COLORADO MEDICAID PROGRAM

1995 ANNUAL REPORT

REPORT AND ANALYSIS BASED UPON
STATE FISCAL YEAR 1993-94 AND
PREVIOUS YEARS' DATA

Health Plans and Medical Services
Colorado Department of Health Care Policy and Financing
Alan Weil, Executive Director
To the Reader of the Medicaid Annual Report:

The Medicaid Annual Report is intended to be a resource for policy-makers, health care consumers and providers, and all citizens of Colorado. It provides a quick overview of the program, as well as more detailed information related to program design and budget. We have made every effort to make this report useful for a wide variety of readers.

The Medicaid program is going through dramatic changes in Colorado as well as around the country. After a few years of double-digit cost growth due to eligibility increases, high medical inflation, and refinancing of state-only programs, Medicaid program growth has moderated. A report prepared by Lewin-VHI for the National Institute for Health Care Management indicated that Colorado had the fourth highest percent increase in the country in the use of capitation in our Medicaid program during fiscal year 1994.

Medicaid is a strong safety-net program for low-income Coloradans requiring both acute and long-term care services. The challenge Medicaid faces is to make the best use of the resources devoted to the program. This report should help the reader understand the efforts the Department has made to meet that challenge.

I welcome your comments.

Sincerely,

Alan Weil
Executive Director
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SECTION I
OVERVIEW

A. THE COLORADO MEDICAID ANNUAL REPORT

The 1995 Medicaid Annual Report provides a summary of Medicaid and related program performance, issues and directions in State Fiscal Year 93-94. Included are summary data, analysis, charts and sources designed to meet the following information needs:

1. An accounting to the Colorado General Assembly of Medicaid program performance and expenditures.
2. An overview and explanation of Medicaid and other Health Plans and Medical Services programs for use by the public and interested professionals.
3. A guide to available sources of information and data on Colorado Medicaid.

Annual Report Organization

I. OVERVIEW and HIGHLIGHTS:
   • Overview of Health Plans and Medical Services program
   • What is Medicaid and who is eligible?
   • Outstanding events and achievements of Colorado Medicaid in FY 93-94.
   • Changes to the Colorado Medicaid program in FY 93-94.

II. THE MEDICAID PROGRAM
   • What is the need for medical care coverage for low income families in Colorado and how well does Medicaid meet this need?
   • Who is covered by Medicaid and for what benefits?
   • How does the Department improve access, coverage, quality of care, and efficiency?

III. UTILIZATION AND COSTS
   • What Medicaid services were used in FY 93-94, by whom, and at what cost?
   • How are providers reimbursed?
   • How are utilization and costs controlled?

IV. OPERATIONS AND FUTURE DIRECTIONS
   • How is the Medicaid program managed and delivered in Colorado?
   • What are the changes and opportunities now facing Colorado Medicaid?
### B. Colorado Medicaid Program

#### What is Medicaid?
Medicaid is a state and federally funded program that pays for health and medical services for low-income families and individuals. Medicaid covers families with children, and individuals who are pregnant, elderly, or disabled. Medicaid reimburses providers for physician services, hospital care, prescriptions, dental and vision services and immunizations for children, nursing facility and home health care, mental health services and a number of other health care services when medically necessary and rendered to enrolled Medicaid clients.

Eligibility, coverage and provider designation policy is established in State law (CRS 26-4-101), within federal requirements (Title XIX of the Social Security Act). The Colorado Department of Health Care Policy and Financing (HCPF) is the designated Single State Agency for the administration of the Medicaid program in Colorado. Staff of the Department's Health Plans and Medical Services Divisions 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.

#### Who is Eligible for Medicaid?
Medicaid coverage is available to persons who can meet income, resource and other criteria of eligibility. Categories of assistance under which persons may qualify for Colorado Medicaid include:

**Families and Children:**
- Adults and children eligible for Aid to Families with Dependent Children (AFDC).
- Baby Care Kids Care -- pregnant women, and children through age 6, in families with incomes at or below 133% of the federal poverty level. Resources available to the child may not exceed the proportionate share of the AFDC standard.
- Children born after September 30, 1983, in families with incomes at or below 100% of the poverty level and limited resources.
- Foster Care Children for whom a county has assumed financial responsibility.

**Elderly Persons and Persons with Disabilities:**
- Qualified Medicare Beneficiaries (QMB) -- persons with limited income and resources (State pays Medicare premiums, deductibles and co-insurance)
- Special Low-income Medicare Beneficiaries (SLMB) -- (State pays Part B of Medicare premium)
- Qualified Working Disabled persons with income up to 200% of federal poverty level
- Colorado Old Age Pension supplement to federal Social Security payments
- Federal Supplemental Security Income payments to Elderly, Blind & Disabled
- Disabled persons needing long term care (in Nursing Facilities or through the Home and Community Based Services program) whose incomes do not exceed 300% of the federal Supplemental Security Income level, including the elderly and people who are HIV positive and/or have an AIDS diagnoses.

**Persons without proof of citizenship or legal residence**
- Persons who have not established legal residence in this country (sometimes referred to as "undocumented aliens") but who meet the income and resource requirements of one of the programs listed above, and who require emergency medical care.
NON-MEDICAID PROGRAMS ADMINISTERED BY HCPF

- Home Care Allowance -- A monthly cash payment for the purchase of in-home services to low-income, frail elderly or disabled clients, to enable them to remain in their own homes as long as possible.

- Adult Foster Care -- 24-hour supervised non-medical care in an AFC facility for individuals who cannot live alone but do not require medical supervision.

- Colorado Indigent Care Program -- Partial reimbursement of costs to participating health care providers for serving medically indigent patients. Providers must assure that emergency care is available. Administration of the program moved from the University of Colorado Health Sciences Center (UCHSC) to the Department, effective July 1, 1994.

- Colorado Old Age Pension Health and Medical Fund -- Medical coverage similar to the basic Medicaid package for individuals who qualify for State Old Age Pension (OAP) but do not qualify for SSI. Coverage does not include psychiatric hospitalization or long-term care services. The Fund pays the premiums for Supplemental Medicare Insurance Benefits (SMIB) for certain Medicaid recipients.

Over one-half million persons were covered by Colorado Medicaid and other Health and Medical Service programs in State Fiscal Year 93-94:

- 280,000 Coloradans were enrolled in Medicaid each month
- 30,000 Coloradans were covered by the Old Age Pension Health and Medical Fund
- 490,000 health care episodes were reimbursed by the Colorado Indigent Care Program

About one-half million Coloradans were not covered by any form of health insurance.

Please see Section II for more information on eligibility.
In State Fiscal Year 1994, Colorado Medicaid:

- Provided health care coverage for 281,213 Coloradans each month - about 8.5% of the State's citizens.

- Paid $1.26 billion for services to Medicaid clients provided by health care practitioners and facilities enrolled as Colorado providers including:
  - Inpatient and Outpatient Hospitals
  - Nursing Facilities and Community Support Service Agencies
  - Pharmacies, Laboratories and Suppliers
  - Clinics and individual health and medical practitioners
  - Health Maintenance Organizations (HMOs) and Prepaid Health Plans (PHPs)
  - Department of Human Services programs for developmentally disabled persons

- Covered prenatal visits, delivery and neonatal care for one in three Colorado births. Covered young children in low income families for:
  - Immunizations
  - Early identification and treatment of developmental problems
  - Preventive and primary health care
  - Vision and dental services

- Provided more funds than any other payer in Colorado for Long Term Care benefits for aged and disabled persons.
  - Provided long term care services to 31,000 Medicaid-enrolled persons
  - Continued the implementation of a community-based Single Entry Point system to improve access to appropriate Long Term Care services

- Implemented innovative health care financing, delivery and administrative strategies including:
  - Improved access to care and cost control through managed care systems:
    - Four new managed care plans (three HMOs/one PHP) in the Denver Metro area
    - Western slope HMO expansion
    - Initiated competitive procurement of health care services
  - Enhanced leverage of federal matching funds.
  - Enhanced and streamlined utilization control, access and quality of care systems for:
    - long term care
    - prescription drugs
    - managed care
    - inpatient hospital services
  - Activated the Automated Medical Payment System (AMPS), which provides an on-line eligibility verification and claims processing system to:
    - streamline providers' communications with Medicaid
    - speed providers' payments
    - provide 95% paperless electronic transmission of claims and provider payments

MAJOR ACHIEVEMENTS AND CHANGES TO THE MEDICAID PROGRAM IN FISCAL YEAR 93-94 ARE SUMMARIZED ON THE NEXT FIVE PAGES
There were fewer Colorado births in 1993 than in 1992 although the number of women aged 15-44 increased. The decrease is attributed to a lower fertility rate among women under the age of 25, primarily in second and higher order births.

Among women aged 20 to 24 the fertility rate dropped from 117.6 (per 1,000) in 1992 to 109.3 in 1993, a decline of 7%. This decline is the sharpest one-year drop in more than 20 years. The decline was found both in the rate of first births (-4%) and second and higher order births (-9%).

Notably, the teen fertility rate, which increased by 18% between 1984 and 1991, fell in both 1992 and 1993. The rate reached a high of 54.7 in 1991, then dropped to 52.8 in 1992 and 50.7 in 1993, an overall decline of 7% in two years. The declines are concentrated in a reduction of second and higher order births to teens and may be associated with increased access by this group to family planning through Medicaid.

Medicaid's share of births, 34%, remained constant. In 1993 an additional 6% of Colorado infants became eligible for Medicaid prior to their first birthday. Consequently, 40% (34% + 6%) of all Colorado infants under the age of one were covered by Medicaid for part or all of the first year of life.

Prior to FY 93-94, the percentage of births covered by Medicaid increased annually, from 11% in 1989 to 34% in 1993. During this same period, Medicaid coverage was extended to mothers and young children in families with incomes up to 133% of the federal poverty line. Prior to this expansion, most families on Medicaid were also receiving AFDC payments. Medicaid is the only health care coverage for many families and provides critical health support for the working poor.

Studies point to the lack of health care in the private sector as a factor in welfare dependency: the incentive to separate from the welfare system is reduced when the individual and family will lose access to health care services as a consequence of increasing family income.

During the period of expansion of Medicaid coverage, key infant health indicators improved. The neonatal mortality rate (deaths in the first 28 days of life) had a steady decrease from 5.5 deaths per thousand births in 1989 to 4.2 in 1992 and 1993. This places Colorado below the national goal of 4.5 deaths per thousand by the year 2000. The infant mortality rate (deaths in the first year of life) shows a similar decline and stabilization, from 8.8 deaths per thousand births in 1989, to 7.1 in 1993. The national goal for 2000 is 7.0.

All of this is good news for Colorado mothers and babies and is expected to reduce public expenditures for services to children born with developmental problems resulting from a lack of prenatal care.

Statistics from Colorado Health Statistics, Sept. 94, Vol. 8 #2 and a January 5, 1995 report from the Colorado Department of Public Health and Environment. The relationship among reduced fertility for younger women, lower incidence of infant mortality and morbidity, and the growth of the Baby Care Kids Care program is associative rather than causally established. Further evaluation is underway on this issue.
HMO EXPANSION

Significant progress was made during the last six months of FY 93-94 toward expanding managed care options to Medicaid clients through a Health Maintenance Organization (HMO) or Prepaid Health Plan (PHP). At the beginning of the year, the only HMO contract was with Rocky Mountain HMO for clients residing on the Western Slope. In January 1994 Rocky Mountain HMO expanded into the Denver metro area, and by October 1994 three additional HMOs and one PHP were serving Medicaid clients.

The Department continues to pursue contracts with HMOs and PHPs to increase access to medical care through prepaid capitated health plans.

SINGLE ENTRY POINTS FOR LONG TERM CARE

Health Plans and Medical Services implemented a new Single Entry Point (SEP) long term care system in FY 92-93 in seven districts and added an eighth district in FY 93-94. This system will be operating state-wide by July 1, 1995.

