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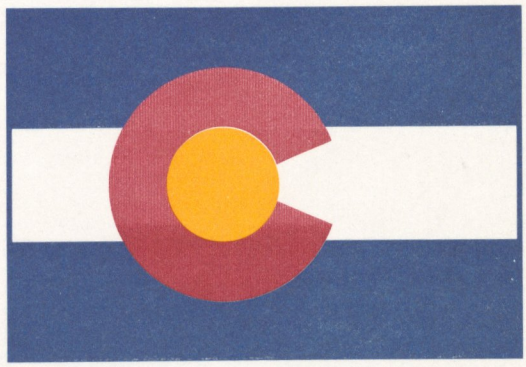
Department of Health Care Policy & Financing

1999-2000 Reference Manual

James T. Rizzuto, Executive Director

May 1999
http://www.chcpf.state.co.us

The mission of the department is to improve access to health care services.



STATE OF COLORADO

DEPARTMENT OF HEALTH CARE POLICY & FINANCING

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Bill Owens
Governor

James T. Rizzuto
Executive Director

May 1999

Dear Reader:

The 1999-2000 Department of Health Care Policy and Financing Reference Manual is provided as a resource for policy-makers, health care consumers, providers, agency staff, and citizens of Colorado. The Reference Manual gives 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 Colorado's health care environment.

As the state agency responsible for the administration of the Medicaid program, the Children's Basic Health Plan (also known as Child Health Plan *Plus*), the Colorado Indigent Care Program, and other health care programs, the Department faces many challenges.

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 is committed to design and operate its procurement and contracting systems in ways that improve access to care, quality of services, and consumer choice of providers, and that encourage providers and plans to compete with one another based on price, quality, and accessibility.

If you would like more detailed information on any of the programs described in the Reference Manual, I encourage you to contact the appropriate agency or office listed in the colored insert "Who Does What In Colorado Health Care." You can also find information about the Department on the Internet: http://www.chcpf.state.co.us. The Department's Customer Service line, 303-866-3513, or 1-800-221-3943, offers an extensive library of "Teletips" and can also refer specific questions to appropriate staff.

I welcome your comments and questions.

Sincerely,

James T. Rizzuto
Executive Director

"The mission of the Department of Health Care Policy & Financing is to improve access to health care services."
http://www.chcpf.state.co.us

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DEPARTMENT OF HEALTH CARE POLICY & FINANCING

MARCH 1999

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

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THE MISSION OF THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING IS TO IMPROVE ACCESS TO HEALTH CARE SERVICES.

HCPF OVERVIEW

The Colorado Department of Health Care Policy and Financing develops and implements financing plans and policy for publicly funded health care programs, and administers Colorado's major public health care programs. The department was established in 1994 when Colorado restructured health and human services delivery systems to streamline government functions to make more efficient and effective use of state and local resources.

The Colorado Department of Health Care Policy and Financing (HCPF), with its partners in the public and private sectors, works to improve access to health care, quality of health care delivery, and health care cost control. These efforts include:

- Improving the health of children
- Implementing Medicaid managed care
- Helping clients move from welfare to work
- Efficiently administering public health care programs, by:
  - Delivering excellent customer service
  - Implementing advanced information technologies, and
  - Effectively managing costs

HCPF is one of the smallest departments in staff size (19th of 22) 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. Figure 2 shows the number of clients served and expenditures by program.

GUIDING PRINCIPLES

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

- The department will treat all clients and potential clients with respect and consideration.
- The department regards our providers, clients, advocacy groups, counties and other local government units as well as the Governor's Office and the General Assembly as our partners. Each is integral to our success.
- The department will be scrupulously honest in all of our relationships: including with each other, with all of our partners and with the public.
- The department will be a focused, accountable, efficient organization.
- The department will work to expand health care coverage and access for low-income Coloradans.

- The department will be a cost-effective and responsible purchaser of health care.
- 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.

DEPARTMENT GOALS

- The Department will make every effort to maximize the resources available for improving access to health care services. Through a thoughtful and creative environmental assessment, the Department will evaluate programs and populations to identify opportunities to assure consistency between program operations and intent/goals and to streamline administration wherever possible. The Department will prioritize the effort commensurate with the degree of financial risk and potential gain. This may include rate and utilization controls, reconsideration of existing programs and the growth of those programs, our ability to sustain the growth of existing programs, our decision to accept new activities, and any other issues identified.
- The Department will seek to define who is in the most need of our services and will determine if we are serving those identified. We will respond to issues such as: Who are the vulnerable populations in Colorado? Are we serving them now? If not, are they being served now and how? This goal will define what it means to improve access to health care services. We will cooperate to generate Executive Branch wide information and policy development in this area.
- The Department will evaluate all cost control mechanisms and agents now operating in our programs to ascertain if we are getting the maximum value and cost benefit. Alternative recommendations first assure that the care that we do render is medically necessary and appropriate and respects the role of the safety net providers in our community.
- The Department will value our "human asset" through effective recruitment, hiring and retention. Through concerted efforts as determined appropriate and meaningful in staff development, training and employee morale, we will make staff stability and technical expertise a priority. We will assure that each staff knows with specificity what their job is and how that relates to achieving the Department's goals. Toward that end, we will seek opportunities for training that enhances employee development. We will use our resources in such a way as to provide an incentive to motivated individuals to do their best. We will examine what motivates employees to work effectively and consider strategies to reinforce employee development.
- The Department will allocate our staff and resources in a way to ensure that we always address the organization's priorities. We will focus on areas of financial risk, care risk and exposure as a way to prioritize the assignment of resources.

ORGANIZATION OF THE DEPARTMENT

The Department of Health Care Policy and Financing (HCPF) is the federally recognized Single State Agency for the Colorado Medicaid program. HCPF develops and provides policy, program and financial administration oversight for the non-Medicaid programs including Children's Basic Health Plan, the Colorado Indigent Care Program and several other statewide health care programs. The department contracts with the Department of Human Services (DHS) for Medicaid eligibility determination and for programs for persons with Developmental Disabilities, Mental Health, and Residential Treatment Center (RTC) needs. The department also contracts components of major administrative functions such as information and billing systems, managed care enrollment facilitation, and utilization review and quality assurance, to companies that specialize in these areas.

The department is organized into six offices, as shown on the Organizational Chart at the front of the Manual:

- Office of the Executive Director, including the Deputy Director/Legislative Affairs
- Office of Program Development
- Office of Information Technology
- Office of Medical Assistance
- Budget Office
- Office of Accounting and Purchasing

James T. Rizzuto was appointed and confirmed as HCPF Executive Director in January 1999. The Deputy Director's Office includes the department's Legislative Liaison and public information functions. The Office of Medical Assistance administers the state/federal Medicaid program and other state-funded health care programs. The Office of Program Development administers the Children's Basic Health Plan, and develops and implements other market-oriented health reforms and 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. The Children's Basic Health Plan Policy Board provides policy direction to that program, and evaluates and reports to the General Assembly on the program's development and administration. Members of the Medical Services Board and the Children's Basic Health Plan Policy Board are appointed by the Governor and are confirmed by the State Senate. Currently, Mr. Richard F. Walker chairs the Medical Services Board, and Mr. William (Bill) Lindsay chairs the CBHP Policy Board. The State Board of Human Services has rule-making authority for the Old Age Pension Health and Medical Fund. Additionally, a number of advisory boards provide important citizen, provider and consumer recommendations to the Medicaid, Child Health, Poison Control and other HCPF programs.

HCPF Program Expenditures

In FY 97-98 the department administered a budget of $1.8 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 $1.8 billion budget.

FIGURE 2: HCPF PROGRAMS: FY1997-1998 NUMBER OF CLIENTS SERVED AND PAYMENTS TO PROVIDERS

Program	Clients Served	Total Payments
Medicaid (HCPF-Medical Services)	258,424	$ 1,088,516,873
Medicaid (DHS-administered MH & DD services)*	N.A.	$ 303,933,274
Disproportionate Share Hospital (DSH) payments**	N.A.	$ 148,648,938
Colorado Indigent Care Program (CICP)	160,117	
Denver Indigent Care	N/A	$ 9,682,778
Specialty:	N/A	$ 19,649,662
University Hospital	N/A	$ 10,727,780
Home Care Allowance***	5,780	$ 15,858,346
Adult Foster Care***	263	$ 650,010
Poison Control Center	57,210	$ 1,148,034
Old Age Pension Health and Medical Fund (OAP-SO)	3,304	$ 9,413,918
Total FY 97-98 HCPF & DHS Medicaid without CBHP/CHP+	**485,098**	**$ 1,608,229,613**

Children's Basic Health Plan (CBHP/CHP+): 1999		
Enrollment as of February 1999	13,089	
Projected FY98-99 payments @$60.88 PMPM****, for est. Average Monthly Enrollment (AME) of 12,342 enrollees		**$ 9,016,572**

Notes:

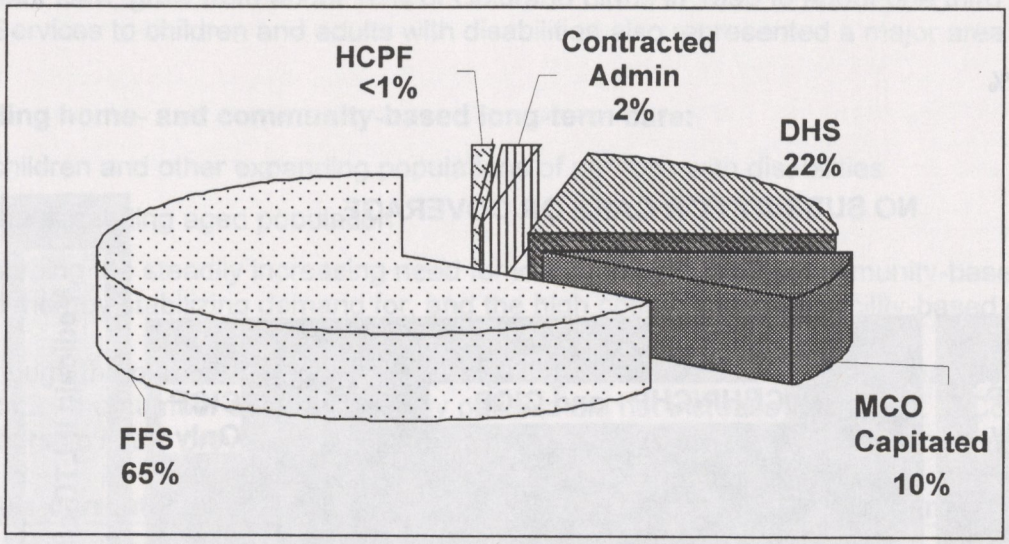
* Dept. of Human Services (DHS) administers most Mental Health (MH) and Developmental Disability (DD) services. MH and DD clients are counted under Medicaid (HCPF-Medical Services) and receive all Medicaid services.

** Medically indigent, bad debt and HMO DSH payments are included on this line; additional DSH payments are included under Medicaid (HCPF-Medical Services). These 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.

*** Monthly average client count duplicates Medicaid in most cases.

**** PMPM = per member per month

FIGURE 3: HCPF BUDGET BY EXPENDITURE CATEGORY (FY 98-99 APPROPRIATION)



HCPF = Personnel and Operating Costs, Department of Health Care Policy and Financing
DHS = Department of Human Services
FFS = Fee For Service (including PCP - Primary Care Physician)
MCO = Managed Care Organization (primarily, HMOs)
Note:
FFS includes long-term care expenditures, as well as primary and acute care service costs

Trends and Program Highlights

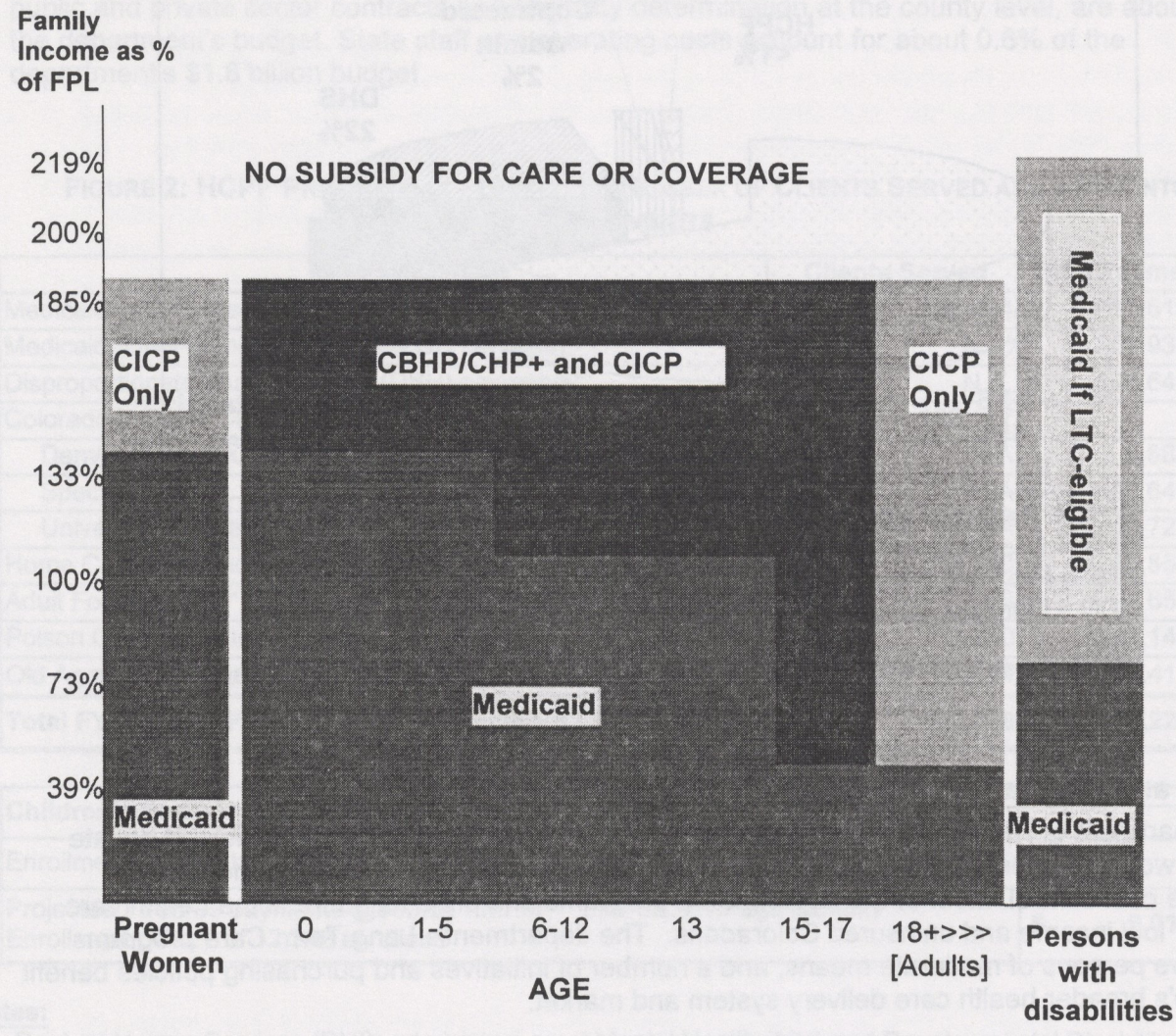
The Department of Health Care Policy and Financing, with its partners in the public and private sectors, works to improve access to health care, quality of health care delivery, and health coverage cost control. Most of the department's programs and projects address the health care needs of low-income and uninsured Coloradans. The department's Long Term Care programs also serve persons of moderate means, and 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, to assure quality, to support and enhance the role of public and not-for-profit health care facilities ("Safety Net" or "Essential Community Providers") and to risk 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.

Public Health Care Coverage Trends

Improving access to health care coverage for uninsured low-income Coloradans and those in need of long-term care is one of HCPF's most important missions. Figure 4 (below) demonstrates the coverage now provided by HCPF programs. The schematic also shows the coverage gaps that still exist for the increasing number of working families that lack employer-based health care. Many working families are unable to pay for adequate health care or health insurance, but the family incomes are slightly above the qualifying levels for existing programs of publicly subsidized coverage.

FIGURE 4: SCHEMATIC: STATE-SUBSIDIZED INSURANCE COVERAGE AND HEALTH CARE SERVICES



Source: 1999 - Office of Program Development, HCPF

KEY

1. **FPL:** Federal Poverty Level - income required to meet basic needs (food, shelter, etc.).
2. **CICP:** Colorado Indigent Care Program - State reimbursement to participating hospitals and clinics statewide that serves uninsured Coloradans (who make sliding scale payments).
3. **CBHP:** Children's Basic Health Plan - CBHP/CHP+ is a statewide program providing state- and federally-subsidized health insurance coverage for children in families below 185% FPL.
4. **LTC:** Coloradans with needs for **Long-Term Care** services and incomes up to about 220% of the federal poverty level can qualify for coverage of in-home, community-based or nursing facility care.

Major Issues faced by the department in the 1990's

- **Medicaid expansions,** including BabyCare/KidsCare Medicaid-covered prenatal and birth/infant care, grew from about 10% of Colorado births in 1990 to about one third of births in 1992. Services to children and adults with disabilities also represented a major area of program growth.
- **Extending home- and community-based long-term care:**
  - to children and other expanding populations of persons with disabilities
  - to the expanding aged population
  - absorbing the steadily increasing need for long-term care in the community-based program, and thereby stabilizing demand for, and the high costs of, nursing facility-based care:

    Although the number of persons requiring long-term care services more than doubled in the decade, the number of nursing facility patients did not increase as a result of Colorado's leadership in the provision of effective and efficient community-based alternatives.

Major issues currently facing the department and its public and private partners

- **Financing existing programs under the statutory 6% spending growth limit,** and under the constitutional amendment revenue/expenditure limit
- **Improving access to health care for increasing numbers of uninsured Coloradans**. The increasing number and percentage of uninsured is due in part to the fact that although the state's economy is healthy and growing, there is increasing employment in low-wage retail and service jobs which typically lack employee health insurance coverage benefits. How will **extension of health care to the underserved/uninsured** [such as the working poor and low-income families] be accomplished?
  - Through state/federal programs [direct services, direct payments to providers, subsidized health insurance coverage, other public programming]?
  - Through "privatized" financing and delivery mechanisms?
  - Through corporate/individual volunteerism? Through reversing the loss of employer-based coverage?
- According to several national studies,[1] Colorado is 47th of 51 states in **covering low-income children**. Medicaid coverage of prenatal/births is slipping - from a high of 34.4% to 31.8%, at the same time that employer-based insurance coverage of young families is also eroding. This could be interpreted to mean that an increasing number of babies are born in Colorado to mothers without adequate prenatal care. Higher incidence of birth and developmental problems, and associated health care costs are likely to result from declining access to prenatal and child health care. The Department addresses the problem of uninsured children in several ways, including:
  - **Implementing the Child Basic Health Plan (CBHP)/CHP+ program**, including managing the following functions and systems:
    - policy support and program development
    - provider and HMO network development

[1] Congressional Research Service Memorandum, July 28, 1998; American Academy of Pediatrics, March 1997; The Urban Institute, 1998; The American Association of Retired Persons, 1997.

  - marketing, outreach and enrollment growth
  - administrative organization, accountability and financing structures
- Through **joint marketing/outreach and eligibility/enrollment systems for CBHP and Medicaid**, children who are eligible but not enrolled in Medicaid are more effectively identified and accessed to health care.

- **Implementing managed care expansions**, and making managed care work to assure access and quality as well as cost control, especially for "vulnerable" or "special needs" populations.

Trends in Medicaid and Other HCPF Health Care Coverage

The department's implementation of Managed Care, and Children's Basic Health Plan initiatives are bringing significant changes to the Medicaid program and to health care coverage for Colorado's children.

Medicaid is the primary payer for acute and long-term health care for over 250,000 of Colorado's low-income citizens. Medicaid coverage includes physician care, prescription drugs, hospital care, mental health care, long-term nursing facility care, and long-term home and community-based care. Expanded Medicaid benefits for children provide preventive care such as immunizations, dental care and early treatment of potentially disabling conditions.

In addition to reimbursements for services and capitated payments, Colorado Medicaid paid over $148 million in 1998 in additional reimbursements to hospitals and community health centers that provide the highest volumes of care for Medicaid clients and uninsured Coloradans, allowing these agencies to continue providing uncompensated care. This funding mechanism is referred to as Disproportionate Share Hospital, or DSH payments.

Coloradans who are not eligible for Medicaid coverage, but whose incomes are below 185% of the poverty level, may qualify for partially subsidized hospital and clinic care, through the Colorado Indigent Care Program (CICP). Children in low-income families may qualify for Children's Basic Health Plan (CBHP) coverage. HCPF also administers the state-funded poison control and home care programs. In all, HCPF programs serve nearly 500,000 Coloradans each year.

Medicaid Enrollment and Expenditures

Medicaid budget growth is driven by enrollment and by health care cost per client. Coverage expansions, utilization increases, federal provider rate requirements, and general health care cost inflation are major components of the rapid enrollment and budget growth over the past 10 years. Enrollment and cost trends vary from group to group. The following factors are particularly significant:

- **About two-thirds of Medicaid clients are low-income adults and children.**
  - In recent years, total expenditures for adults and children have grown fairly slowly.
  - In the early 1990s, changes in federal law brought many new low-income pregnant women and children into the program. Medicaid enrollments and costs for adults saw major changes between 1992 and 1998, and may again change as a result of welfare reform. (See Figure 5)
  - Medicaid enrollment expansions for children, most of whom are now eligible if family income is less than 133% of the federal poverty level, have not significantly affected the Medicaid cost per child.

- **One-third of Medicaid enrollees are elderly or are persons with disabilities.**
  - The 35% of Medicaid clients who are elderly or disabled account for more than 70% of Medicaid program expenditures.
  - Total costs for people with disabilities have grown primarily because of increased enrollment and increased cost per client.
  - While the number of elders served by Medicaid has been fairly stable, there has been rapid growth in per capita and total expenditures for the elderly population through the1990's. This increase is primarily caused by nursing facility rate increases. Implementation in 1998 of nursing facility legislation effectively controlled the rate of expenditure growth for these services.
  - Increasing utilization and costs of home health and community-based services. (Note: see page 49 for more information on increased number and percentage of aged and disables enrollments.)

Improving Access to Health Care for Colorado's Children

In 1997 and 1998, major state and federal initiatives extended health care coverage to children in uninsured low-income families. These initiatives included:

- HB 97-1304 and HB 98-1325, the Colorado Children's Basic Health Plan, and grants to Essential Community Providers
- SB 97-5, Medicaid Managed Care, including investment of managed care 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, and detailed in the Office of Program Development chapter. See also Appendix 1, "1998 Bills."

The Children's Basic Health Plan

The Children's Basic Health Plan (CBHP) provides publicly subsidized health care insurance coverage for low-income children who are not eligible for Medicaid. CBHP is marketed as "Child Health Plan ***Plus***," or **CHP+**, and offers a comprehensive subsidized health insurance product for children ages 0 through 18 with family incomes under 185% of poverty ($29,700 for a family of four in 1999). The program is implemented as a public-private partnership.

CHP+ enrollment grew to 13,500 in the first 9 months of program operation, and was growing at a rate of 700 additional children per month by March 1999. Governor Bill Owens' objective of 60,000 enrolled children in 3 years will be approached through:

- securing appropriate expenditure authority;
- effectively marketing and providing outreach efforts in coordination with Medicaid, and with private and public sector partners;
- streamlining application and enrollment processes;

- developing effective program administration and information systems;
- developing delivery systems and access to quality care; and by
- maximizing potential federal financial support.

The CHP+ benefit package includes outpatient and inpatient pediatric services and is designed to be primarily delivered through managed care organizations. The central goal of the CBHP is to maximize coverage within available resources, which are legislatively determined. To meet this goal, the CBHP provides coverage to children who have no other insurance option. Participants contribute to program costs through co-payments and sliding-scale premium contributions. CBHP coverage growth must also be coordinated with overall health care coverage strategies for children.

By the year 2001, under favorable program funding and enrollment assumptions, CBHP could provide health insurance for at least half or more of the approximately 75,000 uninsured children in Colorado families with incomes below 200% of the federal poverty line. The CBHP will continue to rely on partnerships with school districts, local governments, employers, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) and Federally Qualified Health Clinic (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;
- other possible future sources as determined by the General Assembly, such as "tobacco" settlement funds;
- and possibly, local foundation grants. (See the Office of Program Development chapter for details.)

Health Care Services in K-12 Education

Senate Bill 97-101 allows local school districts to 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.

FIGURE 5: PER CAPITA COSTS: MEDICAID, AND OAP HEALTH AND MEDICAL FUND

(Does NOT include Department of Human Services-administered Medicaid Costs)

Fiscal Year	OAPA	OAPB	AB	AND	AFDCA	AFDCC	FOSTER	BCA	BCC	UNDOC.	QMB	OAPSO	TOTAL
FY 86-87	4,894.26	3,796.54	1,575.26	3,805.65	1,041.10	529.83	2,388.19	NA	NA	NA	NA	1,440.37	1,991.46
FY 87-88	5,400.69	3,815.34	2,434.08	4,105.79	1,086.56	582.44	3,248.95	NA	NA	NA	NA	2,220.60	2,171.42
FY 88-89	5,794.75	3,772.56	2,339.65	3,988.85	1,190.85	565.44	3,107.77	NA	NA	NA	NA	1,984.03	2,230.15
FY 89-90	6,180.44	4,430.32	2,900.49	4,131.98	1,435.60	651.10	2,105.20	NA	NA	NA	NA	1,747.65	2,364.36
FY 90-91	7,053.05	5,551.67	3,552.10	4,835.39	1,737.75	795.20	2,759.33	4,581.87	1,757.78	2,552.84	685.95	2,259.30	2,689.67
FY 91-92	7,819.02	5,781.60	8,379.55	4,981.06	1,840.95	875.25	3,070.66	4,752.78	1,494.73	2,783.93	1,516.45	2,604.68	2,762.64
FY 92-93	8,190.37	6,530.88	2,863.74	5,054.49	2,012.78	891.70	3,149.32	5,172.87	1,334.73	2,584.71	924.55	2,562.24	2,815.79
FY 93-94	8,946.21	6,200.87	4,531.76	4,975.95	2,019.24	838.45	2,773.48	4,658.54	1,321.72	2,324.45	1,552.89	2,498.51	2,876.35
FY 94-95	10,110.94	6,649.11	4,015.79	5,418.57	2,122.62	927.37	2,834.08	4,973.52	1,420.50	2,533.63	1,466.13	2,890.22	3,233.23
FY 95-96	11,178.12	7,460.45	3,589.52	5,583.32	2,362.83	1,079.40	3,372.85	5,463.50	1,406.12	2,659.62	1,435.03	2,994.17	3,625.63
FY 96-97 Actual	12,188.84	7,536.80	3,169.75	6,126.71	2,665.30	1,041.63	3,490.00	6,189.93	1,315.06	2,988.72	1,363.03	2,932.14	3,957.85
FY 97-98 Estimate	12,926.95	8,124.31	3,453.53	6,412.86	2,656.38	1,197.51	2,065.90	5,327.66	1,440.64	3,108.03	1,316.97	2,927.12	4,212.14
FY 98-99 Request	13,722.85	8,597.01	3,572.92	6,801.03	2,771.36	1,222.85	2,034.35	5,457.42	1,304.81	3,387.79	1,328.64	3,000.34	4,475.60

Annual Percent Change:

Fiscal Year	OAPA	OAPB	AB	AND	AFDCA	AFDCC	FOSTER	BCA	BCC	UNDOC.	QMB	OAPSO	TOTAL
FY 86-87	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
FY 87-88	10.35%	0.50%	54.52%	7.89%	4.37%	9.93%	36.04%	NA	NA	NA	NA	54.17%	9.04%
FY 88-89	7.30%	-1.12%	-3.88%	-2.85%	9.60%	-2.92%	-4.35%	NA	NA	NA	NA	-10.65%	2.70%
FY 89-90	6.66%	17.44%	23.97%	3.59%	20.55%	15.15%	-32.26%	NA	NA	NA	NA	-11.91%	6.02%
FY 90-91	14.12%	25.31%	22.47%	17.02%	21.05%	22.13%	31.07%	NA	NA	NA	NA	29.28%	13.76%
FY 91-92	10.86%	4.14%	135.90%	3.01%	5.94%	10.07%	11.28%	3.73%	-14.96%	9.05%	121.07%	15.29%	2.71%
FY 92-93	4.75%	12.96%	-65.82%	1.47%	9.33%	1.88%	2.56%	8.84%	-10.70%	-7.16%	-39.03%	-1.63%	1.92%
FY 93-94	9.23%	-5.05%	58.25%	-1.55%	0.32%	-5.97%	-11.93%	-9.94%	-0.97%	-10.07%	67.96%	-2.49%	2.15%
FY 94-95	13.02%	7.23%	-11.39%	8.90%	5.12%	10.61%	2.18%	6.76%	7.47%	9.00%	-5.59%	15.68%	12.41%
FY 95-96	10.55%	12.20%	-10.61%	3.04%	11.32%	16.39%	19.01%	9.85%	-1.01%	4.97%	-2.12%	3.60%	12.14%
FY 96-97 Actual	9.04%	1.02%	-11.69%	9.73%	12.80%	-3.50%	3.47%	13.30%	-6.48%	12.37%	-5.02%	-2.07%	9.16%
FY 97-98 Estimate	6.06%	7.80%	8.95%	4.67%	-0.33%	14.96%	-40.81%	-13.93%	9.55%	3.99%	-3.38%	-0.17%	6.42%
FY 98-99 Request	6.16%	5.82%	3.46%	6.05%	4.33%	2.12%	-1.53%	2.44%	-9.43%	9.00%	0.89%	2.50%	6.25%

Computed Rate of Change Over Time (Note: Mental Health Capitation has affected expenditures in recent years):

Fiscal Year	OAPA	OAPB	AB	AND	AFDCA	AFDCC	FOSTER	BCA	BCC	UNDOC.	QMB	OAPSO	TOTAL
Compute Rate for FY 91-92 through FY 95-96:	9.35%	6.58%	-19.10%	2.89%	6.44%	5.38%	2.37%	3.55%	-1.52%	-1.14%	-1.37%	3.55%	7.03%
Compute Rate for FY 91-92 through FY 96-97:	9.29%	5.45%	-17.67%	4.23%	7.68%	3.54%	2.59%	5.43%	-2.53%	1.43%	-2.11%	2.40%	7.46%
Compute Rate for FY 91-92 through FY 97-98:	8.74%	5.83%	-13.73%	4.30%	6.30%	5.36%	-6.39%	1.92%	-0.61%	1.85%	-2.32%	1.96%	7.28%

- Note: see Appendix 2, "Acronym List," for explanation of abbreviations on this table.

