Actively participate in Managed Care teams including Enrollment, PCP Conversion, Quality Assurance, etc.

PERFORMANCE MEASURES PROGRAM GOAL 4:

- New managed care contracts will include accurate provisions regarding health care benefits; data collected and reported will be accurate and timely and will provide the basis to assess and improve quality of care for clients.
- Medicaid HMOs will demonstrate a better understanding of their obligations to provide Home Health services as evidenced by a low number of complaints from clients. They will also demonstrate a better understanding of their obligations to provide EPSDT services as evidenced by an increased level in the annual EPSDT participation rate and required HEDIS reports.
- Objectives will be achieved in accordance with team work plans.

PROGRAM PERFORMANCE MEASURES GOAL 2

Community Based Providers	FY 94-95	FY 95-96	FY 96-97	FY 97-98
# of Home Health Providers	160	166	166	163
# Personal Care Agencies	87	107	107	97
Single Entry Point Program	FY 94-95	FY 95-96	FY 96-97	FY 97-98
# CFMC-Registered HCBS-EBD Clients	2,087	2,714	3,753	4,067
# Clients deinstitutionalized HCBS-EBD	286	357	575	610
% Deinstitutionalized HCBS-EBD	13.7%	13.2%	15.3%	15.0%
EPSDT Program	FY 94-95	FY 95-96	FY 96-97	FY 97-98
Number of Medicaid-covered children receiving EPSDT administrative case management and outreach				
Target	59,127	98,000	98,000	98,000
Actual	98,964	100,500		
Number of referrals for care				
Target	135,991	160,000	160,000	160,000
Actual	160,378	160,500		
Number of interagency and provider contacts on behalf of EPSDT clients.				
Target	2,000	5,000	5,000	5,000
Actual	4,912	4,450		
Cost per client for case management				
Target	$44.09	$27.00	$27.66	$28.66
Actual	$26.34	$25.71		
Cost per client referral				
Target	$19.17	$16.80	$17.06	$17.06
Actual	$16.25	$16.10		

* Source: Colorado Department of Public Health and Environment

3. Recent Major Health Care Benefits Section Accomplishments

- Development and implementation of new legislation including:
  - authorization for adding Prosthetic and Orthotic Devices as new Medicaid benefits (funding requested for FY 98-99)
  - adding services in the Home and Community Based Services Program for Persons Living with AIDS
  - providing services to developmental disabled clients who meet the requirements for Home and Community Based Services Program for Elderly, Blind and Disabled
  - clarifying eligibility and services in the Private Duty Nursing Program.
- Participated in the development and analysis of major legislative initiatives in 1997 including: Medicaid Managed Care (SB 5), Case Mix Reimbursement for Nursing Facilities (SB 42), Health Services in Public Schools (SB 101), Welfare Reform (SB 120 and SB 171), and Children's Basic Health Plan (HB 1304).
- Clarifying and updating regulations and providing statewide training for a number of programs including Home Modifications, Durable Medical Equipment, Adult Day Services, Single Entry Point Agencies.
- Conducting special studies in the Hospice, Hospital Back-Up, Private Duty Nursing, CICP, and HCBS Programs. Reports were submitted to the Governor, General Assembly and

public for the Colorado Indigent Care, Prenatal Plus, and Poison Control programs and on rate indexing in community based long-term care and acute care programs.

- The Resident Quality of Care Incentive Payment Program (ResQUIP) continued to provide financial incentives for improvements in the quality of care provided in nursing facilities. ResQUIP rules and procedures were modified to reflect experience gained since the implementation of the Program.
- Initiatives to streamline and improve service efficiency included simplification of the SEP monitoring and review processes, shifting from prior authorization to post pay review in the Home Health Program, clarification of the utilization review process in the Private Duty Nursing Program, reestablishing the Medicaid Policy/Benefit Committee to update existing and review and determine emerging technologies for new Medicaid benefits, transferring the reporting and payment system in CICP to MMIS, clarifying eligibility requirements in CICP.
- Participated in HCPF and interdepartmental team efforts including:
  - managed care implementation and quality assurance
  - MMIS transition to a new fiscal agent
  - feasibility study of a new client eligibility system (CBMS)
  - developing the Integrated Care and Financing Project
  - improving coordination of services to children.

E. DIVISION OF MANAGED CARE CONTRACTING

The mission of the Division of Managed Care Contracting is to develop and administer 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. The Division of Managed Care Contracting supervises

these capitated and non-capitated (fee-for-service) managed care programs. The paragraphs below outline the Department's managed care programs.

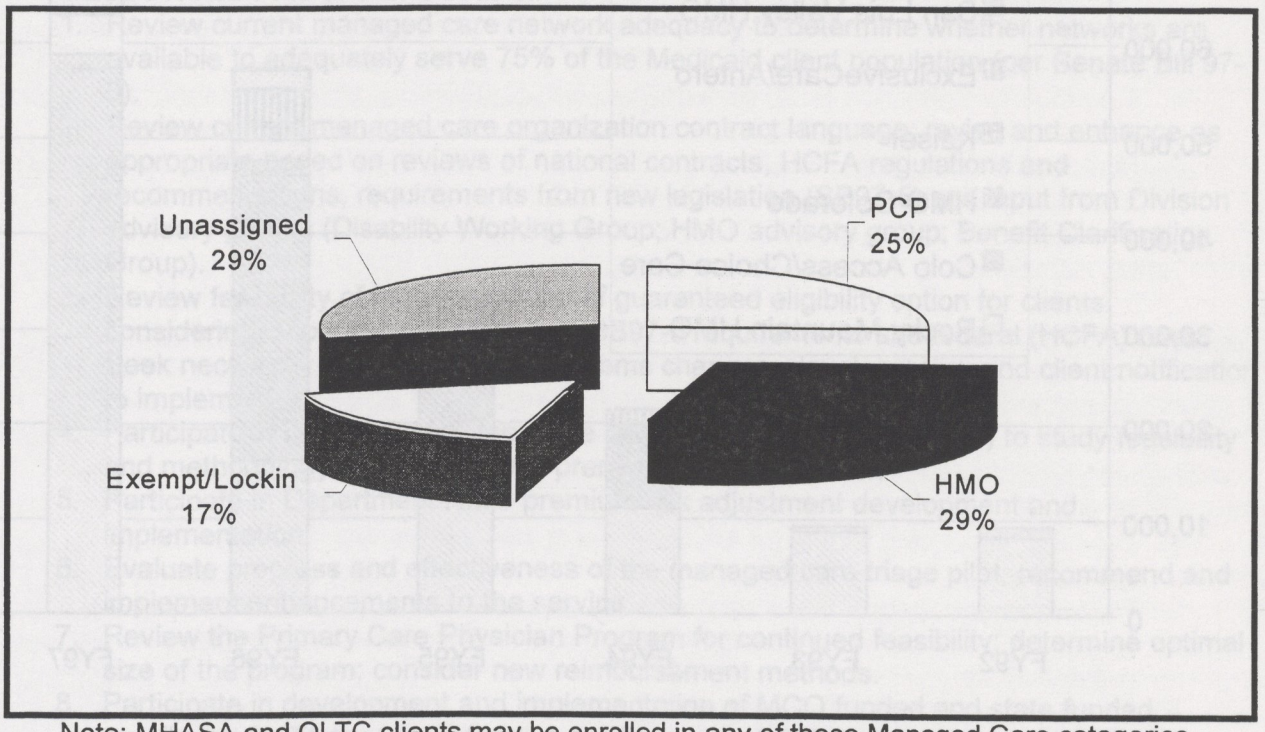
Colorado Medicaid uses two types of managed care programs:

- ***Non-capitated "gatekeeper" programs*** - Medicaid pays a provider or case manager to coordinate and manage clients' health care needs, and Medicaid continues to pay fees to providers for each service delivered ("fee-for-service"). ***"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.

- ***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. ***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):*** MHASAs are responsible for provision of 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 competitively bid contracts, paying MHASA a capitation for each Medicaid client in the service area. In FY 97-98, the Mental Health Capitation program will expand statewide, with the addition of Denver County, Larimer County and the remaining northeast Colorado region.
  - ***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 pilot program integrates acute and long-term care, Medicare and Medicaid services and financing for individuals with disabilities and/or chronic conditions. The ICF project will demonstrate improved health care coordination and reduced cost-shifting among providers and payors. Improved health care outcomes are expected to result. HCPF (OPPI), Mesa County Department of Social Services, Rocky Mountain HMO, HCFA and the Robert Wood Johnson Foundation will implement the project in Mesa County.

The first figure below shows the percentage of Medicaid clients enrolled in each type of managed care, and the percentage not enrolled in managed care. The next figures show the history of Colorado Medicaid HMO enrollments, by plan, and HMO (and other Managed Care Organization - MCO) enrollment levels at the end of FY 96, with the date each plan began enrolling Medicaid clients.

FIGURE 15: MEDICAID CLIENTS BY TYPE OF MANAGED CARE, FY 97



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 the following criteria. 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 16: COLORADO MEDICAID HMO ENROLLMENT BY PLAN

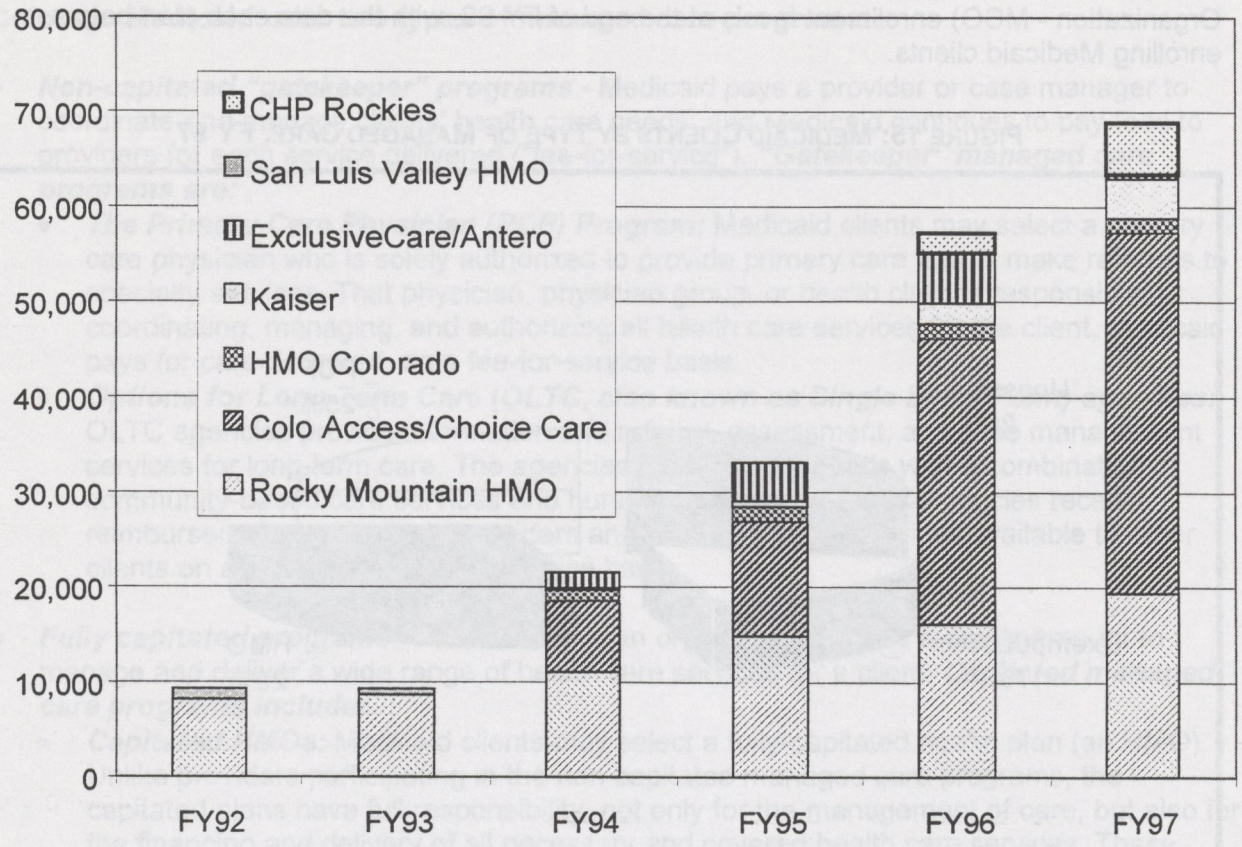


FIGURE 17: MEDICAID MANAGED CARE - START DATE AND ENROLLMENT AS OF JUNE 96

Health Plan	Contract Start Date	Clients Enrolled At 6/97
Colorado Access	December1995	38,692
Community Health Plan of the Rockies	July 1995	5,523
Kaiser Permanente	July 1994	5,253
HMO Colorado	May 1994	1,547
Rocky Mountain HMO-Metro	January 1994	7,770
Rocky Mountain HMO-Western Slope	1974	12,126
Total Longterm Care (PACE)	October 1991	200
Foundation Health		31
Subtotal: Medicaid HMOs		**71,142**
Primary Care Physician Program		59,447
TOTAL MANAGED CARE		**130,589**

Notes to Figures above:
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.

2. MCCD PROGRAM GOALS, OBJECTIVES AND PERFORMANCE MEASURES

FY 97-98 and FY 98-99 PROGRAM GOAL 1:

To negotiate, implement and manage contracts with managed care organizations and providers to ensure that Medicaid clients receive high quality, cost-effective services. Beginning in FY 98-99, also to evaluate managed care organizations participating in the competitive bidding project.