SEPs provide access to publicly supported long term care services at a single agency. Two years following initial implementation, SEPs will provide access to privately-financed long term care services as well. Single Entry Points provide information and referral, case management, assessment, care planning and monitoring services for persons requiring nursing facility and community-based long term care services.

SEPs also coordinate with other local agencies to develop long-term care options and services in their local communities.

INFANT IMMUNIZATION PROGRAM

The Infant Immunization program began in March 1993 as a result of House Bill 92-1208. Under this cooperative program, the Department of Public Health and Environment orders the standard vaccines, at government prices, from the Centers for Disease Control, and distributes them to physicians and public health clinics at no cost to the providers.

The physicians and/or clinics that provide the immunizations to Medicaid-eligible children bill Medicaid and are reimbursed an administration fee. Medicaid reimburses DPHIE the cost of the vaccines plus a fee for administering the program.

In 1991, Medicaid provided 93,142 units of assorted vaccines to enrolled children. In FY 93-94, under the Immunization program, 157,768 units of vaccine were provided, including 3,719 units of vaccine unavailable in 1991 (DTaP and DTP/HIB), an increase of 69% over 1991.

The total cost for the program was $2,220,737. Had the services been provided under the previous fee schedule, the cost would have been $3,173,294. A savings of $952,557 was realized, but more importantly, the goal of immunizing more children is being achieved.
QUALITY OF CARE AND UTILIZATION REVIEW AND CONTROL SYSTEM CHANGES

Inpatient hospital utilization, the highest cost service in Colorado Medicaid, is now reviewed using computerized sampling techniques to focus review effort on admissions with the highest probability of questionable utilization. The inpatient hospital utilization review and control system was offered for competitive bid in FY 93-94 and awarded to the Colorado Foundation for Medical Care, effective July 1, 1994. The new contract will be managed for the first time based on performance rather than cost.

The automated retrospective Drug Utilization Review (DUR) system became fully operational in FY 92-93. This program provides information to pharmacists and physicians on drug prescribing patterns that fall outside predetermined standards. The DUR programs enhance quality of care and decrease expenditures of Medicaid dollars.

An on-line prospective DUR system is in development that will provide clinical information to pharmacists before prescriptions are dispensed. Once implemented, this DUR system will be available through the AMP System, the Department's new automated point-of-service claims processing system.

The Primary Care Physician Program (PCPP) implemented its first quality monitoring program in FY 93-94. Emergency treatment facilities (i.e., emergency rooms) are required to contact the 24-hour PCPP Administrative Hotline to notify the State about issues related to PCP access or inappropriate client utilization of emergency department services.

An automated computer software program, "Patterns of Treatment", underwent pilot testing. This software evaluates the medical necessity of services by using physician-generated medical practice criteria and outpatient claims data. It is anticipated that this program will enhance quality of care and decrease inappropriate utilization of services.

In FY93-94, utilization review and third party liability programs operated by Medicaid recovered the following funds:

- Drug Rebate: $15,821,787
- Surveillance and Utilization Review: $1,295,000
- Third Party Liability: $162,185,513

ACCESS TO CARE INITIATIVE: PRIMARY CARE RATE INCREASES

The Department requested and the General Assembly approved rate increases for physician, dental and transportation providers in order to maintain and increase access to care for Medicaid clients.

Primary care provider rates are proposed to be adjusted annually by indexing them to the Consumer Price Index (CPI), to prevent inflationary erosion of these rates.
MMIS ACCOMPLISHMENTS: ON-LINE ELIGIBILITY VERIFICATION AND CLAIMS PROCESSING PROJECT (AMP)

Over 24,000 hours of systems enhancements were incorporated in the Medicaid Management Information System (MMIS), most notably the Automated Medical Payment System (AMPS), which offers an interactive personal computer screen capability incorporating all billing manual instructions for all claim types for Medicaid providers.

Historically, the Medicaid program operated paper-reliant eligibility verification and claims payment systems. In FY 93-94, Medicaid staff gained approval and funding for the Automated Medical Payment System.

AMPS was activated September 12, 1994 and will become mandatory on April 3, 1995 for providers who file 120 or more claims per year. The system permits Medicaid eligibility to be verified and claims to be submitted and paid electronically.

A provider fee is levied for each transaction, depending on the provider type, to offset the cost to Medicaid for system enhancements. A reduced transaction fee is charged for verification of eligibility.

Electronic claims processing, along with electronic funds transfer, makes AMPS the largest electronic health care system in the State.

Streamlining features include:
1) AMPS accesses reference files of recipients and provider eligibility, benefit limitations and prior authorization in order to identify to providers billing errors that have resulted in a 15-20% denial rate of Medicaid claims in the past; 2) pharmacy claims are processed on-line as part of the drug utilization review program; 3) most paper attachments are eliminated, allowing providers to submit 95% of their claims electronically.

Other major MMIS accomplishments were incorporating the HCFA-mandated UB-92 claim form and electronic fund transfers to providers.

MEDICAID FINANCING

Colorado Medicaid refinancing initiatives over the past three years have been successful in obtaining more than $300 million in new federal funds for the State.

During FY 93-94, Medicaid completed one refinancing initiative and launched four more refinancing plans.

The four proposed new plans include:
- refinancing State payments for the Commission on Family Medicine,
- refinancing Colorado Indigent Care payments to outstate hospital providers,
- making a one-time enhanced payment to disproportionate share hospitals
- increasing payments to disproportionate share hospitals for uncompensated care from 94% to 200% of costs, beginning July 1, 1994.
TRANSITION TO THE NEW
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

In 1993, the Colorado General Assembly passed House Bill 1317, which restructured portions of the Colorado Departments of Social Services, Institutions and Health into the Departments of Human Services (DHS), Public Health and Environment (DPHE) and Health Care Policy and Financing (HCPF). The new Department of Health Care Policy and Financing is organized into three units: Health Plans and Medical Services, Office of Public and Private Initiatives and the Office of Budget and Planning. These major units include the Medicaid program, the Health Data Commission, Colorado Care, the Colorado Indigent Care Program and financing of the Rocky Mountain Poison Control Center, a state-wide contract.

The total budget for HCPF for FY 94-95, including all funding sources, is $1,341 million, of which federal funds comprise 52%. Total HCPF staffing consists of 137 personnel; state staffing costs account for less than 0.5% of the HCPF budget.

HCPF is the Single State Agency for the Medicaid program and is responsible for the provision of health services to the categorically needy under Title XIX of the Social Security Act. HCPF delegates to DHS the eligibility component of the Medicaid program. DHS is further responsible for the administration and monitoring of the delivery of certain health and social services to eligible recipients.

The two Departments coordinate services and distribute administrative costs through a Memorandum of Understanding and a Shared Services Agreement. These procedures define shared staff functions, promote efficiency and effectiveness in departmental administration, allow a smooth transition throughout the restructuring process, maximize program staff and personal services dollars, avoid duplication of effort through combined functions and allocation, and facilitate customer service and responsiveness to the needs and concerns of employees and clients.

MAUDE

The Department's new Decision Support Section implemented the Medicaid Automated Data Extract (MAUDE) system. Developed by Medicaid staff over the past two years, MAUDE software allows Medicaid PC users to extract and download MMIS mainframe data into PCs. This approach minimizes the need to consult or utilize mainframe programmer/analysts to extract eligibility and utilization data.

MAUDE requests are processed within a week after they are entered, which dramatically reduces turn-around time previously required by the more labor-intensive methods of extracting data. The number and complexity of MAUDE reports completed by Medicaid staff during the first four months of FY 94-95 exceeded the amount of work performed by a full-time mainframe programmer/analyst during the entire previous fiscal year.
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| **June 1993**  | SB 122 "Concerning Amendments to the State Medical Assistance Act":  
|                | • Simplifies recovery of Medicaid overpayments to providers  
|                | • Implements an automated claims payment system  
|                | • Restricts participation of capitated providers in certain counties  
|                | • Protects personal funds of persons residing in nursing facilities  
|                | • Allows purchase by Medicaid of individual health insurance policies  
|                | House Bill 1317 - "Restructuring the Health and Human Services Delivery System in Colorado"-abolished the Departments of Social Services and Institutions, created the Department of Human Services and the Department of Health Care Policy and Financing, and renamed the Department of Health the Department of Public Health and Environment. Health Plans and Medical Services (Colorado Medicaid) is the major staffing component of the new Department of Health Care Policy and Financing. Effective: July 1, 1994.  
| **July 1993**  | Case Management changed to be reimbursed as an administrative activity rather than fee-for-service, under the Home and Community-Based Services (HCBS) program for the Elderly Blind and Disabled (HCBS-EBD) and for persons living with AIDS (Human Immune-Deficiency Virus) (HCBS-PLWA).  
|                | As authorized by legislation, certified Audiologist and Speech Pathologists are from this date reimbursed directly for certain clinical services; these providers are no longer required to bill through a physician.  
|                | Implementation of a new computerized post-payment utilization review system for inpatient hospital services.  
<p>|                | Implemented Single Entry Point agencies to improve access to comprehensive long term care services, (implemented in 7 districts covering 15 counties). |</p>
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<td><strong>October 1993</strong></td>
<td>Timely filing deadlines for providers to submit claims for reimbursement were reduced from 180 days to 120 days from the date of service, in order to improve Medicaid expenditure tracking and budget projection.</td>
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<td><strong>January 1994</strong></td>
<td>Increased well-child examination reimbursement rates for children age 12-20 to reflect equity in reimbursements for preventive health services for all children.</td>
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<td><strong>February 1994</strong></td>
<td>The eighth Single Entry Point (SEP) agency for long-term care district was added in Weld County, bringing the total coverage by the Single Entry Point system to 16 counties.</td>
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<td><strong>May 1994</strong></td>
<td>Senate Bill 94-164 implemented many mandated features of the federal Omnibus Budget Reconciliation Act of 1993. Specifically, the statute strengthened requirements that insurance companies coordinate benefits with Medicaid, required insurers and employers to cooperate with medical support enforcement efforts, revised the way trusts can be used to shelter assets for Medicaid eligibility and extended estate recovery to persons aged 55 and older.</td>
</tr>
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<td><strong>June 1994</strong></td>
<td>The new Residential Treatment Center program began, and by the end of June was providing placement coupled with mental health treatment to 78 severely emotionally disturbed children between the ages of 5 and 18 years. Brain Injury waiver legislation authorized a HCBS program for persons with brain injuries. The program is scheduled for implementation in March 1995. Home Health Aide Pilot Project legislation authorized the Department to apply for a federal waiver and implement a program to pay for home health agency services outside the client's home. Services may be provided by a registered nurse or a certified home health aide delegated by an R.N. (as stipulated under the Nurse Delegation rule that recently passed the State Board of Nursing).</td>
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<tr>
<td><strong>July 1994</strong></td>
<td>HCBS for the Mentally Ill became effective, offering services that had not been available before to persons suffering from mental illness who meet admission criteria. Income trusts became effective for HCBS clients, requiring that monies which are distributed from the trust each month be subject to the same post-eligibility treatment of income (PETI) rules as are applied to clients who are not trust beneficiaries.</td>
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<td>July 1994,</td>
<td><strong>Reimbursement Rate increases became effective for:</strong></td>
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<td><strong>•</strong> Emergency transportation</td>
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<td>Legislation was passed authorizing guaranteed eligibility for managed care program enrollees. This optional program will provide federal financial participation (FFP) for premiums paid to certain federally qualified HMOs for clients who lose Medicaid eligibility, providing continued access to health care coverage through the HMO. Premiums may be paid for a maximum of six months. The program is scheduled to begin July 1, 1995.</td>
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<td>Legislation authorized the Department to seek a waiver for capitated mental health and establish a pilot program for a prepaid capitated single entry point system. The capitated mental health program is designed to provide comprehensive mental health services as soon as all necessary waivers are obtained from the Health Care Financing Administration.</td>
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<td>Senate Bill 94-110 became effective, directing the Department to establish a Quality of Care Incentive Payment program for the purpose of promoting and encouraging continued improvement in care provided by nursing facility vendors.</td>
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<td>August 1994</td>
<td>Children's Medical Model, formerly known as Katie Beckett Model 200 Waiver, became effective. The program will continue to provide HCBS eligibility and services to disabled clients up to age 19.</td>
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<td>September 1994</td>
<td>The AMP System was brought on-line to enable providers to bill the majority of their claims electronically, rather than with hard copy attachments as previously required.</td>
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<tr>
<td>January 1995</td>
<td>The Quality Incentive Program, developed in FY 93-94, began making incentive payments to nursing facilities that demonstrate high levels of performance and maintain high quality of care standards.</td>
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A. HEALTH CARE BACKGROUND AND ENVIRONMENT

Medicaid was enacted by Congress in 1964 to fund medically necessary health care services for families and individuals with low incomes. Colorado Medicaid became operational in January, 1969. Medicaid is funded by state and federal dollars, and administered by the states under federal law and regulations. States have limited flexibility in program design and management.