Other HCPF Program Initiatives

Essential Community Provider Grants and Inclusion in HMO Networks

Senate Bill 97-5 recognizes 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 policy is designed to promote access and continuity of care for low-income Coloradans, as well as provide for the ECP financial viability.

Another provision of SB 97-5 establishes a program of Grants to Essential Community Providers. The ECP grant program is funded by legislatively determined allocations of Medicaid Managed care savings and assists agencies that provide health care services to uninsured low-income Coloradans.

Welfare Reform Changes to Medicaid Eligibility - Colorado Works

SB 97-120 establishes welfare reform in Colorado, called "Colorado Works." Colorado Works is the state's version of the Temporary Assistance to Needy Families (TANF) program that was created under federal Welfare Reform efforts 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.

The Enrollment and Eligibility Section chapter details changes to the Colorado Medicaid Program that support and augment the Colorado Works program goal of assisting clients to move from welfare to work.

Managed Care Program Expansions

The department continues to design and implement program modifications 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.

- **Managed Care Enrollment Facilitator**
  In pursuing the goal of enrolling 75% of Medicaid clients in managed care programs by July 1, 2000, the department must assure that clients have clear, unbiased, current and relevant information about choice of providers and health plans. A contractor facilitates enrollment and performs 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.
- **HMO Competitive Bidding**
  SB 97-5 permits the department to 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.
- **Risk Adjustment of HMO Rates**
  The department adjusts 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 individuals who tend to use more resources and pay less for healthy individuals

who consume fewer resources, and therefore, improving both access for clients with health problems, and reimbursement equity for plans. (See the Medicaid Provider Rates chapter.)

- **Managed Care Quality Assurance**
  As managed care is expanded, the department has designed and implemented more comprehensive and well-coordinated quality monitoring systems. Key elements of this program are explained in the Medicaid Quality Assurance Section chapter.
- **Continuity of Care**
  Continuity to appropriate care is assured by means of specific terms and conditions within managed care organization contracts. The contract specifications for continuity of care are updated annually as useful improvements are identified.
- **Ombudsman for Managed Care**
  The department recently selected the Patient Advocacy Coalition as Ombudsman for clients who are enrolled in the Medicaid managed care system and CHP+. The Ombudsman is an independent problem solver who can advise clients and advocate for them when they are having trouble accessing health care services, treatment or providers.

Changes in Long-Term Care

- **Revisions to Nursing Facility Rates**
  The department implemented reimbursement changes and will implement a case mix rate methodology study as authorized by SB 97-42. The new law sets rate increase ceilings of 8% growth for health care costs and 6% for administrative costs. This change substantially reduces growth in nursing facility rates and was designed to save the state $15.7 million in its first year.
- **Case Mix Reimbursement**
  The department is developing a plan to base nursing facility rates on resident care needs and case mix. An advisory board was formed to review and comment HCPF staff and contractor work. (See Rate Setting Sections' chapter.)
- **Utilization Trends**
  The department's Long-Term Care programs continue to experience increased utilization of community-based care, and stable use of institutional settings such as Nursing Facilities. Over the last five years, the number of HCPF clients requiring long-term care services has increased, as has the number of elderly and disabled Coloradans, but the number of clients receiving care in Nursing Facilities has remained steady. More clients are being served in community-based settings. Another trend within the community-based programs is a slowing of the growth in the Home Care Allowance (HCA) program. This also correlates with increased growth in the HCBS-EBD programs. (See the Medical Assistance, Eligibility and Enrollment, and Health Care Benefits.)
- **The Integrated Care and Financing (ICF) Project**
  This pilot program integrates acute and long-term care Medicaid services and Medicare Part B services for individuals with disabilities and/or chronic conditions. Medicare Part A (inpatient) and Part B out-of-network services will continue to be paid by HCFA on a fee-for-service basis. The ICF project seeks to demonstrate improved health care coordination and reduced cost shifting among providers and payers. Improved health care outcomes are expected to result. HCPF, Mesa County Department of Human Services, Rocky Mountain HMO, and the federal Health Care Financing Administration (HCFA) will implement the project in Mesa County. (See the Office of Program Development.)

Systems Readiness

The department continues systems development in response to the needs of Colorado's changing programs of publicly funded health care. These projects include:

- **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.

- **Medicaid Management Information System (MMIS) Transition**
  The redesigned MMIS was implemented in December 1998. The MMIS is operated by a new fiscal agent contractor, Consultec, and provides 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. (See the Information Systems Section.)

- **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 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.

Award-Winning Customer Service

The Customer Service Section's performance was recognized in 1998 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 and the AT&T Language Line was added in April 1999. The AT&T Language Line provides interpreters for approximately 140 different languages. Staff responded to nearly 70,000 phone inquiries in the past year. Further increases in calls are anticipated, 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.)

Additional Information on Department of Health Care Policy and Financing programs:

- Questions on health care policy, financing, programs, or services may be directed to the HCPF Customer Service Information Line in the Denver calling area: 303-866-3513 or statewide toll-free: 1-800-221-3943, (303) 866-3305 TDD/TTY.
- HCPF program information, including client brochures, can be obtained from local County Departments of Social Services, Health Departments, Federally Qualified Health Centers and other health and community service providers. Agencies can obtain brochures for distribution by calling the Customer Service Information Line.
- Children may enroll in the CHP+ program by calling the statewide CHP+ access number, 1-800-359-1991, or by obtaining an application through one of the community agencies listed above.

- Medicaid eligibility determination and enrollment is administered by County Departments of Social Services/Human Services.
- The HCPF publication, "Who Does What in Colorado Health Care" explains where to go for information or assistance on aspects of public health care delivery, financing, regulation and policy.
- Internet access to HCPF information is available at the following address: http://www.chcpf.state.co.us/
- The Ombudsman for Managed Care assists clients or their representatives get more information and assistance to medically necessary services that may have been denied by a managed care organization or the Primary Care Physician Program. This is accomplished through education, information on patient rights and responsibilities and assistance with filing complaints and appeals. The Ombudsman staff routinely offers to meet with interested parties and to supply them with brochures and a recently published "Medicaid Client's Guide to Filing Complaints." The office can be reached by calling (303) 744-7667, or, if outside the Denver metro area, 1-877-HELP123 (1-877-435-7123).

OFFICE OF THE EXECUTIVE DIRECTOR

Overview of the Office of the Executive Director

The department's Executive Director is appointed by the Governor and confirmed by the Senate. He serves as a member of the Governor's cabinet and is responsible also to the Medical Services Board, which is the principal rule-making authority for the department's Medicaid and related programs. James T. Rizzuto was appointed Executive Director of HCPF in January 1999.

Seven offices report to the Executive Director of the department:

- Deputy Director - Legislative Affairs
- Program Development
- Medical Assistance
- Budget
- Accounting and Purchasing
- Information Technology

The functions of these organizational units are described in the chapters that follow.

Colorado Peak Performance

The department will implement Colorado Peak Performance (CPP) on July 1, 1999, however performance-based salary awards may not begin until July l, 2001. CPP is a system of organizational culture change, performance management and reward instituted by Legislative and Executive action. The HCPF CPP design and implementation team composed of staff representatives from throughout the department developed a CPP performance management, evaluation and reward system that was accepted by HCPF management in early 1999 and forwarded to the State Department of Personnel for approval.

The HCPF CPP system includes the following components:

- Performance management which requires development of an individual performance management plan for each employee and performance evaluations based on the following three rating categories, with one sub-category:
  - Needs Improvement
  - Fully Competent [subcategory: Fully Competent Plus]
  - Peak Performer
- Performance awards:
  - Employees who are rated as Fully Competent Plus and Peak Performer are eligible for performance-based financial and/or non-financial awards. Employees who are rated as Needs Improvement are not eligible for any awards.
  - Financial awards: Based on anticipated available funding, salary awards ranging from 0-4.5% will be made to employees based on their performance.

OFFICE OF PROGRAM DEVELOPMENT

THE MISSION OF THE OFFICE OF PROGRAM DEVELOPMENT IS TO WORK WITH PRIVATE AND PUBLIC SECTOR PARTNERS TO EVALUATE, DEVELOP AND IMPLEMENT HEALTH CARE SYSTEM INNOVATIONS THAT IMPROVE ACCESS, QUALITY AND EFFECTIVENESS OF HEALTH CARE SERVICES FOR ALL COLORADANS.

Purpose and Goals of the Office of Program Development (OPD)

- Increase access to health care insurance and services
- Develop new health care delivery systems and programs
- Implement new programs such as the Children's Basic Health Plan
- Reform purchasing in the public and private sectors to improve effectiveness and efficiency
- Evaluate the quality, accessibility and cost-effectiveness of health care programs and systems

Projects and initiatives in these areas are described below.

Health Care Initiatives Section Projects

Children's Basic Health Plan - Child Health Plan Plus - CHP+

Child Health Plan *Plus* (**CHP+**, also known as Children's Basic Health Plan) subsidizes health insurance coverage for low-income children. Eligible children are under 19 years of age, live in a family earning less than 185% of the Federal Poverty Level (FPL), and are not eligible for Medicaid. Families earning more than 100% of the federal poverty level pay a State-subsidized monthly premium for covered benefits. Once a child is found eligible for the program, he or she remains covered by the program for 12 months unless the family changes coverage or fails to make required premium payments.

CHP+ provides benefits including inpatient and outpatient hospital, physician, ancillary, therapies, prescription drugs, and mental health. The CHP+ benefit package excludes dental services. Depending on the geographic area in which an enrollee lives, services are provided either by an HMO or by a fee-for-service network.

As of early 1999, the CHP+ program enrolled over 15,000 children, with an enrollment increase of about 700 per month. The department and its public and private partners are developing strategies and systems that will address Governor Bill Owens' goal of 60,000 enrolled children within the next few years. These strategies include:

- grassroots, provider and State government advocacy for maximizing federal dollars available to CHP+ enrollment and coverage
- coordination with related child health initiatives including: Community Voices [Kellogg/Denver Health Medical Center]; Covering Kids [Department of Public Health and Environment]; Essential Community Provider Grants; Federally Qualified Health Centers, School Based Health Centers and other community providers; existing provider networks and managed care

organizations; community-based advocacy groups, faith communities; media and business groups.

Who is eligible for CHP+?
Children and youth who are:

- 18 years old and younger
- Not eligible for Medicaid
- Living in a financially qualified family
- Colorado residents
- US citizens or permanent US residents who entered the US before August 22, 1996

What services are covered by CHP+?

- Check-ups and shots
- Well child care and immunizations
- Medical office visits
- Prescriptions
- Hospital services, including outpatient services, inpatient care, and inpatient doctors' care
- Glasses and hearing aids
- Mental health care, such as counseling, hospitalization, and outpatient substance abuse treatments

Children can be enrolled in the program by contacting the department's **CHP+ enrollment** contractor, Child Health Advocates, at **1-800-359-1991.**

Children's Basic Health Plan Premiums

Federal Poverty Level (FPL)	Number of Children	
	One Child	Two or more children
Up to 100% FPL	Waived	Waived
101%150% FPL	$9/child/month	$15/family/month
151%-169% FPL	$15/child/month	$25/family/month
170%-185% FPL	$20/child/month	$30/family/month

1998 Federal Poverty Levels (FPL)

Income Level	Annual Family Income: 1 adult + 1 child	Annual Family Income: 1 adult + 2 children
100% FPL	11,060	13,880
150% FPL	16,590	20,820
175% FPL	19,355	24,290
185% FPL	20,461	25,678

History of CBHP/CHP+

In 1996, 16.7% of all Colorado children (181,720) were uninsured. This is the highest percentage and number of uninsured children in Colorado ever reported by the U.S. Census Bureau. Colorado was ranked 8th highest, among the states, in the percentage of low-income, uninsured children and it was also ranked 47th in public coverage of these children.[1] Current HCPF estimates indicate that approximately 72,000 children in Colorado are uninsured and in families with incomes under 200% of poverty.

Beginning in 1992, the University of Colorado Health Sciences Center operated a State financed program called the Colorado Child Health Plan (CCHP). This program was designed to provide services to low-income, uninsured children in the State. In 1997, the Colorado General Assembly passed HB 97-1304 that established a new program, the Children's Basic Health Plan (CBHP), to be marketed as Child Health Plan Plus (CHP+), to provide comprehensive health insurance to children with family incomes under 185% of poverty. CBHP was supported by a diverse coalition of business leaders, child advocates, health plans and providers, physicians, corporate and community-based providers charitable foundations and government agencies. It had broad-based support because of the recognized benefits of providing access to health services to children and the two-for-one federal matching rates in a non-entitlement program.

As part of the Balanced Budget Act of 1997, Congress established the State Children's Health Insurance Program (CHIP, Title XXI of the Social Security Act) to establish and expand health insurance coverage to many of the 10 million uninsured children in the United States. With $20 billion in federal matching funds distributed nationally over five years, the federal effort is aimed at uninsured children through age 18 in families with incomes at or below 200% of poverty.

The General Assembly, in HB 97-1325, modified CBHP and CHP+ to become Colorado's Title XXI children's health care coverage program. Colorado's existing publicly subsidized child health program infrastructure, and the State's rapid response to the opportunity presented by the federal legislation, make it a national leader in expanding health care coverage to low-income children.

Colorado's CBHP/CHP+ program provides a two-to-one federal to state dollar match to finance health care coverage for low-income, uninsured children who do not qualify for Medicaid. Colorado's federal allocation in FFY 1998 was $41.99 million. This allotment remains available for expenditure for a 3-year concurrent period, even if the annual allotment is not used during any one fiscal year. The projected allotment for Colorado for FFY 1999 is $52 million.[2]

Implementation of CBHP and CHP+

The Department of Health Care Policy and Financing is responsible for implementing the CBHP/CHP+ program statewide using a managed care model and privatized administrative contracts for enrollment, marketing, outreach, actuarial support, and provider payments. HCPF is responsible for the design of CHP+ health care benefits, design and operation of a provider reimbursement system, quality assurance, contract procurement and management, implementation of all federal, state and departmental rules, regulations and procedures, and federal and state reporting and analysis.

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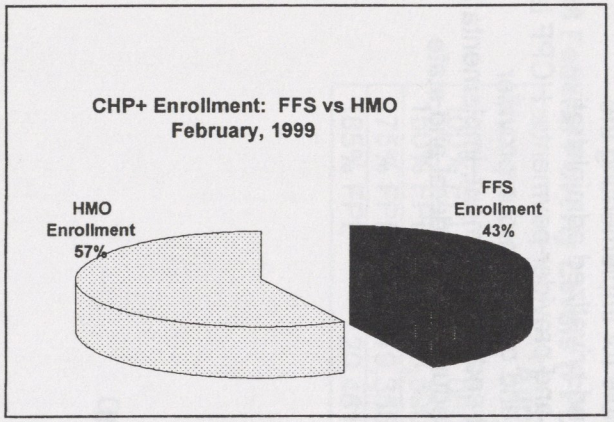
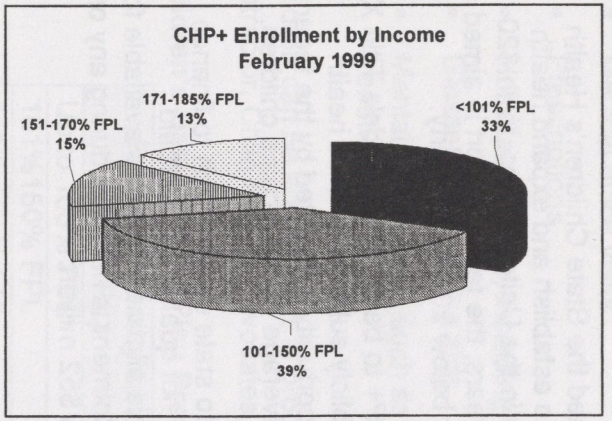
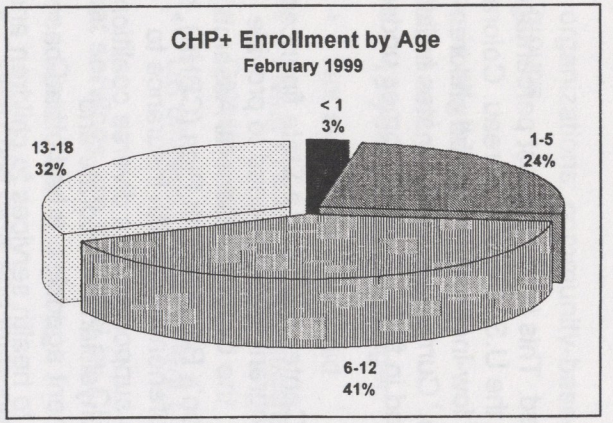
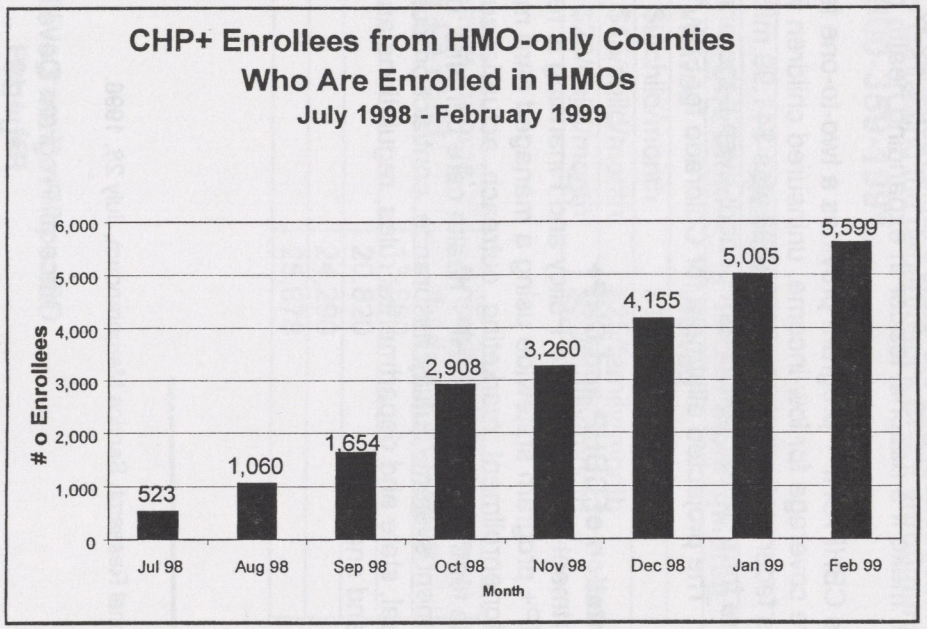
[2] Congressional Research Service Memorandum, July 28, 1998.

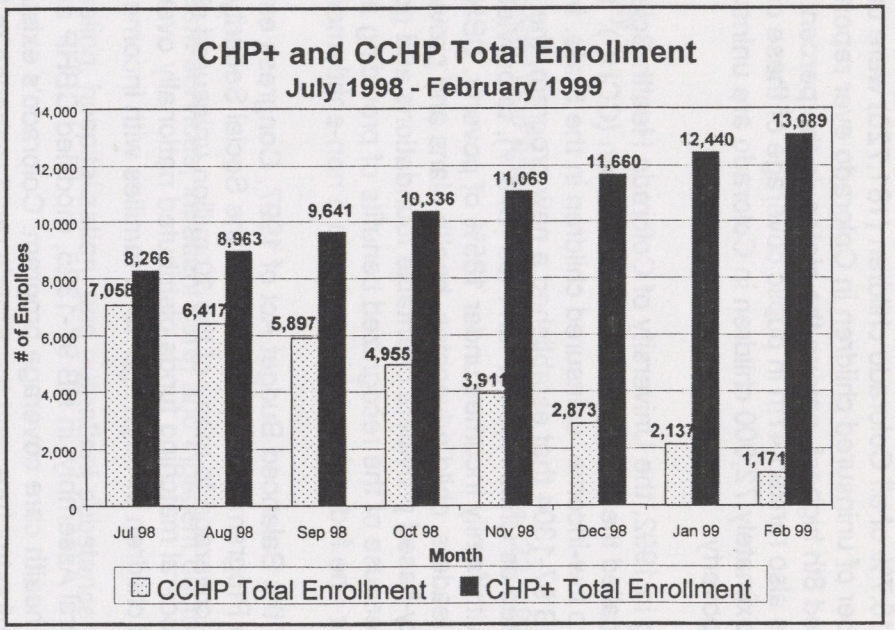
FIGURE 6: CHP+ ENROLLMENT STATISTICS











An eleven member CBHP Policy Board is established by statute and charged with promulgating program rules. The Policy Board provides a public forum for discussion of major policy issues, offers policy direction to the department, sets programmatic rules on a number of key areas, and reports regularly to the General Assembly on program impact and effectiveness. The Policy Board is composed of Governor-appointed/Senate-confirmed leaders in the business, provider, health plan and advocacy fields, including the Executive Directors (or their designees) of the Departments of Health Care Policy and Financing, Human Services, Public Health and Environment, and Education. The Board established subcommittees and advisory teams to recommend plans and methods based on the state and federal legislation. Team members include representatives of the business, provider, academic, insurance and consumer communities, as well as Health Care Policy and Financing and other government agency staff.

Currently, HCPF estimates that by June 30,1999, approximately 17,000 children will be enrolled in the CHP+ program. Six managed care organizations currently contract with HCPF to provide services to children, primarily in urban areas of the state. A separate provider network is currently managed under contract to the department to provide services to children in rural Colorado.

Other Access Initiatives

- **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.

- **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 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 is 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).

- **Health Care Coverage Cooperatives**
  HCPF provides regulatory and development oversight for private sector health insurance purchasing cooperatives which are also known as small employer purchasing groups. As part of Colorado's small group health insurance reforms of 1995, backed by a broad coalition of employers and consumers, small employers can offer more health care coverage choices to their employees, reduce administration burdens and increase their negotiating power with health plans by joining together in cooperatives to purchase insurance coverage. OPD 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 and oversight is to guard against risk skimming and cost shifting on the part of cooperatives.

In August of 1995, the department awarded a certificate of authority to the Cooperative for Health Insurance Purchasing (CHIP). CHIP offers a choice of four HMOs to employers of all sizes throughout the State. As of early 1999, CHIP covered over 8,000 subscribers and 17,000 lives. In 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, also serves all 63 counties and will offer a choice among 3 carriers and several benefit plans (HMO and PPO).

- **Procurement and Contracting, Systems Development and Quality Assurance Projects**
  The Office of Program Development (OPD) staffs department-wide project teams including:
  - competitive procurement and other procurement and contracting methodologies
  - program coordination and systems development
  - quality assurance

Health Care Delivery Systems Development Section Projects

OPD staff develops, administers, or facilitates 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:

- **Integrated Care and Financing Project**
  The Integrated Care and Financing Project, funded under a Robert Wood Johnson Foundation Grant, was originally designed as a fully capitated Medicaid/Medicare pilot program in Mesa County. Although Federal Health Care Financing Administration (HCFA) granted Colorado the required waivers on July 1, 1997, we were unable to reach agreement with HCFA on a Medicare capitation rate methodology. The Department and its partners, Rocky Mountain HMO and Mesa County Options for Long Term Care, are now pursuing a design that integrates Medicaid services (acute and long term care) for the project's dual eligible enrollees with services provided under Rocky Mountain HMO's Part B Cost Contract with Medicare. Medicare Part A (inpatient) and Part B out-of-network services would continue to be paid on a fee-for-service basis.

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

- **Home Health Aide Pilot Program**
  Because current federal Medicaid regulations require home health services to be provided in a client's home, some active disabled clients are prevented from leaving their homes for school, work, or other activities. In addition, state law concerning delegation of specific tasks from nurses to home health aides has changed. Medicaid has also changed its payment incentives to facilitate this delegation. Under the Home Health Aide Pilot program, home health aides, rather than registered nurses, will provide care in alternative settings, permitting disabled clients to move about the community without foregoing necessary care. Although it can be more costly to provide care in settings outside the home, the use of nurse-supervised home health aides for delegated tasks, rather than the use of nurses will offset costs. The Health Care Financing Administration granted the necessary waiver of Medicaid regulations in October 1997. Admission of clients will begin July 1, 1999.

- **Consumer-Directed Attendant Support Program**
  In 1996, the General Assembly passed a law calling for the development of a pilot program to test more effective and efficient ways of delivering attendant support services to disabled individuals. The pilot program will allow Medicaid clients to employ, train, and pay personal care providers of their choosing and to receive care in locations other than the home. Staff will submit a waiver to HCFA in early 1999 to enroll 150 clients in the program. Once operational, the pilot is expected to run for three years.
- **Safety Net Project**
  In 1997, the Office of Program Development obtained a three-year grant from the Robert Wood Johnson Foundation (RWJF) to improve service delivery and care coordination for children with special needs enrolled in Medicaid HMOs. The Safety Net project is a voluntary collaboration among HCPF, Medicaid HMOs, community-based organizations, consumers, and consumer advocates to define and implement *best practices* in the area of care coordination and community collaboration.
- **Medicaid HIV Coverage Expansion Project**
  The department is exploring the cost-effectiveness and feasibility of expanding (limited) Medicaid coverage to persons with HIV/AIDS, in order to fund drug coverage and related services for those individuals in order to keep them from becoming higher-cost Medicaid clients in the future. The Kaiser Family Foundation has offered financial and in-kind support. State legislation and Federal waivers would be required to implement this program.