OBJECTIVES PROGRAM GOAL 1:

1. Review current managed care network adequacy to determine whether networks are available to adequately serve 75% of the Medicaid client population (per Senate Bill 97-5).
2. Review current managed care organization contract language; revise and enhance as appropriate based on reviews of national contracts, HCFA regulations and recommendations, requirements from new legislation (SB97-5) and input from Division advisory groups (Disability Working Group; HMO advisory group; Benefit Clarification Group).
3. Review feasibility of implementation of guaranteed eligibility option for clients considering incongruencies between SB97-5 requirements and federal (HCFA) rules. Seek necessary waivers, request systems changes, develop policy and client notification to implement.
4. Participate in Department competitive bidding effort (HMOBid Team) to study feasibility and methodology for setting HMO premiums in this manner.
5. Participate in Department HMO premium risk adjustment development and implementation.
6. Evaluate progress and effectiveness of the managed care triage pilot; recommend and implement enhancements to the service.
7. Review the Primary Care Physician Program for continued feasibility; determine optimal size of the program; consider new reimbursement methods.
8. Participate in development and implementation of MCO funded and state funded enrollment facilitator (state funding contingent on SB97-5 passage).
9. Participate in implementation of MCO funded PCP conversion process.

PERFORMANCE MEASURES PROGRAM GOAL 1:

- Initiate 10 target hospital pilot programs in FY 97-98. Continue in FY 98-99if cost effective.
- Complete Primary Care Physician Program review; set physician incentive payment rate.
- Report on current managed care network adequacy to serve 75% of Medicaid clients.

FY 97-98 AND FY 98-99 PROGRAM GOAL 2:

To provide 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.

FY 97-98 OBJECTIVES PROGRAM GOAL 2:

1. Participate in Department evaluation and enhancement of fee-for-service and HMO complaint and grievance process.
2. Participate in Department development and implementation of quality assurance processes for the fee-for-service component of the managed care program (Primary Care Physician Program).
3. Clarify Medicaid MCO benefits package
4. Clarify non MCO benefits for clients, providers, MCOs and other relevant groups and individuals (wrap-around benefits).

5. Implement contractor requirements and contract language to ensure continuity of care for persons with disabilities in managed care.

FY 98-99 OBJECTIVES PROGRAM GOAL 2:

1. Participate in evaluation and enhancement of fee-for-service and HMO complaint and grievance process.
2. Participate in development and implementation of quality assurance processes for the fee-for-service component of the managed care program (Primary Care Physician Program).
3. Continue to clarify and expand as needed the Medicaid managed care organization (MCO) benefits package
4. Continue to clarify non MCO benefits for clients, providers, MCOs and other relevant groups and individuals (wrap-around benefits) for current benefits and additions.
5. Monitor implementation of contractor requirements and contract language to ensure continuity of care for persons with disabilities in managed care.

PERFORMANCE MEASURES PROGRAM GOAL 2:

Timely completion of measurable objectives above.

FY 97-98 and FY 98-99 PROGRAM GOAL 3:

To monitor the performance of managed care organizations to ensure that enrolled clients receive high quality care and appropriate customer service as defined by the managed care contract. In FY 98-99, in addition, to encourage the enrollment of persons with disabilities in HMOs.

FY 97-98 OBJECTIVES PROGRAM GOAL 3:

1. Develop monitoring tool(s) for MCO review in conjunction with Managed Care Accountability Team (MCAT).
2. Perform appropriate reviews of all new and existing managed care contractors .
3. Update administrative rules consistent with Department policy, contract and legislative requirements

FY 98-99 OBJECTIVES PROGRAM GOAL 3:

1. Seek appropriate waivers for encouragement of HMO enrollment by persons with disabilities.
2. Seek consumer and providers support for HMO enrollment of persons with disabilities.

PERFORMANCE MEASURES PROGRAM GOAL 3:

Develop MCO monitoring tool(s) [with Managed Care Accountability Team (MCAT)]			
Item	FY 95-96	FY 96-97	FY 97-98
Target	NA	Complete monitoring tool	Substantial development of monitoring tool
Actual	NA	Form team to initiate review and tool development	
Perform appropriate reviews of all new and existing managed care contractors			
Item	FY 95-96	FY 96-97	FY 97-98
Target	NA	Review all plans	Substantial review of all contractors
Actual	NA	Network analysis and compliant systems reviewed	
Update administrative rules consistent with policy, contract and legislative requirements			
Item	FY 95-96	FY 96-97	FY 97-98
Target	NA	Complete rules update	Updated rules completed
Actual	NA	1st draft complete; 2nd draft underway	

Seek appropriate waivers for encouragement of HMO enrollment by persons with disabilities.				
Item	FY 95-96	FY 96-97	FY 97-98	FY 98-99
Target	NA	NA	HCFA filing of 1915(b)4 waiver	Acceptance of waiver

OVERALL MANAGED CARE CONTRACTING DIVISION PROGRAM PERFORMANCE

Managed Care Performance Measures	FY 94-95	FY 95-96	FY 96-97	FY 97-98	FY 98-99*
Average monthly HMO enrollees					
TARGET			87,286	96,879	
ACTUAL	33,291	58,459			
Number of participating HMOs					
TARGET			10*	11**	
ACTUAL	7	9			
Number of Medicaid Primary Care Physicians					
TARGET			1,550	1,550	
ACTUAL	1,602	1,630			
Number of Medicaid Clients enrolled with a PCP					
TARGET			60,764	60,764	
ACTUAL	104,164	81,481			
Total Number of Persons in Medicaid HMO or PCP programs					
TARGET			148,050	157,643	
ACTUAL	137,455	139,041			

* A number of factors can affect the estimated enrollments in PCP vs HMO and impact on the number of providers who participate in the PCP program. Depending upon how enrollments are handled (e.g., enrollment facilitator vs. conversions), the estimates presented here could materialize quite differently.

** Antero dropped out as a Medicaid provider effective July 1, 1996. This explains the reduction in the number of contracting HMOs by one from the estimate contained in the FY 96-97 Long Bill Appropriations Report.

3. Managed Care Contracting Division Accomplishments - FY 96-97

- **Increased enrollment in Medicaid capitated managed care programs** - Enrollment of Medicaid clients in capitated managed care programs (HMOs) increased substantially in FY 96-97.
  - 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 Figures 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.

- ***FirstHelp* Telephone Triage** - Colorado Medicaid's FirstHelp triage line assists unassigned and PCP Medicaid clients to make informed decisions on accessing medical care. Nurses, with physician back-up, provide round the clock, toll free, statewide access to a computer-assisted triage service.
  - In its first six months of operation, ***FirstHelp*** handled 2,251 inbound calls from 2,051 Medicaid clients. Nearly half (42.9%) of all calls concerned medical complaints of children under age 17; 29.4% concerned children under the age of four. Of the 1,606 requesting assessment of a current medical complaint, nearly half (45%) were given home care instructions instead of medical referral. Almost a third (29%) were referred to their physician for further telephone assessment, and 15% were advised to make an appointment to see their doctor (PCP). Only 11% (183 clients) were referred to seek care immediately in the emergency room.
  - The Department is also piloting use of ***FirstHelp*** in four hospital emergency departments (ERs), in mid-winter 1997-1998. The goals of the emergency department pilot are to improve access to care, reduce unnecessary ER utilization, reduce ER claim appeals, demonstrate alternative options of care and reinforce the use of the triage line before going to the ER when symptoms are not life/limb threatening. Medicaid clients presenting in the ERs will receive a physical assessment to determine emergent/non-emergent status. Before receiving care in the ER, non-emergent clients are asked to call the triage line from the ER and next time from home, before they seek ER care. If appropriate, ***FirstHelp*** will refer the client to a clinic or physician within the area and ask the client to contact Medicaid Customer Service to enroll with the physician

- **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.

- **Managed Care Contracting** - The MMCD negotiated, implemented and managed contracts with managed care organizations and providers to ensure that Medicaid clients receive high quality, cost-effective services. The Division implemented a new HMO contract format, with improved quality and accountability features.

- **Marketing Project** - A mini-marketing project involving approximately 32,200 clients and 14,000 households is planned and will be completed in November/December 1997. The project will acquaint unassigned Medicaid clients in the Denver metropolitan area, and in El Paso and Pueblo counties, with the meaning of managed care, the advent of mandatory managed care enrollment, the managed care programs available to them, and an opportunity to choose a plan and enroll early.

- **Guaranteed eligibility** - The Guaranteed Eligibility project is on schedule for implementation in 1998. Work is underway to 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. Automated support systems have been enhanced to avoid "auto-drop-off" of clients. HMOs now have direct COIN access to limited screens in a read-only capacity. Automated support systems are being enhanced to include correction of "auto-drop-off"; and full direct COIN access for HMOs.

F. MANAGED CARE TRANSITION PROJECT

1. Objective and Methodology

The Managed Care Transition Project provides coordination and organizational support to staff teams implementing the Medicaid transition from a fee-for-service to a managed care environment that is mandated by Senate Bill 97-05 and by House Bill 97-1304. Three major development and implementation projects are underway:

- Enrollment facilitator
- Children's Basic Health Plan
- Competitive bidding of HMO contracts

2. Managed Care Project Teams

a) Enrollment Facilitator

After review and re-design of the current Medicaid Enrollment System to standardize and simplify enrollment processes, reduce fragmentation, and develop requirements for an independent enrollment facilitator, this team produced an RFP for the competitive procurement of a contractor. The contractor will begin implementation of the enrollment facilitator functions in early 1998.

b) HMO Competitive Bid

The goal of the HMO Competitive Bid project is to competitively procure HMO contracts with:

- improved quality, access and cost accountability
- streamlined, coordinated procurement and contract management systems

c) Children's Basic Health Plan

The Children's Basic Health Plan team is charged with developing Colorado's State Health Insurance Program plan based on the parameters of state and federal legislation. There are six CBHP teams:

- Benefit Design and Pricing
- Marketing
- Eligibility, Enrollment, and Management Information
- Financing
- Employer Advisory
- Contracting

These Managed Care Projects are detailed elsewhere in the Reference Manual. General descriptions are in "Trends and Highlights." Further description of the Enrollment Facilitator project can be found in "Eligibility and Enrollment"; Competitive Bid and CBHP in "OPPI."

G. QUALITY ASSURANCE SECTION

The mission of the Quality Assurance Section is to facilitate, monitor, and improve access, fiscal accountability, and quality health care for all Medicaid clients.

1. Purpose and Goals of the Quality Assurance Section

The activities of the Quality Assurance Section support Department-wide quality assurance and utilization management programs as well as the detection and pursuit of fraudulent and abusive use of Medicaid resources. The Section maintains a quality management program using population based review, individual case review, and oversight of managed care organizations. The Section conducts and oversees quality and utilization review activities for Medicaid. This includes provider audits, prior authorizations, site reviews, and professional review organization contract management.

The Section:

- monitors the cost-effectiveness, access, and quality of services provided to clients under both fee-for-service and managed care programs;
- identifies incidents of substandard quality of care, inappropriate billing, and fraudulent or abusive practices by provider or clients and supports appropriate follow-up;
- works collaboratively with health plans and shares 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.

Monitoring of managed care organizations contracted to serve the Medicaid population is conducted by:

- on-site monitoring of HMOs' compliance with standards and contractual requirements;
- requiring and analyzing quality and utilization indicators (using standard HEDIS measures);
- using patient satisfaction surveys to gather consumer concerns and opinions;
- implementing quality improvement plans with the HMOs; and
- procuring and managing a contract with an external quality review organization to conduct medical record review and other quality of care reviews.

The Quality Assurance section's fee-for-service quality assurance and utilization review program is conducted by:

- developing and managing the Department's acute care and long-term contract with the Peer Review Organization (Colorado Foundation for Medical Care);
- prospectively evaluating certain services prescribed by physicians and authorizing appropriate treatment ("prior approval" procedures);
- detecting and pursuing fraudulent and abusive practices that misuse Department resources or that result in substandard care for program clients; and by
- including the fee-for-service population in external review studies, HEDIS calculations and client surveys.

a) Fee-for-Service Utilization Review Programs

Some of the larger fee-for-service utilization review programs include:

- **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. Assuring appropriate access to community-based care reduces the utilization of high cost nursing facility services. 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, provides appropriate admission to all 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 PRO operates the state's system for utilization review and control under contract. 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.

- **Durable Medical Equipment (DME), Early Periodic Screening Diagnosis and Treatment (EPSDT) and Transportation Services** - Prior authorizations for some DME, EPSDT and transportation services are conducted by the PRO under supervision of the Quality Assurance Section. Prior approval procedures are designed to assure that clients have access to appropriate and cost effective equipment and services.

b) Monitoring of Managed Care

- **Site reviews** – The health plans that serve Medicaid clients are visited each year by the Department to ensure they are in compliance with contractual and regulatory standards. Resulting reports are sent to health plans and action plans are submitted by the health plans to address deficiencies. The Department follows up on the action plans throughout the year to ensure changes are made.

- **External quality review** – The Department contracts with an independent party to perform quality review of the health plans. Fee-for –service programs are also often included to facilitate comparison. The reviews largely involve medical records analysis, but other activities are also included. Reports are submitted by HMO and overall to determine areas for improvement. Studies are often focused on specific areas important for the Medicaid populations.

- **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. The Quality Assurance Section will analyze encounter records and validate the data against medical records in 1998.