By the 1970s it became apparent that Medicaid was falling short of realizing the original goal of financing medically necessary health care for categorically needy persons. Problems included:
- cost-shifting to other payers,
- low Medicaid payment rates,
- lack of private health care providers where low-income individuals lived, and
- cultural gaps between low income citizens and the private health care delivery system.

Federal, state, and local governments made significant investments to address these problems. The publicly-funded health care system gained support through federal Public Health Service grants, increased federal and state Medicaid payments, and through direct state and local funding. Large urban public hospitals, community and rural health centers, and public health agencies are the foundation for this public health care delivery system.

Congressional action and court decisions in recent years have extended public coverage, especially through Medicaid, to groups of individuals such as pregnant women, the elderly and the disabled of all ages. Many of these newly-eligible individuals are in need of high-cost care. Congressional action has also required public payers including Medicaid to reimburse a number of provider groups such as hospitals, clinics and nursing facilities at substantially higher rates than before.

Today, Medicaid is a major source of revenue for hospitals, clinics and nursing facilities in Colorado. Medicaid pays for about one-third of all births. The growth in the number and type of individuals served by the public health care system, and in the rates paid to providers, has provided health care coverage to persons needing it, and reduced cost-shifting to other payers, but has also substantially increased Medicaid expenditures.

Because of these new financing pressures, states have found new ways to use the federal-state Medicaid program’s funding mechanisms to refinance state health care costs. By defining services previously funded with only state and local funds as a Medicaid benefit, states became eligible to receive federal Medicaid matching funds for the costs of those services. These refinancing strategies have contributed to rapid Medicaid budget growth in recent years. Because this growth in expenditures has largely been financed by federal dollars, Congress has in turn enacted laws restricting states’ refinancing options.
The Colorado Medicaid program has responded to these challenges with innovations and improvements in the administration and financing of existing systems. This section of the Annual Report provides a summary of the need for publicly supported health care services in Colorado, and the methods and systems that the program uses to address them, including:

- appropriate access to quality health care
- control of utilization and costs
- reimbursements to providers
- accountability, administration and information

The last part of Section IV, "Future Directions," identifies challenges and opportunities that Colorado Medicaid will address in FY 94-95 and beyond as the Nation's and State's health care systems continue to change.

**B. THE NEED FOR PUBLIC HEALTH CARE COVERAGE IN COLORADO**

**Who needs health care coverage in Colorado?**

Lack of health insurance remains a problem for a significant number of Colorado families. About 395,000 (14%) non-elderly Coloradans are uninsured.¹

![Chart 1, Uninsured Coloradans by Age](chart1)

![Chart 2, Colorado Rates of Insurance by Age Group](chart2)

¹ The statistics in this section are taken from the Urban Institute's State Level Data Book on Health Care Access and Financing, October 1994. The data reported by the Urban Institute is drawn from the Current Population Survey (CPS) of the Census Bureau for 1991, 1992, and 1993. The CPS sample is based on the civilian noninstitutionalized population of the United States. Medicaid enrollment and expenditure data is drawn from required reporting by states on the HCFA 2082 and HCFA 64 formats.
Persons in families in or near poverty are most likely to be uninsured. Twenty-seven percent of non-elderly Coloradans with family incomes under the federally defined level of poverty ($14,763 for a family of four in 1993) are uninsured, while 25% of those with incomes between 100 and 199% of poverty, 12% of those with incomes between 200 and 399% of poverty, and only 6% of those with incomes over 400% of poverty are uninsured. 12% of non-elderly Coloradans have family incomes below poverty, yet this segment of the population comprises 24% of the non-elderly uninsured. While 16% of non-elderly Coloradans have family incomes between 100 and 199% of poverty, this income group makes up 29% of the non-elderly uninsured. Medicaid covers 46% of Coloradans in families with incomes below poverty, but covers only 8% of persons in families between 100 and 199% of poverty.

Adults between the ages of 18 and 34 are more likely to be uninsured than other age groups. Although adults from age 18 to 34 comprise 30% of the non-elderly population, they account for 42% of the non-elderly uninsured population. This is partly because the 18 to 34 age group has lower incomes than children or older adults. Medicaid is the major reason uninsurance rates for children are relatively low. Medicaid covers 14% (116,280) of all Coloradans under age 18.

Twenty-five percent of single-person families are uninsured and single persons make up 40% of the non-elderly uninsured. This is partly because Medicaid does not cover non-elderly single persons unless they are disabled. Medicaid does cover 41% of the single-parent families in Colorado; 47% of single-parent families in Colorado are in poverty.

The vast majority (88%) of the non-elderly uninsured are in working families even though 68% of Coloradans under the age of 65 have insurance coverage through their own or a family member’s employment. Twenty-three percent or 112,700 of the workers in businesses with fewer than 25 employees are without health insurance. These uninsured workers in small businesses make up 46% of the total uninsured. Workers in the wholesale and retail trade industries have a much higher rate of uninsurance (25%) than other sectors. Even though the vast majority of the uninsured have at least one worker in their family, Medicaid covers only 3.8% of non-elderly Coloradans in working families.

Medicaid has been very effective at keeping down the rate of uninsurance among people in non-working families below or near poverty, particularly for children and women in single-parent families. However, Medicaid does not cover many Coloradans in low-income working families. For this reason low-income working families have the highest rate of uninsurance.

Although the uninsurance rate among the elderly is only .3% in Colorado because of coverage by Medicare, Medicaid plays a major role in providing services not covered by Medicare. The Medicaid program provides long-term care services to over 31,000 persons, and pays Medicare premiums and deductibles for 2,500 low-income elderly Coloradans.

Does Medicaid meet the need for coverage of low-income Coloradans? Colorado Medicaid coverage meets the needs of certain low-income Coloradans by

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2 Statistic from the 1993 Robert Wood Johnson Foundation Survey of Family Health Insurance. Study conducted by the RAND Corporation.
providing comprehensive health care coverage for those enrolled in the program. With few exceptions, Medicaid enrollees receive all medically necessary services. Some services provided to Medicaid clients require nominal client co-payments, but there are exemptions for children and certain conditions, such as pregnancy. Additional benefits such as transportation to medical appointments, services for technologically dependent and homebound patients, long-term care services, and comprehensive clinic services are provided to Medicaid enrollees to meet the special needs of low-income, elderly and disabled persons.

**Medicaid does not enroll all Coloradans in need of coverage.**

Colorado Medicaid and other public health care coverage does not address the lack of coverage for an additional half-million citizens who have no health insurance. The uninsured are persons who are ineligible for Medicare because they are under 65 years of age and not totally disabled, and who are ineligible for Medicaid because their household income is too high, their children were born before September 30, 1983, and/or they have other resources in excess of the limits for eligibility. These Coloradans may access only emergency or urgent care, since their out-of-pocket costs for health care often exceed their ability to pay for routine care.

Although the Colorado Indigent Care Program (CICP) reimburses hospital and clinic providers for some costs of serving low-income persons not covered by Medicaid, providers of care to this group are frequently unable to recover remaining costs of provision from the clients, since those clients have inadequate financial resources. Providers must then "shift" these unrecovered costs to other payers, or absorb the losses.

Colorado's enrollment of eligible children by Medicaid is significantly below the national average. This is in part because Colorado is one of only 14 states that does not offer a Medically Needy program. Also, while Colorado offers coverage to low-income families under the Baby Care Kids Care Program, eligibility in the state's program is limited to families with income below 133% of the federal poverty level. Under federal law, many other states have chosen to cover children and pregnant women in families with incomes up to 185% of the poverty level, with additional income disregards that Colorado does not currently allow.

Medicaid enrollment as a percentage of low-income persons varies from county to county. See Table 2 below for this information.

### C. MEDICAID ELIGIBILITY AND ENROLLMENT

**Who is eligible for Medicaid coverage?**

Medicaid coverage is available to persons who can meet income, resource and other criteria of eligibility for specific State and federally-defined assistance programs.

Categories of assistance under which persons may qualify for Colorado Medicaid are:

- Aid to Families with Dependent Children (AFDC)
- Baby Care Kids Care -- pregnant women, and children through age 6, in families with incomes at or below 133% of the federal poverty level. Resources available to the child may not exceed the proportionate share of the AFDC standard.
- Children born after September 30, 1983, in families with incomes at or below 100% of poverty level and limited resources ("Ribicoff children")
- Foster Care Children -- when a county assumes full or partial financial responsibility
• Undocumented Aliens -- persons who have not established permanent legal residence in this country but who can meet the income and resource requirements of one of the other programs listed above, and who require emergency care including prenatal and delivery services
• Qualified Medicare Beneficiaries -- persons with limited income and resources
• Disabled widow(ers) at least 50 years old who have become ineligible for SSI as a result of becoming eligible for federal social security survivor's benefits
• Special Low-income Medicare beneficiaries (SLMB)
• Qualified Working Disabled persons -- up to 200% of federal poverty level
• Colorado Old Age Pension supplement to federal Social Security payments
• Elderly, Blind & Disabled persons who receive Supplemental Security Income (SSI) and the Colorado Old Age Pension supplement
• Persons with incomes below 300% of the federal Supplemental Security Income level who require long term care in Nursing Facilities or through the Home and Community Based Services (HCBS) programs. Eligibility for HCBS includes persons with HIV/AIDS diagnoses, mentally ill, brain injured, developmentally disabled and children who qualify for the Children's HCBS (Model 200) Waiver, as well as elderly, blind and disabled
• Persons needing nursing facility care or HCBS services whose monthly income is over 300% of the SSI payment level - the income in excess of the 300% level is diverted to a specific type of court-approved income trust
• Disabled children up to age 19 who qualify for the HCBS Children's Medical Model

Medicaid is an "entitlement" program. In order to be determined eligible for Medicaid, an applicant must fall into one of the listed categories of need and not exceed applicable financial resources. An eligible person is then entitled by law to receive all medically necessary health services in the Medicaid benefit package. There are exceptions to this rule. For example:
• Adults are not eligible for hearing services, or for restorative, reconstructive or preventive dental care. Limited vision services are available.
• Persons without proof of U.S. citizenship or permanent legal residence status are entitled by federal law to receive emergency medical care only.
• Qualified Medicare Beneficiaries and Qualified Disabled Working Individuals are entitled to have Medicaid pay premiums and/or cost sharing (co-insurance and deductibles) for Medicare benefits.
• The HCBS Children's Medical Model provides an alternative to children who require hospital or skilled nursing facility services, but whose parents have income that makes the child ineligible for SSI payments.