Recent Accomplishments of the Office of Program Development and its Partners

- A rule-making board for the CBHP program, the Child Basic Health Plan Policy Board, was appointed and provided with staff support.
- Pursuant to the CBHP statute, OPD and department staff developed and procured contracts and established contract management systems with private entities that perform many of the administrative functions of CHP+ including marketing and outreach, eligibility determination and CHP+ enrollment, managed care plan enrollment, customer service related to the contract work, ombudsman, health and medical service delivery, premium collection, provider and plan payment and information systems.
- OPD staff designed and implemented CBHP financial management and program accountability systems.
- The CBHP Policy Board, with OPD staff support, approved a premium subsidy program for enrollees of one managed care organization that is participating in the Kellogg Foundation's grant program: "Community Voices: Health Care for the Underserved – A National Demonstration of Local Visionary Models." This program is part of a research project to determine the impact of premiums on enrollment and to test the hypothesis that, for families with low incomes (under 185 % of poverty), premiums will impact both enrollment and retention.
- OPD and CBHP Policy Board members participated with Denver Health Medical Center in another Kellogg Foundation grant project to continue simplifying the enrollment process through further automation of the eligibility determination process.
- OPD and other department staff completed the "Annual Savings Report" to the General Assembly, reporting on the savings that the department expects to realize from reforms, consolidations, and streamlining of health care programs. The General Assembly will consider applying these savings to the financing of the Children's Basic Health Plan. The report submitted on October 1, 1998 indicates potential savings of nearly $18 million this fiscal year

(1998-1999), from expansion of Medicaid managed care, nursing facility rate changes and other efforts.

- OPD CBHP staff, in cooperation with the Policy Board, contractors and other partners also:
  - Submitted a request for State Funding along with the HCPF Budget Staff, to the Colorado General Assembly for funding the Children's Basic Health Plan in fiscal year 1999-2000.
  - Designed and began implementation of plans to modify and potentially replace the primary care provider-based network that delivers care to children in non-HMO-covered rural areas of the state.
  - Studied and made recommendations on the ability of CHP+ managed care partners to handle financial risk during the implementation phase with small enrollment.
  - Initiated program integration activities with other state agencies, including:
    - Colorado Indigent Care Program
    - Department of Human Services, Mental Health Programs
    - Department of Public Health and Environment, including a high-risk screening to identify children with special needs, and outreach and marketing. The DPHE has taken the leadership role in the State in coordinating the Covering Kids Coalition to implement an expansion of outreach efforts to populations in need.
    - Division of Insurance; developing an insurance program for uninsured children, and to resolve a number of regulatory issues including mandated benefits and evidence of coverage.
  - Essential Community Provider Grants Program
  - School-Based Health Centers
  - Obtained section 1915 (c) waiver approval for Brain Injury Program.
  - Obtained section 1115 waiver approval for Home Health Aide Pilot Project.

OPD staff is addressing the following projects in 1999:

- Negotiation with the Health Care Financing Administration for the approval and terms and conditions of the Section 1115 waiver for the Consumer Directed Attendant Support Program.
- Select and train up to ten Home Health agencies in the Home Health Aide Pilot Project.
- Finalize implementation tasks for the Integrated Care and Financing Project and enroll clients.
- Complete the budget-neutral cost calculations for an HIV Coverage Expansion program.

OFFICE OF INFORMATION TECHNOLOGY

THE MISSION OF THE OFFICE OF INFORMATION TECHNOLOGY IS TO DESIGN, DEVELOP AND MAINTAIN INFORMATION SYSTEMS INFRASTRUCTURE THAT SUPPORTS THE DEPARTMENT'S MISSION AND GOALS.

Information Technology Office Functions

The Office of Information Technology (OIT) was formed to meet the department's expanding needs for a departmental local area network (LAN), and for access to program information needed to support analysis and decisions by policy-makers and program managers. The OIT is engineering an information technology foundation to meet the department's diverse computing requirements, and providing training and methods for its use.

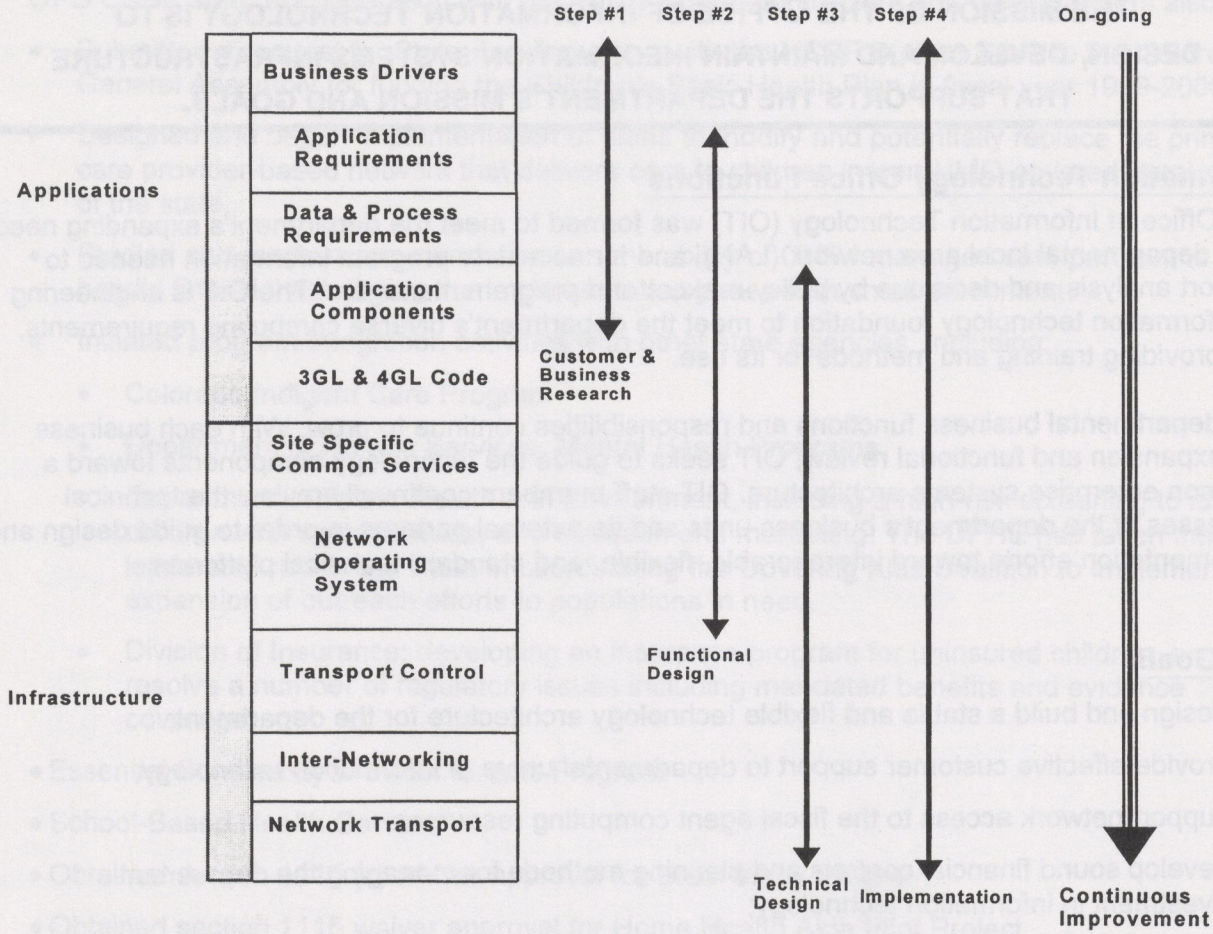
The departmental business functions and responsibilities continue to grow. With each business unit expansion and functional review, OIT seeks to guide the technology components toward a common enterprise systems architecture. OIT staff members continually review the technical processes of the department's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

OIT Goals

- 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;
- 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 the department's 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 7: 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

FY97-98 accomplishments

- Implemented procedures for the stabilization of the departmental local area network (LAN). These included procedures for: backup and 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.
- Developed an informal and comfortable interface with customers by establishing a database of customer requests. Delivered solutions to 80% of the "quick fix" requests within four hours.
- Helped with the design and implementation of the network among the department, fiscal agent, and the General Government Computer Center (GGCC).
- Learned the fiscal agent architecture enough to support basic user access requirements.
- Designed and built a centralized inventory control database for hardware owned by the department.
- Administered a structured education and training program for the department with over 100 classes.
- Developed the department's State of Colorado Internet web site to include departmental reference material, publications, research findings, frequently asked questions, and current health care policy news.
- Developed the departmental Intranet capabilities to include an index server and search engine for internal reference documents.
- Prepared, presented, defended, developed and implemented the department's five-year and yearly Information Management Annual Plan (IMAP) as required by the state's Information Management Commission.
- Completed departmental Intranet and Internet Web Sites, and now they are in a maintenance mode.
- 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.

Fiscal Year 98-99 goals

- Maintain and enhance a stable and flexible departmental technical architecture.
- 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. Summarize the effectiveness of customer interactions. Deliver solutions to 80% of the "quick fix" requests within four hours.
- Develop sound financial controls and planning methods for managing the department's investment in information technology.
- Coordinate departmental information technology planning.

Anticipated performance during FY 98-99

- Revise and refine procedures for the stabilization of the departmental local area network by December 1999. Develop new procedures tracking system.
- Revise and refine a centralized inventory control database for hardware and software purchased by OIT.
- Develop financial statements, tracking databases, and control procedures for budget appropriations, budget forecasts, and office expenses.
- Consult 200 hours with department managers in planning their information technology strategies, methods, and systems development per year.
- 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.

Fiscal Year 99-00 goals

- Enhance and maintain the departmental local area network by December 1999. Develop new procedures issues tracking system.
- Enhance and maintain the centralized inventory control and financial control.
- Consult 200 hours with department managers in planning their information technology strategies, methods, and systems development per year.
- 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.

OFFICE OF INFORMATION TECHNOLOGY - ELIGIBILITY SYSTEMS DEVELOPMENT SECTION

THE MISSION OF OIT-ELIGIBILITY SYSTEMS DEVELOPMENT SECTION IS TO DEVELOP AN AUTOMATED SYSTEM THAT SUPPORTS BROAD ACCESS TO MEDICAL ASSISTANCE INFORMATION AT A VARIETY OF APPLICATION SITES IN ORDER TO DELIVER SPEEDY, ACCURATE ELIGIBILITY DECISIONS.

Function of the Eligibility Systems Development Section

In coordination with the Department of Human Services, the Office of Information Technology's Eligibility Systems Development Section provides systems design, development and implementation support to the developing Colorado Benefits Management System (CBMS). Initially the project was a temporary assignment of two state employees and one contract staff to spearhead project design. After successful pursuit of a legislative budget allocation the Eligibility Systems Development Section now consists of 5.7 FTE and one contractor.

Fiscal Year 1997-98 Goals

- A common goal of the two departments collaborating on this project is to use this new eligibility system (CBMS) to better serve the citizens. Beyond this common goal, each department advances its own mission critical goals. For the Department of Health Care Policy & Financing these goals include:
  - Expediting access to health care through the use of county-based and non-county program application sites.
  - Increasing continuity of coverage and care through application processes that are integrated across various health care coverage programs.
  - Increasing coordination of benefits for clients who migrate through coverage groups.
- CBMS will replace eligibility systems for Medicaid, Colorado Indigent Care Program, Child Health Plan+, Food Stamps, Temporary Assistance to Needy Families, Work Programs with:
  - Automated application, eligibility processing, benefit issuance, case tracking, reporting, noticing, and workload management.
  - Integrated cash, medical and public assistance in one system (such as within CBMS and between CBMS & CYF, the Children, Youth and Families system which replaces current systems related to child welfare services).
  - Outsourced system to State Contractors (development and operations).
  - Internet browser technology for non-county medical application sites to access CBMS.
  - Centralized automated eligibility rules for each department.

Fiscal Year 1997-98 Accomplishments

- Identified proposed functionality of CBMS at medical assistance sites, to support stronger use of non-county sites in medical application and eligibility.
- Designed direct electronic input of client applications & documents information

- Reengineered business processes
- Child Health Plan+ CBMS prototype implemented in 1998 with selected functionalities
- Implemented and strengthened a system of CBMS user and stakeholder input groups to assure adequate system design and functionality, including:
  - HCPF Management Advisory Group, meeting monthly to provide oversight and policy guidance to the project
  - HCPF CBMS Project Team comprised of business area experts to advise the project from an operational level
  - Increased medical service representatives on CBMS project steering and oversight committees
  - Joint Application Design (JAD) Processes
  - Open invitation meeting for non-county medical application sites
  - Site visits to 15 selected non-county medical application sites
  - Meeting with fiscal directors of non-county medical application sites
  - Contest for HCP&F employees on use of/needs from the eligibility system
  - Working design conference for non-county medical application sites
  - Internal HCP&F review of interim design materials

Fiscal Year 1998-99 Trends and Anticipated Challenges

- Identified Guiding Principles including:
  - Take client information once
  - Process the information quickly and timely
  - Simplify processes
  - Eliminate paper to the greatest extent possible
  - Use enabling technologies
- Integrate policy through technology
  - Analyzing who "owns" the case and the data and who has ultimate responsibility?
  - Analyzing the degree of reporting/query capability the system will require.
  - Analyzing the range of functionality outside counties.
  - Analyzing the degree of interface with other enterprise systems.
  - Level of referral support between CBMS and community support agencies.
  - Federal approval of Internet use for transmission eligibility data between application sites and the system
- Final design, hardware & software needs for CBMS
- Implementation
  - Vendor selection (participation in vendor proposal evaluations)

- Cost and allocation of cost among federal, state, and county payers of the system
- Establishing "business rules" for shared issues such as security, etc.

Fiscal Year 1998-99 Goals

- Implement CBMS components as follows:
  - The two state departments have obtained federal approval to proceed, and the RFP for an implementation vendor was issued in December 1998. Vendor proposals are due in April 1999.
  - It is anticipated that the contract with the successful bidder will be finalized during summer 1999 and work on CBMS implementation will begin immediately.
  - The first applications in CBMS are planned for release in winter of 2000-01.
  - The earliest application releases will address medical assistance applications for programs serving families and children, followed quickly by other medical applications, cash and food stamps, and self-sufficiency work programs.
- Project funding development:
  - Provide a mechanism for funding the transition to CBMS that will protect the client's access to medical care and minimize discontinuity of service in the field.
  - As CBMS is funded and the automated system becomes the sole means of submitting applications, establish a fund from which non-county application sites can apply for funds to purchase CBMS standard hardware and software.
  - Determine how costs are presently allocated and funded in the various rate methodologies now used to support the eligibility determination functions that will be replaced or enhanced by CBMS.

OFFICE OF MEDICAL ASSISTANCE

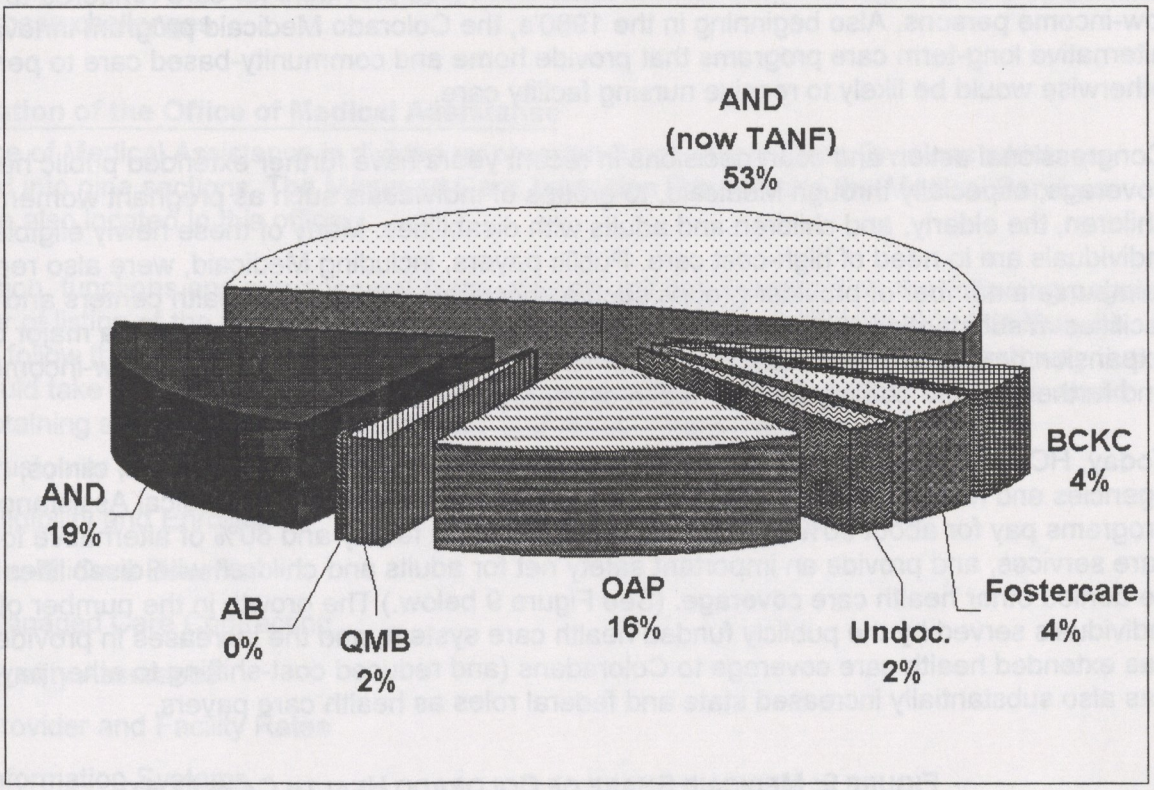
Overview

The 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 over 250,000 low-income Coloradans. State-funded programs such as the Poison Control Center and the Old Age Pension Health and Medical Fund, Home Care Allowance, and Adult Foster Care provide services to meet specific health care needs. The 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 in reimbursements for services rendered to those clients. [See Figure 2, "Number of Clients Served and Payments to Providers" for detail.]

The largest responsibility of the Office of Medical Assistance is the 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.). 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 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.

FIGURE 8: MEDICAID POPULATION BY CATEGORY OF AID FY 97 - 98



KEY:

AND	Aid to the Needy Disabled	FC:	Foster Care
AB	Aid to the Blind	BCKC	Baby Care/Kids Care
QMB	Qualified Medicare Beneficiary	AFDC	Aid to Families with Dependent Children
OAP	Old Age Pension		

Background: Medicaid and Other Public Health Care 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 reaching 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.

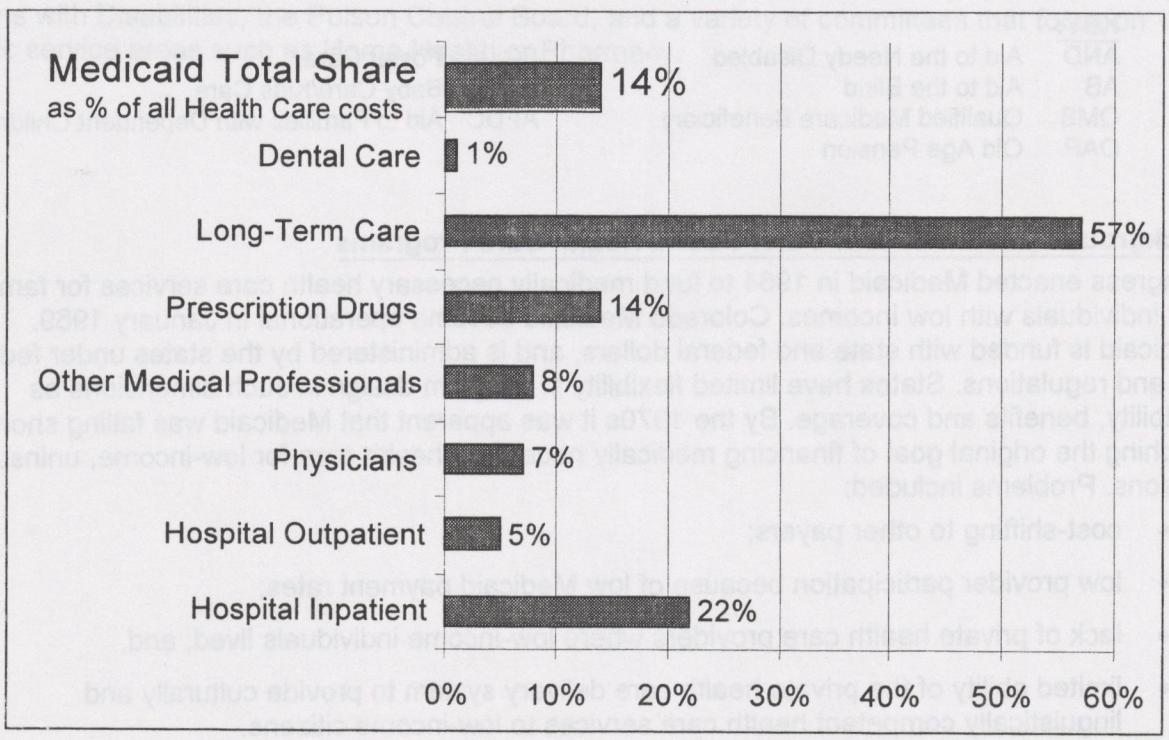
Federal, state, and local governments made significant investments in the following decades to address these problems. To improve access to health care, all levels of government increased

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 Figure 9 below.) The growth in the number of individuals served by the publicly funded health care system, and the increases in provider rates, has extended health care coverage to Coloradans (and reduced cost-shifting to other payers), but has also substantially increased state and federal roles as health care payers.

FIGURE 9: MEDICAID SHARE OF COLORADO HEALTH CARE COSTS



Source: HCPF Office of Program Development, 1998

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 is engaged in major restructuring of programs and operations to meet these challenges.

Organization of the Office of Medical Assistance

The Office of Medical Assistance is divided by program function into three Divisions which are organized into nine sections. The Managed Care Transition Project and the Medical Services Board are also located in this office.

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
- Quality Assurance
- Provider and Facility Rates
- Information Systems
- Third Party Resources

NOTE:
In order to present program information coherently in the Reference 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 in the chapters below where this convention is followed.

Please reference Appendix 2, Acronyms and Abbreviations, for explanation of program abbreviations used throughout the Manual.

CUSTOMER SERVICE SECTION

THE MISSION OF THE CUSTOMER SERVICE SECTION IS TO ASSIST CUSTOMERS TO ACCESS APPROPRIATE HEALTH CARE AND ASSIST ALL CUSTOMERS TO BETTER UNDERSTAND THE SERVICES AND BENEFITS OFFERED BY THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING.

The Customer Service Section's staff and Section Manager were recognized in 1998 with two awards for excellence:

- The Francis T. Ishida Award for "...distinguished record of Excellence in service to Medicaid program clients in Colorado." This award was given by the Federal Health Care Financing Administration's Denver regional Office, October 6, 1998; and
- The Governor's Award for " Linking Citizens to Government in the New Millennium" Citizens Satisfaction Workshop, August 31, 1998.

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 and other 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' issues, assist clients to navigate the health care system.
- Direct clients who wish to enroll in managed care, or need additional information about managed care, or to change Primary Care Physicians, and/or enroll into HMOs, to HealthColorado, the enrollment broker.
- Refer providers to the contracted Provider Relations 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 customers, HMO member services and advocacy groups to ensure that consistent and accurate information is provided and issues are resolved quickly including:
    - Coordinate resolution of problems with the contracted Ombudsman for managed care or Client Advocacy Office of the Department of Human Services.
    - Coordinate with HealthColorado (the Medicaid Managed Care program) on client enrollment into managed care
    - Propose, develop and implement policies, procedures and systems modifications to improve customer service and to assure that proposed policy and procedures incorporate the best interests of the clients

- Manage a contract to operate the Ombudsman for Managed Care program. The Ombudsman advises and advocates for clients to assist them in accessing health care services or treatment.

Customer Help Lines and Services

- The Customer Service Section is made up of ten staff positions and two contractor staff. All Customer Service staff are trained and committed to effective delivery of the following specific functions:
- The Customer Service section operates the Customer Service Information Line. This toll-free telephone service is staffed Monday through Friday 7:00 AM to 5:30 PM and provides quick and accurate information to client and provider questions regarding HCPF programs and benefits, managed care, general Medicaid questions, Colorado Indigent Care Program (CICP) and CHP+ programs general information. Staff can also assist Spanish speaking and German speaking clients.
- "Teletips" is an automated function that 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. Calling either the local or toll free number and following the prompts to get to the automated information may access the information.
- The Information Line number is distributed to all Medicaid clients by county-level eligibility technicians, and is printed in Medicaid program brochures, publications, and the Medicaid cards.
- 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 will assist clients and providers in resolving the issues. Staff also advocates 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 maintains the smooth running of the department's automated attendant and maintain current publications on the Internet such as "Who Does What at HCPF?"
- Staff responds to inquiries from:
  - state representatives, senators and Governor's office staff needing information on behalf of constituents.
  - inquiries from the Internet.
  - clients and providers with questions regarding home health, private duty nursing, EPSDT as well as responding to home health industry issues.
  - monolingual Spanish or German speakers.
- Staff coordinate with:
  - Colorado Indigent Care Program staff and the Child Health Plan Plus staff to resolve client issues. Oftentimes, people who are not eligible for Medicaid may qualify for assistance through these programs. Staff in the Customer Service Section is trained to answer basic questions about these programs.
  - Enrollment counselors: Clients wishing to enroll and disenroll from the PCP Program or HMO are referred to HealthColorado, the department's contracted Medicaid Managed Care

program assistance line. HealthColorado conducts a telephone interview with the client in order to assist him/her in making informed choices.

- The Ombudsman for Managed Care to assist clients to file and resolve complaints.
- Member Services staff at each HMO to help clients to access services.
- County Department of Human/Social Services eligibility technicians.
- Community and not for profit organizations to assist clients to obtain and pay for services that are not covered by HCPF programs.
- Department Front Desk: The department maintains a central number that is staffed from 8 a.m. to 5:30 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 Governor's Advocacy Corps: Staff in the Department of Human Services Client Advocacy Office answers basic questions regarding HCPF programs, typically Medicaid and Indigent Care Program eligibility and benefits. This staff provides intervention to clients who have eligibility denials. 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.
- Medicaid Advisory Committee for Persons with Disabilities.

Goals

- To assist Medicaid clients to make quality health care choices, by coordinating this function with HealthColorado.
- To provide accurate, timely information to customers.
- To provide superior interactions with the general public and internal customers.
- To improve the ability of assisting targeted client populations.
- To be a one-stop-shop for callers.

Accomplishments

- The Customer Service Line representatives responded to 69,654 total calls in FY 97-98. Of these total calls, the information line specialist resolved 95% and transferred only 5% of the calls. This compares to the prior years performance of 84% of total calls answered with 16% transferred to subject matter experts. This represents an increase in 1998 of 11% of calls answered vs. transferred due to staff training and in-service over the past year.
- Customer Service Information Line has used the new telephone system that was designed in 1997, and continues to develop operational procedures to better serve the customer. Through the restructuring of staff positions, the customer service section has been able to provide greatly enhanced telephone information and assistance to customers. Call wait times have been substantially reduced. Customer complaints are less than 5 per year.
- Implemented and maintained current information on Teletips, which is over 150 information segments.

- Continue full service availability in Spanish. Added a German speaking customer service representative.
- Reduced average caller wait time to less than 300 seconds and resolved all legislative inquiries in less than 10 working days.
- AT&T Language Line, installed in April 1999, allows the department to improve access to departmental information for limited and/or non English speakers. AT&T provides interpreters for approximately 140 different languages.
- Developed and installed Teletip scripts on all staff desktops and the Internet.
- Installed automated directory systems on Customer Service representatives' personal computer desktops, including:
  - US West DEX, to assist clients in obtaining needed phone numbers and maps
  - CallsPLUS and the United Way Directory, to assist clients to obtain community resources for benefits not covered by HCPF programs
  - An electronic binder of information to quickly assist callers who need phone numbers, form letters, etc.
- Began documenting problem calls in a Customer Service call tracking database.
- Completed RFP process for procurement of a contract to operate a Managed Care Ombudsman program.