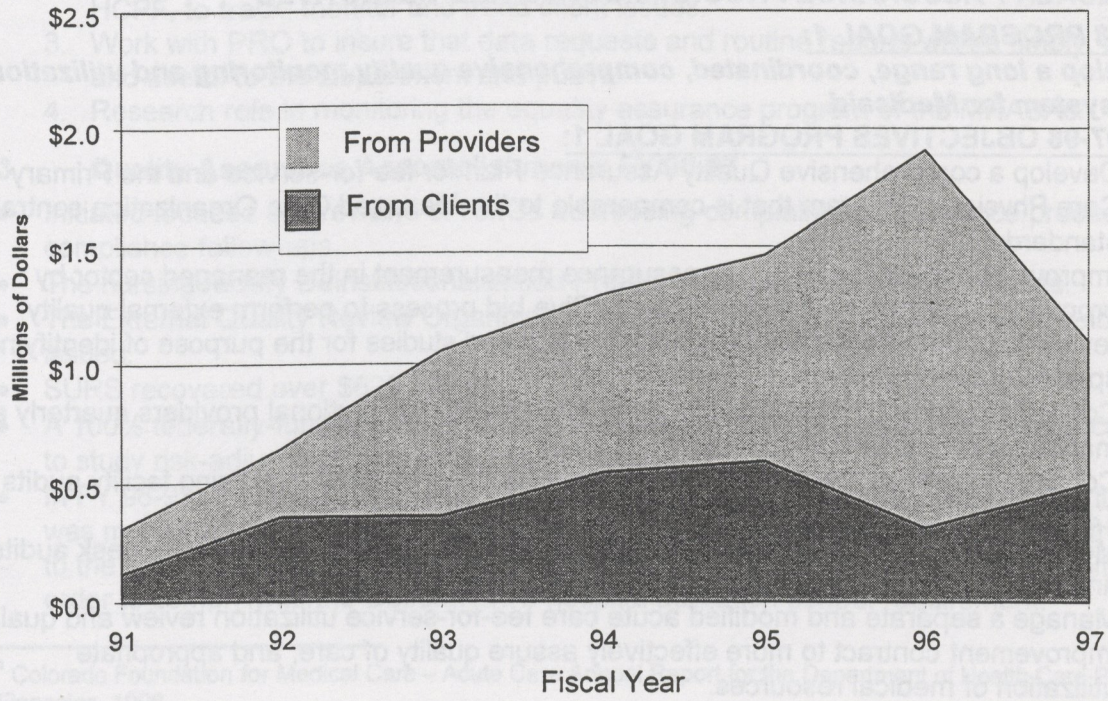
c) *Detection of Fraud and Abuse of Medicaid Resources*

- **Surveillance and Utilization Review Subsystem (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 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 Department of Law. Recoveries resulting from SURS operations are substantial as shown in the figure on the next page. 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.

FIGURE 18: RECOVERIES OF INAPPROPRIATE PAYMENTS, FY 90-91 THROUGH FY 96-97



Note to chart above: The increase in "Recoveries from Providers" in FY 95-96 is attributable to global settlements coordinated by the National Association on Medicaid Fraud Control Units. Since FY91 Colorado Medicaid has received a total of $1,926,131.63 ($256,962.58 in FY 97, $985,450.00 in FY 96, $518,020.00 in FY 95, and $165,698.97 in FY 93) from global settlements (often as the result of national investigations into billings by pharmaceutical companies). Colorado Medicaid provides the U.S. Department of Justice with detail of fraudulent provider billings. The QA section works with the Department of Law to assure that Colorado receives its share of these settlements.

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** – Complaint systems and data are being improved for better analysis and quality improvement direction. Complaints come to the Department are also reported by the HMOs.
- **Patient satisfaction surveys** – Satisfaction surveys are conducted for clients in managed care and fee-for-service programs. This data is used to determine areas for improvement and to assist clients' choice of HMO or PCPP providers. The consumer perspective is a very important aspect of assuring quality care and appropriate access to services.
- **Quality utilization indicators** – The Department collects quality and utilization indicators that will enable evaluation of the performance of contracting managed care health plans, unassigned fee-for-service providers and Primary Care Physician program providers. These indicators are from the Health Plan Employee Data and Information Set (HEDIS), a publication of the National Committee on Quality Assurance. Health plans submit these data annually and the Department calculates the indicators for the fee-for-service providers.

2. QUALITY ASSURANCE PROGRAM GOALS AND OBJECTIVES

FY 97-98 PROGRAM GOAL 1:

To develop a long range, coordinated, comprehensive quality monitoring and utilization review system for Medicaid.

FY 97-98 OBJECTIVES PROGRAM GOAL 1:

1. Develop a comprehensive Quality Assurance Plan for fee-for-service and the Primary Care Physician Program that is comparable to the Managed Care Organization contract standards.
2. Improve effectiveness of quality assurance measurement in the managed sector by procuring a contractor, through a competitive bid process to perform external quality review to updated specifications including focused studies for the purpose of identifying specific quality problems.
3. Continue to open 0.5% of the total body of active non-institutional providers quarterly as mandated by the SPR requirements.
4. Continue to reduce the average backlog of change of ownership nursing facility audits to 120 days.
5. Monitor quality of nursing visits and services for home health clients during desk audits and field visits, and identify incidents of duplicated services.
6. Manage a separate and modified acute care fee-for-service utilization review and quality improvement contract to more effectively assure quality of care, and appropriate utilization of medical resources.

FY 97-98 PROGRAM GOAL 2:

To transition from traditional quality and utilization review activities to a proactive, outcome-based process.

FY 97-98 OBJECTIVES PROGRAM GOAL2:

1. Develop outcome based measurements that incorporate utilization and quality of care element for review, other than billing and reimbursement, for the fee-for-service and Primary Care Physician programs.
2. Assess the need for a minimum percentage (not less than 50%) for offsets against claims submitted by a provider who is indebted to the State and reduce non-institutional provider repayment time period form the standard one year to six months, with and ability to waive the requirement for just cause and recommend for rule.
3. Develop and identification and prioritization system for annual nursing facility audit planning and test an audit program for each of the major types of financial related audits applicable to nursing facilities, including change of ownership, potential fraud referral, customer complaint, and interim review of a nursing home continuing under the same ownership.
4. Evaluate current contractor and state quality utilization review activities for possible cost effectiveness improvement and savings and identify potential areas for fraud and abuse initiatives such as focused reviews and collaboration with other states and participate in Operation Restore Trust.

FY 97-98 PROGRAM GOAL 3:

To pilot a program that identifies, prioritizes, and addresses gaps in quality of care monitoring of medical assistance services.

FY 97-98 OBJECTIVES PROGRAM GOAL 3:

Initiate a committee of Quality Improvement Coordinators for Medicaid Managed Care Organization contractors, HCPF Staff, and other agency staff to outline known gaps.

1. Eliminate the overutilization and abuse in Home Health by educating providers and recouping these service billings.
2. Contribute to the development of an effective complaint and grievance system within HCPF, to track, monitor and trend client issues.
3. Work with PRO to insure that data requests and routine reports will be timely, accurate and useful to the Department and public.
4. Research role in monitoring the equality assurance program of the MHASAs.

3. Quality Assurance Accomplishments FY 96-97

- Initiated focused site reviews of HMOs addressing complaint and grievance procedures with compliance follow-ups.
- The nursing facility Deinstitutionalization Project is active now in three counties.
- The External Quality Review Organization request for proposals (RFP) was developed and issued.
- SURS recovered over $620,000.00.
- A 100% federally-funded grant for $213,334 was awarded to the Quality Assurance Section to study risk-adjustment and loop holes in Medicaid.
- In FY 96-97, the measurable savings attributable to the PRO review of inpatient utilization was more than $4.5 million.[4] 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 requirement.

[4] Colorado Foundation for Medical Care – Acute Care Annual Report for the Department of Health Care Policy and Financing, 1996.

H. 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 and outpatient 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 summary of rate-setting methods for the major service categories is presented below.:

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.

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). Prior to changes to federal law made as part of the 1997 Balanced Budget Reconciliation Act (See paragraph **b)** below), the federal Boren amendment required states' Medicaid programs to pay rates to inpatient hospitals and nursing facilities that covered 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).

Since the Boren amendment was repealed, the Department will be evaluating its reimbursement of hospitals and nursing facilities and may pursue changes in its methodology. In addition, state legislation (SB 97-42) changed the nursing facility reimbursement system by setting rate increase ceilings of 8% growth for health care costs and 6% for administrative costs. These changes are discussed below.

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) Medicaid reimbursement changes in 1997

- ***Reimbursement of reasonable cost***
  - Pursuant to the federal Balanced Budget Reconciliation Act of 1997(H.R.97-2015), "Boren amendment" requirements are repealed for hospital services, nursing facility services, and services of intermediate care facilities for the mentally retarded. However, the Act provides for a public process for determination of rates of payment under which proposed and final rates, the methodologies underlying the establishment of such rates, and justifications for the proposed rates are published; providers, beneficiaries and other concerned State residents are given a reasonable opportunity for review; and, in the case of hospitals, such rates take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs.
  - Reasonable cost-based reimbursement of Federally Qualified Health Centers is phased out. Effective October 1, 1997, the 100% of reasonable cost requirement is amended to 95% for services furnished during FY 2000, 90% in FY 2001, 85% in FY 2002, and 70% in FY 2003. For services furnished after October 1, 2003, the transitional payment rules are repealed, and there is no longer a requirement for payment based on reasonable cost. The Act also requires that FQHCs and rural health clinics be paid equally under a

managed care contract and in a non-managed care situation. The State must make a supplemental payment to the FQHC or rural health clinic equal to any difference in payments. Also, managed care contracts must provide, "in the case of an entity that has entered into a contract for the provision of services with a Federally-qualified health center or a rural health clinic, that the entity shall provide payment that is not less than the level and amount of payment which the entity would make for the services if the services were furnished by a provider which is not a Federally-qualified health center or a rural health clinic."

- ***Revisions to Nursing Facility Rates***

The Department implemented reimbursement system changes and a case mix rate methodology study as authorized by SB 97-42.

- ***Nursing Facility Rate Ceilings*** - Senate Bill 97-42 substantially altered the methodology for nursing facility rate-setting. The new law sets rate increase ceilings of 8% growth for health care costs and 6% for administrative costs. This change will substantially reduce the rate of growth in nursing facility rates and save the state over $15 million annually.
- ***Case Mix Reimbursement*** - The Department is also required to research the potential for basing nursing facility rates on case mix, and to provide a case mix report and recommendations to the General Assembly. An advisory board was convened to review and comment upon HCPF staff work. Staff have surveyed states that currently utilize Case Mix reimbursement systems, reviewed existing Colorado Case Mix components and are preparing a Request for Proposals (RFP) for a contractor to assist in conducting an in-depth analysis of Case Mix options.

- ***Disproportionate Share Hospital (DSH) payments***

DSH payments to hospitals that serve a high proportion of low-income, uninsured and Medicaid clients are capped. For fiscal year 2003 and thereafter, the DSH allotment is equal to the DSH allotment for the preceding year plus the percentage change in the consumer price index for all urban consumers (all items; U.S. city average), for the previous fiscal year. However, the DSH allotment cannot exceed the greater of: (A) the DSH allotment for the previous year, or (B) 12% of the total amount of expenditures under the State Plan for Medical Assistance during the fiscal year. Colorado should be eligible for a CPI increase starting in 2003, since the $74,000,000 allotment cap divided by 12% is only $616,667.

FIGURE 19: DSH CAPS FOR FEDERAL FINANCIAL PARTICIPATION FYS 98-02

Federal Fund Earnings Caps	
FY 97-98	$93.0 Million
FY 98-99	$85.0 Million
FY 99-00	$79.0 Million
FY 00-01	$74.0 Million
FY 01-02	$74.0 Million

DSH expenditures for Mental Health facilities are also capped, but this may have little effect upon Colorado's federal reimbursements because most fee-for-service mental health payments are capitated and paid through MCOs.

c) *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.[5] 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. The table 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 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 20: REIMBURSEMENT METHODS FOR SELECTED SERVICES

Service Type	Type of Reimbursement	Federal or State Mandate?	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)[6]	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* Amendment ***(* repealed effective 10/1/97)***	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[7]
Colorado Indigent Care Program	Non-cost-based	State	Not discussed in Rate Study

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

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

[7] "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.

d) Outpatient Hospital Services

Outpatient hospital services are reimbursed at the lower of 72% of cost or charges.[8] 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.

e) 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. The Department assigns every practitioner procedure a relative value. These relative values are multiplied by a conversion factor, which turns them into dollar amounts per procedure. State policy sets the conversion factor.

f) Outpatient Care Provided at Federally Qualified Health Centers

Outpatient care provided at Federally Qualified Health Centers (FQHC) is reimbursed according to federal guidelines. An FQHC is a community-based clinic in a medically-underserved area that receives funding from the U.S. Department of Health and Human Services to provide comprehensive health services to low-income and indigent patients. The federal government requires Medicaid to reimburse FQHCs at 100% of their "reasonable costs," in order to promote and preserve access to health care for Medicaid clients and for other low-income uninsured persons in these underserved areas. The federal Medicaid requirement to reimburse FQHCs at 100% of costs was amended in 1997, as discussed above.

g) 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 toward covering providers' costs.

h) Inpatient Hospital Services

The Department reimburses hospitals for inpatient care using a cost-based methodology, based upon the federal "Boren amendment" requirements. Boren required Medicaid to pay 100% of the "reasonable costs of an economic and efficiently-operated facility." The Department determined, within federal law, the "reasonable" costs and "economic and efficiently-operated facility" definitions. As previously mentioned, the repeal of the Boren amendment may lead to changes in inpatient reimbursement methodology.

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

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

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 and long-term stay (specialty-acute) hospitals were converted from the non-PPS to the PPS payment system beginning Fiscal Year 1998. Colorado's pediatric specialty hospital was converted to the PPS payment system beginning Fiscal Year 1997. (See below – "Rate Setting Accomplishments" -- for more detail.)

i) Nursing Facility Services

The Department reimburses nursing facilities using a cost-based methodology that is set in state statute. The state statute is in compliance with the federal (Boren) requirement that nursing facilities be reimbursed their reasonable costs of providing care, but it produces rates that are probably higher than those required under the Boren amendment. These rates may be subject to review because of the repeal of the federal cost-based reimbursement requirements. As noted in paragraph b) above, SB 97-42 sets rate increase ceilings of 8% growth for health care costs and 6% for administrative costs. Medicare Part B costs were removed from the cost base, and the growth of Medicare Part A costs is limited to the annual increase in the consumer price index medical care component.