Who enrolls in Medicaid, and why?
The State's economy, and federal, state and local policies and mandates, influence Medicaid expenditures by causing more or fewer persons to be eligible and/or to enroll in the program. Medicaid enrollment levels are generally counter-cyclical to growth or recession in the State's economy but are affected by many other factors. If the State's economic conditions change for the worse (for example, job losses, increase of migration of uninsured persons from other states, or an increased proportion of jobs without health care coverage), Colorado Medicaid enrollments will increase. Actual enrollment in the Medicaid program often occurs at the time an individual experiences high health care costs, such as during pregnancy or as a result of serious illness or injury. The following charts show the actual number of Medicaid enrollees through FY 94, and projected enrollments for FY 95.
Chart 3,
Average Monthly Medicaid Enrollment -
Summary of Group Subtotals

SOURCE: Medicaid Budget Request and Narrative
Chart 3a, Medicaid Enrollment Detail - Children

Chart 3b, Medicaid Enrollment Detail - Elderly & Disabled

Chart 3c, Medicaid Enrollment Detail - Adults
Qualifications to charts 3, 3a, 3b, 3c:

- The AFDC adult and child categories of eligibility include two groups - 1) families receiving a financial payment and Medicaid and 2) those receiving Medicaid only and no financial payment. The number of AFDC adults and children eligible for both a financial payment and Medicaid is decreasing. The number of AFDC adults who receive Medicaid only has stabilized and is expected to remain stable. The same is true for Baby Care Kids Care adults and children.

The only AFDC sub-group that shows an increase is children who receive Medicaid only. This category is increasing because children's eligibility expands annually by one year of age. Under this eligibility category, children must meet three criteria: 1) income at or below 100% of the poverty level; 2) resources below the allowable limit of $1,000; and 3) born after September 30, 1983. By the year 2001, all Colorado children under age 18 who have limited income and resources will be Medicaid eligible. As a result, enrollment in this category of eligibility will continue to grow.

- Medicaid coverage of emergency services for undocumented aliens is mandated under federal regulations. This group is composed of adults, children, elderly and disabled persons.

Medicaid enrollment in FY 93-94:

With the exception of two new population groups (mentally ill and clients with income trusts) that were added to the Home and Community Based Services Program, there were no new federal Medicaid eligibility mandates in FY 93-94. Enrollment growth in most categories of eligibility moderated.

Enrollment patterns differ among different populations (categories of eligibility). For example, Medicaid enrollment of pregnant women increased dramatically in Fys 90-91 and 91-92 as a result of the federal requirement to cover pregnant women and young children in families with incomes up to 133% of the federal poverty line. Most other categories of eligibility were held to much lower income maximums. The increase in AFDC and Baby Care enrollment of children appears to be moderating. This may be attributable in part to factors such as the state's improving economy and increased child support enforcement.

Enrollment of elderly persons has not increased as much as might be expected from the increase in the size of this demographic group. This may be because Medicare and Social Security have helped older persons to remain independent longer.

The steady rise of enrollment of persons with disabilities is significant because this group has the highest utilization of health care services. Inpatient hospital and long-term care services required by many persons with disabilities are also the highest cost health care services. This combination of increasing enrollment and high costs of care in the disabled group continues to comprise a major component of Medicaid budget growth.

Patterns of continuing enrollment also differ among eligibility groups. For example, some pregnant women remain Medicaid-enrolled for less than a year, while elderly and disabled persons usually remain covered for many years.
Enrollment variation by area of the State:
As the table on the following page shows, the percentage of persons eligible to receive Medicaid coverage who actually enroll varies across the state. For example, counties in the southern part of Colorado have a higher percentage of low-income persons than other parts of the state, and these counties with a high incidence of poverty tend to enroll a high percentage of their low-income residents in Medicaid. Adams and Denver counties also enroll a high percentage of low-income residents in Medicaid. Central mountain counties enroll the lowest percentage of their residents with low incomes.

Percentage of births covered by Medicaid (including Baby Care coverage of women with family incomes to 133% of poverty level) follows a similar pattern, but differs in some counties. The difference may be attributable to a combination of factors including local availability of Medicaid-enrolled pre-natal and obstetric providers, and the fact that the percentage of Baby Care births is closely associated with the economic level of young families and single mothers in each county.

Sources for Table 2 below:

FY 92-93 Estimated Medicaid Enrollments and Demographics:

Colorado Births:
  Department of Public Health and Environment, Family and Community Health Services, September 1994.
### Table 2,
Medicaid Enrollments and Births by County

<table>
<thead>
<tr>
<th>COUNTY</th>
<th>Estimated Number of Medicaid Enrollees</th>
<th>Population Below Poverty Line</th>
<th>Percentage of BPL Enrolled in Medicaid</th>
<th>Total Births</th>
<th>Number of Births by Medicaid</th>
<th>Percentage of Births Covered by Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADAMS</td>
<td>22,900</td>
<td>27,267</td>
<td>84%</td>
<td>4803</td>
<td>1838</td>
<td>38%</td>
</tr>
<tr>
<td>ALAMOSA</td>
<td>2,160</td>
<td>3,127</td>
<td>69%</td>
<td>232</td>
<td>155</td>
<td>67%</td>
</tr>
<tr>
<td>ARAPAHOE</td>
<td>16,140</td>
<td>22,973</td>
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<td>6237</td>
<td>1367</td>
<td>22%</td>
</tr>
<tr>
<td>ARCHULETA</td>
<td>530</td>
<td>903</td>
<td>59%</td>
<td>74</td>
<td>56</td>
<td>76%</td>
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<tr>
<td>BACA</td>
<td>422</td>
<td>853</td>
<td>49%</td>
<td>47</td>
<td>29</td>
<td>62%</td>
</tr>
<tr>
<td>BENT</td>
<td>810</td>
<td>957</td>
<td>85%</td>
<td>56</td>
<td>46</td>
<td>82%</td>
</tr>
<tr>
<td>BOULDER</td>
<td>9,120</td>
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<td>38%</td>
<td>3176</td>
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<td>CHAFFEE</td>
<td>850</td>
<td>1,649</td>
<td>52%</td>
<td>136</td>
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<tr>
<td>CHEYENNE</td>
<td>120</td>
<td>273</td>
<td>44%</td>
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<td>11</td>
<td>39%</td>
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<tr>
<td>CLEAR CREEK</td>
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<td>716</td>
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<td>35%</td>
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<tr>
<td>CONEJOS</td>
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<td>2,510</td>
<td>60%</td>
<td>114</td>
<td>79</td>
<td>69%</td>
</tr>
<tr>
<td>COSTILLA</td>
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<td>1,101</td>
<td>73%</td>
<td>43</td>
<td>32</td>
<td>74%</td>
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<tr>
<td>CROWLEY</td>
<td>660</td>
<td>693</td>
<td>95%</td>
<td>37</td>
<td>29</td>
<td>78%</td>
</tr>
<tr>
<td>CUSTER</td>
<td>160</td>
<td>352</td>
<td>45%</td>
<td>26</td>
<td>17</td>
<td>68%</td>
</tr>
<tr>
<td>DELTA</td>
<td>2,470</td>
<td>3,647</td>
<td>68%</td>
<td>263</td>
<td>179</td>
<td>68%</td>
</tr>
<tr>
<td>DENVER</td>
<td>61,510</td>
<td>78,515</td>
<td>78%</td>
<td>8739</td>
<td>3824</td>
<td>44%</td>
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<tr>
<td>DOLORES</td>
<td>100</td>
<td>217</td>
<td>46%</td>
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<td>65%</td>
</tr>
<tr>
<td>DOUGLAS</td>
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<td>53%</td>
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<td>ELBERT</td>
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<td>654</td>
<td>49%</td>
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<tr>
<td>EL PASO</td>
<td>28,130</td>
<td>38,515</td>
<td>71%</td>
<td>7409</td>
<td>2227</td>
<td>30%</td>
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<td>FREMONT</td>
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<td>4,577</td>
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<td>240</td>
<td>63%</td>
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<td>GARFIELD</td>
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<td>2,720</td>
<td>71%</td>
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<td>168</td>
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<td>GILPIN</td>
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<td>321</td>
<td>22%</td>
<td>44</td>
<td>11</td>
<td>25%</td>
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<tr>
<td>GRAND</td>
<td>240</td>
<td>735</td>
<td>33%</td>
<td>83</td>
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<td>1,497</td>
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<td>71</td>
<td>47%</td>
</tr>
<tr>
<td>HINSDALE</td>
<td>10</td>
<td>65</td>
<td>15%</td>
<td>7</td>
<td>3</td>
<td>43%</td>
</tr>
<tr>
<td>HUERFANO</td>
<td>1,100</td>
<td>1,511</td>
<td>73%</td>
<td>72</td>
<td>54</td>
<td>75%</td>
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<td>JACKSON</td>
<td>70</td>
<td>180</td>
<td>44%</td>
<td>16</td>
<td>10</td>
<td>63%</td>
</tr>
<tr>
<td>JEFFERSON</td>
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<td>62%</td>
<td>6827</td>
<td>1269</td>
<td>19%</td>
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<td>KIOWA</td>
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<td>73</td>
<td>48%</td>
<td>13</td>
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<tr>
<td>KIT CARSON</td>
<td>500</td>
<td>1,076</td>
<td>46%</td>
<td>100</td>
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<td>38%</td>
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<tr>
<td>LAKE</td>
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<td>737</td>
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<td>43</td>
<td>47%</td>
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<td>LA PLATA</td>
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<td>4,804</td>
<td>38%</td>
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<td>48%</td>
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<td>33%</td>
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<td>LAS ANIMAS</td>
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<td>12</td>
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<tr>
<td>MOFFAT</td>
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<td>69%</td>
<td>161</td>
<td>81</td>
<td>50%</td>
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<td>3,735</td>
<td>48%</td>
<td>315</td>
<td>166</td>
<td>53%</td>
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<td>3,412</td>
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<td>50%</td>
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<td>OTERO</td>
<td>3,470</td>
<td>4,698</td>
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<td>325</td>
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<td>66%</td>
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<td>220</td>
<td>23%</td>
<td>18</td>
<td>5</td>
<td>28%</td>
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<td>669</td>
<td>34%</td>
<td>102</td>
<td>26</td>
<td>25%</td>
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<td>24</td>
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<td>1767</td>
<td>1076</td>
<td>61%</td>
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<td>787</td>
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<td>76</td>
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<td>54%</td>
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<td>171</td>
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<td>61%</td>
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<td>310</td>
<td>1,362</td>
<td>23%</td>
<td>194</td>
<td>40</td>
<td>21%</td>
</tr>
<tr>
<td>SAGUACHE</td>
<td>850</td>
<td>1,399</td>
<td>61%</td>
<td>89</td>
<td>69</td>
<td>78%</td>
</tr>
<tr>
<td>SAN JUAN</td>
<td>40</td>
<td>96</td>
<td>42%</td>
<td>3</td>
<td>3</td>
<td>100%</td>
</tr>
<tr>
<td>SAN MIGUEL</td>
<td>80</td>
<td>416</td>
<td>19%</td>
<td>62</td>
<td>13</td>
<td>21%</td>
</tr>
<tr>
<td>SEDGWICK</td>
<td>180</td>
<td>305</td>
<td>59%</td>
<td>25</td>
<td>6</td>
<td>24%</td>
</tr>
<tr>
<td>SUMMIT</td>
<td>140</td>
<td>1,004</td>
<td>14%</td>
<td>195</td>
<td>43</td>
<td>22%</td>
</tr>
<tr>
<td>TELLER</td>
<td>580</td>
<td>1,251</td>
<td>46%</td>
<td>171</td>
<td>58</td>
<td>34%</td>
</tr>
<tr>
<td>WASHINGTON</td>
<td>260</td>
<td>748</td>
<td>35%</td>
<td>52</td>
<td>20</td>
<td>35%</td>
</tr>
<tr>
<td>WELD</td>
<td>11,910</td>
<td>19,594</td>
<td>61%</td>
<td>2330</td>
<td>972</td>
<td>42%</td>
</tr>
<tr>
<td>YUMA</td>
<td>490</td>
<td>1,171</td>
<td>42%</td>
<td>108</td>
<td>37</td>
<td>34%</td>
</tr>
<tr>
<td><strong>OVERALL TOTAL</strong></td>
<td><strong>251,590</strong></td>
<td><strong>375,214</strong></td>
<td><strong>67%</strong></td>
<td><strong>54012</strong></td>
<td><strong>18596</strong></td>
<td><strong>34%</strong></td>
</tr>
</tbody>
</table>
D. Medicaid Benefits & Coverage

Colorado Medicaid benefits include the following services when medically necessary and rendered to an enrolled Medicaid client by an enrolled Medicaid provider.