Performance Data

- Customer Service representatives processed 69,654 telephone calls in FY98. FY97 totals were 46,752. This represents an increase of 22,902, or 49%, for FY98.
- Staff assisted 58,583 people via FAX and mail in FY98, compared to 52,667 in FY97. This is an increase of 5,916, or 11%.
- 85 walk-in clients were also assisted.
- All contacts including phone, FAX, mail and walk-in totaled 128,322 customers served for FY98.
- Services to Spanish speaking customers included 757 calls and production of Spanish-language letters and brochures.

Future Trends and Challenges

With the complexity and constant change within the department and health care industry, it is crucial that staff on the frontline have access to the most current information and be informed of activities within the department that may generate calls to staff. In addition, clients who are upset with services may write to or call their state representatives. HCPF's challenge is to create a rapid response system, including shared client history, complaint and rules database in order to better coordinate the information being provided.

In response to this challenge, Customer Service 98-99 and 99-00 development goals include:

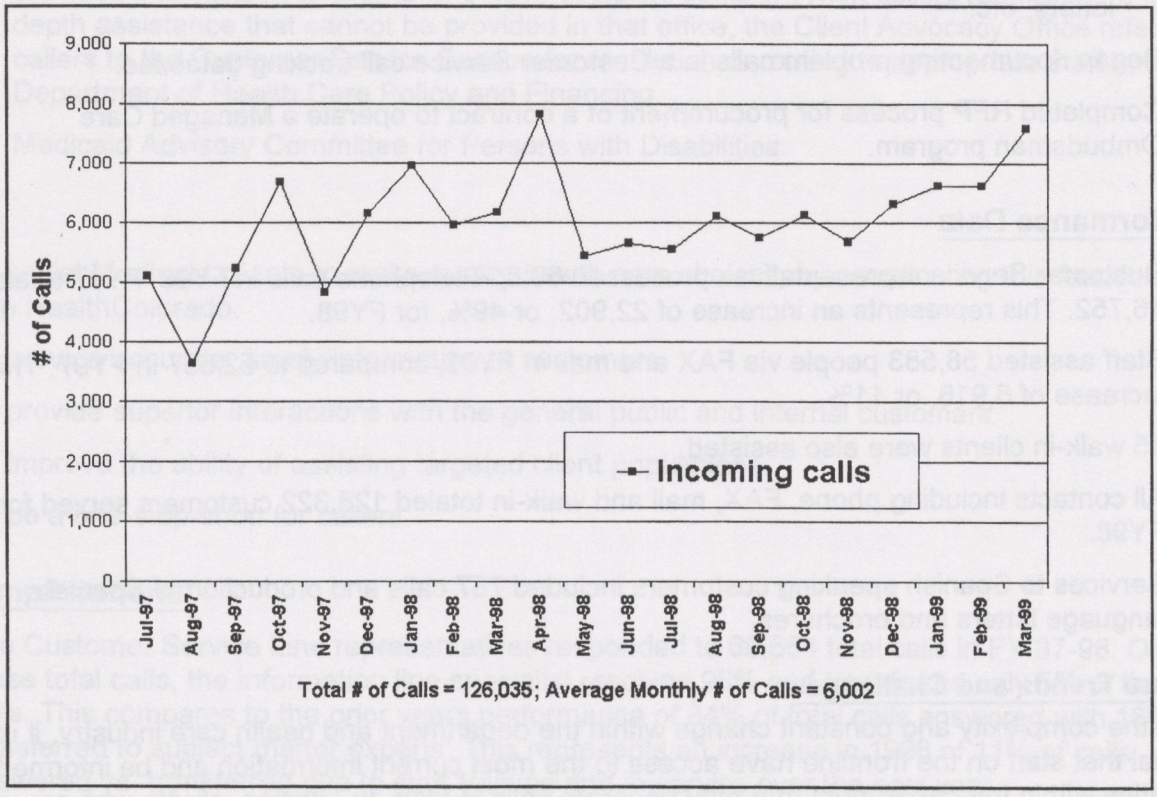
- Tracking the numbers and types of complaints about HMOs and other managed care policies.
- Increasing the presence of Ombudsman services in communities throughout the state.

- Working with the Office of Information Technology to develop on-line search capacities for relevant statures, regulations and procedures documentation for accurate information.

Future Goals

- Continue to find ways to use technology to better serve clients.
- To assure that the Customer Service Information Line staff has the most current departmental information, both in hard copy and in electronic copy.
- Coordinate with the HCPF Office of Information Technology to fully automate information on-line for easy access.
- Develop Ombudsman capabilities for analysis and reporting of information pertinent to managed care inquiries and all types of client complaints, statewide.
- Develop procedures for assessing client satisfaction with customer services functions.

FIGURE 10: TOTAL MONTHLY INCOMING CALLS ANSWERED BY CUSTOMER SERVICE REPRESENTATIVES



ELIGIBILITY AND ENROLLMENT SECTION

THE MISSION OF THE ELIGIBILITY AND ENROLLMENT SECTION IS TO PROVIDE A GATEWAY TO BENEFITS FOR ELIGIBLE CLIENTS.

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.

Major E&E responsibilities are:

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.

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).

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.

Financing and 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 immigrants.

Welfare Reform Changes to Medicaid Eligibility

Pursuant to Federal and State Welfare Reform initiatives, Medicaid eligibility for low-income families is no longer linked to financial assistance. Despite this major change and lack of additional Medicaid funding, the county departments of social services continued to determine eligibility for these families. The de-linking of the two programs and transitioning back to work of this population resulted in a caseload drop. Colorado maintained over 80% of our caseload which, compared to other many state's experiences, is minimal. In part this is due to the creation of a new Medicaid only category called 1931. The new 1931 category includes families who meet the eligibility criteria of the old AFDC program, and also those who meet the income and resource criteria of the Colorado Works cash assistance program. However, families need not be receiving financial assistance to receive Medicaid under 1931, and there is no time limit on eligibility. These and other changes are detailed below.

Services to Families and Children

TANF (Temporary Assistance to Needy Families) - The "Colorado Works" program is Colorado's version of the federal TANF program. TANF reforms and replaces the Aid to Families with Dependent Children (AFDC) program. To be eligible, families must meet the eligibility standards of the AFDC program of July 16, 1996, except that the Colorado Works is also available to two parent families and to those with additional resources ($2000/one car exempt). Medicaid benefits continue at least as long as the family remains in the Colorado Works Program. Additionally, the five-year lifetime limitation on the receipt of TANF benefits does not apply to Medicaid. Families can continue to receive Medicaid benefits as long as they meet the income and resource criteria.

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.

Transitional Medicaid - One year of additional Medicaid benefits are available to families who are discontinued due to increased work income. To be eligible, families must have been receiving Medicaid for three out of the past six months and have income that doesn't exceed 185% FPL. Families must continue to meet all additional eligibility criteria.

- **Work Incentives Program for People with Disabilities**

  Senate Bill 97-147 created the Disability Work Incentive (DWIN) Program to remove statutory or regulatory disincentives to work by assuring persons with disabilities that Medicaid will be available for them at a reasonable cost even if they go to work. DWIN is a pilot program that requires a HCFA waiver and is limited to 150 eligible participants.

  An eligible person with a disability is someone whose disability is permanent; someone who is currently receiving Supplemental Security Income (SSI) and Medicaid or Social Security Disability Income (SSDI) and Medicaid; and who is unemployed. The proposed program requires the participant to purchase Medicaid on a sliding fee scale as a wrap-around to an employer-based private health insurance plan. If the employer does not offer health insurance, the full Medicaid package will be offered on a sliding fee scale. There will be no limit on earnings and a wide range of professions will be represented.

- **Services for Immigrants**

  Legal immigrants -- Those legal immigrants in the following categories, who were in the U.S. prior to August 22, 1996, if otherwise eligible, 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 August 22, 1996. 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 (or human services) to insure their continued coverage.

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

  - U.S. 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 financially eligible, regardless of their immigrant status or date of entry, are eligible for emergency services. Emergency services include 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.

SSI-Children

It is estimated that between 2,000 to 3,000 children in Colorado may lose SSI income due to the federal 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.

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.

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) Baby Care Kids care (BCKC-Adult)** - pregnant women whose family income exceeds the AFDC need standard but does not exceed 133% of the federal poverty level (FPL). (133% FPL = $22,212 for a family of four in 1999).

- **Undocumented Immigrants** - 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 Immigrants** - 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 Immigrants 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 person over 65 years of age; and, Old Age Pension-State Only (OAP-SO) medical coverage for some non-disabled but poor Coloradans 60-64 years old - for persons with incomes below $536 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 aged 60 -64 with incomes below $536 per month and limited assets.
- **Long-Term Care (LTC)** - persons of any age with incomes below 300% of the federal Supplemental Security Income level ($1,500 per month in 1999) 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 age 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).

Managed Care Enrollment Broker:

- Pursuant to Senate Bill 97-5's requirements to enroll 75% of all eligible Medicaid recipients in managed care plans by July 1, 2000, and to provide clients with information and education necessary to make an informed choice from an independent, objective and State monitored source, the E&E Section manages the Enrollment Broker contractor. The Managed Care Enrollment procedure is conducted as follows:
- The Enrollment Broker notifies clients in mandatory managed care counties [see below] who are not exempt from managed care assignments of the need to choose a managed care option within 65 days. Clients who do not choose a plan receive a second notification no less than 45 days following the first notice. Clients who still do not choose a plan receive a third and final letter no less than 20 days following the second letter. The third letter advises the client of the managed care option chosen for them, which is known as a default assignment.
- Default assignments are made on the basis of past managed care enrollment, family/member enrollments, and availability of MCO choice. If a client or family member has an existing health care relationship with one of the available MCOs, assignment is made to that MCO. If there is no prior relationship and a client has only one Managed Care Organization (MCO) choice and one or more Primary Care Physician Program (PCPP) choices, the default assignment is made to the MCO. Assignments for clients with multiple MCO options are made on the basis on random assignment to the MCOs.
- As of March 1999, mandatory managed care enrollment has been implemented in 13 counties. Prior to being designated as a mandatory county, managed care choice must be available; managed care choice is defined as two or managed care options in the county. This may be any combination of two or more MCO or PCPP options.
- Mandatory clients may disenroll from their managed care choice within the first 30 days of enrollment. Thereafter, disenrollment may only occur during the client's open enrollment, which occurs at six-month intervals following enrollment.

Medicaid enrollment statistics and trends

FIGURE 11: MEDICAID CLIENT ENROLLMENT BY ELIGIBILITY CATEGORY

Category of Eligibility (Budget Category)	FY 96-97		FY 97-98		FY 98-99	
	# of Clients	%	# of Clients	%	# of Clients	%
Adults						
Colorado Works / TANF / AFDC - A	35,614	13.2%	29,474	11.4%	26,369	10.2%
Baby Care - Kids Care - Pregnant Women (BCKC - A)	5,421	2.0%	5,307	2.1%	5,109	2.0%
Undocumented Aliens	5,325	2.0%	5,824	2.3%	6,588	2.5%
Subtotal	**46,360**	**17.2%**	**40,605**	**15.7%**	**38,066**	**14.7%**
Children						
Colorado Works / TANF / AFDC - C; Ribicoff Children	110,060	40.9%	104,999	40.6%	104,840	40.4%
Baby Care - Kids Care (BCKC - C)	7,465	2.8%	6,230	2.4%	5,529	2.1%
Foster Care Children (FC - C)	9,404	3.5%	10,663	4.1%	12,349	4.8%
Subtotal	**126,929**	**47.2%**	**121,892**	**47.2%**	**122,718**	**47.3%**
Elderly						
Qualified Medicare Beneficiaries (QMB) and Special Low-Income Medicare Beneficiaries (SLMB)	4,247	1.6%	4,508	1.7%	4,834	1.9%
Old Age Pension (OAP-A and State-Only OAP Health and Medical Fund)	36,325	13.5%	36,901	14.3%	37,536	14.5%
Subtotal	**40,572**	**15.1%**	**41,409**	**16.0%**	**42,370**	**16.3%**
Disabled						
Aid to the Blind (AB)	154	<0.1%	150	0.1%	147	0.1%
Aid to the Needy Disabled (AND)	50,237	18.7%	49,682	19.2%	51,152	19.7%
Old Age Pension (OAP-B)	4,627	1.7%	4,686	1.8%	4,923	1.9%
Subtotal	**55,018**	**20.4%**	**54,518**	21.1%	**56,222**	**21.7%**
TOTAL	**268,879**	**100.0%**	**258,424**	**100.0%**	**259,376**	**100.0%**

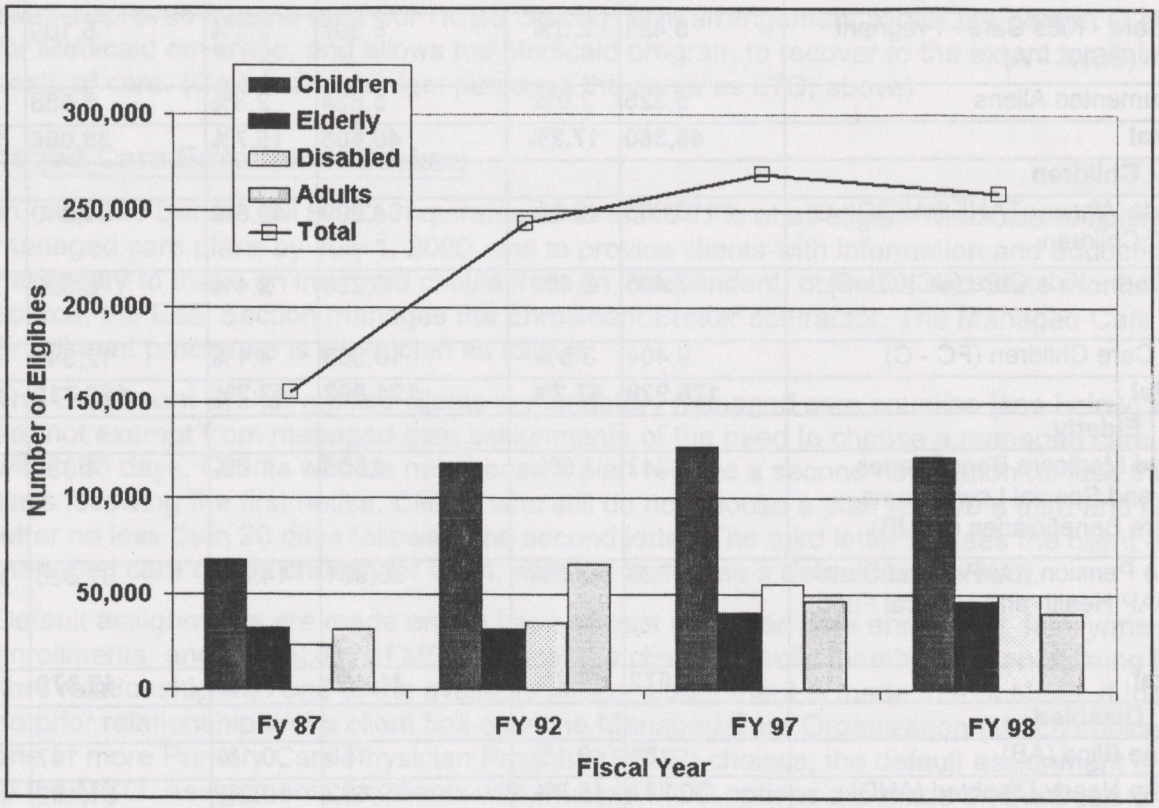
Notes:

- Undocumented Immigrants budget category includes both adults and children, although most persons served are adults.
- 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.
- AND budget category also includes SSI Qualified Working Disabled, some Disabled Widow(er)s, Long-Term Care and Income Trust beneficiaries.

Medicaid Enrollment Trends

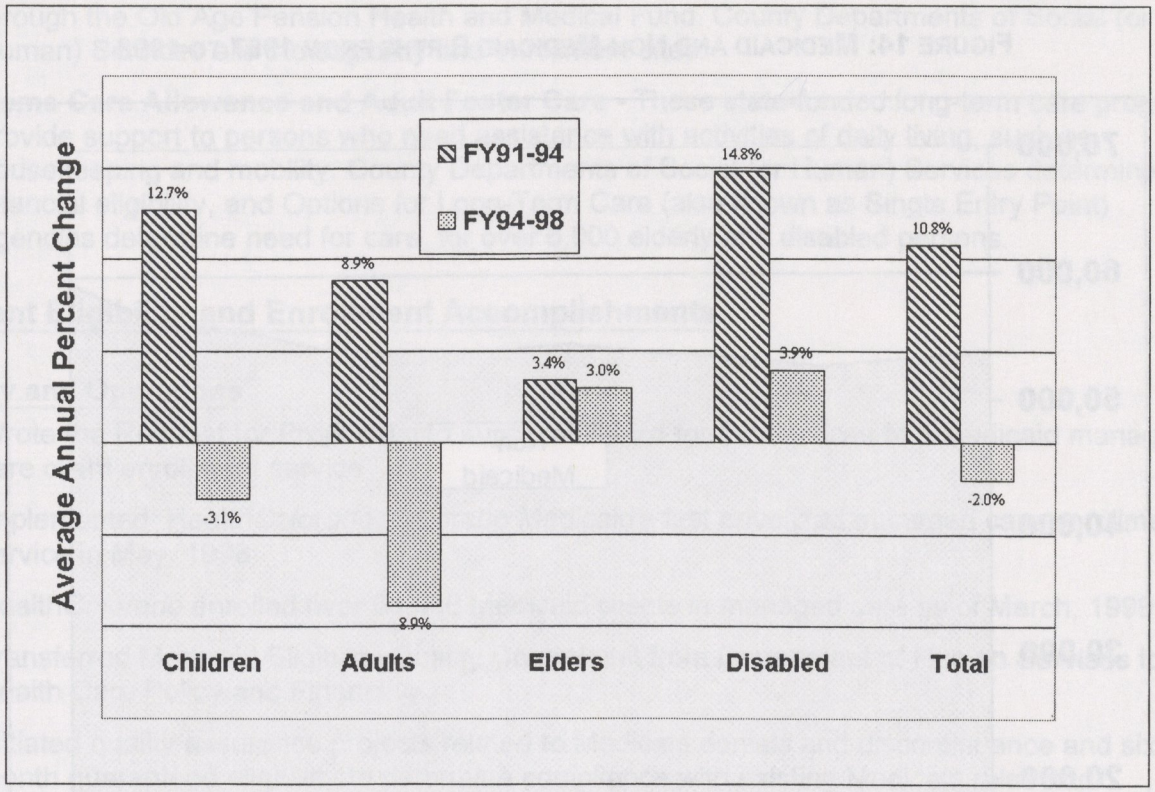
The state's economy and federal, state and local policies and mandates influence client enrollments in the department's medical assistance programs. Because program eligibility is based in part upon client household income, enrollment levels are generally counter-cyclical to growth or recession in the 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 in numbers of disabled persons require assistance.

FIGURE 12: MEDICAID ENROLLMENT, FY 86-87 THROUGH 96-98



Welfare Reform (TANF/Colorado Works) initiatives and children's health care coverage expansions may continue to cause significant changes in Medicaid enrollments in FY 98-99 and subsequent years, but the nature and extent of these effects are unknown at the Reference Manual publication date. The following figure shows the change in Medicaid enrollment growth during FYs 91-94 compared to FYs 94-98. Although there are large variances by eligibility group, overall enrollment decline in recent years eroded the increase of the early 90's.

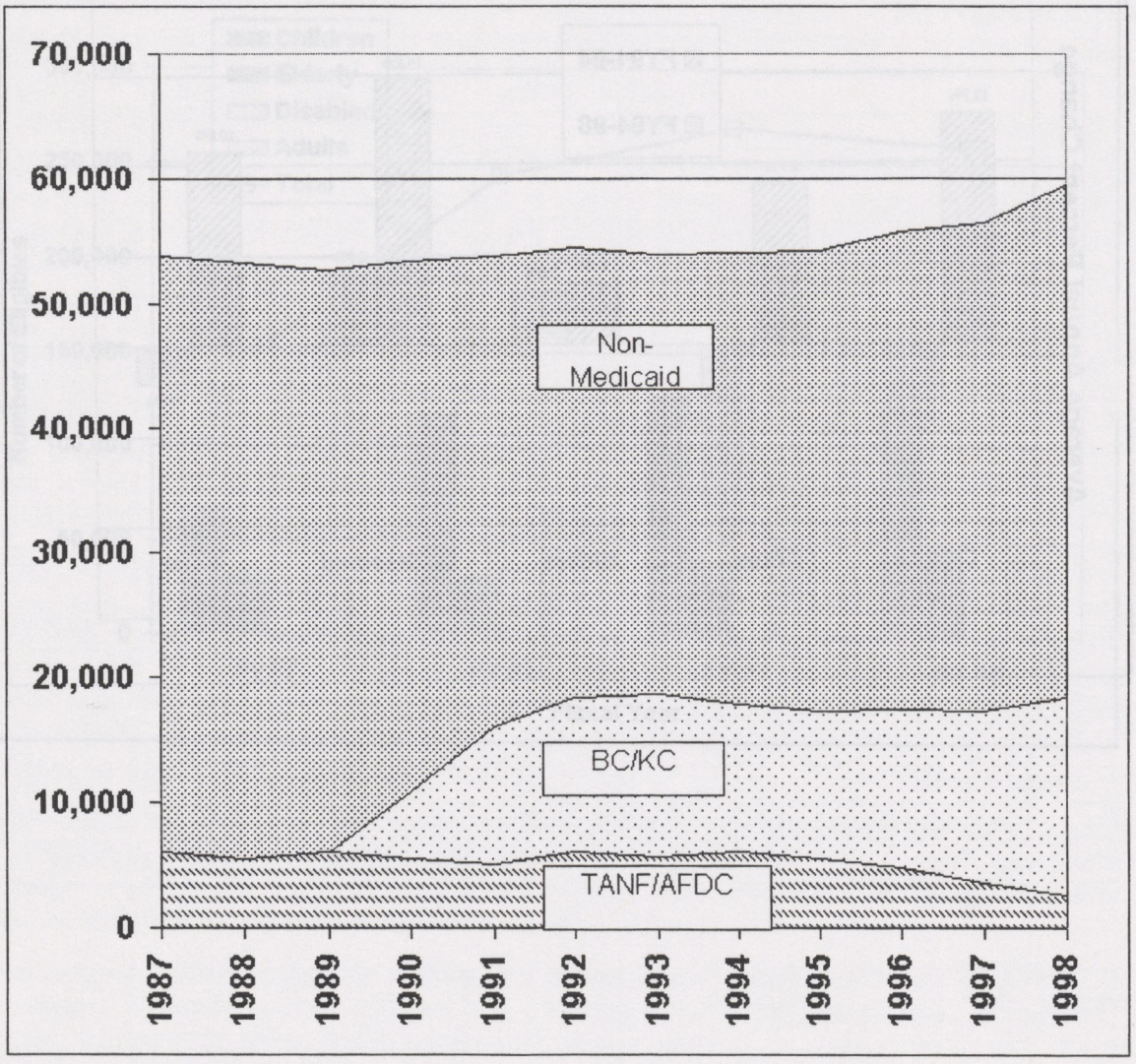
FIGURE 13: MEDICAID ENROLLMENT CHANGE, FYS 91-94 COMPARED TO FYS 94-98



Medicaid-covered Births

Medicaid-covered births have remained in the range of 17,000 -20,000 (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 up to 133% of the federal poverty level. Although enrollment continues to decline in both the AFDC-Adult and Baby Care-Kids Care (BK-KC) categories, the figures below show that the percentage of births to mothers covered by Medicaid has not significantly declined, and that the number of Medicaid-covered births continues to rise, as does the State's overall number of births.

FIGURE 14: MEDICAID AND NON-MEDICAID BIRTHS FROM 1987 TO 1998



* AFDC is the Medicaid eligibility category now called TANF; see Appendix 2, "Acronyms"

Data Source: Colorado Department of Public Health and Environment

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 $520 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 (also known as Single Entry Point) agencies determine need for care, for over 6,000 elderly and disabled persons.

Recent Eligibility and Enrollment Accomplishments

Policy and Operations

- Wrote the Request for Proposal and successfully bid for the services of a Medicaid managed care client enrollment service
- Implemented Health*Colorado*, Colorado Medicaid's first privatized managed care enrollment service in May, 1998
- Health*Colorado* enrolled over 68,856 Medicaid clients in managed care as of March, 1999
- Transferred Medicaid Eligibility Quality Control unit from Department of Human Services to Health Care Policy and Financing
- Initiated quality assurance projects related to Medicaid denials and discontinuance and six-month guaranteed eligibility to determine compliance with existing Medicaid rules and procedures
- Provided technical support for the development of the new MMIS, with interfaces to COIN and the enrollment broker Maxstar system
- Provided staff to assure that Medicaid eligibility rules in CBMS reflect most current policy and procedures
- Coordinated development, distribution and training for the joint Medicaid/Children's Health Plan application

Medicaid Elegibility and Enrollment Training

- Provided over 30 statewide training sessions on the Health*Colorado* enrollment process to county technicians, Medicaid providers and client advocates
- Provided training for counties on managed care plans
- Provided statewide training to over 400 county technicians on 1931 Eligibility and minimal verification

- Provided informational presentations on eligibility and managed care enrollment at various conferences
- Participated in coordinated training of over twenty CHP sites on Medicaid eligibility
- Provided training to new and existing presumptive eligibility sites statewide.

Publications

- Revised and updated the Colorado Medicaid brochure to include managed care and enrollment broker information
- Developed, in collaboration with Health*Colorado,* client brochures on Medicaid managed care and enrollment outreach letters specific to a Medicaid client's category of aid for use in the enrollment notification process
- Created Medicaid home and community based services waiver programs comparison chart
- Prepared rules and agency letters related to federal changes in Medicaid eligibility policy.

Operations

- Managed the Children's Home and Community Based Services Program for 200 clients
- Received approval for an additional 230 slots for the Children's Home and Community Based Services Program in November of 1998 and filled all new slots by May, 1999
- Developed and produced monthly management reports on eligibility data and managed care enrollment for county costs related to the de-linking of cash assistance and Medicaid
- In coordination with the Department of Human Services, administered the teen pregnancy prevention program and the Special Connections program for pregnant teens with substance abuse issues
- Responded to eligibility questions from clients, counties and providers for all categories of eligibility

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 CLIENTS.

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 clients 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.

Medicaid Benefits

Colorado Medicaid clients are covered for a comprehensive package of health care services. The Medicaid program reimburses enrolled providers for medically necessary, covered 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 Early and Periodic Screening, Diagnosis and Treatment of developmental problems (EPSDT), 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 (Customer Service) or from local eligibility sites.

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 37% of Medicaid enrollment but account for 74% of total expenditures.