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

- Class 1: skilled nursing facilities (187 facilities)
- Classes 2 and 4: intermediate care facilities for the mentally retarded (4 facilities)
- Class 5: rehabilitation facilities (1 facility)

For each class, the Department establishes a maximum reasonable payment for 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 $3 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.

In accordance with Senate Bill 97-42 the Department is developing systems for payment to nursing facilities to be based upon each individual patient's health care requirements. Popularly known as "Case Mix reimbursement" these reimbursement systems are designed to allow greater access to care by those patients who are most in need. Case Mix payment rates are regularly adjusted for each nursing facility to that facility's estimated patient health care resource utilization, so that each facility receives adequate reimbursement for the mix of patients it serves. An Advisory Committee representing nursing facilities, patient advocates and others is participating in the Department's Case Mix development and implementation.

j) 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.

k) 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 rates are set at 95% of the average historical per-capita fee-for-service cost of services for each client eligibility category. 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.

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

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 channels funds to some programs through Medicaid. This allows the state to draw down federal matching funds for these other 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 $1.9 million to the program in FY 96, including matching federal dollars.

- **Major Teaching Hospital Payments** - The State of Colorado makes payments to University Hospital and Denver Health Medical Center, both of which serve a high proportion of indigent and Medicaid patients, to defray the cost of training interns and residents. In FY 97, these payments to University Hospital and Denver Health Medical Center, 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, enabling facility and service expansions, and reducing cost-shifting onto private payers. The table below shows total disproportionate share payments made to inpatient hospital providers from FY 93 to FY 97, and projected to be made in the current fiscal year.

FIGURE 21: DISPROPORTIONATE SHARE PAYMENTS TO HOSPITALS FYS 93 THROUGH 98

($ millions*)

FY 93	FY 94	FY 95	FY 96	FY 97	FY 98 (projected)	Total FY 93 - FY 98
$358.0	$290.4	$177.7	$104.7	$121.7	$124.4	$1,176.9

* DSH amounts are calculated on an accrual basis (tied to the fiscal year for which the plan was approved) rather than a cash basis (the year of the actual payment) and therefore will not tie to COFRS-based budget reports.

- **Colorado Indigent Care Program** - 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. The CICP Program is described in detail in the Health Care Benefits section of this manual.

2. PROGRAM GOALS, OBJECTIVES AND PERFORMANCE MEASURES

a) PROVIDER RATES SECTION

Program purpose and description

The mission of the Provider Rates Section is to provide resources to ensure the financial integrity of non-institutional health care services while preserving or improving access to quality care.

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.

FY 97 and FY 98-99 PROGRAM GOAL 1:

To effectively administer managed care organization rates.

FY 97-98 OBJECTIVES PROGRAM GOAL 1:

1. Annually review managed care rates to determine that existing rates comply with Federal and State regulations and are adequate to provide access and quality of care. The review would include the acute, PACE program, mental health, Integrated Care & Financing Project and Single Entry Point rates.
2. To ensure that the data used in the calculation of managed care acute rates is accurate for the services provided in the managed care contract.
3. Provider Rates will assist and monitor the development and implementation of risk adjustment methodologies for FY 96-97.
4. Respond positively and timely to problems regarding the financial feasibility of Managed care contractors and sub-contractors.

FY 98-99 OBJECTIVES PROGRAM GOAL 1:

1. Reduce the amount of time it takes to prepare the rates, by refining the rate setting process.
2. Respond positively and timely to problems regarding the financial feasibility of managed care contractors and sub-contractors.

3. Determine the effectiveness of risk adjustment in managed care rates.
4. Annually review managed care rates to determine that existing rates comply with federal and State regulations and are adequate to provide access and quality of care. The review would include the acute, PACE program, mental health, Integrated Care & Financing Project and Single Entry Point rates.
5. Ensure that the data used in the calculation of managed care acute rates is accurate for the services provided in the managed care contract.
6. Develop a mechanism that allows the managed care plans to receive the same discount that Medicaid receives from the pharmaceutical manufactures.

PERFORMANCE MEASURES PROGRAM GOAL 1:

Rate Setting Timelines	FY 95-96	FY 96-97	FY 97-98	FY 98-99
Target	April 1	April 1	April 1	March 15
Actual	May 15	April 11		

FY 97-98 PROGRAM GOAL 2:

To provide oversight of Mental Health Capitation rate calculation.

FY 98-99 PROGRAM GOAL 2:

To provide oversight of Mental Health Capitation rate calculation.

FY 97-98 OBJECTIVES PROGRAM GOAL 2:

1. Review the payment of Mental Health capitation and assure that the program complies with Federal and state regulations.
2. To make certain that mental health capitation rates are internally consistent with other managed care capitation rates.

FY 98-99 OBJECTIVES PROGRAM GOAL 2:

1. That the Mental Health and Acute Managed Care rate setting processes are consistent with each other.
2. That, although separate, the two methodologies are consistent with each other and that Cost, Quality and Access are maintained.

FY 97-98 and FY 98-99 PERFORMANCE MEASURES PROGRAM GOAL 2:

- Reimbursements under Mental Health Capitation rates prove equal to the fee-for-service costs that would have been incurred.

FY 97-98 and FY 98-99 PROGRAM GOAL 3:

To effectively administer the Drug Rebate Program in accordance with Federal and State Regulation.

FY 97-98 OBJECTIVES PROGRAM GOAL 3:

1. To monitor proposed Federal regulations that affect the Drug Rebate Program. To implement these regulations if these regulations go into effect. This includes a different scale of financial reporting, responding to requirements of audits of drug claims, developing an administrative appeal process for drug manufactures and meeting specific time requirements for dispute resolution.
2. To complete implementation of changes to the Drug Rebate System modification.
3. Efficiently handle drug rebate transactions including the development of a "lock-box" deposit capability. To simplify and expedite the routing and lower the risk of loss of drug rebate checks. To expedite deposit of drug rebate revenues to increase the interest income to the State of Colorado.

FY 98-99 OBJECTIVES PROGRAM GOAL 3:

- To use the MMIS and Fiscal Agent to administer the Drug Rebate System

PERFORMANCE MEASURES PROGRAM GOAL 3:

Total Drug Rebate	FY 95-96	FY 96-97	FY 97-98	FY 98-99
Target	$18.2 Million	$20 Million	$22 Million	$24.2 Million
Actual	$18.5 Million	$19.3 million		

FY 97-98 AND FY 98-99 PROGRAM GOAL 4:

To administer the Single Entry Point program for the benefit of LTC clients.

FY 97-98 OBJECTIVES PROGRAM GOAL 4:

1. To monitor the screening and deinstitutionalization process, administered by Options for Long-Term Care (Single Entry Point) Agencies for Medicaid eligible and potentially eligible clients and families, including:
   - Refining profiles to identify clients most likely to be best served in community-based programs.
   - Refining methodologies and procedures to enable Single Entry Point (SEP) intervention before or promptly after institutionalization.
   - Providing public information to enable the public to know the LTC options that exist.
   - Assuring system of fees to enable Options for Long-Term Care (SEP) agencies to intervene with clients identified by the profiles.
   - Investigating rates of pay for alternative care resources in the community to create an incentive for care resource development.
     - Exploring the possible continuation of payment of commercial LTC insurance premiums when eligible families are at risk of default.
2. To pursue accurate calculation and full funding of the Options for Long-Term Care (SEP) funding inflationary adjustment from FY 96-97 to FY 97-98

FY 98-99 OBJECTIVES PROGRAM GOAL 4:

1. Monitor the screening and deinstitutionalization process, administered by Single Entry Point Agencies for Medicaid eligible and potentially eligible clients and families:
   - Refining profiles to identify clients most likely to be best served in community based programs.
   - Refining methodologies and procedures to enable single entry point agency intervention before or promptly after institutionalization.
   - Providing public information to enable the public to know the LTC options that exist.
   - Assuring system of fees to enable single entry point agencies to intervene with clients identified by the profiles.
   - Investigating rates of pay for alternative care resources in the community to create an incentive for care resource development.
   - Exploring the possible continuation of payment of commercial LTC insurance premiums when eligible families are at risk of default.
2. Prepare accurate calculation of the single entry point funding budgetary need.

FY 97-98 PERFORMANCE MEASURES PROGRAM GOAL 4:

- Implement the improved inflationary indicator, the "Community Provider Rate" as a substitute for the CPI. Pursue indexing of Options for Long-Term Care (SEP) funding as a decision item.

NF Deinstitutionalization: Interventions	FY 95-96	FY 96-97	FY 97-98	FY 98-99
Target	0	0	200	200
Actual	0	0		

FY 97-98 and FY 98-99 PROGRAM GOAL 5:

To efficiently administer Disproportionate Share Hospital (DSH) payments and refinancing. Identify DSH programs that can be made ongoing without additional State Plan amendments.

OBJECTIVES PROGRAM GOAL 5:

1. To calculate a separate payment for DSH and pay separately to participating hospitals.
2. To identify DSH programs that can be made ongoing to avoid additional State Plan amendments; determine if these programs use state match comprised of certification of public expenditures or contribution-related or both.
3. To explore refinancing opportunities within DSH as long as federal funds are available.

FY 97-98 and FY 98-99 PROGRAM GOAL 6:

To administer and monitor expenditures for programs related to provider rates.

OBJECTIVES PROGRAM GOAL 6:

1. Monitor expenditures for acute and ambulatory program areas. Report expenditures on a timely basis and manage the program to ensure compliance with appropriation.
2. Implement appropriated rate adjustments. Rate increases will be designed to meet the competing requirements of the applicable programs, and to maintain or improve access and quality of care.
3. Apply cost containment measures on the Federally Qualified Health Centers (FQHC) and all other programs in contemplation of future budget constraints.

PERFORMANCE MEASURES PROGRAM GOAL 6:

Timeliness of Rate Setting	FY 95-96	FY 96-97	FY 97-98	FY 98-99
Target	April 1	April 1	April 1	April 1
Actual	June 1	Mar 1		

b) FACILITY RATES SECTION

Program purpose and description

Facility Rates' mission is to reimburse providers sufficiently to ensure Medicaid clients have appropriate access to necessary medical services, comply with federal and state law, control program expenditures, and to encourage a high level of quality of care for high-risk Medicaid clients in nursing facilities and hospitals.

The Facility Rates Section sets provider reimbursement rates for care delivered to Medicaid clients in Hospitals, Nursing Facilities, and the Colorado Indigent Care Program. This Section also directly administers the Poison Control Program. The benefits and eligibility information on these two programs can be found under the Health Care Benefits and Eligibility and Enrollment Sections. The goals, objectives and performance measures for the two programs, and for the rate functions carried out by the Facility Rates Section, are listed below.

FY 97-98 and 98-99 PROGRAM GOAL 1:

To set rates for hospitals and nursing facilities which reimburse the costs of efficiently and economically operated facilities in accordance with the provisions of the State statutes, federal Medicaid requirements and departmental regulations.

FY 97-98 and 98-99 OBJECTIVES PROGRAM GOAL 1:

1. Review rate setting methodology to determine if rates are sufficient to satisfy federal requirements and to ensure that only those costs that are reasonable, necessary and patient-related, are included in the rates.
2. Contract with an outside CPA firm to perform audits of hospitals and nursing facilities in accordance with Generally Accepted Auditing Standards (GAAS), Medicaid and Medicare rules, and departmental regulations.
3. Contract with an outside appraisal firm to perform appraisals of nursing facilities every fourth year. The appraisals shall be used to calculate the fair rental allowance (property) portion of the Medicaid rate set for each facility.
4. Monitor fiscal agent to ensure reliability of retroactive rate adjustments and percentages for recoveries of overpayments. This is to ensure that each provider is reimbursed using the proper rate and that any overpayments to providers are recovered in accordance with State statute.
5. Perform analysis of alternative rate setting options and fiscal impact on the State, providers and the public. Analyze the impact of any proposals or changes in federal and State reimbursement laws and regulations.
6. Conduct surveys for census information, private pay and owner-administrator salaries. Use information in auditing, rate setting, and to calculate cost ceilings.
7. Draft, revise and present regulations to clarify rules concerning allowable costs and rate setting methodologies for facilities.

FY 98-99 PERFORMANCE MEASURES PROGRAM GOAL 1:

Rate Setting	**FY 95-96**	**FY 96-97**	**FY 97-98**	**FY 98-99**
Target	100% within 2 weeks	100% within 2 weeks	100% within 2 weeks	100% within 2 weeks
Actual	99%	99%		
Rate Adjustment Errors	**FY 95-96**	**FY 96-97**	**FY 97-98**	**FY 98-99**
Target	2%	2%	2%	2%
Actual	2.5%	1.9%		

FY 97-98 and 98-99 PROGRAM GOAL 2:

To respond to provider appeals and conduct the informal reconsideration process.

FY 97-98 and 98-99 OBJECTIVES PROGRAM GOAL 2:

1. Participate in the provider appeal process by providing documents, negotiating with attorneys and serving as witnesses in rate appeals.
2. Review rate appeals and research cases as necessary.
3. Perform rate analysis and review rate adjustments with auditor to determine Department's position and policy related to the appeals.
4. Negotiate settlements and avoid unnecessary litigation whenever possible.
5. Respond to provider requests for informal reconsideration, research issues, confer with auditors and draft decisions that are consistent with State statues and Medicaid regulations.

FY 98-99 PERFORMANCE MEASURES PROGRAM GOAL 2:

Rate adjustment appeals completed	FY 95-96	FY 96-97	FY 97-98	FY 98-99
Target	100% in 45 days			
Actual	99%	100%		

FY 97-98 and 98-99 PROGRAM GOAL 3:

To provide accurate and timely information to providers, family members, other agencies, and other interested parties about rates and rate setting methodology.

FY 97-98 and 98-99 OBJECTIVES PROGRAM GOAL 3:

1. Engage in face-to-face meetings, telephone and written discussions/instructions to providers and the public regarding rules and regulations.
2. Provide information to other agencies and outside research groups timely.
3. Improve customer support and response time to inquiries.