Federally Required Services:
Colorado covers all federally mandated Medicaid services, including:
- Inpatient hospital services
- Outpatient hospital services
- Physician and other practitioner services
- Rural Health Clinics and Federally Qualified Health Centers (FQHC’s)
- Laboratory and radiology services
- Nursing Facility care, including long-term care in designated hospital beds
- Family planning
- Early and Periodic Screening, Diagnosis, and Treatment. (Includes dental, vision, hearing and lead screening services for children to age 21; and includes all medically necessary services to treat conditions identified in the EPSD&T screening)
- Home health services
- Nurse midwife services
- Pediatric and family nurse practitioner services
- Durable Medical Equipment, supplies and appliances suitable for use in the home, (when provided under Home Health Services)
- Emergency medical assistance to eligible undocumented aliens

Optional Services
Colorado covers additional services designated "Optional" under federal Medicaid regulations. These include:
- Additional Home Health (Therapies)
- Rehabilitation services as appropriate to community mental health centers
- Transportation
- Intermediate care facilities for the mentally retarded
- Case management
- Services of a licensed psychologist
- Podiatry
- Alcohol and drug abuse treatment for pregnant women
- Private duty nursing
- Other Clinics (Community Mental Health, Ambulatory Surgical Centers, Dialysis Clinics, certified health agencies)
- Prescription Drugs
- Durable Medical Equipment and Supplies (in addition to those listed above, which are required for clients receiving home health services)
- Optometrist services and (after eye surgery) eyeglasses for clients aged 21 and over
- Under 21 and Over 65 Inpatient Mental Health care (Institutional)
- Hospice care
- Prosthetic devices, when surgically implanted
- Community-supported living arrangements for the developmentally disabled
- Program of All-Inclusive Care for the Elderly (PACE), demonstration status
- The program for residential treatment/mental health for clients up to age 18
Waivered Services
The federal government has granted the State waivers of certain Medicaid regulations. These waivers allow Colorado the following program flexibility:

- **Long Term Care/Home and Community Based Services (HCBS) programs**
  These waivers allow reimbursement for services to persons who can be safely and cost-effectively served in their homes or in community (non-institutional) settings as an alternative to institutional care. The following client groups are eligible for home or community-based care:
  - Elderly, Blind & Disabled
  - Developmentally Disabled
  - Persons Living With AIDS/HIV
  - Children’s HCBS Waiver (formerly Model 200 - Katie Beckett) for persons under 18 years of age
  - Persons with major mental illness
  - Persons with brain injury (pending federal approval)

- **Acute Care/Managed Care**
  In order to develop and operate its Managed Care program, the State has obtained waivers of federal regulations pertaining to:
  - Statewide uniformity of benefits (statewideness)
  - Comparability of benefits and coverage among all groups of enrollees, and
  - Freedom of choice of any provider by clients

These waivers permit the State to:
- operate a Capitated Mental Health Program, and to
- require Medicaid enrollees to choose a Managed Care provider of one of the following types:
  - Health Maintenance Organization (HMO)
  - Primary Care Physician (PCP)
  - Prepaid Health Plan (PHP)

- **Demonstration Waiver to Operate a Managed Care Program for the Frail Elderly**
  Beginning in October 1991, the Colorado Medicaid program utilized a demonstration waiver to operate the Program of All-Inclusive Care for the Elderly (PACE)
Other Non-Medicaid Programs managed by Health Plans and Medical Services

"State Only" Health Care Services: In addition to Medicaid services, Colorado offers several health care programs which are funded solely by the State. As a general rule, these programs are not subject to federal Medicaid regulations; therefore, they are not entitlement programs under which eligible persons have a federally-mandated right to receive a particular kind or level of services. Benefits and eligibility for "State Only" programs are provided in accordance with State law and budgetary limits. The following “State-only” programs are administered by the Colorado Department of Health Care Policy and Financing’s Health Plans and Medical Services Divisions:

The Colorado Old Age Pension Health and Medical Fund program is financed from the Colorado Old Age Pension Fund under a State Constitutional provision. $10 million is appropriated annually by statute for a revolving fund to provide medical services. Inpatient psychiatric and long-term care are not included.

The Home Care Allowance and Adult Foster Care programs are components of the Long Term Care system, and are funded by 95% General Fund and 5% cash funds from counties. These programs operate as follows:

Home Care Allowance: This program makes direct client payments, up to a maximum of $330 per month, for the purchase of services related to activities of daily living. These services are designed to enable the client to remain at home and prevent more restrictive, expensive care, such as nursing facility services. Priority for services is given to clients with the lowest functional abilities and the highest unmet need for paid care. Services may include dressing, bathing, assistance in getting in and out of bed, eating, grooming, care related to bowel and bladder control, homemaking services and other supportive services.

Adult Foster Care: This program provides twenty-four hour supervised residential non-medical care for no more than 16 individuals per facility who cannot live alone but do not need continuous medical supervision. Services include protective oversight, supervision of medications, and assistance with activities of daily living.

Colorado Indigent Care Program (CICP): CICP reimburses a portion of costs for care provided to medically indigent persons who receive services through one of the four following programs:

1. Denver Indigent Care Program
2. University Hospital Indigent Care Program
3. Out-State Indigent Care Program
4. Specialty Indigent Care Program

In order to qualify for assistance from CICP, a family’s income must be less than 185% of the federal poverty level. Approximately 356,000 Coloradans have incomes below 200% of the poverty level (Colorado Health Source Book). CICP patients used inpatient and outpatient health care services about 489,000 times in 1994. The CICP published in January 1995 a report on its 1994 operations entitled “FY 94 Annual Report of the Colorado Indigent Care Program” which is available from HCPF.
E. ACCESS TO CARE

Who delivers health and medical services to Medicaid enrolled clients?
About 9,200 active providers in Colorado, and another 800 providers outside the State, are enrolled in the Colorado Medicaid program and are eligible to receive reimbursement for services rendered to Medicaid covered persons. Enrollees usually obtain health care from Colorado providers, but may use out-of-State providers when they are more accessible in areas adjacent to the Colorado border, or when medical necessity is established for care not available in the State. Foster children placed outside the state may receive the usual Medicaid benefits from providers in their locality, and clients traveling outside the state may receive emergency care, if the rendering provider enrolls as a Colorado Medicaid provider.

Managed Care
Colorado Medicaid has established a system of Managed Care under which Medicaid clients select a primary care provider upon enrollment. Enrollees, unless exempt for reasons of provider availability or Medicare enrollment, are required to choose either a Primary Care Physician (PCP), a Health Maintenance Organization (HMO) or Prepaid Health Plan (PHP) as a primary care provider. The selected PCP, PHP or HMO provider delivers primary care, manages the individual's health care and controls access to more specialized care providers.

In FY 93-94, the Department intensified development of managed care system HMO options. Contracts were negotiated with four new Medicaid HMOs, and clients were offered new managed care options. As a result, a major increase in Medicaid HMO enrollments is underway. According to the National Institute for Health Care Management, the Colorado Medicaid Program's capitation growth rate between 1993 and 1994 was the fourth largest in the United States. The following chart shows the growth in Managed care (PCP and HMO) enrollments over the past four years:

Chart 4,
Medicaid Managed Care Enrollments
in HMO/Pre-Paid Health Plan and Primary Care Physician Program

![Chart showing Managed Care Enrollments]

SOURCE: Managed Care Section Enrollment Data.
Overall, Medicaid clients in FY 93-94 were enrolled with primary care providers as follows:

Chart 5,
Medicaid Managed Care Enrollments and "Not Assigned" clients as of 10/1/94

<table>
<thead>
<tr>
<th>PCP</th>
<th>39%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rocky Mountain</td>
<td>5%</td>
</tr>
<tr>
<td>Exclusive Care</td>
<td>2%</td>
</tr>
<tr>
<td>Kaiser</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>ChoiceCare</td>
<td>4%</td>
</tr>
<tr>
<td>HMO-Colo</td>
<td>1%</td>
</tr>
<tr>
<td>Lock-In</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Not Assigned</td>
<td>49%</td>
</tr>
</tbody>
</table>

KEY: HMOs: Rocky Mountain, Exclusive Care, Kaiser-Permanente, ChoiceCare, HMO-Colorado
PCP: Primary Care Physician program (Fee-for-Service Managed Care)
Lock-In: Clients restricted to single providers of primary care and pharmacy

NOTE: Managed Care enrollments are shown as of 10/1/94 rather than as of the end of FY 93-94, in order to show the rapid growth in HMO enrollments that are resulting from HMO program development accomplished in FY 93-94.

SOURCE: Managed Care Section Enrollment Data

Is access to health care services available to Medicaid enrollees?
Access to care for Medicaid-enrolled persons is available in most geographic locations in the State but remains a major concern of the program. The major access problems faced statewide by the Medicaid program and by Medicaid clients are 1) the availability of Primary Care Physicians (PCPs willing to accept new Medicaid clients into their practices), and 2) the availability of some medical specialists. Many physicians cite Medicaid’s physician reimbursement rates as the reason for limiting the number of Medicaid clients they will accept into their practices. If an HMO, Rural Health Clinic or Federally Qualified Health
Center is not available in the client's geographic area, the lack of PCPs willing to accept new Medicaid clients is a primary care access problem.

Other services, such as pre-natal, dental, or specialty care, may be difficult for Medicaid enrollees to access close to their place of residence. Payment rates for long term care services are too low to encourage provider participation, and with the exception of nursing facilities and home health agencies, are not always accessible near enrollees' place of residence (and family supports).

There are several counties in the State where primary care, emergency, and/or long term care services are not available within the 45-minute travel radius customarily used to measure emergency care accessibility. Most of these areas are very rural, and the health care access problem is the same for all persons in the area regardless of the funding source. A few counties have adequate service access for non-Medicaid clients, but primary care and/or specialty care physicians decline to serve Medicaid clients. Where access problems exist, two forms of less-than-optimal utilization can occur: under-utilization of needed services, and over-utilization of urgent care and emergency room services.

What is Medicaid doing to assure adequate access to care for enrollees?
The Medicaid program employs a variety of techniques to assure and improve access to care, including:

- Operating the Primary Care Physician program (PCP) that links clients with a PCP or a HMO to facilitate early access to primary and preventive care. During FY 93-94, a Prepaid Health Plan (PHP) was added as a provider-type eligible to act as a PCP.
- Working through County Departments of Social Services to inform clients of PCP, HMO, PHP and other care options.
- Distributing informational brochures on the Medicaid program through providers, community agencies and directly to clients, to educate clients and potential clients, providers and the general public about Medicaid coverage, benefits and procedures for access.
- Operating the Managed Care Hotline, providing telephone referral to available practitioners. Over 3,000 individual clients per week use the Hotline.
- Improving reimbursement rates for primary care services as well as for dental and transportation services.
- Reimbursing for costs of transportation to medical appointments.
- Working with local and statewide consumer, governmental and provider groups and institutions to develop cooperative solutions to local access problems and to improve availability of health personnel and delivery systems.
- Improving reimbursement rates for Home and Community Based Long Term Care services.

The Medicaid Reform/Baseline Study includes an independent analysis of access issues. The Medicaid Rate Study addresses the inequities in provider reimbursement that affect access to care. See "Sources" at the end of this Report.
F. QUALITY OF CARE ASSURANCE

The Colorado Medicaid program is committed to the principle that Medicaid-covered individuals will have adequate access to the same high quality of health care as other Coloradans. Various methods are used to monitor, control and improve the quality of care, while also controlling expenditures. These methods include contractual specification and monitoring for compliance, licensure and certification of providers, computerized and manual quality assurance reviews, surveying client satisfaction, follow-up on comments and complaints, and other program and contractor performance evaluation. Examples of how these combined cost and quality control systems work are provided below.