FIGURE 15: MEDICAID SERVICE EXPENDITURES BY ELIGIBILITY CATEGORY

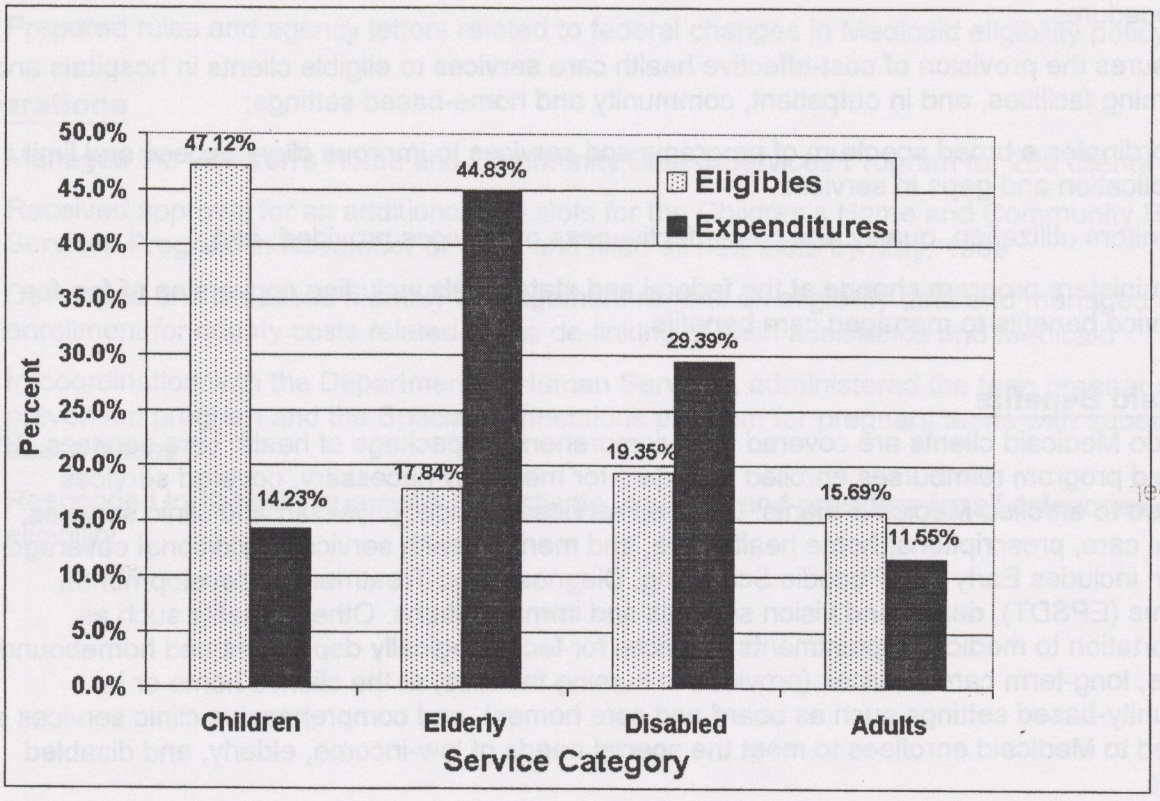


FIGURE 16: DISTRIBUTION OF MEDICAID EXPENDITURES BY SERVICE AND ELIGIBILITY, FY 97-98

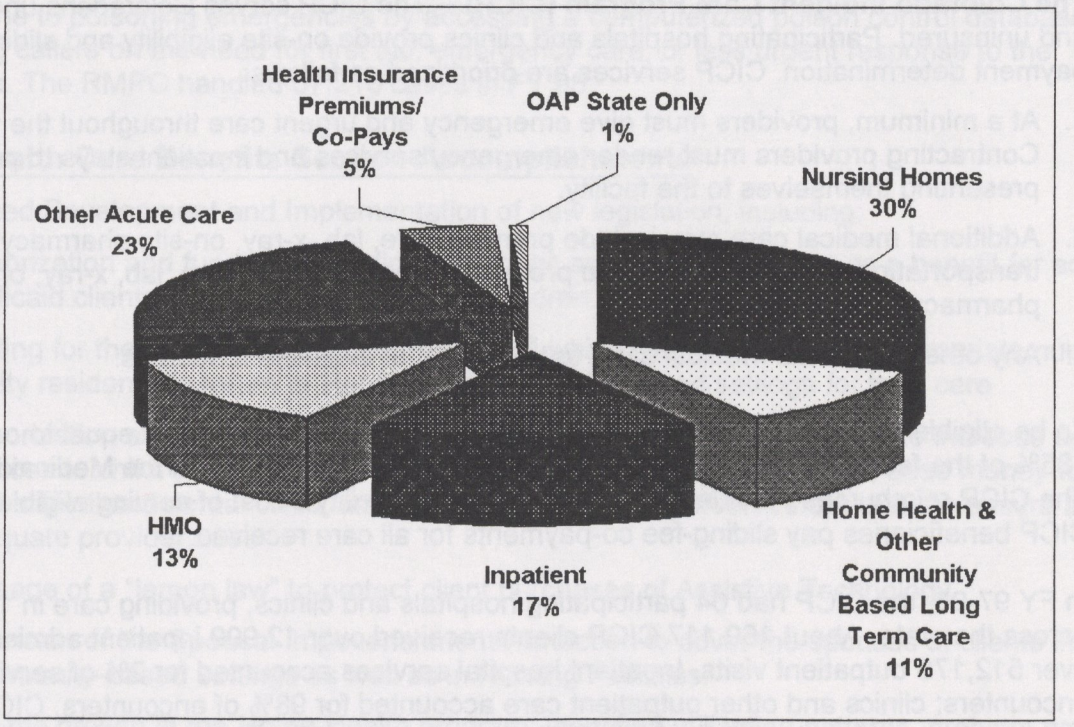
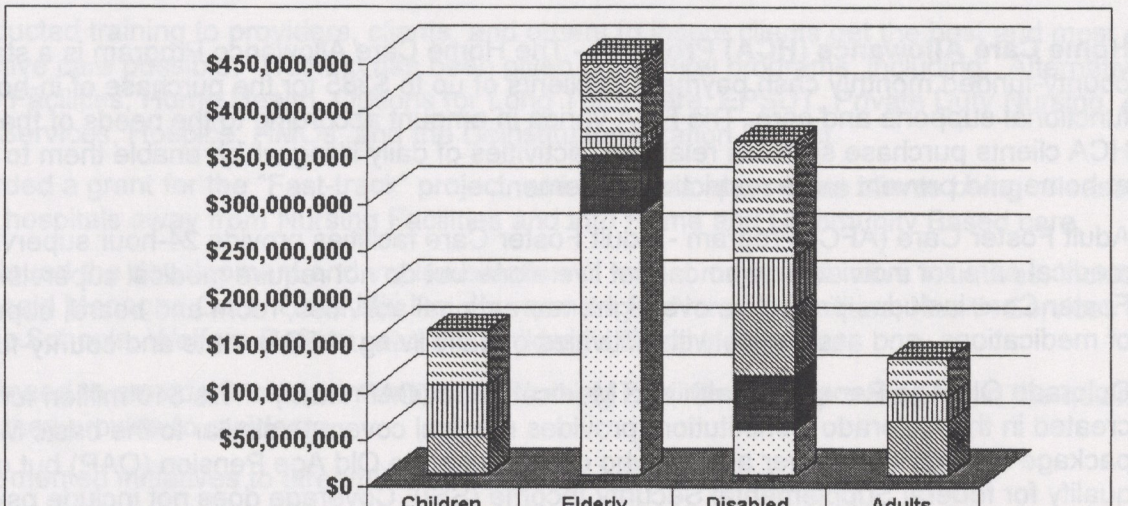


FIGURE 17: MEDICAID SERVICE EXPENDITURES BY ELIGIBILITY TYPE, FY 97-98



	Children	Elderly	Disabled	Adults
OAP State Only	0	8603759	0	0
Health Insurance Premiums	16510	35109441	15420037	77339
Other Acute Care	57041019	43640882	108057814	39939977
HMO	53802883	10913487	53246546	27176980
Inpatient	40901099	8065473	72109452	57636682
Home Health & Other LTC	2392014	62310467	58386075	233921
Nursing Homes	8251	279237606	48614400	61597

Non-Medicaid Programs

- **The Colorado Indigent Care Program (CICP)** -- The CICP serves Coloradans under-insured and uninsured. 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 and inpatient stays to persons presenting themselves to the facility.
  2. Additional medical care may include 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 97-98, the CICP had 64 participating hospitals and clinics, providing care in 114 facilities across the state. About 160,117 CICP clients received over 12,999 inpatient admissions and over 512,176 outpatient visits. Inpatient hospital services accounted for 2% of service encounters; clinics and other outpatient care accounted for 98% of encounters. CICP providers received approximately $35.8 million in CICP payments, plus about $15 million in CICP-related Disproportionate Share Hospital payments. These payments reimbursed about 30% of providers' costs. The CICP utilization and reimbursement figures for FY 97-98 has reported in the CICP Annual Report, released in February 1999.

- **Home Care Allowance (HCA) Program** - The Home Care Allowance Program 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) Program - 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 57,210 cases in FY 98.

Recent Health Care Benefits Section Accomplishments

- Supported Development and Implementation of new legislation, including:
  - authorization and funding for adding Prosthetic and Orthotic devices as a benefit for adult Medicaid clients (previously available for children only)
  - funding for the "deinstitutionalization project," which identifies and aids appropriate nursing facility residents to return to Home and Community Based settings for their care
  - authorization and funding for phase one of the Colorado Dental Initiative to increase dental services to children. Phase one includes client and provider education, seed money to help fund a Medicaid dental clinic, and increasing provider reimbursement rates to ensure an adequate provider base
  - passage of a "lemon law" to protect client purchases of Assistive Technology
  - Extension of the Spousal Impoverishment Protection to cover the spouses of clients in Community-based settings as well as in Nursing Facilities.
- Studied the growth in the Home Health program: identified utilization patterns, problem areas, and made recommendations for controlling unwarranted growth.
- Changed the method by which "Option for Long Term Care" Agencies are reimbursed to be more performance-based.
- Conducted training to providers, clients, and others to insure clients get the best and most cost-effective care possible. Training has been given on several programs, including: Alternative Care Facilities, Home Health, Options for Long Term Care, EPSDT, Private Duty Nursing, Adult Day Services, Hospice, HMOs, and the Deinstitutionalization Project.
- Awarded a grant for the "Fast-track" project, which diverts appropriate clients being released from hospitals away from Nursing Facilities and into Home and Community Based care.
- Continued the development and implementation of recent major legislative initiatives, including Medicaid Managed Care, Case Mix Reimbursement for Nursing Facilities, Health Services in Public Schools, Welfare Reform, and the Children's Basic Health Plan.
- Continued to provide financial incentives to Nursing Facilities for improvements in the quality of care they provide to residents.
- Implemented initiatives to streamline and improve efficiency included:
  - simplify the LTC Single Entry Point (SEP) monitoring and review processes by shifting from prior authorization to post pay review in the Home Health Program
  - clarify the utilization review process in the Private Duty Nursing Program
  - reestablish a Policy/Benefit Committee to update policies for new Medicaid benefits
- Health Care Benefits Section staff 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)
- improving coordination of services to children

- Provided Legislative Reports on Home Health, Dental, the Deinstitutionalization Project, HCBS-EBD Personal Care and Homemaker services, and the Prosthetics and Orthotics benefit.

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.

Managed Care Contracting Division Functions

The Division of Managed Care Contracting (MCCD) 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.
- Offers 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.
- Offers Guaranteed Eligibility whereby the client continues to receive health care services for up to six months even if Medicaid eligibility is terminated. In order to qualify for the GE project, a client must:
  - Be newly Medicaid eligible – been determined eligible after May 1, 1998;
  - Enroll in one of the Medicaid HMOs within 90 days of becoming Medicaid eligible. This means the client must select an HMO within the first 45 days of eligibility;
  - Remain in the selected HMO until the end of the 6-month period. If the client disenrolls from the HMO at any time he/she will no longer be eligible for the Guaranteed Eligibility Program.

  The client's medical and health care services will be provided by the HMO in which he/she is enrolled. Clients are notified by letter from the HMO that he or she will continue as their member, but will no longer be eligible for Medicaid services. The notice from the HMO lists the health care services that are still available. GE clients are not entitled to any Medicaid Program benefits such as mental health services, long term care, wrap-around benefits or the private duty nursing program.
- Uses risk-adjusted capitated rates - The department utilizes diagnosis-based risk-adjusted rates for HMOs. Diagnosis-based risk adjustment enables the department to pay contracted managed care organizations more if they have a higher than average number of members with

chronic conditions; plans that enroll a lower than average number of such members are paid less.

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.

Colorado Medicaid uses two types of managed care programs:

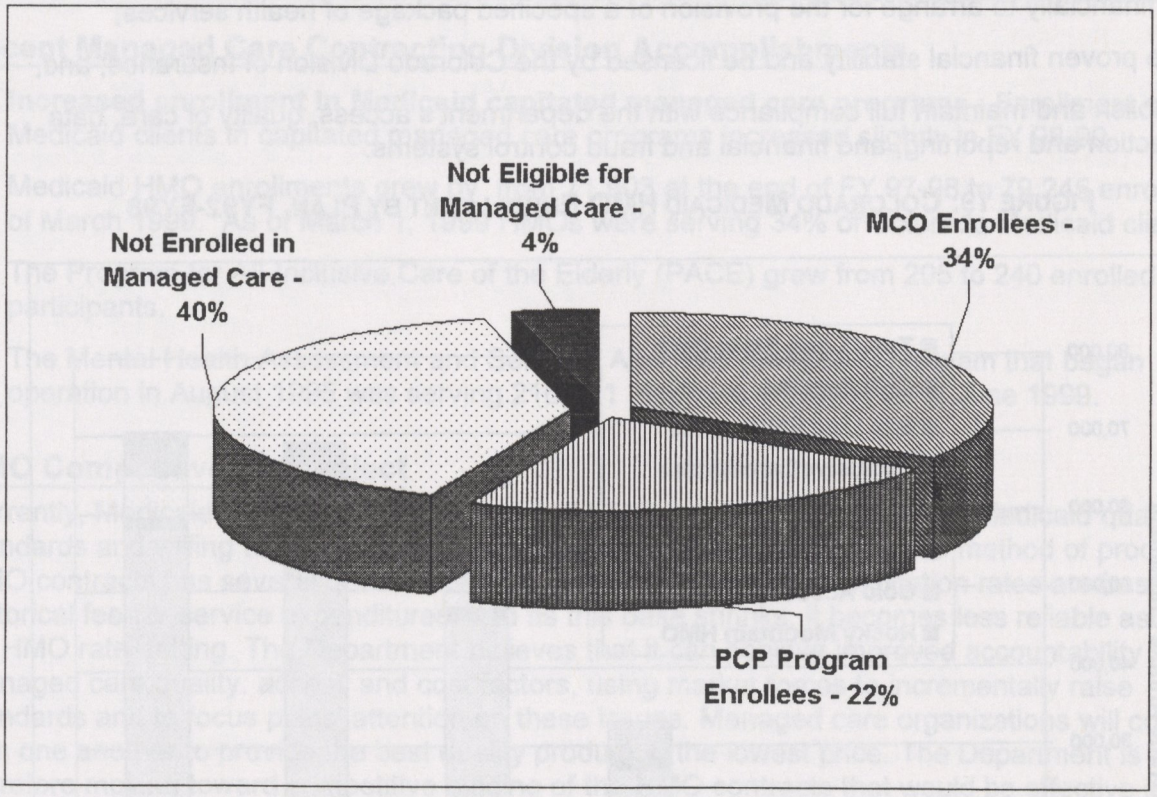
- ***Non-capitated "gatekeeper" programs -*** Medicaid pays a provider or case manager to coordinate and manage clients' health care needs, and Medicaid continues to pay fees to providers for each service delivered ("fee-for-service"). "Gatekeeper" managed care programs are:
  - ***The Primary Care Physician (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.
  - ***Capitated HMOs:*** Medicaid clients may select a fully-capitated health plan (managed care organization or health maintenance organization). 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, pre-paid monthly fee (premium) from Medicaid for each Medicaid client enrolled in the plan.
  - ***Mental Health Assessment and Services Agencies (MHASAs):*** MHASAs are responsible for provision of 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. As of June 1998, the Mental Health Capitation program became operational 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 Care and Financing Project (ICFP):*** This pilot program managed by the Office of Program Development integrates acute and long-term care, Medicare and

Medicaid services and financing for individuals with disabilities and/or chronic conditions. The ICFP project will demonstrate improved health care coordination and reduced cost-shifting among providers and payers. Improved health care outcomes are expected to result. HCPF (Office of Program Development), Mesa County Department of Social Services, Rocky Mountain HMO, HCFA and the Robert Wood Johnson Foundation will implement the project in Mesa County.

Managed Care Enrollment

Figure 18 shows the percentage of Medicaid clients enrolled in each type of managed care (as of December 31, 1998), and the percentage not enrolled in managed care. Figures 19 and 20 show the history of Colorado Medicaid HMO enrollments, by HMO (and other Managed Care Organization - MCO) enrollment levels at the end of FY 97-98, with the date each plan began enrolling Medicaid clients.

FIGURE 18: MEDICAID MANAGED CARE ENROLLMENTS, AS OF 12/31/98



Notes:

1. MHASA clients may be enrolled in any of these Managed care categories.
2. MCO = Managed Care Organization; usually, an HMO
3. Not Eligible for Managed Care = Foster Care children and clients residing in institutions
4. Source: Medicaid Division of Managed Care Contracting, 5/99

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 HMO 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 19: COLORADO MEDICAID HMO ENROLLMENT BY PLAN, FY92-FY98

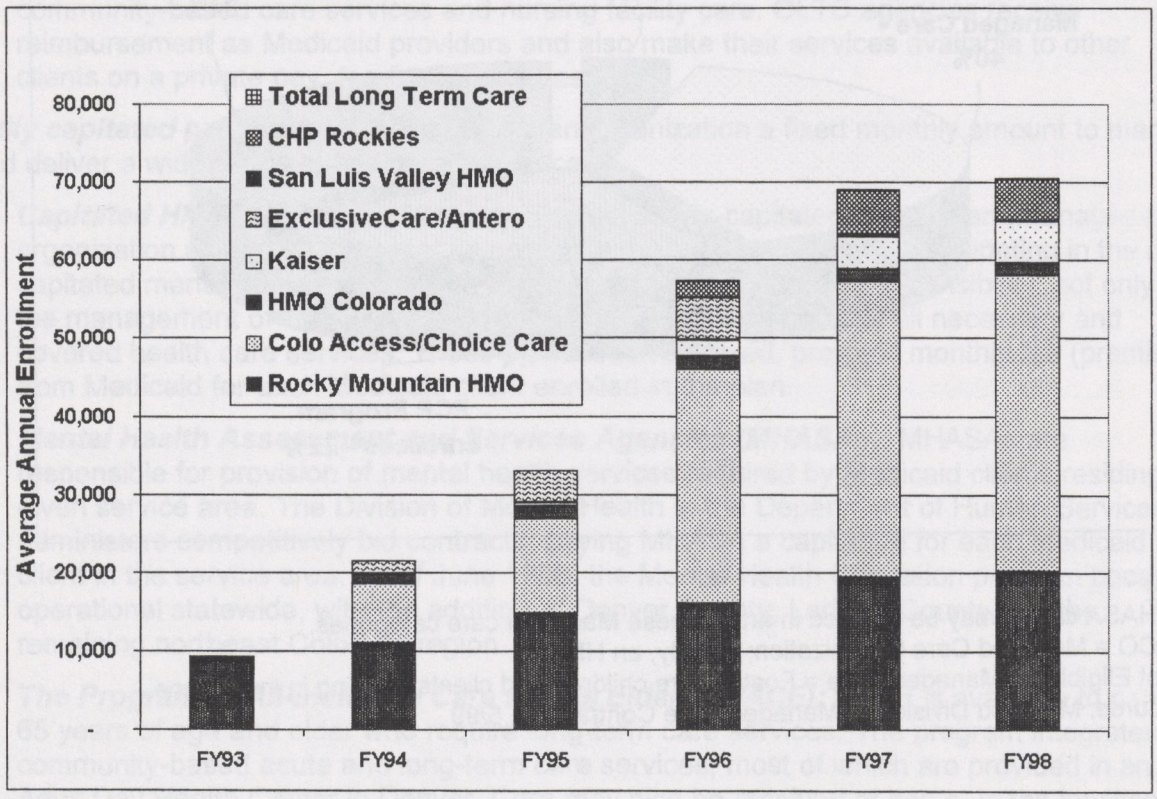


FIGURE 20: MEDICAID MANAGED CARE - ENROLLMENT AS OF MARCH 99

Health Plan	Medicaid Contract Start Date	Clients Enrolled As of March 1999
Colorado Access	December 1995	38,665
Community Health Plan of the Rockies	July 1995	11,791
Kaiser Foundation Health Plan	July 1994	3,548
Rocky Mountain HMO	January 1994	19,584
Total Long-term Care (PACE)	October 1991	240
United HealthCare	April 1997	2,518
Subtotal: Medicaid HMOs		**79,245**
Primary Care Physician Program	FY 80-81	49,907
TOTAL MEDICAID MANAGED CARE		**129,152**
Unassigned to Managed Care		121,432

Recent Managed Care Contracting Division Accomplishments

- **Increased enrollment in Medicaid capitated managed care programs** - Enrollment of Medicaid clients in capitated managed care programs increased slightly in FY 98-99.
- Medicaid HMO enrollments grew by from 71,903 at the end of FY 97-98 to 79,245 enrollees as of March 1999. As of March 1, 1999 HMOs were serving 34% of Colorado Medicaid clients.
- The Program for All-Inclusive Care of the Elderly (PACE) grew from 205 to 240 enrolled participants.
- The Mental Health Assessment and Services Agencies (MHASAs) program that began operation in August 1995 was serving 216,351 Medicaid enrollees as of June 1999.

HMO Competitive Bid Project

Currently, Medicaid contracts with any licensed HMO that is able to meet the Medicaid quality standards and willing to accept the Medicaid capitation rates. However, this method of procuring HMO contracts has several drawbacks. One is that Medicaid HMO capitation rates are based on historical fee-for-service expenditures, and as this base shrinks, it becomes less reliable as a basis for HMO rate-setting. The Department believes that it can achieve improved accountability for managed care quality, access and cost factors, using market forces to incrementally raise standards and to focus plans' attention on these issues. Managed care organizations will compete with one another to provide the best quality product at the lowest price. The Department is therefore moving toward competitive bidding of the HMO contracts that would be effective in the year 2001.

SB 97-05 authorized the Department of Health Care Policy and Financing to institute competitive bidding by Managed Care Organizations (MCOs) for Medicaid contracts. MCOs will compete with each other to provide the best quality of care at the lowest cost. Only the winning bidders will contract with the department. The objectives of the project are to:

- Optimize health care savings through managed care enrollment
- Improve access to appropriate health care
- Improve quality of health care delivered
- Set HMO rates through open competitive bidding

Completed Items and Deliverables

July – August 1998

- Mercer, Inc. of Phoenix, Arizona, was contracted as the HMO Bid Project consultant in June 1998. Mercer completed interviews with stakeholders including health plans, advocacy groups, Medicaid clients, Medicaid providers, legislators, DHCPF personnel, Medical Services Board members, Office of State Planning and Budget and the Joint Budget Committee.

October - December 1998

- Mercer issued a report to the department summarizing the recommendations of interviewees. The HMO Competitive Bid Project Team analyzed the report and made recommendations to the Department in December, 1999.

January - April 1999

- Stakeholder consultations and further Team and consultant work on the HMO Competitive Bid model were conducted in late Winter 1999.
- Consultant contract extensions were accomplished in March 1999, for delivery of development of procurement instruments and procedures in Spring 1999.
- Implementation timeframes were under discussion at May, 1999. Considerations for timing the competitive procurement of HMOs include HMO market volatility, and the development and implementation of a new claims processing system, quality assurance, encounter data, and risk adjustment systems, procurement model and methods.

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.

Functions

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.

Goals

- To develop a long range, coordinated, comprehensive quality monitoring and utilization review system for Medicaid.
- To transition from traditional quality and utilization review activities to a proactive, outcome-based process.
- To pilot a program that identifies, prioritizes, and addresses gaps in quality of care monitoring of medical assistance services.

Recent Accomplishments

- Designed quality monitoring tool to be used for all Managed Care Organizations
- Completed nursing facility audits on schedule
- Designed and completed consumer satisfaction surveys
- Successfully monitored external contracts
- Contracted with External Quality Review Organization (EQRO) for Focus Studies to improve quality of care
- Program Integrity Unit expanded reviews to address medical necessity issues
- Collected and Prepared Health Plan Employer Data and Information Set (HEDIS) Data for HMOs and fee-for-service
- Monitored Prior Authorization Reviews (PARs) for Durable Medical Equipment (DME), transportation and Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
- Developed a complaint and grievance procedure for the clients in HMOs
- 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 Utilization Review and Surveillance (SURS) unit recovered over $620,000 in inappropriate Medicaid payments in FY 97-98.

- A 100% federally-funded grant for $213,334 was awarded to the Quality Assurance Section to study risk-adjustment and reimbursement loopholes in Medicaid.
- In FY 96-97, the measurable savings attributable to the Peer Review Organization (PRO) review of inpatient utilization was more than $4.5 million. 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.

Quality Assurance Projects

HMO Quality Assurance Results

Figure 21 represents several measures from the Health Plan Employer Data and Information Set (HEDIS®[3]) published by the National Committee for Quality Assurance (NCQA). NCQA assisted the Department in analyzing data from five department-contracted Health Maintenance Organizations (HMOs) providing services to Colorado's Medicaid clients. Colorado Medicaid HMOs differed in the extent to which they produced HEDIS® 3.0 results suitable for public reporting. They also differed in the extent to which those publicly reported measures suited for interplan comparison fell above or below the results reported by the other Medicaid HMOs to a statistically significant degree. The table summarizes each HMO's reported results on those audited HEDIS® 3.0 measures required by the Department which are suitable for interplan comparison. It indicates whether the results were statistically above or below the results submitted by the other plans.

FIGURE 21: RESULTS OF SURVEY ON HMO QUALITY OF SERVICE

Summary 1998 HEDIS® Results from Colorado Medicaid HMOs for 1997 Dates of Service HEDIS is a registered trademarked product of by the National Committee for Quality Assurance	**Colorado Access**	**Community Health Plan of the Rockies**	**HMO Colorado**	**Kaiser Foundation Health Plan**	**Rocky Mountain HMO**
Effectiveness of Care					
Childhood Immunization	↔	↔	DNC	NA	↑
Cervical Cancer Screening	↓	↓	↑	↑	↓
Check Ups after Delivery	↔	↔	↓	↑	↑
Access/Availability of Care					
Adults' Access to Preventive/Ambulatory Care					
20-44 years	↓	↓	↔	↑	↔
45-64 years	↓	↔	NA	NA	↑
Children's Access to Primary Care Physicians					
12-24 months	↓	↔	↔	↔	↑
25 months to 6 years	↓	↔	↔	↑	↑
7-11 years	↓	↓	↔	↑	↑
Initiation of Prenatal Care	↓	↓	↓	↑	↑
Use of Services					
Well child visits in the 3rd, 4th, 5th, and 6th years	↔	↔	↔	↔	↔
Adolescent Well Care Visits	↔	↔	↔	↔	↑

KEY
↑ = significantly above other results
↓ = significantly below other results
↔ = not significantly different from other results
NA = not publicly reported

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

Medicaid Consumer Satisfaction Survey

Figure 22 represents first year data from the Consumer Assessment of Health Plans Study (CAHPS) performed by the Department. The survey was administered by Healthcare Research Systems, Ltd., and CAHPS was developed by Agency for Health Care Policy and Research through cooperative agreements with Harvard University, RAND, and Research Triangle Institute.