FY 98-99 PERFORMANCE MEASURES PROGRAM GOAL 3:

Phone response time	FY 95-96	FY 96-97	FY 97-98	FY 98-99
Target	24 hours	24 hours	24 hours	24 hours
Actual	26 hours	22 hours		
Written response time	**FY 95-96**	**FY 96-97**	**FY 97-98**	**FY 98-99**
Target	2 weeks	2 weeks	2 weeks	2 weeks
Actual	2 weeks	12 days		

FY 97-98 and 98-99 PROGRAM GOAL 4:

To increase efficiency of rate setting processes and office functions through the use of new technology and computer networks, contractors and the fiscal agent.

FY 97-98 and 98-99 OBJECTIVES PROGRAM GOAL 4:

1. Establish on-line networks with the auditors and the fiscal agent to increase the efficiency of rate processing and retroactive adjustments.
2. Eliminate manual processes that are time consuming and delay rate setting calculations.
3. Convert paper rate setting methodology to computerized formats that perform calculations, set cost arrays and compile and organize data for rate analysis.
4. Establish a rate information database for rate analysis, Boren data, budget information, legislative analysis and management reporting.

FY 98-99 PERFORMANCE MEASURES PROGRAM GOAL 4:

Scanning	FY 95-96	FY 96-97	FY 97-98	FY 98-99
Target	33%	75%	80%	90%
Actual	20%	50%		

FY 97-98 and 98-99 PROGRAM GOAL 5:

To study the feasibility of implementing a case-mix reimbursement system for nursing facilities, and implement as feasible.

OBJECTIVES PROGRAM GOAL 5:

1. Conduct feasibility study to determine whether case-mix reimbursement can be implemented in Colorado.
2. Establish an advisory group made up of industry, consumer, advocate and health care personnel to bring in expertise for creating and evaluating case-mix alternatives.
3. If found to be feasible, implement Case Mix System. Revise rules, regulations, and statutes.
4. Evaluate Case Mix System compared to Prospective Reimbursement.

PERFORMANCE MEASURES PROGRAM GOAL 5:

- Complete Legislative Report due 11/1/97. Conduct feasibility study by 7/1/98
- If found to be feasible, implement Case Mix System between 7/l/98 and 7/1/99.
- Evaluate by 12/31/99.

FY 97-98 and 98-99 POISON CONTROL PROGRAM GOAL #1

To provide Statewide access to high-quality, cost-effective poison control services.

OBJECTIVES POISON CONTROL PROGRAM GOAL 1:

1. Rocky Mountain Poison and Drug Center (RMPDC) will provide a toll-free direct incoming number for Colorado.
2. RMPDC will establish and implement a formal protocol for the toxicology system.
3. RMPDC will enhance the outreach educational programs to rural Colorado.
4. RMPDC will establish and maintain complaint response and reporting system.

PERFORMANCE MEASURES

- For Objective 1, sufficient lines, for the local and toll-free phone line, will be maintained to assure that all incoming calls are answered within four rings.
- For Objective 2, toxicologists will respond to calls or pages within 10 minutes.
- For Objective 3, at least four outreach programs will be targeted to communities in rural Colorado and in those areas without a toll free access number to the RMPDC. The Center will submit quarterly reports on the community outreach public education programs and presentations given.
- For Objective 4, RMPDC will submit monthly log sheets to the Department which identify the nature of the complaint, the follow up procedures, and level of validity concerning the complaint.

FY 97-98 and 98-99 COLORADO INDIGENT CARE PROGRAM GOAL 1:

To define, develop, and integrate CICP policies and benefits in statutes, regulations, and procedures.

OBJECTIVES CICP GOAL 1:

1. Develop, implement, and update current policy in rules and procedures for the Colorado Indigent Care Program (CICP).
2. Update the CICP Manual to reflect current policies, procedures, and claims processing.
3. Provide technical assistance to providers on the policy changes described above.
4. Request and support legislation for the CICP statutes and program definitions.
5. Implement standardized reporting for the UB-92 format and convert all CICP claims processing to the current Fiscal Agent (Blue Cross/Blue Shield).
6. Convert claims processing from the old to the new Fiscal Agent (Blue Cross/Blue Shield to Consultec) and standardize reports.

PERFORMANCE MEASURES CICP GOAL 1:

- For Objective 1, rule changes will be presented to the State Board by January 1998.
- For Objective 2, the CICP Manual will be updated by August 1997.
- For Objective 3, technical assistance for the rule changes described above will be available to providers.
- For Objective 4, revised (if needed) rule changes will be presented to the State Board before January 1999. The CICP Manual will be updated by February 1999.
- For Objective 5, implementation of electronic filing shall be on line by July 31, 1997
- For Objective 6, BCBS will provide history for conversion to Consultec for CICP claims processing. Consultec will implement the electronic filing and standard reports for CICP.

FY 97-98 and 98-99 CICP GOAL 2:

To promote access to CICP services.

OBJECTIVES CICP GOAL 2:

1. Conduct studies and prepare reports to the Legislature, the Governor, HCFA, and other departments/agencies as mandated to identify areas for CICP improvement.
2. Develop, implement, and monitor contracts, cooperative agreements, and provider agreements to ensure timely delivery of high-quality, cost-effective services.
3. Use the data systems tools available to the section to the fullest extent possible. Assist co-workers with finding and using data information, monitor and enhance the systems' performance, and work to improve the systems for more efficient access and management of data information. The primary data systems tools available are:
    - Medicaid Management Information System (MMIS)
    - Health Care Policy and Financing Local Area Network (HCPF LAN)

PERFORMANCE MEASURES CICP GOAL 2:

- For Objective 1, prepare the following reports/studies: Growth in the Medically Indigent program (Joint Budget Committee; November 1, 1997); effects of Welfare Reform - Impact on the Medically Indigent program (in the HCPF Budget Request; November of each year); Annual CICP report (General Assembly; February 1, of each year).
- For Objective 2, periodic monitoring meetings will be held with the Indigent Care contractors and the University of Colorado Health Sciences Center (UCHSC) to monitor contract performance. Contracts and cooperative agreements will be negotiated and in place by July of each year.
- For Objective 3, implement enhancements to the systems as appropriate. Projects for the MMIS will include any enhancements necessary to transition the data and applications (AMPS) to the new MMIS (Consultec system).

3. Recent Rate Setting Accomplishments

The Rate Setting sections implemented the following projects in FY 96-97:

- Automated nursing facility rate-setting process and streamlined rules and regulations for administering rates for nursing facilities and hospitals. These changes improve efficiency, contain Medicaid costs and increase the number of rate appeals that are settled informally.
- Implemented effective July 1, 1997 a new state law (Senate Bill 97-42) that limits the growth of reimbursement rates for class I and class V Medicaid nursing facilities to no more than 6% per year for "administrative costs" and 8% per year for "health care services costs." This initiative will save the state at least $15 million per year in nursing facility reimbursements.
- Converted 6 rehabilitation, specialty acute (acute long-stay), and pediatric specialty hospitals from the non-PPS to the PPS (DRG) payment system. Modifications included the addition of 11 new rehabilitation DRGs and 5 new neonatal DRGs.
- Adjusted 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" chapter.]
- Let contracts and began work 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.]

I. 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 as it applies to Medicaid eligibility;
- 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 the fiscal agent administrative operation of the MMIS to ensure State Plan and contract compliance;
- coordinates HCPF direction of fiscal agent administrative activities;
- 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.

The Information Systems Section also manages the implementation of the new MMIS that was procured in FY96-97. This $26,000,000 development project is expected to drive over 25,000 hours of personnel resource from the Information Systems Section between startup in August of 1996 and final implementation July 1, 1998.

2. PROGRAM GOALS, OBJECTIVES AND PERFORMANCE MEASURES

FYs 97-98 and 98-99 PROGRAM GOAL 1:

To manage the implementation of a new Medicaid Management Information System (MMIS). To ensure that the MMIS implementation is complete and accurate for Health Care Financing Administration certification.

FY 97-98 OBJECTIVES PROGRAM GOAL 1:

1. Complete the development of test situations for an acceptance test to ensure Colorado requirements have been incorporated in the new MMIS.
2. Complete conversion specifications of all MMIS and interface files.
3. Complete the design and implementation of an interim EIS/DSS solution.
4. Complete User Acceptance Testing of the new MMIS to ensure complete and accurate implementation of Colorado Program requirements.
5. Perform a pilot test phase of the new MMIS to ensure that the system will perform in a live environment prior to full implementation.
6. Complete conversion of all appropriate data from BC/BS to the new system.
7. Complete certification activities and Health Care Financing Administration review to receive enhanced federal financial participation in the operation of the MMIS.

PERFORMANCE MEASURES PROGRAM GOAL 1:

Test Situations	FY 96-97	FY 97-98
Target	6/30/97	12/31/97
Actual @ 10/97	Not Started	60% of test situation development completed
Conversion Specifications	FY 96-97	FY 97-98
Target	4/30/97	7/31/97
Actual @ 10/97	Start 3/24/97	Conversion specification complete for Client, Provider and Reference Subsystem
Interim EIS/DSS	FY 96-97	FY 97-98
Target	N/A	10/01/97
Actual	System Design approved	12/01/98
Pilot Testing	FY 96-97	FY 97-98
Target	N/A	6/30/98
Actual		Pilot test design approved 10/1/97
File Conversion	FY 96-97	FY 97-98
Target		6/30/98
Actual		Client Case & Reference Diagnosis File converted
Certification	FY 98-99 w/out DI	FY 98-99 w/DI
Target		6/30/99
Actual		

FY 97-98 and FY 98-99 PROGRAM GOAL 2:

To provide automated data support to Quality Assurance.

FY 97-98 OBJECTIVES and PERFORMANCE MEASURES PROGRAM GOAL 2:

1. Build start-up database for summary profiles for exception processing (by 6/30/98).
2. Implement EIS/DSS solution with VIPS product and converted database (by 7/31/98).
3. Generate HEDIS measures for Medicaid Fee-for-Service component (by 6/01/98).

FY 98-99 OBJECTIVES PROGRAM GOAL 2:

1. Train Surveillance Utilization Review staff in the development methodology to create summary profiles & treatment analysis.
2. Collaborate with Quality Assurance to expand Long-term Care managed care options.

FY 97-98 PROGRAM GOAL 3:

To support and increase access to managed care.

FY 98-99 REVISED PROGRAM GOAL 3:

To implement initiatives legislated by SB97-5.

FY 97-98 OBJECTIVES PROGRAM GOAL 3:

1. Ensure COIN Processes are operational by 7/97.
2. Ensure additional MMIS assignment is operational by 8/97.
3. Process PCP conversions associated with new HMO contracts by 9/97.
4. Download eligibility and capitation data to MC plans on the BBS (original target 7/97; new target date 10/97).
5. Provide eligibility and provider data to MC by 2/1/98.
6. Implement Integrated Care Demonstration Project by 2/15/98.
7. Implement SB 97-5 initiatives by 6/30/98.

FY 98-99 OBJECTIVES PROGRAM GOAL 3:

1. Provide Medicaid Provider Affiliation data in addition to MMIS eligibility and provider data to Medicaid subcontractors.
2. Implement 6 month guaranteed eligibility with additional SB 97-5 requirements.

FY 97-98 PROGRAM GOAL 4:

To ensure timely and accurate Medicaid eligibility identification of current Medicaid and expanded Medicaid populations

FY 98-99 REVISED PROGRAM GOAL 4:

To ensure automated eligibility capability is transferred successfully to the new MMIS and that all current as well as expanded eligibility categories are supported in the new MMIS

FY 97-98 OBJECTIVES PROGRAM GOAL 4:

1. Maintain daily eligibility updates to the MMIS from COIN and CWEST.
2. Ensure accurate integration of all sources of eligibility including COIN, CWEST, Presumptive Eligibility.
3. Provide certificate of insurance for Kennedy-Kassenbaum identified clients.

FY 98-99 OBJECTIVE PROGRAM GOAL 4:

Ensure that expanded Medicaid eligibility determination is integrated into new systems.

FY 97-98 PROGRAM GOAL 5:

To ensure continuity of service in the current MMIS and complete all enhancements in the current MMIS by the end of Calendar Year 1997.

FY 98-99 REVISED PROGRAM GOAL 5:

To ensure continuity of service in the new MMIS by implementing State and Federal legislative initiatives.

OBJECTIVES PROGRAM GOAL 5:

1. Develop capability to receive and convert CICP and encounter data to current MMIS claim formats.
2. Implement claim form and AMP software changes needed in the new MMIS.
3. Implement National Provider Identification including CLIA accommodation.
4. Implement annual HCPCS, DRG & MSIS changes.
5. Implement School Based Clinics.
6. Implement Case Mix Reimbursement.