Automated Review Systems
The Medicaid Management Information System (MMIS) collects and processes billing data to reimburse providers and to control utilization and costs. The MMIS data base is used to identify access and quality of care problems such as over-provision or under-provision of care. The Drug Utilization Review program, the Inpatient Hospital Review system and the Surveillance and Utilization Review System are three examples of combined cost and quality control systems that use MMIS data. These systems are discussed elsewhere in the Annual Report.

Managed Care
Managed Health Care strategies combine aspects of quality of care assurance and cost control by providing continuity of care and access to timely and necessary care, while at the same time limiting access to care that is not needed or that is more expensive than necessary. Managed Care strategies include the Primary Care Physician Program (PCP or PCPP), contracts with Health Maintenance Organizations (HMOs) and Prepaid Health Plans (PHPs), and various long term care case management programs, notably the Single Entry Point (SEP) system now being implemented.

Medicaid enrollees (with some exceptions such as dually eligible Medicare/Medicaid enrollees) are required to select a PCP, PHP or HMO. The PCP, PHP or HMO provides 24 hour access to primary or urgent care, and manages the individual's health care. The care provider is responsible for determining when referral to specialist or other care such as hospitalization is required, assuring that access to care is appropriate, and that care delivered is of adequate quality to meet the health care needs of the enrolled individual.

Frail elderly clients who participate in the Program of All-Inclusive Care for the Elderly (PACE) demonstration project are provided services through a comprehensive medical, rehabilitative and social services model. The services are provided through Total Longterm Care, Inc., and reimbursed on a monthly capitation basis. Services may be provided in the client's home, adult day center, nursing facility or acute care hospital. Since the service strategy is to provide preventative and rehabilitative care as substitutes for costly institutional services, the provider must assure that health care services provided to the clients are not only comprehensive, but exceptional. The program is dedicated to keeping clients functional in a community setting, requiring that both the client and his or her family are satisfied with the quality of care. A yearly participant satisfaction survey is conducted by staff from the Department. The Survey conducted in FY 93-94 indicated PACE clients are satisfied with the program.
Single Entry Points provide managed long term care including referral to appropriate services, care planning and monitoring to persons seeking Medicaid and “State Only” long term care services. Clients seeking long term services are able to utilize “one-stop shopping”, instead of being required to go through several different agencies. The SEP concept is based on a case management approach, which includes information and referral, resource development, brokering and monitoring of services. By coordinating services through one focal point, not only is duplication avoided but quality oversight is also provided.

During FY 94-95, the Department will conduct a pilot managed care program sponsored by the Robert Wood Johnson Foundation. Acute, ambulatory and long term care services are included in the pilot program.

**Licensure and certification:**
Medicaid providers must be licensed and/or certified as required by federal and state law. This certification and licensure assures that Medicaid clients receive services only from qualified providers, and that a minimal standard of care is delivered.

All of the physicians, nurses, health aides, and therapists who are enrolled as Medicaid providers are licensed by the Colorado Department of Regulatory Agencies before they can treat Medicaid clients. The program routinely assures that such providers have the necessary licenses before Medicaid makes payment for services.

In addition, physicians are licensed by the State Board of Medical Examiners. Hospitals are accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO), which reviews all systems for quality of care and other conformance to standards. Some providers are specifically regulated under the Medicaid and/or Medicare programs.

**Certification of Agencies:**
The Medicaid program contracts with the Colorado Department of Public Health and Environment, Health Facilities Division, to conduct surveys of the following agencies:

- Nursing Facilities
- Home Health Agencies
- Alternative Care Facilities
- Personal Care, Homemaker and Adult Day Care Agencies
- Medical Laboratories
- Hospice Agencies

Many of the standards of care and certification for nursing facilities, laboratories, home health and hospice agencies are established by federal Medicaid/Medicare law and regulation. Nursing facilities are surveyed on an average of every twelve months. In addition to the survey process, the Department has the authority to impose enforcement remedies when quality of care standards are not met. Several civil monetary penalties have been imposed in the past year.
Acute and Ambulatory Care:

- **Infant Immunization:** Pursuant to House Bill 92-1208, the Colorado Department of Public Health and Environment (DPHE) and HCPF developed the Infant Immunization program that makes vaccine for immunizing Medicaid-enrolled children available at no cost to physicians. In its first full year of operation, the program provided 157,768 units of vaccine to enrolled children - an increase of 69% over 1991, the base year. The goal of immunizing more Colorado children is being met.

- **Capitated Mental Health demonstration:** Federal waivers were obtained to demonstrate the effectiveness of prepaid, capitated, comprehensive mental health services. HCPF Managed Care staff collaborated with the Department of Human Services to issue a Request for Proposal (RFP) to implement the project. Contracts had not yet been signed at the time of publication of this report.

- **Primary Care Physician Program:** The Department revised protocols for Medicaid recipients who use emergency treatment facilities. Hospital emergency departments are now required to perform triage, provide only emergency care unless authorized by the PCP and to notify the Department of any access or quality of care issues identified. A 24-hour, seven day per week Managed Care Hotline is available for this purpose.
  - An automated telephone system assists PCPP Hotline staff to handle an average of 600-700 calls per day. Medicaid clients and providers now have direct access to names of physicians willing to provide PCP services.
  - As of October 31, 1994 there were 1,940 physicians enrolled as primary care providers; they had a patient load of 108,804 clients - 40.71% of total Medicaid enrollment.

- **Client Satisfaction Surveys:** Satisfaction survey forms were mailed to a random sample of PCPP and HMO enrollees in order to determine how clients perceive their access and quality of services. Clients enrolled in both programs consistently express a high level of satisfaction with the care received.

- **Best Practice Guidelines program:** Clinical and practice management guidelines were published for pediatric immunizations. These guidelines are the first of a series of Best Practice Guidelines developed to improve the quality of care received by PCP enrollees. The program will be implemented in July 1995.

- **Drug Utilization Review (DUR) program:** The Colorado Medicaid retrospective DUR program achieved national recognition and has been used as a prototype by other state Medicaid agencies. Two new drug utilization review procedures were added to the program in order to reflect medical and pharmaceutical expertise statewide and in the mental health specialty area.
• **Managed Care Expansion:** During the last half of FY 93-94 significant progress was made on expanding managed care options to Medicaid clients through a Health Maintenance Organization (HMO) or Prepaid Health Plan (PHP). At the beginning of the fiscal year Colorado Medicaid's only HMO contract was with Rocky Mountain HMO for clients residing on the Western slope. Starting in January 1994, Rocky Mountain HMO expanded its service area to include Medicaid clients residing in the Denver metro area. Agreements were reached with the additional HMO or PHPs as illustrated in Table 3, below, and as of June 1994, 23,012 Medicaid clients were enrolled in prepaid capitated plans statewide. Of this number, 12,012 were in the Denver metro area.

During FY 93-94, the Department successfully attracted additional HMOs to provide services to Medicaid clients. ChoiceCare began serving clients through Denver Health and Hospitals in April 1994 and HMO Colorado began enrolling AFDC and Baby Care Kids Care clients May 1. Kaiser began serving AFDC clients in the Denver metro area on July 1, 1994 and Exclusive Care began serving Medicaid clients in Pueblo County on October 1, 1994.

By October 1994, there were four HMOs and one PHP serving Medicaid clients in Colorado. The number of clients enrolled as of December 1 was 32,996, approximately 12.35% of Medicaid’s total enrollees.

<table>
<thead>
<tr>
<th>HMO/PLAN</th>
<th>AREA COVERED</th>
<th>ENROLLMENT</th>
<th>DATE (AS OF)</th>
<th>ELIGIBILITY CATEGORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rocky Mountain HMO</td>
<td>Western Slope</td>
<td>11,000</td>
<td>June 1994</td>
<td>All</td>
</tr>
<tr>
<td>Rocky Mountain HMO</td>
<td>Metro Denver</td>
<td>2,661</td>
<td>June 1994</td>
<td>All</td>
</tr>
<tr>
<td>ChoiceCare (PHP)</td>
<td>Denver areas served by</td>
<td>7,784</td>
<td>June 1994</td>
<td>All</td>
</tr>
<tr>
<td></td>
<td>East and Westside Neighborhood</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Health Centers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HMO Colorado</td>
<td>Metro Denver</td>
<td>1,567</td>
<td>June 1994</td>
<td>AFDC, Baby Care Kids Care</td>
</tr>
<tr>
<td>Kaiser</td>
<td>Metro Denver</td>
<td>544</td>
<td>December 1994</td>
<td>AFDC</td>
</tr>
<tr>
<td>Exclusive Care</td>
<td>Pueblo County</td>
<td>4,968</td>
<td>October 1994</td>
<td>All</td>
</tr>
</tbody>
</table>

The Department continues to work with other HMOs to increase access to prepaid capitated health plans for Medicaid clients.
• **PACE (Program of All-Inclusive Care for the Elderly) Demonstration:** PACE is a nationwide demonstration project that provides health care services to frail elderly persons age 65 and over who qualify for nursing home-level care. PACE is a comprehensive, capitated delivery system with the goal to keep the elder in his/her own home and community, when possible, and to produce cost savings to the program for this category of clients. Services are delivered primarily in the adult day care setting, and in the inpatient or nursing home setting when necessary. The demonstration phase of the Colorado project concluded on October 31, 1994 and is under review during the 1995 General Assembly to determine whether the program will continue.

• **Medicaid Advisory Committee for Persons with Disabilities:** This forum was established for consumers of Medicaid-financed health care services to provide input on coverage, quality, program development, cost containment, efficiency and effectiveness issues. Monthly meetings are attended by 15-25 persons. Issues addressed in 1994 have included:
  - improving access to Medicaid programs for specific groups
  - durable medical equipment coverage, costs, quality and maintenance
  - recommendations to the Joint Budget Committee, to:
    - (administrative structure) - establish a long-term advisory committee to minimize expenses and maximize benefits; appoint an ombudsman for community-based services
    - (cost containment) - remove the requirement for oversight by medical personnel of non-medical services when a consumer is able to direct and supervise his/her own care; offer incentives to recipients for reporting provider fraud; make reports of Medicaid fraud convictions available to the public; strengthen penalties
    - (quality of care) - establish a quality-of-care review committee composed primarily of recipients; monitor and regulate providers while empowering consumers with maximum choice and flexibility to access services; set up a pilot project creating a Medicaid facility to repair and modify equipment; make loaner equipment readily available
    - (eligibility) - develop a procedure for inter-county eligibility transfers that requires no more than notification of change of address; provide transitional services; widen eligibility to increase Medicaid coverage
• **Long Term Care**
  - **Quality of Care in Nursing Facilities:** Medicaid has a responsibility as the State's largest payer for Long Term Care services to enhance the quality of care delivered and to maintain the dignity of residents of these facilities. Major changes in the Nursing Facility quality assurance program in FY 93-94 were:
    - Significant improvements to nurses' aide training and certification, and to care planning and monitoring.
    - Nursing Facilities are now required to refer private pay individuals who are identified as possibly mentally ill or mentally retarded for an evaluation by Community Mental Health Centers or Community Centered Boards, and to give notice to the individual and his/her legal representative upon such referral.
    - A Pre-Admission Screening and Annual Resident Review (PASARR) is required for all individuals who apply to or reside in a Medicaid certified nursing facility. The purpose is to identify all individuals seeking admission for whom it appears a diagnosis of mental illness or mental retardation is likely. A person who is admitted for convalescent care and remains in the nursing facility days must be referred for a PASARR evaluation after 60 days instead of within 120 days as previously required.

• **Single Entry Points:** Over the past few years, the Department developed a Single Entry Point (SEP) system to improve access to long term care services for publicly funded and private pay clients through a case management system. Clients seeking long term care services will be able to utilize "one-stop-shopping" instead of being required to go through several different agencies. Case Management services include information and referral, brokering of services and monitoring of services. Use of SEPs will provide greater client choice, and focus greater effort on monitoring quality of care for long term care clients. This system will provide a managed care model for Long Term Care programs including nursing facilities and home-based care.