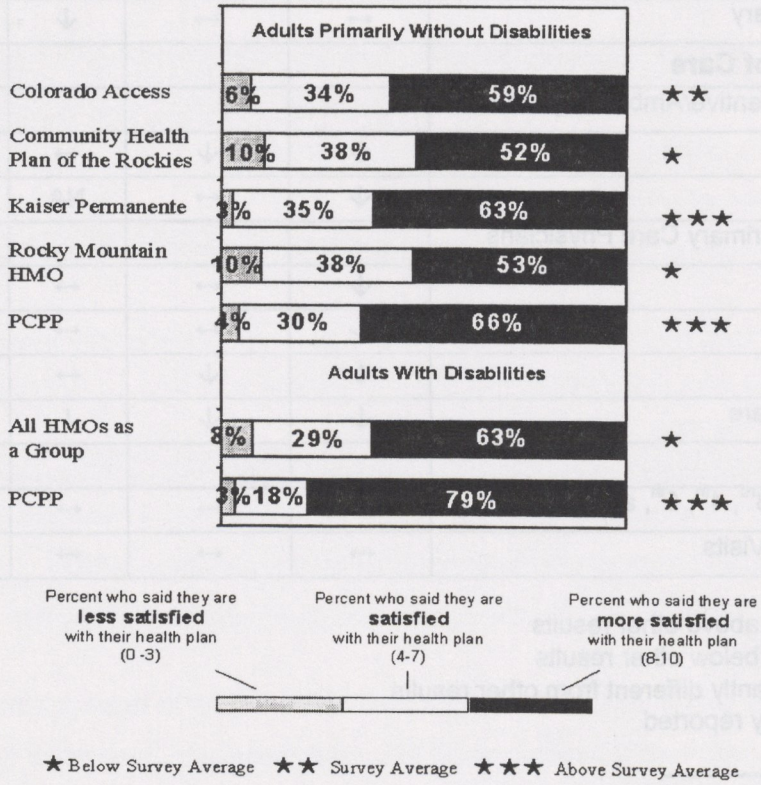
Two surveys were conducted: one of adults primarily without disabilities and one of adults with disabilities. The adults primarily without disabilities are comprised largely of low-income Medicaid clients with dependents and the results are available at the HMO, Primary Care Physician Program (PCPP), and unassigned fee-for-service level. The adults with disabilities include low-income Medicaid clients with a specific disability or disabilities, and these results are available by all HMOs combined and the PCPP, since there were not enough population in each HMO to measure at that level. Surveys were distributed in English and, upon request, Spanish, to clients in seven front range counties: Arapahoe, Boulder, Denver, Douglas, El Paso, Jefferson, and Pueblo. The front range counties were targeted due to the prevalence of managed care organizations in these areas.

The following graphic displays the results for one of the questions asked of Medicaid clients in 1998. The full report card can be found on the internet at http://www.chcpf.state.co.us/mcc/consumer.html.

FIGURE 22: HEALTH PLAN CLIENT SATISFACTION SURVEY RESULTS

Overall Satisfaction with Health Plan

The graph below depicts the ratings for the question "How would you rate your health insurance plan now?" This item was rated on a scale from zero to ten, where zero is the worst health insurance plan possible and ten is the best health insurance plan possible.



Future Trends and Challenges

- New MMIS tools including Executive Information System/Decision Support System, Services, Tracking, Analysis and Reporting System, and Surveillance Utilization Review Subsystem
- Transfer Prior Authorization Reviews for transportation, Durable Medical Equipment, and Early Periodic Screening Diagnosis and Treatment to contractors
- Continue to customize Program Integrity Unit activities to address current health care issues
- Comprehensive reviews will be conducted annually to monitor HMOs with follow-up review to assure HMO addresses required actions
- More closely monitor Home Health, to decrease inappropriate utilization
- Use HEDIS calculations and satisfaction surveys for quality improvement activities
- Review of all HMO contracts and activities
- Use encounter data from MCOs for quality of care analyses
- Integrate a program for addressing fraud and abuse in Medicaid managed care into the post-payment review system

Future Goals

- Utilize focused study data from External Quality Review Organization to evaluate and monitor quality improvement plans with Managed Care Organizations
- Continue to conduct a comparable, valid client satisfaction survey for clients of Managed Care Organizations, Fee for Service, and Primary Care Physician programs
- Monitor and enforce Memorandum of Understanding language for Department of Human Services to review the Mental Health Assessment and Services Agencies
- Expand and continue to audit nursing facilities annually
- Monitor external contracts for department data requests and reports
- Monitor and improve quality of care in programs
- Work closely with related survey teams in the state to report and limit fraud and abuse
- Implement Balanced Budget Ammendment regulations for quality assurance

THE PROVIDER RATES AND FACILITY RATES 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.

Rate-Setting Objectives, Functions and Principles

In setting reimbursement or capitation rates the department will:

- 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.

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.

Provider Rates Section Functions

- setting ambulatory care and outpatient provider rates;
- administering the drug rebate program;
- administering Disproportionate Share Hospital (DSH) and Graduate Medical Education (GME) programs;
- setting HMO rates, risk adjustment factors and performing financial review of HMOs;
- administering the finances of the Single Entry Point Program;
- administering the Pharmacy Program, including Prior Authorization Requests (PAR) for pharmacy benefits; and,
- administering the School Based Refinancing Program which allows providers who serve Medicaid clients in the school setting, to bill for those services.

Facility Rate Section Functions

- 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, governing federal and state law, customs, and the health care delivery environment. Provider payment rates are either cost-based or non-cost-based.

- **Cost-based rates**. 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 reimbursement 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, 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). With the repeal of the Boren amendment, the department will be evaluating its reimbursement of hospitals and nursing facilities and may pursue changes in its methodology.
- **Non-cost-based rates.** 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).

Medicaid Reimbursement Changes in 1998

Recent changes in federal and state legislation have had a major impact on the determination of Medicaid reimbursement for several classes of providers. To support its growing reliance on HMOs, the department is refining how it determines HMO rates.

The Balanced Budget Reconciliation Act of 1997

- The federal Balanced Budget Reconciliation Act of 1997(H.R.97-2015) repealed the Boren amendment, changed requirements for paying Federally Qualified Health Centers and established a cap on Disproportionate Share Hospital (DSH) payments.
  - 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 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."
- Disproportionate Share Hospital (DSH) payments to hospitals that serve a high proportion of low-income, uninsured and Medicaid clients are capped. For federal fiscal year (FFY) 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 (CPI) 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.
- 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.

SB 97-42

- SB 97-42 directed the department to implement reimbursement system changes and to conduct a case mix rate methodology study for nursing facilities.
  - New Nursing Facility Rate Ceilings - The new law set 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 Study - The department researched the potential for basing nursing facility rates on case mix, and provided a case mix report and recommendations to the General Assembly in November 1997. An advisory board was convened to review and comment upon case mix proposals. 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.

Methodologies

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 most recent 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 23: REIMBURSEMENT METHODS FOR SELECTED SERVICES

Service Type	Type of Reimbursement	Federal or State Mandate
Outpatient Hospital	Cost-based (72% of audited costs)	State
Physicians and other Practitioners	Non-cost-based, set by department within limits set by the Legislature (RVU -related)[4]	State
Outpatient Federally-Qualified Health Clinics	Cost-based (100%)	Federal and State
Community-Based Services	Both Cost-Based and Non-Cost-Based (depends on type of service)	State
Inpatient Hospital	Cost-based	Federal - Boren* Amendment (* repealed effective 10/1/97)
Nursing Facility	Cost-based (100%)	Federal - Boren* and State - State legislative requirements are more prescriptive than Boren.
DME, Lab and X-Ray Services	Non-cost-based, set by department within limits set by the Legislature	State
Prescription Drugs	Non-cost-based, set by department within limits set by the Legislature and federal policy	Federal and State
Colorado Indigent Care Program	Non-cost-based, set by department within limits set by the Legislature	State

Risk Adjusted Rates for Health Maintenance Organizations Adjustment

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 an actuarially equivalent population. Per capita fee-for-service expenditures by geographic region and eligibility category 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.

A risk adjustment factor is calculated to compensate for the fact that an HMO's Medicaid members may, on average, be sicker or healthier than the average fee-for-service client. This procedure, implemented in FY98, assigns weights to various demographic and diagnostic conditions. Rates for HMOs that have a sicker population are adjusted upward, those with a healthier population are adjusted downward. This procedure redistributes about 2 percent of the HMO premium.

Outpatient Hospital Services

Outpatient hospital services are reimbursed at the lower of 72% of cost or charges.[5] 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.

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

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

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.

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.

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.

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 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.

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 (192 facilities)
- Classes 2 and 4: intermediate care facilities for the mentally retarded (3 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 $4.09 million in quality incentive payments to nursing facilities in FY 98-99. The Resident Quality of Care Incentive Payment Program (ResQUIP) is described further in the Health Care Benefits section.

As directed by SB 97-042, the department is implementing a case mix payment system for Nursing Facilities. Expected to be operational beginning in July, 1999, the system does have many useful, although new, features. Here is a brief description of the rationale and features of Colorado's case mix system.

Case mix reimbursement is a method of paying for nursing home care which takes into account the fact that some residents are more costly to care for than others. About 25 states have implemented various forms of case mix reimbursement since West Virginia implemented the first system in 1975. Implementation of the case mix reimbursement system requires:

- An assessment form to collect information about residents' conditions;
- A way to classify residents into groups which are similar in costs; and
- A weighting system that can quantify the relative costliness of caring for different classes of residents.

The MDS 3.0 assessment form (currently used by almost all Colorado nursing homes) will be used to gather information about resident characteristics, including dependencies in activities of daily living (ADLs); need for particular skilled nursing services, such as tube feeding or clinical monitoring; and various challenging behaviors, such as "wandering." Information from the assessment form is used to classify residents into groups which are indicative of residents' need for nursing time. For example, in the RUGs III (Resource Utilization Groups) method, patients are classified into 1 of 44 different categories, based on clinical and behavioral characteristics and need for assistance with ADLs. These categories were developed from research on thousands of nursing home residents, including a study of the amount of nursing time provided to these

residents. Using this same established methodology, Colorado is also completing studies for specific times for Colorado nursing home residents.

A series of weights that indicate the relative cost associated with different resident classifications have been developed by measuring the time needed to care for different groups and factoring in the cost of nursing wages. Several states, including Colorado have or will modify the "national" weights to include important state specific data. Resident case mix weights are then used to calculate reimbursement rates and/or payment limits. Only part of the reimbursement rate (mainly the patient-care component) is linked to resident case mix. Other components of the rate (such as reimbursement for indirect costs) are not casemix adjusted.

National studies of nursing home costs have consistently found that resident case mix affects average costs. Facilities with higher case mix (e.g., more severely disabled patients) are commonly found to have higher costs, compared to other facilities. Therefore, reimbursement systems which account for case mix are more likely to result in more appropriate limits than those which do not. All other things equal, case mix systems like the one planned for Colorado:

- are less likely to penalize facilities for higher costs due to heavier care residents;
- improve access to care by mitigating disincentives for facilities to admit heavy-care residents;
- promote provider and payer equity: providers should not be penalized for caring for heavier care residents, and private payers should not have to disproportionately subsidize the care of these residents;
- better target public funds appropriately; and,
- promote quality of care by allowing facilities that serve heavier care residents to spend more thereby mitigating access problems for heavier care residents.

Finally and importantly, the case mix system has usefulness in other areas regarding resident care in addition to its usefulness for rate-setting, - case mix information can also be used for care planning, quality assurance monitoring, and a variety of other clinical and administrative functions.

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.

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.

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 $2.055 million to the program in FY 98, 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 98, 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. Figure 24 shows total disproportionate share payments (state and federal shares) made to inpatient hospital providers from FY 93 to FY 98.

FIGURE 24: DSH CAPS FOR FEDERAL FINANCIAL PARTICIPATION - FEDERAL FISCAL YEARS 98-02

In millions of dollars								
FY 91-92	FY 92-93	FY 93-94	FY 94-95	FY 95-96	FY 96-97	FY 97-98	FY 98-99	GRAND TOTAL
$122.7	$358.0	$290.4	$178.0	$105.1	$121.7	$148.4**	$138.8*	$1,463.3

* Includes Certified Public Expenditures.

Recent Rate Setting Accomplishments

- Implemented provisions of Senate Bill 42, which produced $15 million in savings to Medicaid by capping the growth of nursing facility rates.

- Nursing facility caseload dropped by 1.03 percent. This is an indication of successful diversion of residents to home and community based care settings.
- Participated in the design and testing of functions in the new MMIS affecting nursing facility and hospital rates and reimbursement.
- Implemented provisions of Senate Bill 97-5, which required the department to make direct payments to hospitals for graduate medical education costs and disproportionate share payments for Medicaid managed care clients. A system was established to calculate and process these payments on a quarterly basis.
- Electronic claims for the CICP program were successfully submitted to MMIS.
- Poison Control Board conducted three statewide consumer satisfaction surveys of services received from the Rocky Mt. Poison Control Center. Results showed consumers were very satisfied with the services provided.

Upcoming challenges

- Identify, develop, and evaluate possible scenarios for reimbursing hospitals and nursing facilities in light of the recent repeal of the Boren Amendment.
- Address economic challenges facing providers. These issues must be addressed to ensure the delivery of Medicaid services in nursing facilities and hospitals.
- Recalibrate Prospective Payment (also known as Diagnostic Related Groups or DRG) methodology's formulaic relative weights to ensure hospital reimbursement remains fair, equitable, and consistent with the cost of services.
- Respond to appeals and litigation on provider rates.
- Transition of the CICP electronic claims process to the department's new fiscal agent.

INFORMATION SYSTEMS SECTION

THE MISSION OF THE INFORMATION SYSTEM SECTION IS TO ENSURE ACCESS TO MEDICAL SERVICES BY ASSURING: TIMELY AND ACCURATE REIMBURSEMENT TO MEDICAID PROVIDERS; ACCESS TO TIMELY AND ACCURATE MEDICAID ELIGIBILITY DATA BY MEDICAID PROVIDERS; AND, REIMBURSEMENT COMPLIANCE WITH ALL ASPECTS OF STATE AND FEDERAL REGULATIONS GOVERNING THE ADMINISTRATION OF MEDICAID DOLLARS.

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. It also is responsible for eligibility extract information from the Department of Human Services eligibility systems and the 25 interfaces with other information systems that the department maintains.

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 90 percent federal funding for MMIS enhancement efforts; 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 Consultec, Inc. that includes operation and enhancement 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.

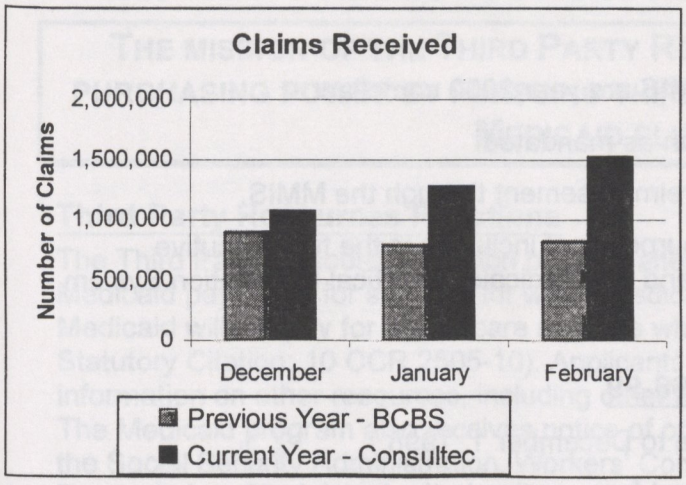
Recent Achievements

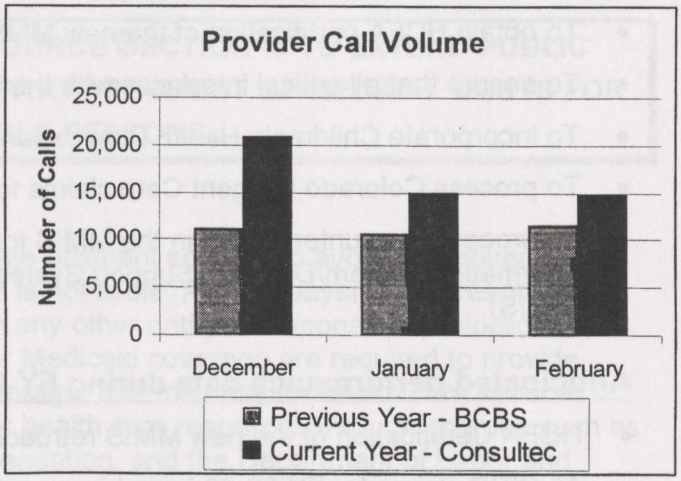
The Information Systems section's largest effort in the past year was to implement a new Medicaid Management Information System (MMIS). This system is the information backbone of the Colorado Medicaid program. The ability to process and pay claims to the service providers is necessary in order to deliver health care to clients. The MMIS processes between 11 and 12 million health care claims per year and disburses the entire Medicaid health care reimbursement budget of approximately $1.4 billion including the Department of Human Services. Additionally the system will process other low-income health care programs administered by the state such as the Colorado Indigent Care Program and the Children's Health Plan Plus.

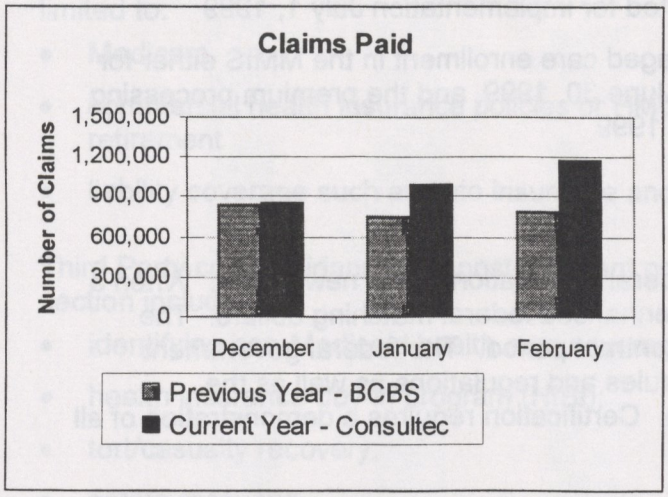
The new MMIS became operational on December 1, 1998. The contract was awarded to Consultec, Inc. replacing Blue Cross Blue Shield, the vendor for the previous 12 years. This has been a successful transition and interruption of payments to Medicaid providers has been minimal. There have been some early difficulties that Department staff and the fiscal agent staff worked quickly to resolve.

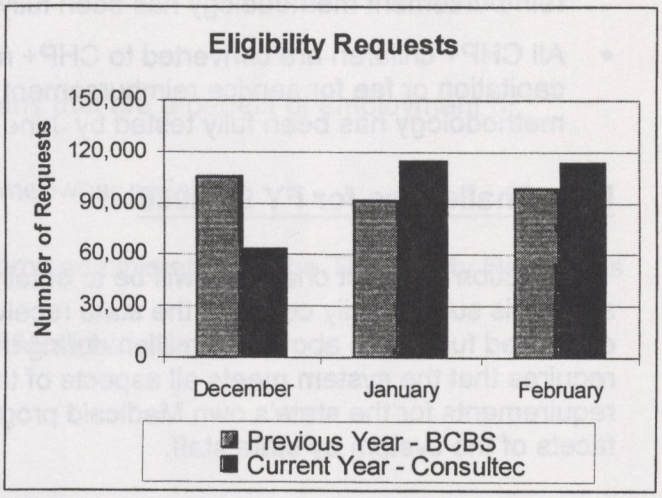
At the time of this writing the state has statistics comparing December of 1998 and January and February of 1999 claims processing under the new system to statistics of the previous year, using the old MMIS. The statistics are represented on the following charts.

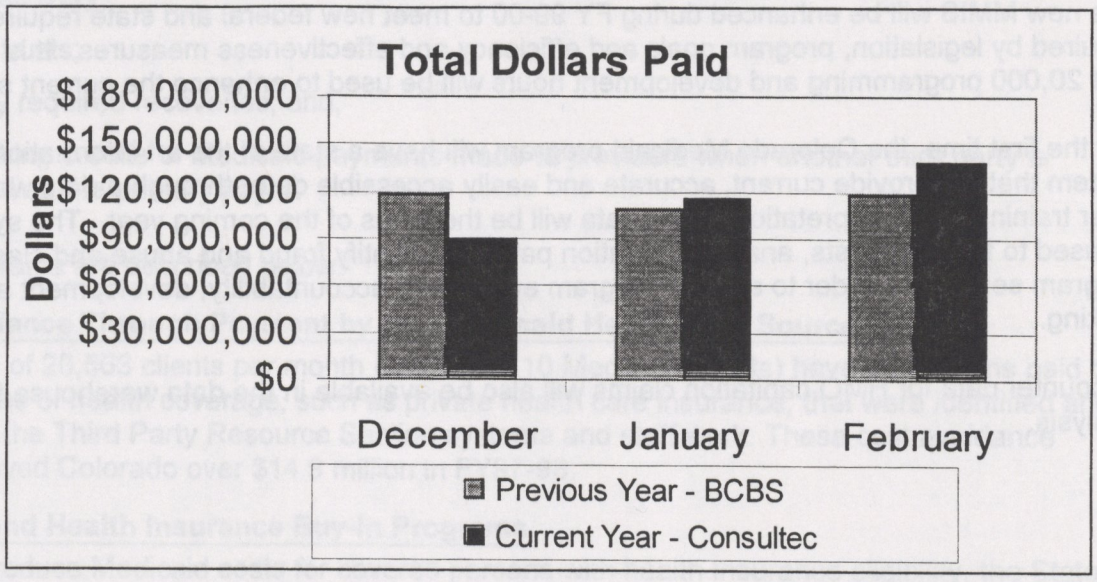
FIGURE 25: MMIS PERFORMANCE COMPARISON











BCBS - Blue Cross and Blue Shield of Colorado Consultec - Consultec, Inc.

Fiscal Year 1998-99 identified goals

- To obtain HCFA certification of the new MMIS.
- To ensure that all critical interfaces with the MMIS are year 2000 compliant.
- To incorporate Children's Health Plan expansion as mandated.
- To process Colorado Indigent Care claims for reimbursement through the MMIS.
- To process encounter claims in the MMIS for purposes of inclusion in the full Executive Information System/Decision Support System and the Medicaid Statistical Information System (MSIS).

Anticipated performance data during FY 1998-99

- HCFA Certification of the new MMIS retroactive to December 1, 1998
- All CICP claims for FY 98-99 have been captured for reporting to the legislature; and a reimbursement methodology has been fully tested for implementation July 1, 1999
- All CHP+ children are converted to CHP+ managed care enrollment in the MMIS either for capitation or fee for service reimbursement by June 30, 1999, and the premium processing methodology has been fully tested by June 30, 1999

New Challenges for FY 99-2000

This section's largest challenge will be to obtain federal certification of the new MMIS. When a system is successfully certified, the state receives enhanced federal matching dollars. The enhanced funding is about $10 million during this contract period. The federal government requires that the system meets all aspects of their rules and regulations as well as the requirements for the state's own Medicaid program. Certification requires a demonstration of all facets of the system by state staff.

The new MMIS will be enhanced during FY 99-00 to meet new federal and state requirements as required by legislation, program goals and efficiency and effectiveness measures. It is anticipated that 20,000 programming and development hours will be used to enhance the current system.

For the first time, the Colorado Medicaid program will have a state of the art information retrieval system that will provide current, accurate and easily accessible data, through a data warehouse. User training and interpretation of this data will be the focus of the coming year. The system will be used to forecast costs, analyze utilization patterns, identify fraud and abuse and classify program services in order to support program evaluation, accountability, development and decision making.

Encounter data for HMO capitation claims will also be available in the data warehouse for user analysis.

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.

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 when 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;
- estate recovery;
- income trusts;
- 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.

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 $14.9 million in FY97-98.

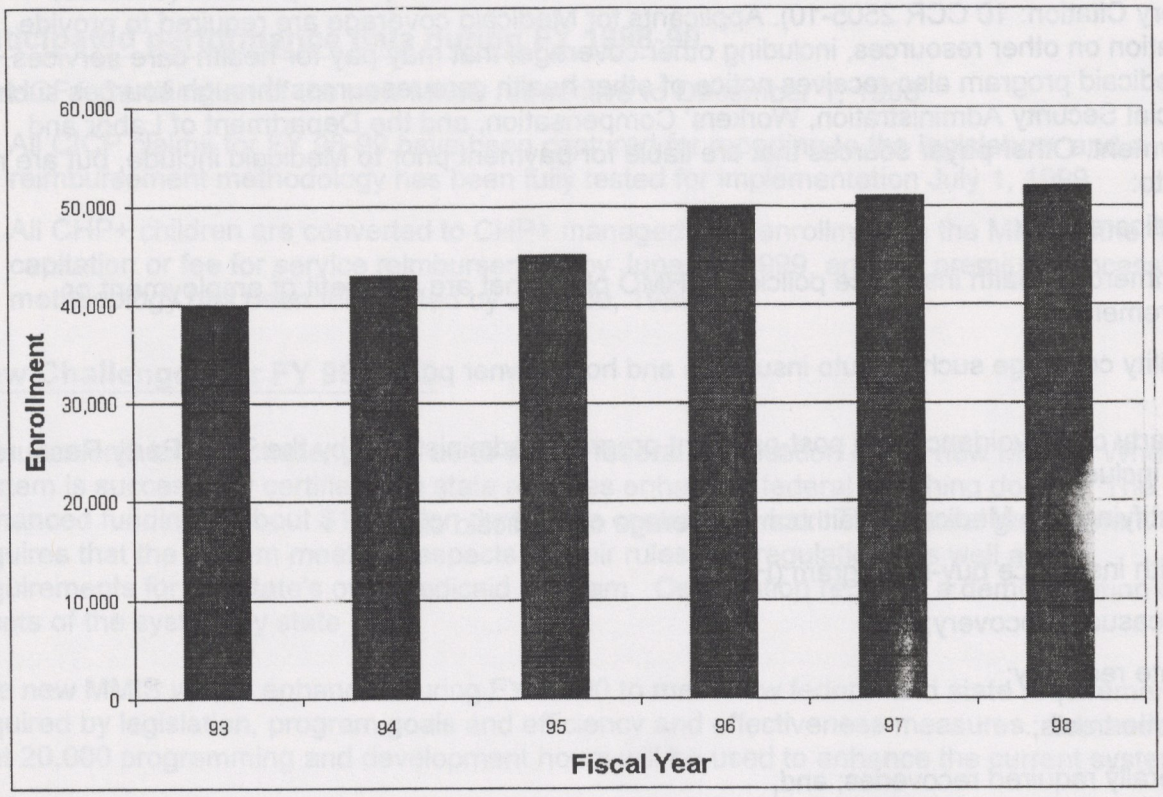
Medicare and Health Insurance Buy-In Programs

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 98, approximately 52,000 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 97. Nearly $30 million in Medicare premiums were paid on behalf of clients, saving the State over $100 million in Medicaid costs.

In FY 98, $257,704 in private health insurance buy-in premiums were paid for Medicaid clients, and $400,163 in health care costs were paid under the purchased coverage that would otherwise have been a Medicaid program liability. In addition, $79,820 was recovered from Medicare after Medicaid had paid but Medicare was found to be the primary insurer.

FIGURE 26: MEDICARE AND HIBI ENROLLMENTS FYS 93 THROUGH 98



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 97-98, total recoveries were $2.2 million. The figure below shows tort/casualty recoveries in fiscal years 95 through 98.