PERFORMANCE MEASURES PROGRAM GOAL 5:

Develop capability to receive CICP & encounter data	FY 96-97	FY 97-98
Target	N/A	7/1/98
Actual		8/1/98
Implement Claim form and AMP changes	FY 96-97	FY 97-98
Target	N/A	1/31/98
Actual		
Implement NPI CLIA changes	FY 96-97	FY 97-98
Target	N/A	1/1/98
Actual		
Implement HCPCS,DRG & MSIS changes	FY 96-97	FY 97-98
Target	N/A	1/31/98
Actual		
Implement School-Based Clinics	FY 96-97	FY 97-98
Target	N/A	1/1/98
Actual		

3. Recent Information Systems Section Accomplishments

- **MMIS Operations and Development** - MMIS processed 9,963,626 Medicaid claims for 270,050 Medicaid clients in FY 97. 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 15,000 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 were approximately 68,526 and 871,685 capitations were paid in FY97. 2,149,961 Mental health capitation payments were also processed in FY 97.
  - Automated Medical Payment System (AMPS) - 7,466,393 transactions were processed through AMPS in FY 97, with a reduction in the rejected claim percentage (denial/ error rate) from 14.25% in FY 95 with the old paper claims system to 5.9% in FY 97 with electronic claims. Initial claims rejections (errors) were also down, to 16.9% of claims.
  - Electronic Funds Transfer (EFT) - Approximately 2,000 providers used EFT as of June 1997. For these providers, EFT and AMP systems changes reduced the time for 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 also installed in FY 97:
  - Diagnostic Related Grouping (DRG) expansion for specialty services
  - Daily Eligibility Updates to the MMIS and AMP Eligibility Verification Process.
  - Minimum Support Waiver enhancements to allow extension of HCBS services to persons with Developmental Disabilities

- **New MMIS Implementation**
- In FY 97 the Information Systems Section began implementing the new MMIS contract that was awarded to Consultec in a competitive bid procurement. 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.
- A Requirements Analysis was completed with Information System and Department program staff and subsequent Requirements Definition Document and Detail System Design Document were reviewed and approved at a total Department resource utilization of over 15000 hours for FY96-97.
- An interim Executive Information System/Decision Support System (EIS/DSS) was designed for an implementation in the October/November 1997 timeframe. The EIS/DSS database is currently being loaded for access during the FY98 legislative session.
- A Verification and Validation Test Plan to include system test and user acceptance test situations has been developed and approximately 60% of the test situations are complete.

J. THIRD PARTY RESOURCES SECTION

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 avoid or recover Medicaid payments 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 (Colorado Statutory Citation: 10 CCR 2505-10). Applicants for Medicaid coverage are required to provide information on other resources, including other coverage, that may pay for health care services. The Medicaid program also receives notice of other health care resources through sources such as the Social Security Administration, Workers' Compensation, and the Department of Labor and Employment. 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
- liability coverage such as auto insurance and homeowner policies

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

- identifying non-Medicaid health care coverage of Medicaid clients;
- health insurance buy-in program (HIBI);
- tort/casualty recovery;
- undocumented alien program;
- estate recovery;
- income trusts;
- prescription drug and federally required recoveries; and,
- establishing credits of Medicaid payments made to providers when another third party is identified as the primary payer.

These programs are described below.

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

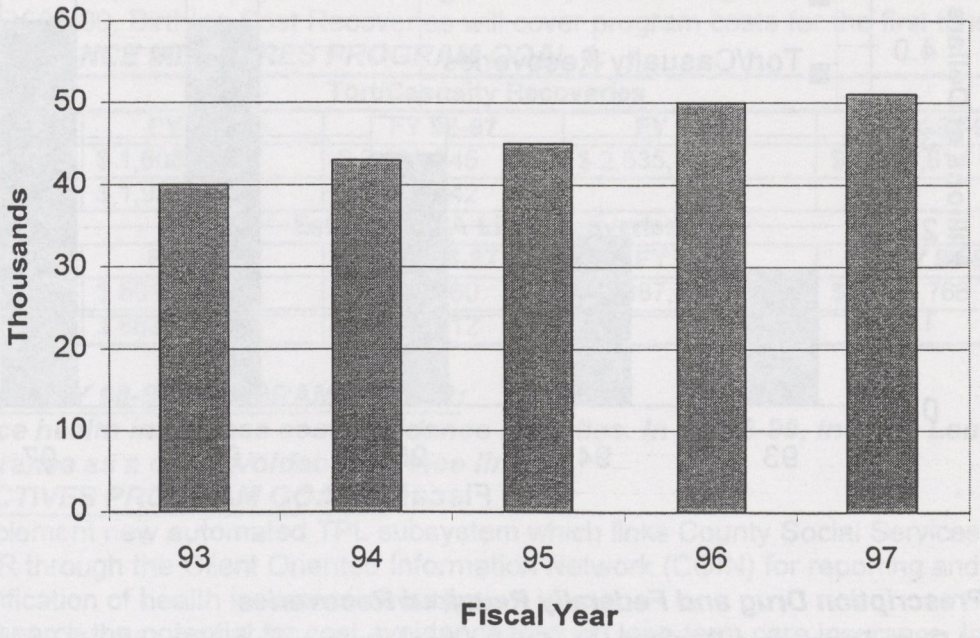
An average of 20,563 clients per month (about 1 in 10 Medicaid clients) have their claims paid by other sources of health coverage, such as private health care insurance, that were identified and pursued by the Third Party Resource Section systems and staff work. These cost avoidance activities saved Colorado over $ 14.6 million in FY 97.

b) Medicare and Health Insurance Buy-In Programs

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 under Medicaid for health services rendered. As shown in the figure below, during FY 97, approximately 51,000 Medicaid clients per month had Medicare or private health insurance coverage purchased by the State. This is a 2% increase in buy-in clients over FY 96. In FY 97, $269,432 in health insurance buy-in premiums were paid for Medicaid clients, and

$104.7 million in health care costs were paid under the purchased coverage that would otherwise have been a Medicaid program liability. In addition, $87,713 was recovered from Medicare after Medicaid had paid but Medicare was found to be the primary insurer.

FIGURE 22: MEDICARE AND HIBI ENROLLMENTS FYS 93 THROUGH 97



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. During FY 97, total recoveries were $1.7 million. The figure below shows tort/casualty recoveries in fiscal years 93 through 97.

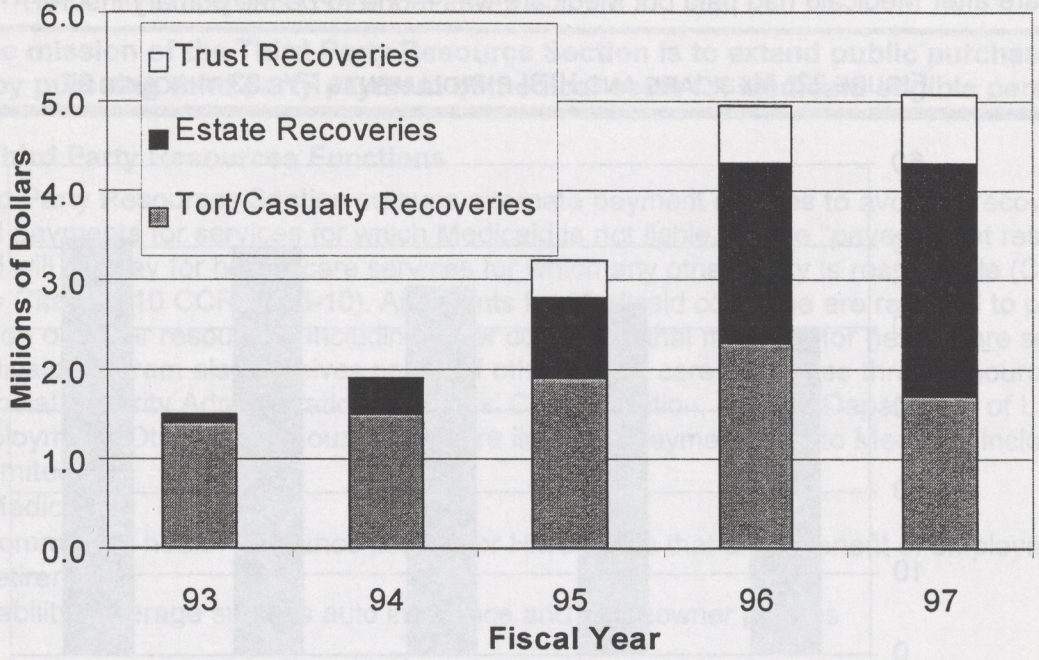
d) *Estate Recovery*

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. Total estate recoveries during the fourth full year of operations were $2,559,512, up 29% from FY 96.

e) *Income Trust Recovery*

Income trusts provide a mechanism for individuals to pay a portion of their nursing home costs, placing the remainder of their income in a qualifying trust, while the Medicaid program assumes remaining costs and the state is beneficiary of those trust monies when the trust closes. This mechanism allows persons whose income is more than Medicaid eligibility limits but less than the cost of nursing facility care to qualify for Medicaid coverage of their care. As shown in the figure below, $775,643 was recovered in FY 97 - an increase of 19% over 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 administers closing and accounting for these trusts.

FIGURE 23: TORT/CASUALTY, ESTATE AND TRUST RECOVERIES



f) Prescription Drug and Federally Required Recoveries

The Third Party Resources Section coordinates post-payment recovery activities performed by the Medicaid Fiscal Agent 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 a 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 97 amounted to $2 million dollars, up from $0.5 million in FY 96.

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 97 , these credits saved the state $1.8 million, up from $1.5 million in FY 96.

2. PROGRAM GOALS, OBJECTIVES AND PERFORMANCE MEASURES

FY 97-98 and PROGRAM GOAL 1:

To increase recoveries in the following areas; Tort/Casualty Recoveries, Estate/TEFRA Lien Recoveries, Trust Recoveries, Birth Related Cost Recoveries. In FY 98-99, centralize all recovery functions through the MMIS.

OBJECTIVES PROGRAM GOAL 1:

1. Increase proactive use of HCPF LAN tracking database tools to increase recoveries.
2. Increase Estate/TEFRA lien recoveries to at least $ 3 million through contingency fee contracting. Reintroduce legislation to provide changes to probate code requiring notification of probate filings as well as extend the time the State has to file claims on those estates.

3. Continue to shift income trust recovery program to cost-avoidance strategies by accessing the trust proceeds at the time that care is reimbursed by Medicaid.
4. Begin collection activities from non-custodial parents for the repayment of public moneys expended for birth related medical costs. Coordinate with the Child Support Enforcement unit of the DHS in establishing paternity upon the birth of the child and in identification of non-custodial parents.
5. In FY 98-99, reduce paper flow through TPR by 50% through MMIS automation.
6. In FY 98-99, Birthing Cost Recoveries will cover program costs for the first time.

PERFORMANCE MEASURES PROGRAM GOAL 1:

Tort/Casualty Recoveries				
Item	**FY 95-96**	**FY 96-97**	**FY 97-98**	**FY 98-99**
Target	$ 1,608,268	$ 2,119,745	$ 2,535,104	$ 2,788,614
Actual	$ 1,927,041	$ 1,683,442		
Estate/TEFRA Lien Recoveries				
Item	**FY 95-96**	**FY 96-97**	**FY 97-98**	**FY 98-99**
Target	$ 501,869	$ 1,059,860	$ 2,387,305	$ 2,864,766
Actual	$ 883,217	$ 2,559,512		

FY 97-98 and FY 98-99 PROGRAM GOAL 2:

To enhance health insurance cost avoidance activities. In FY 98-99, include Long-term Care insurance as a cost avoidable service line.

OBJECTIVES PROGRAM GOAL 2:

1. Implement new automated TPL subsystem which links County Social Services to State TPR through the Client Oriented Information Network (COIN) for reporting and verification of health insurance coverage.
2. Research the potential for cost avoidance through long-term care insurance. Implement as feasible.
3. Monitor cost avoidance and the payment of co-pays in primary managed care plans.
4. Enhance and streamline identification and processing of Health Insurance Buy- In clients.
5. Research the potential of reinsuring the Medicaid program both at the fee-for-service as well as the managed care level.
6. Determine feasibility of a large purchase of Medicare supplemental insurance for dual eligible clients and the potential to reduce pharmaceutical costs.
7. Pursuant to state legislation, monitor Medicaid client cooperation with third party insurance coverage requirements, and attempt to recover from clients Medicaid costs for which the third party would have been liable had the client met these requirements.
8. Purchase Medicare supplemental insurance for dual eligible clients.

PERFORMANCE MEASURES PROGRAM GOAL 2:

1. By the end of FY 98-99, process 70% of all insurance verifications through the MMIS TPL subsystem and load 100% of all identified third party insurance plans (including managed care plans) to the recipient resource file for future cost avoidance of medical claims.
2. Implement a new Windows based ACCESS database system for the identification and processing of health insurance buy in clients.
3. Initiate a study of the cost effectiveness of purchasing Medicare supplemental insurance for dual eligible clients.

[See performance measures table, next page.]

Primary Insurance Cost Avoidance Savings					
Item	**FY 93-94**	**FY 94-95**	**FY 95-96**	**FY 96-97**	**FY 97-98**
Target				$ 16,780,379	$ 14,646,381
Actual			$ 15,254,890	$ 14,646,381	
Private Health Insurance Buy-In (HIBI) Cost Avoidance					
Item	**FY 93-94**	**FY 94-95**	**FY 95-96**	**FY 96-97**	**FY 97-98**
Target				$ 561,433	$ 795,049
Actual			$ 510,394	$ 795,049	

3. Third Party Resources Section FY 97 Accomplishments

- **Recoveries** - Third Party Resources operated and expanded resource recovery programs that recovered $ 99.3 million in FY 97. Cost-avoidance activities saved the state $ 90.3 million in FY 97. Recoveries and credits yielded $ 9 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 24: THIRD PARTY COST AVOIDANCE AND POST-PAYMENT RECOVERY

PROGRAM	FY 97 ($ millions)
Cost Avoidance	
Primary Insurance (non-Medicaid payment sources)	$ 14.6
Buy-in (Medicare and private; net after premiums paid)	$ 75.7
Recoveries	
Medicare	$ 0.1
Tort/Casualty	$ 1.7
Estates	$ 2.6
Income Trusts	$ 0.8
Prescription Drug/Federally-Required	$ 2.0
Credits	$ 1.8
TOTAL AVOIDED AND RECOVERED COSTS	**$ 99.3**

VI. 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 Department. 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 97-98 appropriation for the Department is $1,704,925 531, and 146.0 full-time equivalent (FTE) staff. The State General Fund share of the largest component of the total budget, Medicaid services, is 47.97%, with a current federal financial participation of 52.03%. The table below shows the funding source components of the Department's budget.