• **Residential Treatment Centers:** A new program was planned, developed and implemented during FY 93-94 to serve children age 5 to 18 years who have mental health diagnoses. When the program began in June 1994 there were 78 enrollments. Room and board in the facilities is covered through county and General Fund dollars; the mental health treatment component is reimbursed by Medicaid. Children in the program have experienced severe emotional problems affecting them at home or in school, and many average four to six failed foster placements. As of December 31, 1994 the program had been billed for 483 resident children served by 28 certified facilities.

• **Quality of Care Incentive program:** A quality of care incentive program was established to encourage improvement in the quality of care provided by nursing facility vendors. In the past, nursing facilities received a reimbursement incentive for containing administrative costs. This new program recognizes a need to focus on the quality of care in nursing facilities and to give providers an incentive to improve care rather than just efficiency of operations. A nine-person advisory committee was established to study methods for measurement of quality of care; the committee then created criteria and regulations were written to define and regulate the program. Quality incentive payments are made to providers who continually strive for high levels of performance and maintain high quality of care standards at their facilities.
SECTION III

UTILIZATION AND COSTS

This section of the Annual Report provides statistical and budget information on the utilization of Medicaid-reimbursed services, and on the costs of reimbursements for that care. The section is divided into three parts:

• Utilization of Health Care Services
• Rates and Reimbursement
• Cost Containment and Utilization Controls

Overall, Medicaid budget increases in recent years have been driven largely by federal legislation and by the State’s health care refinancing efforts, but these effects began to level off in FY 92-93. The effect upon the Medicaid budget of these enrollment and rate changes has been greater than changes in utilization (patterns of use of each type of health care service, and all services together, by enrollees).

The largest increases in Medicaid reimbursements since FY 89-90 occurred as a result of federal requirements to:

• enroll expectant mothers and children in families with incomes up to 133% of the federal poverty line, and to
• pay inpatient hospitals and nursing facilities at a level no less than the cost of an efficient facility providing services to Medicaid clients

and Colorado-specific changes, including:

• general enrollment increases resulting from economic factors
• reallocating the cost of previously “State Only,” local government, or charity care for low-income persons to the Medicaid program budget (“refinancing”).

Recent changes in inpatient hospital utilization, and the expanding Medicaid Managed Care and Utilization Control Programs, may result in a greater influence of utilization patterns upon future Medicaid budgets. Although variation in enrollment patterns may continue to affect overall Medicaid expenditures, the various health care trends and management methods described in this section are expected to continue moderating and controlling costs per person enrolled in Medicaid. The reimbursement and cost containment methods in use and in development by Colorado Medicaid are intended to maintain and enhance access to care and quality of care, while controlling expenditures.
A. UTILIZATION

For purposes of this report, utilization of health care is discussed in terms of the total payments per provider type, per person or per group of persons. Utilization is therefore analyzed by category of service and by category of client receiving services.

Utilization by Category of Service
Charts 6 and 7 and Table 4 show Colorado Medicaid utilization by category of service:

![Chart 6, Provider Payments by Budget Category](image)

SOURCE: Detailed Expenditure Status Report, HCPF Budget Office
Chart 7,
Medicaid Provider Payments by Service Category

SOURCE: Utilization Data, DHCP&F Budget Office

Notes:
1) Does not include expenditures for Department of Human Services (formerly Department of Institutions) programs for Developmentally Disabled Persons and Mental Health.
2) “Medicare” includes premiums, co-payments and deductibles paid by Medicaid for Medicare coverage of dually-eligible persons. Included are Qualified Medicare Beneficiaries (QMBs), Qualified Working Disabled Individuals (QWDIs) and recipients of Social Security Supplemental Assistance (SSA) payments.
3) “Mental Health >21 includes clinic, practitioner and inpatient services for persons under 21 years of age and Residential Treatment Center (RTC) services for persons between 5 and 18 years of age.
<table>
<thead>
<tr>
<th>PROVIDER TYPE</th>
<th>PAYMENTS TO PROVIDERS ($ IN MILLIONS)</th>
<th>AVG. # OF CLIENTS UTILIZING PER MONTH</th>
<th>AVG. MONTHLY PAYMENT PER UTILIZING CLIENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLASS I NURSING FACILITIES(a)</td>
<td>$242.0</td>
<td>10,866</td>
<td>$1,856</td>
</tr>
<tr>
<td>CLASS II/IV NURSING FACILITIES(b)</td>
<td>$8.0</td>
<td>158</td>
<td>$4,219</td>
</tr>
<tr>
<td>HOME HEALTH</td>
<td>$12.2</td>
<td>861</td>
<td>$1,181</td>
</tr>
<tr>
<td>HCBS(c)</td>
<td>$19.9</td>
<td>2,293</td>
<td>$723</td>
</tr>
<tr>
<td>HOSPICE</td>
<td>$1.9</td>
<td>60</td>
<td>$2,639</td>
</tr>
<tr>
<td>INPATIENT HOSPITAL</td>
<td>$229.3</td>
<td>3,628</td>
<td>$5,267</td>
</tr>
<tr>
<td>OUTPATIENT HOSPITAL(d)</td>
<td>$45.8</td>
<td>20,265</td>
<td>$188</td>
</tr>
<tr>
<td>DENTAL</td>
<td>$5.1</td>
<td>6,046</td>
<td>$70</td>
</tr>
<tr>
<td>CLINICS(e)</td>
<td>$15.5</td>
<td>9,755</td>
<td>$132</td>
</tr>
<tr>
<td>INDEPENDENT LABS &amp; X-RAY</td>
<td>$8.9</td>
<td>16,477</td>
<td>$45</td>
</tr>
<tr>
<td>PHYSICIANS/OTHER PRACTITIONERS(f)</td>
<td>$66.8</td>
<td>55,719</td>
<td>$100</td>
</tr>
<tr>
<td>TRANSPORTATION(g)</td>
<td>$3.2</td>
<td>2,368</td>
<td>$113</td>
</tr>
<tr>
<td>FAMILY PLANNING</td>
<td>$1.0</td>
<td>491</td>
<td>$170</td>
</tr>
<tr>
<td>DME &amp; SUPPLIES</td>
<td>$19.5</td>
<td>6,707</td>
<td>$242</td>
</tr>
<tr>
<td>PRESCRIBED DRUGS</td>
<td>$54.3</td>
<td>72,814</td>
<td>$62</td>
</tr>
<tr>
<td>PACE(h)</td>
<td>$2.1</td>
<td>114</td>
<td>$1,535</td>
</tr>
<tr>
<td>HMO/PHP(i)</td>
<td>$24.7</td>
<td>11,552</td>
<td>$178</td>
</tr>
<tr>
<td>MEDICARE/SMIB</td>
<td>$43.6</td>
<td>27,039</td>
<td>$134</td>
</tr>
<tr>
<td>INPATIENT PSYCH (&lt;21)(j)</td>
<td>$5.4</td>
<td>132</td>
<td>$3,409</td>
</tr>
<tr>
<td>TOTAL(k)</td>
<td>$808</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

NOTE: See table notes on next page.
Notes to Table 4:

FORMULA:
Number of clients utilizing (Column 2), is the monthly average of people using Medicaid-reimbursed health care services. The payments to providers (Column 1) is the payments made for services rendered in FY 93-94 through November 1994. To arrive at the average payment per client per month, the yearly expenditure was divided by 12 (months) and by the average number of clients utilizing per month.

FOOTNOTES:
(a) Includes Nursing Facility Services provided to elderly and disabled persons under the Department of Health Care Policy and Financing. Does not include services provided under the Department of Human Services programs for persons with mental illness and persons with developmental disabilities.
(b) Includes services provided to persons with moderate developmental disabilities in Intermediate Care Facilities for the Mentally Retarded (ICF/MRs) and people with profound medical and developmental disabilities served at the State Homes and Training Schools and a private ICF/MR.
(c) Includes providers of services for the Home and Community-Based Services programs for Elderly, Blind and Disabled persons, Persons Living With AIDS, Private Duty Nursing Program, Model 200 Waiver Program, and Developmentally Disabled persons. Case management for HCBS eligibility groups is included.
(d) Includes outpatient hospitals, Ambulatory Surgical Centers, and Dialysis Centers.
(e) Includes Federally Qualified Health Centers, Rural Health Clinics, and Denver Health and Hospitals Neighborhood Clinics.
(f) Includes physicians and providers of ancillary and allied health services, including Podiatrists, Therapists, PhD Psychologists, Certified Nurse Midwives, Optometrists, Nurse Practitioners and others.
(g) Includes emergency, specialty and clinic transportation.
(h) Average monthly capitation payment.
(i) Approximate monthly capitation payment to prepaid health plans for HMO/PHP. Does not include long-term care, community mental health, non-emergency transportation, care in a state institution, or dental care.
(j) Includes Under 21 Psychiatric Inpatient and Residential Treatment Centers (RTC's) for children age 5 to 18.
(k) Does not include expenditures for services to developmentally disabled or mentally ill persons provided by programs of the Department of Human Services, administration, new programs, or refinancing.

Data sources for this table are budget documents prepared by the Office of Budget & Planning.

Utilization by Category of Client Eligibility
The charts on the following pages show Colorado Medicaid FY 93-94 utilization by category of client eligibility. To more easily read the stacked chart on the next page, please refer across to the labels and figures shown in the table on the opposite page.
Chart 8,
Distribution of Medicaid Enrollees & Payments by Eligibility Group FY 94

SOURCE: Data: HCPF Budget Office; Sourcefile: Program Development
Path: \ANREP\CO\ENEL\XLS
Table 5,
Distribution of Medicaid Enrollees and Payments by Eligibility Group

<table>
<thead>
<tr>
<th>ELIGIBILITY CATEGORY</th>
<th>Enrollment by Eligibility Group FY 94</th>
<th>Percentage of Total Medicaid Enrollment</th>
<th>Total Cost by Eligibility Group FY 94</th>
<th>Percentage of Total Cost by Eligibility Group</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CHILDREN</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baby Care-Kids Care</td>
<td>16,749</td>
<td>6%</td>
<td>22,104,584</td>
<td>3%</td>
</tr>
<tr>
<td>AFDC-Child</td>
<td>115,416</td>
<td>41%</td>
<td>96,693,132</td>
<td>12%</td>
</tr>
<tr>
<td>Foster Care</td>
<td>6,508</td>
<td>2%</td>
<td>18,436,641</td>
<td>2%</td>
</tr>
<tr>
<td><strong>ADULTS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baby Care-Adult</td>
<td>8,521</td>
<td>3%</td>
<td>40,008,555</td>
<td>5%</td>
</tr>
<tr>
<td>AFDC-A</td>
<td>47,495</td>
<td>17%</td>
<td>94,310,967</td>
<td>12%</td>
</tr>
<tr>
<td><strong>OTHER</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Undocumented Alien</td>
<td>3,054</td>
<td>1%</td>
<td>7,047,662</td>
<td>1%</td>
</tr>
<tr>
<td>Qualified Medicare Beneficiaries</td>
<td>2,630</td>
<td>1%</td>
<td>4,077,230</td>
<td>1%</td>
</tr>
<tr>
<td><strong>ELDERLY AND DISABLED</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Old Age Pension-Eligibility Category A</td>
<td>31,121</td>
<td>11%</td>
<td>279,262,081</td>
<td>34%</td>
</tr>
<tr>
<td>Old Age Pension-Eligibility Category B</td>
<td>3,985</td>
<td>1%</td>
<td>25,145,014</td>
<td>3%</td>
</tr>
<tr>
<td>Old Age Pension - State Only</td>
<td>3,006</td>
<td>1%</td>
<td>7,451,267</td>
<td>1%</td>
</tr>
<tr>
<td>Aid to the Blind / Aid to the Needy Disabled</td>
<td>42,728</td>
<td>15%</td>
<td>215,513,166</td>
<td>27%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>281,213</td>
<td>810,050,298</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>
Analysis of Utilization by Category of Eligibility:

Although disabled persons comprise only 17% of Medicaid enrollment (in categories AND, AB, and OAP-B), services to this group account for almost 31% of Medicaid expenditures. This is because of high rates of utilization of high cost services such as inpatient hospital and long term care. Total dollars for care to disabled persons are not increasing as rapidly as for some other groups, however, because enrollment increases have been relatively modest as compared to other Medicaid eligible populations. Note: Medicaid-reimbursed services provided to developmentally disabled and mentally ill persons through the Department of Human Services are not included here.