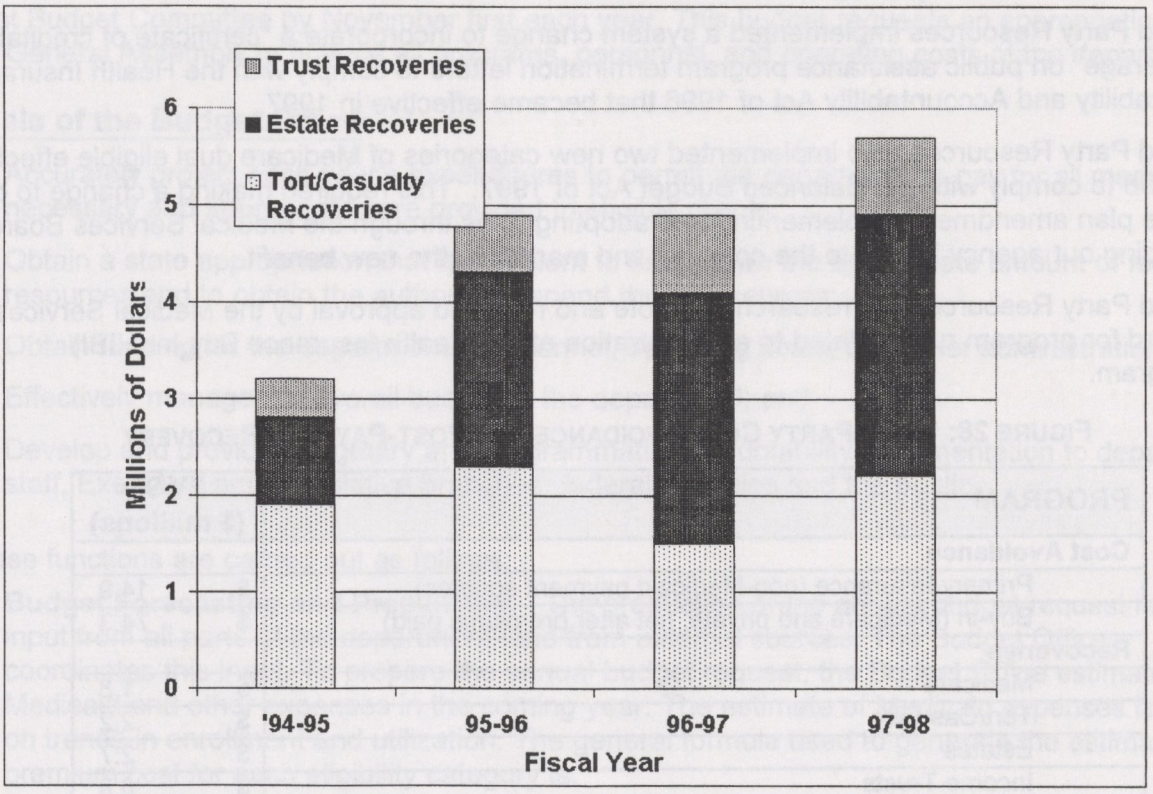
Estate Recovery

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 FY 98 (the fourth full year of operations) were $2,727,744, up 6.5% from FY 97.

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, $780,075 was recovered in FY 98 - a slight increase over FY 97. 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 27: TORT/CASUALTY, ESTATE AND TRUST RECOVERIES



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 $1.45 million, down from $1.8 million in FY 97.

Third Party Resources Section FY 97 Accomplishments

- Costs Avoided - Third Party Resources operated and expanded efforts to avoid paying for health related costs where another insurance should be liable for the costs over $8.9 million for state dollars were not spent because of these efforts.
- Recoveries - Efforts to increase recoveries have resulted in nearly $9 million being re-paid to the State for health care services.

- Third Party Resources operated and expanded resource recover programs that recovered $98,195,606 in FY97-98. Figure 28 shows that cost-avoidance activities saved the State $89,165,410 in FY 97-98. Recoveries and credits yielded $9,030,396.
- Third Party Resources successfully undertook a large project to recover Medicaid dollars from Medicare for health claims incurred from 1995 through the end of 1997. This recovery, in partnership with our Medicaid Fiscal agent resulted in a recovery of $1,787,325 through the end of FY 97-98.
- The Estate Recovery program was re-bid through the competitive bid process. As a result of this process, the contingency fee for the estate recover program was lowered from 16% to 13.5% of total recoveries. It is expected that this lowered contingency fee will result in savings to Medicaid of approximately $70,000 per fiscal year.
- Third Party Resources implemented a system change to incorporate a "certificate of creditable coverage" on public assistance program termination letters to comply with the Health Insurance Portability and Accountability Act of 1996 that became effective in 1997.
- Third Party Resources also implemented two new categories of Medicare dual eligible effective 1/1/98 to comply with the Balanced Budget Act of 1997. This required making a change to our state plan amendment, implementing and adopting rules through the Medical Services Board, sending out agency letters to the counties and marketing the new benefit.
- Third Party Resource staff researched, wrote and received approval by the Medical Services Board for program rules related to administration of the Health Insurance Buy In (HIBI) program.

FIGURE 28: THIRD PARTY COST AVOIDANCE AND POST-PAYMENT RECOVERY

PROGRAM	FY 98 ($ millions)
Cost Avoidance	
Primary Insurance (non-Medicaid payment sources)	$ 14.9
Buy-in (Medicare and private; net after premiums paid)	$ 74.3
Recoveries	
Medicare	$ 1.8
Tort/Casualty	$ 2.2
Estates	$ 2.7
Income Trusts	$ 0.8
Recoupment by Fiscal Agent	$ .1
Credits	$ 1.4
TOTAL AVOIDED AND RECOVERED COSTS	**$ 98.2**

BUDGET OFFICE

THE MISSION OF THE BUDGET OFFICE IS TO PROJECT, SECURE AND MANAGE SUFFICIENT RESOURCES TO ACHIEVE DEPARTMENT GOALS.

Functions of the Budget Office

The Budget Office is a single unit composed of six staff and is responsible for projecting, constructing, defending, monitoring and managing the budget for the department. The department projects caseloads and expenditures from available data. The budget request is submitted 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.

Goals of the Budget Office

- 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, operating costs, and other administration;
- Effectively manage the overall budget 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 premium cost for each eligibility category is:

  (cost/eligible + trend + policy) x (eligible + trend + policy) = Medicaid premiums

  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 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 the preparation and does primary projections of HCPF fiscal notes.

Management of the Operational Budget - The Budget Office manages the department's operational budget. The Office maintains data and reports on personal services, operating and other administrative expenses, grants and program expenditures and initiates actions appropriate to assure compliance of appropriation levels.

Departmental Planning, Reporting and Analysis - The Budget Office coordinates the department planning process particularly as it relates to budget requests preparation, and prepares weekly and monthly reports on budget and program status.

Recent Budget Office Accomplishments

- Published a detailed budget database on the Department's Local Area Network (LAN), with narrative and spreadsheet information including:
- Medicaid expenditures
- Caseload per capita costs by eligibility category and service category
- Lag factors from date service is rendered to date claim is paid, etc.
- Actual data from FY 68-69 to FY 97-98 plus projections for request years.
- Together with Program staff, established the linkage between HMO rates and budget and verified the relationship.
- Prepared extensive analysis 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, accurate and complete budget and supplemental requests.
- Prepared, reviewed and verified fiscal notes to proposed legislation.
- Developed and implemented improved reporting and management of administrative budget.
- Budgeted for and assisted in transacting disproportionate share hospital payments that yielded a net General Fund gain to the State.

Fiscal Year 1998-99 Challenges

- The Budget Office continues to work to improve accuracy in projections of enrollment and expenditures.
- The budget forecasting function has become even more critical with the federal and State changes in the Medicaid program and the addition of Title XXI.
- As the new MMIS becomes operational and passes federally required Systems Performance Review, new budget mechanisms will be identified and used for the budget cycle.

OFFICE OF ACCOUNTING AND PURCHASING

THE MISSION OF THE ACCOUNTING AND PURCHASING DIVISION IS TO ADMINISTER AND PROTECT THE ASSETS OF, PROCURE GOODS AND SERVICES FOR, AND PROVIDE PERSONNEL SERVICES TO THE EMPLOYEES OF THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING.

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 (MMIS) 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.

Staff

The Office of Accounting and Purchasing is one formal unit of 11 people in total. Informally, the office has the procurement section, the personnel section, the financial reporting section and an administrative section.

Fiscal Year 1997-98 Identified Goals

- To continue to improve working relationships among department organizational units by improving the fiscal and procurement information being disseminated.
- To improve effectiveness and efficiency within the Office of Accounting and Purchasing by automating reports.
- To improve collection process for the department's past due accounts receivable accounts.

Fiscal Year 1997-98 Identified Accomplishments

- **Automation:** The Office purchased a new SQL server, which has been configured by OIT to download the general ledger weekly from COFRS. This allows the Office to develop an in-house query and reporting capability that reduces our dependence on costly extracts and provides a powerful tool to accomplish ad-hoc reporting.
- **Cost Allocation:** In conjunction with the Budget Office, Accounting and Purchasing designed and wrote a Cost Allocation Plan for the department. The department continues working with HCFA to obtain Plan approval.
- **Medicaid Accounts Receivable**: Many outstanding issues on the Medicaid Accounts Receivable reconciliation were resolved during FY 97-98. 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. This allowed the department to convert to the new MMIS with a clean record of provider receivables.
- **Extended Purchasing System:** The Office of Accounting and Purchasing developed a presentation about the Purchasing process. This presentation with related handout will be given to all employees at each section's all-staff meeting on an annual basis. After all sections have been offered this training, an additional training session will be held to reach new personnel or any employees who missed their section's presentation. In addition to the annual training/refresher, a folder on the HCPF LAN has been dedicated to Purchasing and Contracting documents and information to keep all department employees informed of current requirements.
- **Personnel Functions:** The department signed an Interagency Agreement with General Support Services (GSS) to continue performing personnel functions. The Accounting Office prepares all personnel forms and transaction documents, posts positions, and provides orientation for all new department employees. The Accounting Office continues to enter leave information into the KRONOS leave tracking system and produces quarterly and annual reports for all department employees.

- **ECO Pass Program:** The department continues its contract with RTD for the ECO Pass program for employees. The Accounting Office performs all duties associated with the Program. The department has a 68% participation rate, one of the highest of all participating State agencies.

Fiscal Year 1998-99 Anticipated Challenges

- Provider Agreements: The Office of Accounting and Purchasing will be working with the department's program staff and the State Controller's Office and the Attorney General's Office to revise and improve the departments medical services provider agreements. Both the agreements themselves and the process around them will be evaluated and revised. This includes both the Medicaid program and the Children's Basic Health Plan.
- Children's Basic Health Plan: As this program grows, the Office of Accounting and Purchasing will have to absorb the additional workload within its current resource structure. This requires the office to not only ensure that all duties are properly allocated but to also ensure that the office operates as efficiently as possible.
- Cost Allocation Plan: The Office of Accounting and Purchasing is working closely with the federal government to obtain approval on its cost allocation plan. Once this plan is approved for fiscal year's 96-97 and prior, it must immediately be revised to reflect the impact of the Children's Basic Health Plan in fiscal years 97-98 and into the future.
- Medicaid Management information System: The Office of Accounting and Purchasing is dealing with the issues that have arisen due to the implementation of the new MMIS system on December 1, 1999. All payments to medical providers flow to the state's accounting system and the office is charged with the responsibility to make sure these payments are made, are made in the proper form and to attempt to resolve any payment problems. In addition, the office must ensure that any amounts due to the state form a provider are properly identified, recorded and ultimately collected.

Fiscal Year 1998-99 Identified Goals

- **Contracts:** It is the goal of the Office of Accounting and Purchasing to complete a comprehensive review of the department's contract process during FY98-99 and FY99-00. This review will include the process with the Office of Accounting and Purchasing as well as how contracts are processed in the departments programmatic areas. Improvements will be implemented as the review is conducted.
- **Personnel/Payroll**: Beginning on July 1, 1999, the Department of Personnel will no longer provide personnel and payroll services to our department. It is the goal of the Office of Accounting and Purchasing to work with the department's Executive Director's Office and Budget Office to have identified and implemented a solution prior to July 1, 1999.
- **Cost Allocation Plan**: It is the goal of the Office of Accounting and Purchasing to have an approved federal cost allocation plan for all fiscal years prior to FY97-98. Then that plan must be amended because of the advent of the Children's Basic Health Plan for FY97-98 and beyond.
- **School Based Medicaid Program**: It is the goal of the Office of Accounting and Purchasing to have effective and efficient internal procedures for the School Based Medicaid program designed and implemented. These procedures must be designed to ensure that school districts are appropriately reimbursed and that the state collects the cost of administration.

- **Customer Service:** It is the goal of the Office of Accounting and Purchasing to continue to explore ways to not only maintain quality customer service, but to also enhance the quality of our customer service. This effort will be undertaken at both the individual staff person level and the Office wide level. It is our goal to be recognized as a quality customer service provider to both our customers within the department and those that are external to the department.
- **Accounts Receivable:** It is the goal of the Office of Accounting and Purchasing to have a firm and detailed understanding of provider accounts receivable balances. With the new tolls provided to us in the new Medicaid Management Information System and the Office's SQL server, we will be able to gain a level of understanding and research problems at a level that was not possible before.
- **Fiscal Year Open and Close:** It is the goal of the Office of Accounting and Purchasing to improve the department's fiscal year open and close process. These improvements will be obtained by improving the written instructions for the process, but also by providing training to department staff that participate in the process.
- **Automation:** The Office of Accounting and Purchasing will continue to pursue automation of its functions. Office Staff will take advantage of computer software training and the computer tools it has to enable them to produce ad hoc reports and to do research from the downloaded COFRS files. Staff will continue to pursue the copying of files to CD-ROM to save storage space and to facilitate access to information.

APPENDIX 1 - 1998 BILLS PASSED AND SIGNED BY THE GOVERNOR

Relating to the Colorado Department of Health Care Policy and Financing

Bill Number Sponsor(s) Date Signed	Topic and Summary
SB 079 Pascoe Lawrence 6/1/98	**Concerning Parity for Long Term Care Services In Medicaid.** This bill expands the definition of "Community Spouse" extending spousal protection of income and resources to Medicaid clients who are at risk of institutionalization. A "Community Spouse" now includes the spouse of a person: in an institution or nursing facility; in the PACE program; receiving Home and Community-Based Services; or in the Integrated Care and Financing Project. The bill has a "no appropriation" clause and the extended protection is to be implemented within existing appropriations or from moneys saved from deinstitutionalization of Medicaid clients. The bill was effective upon passage.
SB 104 Reeves Alexander, K. 3/24/98	**Concerning a Requirement That Managed Care Plans Provide Patients with Direct Access to the Services of a Certified Nurse Midwife.** This bill: requires managed care plans provide their patients with access to an advanced practice nurse who is a certified midwife; and for the Department of Regulatory Agencies to amend current regulations, policies and procedures.
SB 173 Rizzuto Owen 4/10/98	**Concerning the Exclusion of Direct Medicare Part B Costs from Allowable Medicaid Reimbursement to Certain Nursing Facilities.** This bill is an extension of SB97-42 and clarifies that Medicare Part B *direct* costs are excluded as allowable costs for computation of Medicaid reimbursement for services provided by Class I and V nursing homes.
HB 1015 Leyba Wham	**Continuation of DPH&E Regulation of Administration & Monitoring of Medications by Qualified Unlicensed Persons.** This bill continues the authority for the Department of Public Health and Environment to regulate the administration of medications by qualified unlicensed persons, including the addition of authority for such persons who are trained to fill and label medication reminder boxes, making the facility responsible for on-the-job training of unlicensed persons to fill medication reminder boxes.
HB 1019 Morrison Reeves 3/23/98	**Concerning the Terms of Mandatory Health Care Coverage Provisions for Newborn Children and Maternity.** This bill requires health insurers to provide mandatory coverage for newborn children and maternity for a 48-hour hospital stay following normal childbirth and a 96 hour hospital stay following a cesarean section delivery. If the 48th or 96th hour would be after 8 p.m., the patient shall remain in the hospital until 8 a.m. the following morning. The bill was amended in the House to exclude cases where the mother and provider agreed to a discharge prior to 48 or 96 hours.
HB 1092 Kreutz Coffman	**Creation of a Self-Sufficiency & Employment Program for Certain Public Assistance Recipients.** As amended, this bill: creates an employment and self-sufficiency pilot program for Old Age Pension (OAP) recipients; assures program participation is voluntary for counties and OAP clients; requires the department to establish a competitive bid process to select one urban and one rural county or group of rural counties to participate; establishes a system which will identify available opportunities for employment for OAP clients including referral and placement assistance.
HB 1131 Alexander, K. Bishop 4/10/98	**Concerning Self-Sufficiency for Persons With Disabilities by Assuring Reliable Facilitative Technology.** This bill provides rights and remedies to persons with disabilities who utilize any type of technology which facilitates or enhances their ability to be self-sufficient. The bill requires manufacturers of facilitative devices to furnish express warranties and lists conditions of the warranty or penalties for a manufacturer's failure to comply. It also lists remedies available to the consumer. This bill covers a wide variety of devices.

HB 1143 Spradley Arnold 3/27/98	**Concerning Eligibility Requirements for Children to be Enrolled in Health Care Plans.** This bill establishes guidelines for any unmarried, dependent children, who reside full time with the benefit recipient, to be enrolled in health care programs offered to employees by the Public Employees Retirement Association (PERA).
HB 1204 Entz Dennis 4/1/98	**Concerning the Administration of State Nursing Homes.** This bill was initiated by the Department as a result of an audit of this program performed by the State Auditor's Office. The bill is a complete repeal and re-enactment of all State and Veterans Nursing Home statutes. The bill streamlines current statutes and addresses recommendations of the audit report. Primary changes include: simplifies the statutes concerning admission and eligibility requirements; combines statutes of the facility at Homelake with other state veterans nursing homes; clarifies that Homelake no longer bears the costs of burial in its cemetery; requires regulations to be updated. Changes to address audit recommendations include: clarifies that the homes are an "enterprise," managed collectively as a group, and shall comply with TABOR calculations; clarifies the conditions for selecting future home sites; provides specific statutory authority for entering into contracts with the nursing homes; requires the inclusion of financial information in the annual report to the General Assembly for homes operated by an outside entity.
HB 1210 Tupa Wham 3/16/98	**Concerning the Infant Immunization Tracking System.** This bill modifies existing infant immunization tracking system by authorizing health departments to also gather immunization information from schools, parents or infants, children, students, managed care organizations, doctors, clinics, third party payers and persons who operate a "comprehensive immunization tracking system." The bill was amended in the House to include immunization records for children be provided as a condition of eligibility for TANF.
HB 1229 Chavez Wham 3/23/98	**Concerning Extending Home and Community Based Services for Mentally Ill.** This bill permits the continuation of Home and Community Based Services to Mentally Ill persons until July 1, 2002. The program was also extended through a federal waiver received by the Department of Human Services.
HB 1243 Lawrence Hopper 4/22/98	**Concerning Required Health Care Coverage for Medical Costs Associated with the Administration of General Anesthesia for Dental Procedures Performed on Dependent Children.** This bill would require all individual and group sickness and accident insurance policies, individual and group health care plans or indemnity contracts to provide general anesthesia when dependent children receive dental services in an outpatient hospital or other surgical facility. The bill would allow carriers to require prior authorization or restrict coverage.
HB 1309 Gotlieb Chlouber 4/17/98	**Concerning the Requirement of Health Insurers to Provide Coverage for the Treatment of Diabetes.** This bill requires any health benefit plan, except supplemental policies, to provide coverage for diabetes. Such coverage shall include equipment, supplies, and outpatient self-management training and education, including medical nutrition therapy. The benefits are subject to the same deductibles or co-payments established for all other covered benefits within a given policy.
HB 1325 Owen Rizzuto 4/21/98	**Concerning the Implementation of the Non-Medicaid Children's Basic Health Plan.** This bill, as sent to the Governor: increases age of eligibility in the program from 18 to 19; changes the implementation date to March 1, 1998 to allow the State to access federal moneys; creates a Children's Basic Health Plan Policy Board which is charged to oversee and report periodically on the progress of program implementation; allows the schedule of health care services to be approved by the policy board; clarifies the competitive bidding process whether a county has a single managed care plan or multiple managed care plans; replaces the $25 per child enrollment fee with a premium-based enrollment fee to be established by the Department of Health Care Policy and Financing; assures utilization of essential community providers, and that they receive equitable opportunities to serve this population; establishes an appeal process for essential community providers; mandates the Department of Health Care Policy and Financing give preference to managed care organizations which have executed contracts with one or more essential community providers.

HB 1360 Owen Rizzuto 4/6/98	**Concerning the Authorization of the Drug Assistance Component of the Federal "Ryan White C.A.R.E. Act of 1990."** This bill authorizes the Department of Public Health and Environment to implement and administer an AIDS drug assistance program that provides pharmaceutical products that are effective in treating persons infected with AIDS or HIV. The bill creates an advisory group to be convened by the Governor which shall advise and recommend pharmaceutical products to be listed on the drug formulary of the program.
HB 1391 Johnson, S. 5/18/98	**Concerning the Conditions Under Which a Health Care Coverage Entity May Modify Benefits Within an Existing Small Group or Individual Health Benefit Plan.** As passed, this bill permits small group and individual health plans to make reasonable modifications at the time of renewal of such policies. The Commissioner of Insurance would promulgate regulations as may be necessary.
HB 1394 Pankey Blickensderfer 5/27/98	**Concerning the Personal Identification of Persons Applying for State Benefits.** This bill: requires all applicants for public assistance and medical assistance over the age of 18 to supply a photographic identification (driver's license or State identification card) as a condition of eligibility; makes exceptions for unreasonable hardship, or if the requirement is in conflict with federal law; requires the Departments of Human Services and Health Care Policy and Financing to establish regulations that allow for recipients to receive emergency services until such time as they are able to supply photo identification; permits the Department of Revenue to waive the fee for an identification card for these persons.

Source: HCPF Office of Legislative Affairs - 6/98

APPENDIX 2 - ACRONYM LIST

300%ers--Persons whose income is up to three times the SSI payment limit. This optional eligibility category is eligible for Medicaid by virtue of need for long term care services.

A & A--Aid and Attendance (VA Benefit)

A/CSA--Alcohol/Controlled Substance Abuse

AAA--Area Agency on Aging

AABD--Aid to the Aged, Blind, and Disabled (Federal Term)

AARP--American Association of Retired Persons

AAS--Aging and Adult Services

AASD--Aging and Adult Services Division

AB--Aid to the Blind

AB-T--Aid to the Blind- Treatment

ACF--Alternative Care Facility

ACSES--Automated Child Support Enforcement System

Acute Care & EQRO--Adult Care & External Quality Review Organization

ADA--Americans with Disabilities Act

ADAD--Alcohol and Drug Abuse Division

ADC--Adult Day Care

ADL--Activities of Daily Living

ADP--Automated Data Processing

ADS--Adult Day Services

Adult Foster Care (AFC)--This is not a Medicaid program or service; however, many AFC eligible are also Medicaid eligible. This provides residential care with supervision for client medications, etc. While these services are not as extensive as those rendered in a nursing home, they do represent an important component of a "continuum" of long term care. It is funded through a 95% General Fund and a 5% local match.

AFDC-A--Aid to Families with Dependent Children-Adults

AFDC-C--Aid to Families with Dependent Children-Children

AFDC-FC--Aid to Families with Dependent Children-Foster Care

AFDC-I--Aid to Families with Dependent Children-Incapacitated Parent

AFDC-U--Aid to Families with Dependent Children-Unemployed Father

AG--Attorney General

AIDS--Acquired Immune Deficiency Syndrome

ALJ--Administrative Law Judge

Allowed Charge--The Amount Medicare Will Consider for Payment for a Given Service or Supply

AMPS --Automated Medicaid Payment System-Electronic Claims System

Ancillary Services--Those Service and Supplies Provided to Patients on an As-Needed Basis

AND-SSI--Aid to the Needy Disabled- SSI

ANSI--American National Standards Institute

AOA--Administration on Aging

AP--Assistance Payments

AP-700--Financial and Medical Eligibility Reporting Form

APD--Advance Planning Document

APPLS--Automated Personnel Payroll Ledger

APS--Adult Protective Services

ASA--American Society of Aging

ASC--Ambulatory Surgical Centers

AU--Administrative Unit

BBA--Balanced Budget Amendment

BC/BS--Blue Cross/Blue Shield of Colorado, Medicaid's former Fiscal Agent

BCA--Baby Care Adults

BCC--Baby Care Children

BC-KC--Baby Care – Kids Care Program

BCR--Birthing Cost Recovery

BENDEX--Beneficiary Data Exchange

Beneficiary--One Who is Entitled to Receive Benefits

Benefits--The Scope of Services Available to Beneficiaries

BI--Brain Injury

BIA--Bureau of Indian Affairs

BIDS System--Colorado procurement information system

BL--Black Lung

BMS--Bureau of Medical Services (Obsolete- Now MS)

BPR--Business Process Reengineering

CACTIS--Colorado Automated Client Tracking Information System

CAFSS--Colorado Automated Food Stamp System

CAHHA--Colorado Association of Home Health Agencies

CAHPS--Consumer Assessment of Health Care Study

CAHSA--Colorado Association of Homes and Services for the Aging

CAP--Colorado Admissions Program

CAPD--Continuous Ambulatory Peritoneal Dialysis

CAPS--County Automated Payment System

CARC--Colorado Association for Retarded Children

Carve-Out--A Benefit or Service that is not Included Under an Otherwise Global Services Agreement, Such As a Medicaid HMO Contract

Case Mix Demo--Pilot Effort Directed by HCFA to Test & Prove CM Using the MDS & RUG 3 as the Case Mix Reimbursement System for Medicare SNF Patients. KS, MS, ME, TX, NY, SD are the Participating States

CAT Scans--Computerized Axial Tomography

CBHP--Children's Basic Health Plan

CBLTC--Community Based Long Term Care

CBMS--Colorado Benefits Management System

CBP--Common Business Process

CBT--Computer-Based Training
CCB--Community Centered Board (for DD) or Change Control Board
CCHN--Colorado Community Health Network (Assoc. of FQHCs)
CCI--Colorado Counties, Inc.
CCOA--Colorado Commission on Aging
CCPD--Continuous Cycling Peritoneal Dialysis
CCR--Code of Colorado Regulations
CCSO--Colorado Congress of Senior Organization
CDAS--Consumer Direct Attendant Support
CDBG--Community Development of Social Services
CDF--Colorado Drug Formulary
CDHCPF--Colorado Department of Health Care Policy and Financing
CDHS--Colorado Department of Human Services
CDOLE--Colorado Department of Labor and Employment
CDOR--Colorado Department of Revenue
CDPHE--Colorado Department of Public Health and Environment
CDSS--Colorado Department of Social Services or County Department of Social Services or County Department of Human Services
CEDARS--Colorado Eligibility Disbursement and Reporting System
CFMC--Colorado Foundation for Medical Care- HCPF 's PRO Contractor
CFR--Code of Federal Regulations
CGS --Colorado Gerontological Society
CHAMPUS--Civilian Health and Medical Program of the Uniformed Services
CHATS--Child Care Automated Tracking System
CHFA--Colorado Housing Finance Authority
Children's HCBS--HCBS for children with physical disabilities
CHINS--Children in Need of Supervision
CHP+--Children's Health Plan Plus
CICP--Colorado Indigent Care Program
CIDS 2000--Client Information Data Subsystem for the 21st Century
CIN--Colorado Information Network
CLASS I --Refers to general nursing facilities
CLASS II/IV--Refers to nursing facilities for physically and developmentally disabled individuals
CLASS IV Nursing Homes--Regional Centers for persons with developmental disabilities (operated by CDHS)
CLEAR--Colorado List of Emergency Assistance Recipients
CM--Case Manager
CMA --Case Management Agency
CMER--Colorado Medicaid Eligibility Response
CMI--Comparative Measure Index
CNS--County Nursing Service
CO/EBTS--Colorado Electronics Benefits Transfer Service
COBRA--Consolidated Omnibus Budget Reconciliation Act of 1985
COFRS--Colorado Financial Reporting System
COIN--Client Oriented Information System (CDHS-HCPF eligibility database)
Co-Insurance--The amount of the allowed charge the beneficiary is responsible for paying on assigned medicare beneficiaries
COLA--Cost of Living Adjustment
COLO R/X--Colorado Drug Formulary
Colorado Works--Colorado's Welfare Reform Program (see: TANF)
Consultec--Medicaid, CBHP, CICP, etc., fiscal agent beginning December 1st, 1998
CPAS--Claims Processing Assessment System
CPT-6--Current Procedural Terminology (Physician Reimbursement Guide)
CQC--County Quality Control
CRCP--Central Registry for Child Protection
CRD--Chronic Renal Disease
CRLS--Colorado Rural Legal Services
CRSP--Colorado Refugee Service Programs
CS--Federal SSI-Colorado Supplement
CSBG--Community Services Block Grant
CSE--Child Support Enforcement
CSL--Colorado Senior Lobby
CSPR--Control System for Proposed Rules (State Regulations)
CSR--Continued Stay Review
CSU--Child Support Unit
CTRANS--County Transportation Refers to Non-Emergency or Non-Wheel Chair Transportation Services
Customary Charge --The most common charge by a provider for a particular service to the majority of patients
CW--Child Welfare
CWEST--Child Welfare Eligibility and Services Tracking System
CW-FC--Child Welfare - Foster Care
CWS--Division of Child Welfare Services
CY--Calendar Year
CYF--Children, Youth, and Families
Day Program--Part of the home and community based services for persons with developmental disabilities. This is the day program part of the waiver.
DC--Day Care
DD--Developmentally Disabled
DEFRA--Deficit Reduction Act
DHMC--Denver Health Medical Center
DHS--Colorado Department of Human Services
DIH--Department of Indian Health
DLE--Colorado Department of Labor & Employment
DMA--Division of Medical Assistance (obsolete now AAS)

DME/MED EQUIP.--Durable Medical Equipment and Supplies

DORA--Colorado Department of Regulatory Agencies

DPHE--Colorado Department of Public Health and Environment

DRG--Diagnosis Related Group

DSH--Disproportionate Share Hospital

DSS--Decision Support System

DYC--Division of Youth Corrections

EA--Emergency Assistance

EBD--Elderly, Blind, and Disabled

EBT/EFT--Electronic Benefit Funds Transfer

EGHP--Employer Group Health Plan

EID--Employment Information Data

EIS/DSS--Executive Information System/Decision Support System

EJB--Enterprise Java Beans

Eligible --This refers to one full time equivalent client for a defined period of time. Every person who is issued a MAC Is called an "eligible." It does not refer to the number of clients who actually use a medical service. When a MAC is issued, the computer system assigns a prescribed span of time for which the person is eligible. If eligibility is not renewed at the end of the span, eligibility lapses.