FIGURE 25: HCPF APPROPRIATIONS BY FUND SOURCE FY 97-98

Funding Source	Appropriation
State General Funds	$809,808,529
Cash Funds	$10,136,365
Cash Funds Exempt**	$11,350,800
Federal Funds	$873,629,837
Total	**$1,704,925,531**

* Old Age Pension Health and Medical Fund

** "Exempt" funds are exempt from being counted against budge limits established in Article X of the Colorado Constitution (the Tabor Amendment). Gifts and donations are exempt. County cash funds paid through the state are also exempt, 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;
- obtain funding for all other programs and responsibilities of the Department;and,
- develop and provide budgetary and programmatic accountability documentation to Department staff, Executive and Legislative branches, federal agencies and the public.

These functions are carried out as follows:

- **Budget Forecasting and Preparation** - The production of the annual budget request requires input from all parts of the Department, and from external sources. The Budget Office coordinates this input. To prepare the annual budget request, the Budget Office estimates 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

Notes to formula:
1. Enrolled Medicaid clients are called "eligibles" in the Medicaid budget process.
2. Cost per eligible is calculated separately for each category of eligibility.
3. Policy and trend inflators used may vary by category of eligibility, by year, etc.

- **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.

- **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 HCPF fiscal notes.

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

- **Departmental Planning, Reporting and Analysis** - 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 the goals, objectives, and performance measures for each unit of the Department. Pertinent elements of the MAP are included in the budget request and in the Reference Manual.

  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. The figures on the following pages illustrate the type of analysis that the Budget Office performs. They show Medicaid historical expenditures and staffing, expenditures by client group, and cost per client by group.

Following is summary budgetary information for the Department (and for the Medicaid program when it was located within the Colorado Department of Social Services). These data provide an overview of the size of the budget, the rate of budgetary change and the change in federal matching rates. The federal matching rate, or federal financial participation (FFP) rate, is computed by the Federal Funds Information Service for all states based on their state's economic situation (per capita earnings) relative to the nation. Matching rates range from a low of 50% to over 80% (for impoverished states). Note the volatility of the Disproportionate Share (DSH) program. This program began during the same period of time that the major federal expansions were occurring and contributed to the extreme growth rates of the early 1990s.

FIGURE 26:
DEPT. OF SOCIAL SERVICES, DIVISION OF MEDICAL SERVICES AND
DEPT. OF HEALTH CARE POLICY AND FINANCING
BUDGET GROWTH HISTORY

FISCAL YEAR	HCPF ADMIN.& PREMIUMS	% CHG	DISPROP. SHARE PAYMENTS	MMIS & DHS MIS	%CHG	TOTAL*	% CHG	GENERAL FUND	% CHG	CASH FUNDS	FEDERAL FUNDS
FY 81-82	NA	NA	0	42,393,071	NA	241,636,785	NA	114,494,964	NA	177,387	126,964,434
FY 82-83	242,057,308	NA	0	51,439,189	21.34	278,129,756	15.10%	138,129,364	20.64	12,240	139,988,152
FY 83-84	263,910,306	9.03%	0	55,525,691	7.94	312,548,747	12.38	160,057,996	15.88	13,385	152,477,366
FY 84-85	276,909,812	4.93%	0	71,193,852	28.22	333,272,450	6.63%	164,206,999	2.59%	609,308	168,456,143
FY 85-86	299,959,928	8.32%	0	63,471,421	-10.85	352,023,853	5.63%	173,621,753	5.73%	14,305	178,387,795
FY 86-87	325,892,065	8.65%	0	99,187,924	56.27	421,876,014	19.84%	207,921,892	19.76%	1,139,474	212,814,648
FY 87-88	374,712,207	14.98%	0	98,478,087	-0.72	459,142,221	8.83%	225,250,411	8.33%	18,284	233,873,526
FY 88-89	394,986,108	5.41%	0	104,248,223	5.86	506,319,766	10.28%	243,111,807	7.93%	11,497,943	251,710,016
FY 89-90	434,357,798	9.97%	0	120,701,602	15.78	599,510,338	18.41%	286,663,263	17.91%	11,545,323	301,301,752
FY 90-91	578,864,698	33.27	0	144,902,089	20.05	765,330,811	27.66%	353,232,007	23.22%	11,224,164	400,874,641
FY 91-92	696,263,212	20.28%	122,715,899	150,736,226	4.03%	1,013,969,433	32.49%	457,155,839	29.42%	10,705,469	546,108,125
FY 92-93	782,235,501	12.35%	358,049,788	169,321,961	12.33%	1,385,422,908	36.63%	644,926,119	41.07%	10,613,085	729,883,704
FY 93-94	836,435,780	6.93%	290,361,782	181,577,696	7.24%	1,324,241,361	-4.42%	606,127,072	-6.02%	28,741,090	689,388,348
FY 94-95	937,112,198	12.04%	177,994,881	207,655,598	14.36%	1,382,732,270	4.42%	652,246,000	7.61%	10,450,258	720,036,012
FY 95-96	1,037,708,671	10.73%	105,088,235	237,209,576	14.23%	1,441,849,135	4.28%	688,167,127	5.51%	11,759,284	741,922,724
FY 96-97 SB97-180**	1,117,050,367	7.65%	121,745,322	276,130,996	16.41%	1,577,784,363	9.43%	752,551,568	9.36%	12,363,438	812,869,357
FY 97-98 SB97-215**	1,217,960,618	9.03%	110,886,355	304,032,830	10.10%	1,698,974,697	7.68%	816,299,700	8.47%	10,922,445	871,752,552

NOTES:

- The detailed expenditure breakdowns will not sum to the total column because certain smaller non-MMIS service items have not been included in the data.
- ***"DSH"*** refers to disproportionate share financing.
- ***"MMIS DHS"*** refers to Department of Human Services Medicaid services that were paid through the Medicaid Management Information System.
- ** Includes $8,804,584 for FY 96-97 and $10,910,782 for FY 97-98 for two of the three years of MMIS Transition implementation costs. 3-year total is approximately $25 million.

FIGURE 27: MEDICAID EXPENDITURES BY CLIENT GROUP, FY 87 TO 97

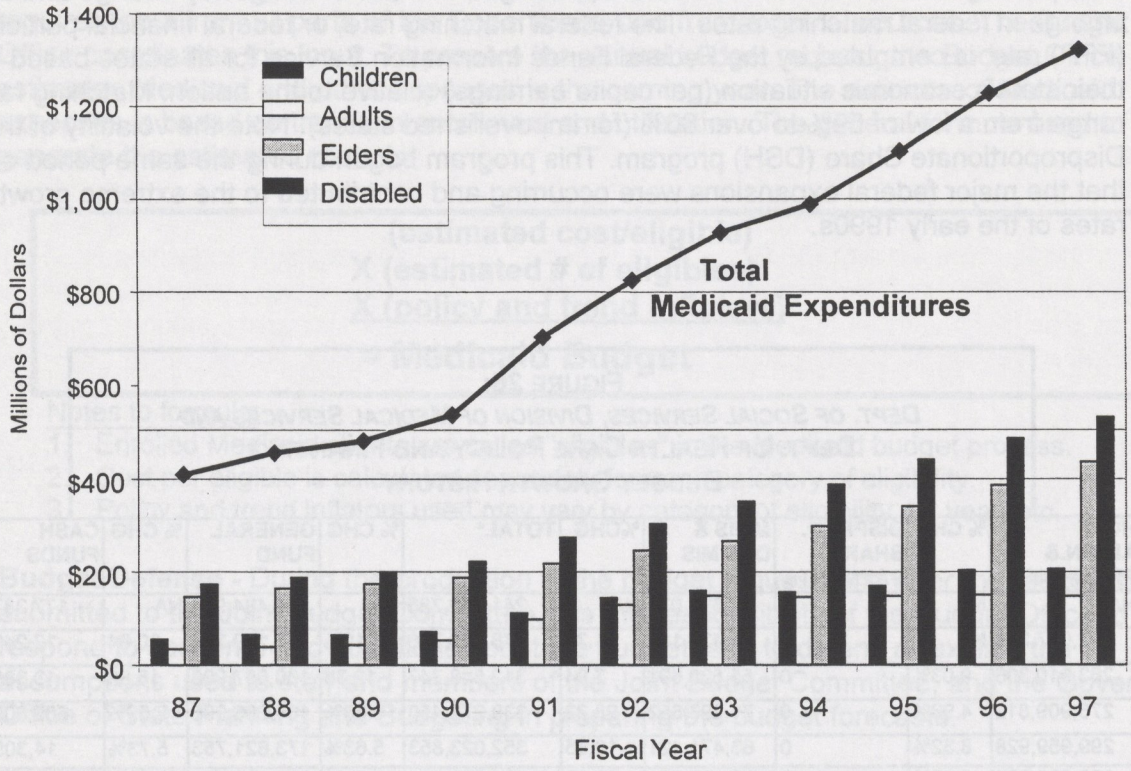
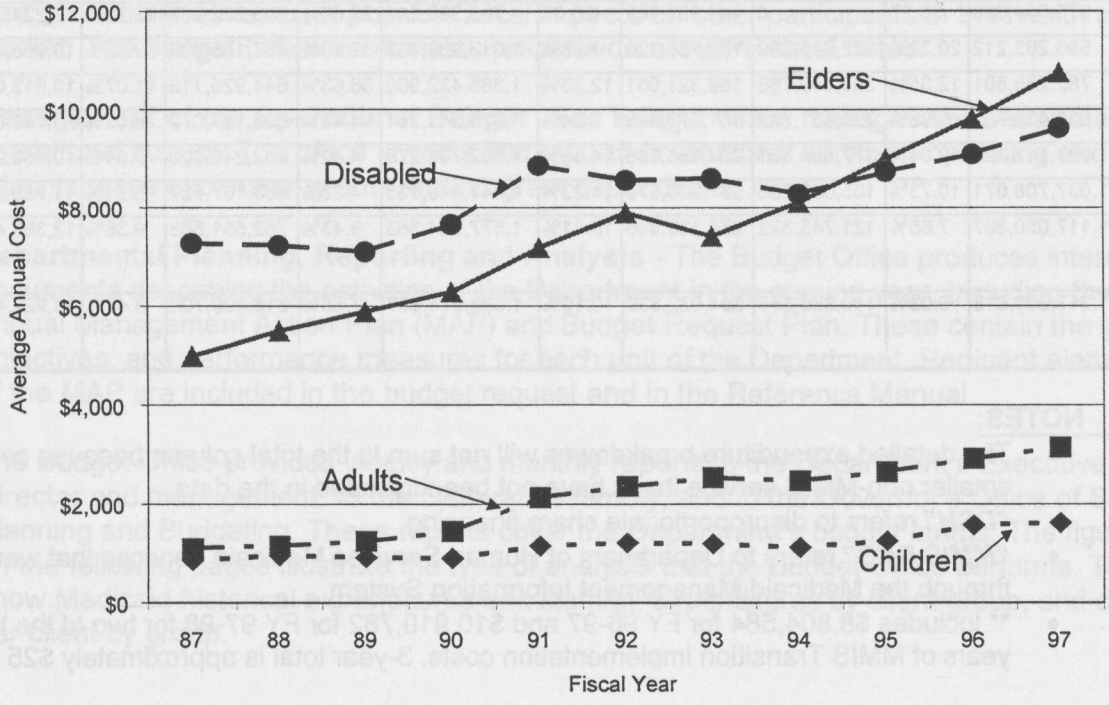


FIGURE 28: MEDICAID PER CAPITA COSTS BY CLIENT GROUP, FY 87 TO 97



2. PROGRAM GOALS, OBJECTIVES AND PERFORMANCE MEASURES

FY 97-98 and 98-99 PROGRAM GOAL 1:

To accurately project the Department's budgetary need.

OBJECTIVES PROGRAM GOAL 1:

1. Medicaid projections will be within +/- 2.5% of final actual costs for the fiscal year. Continuous improvement in caseload and expenditure projection technique will be made, with focused attention on the impact of welfare reform and capitated programs on the base.
2. Continuation levels of funding for the Department will be accurately constructed in conformance with published guidelines.
3. The impact of policy changes (e.g., federal changes, lawsuits, new legislation, etc.) will be effectively forecast.

FY 97-98 and 98-99 PROGRAM GOAL 2:

To obtain state and federal spending authority sufficient to allow the Department to perform its responsibilities and to make progress toward achievement of its collective goals.

OBJECTIVES PROGRAM GOAL 2:

1. Budget Request (November 1), Supplemental Requests/Budget Request Amendments and Fiscal Notes accurately and persuasively reflect the Department's need for funding to serve the populations eligible for care.
2. Federal funds are available each quarter in amounts that reflect the quarter's cash management environment.
3. Requests are prepared in conformance with published guidelines, accurately, timely and in such a way as to provide compelling arguments for the need for requested funding.
4. Office of State Planning and Budgeting and Joint Budget Committee Staffs' questions and requests for data are responded to fully, on time and demonstrate/support the logic for the request as presented.
5. Budget documents are accurate. Amending information to requests will not be necessary to correct inaccuracies in databases or calculations. All schedules tie to source documents (e.g., COFRS, actual appropriations bills, etc.). Quality assurance methodologies outlined in the Office's Procedural Policies and Guidelines and Worksheet Integrity protocols eliminate the opportunity for errors in work products and transmittals.
6. Materials prepared for the Joint Budget Committee are prepared in a manner that establishes the tie to departmental goals and objectives and that makes compelling arguments for the appropriateness of requested levels of funding.
7. Fiscal notes for new bills are prepared and defended within allotted timeframes, are sustained by Legislative Council/Joint Budget Committee staffs and are accurate reflections of budgetary need.

FY 97-98 and 98-99 PROGRAM GOAL 3:

Financial management of Department resources maximizes the opportunity for achievement of strategic goals.

OBJECTIVES PROGRAM GOAL 3:

1. Managers understand their budgets and have the tools available to manage within them.
2. Allocation of central appropriations are performed timely, adjusted quarterly for need and support Department's central objectives.

3. Expenditures of needed equipment and services will be planned and made throughout the fiscal year.
4. Personal Services Vacancy Savings targets are managed and achieved.

FY 97-98 and 98-99 PROGRAM GOAL 4:
New MMIS will be operational July 1, 1998 and passes federally required Systems Performance Review.

FY 97-98 OBJECTIVES PROGRAM GOAL 4:

1. Requirements of the system as relate to budget formulation and management are identified and incorporated into the new system.
2. MMIS is built and tested successfully within stipulated critical path timeframes.

FY 98-99 OBJECTIVE PROGRAM GOAL 4:

Testing is completed by July 1, 1998 and Systems Performance Review is completed by December 1998.

PERFORMANCE MEASURES PROGRAM GOAL 4:

The Department has a certified, fully operational MMIS in FY 98-99.

3. Recent Budget Office Accomplishments

Budget Office staff, in cooperation with other HCPF, OSPB and JBC staff and contractors, accomplished the following projects in FY97:

- Created a detailed database in Excel on Medicaid expenditures, caseload per capita costs by eligibility category and service category from FY 86-87 to FY 95-96.
- 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.
- Participated in budgeting for and transacting disproportionate share hospital payments.

VII. 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:

- **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 cash receipts and maintain accounts receivable records** - Receive and deposit over $922,000,000 annually from sources including federal revenue and cash received throughout the department. Monitor 250,000 provider accounts receivable transactions per year that are transferred by computer tape from the Medicaid Management Information System to the statewide Colorado Financial Reporting System (COFRS). The office also enters directly into COFRS an additional 3,500 accounts receivable transactions for the Drug Rebate program.

- **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.

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

- **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.

- **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.

- **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.

- **Review and process Department contracts -** Ensure that all constitutional and statutory requirements have been met prior to execution of 250 contracts and 30 Memoranda of Understanding annually.

- **Process all procurement documents for the Department under the direction of the State Purchasing Director -** Process 90 purchase orders and 6 Requests for Proposals or Invitations for Bids annually and ensure compliance with the state procurement code.

2. PROGRAM GOALS, OBJECTIVES AND PERFORMANCE MEASURES

FY 97-98 and FY 98-99 PROGRAM GOAL 1:

To continue to improve working relationships among Department organizational units by improving the fiscal and procurement information disseminated.

FY 97-98 OBJECTIVES PROGRAM GOAL 1:

1. Continue a memorandum of understanding with the Department of Human Services whereby they serve as the supervisor of HCPF Group I purchasing delegation. The Department of Human Services currently has a Group II purchasing delegation. This arrangement allows more purchasing flexibility than is currently available, and provides a shorter turn around time on processing Request For Proposals (RFPs) and other purchasing documents. It provides for a backup purchasing agent when the HCPF purchasing agent is not available. Write procedures and inform HCPF staff on the new process.
2. Identify one person in each division within HCPF to learn how to access accounting data through the COFRS Infopac system. Accounting & Purchasing staff will train the identified person on the Infopac system to give them on line access to accounting data for each division. This will give each division information on a daily basis. The individualized training will begin January 15, 1998 and will be completed by March 31, 1998. This process will continue in subsequent years as staff changes occur.

FY 98-99 OBJECTIVES PROGRAM GOAL 1:

1. Monitor agreement with the Department of Human Services (DHS) to document success/issues of the project. Hold monthly meetings with HCPF program staff for input and progress being made. One monthly meeting each quarter will include DHS purchasing staff. As a part of the monitoring process, an evaluation will be made of the possibility for requesting a group II purchasing delegation for HCPF.
2. Continue training individuals within the program area to access accounting information on line through the COFRS Infopac system

PERFORMANCE MEASURES PROGRAM GOAL 1:

Timely completion of the measurable objectives above.

FY 97-98 and FY 98-99 PROGRAM GOAL 2:

To improve effectiveness and efficiency within the Office of Accounting & Purchasing by automating reports:

FY 97-98 OBJECTIVE PROGRAM GOAL 2:

1. Design, develop, and produce an automated Health Care Financing Administration-64 Federal Report, Accounts Receivable Aging Report and an Open/Close Invoice Balance Fiscal Year End Report.

FY 98-99 OBJECTIVES PROGRAM GOAL 2:

1. Implement the automated Accounts Receivable Aging Report at the new Fiscal Agent (Consultec) and produce reports on a monthly basis. Monitor reports for accuracy and ease of use.
2. Continue to design, develop, and produce additional automated reports.

PERFORMANCE MEASURES PROGRAM GOAL 2:

Produce useful automated reports on the timelines indicated.

FY 97-98 and FY 98-99 PROGRAM GOAL 3:

To improve collection process for the Department's past due accounts receivable accounts.

OBJECTIVE PROGRAM GOAL 3:

- **FY 97-98:** Increase percentage of past due accounts turned over to Central Collections from previous year by 3%.
- **FY 98-99:** Increase percentage of past due accounts turned over to Central Collections from previous year by 5%.

PERFORMANCE MEASURES PROGRAM GOAL 3:

Past due Accounts Receivable accounts turned over to Central Collections				
Item	**FY 95-96**	**FY 96-97**	**FY 97-98**	**FY 98-99**
Target	1% turnover	2% turnover	5% turnover	10% turnover
Actual	1% turnover	4.6% turnover		

OPERATIONS GOALS of the Office of Accounting & Purchasing

1. The office staff will take advantage of computer software training in order to produce ad hoc reports and to conduct research from the downloaded COFRS files on CD-ROM. The staff will continue to pursue the copying of files to CD-ROM to save on storage space and for ease of access to information.
2. The Department has purchased the Windows version of the KRONOS leave-tracking system. This will be installed during fiscal year 1997-98 on our LAN. The accounting office will be responsible for training department employees in the use of the system.

3. Recent Accounting and Purchasing Accomplishments

Extended purchasing system (EPS) - The Office of Accounting & Purchasing implemented the Extended Purchasing System (EPS) within COFRS. Using EPS transactions allows reporting of purchases by commodity, quantity and dollars. Implementation included training of users and follow-up after the classroom. Implementing EPS required development of new internal procedures.

Automation

- Implemented an automated cash receipt process for the federal drawdowns. This process saved the office one (1) man-hour a day and improved the accuracy of posting federal revenues.
- Implemented an automated process for filing the federal Payment Management System (PMS) 272 reports. This improved communications between the Department and the Health Care Financing Administration (HCFA).

Cost Allocation Plan - In conjunction with the Budget Office, designed and wrote a Cost Allocation Plan for the Department. HCFA approval is pending.

Accounts receivable - Reduced many outstanding issues on Medicaid accounts receivable reconciliations during FY96-97. This was a cooperative effort with programming assistance from the Office of Information Technology in closing and opening invoices on COFRS and running monthly extract reports.

Personnel Administration

- The Department signed a Memorandum of Understanding (MOU) with General Support Services (GSS), Department of Personnel (DOP) to perform HCPF personnel administration functions. The Accounting Office took over the preparation of all personnel forms and transactions, including the posting of positions and orientation of new employees.
- Leave tracking was transferred to the Accounting Office. Leave information was entered into the KRONOS leave tracking system. Produced quarterly and yearly leave statements for all employees.

EcoPass Program

- Negotiated a contract with RTD and established the EcoPass program for employees.
- The department has a 70% employee participation rate, the highest of any State agency.

VIII. APPENDIX 1: SOURCES/PUBLICATIONS/CITATIONS

Statutory and regulatory citations relevant to HCPF programs follow the list of publications.

The reports listed below 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

Internet access is also available for many publications:
WWW: state.co.us \Executive\Agencies\HCPF

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

Authors for all publications listed are staff of the Colorado Department of Health Care Policy and Financing (HCPF), unless otherwise noted. (Names in parentheses after some citations are HCPF staff custodians of these reports. If no name is listed, contact Sharon Powers in OPPI.)

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

1. Colorado Department of Health Care Policy and Financing Budget Request, FY 98-99; also FY 97-98, FY 96-97, etc. (Golden)
2. Department of Health Care Policy and Financing Reference Manual, 1995, 1996, 1997, and 1998 (this document). (Kowal)
3. Improvements and Considerations in Forecasting Medicaid Caseload and Expenditures, SB 95-214 - Footnote #31, 1995. (Golden)
4. Report to the General Assembly Pursuant to House Bill 94-1029, 1996. (Tollen)

- ***Program Reports***

5. Acute Care Annual Report for (HCPF), Colorado Foundation for Medical Care, 1995 and 1996; 1997 available 1/98. (Tyler)
6. Annual Savings Report to the Joint Budget Committee, Pursuant to SB 97-5, 1997. (Muller)
7. Children's Basic Health Plan Premium Cost-Sharing Report to the Joint Budget Committee, Pursuant to HB 95-1304, 1997. (Schulte)
8. Colorado Indigent Care Program FY 1995 Annual Report, 1996. [FY 96-97 report will be available 2/98] (Laisure)

9. Colorado Medicaid Report on Community Health Programs: HCBS-EBD, HCBS-PLWA, and Home Health, 1996. (Traudt)
10. Department of Health Care Policy and Financing Annual Report, 1996, and 1997 (insert to this document and stand-alone report). (Kowal)
11. An Integrated Quality Assurance System for Home Based Services, 1992. (Traudt)
12. Long-Term Care Single Entry Point Access System Annual Evaluation and Status Reports: 1993, 1994, 1995 and 1996. (Bell)
13. Managed Care Guide; Directory of Colorado Medicaid Managed Care Health Plans and Providers (Updated Quarterly), (available from HCPF Eligibility and Enrollment Section) 1996.
14. Medicaid Rate Study - Footnote #26, FY 95 Long Bill, 1994. (Peters)
15. Poison Control Services Annual Report, Fiscal Year Ending, 1995. And 1996. (Laisure)

- **Access to Health Care Coverage**

16. ColoradoCare Preliminary Feasibility Study: Report to the Colorado General Assembly (and Appendix), 1993.
17. ColoradoCare Public Hearing Results: Report to the Colorado General Assembly, 1994.
18. Colorado Title XXI State Plan for Children's Health Insurance, 1997. (Powers)
19. Findings from the Health Care Reform Public Hearings Survey, Office of Public and Private Initiatives, 1995.
20. (Report from the) Governor's Task Force on Coloradans Without Health Insurance, 1996.
21. 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.
22. Healthy Kids Replication Grant: Proposal for fuding to the Robert wood Johnson Foundation, 1997. (Schulte)
23. Who Does What in Colorado Health Care? (annotated directory; insert to this Reference Manual and can also be ordered separately) (Kowal)

- **Health Care Research and Data**

24. Colorado Hospital Outcomes, 1993-1994. Health Data Commission, 1997. (Reynolds)
25. Colorado Medicaid's Primary Care Physician Initiative and Ambulatory Care Sensitive Hospitalizations: General Report; Technical Report, Health Data Commission, 1995. (Reynolds)
26. 1994 Colorado State Health Expenditure Account, published 2/97. (Muller)
27. 1995 Colorado State Health Expenditure Account, published 1/98. (Muller)
28. Survey Data on Family and Employer Health Insurance: Implications for Colorado, Office of Public and Private Initiatives, 1995.

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

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

- ***Antitrust Issues***

33. 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***

34. The Public Employers' Health Care Purchasing Project: Progress Report to the General Assembly, 1996. (Tollen)
35. 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.
36. Options for the Governance of a State Employer Health Insurance Purchasing Pool, 1995, 1996. (Tollen)
37. The Feasibility of Consolidating Health Benefits Purchasing for Medicaid Recipients and State Employees, 1995.

- ***Integrated Care and Financing***

38. Integrated Long-Term Care and Financing Project: Reforming Long-Term Care Financing and Delivery in Colorado, Annual Progress Report, 1996. (Snell)

- ***Risk Adjustment***

39. 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. (Tollen)

- ***Health Plan Accountability***

40. Options for a Medicaid Quality Assurance Program, (Esgar) 1995.
41. Review of Public and Private Efforts to Ensure Health Plan Accountability, Office of Public and Private Initiatives, 1995.

- ***School-Based Health Centers***

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

- ***Prescription Drugs***

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

- ***Competitive Procurement***

44. Competitive Procurement and Selective Contracting Project Report and Plans, (Draft), 1996. (Kowal)

CITATIONS

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

Colorado Statutes

- 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.
- Statewide Managed Care System, § 26-4-111, *et seq.*, C.R.S.
- Disabled Work Incentive Program, § 26-4-511.2, C.R.S.
- Children's Basic Health Plan, § 26-19-101, 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, XIX and XXI, Social Security Act.

Federal Regulation

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

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; the Colorado Department of Health Care Policy and Financing, the Colorado Civil Rights Commission; or the U.S. Department of Health and Human Services.

HCPF Customer Service:

303-866-3513 (Denver Metro) or 1-800-221-3943 (toll-free statewide)

Proteción Ante la Ley:

Nadie puede ser excluido de participar en el Medicaid de Colorado o ser privado de los beneficios de la Programa de Medicaid por cuestones de sexo, raza o etnicidad, pais de origen o ciudadanía, impedimento mental o fisico, o su religión.

Se Habla Español:

Departmento de Regulación y Financiamiento de Atencion a la Salud **(Medicaid de Colorado)**
Llame al: 866-3513 (en Denver), o 1-800-221-3943 (número gratuito en Colorado)

IX. 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 -SSI
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)
CCHN	Colorado Community Health Network (Assoc of FQHCs)
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)
ColoradoWorks	Colorado's Welfare Reform program (see: TANF)
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; now Denver Health Medical Center
DHMC	Denver Health Medical Center
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
Title XXI	(Social Security Act) - Children's Health Insurance
TANF	Temporary Assistance for Needy Families (replaced AFDC in FY98)
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

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1-800-221-3943 (toll-free statewide)