EMC--Electronic Media Claim

EMS--Eligibility Management Systems

EOMB--Explanation of Medicare Benefits

EPM--Enterprise Project Manager

EPSDT Dental--Early and Periodic Screening, Diagnosis and Treatment (Preventive Health Care Program for Medicaid Clients Up to age 21)

EQRO--External Quality Review Organization

ERS--OYS Education Records System

ESC--Employment Status Code

F PLAN--Family Planning refers to services which are paid through the family planning clinics for which an annual capitation is paid for all family planning services eligible for one year

FA--Fiscal Agent (Blue Cross/Blue Shield of Colorado)- Medicaid's Fiscal Intermediary; operates the provider claim system and MMIS database

FAMIS--Family Assistance Management Information Systems

FC--Foster Care Children

FCS-100--Foster Care and Subsidized Adoption and Medicaid Eligibility Tracking

FDA--Food and Drug Administration

FDDI--Fiber Distributed Data Interface

FFP--Federal Financial Participation

FFS--Fee for Service (non-capitated health care payment system)

FFY--Federal Fiscal Year

FGP--Foster Grandparent Program

FI--Fiscal Intermediary (Medicare)

FIPS PUB--Federal Information Processing Standard Publication

Fiscal Intermediary --An insurance company which manages medicare claims and provides audit-reimbursement services for HCFA to assure providers utilize program benefits appropriately

FLOOR--Medicare statute for the minimum amount of time a claim must be held before payment/also minimum payment, etc.

FNS--Food and Nutrition Services

FPL--Federal Poverty Limit

FQHC/Rural Clinic--Federally Qualified Health Clinic (or center)- health service facility for low income persons in a medically under served area

FR--Federal Register (Publication of Federal Regulations)

FRV--Fair Rental Value

FS--Food Stamps

FSJS--Food Stamp Job Search System

FSR--Feasibility Study Report

FTE--Full Time Equivalent

FY--Fiscal Year (state)

GA--General Assistance

GB--Giga Bytes

GGCC--General Government Computer Center

GJTO--Governor's Job Training Office

GSS--(Colorado Department of) General Support Services

GUI--Graphic User Interface

HB--House Bill (introduced to the Colorado House in the General Assembly/Legislature)

HB 97-1304, HB 97-1325- Authorizing legislation for the Children's Basic Health Plan (CBHP)

HCA--Home Care Allowance

HCBS--Home and Community Based Services

HCBS-BI--HCBS (persons with brain injury)

HCBS-CES--HCBS (Children's Extensive Support)

HCBS-CM--Home and Community Based Services for the Elderly, Blind, and Disabled Case Management

HCBS-CMW--HCBS (Children's Medical Waiver)

HCBS-CS--Home and Community Based Services for the Elderly, Blind, and Disabled Client Services

HCBS-DD--HCBS (Persons with Developmental Disabilities)

HCBS-EBD--HCBS (Elderly, Blind, and Disabled)

HCBS-MI--HCBS (Mentally Ill)

HCBS-PLWA--HCBS (People Living with AIDS)

HCBS-SLS--HCBS (Supported Living for persons with developmental disabilities)

HCFA--Federal Health Care Financing Administration

HCPCS--HCFA Common Procedure Coding System (Outpatient)

HCPF Medicaid--Colorado Department of Health Care Policy & Financing

Health Insurance Buy-In--Premium and coinsurance/deductible payments for private health

insurance policies for medicaid clients when it can be shown to be cost effective

HEDIS--Health Plan Employer Data and Information Set

HEWI--Health, Environment, Welfare & Institutions

HH--Home Health Care

HH#--County Household #

HHA--Home Health Aide or Home Health Agency

HHS--Health and Human Services Federal agency

HIBI--Health Insurance Buy-In Program

HIM--Health Insurance Manual

HIMS--Health Information Management System

HIS--Indian Health Services

HM--Home Maker

HMO--Health Maintenance Organization

Home Care Allowance --This is not a Medicaid program or service; however, most Home Care Allowance eligible are also Medicaid eligible. Services are for persons residing in their own homes and include personal care and supportive services. While these services are not medical in nature, they do represent an important component of a "continuum" of long term care. It is funded through 95% General Fund and 5% Local Match

Home Mod--Home Modification

HOSPICE--Hospice

HRC--Human Resources Committee

HSP--Hospital Specific Portion

HTML--Hyper Text Markup Language

HTTP--Hyper Text Transfer Protocol

HUD--Housing and Urban Development

HW--Hardware

IADL--Independent Activity of Daily Living

IAPD--Implementation Advance Planning Document

ICD-9-CM--International Classification of Diseases, version 9, Clinical Modification

ICF--Intermediate Care Facility

ICF-MR--Intermediate Care Facility for the Mentally Retarded

ICN--Internal Control Number

IEVS--Income Eligibility Verification System

IFF--Intrastate Funding (Allocation) Formula for QAA Funds

IM--Income Maintenance

IMAP--Information Management Annual Plan

IMC--Information Management Commission

Inpatient--Inpatient Hospital Care

Intermediary (F.I.)--An independent insurance company contracted by HCFA to administer payments for Medicare

IPV--Intentional Program Violation

IRFP--Implementation Request for Proposal

ISP--Internet Service Provider

IT--Information Technology

ITS--Information Technology Services

IV-A--Title IV-A, Social Security Act Federal AFDC regulations

IV-D--Title IV-D, Social Security Act Federal Child Support Enforcement Program regulations

IV-E--Title IV-E, Social Security Act, Generally refers to children eligible for TANF payments but the child is in foster care

IVES--Income Eligibility Verification System

JAD--Joint Application Development

JAVA--A programming language

JBC--Joint Budget Committee

JDBC--Java Database Connectivity

JHAC--Joint Commission of the Accreditation of Hospitals

JOBS--Job Opportunity Basic Skills (Federal employment program)

JTPA--Jobs Training Partnership Act

Lab/X-ray--Laboratory and Radiology Services

LAC--Lifetime Authorization Cards

LAN--Local Area Network

LEAP--Low-income Energy Assistance Program

LGHP--Large Group Health Plan

LOC--Level of Care or Line of Code

LOP--Local Operational Plan

LOS--Length of Stay

LPN--Licensed Practical Nurse

LSC--Legal Services Corporation

LSD--Legal Services Developer

LTC--Long Term Care

LTC-101--Long Term Care Assessment Form

LTC-102--Monthly HCBS Non-Diversion/Termination Report Form

LTC-103--HCBS Case Plan Form

LTC-104--HCBS Case Plan Revision Form

LTC-105--HCBS Prior Approval and Cost Containment Form

LTC-106A--Client Payment Form for HCBS- 300% Non ACF Clients

LTC-106B--Client Payment Form for HCBS- All ACF Clients

LTC-107--HCBS Notice of Service Status/Eligibility Form

LTC-108--HCBS Statement of Services (Claim Form)

LTC-109--HCBS Form for Application of Individual Providers

LTC-110 --HCBS Form for Monthly Listing of New Individual Providers, Re-certifications, De-certification

LTC-111--HCBS Complaint Information Form

LTCO--Long Term Care Ombudsman

LVN--Licensed Vocational Nurse

MA--Medical Assistance

MAC--(Mutually exclusive meanings depending upon context):

- Medical Authorization Card (Client's Medicaid Card)
- Medical Assistance Advisory Council
- Maximum Allowable Cost

MAPI--Messaging Application Program Interface
MB--Mega Bytes - a measure of computer memory or file size
MBE/WBE--Minority-owned Business Enterprise/Woman-owned Business Enterprise
MC--Medicaid
MCO--Managed Care Organization
MCPI--Medical Consumer Price Index
MCR or M18--Medicare
MDS 2.0--Minimum Data Set for resident assessment
MDS Automation Demonstration--Pilot effort directed by HCFA to test & prove automated MDS submission by nursing facilities
MDS+--The NF Demonstration version of the MDS, Main, Mississippi & South Dakota us 12/1/90 b version. It meets the federally mandated requirements for primary resident care screening & assessment.
Medicare--That portion of the Social Security Act which provides health care benefits to citizens over age 65 or under age 65 who are permanently disabled or suffering from chronic renal failure
Medicare Part A--That part of medicare law providing for in-patient hospitalization, SNF care, NH benefits, & home health services to senior citizens
Medicare Part B--A supplementary program to Part A providing for physicians' services, outpatient hospital services, & other supplies. Waivers were granted in 1996 to enable use of RUGs 3 for routine costs.
Medicare/TPL--Medicare/Third Party Liability
Mental Health --This refers to the mental health care provided through the community
MHASA--Mental Health Assessment & Services Agency
MI--Medically Indigent
MK or M19--Medicaid
MMIS--Medicaid Management Information System
MMQ--A Case Mix RAI developed by Hill haven & used by MA
MOE--Maintenance of Effort - This is a federal mandate requiring states (and, where applicable counties) to spend at least 80% of the funding amounts expended in base year 1993. If the state pays 80% of the base year expenditures, then even if welfare rolls escalate in future years, the federal government will continue to supply its share of funds for the higher costs. This is intended to assure that states expend a proper amount of state funds relative to federal funds.
MOU--Memorandum of Understanding
MOW--Meals on Wheels
MR--Mentally Retarded
MRI--Magnetic Resonance Imaging
MS--Medical Services
MSA--Metro Statistical Area
MSP--Medicare Secondary Payer
MSR--Monthly Status Report
MSW--Master's of Social Work or Medical Social Work
MTBD--Mean Time Between Defects
MTBF--Mean Time Between Failures
MTS--Medicare Transaction System
MTTR--Mean Time To Restore
MVS--IBM Mainframe Operating System
MVS--Multiple Virtual Storage
NAAAA--National Association of Area Agencies on Aging
NASUA--National Association of State Units on Aging
NASW--National Association of Social Workers
NCANDS--National Child Abuse and Neglect Data Systems
NCOA--National Council on Aging
NCQA--National Commission on Quality Assurance
NCSC--National Council of Senior Citizens
ND--Non-Diversion
NDS--Net ware Directory Services
NF--Nursing Facility
NH--Nursing Home
NON-PPS--Non-Prospective Payment System
NPE--Nutrition Program for the Elderly
NRST--Non-Resident Specific (Nursing or Therapy Staff Times)
NRTA--National Retired Teachers Association
NT Windows--Windows New Technology Operating System
NTS--Nonresident Tracking System
OAA--Older Americans Act
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
OAVP--Older American Volunteer Programs
OBRA--Omnibus Budget Reconciliation Act
OCA--Older Coloradans Act
OCYF--Office of Children, Youth, and Families
ODBC--Open Database Connectivity
OIG--Office of Inspector General
OIT--Office of Information Technology
OLTC--Options for Long Term Care
OLTP--Online Transaction Processing
OMB--Office of Management and Budget
OP--Outpatient
Option/Mandate--Certain Medicaid services are mandated by federal law as a cost of participating in the federal Medicaid program and certain others are optional for the states.
Option/Mandate--Certain Medicaid services are mandated by federal law as a cost of participating in the federal Medicaid program and certain others are optional for the state
ORB--Object Request Broker

ORD--Office of Research and Demonstrations
OSPB--Office of State Planning and Budget (Governor's Office)
OT/PT/ST--Occupational Therapy/Physical Therapy/ Speech Therapy
OTC --Over the Counter Drugs
OUT--Outcome Tracking Unit
Outpatient--Outpatient Hospital Services includes all hospital-based outpatient care ranging from emergency room to hospital based care
Over 65--Inpatient Psychiatric Hospital Care for Persons over age 65. State owned and operated hospital care.
OYS--Office of Youth Services
PA--Public Assistance
PA-1--Program Area One- Adult Self Sufficiency, Social Services Block Grant, Social Security Act
PA-2--Program Area 2- Adult Protective Services, Social Services Block Grant, Social Security Act
PAC--Political Action Committee, also Policy Advisory Committee to CDSS
PACE--Programs of All Inclusive Care for the Elderly
PAPD--Planning Advance Planning Document
PAR--Prior Authorization Review
PASARR--Pre Admission Screening and Annual Resident Reviews
PC--Personal Care
PCBH--Personal Care Boarding Home
PCD--Project Control Document
PCP/PCPP--Primary Care Physician/Primary Care Physician Program
PDCS--Prescription Drug Card System
PDN--Private Duty Nursing
PE--Presumptive Eligibility
PERA--Public Employees' Retirement Association
PETI--Post Eligibility Treatment of Income
PHN--Public Health Nurse
PHP--Prepaid Health Plan
Physician--Physician's services are those ranging from family practice to specialty care.
PI--Program Integrity
PIN--Personal Identification Number
PLWA--People Living With AIDS
PMR--Planning and Management Region
PN--Personal Needs
POC--Plan of Care
POPs--Points of Presence
POS--Point of Service- child based HMO or Point of Sale
PPD--Per Patient Day
PPHP--Pre Paid Health Plan
PPO--Preferred Provider Organization
PPS--Prospective Payment System
PPV--Pneumococcal Pneumonia Vaccine
Prescription Drug--Includes payment for all drugs provided through Medicaid including those dispensed in nursing home, but excluding those which are dispensed in the inpatient hospital setting
PRO--Peer Review Organization
PROC--Procedure
PRO-DUR--Prospective Drug Utilization Review
PSA--Planning and Service Area
PSRO--Professional Standards Review Organization
QA--Quality Assurance
QC/QA/ME--Quality Control/Quality Assurance/Management Evaluation
QDWI--Qualified Disabled & Working Individuals
QMB--Qualified Medicare Beneficiary
R/R/R--Re-determination/Re-certification/Reassessment
RA--Remittance Advice
RAD--Rapid Application Development
RAI--Resident Assessment Instrument
RAPs--Resident Assessment Protocols
RAS--Remote Access Services
RDBMS--Relational Database Management System
Rebate- Prescription Drugs --Medicaid prescription drug optional benefit. In an effort to offset the additional costs related to the items above, manufacturers rebate Medicaid drug expenses for certain items. The rebates are not accounted for in MMIS data and are handled manually through accounting transactions.
Residential Program--Part of the Home and Community Based Services for the Developmentally Disabled, is the residential care provided for under the waiver.
RETRO-DUR--Retrospective Drug Utilization Review
RFP--Request for Proposal
RHC--Rural Health Clinic
RN--Registered Nurse
RO--Regional Office (HCFA)
ROI--Return on Investment
RPC--Remote Procedure Call
RRB--Railroad Retirement Benefits
RSDI--Retirement, Survivors, Disability Insurance
RST--Resident Specific- Nursing or Therapy Staff Times
RSVP--Retired Senior Volunteer Program
RTC--Residential Treatment Center (Children with behavioral problems)
RTD--Resubmission Turn-Around Document
RTP--Return to Provider Form Used by BC/BS
RUGs--Resource Utilization Groupings
RUGs III--The most recent version of RUGs
SACWIS--Statewide Automated Child Welfare Subsystems
SAM--Employment First System
SB--Senate Bill (introduced to the Senate in the Colorado General Assembly/Legislature)
SB 5-- Medicaid Managed Care legislation
SB 138--Obsolete term for the HCBS-EBD Program
SB 38--Pilot Program that Preceded HCBS

SB 42--Social Security Legislation directing Case Mix
SBSS--State Board of Social Services
SCP--Senior Companion Program
SCSEP--Senior Community Service Employment Program
SCW I, II, III--Social Case Worker under the Merit System
Section S--Only MDS section allowed for unique state use & change
Section T--Record Nursing Therapy
Section U--Records Medication Information
SEP--Single Entry Point
SHEA--State Health Expenditure Account
SIDMOD--State Identification Module
SISC--SSI Status Code
SLMB--Special Low-Income Medicare Beneficiaries
SLP--Service Level Plan
SMIB--Supplementary Medical Insurance Benefits
SMSA--Standard Metropolitan Statistical Area
SN--Skilled Nursing
SNA--Systems Network Architecture
SNF--Skilled Nursing Facility
SOW--Statement of Work
SPA--Single Purpose Application
SPSS--Statistical Package for the Social Sciences
SQL--Structured Query Language
SS-4--County Department of Social Services Form to Notify Clients of Service Status/Eligibility
SS-6--County Department of Social Services Case Plan Form
SSA--Social Security Administration
SSBG--Social Services Block Grant
SSCN--Social Security Claim Number
SSI--Supplemental Security Income
SSI-CS--Supplemental Security Income- Colorado Supplement (OAP)
SSL--Secure Socket Layer
SSN--Social Security Number
- **SSO**--Single Sign-On
- **SSO**--Social Security Office

SSS--Social Services Syndrome
SSTABS--Social Service Technical & Business Staffs (Association)
ST--Speech Therapist or Therapy
ST. I.D. #--State Identification Number (Medicaid #)
STAC--Specialized Transportation Association of Colorado
STARS-Services, Tracking, Analysis & Reporting System
STM--Staff Time Measurement (SNF)
SUA--State Unit on Aging
SURS--Surveillance Utilization Review Subsystem
SW--Software
TANF--Temporary Assistance to Needy Families
TCM-DD--Targeted Case Management-Developmentally Disabled
TCP/IP--Transmission Control Protocol/Internet Protocol
TILES--A Case Mix RAI developed & discontinued by Texas
Title XIX--Social Security Act- Medicaid
Title XVIII--Social Security Act- Medicare
Title XXI--Refers to State Children's Health Insurance Plan
TP--Transaction Processing
TPL--Third Party Liability
- **TPR**--Third Party Recovery
- **TPR**--Third Party Resources

Transportation--Emergency Transportation
TRIGGERS--MDS data which points to specific RAPS
TTS--Title 4-E Tracking System
UAT--User Acceptance Test
UB92--Uniform Billing Form HCFA 1450
UCB--Unemployment Compensation Benefits
ULTC-100--Uniform Long Term Care (client needs assessment tool form)
Under 21 Psych.--Private Psychiatric Hospital Care for Persons under age 21
Undoc--Undocumented Immigrants
Unknown--Refers to appeal or adjustment activity which is not necessarily specific to one single claim/eligible or for a client who no longer has an active eligibility span on the recipient eligibility file in the MMIS.
UR--Utilization Review of medical providers
URL--Universal Resource Locator
USC--United States Code
USD--Unified Software Distribution
USDA--United States Department of Agriculture
VA--Veterans Administration
VISTA--Volunteers in Service to America
Vol 10--CDSS Staff Policy Manual for State Policy on Older Americans Act
Vol 7--CDSS Staff Policy Manual for Social Services
Vol 8--CDSS Staff Policy Manual for Medicaid
VR--Vocational Rehabilitation
VRS--Voice Response System
VSAM--Virtual Sequential Access Method
WAN--Wide Area Network
WC--Worker's Compensation
WIC--Women, Infants, and Children
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.
XML--Extensible Markup Language
Y2K--Year 2000
YTD--Year To Date

Appendix 3A: County Data on Medicaid Expenditures and Eligibility, FY 96-97

County	Total Expenditures	Avg. # Eligibles	Expenditures As % of State Total	Avg. # Eligibles as % of State Total
Adams	113,416,600.44	22,861	8.61	9.04
Alamosa	9,800,292.60	2,240	0.74	0.89
Arapahoe	98,062,806.86	17,626	7.45	6.97
Archuleta	1,479,294.46	503	0.11	0.20
Baca	3,179,828.95	478	0.24	0.19
Bent	3,556,399.74	872	0.27	0.34
Boulder	59,023,649.98	9,300	4.48	3.68
Chaffee	5,135,396.04	896	0.39	0.35
Cheyenne	1,789,312.51	145	0.14	0.06
Clear Creek	1,214,924.33	258	0.09	0.10
Conejos	4,368,625.15	1,542	0.33	0.61
Costilla	2,524,440.12	940	0.19	0.37
Crowley	2,554,799.47	743	0.19	0.29
Custer	640,160.39	209	0.05	0.08
Delta	10,778,492.66	2,429	0.82	0.96
Denver	281,071,554.39	60,029	21.35	23.74
Dolores	1,094,849.61	122	0.08	0.05
Douglas	5,829,549.56	1,043	0.44	0.41
Eagle	2,230,848.34	625	0.17	0.25
Elbert	1,545,894.62	578	0.12	0.23
El Paso	123,747,016.38	28,175	9.40	11.14
Fremont	21,653,729.74	3,803	1.64	1.50
Garfield	12,665,084.41	2,061	0.96	0.82
Gilpin	323,724.96	75	0.02	0.03
Grand	1,381,845.27	285	0.10	0.11
Gunnison	1,638,231.75	429	0.12	0.17
Hinsdale	53,658.71	13	< .01	0.01
Huerfano	4,755,251.44	1,100	0.36	0.44
Jackson	369,552.31	68	0.03	0.03
Jefferson	129,917,980.84	15,661	9.87	6.19
Kiowa	978,542.72	120	0.07	0.05
Kit Carson	1,979,309.07	466	0.15	0.18
Lake	1,709,160.20	274	0.13	0.11
La Plata	9,703,291.61	1,470	0.74	0.58
Larimer	56,820,787.69	10,014	4.32	3.96
Las Animas	10,430,494.89	2,304	0.79	0.91
Lincoln	2,753,476.48	378	0.21	0.15
Logan	8,714,692.60	1,566	0.66	0.62
Mesa	74,960,225.85	10,073	5.69	3.98
Mineral	5,242,110.15	476	0.40	0.19
Moffat	4,183,923.22	817	0.32	0.32
Montezuma	10,298,601.20	1,946	0.78	0.77

County	Total Expenditures	Avg. # Eligibles	Expenditures As % of State Total	Avg. # Eligibles as % of State Total
Montrose	14,628,701.70	2,364	1.11	0.94
Morgan	11,533,203.89	2,520	0.88	1.00
Otero	16,078,039.04	3,482	1.22	1.38
Ouray	719,405.18	71	0.05	0.03
Park	1,101,208.44	310	0.08	0.12
Phillips	1,702,830.76	278	0.13	0.11
Pitkin	488,252.67	98	0.04	0.04
Prowers	8,307,455.66	1,937	0.63	0.77
Pueblo	89,357,355.91	19,832	6.79	7.84
Rio Blanco	2,293,518.33	366	0.17	0.14
Rio Grande	6,375,318.72	1,748	0.48	0.69
Routt	2,321,140.16	339	0.18	0.13
Saguache	2,548,879.02	950	0.19	0.38
San Juan	96,464.45	36	0.01	0.01
San Miguel	369,712.95	112	0.03	0.04
Sedgwick	1,403,104.93	217	0.11	0.09
Summit	1,164,256.17	167	0.09	0.07
Teller	3,206,796.93	809	0.24	0.32
Washington	1,302,047.54	258	0.10	0.10
Weld	55,014,316.99	11,309	4.18	4.47
Yuma	3,199,249.48	604	0.24	0.29
	Total Exp.	**Total Avg. Elig.**	**Total % Expend.**	**Total % Avg. Elig.**
	$1,316,789,670.63	**252,820**	**100.00%**	**100.00%**

Source: HCPF Budget Office

Notes: Expenditures are on a cash basis of accounting and will not match other Budget Office data; "eligibles" Exclude the impact of retroactivity, thus causing counts that are substantially lower than the Long Bill. The actual percent total may exceed or fall short of 100.00% due to rounding of county percentages.

Appendix 3B:
Estimated Number of Children in Families with Incomes At Or Below 185% of Federal Poverty Level, By County

Surrogate CBHP/CHP+ Data: Free/Reduced-Price Lunch Eligibles
(Colorado Data by County for 1997-98 School Year)[a]

County in Colorado	F/R Lunch (# Eligible) [b,c,d]	Proportion of State Total (in percents)	County in Colorado	F/R Lunch (# Eligible)	Proportion of State Total (in percents)
Adams	21798	12.03	Kit Carson	584	.32
Alamosa	1555	.86	Lake	554	.31
Arapahoe	21616	11.93	La Plata	1804	1.00
Archuleta	490	.27	Larimer	7925	4.37
Baca	387	.21	Las Animas	1576	.87
Bent	546	.30	Lincoln	300	.17
Boulder	6890	3.80	Logan	1223	.68
Chaffee	635	.35	Mesa	7032	3.88
Cheyenne	108	.06	Mineral	43	.02
Clear Creek	266	.15	Moffat	617	.34
Conejos	1285	.71	Montezuma	2193	1.21
Costilla	580	.32	Montrose	2200	1.21
Crowley	373	.21	Morgan	2724	1.50
Custer	116	.06	Otero	2521	1.39
Delta	2022	1.12	Ouray	95	.05
Denver	38151	21.06	Park	381	.21
Dolores	106	.06	Phillips	284	.16
Douglas	864	.48	Prowers	1462	.81
Eagle	886	.49	Pueblo	11097	6.13
Elbert	339	.19	Rio Blanco	283	.16
El Paso	2096	1.16	Rio Grande	1317	.73
Fremont	2203	1.22	Routt	274	.15
Garfield	1864	1.03	Saguache	867	.48
Gilpin	30	.02	San Miguel	109	.06
Grand	328	.18	Sedgwick	203	.11
Gunnison	161	.09	Summit	253	.14
Huerfano	737	.41	Teller	576	.32
Jackson	102	.06	Washington	443	.24
Jefferson	13474	7.44	Weld	11285	6.23
Kiowa	150	.08	Yuma	790	.44
			TOTAL	**181,173**	**100.00**

Notes:

a: Source: Colorado Department of Education, *The Status of Child Nutrition Programs in Colorado*, June, 1998, derived from applications by families in each School District for free or reduced price school lunch program.

b: Eligibility for free or reduced price lunch is determined by a family income of ≤ 185% Federal Poverty Level (FPL), which is the same income limit used for CBHP/CHP+.

c: Limitations of this data that may contribute to under-counting of children in families with incomes ≤ 185% (FPL):

- Data represent numbers of children who applied and were found eligible for free/reduced-price lunch eligibility. Other families in the county/district with incomes of ≤ 185% FPL may not have applied for the free/reduced price lunch program.
- Data do not include children who are under school-age, or who are out of school.

d. The number of children in families with incomes of ≤ 185% FPL does not equate to CBHP/CHP+ eligibility because some of the children represented may be enrolled in Medicaid or an employer-based coverage plan, and therefore would be ineligible for CBHP/CHP+. Rates of enrollment for these other types of coverage vary by county.

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