Persons over 65 years of age account for 12% of enrollments (in categories OAP-A and OAP-B) but 37% of expenditures. Total dollars expended for care to the elderly is higher because of higher need for long term care services including Nursing Facility and Home and Community Based Services, particularly by persons in the 85+ year-old group.

Children comprise about 50% of Medicaid enrollment, but consume about 17% of Medicaid expenditures. Children as a group are seldom hospitalized, seldom require long term care, and consume most other health care services at a lower rate than other Medicaid groups.

The "AFDC-Adult" category consists of mothers of dependent children. Although this group consumes a higher proportion of hospital services than other adult groups because it is predominantly women of child-bearing age, the overall utilization of the group is lower than for the elderly and disabled. (17% of enrollment, 12% of expenditures.)

Baby Care Kids Care adults also cost more per person enrolled than children do. To be eligible, a woman must be pregnant. Therefore, almost all of these women will have a hospital stay and prenatal, delivery and postnatal care charges, in an eligibility period of less than one year. (3% of enrollments, 6% of costs.)

Baby Care Kids Care children have slightly higher utilization and costs than other children who are eligible through the Aid to Families with Dependent Children financial assistance program. The relatively higher costs for Baby Care Kids Care children is attributable to their age: Kids Care enrollees are infants aged 0-1 year, who have higher health care costs than older children. (6% of enrollment, 3% of costs).

Analysis of Utilization by Category of Service:

• The expenditure for nursing facility services is the largest single service item in terms of total Medicaid dollars. Nursing facility services are also among the most expensive services per person utilizing them. Nursing facility reimbursements in FY 94 comprised a smaller percentage of the Medicaid budget than in past years, however, because large increases in enrollment of non-elderly persons in the Medicaid Program has caused increased acute and ambulatory services expenditures. Nursing facility days paid by Medicaid have been relatively stable over the past 10 years.

• Home Health Services are increasing in terms of cost per person utilizing and total dollars paid by Medicaid. This is because these services are increasingly used as alternatives to more costly nursing facility and hospital care.
• Managed Care enrollment increases caused a 55% increase in payments made to HMO and PHP's in FY 93-94.

• The most frequently used Medicaid service is prescription drugs. Most of the enrolled persons had at least one prescription reimbursed by Medicaid during the fiscal year. The number of claims per enrolled person remained constant at 10 claims per year. The cost per enrolled person increased from $183 in FY 92-93 to $197 in FY 93-94. This represents a 7.65% increase.

• More Medicaid clients received care in clinic settings or group practices than in individual physicians' offices.

• The number of persons shown as receiving Family Planning services does not include the clients receiving Family Planning services from their physicians or clinics. Family Planning services reported here are only those services received at Family Planning Clinics which are reimbursed on an annual capitated basis.

Summary of Hospital Utilization

The number of hospital admissions decreased for FY 93-94. The average length of stay decreased from 5.4 to 5.3 days. However, the acuity of the patients (as measured by the Prospective Payment System's weight, or reimbursement factor, for the admission), increased. The overall decreases in inpatient utilization is the cause of an unprecedented decline in overall Medicaid expenditures for inpatient hospital services in FY 93-94 (see Chart 7).

These utilization changes may reflect some combination of the transition to managed care contracts, a shift to outpatient treatment for the services previously provided in hospitals, various managed care strategies in use by Medicaid and other payers, and other efficiencies by the hospitals. The decline in Medicaid inpatient utilization is consistent with the Colorado Hospital Association's information on hospital utilization for all payers in Colorado for 1994. The Department and its contractors will analyze the unexpectedly large decline in hospitalization to assure that access and quality have not diminished.

In FY 94 there were an average of 249,047 Medicaid enrollees each month who were not covered by capitated managed care contracts. There were 42,731 inpatient hospital discharges and 225,235 Medicaid acute care days paid for this group in the year. The year-to-year comparisons of utilization shown below are made on the basis of discharges and rates per 1,000 Medicaid enrollees not covered by capitated plans, rather than total Medicaid-paid days or discharges, because hospital admissions of enrollees in capitated plans are not presently included in the Medicaid inpatient utilization data base.

The tables below show these trends for Prospective Payment System (PPS) and non-PPS hospitals. (PPS hospitals receive payment for each admission from Medicaid, based in part on acuity of care required, commonly known as the Diagnostic Related Group (DRG) System. Non-PPS hospitals are reimbursed according to the number of inpatient days for each admission.)

'SOURCE: Medicaid Acute Care Annual Report, Colorado Foundation for Medical Care, December 1994.
Discharges per year per 1,000 enrollees:

<table>
<thead>
<tr>
<th>Fiscal year</th>
<th>TOTAL</th>
<th>PPS</th>
<th>NON-PPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1994</td>
<td>172</td>
<td>157</td>
<td>15</td>
</tr>
<tr>
<td>1993</td>
<td>198</td>
<td>182</td>
<td>16</td>
</tr>
<tr>
<td>1992</td>
<td>190</td>
<td>174</td>
<td>16</td>
</tr>
<tr>
<td>1991</td>
<td>190</td>
<td>175</td>
<td>15</td>
</tr>
</tbody>
</table>

*FY 94 excludes managed care eligibles

Days per year per 1,000 enrollees:

<table>
<thead>
<tr>
<th>Fiscal year</th>
<th>TOTAL</th>
<th>PPS</th>
<th>NON-PPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1994</td>
<td>904</td>
<td>702</td>
<td>202</td>
</tr>
<tr>
<td>1993</td>
<td>1072</td>
<td>848</td>
<td>224</td>
</tr>
<tr>
<td>1992</td>
<td>1023</td>
<td>801</td>
<td>222</td>
</tr>
<tr>
<td>1991</td>
<td>1115</td>
<td>884</td>
<td>231</td>
</tr>
</tbody>
</table>

*FY 94 excludes managed care eligibles

Even when taking into account only enrollees not covered by managed care, the discharge rates and days per 1,000 show a considerable decline from a relatively stable level in prior years.

Average Length of Stay per inpatient hospital discharge:

<table>
<thead>
<tr>
<th>Fiscal year</th>
<th>TOTAL</th>
<th>PPS</th>
<th>NON-PPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1994</td>
<td>5.3</td>
<td>4.5</td>
<td>13.7</td>
</tr>
<tr>
<td>1993</td>
<td>5.4</td>
<td>4.7</td>
<td>14.2</td>
</tr>
<tr>
<td>1992</td>
<td>5.4</td>
<td>4.6</td>
<td>13.7</td>
</tr>
<tr>
<td>1991</td>
<td>5.9</td>
<td>5.0</td>
<td>15.5</td>
</tr>
</tbody>
</table>

*FY 94 excludes managed care eligibles

Utilization by Major Diagnostic Category (MDC)

Medicaid utilization of the five most frequently used MDCs for both PPS and Non-PPS discharges also changed in FY 94:

<table>
<thead>
<tr>
<th>Major Diagnostic Category</th>
<th>% of Discharges</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>FY 94</td>
</tr>
<tr>
<td>Pregnancy, Childbirth</td>
<td>42.5</td>
</tr>
<tr>
<td>Respiratory</td>
<td>9.6</td>
</tr>
<tr>
<td>Mental Diseases</td>
<td>8.3</td>
</tr>
<tr>
<td>Newborn &amp; Neonates</td>
<td>5.7</td>
</tr>
<tr>
<td>Digestive</td>
<td>4.7</td>
</tr>
<tr>
<td>All Others</td>
<td>29.2</td>
</tr>
</tbody>
</table>

Mental diseases, respiratory and digestive MDCs have increased from their level in previous years.

The Department and its contractors will analyze the relationships, if any, among days/admissions per thousand, average length of stay, and the MDC changes.
B. Rates and Reimbursements

How Colorado Medicaid providers are reimbursed:
Health care providers bill Colorado Medicaid by submitting claims to the Department's Fiscal Agent contractor (Colorado Blue Cross/Blue Shield of Colorado). If a Medicaid covered person has other health care insurance, such as Medicare, employer group or other private insurance, the client is required to report this, and the Medicaid program will pay only those allowable costs not covered by the other payment source.

Reimbursement rates are set by the Department of Health Care Policy and Financing with reference to information gathered from the Executive/Legislative Medicaid Joint Forecasting Team and representatives of consumer and provider groups, and within the constraints of federal and State law. Medicaid is funded by State General Fund appropriations (at about 46% of costs for most services) and the federal government's Health Care Financing Administration (at about 54%). As of November 1994, Colorado health care providers had been reimbursed over $800 million in Medicaid payments for services provided in FY 93-94, not including amounts expended for administration, new programs or refinancing:

Purpose of Rate and Reimbursement Methods

The goals of the Medicaid reimbursement system are to:
- reimburse providers sufficiently to allow Medicaid enrollees appropriate access to necessary services
- equitably compensate providers to minimize cost-shifts to other programs or payers
- comply with federal and State law
- control program expenditures

Much of the information included in this section of the Annual Report is taken from the Medicaid Rate Study (Footnote #26, FY 95 Long Bill HB 94-1356), prepared in November 1994 by the Department.

Reimbursement rates are either cost-based or non-cost-based. Federal law is the driving force behind most cost-based reimbursement in the Medicaid program in Colorado, affecting institutional and some clinic providers. Under provisions of the federal Boren Amendment, the Department must assure that it is paying rates to inpatient hospitals and nursing facilities that cover the reasonable costs of an economic and efficiently-operated facility. Facilities typically submit annual cost reports showing facility costs and some measure of utilization (i.e., number of patients seen per year). Some hospitals providing a high level of service to uninsured persons are paid additional reimbursements by Medicaid, known as "Disproportionate Share Hospital" payments.

Colorado sets non-cost-based reimbursement by taking into consideration the costs of products and services, other payer rates, discussions with providers and available appropriations. The Department uses Medicare fee schedules and rate methods, if available, as a standard to gauge levels and methods of reimbursement.

Specific reimbursement methods vary by type of provider, because of the variations in law, custom and the health care delivery environment. The Department, at the request of the

**Acute and Ambulatory Services Rate and Reimbursement Methods**

Acute and Ambulatory Services rates are set by a variety of methods specific to the type of provider. Rates paid for inpatient hospital services, and for Federally Qualified Health Centers and Rural Health Clinics, are cost-based and must meet federal requirements that reasonable costs be covered by Medicaid payments. Outpatient services are reimbursed at 72% of the lower of cost or charges. All other Acute and Ambulatory Services are reimbursed by fee schedules.

Acute and Ambulatory Service's 1994 study of rate methodologies assessed appropriateness and adequacy of reimbursement for each type of service. Appropriateness of the reimbursement amount was measured by comparison to:
- Medicare payments
- usual and customary charges for the same service
- actual cost to the vendor of providing the service or product (for example: reimbursement may be based on wholesale cost plus a percentage)
- other State Medicaid programs or major third party payers

Findings of the 1994 study included:
- Medicaid inpatient hospital rates meet federal guidelines for reimbursement of reasonable costs
- Lower outpatient rates may lead to higher reliance upon inpatient services. Alternate reimbursement methodologies are being explored to encourage use of outpatient facilities.
- A cost comparison by the U.S. Department of Health and Human Services disclosed that Colorado's reimbursement covers 94% of pharmacists costs.
- Colorado's reimbursement of FQHCs meets the federal mandate to pay 100% of reasonable costs. Reimbursement to rural health clinics is equal to the Medicare encounter rate.
- The Department's reimbursement for family planning services covers the average statewide cost.
- Low rates of payment are often cited as a barrier to physician and dentist participation. For example, dental services are often difficult to access for Medicaid-covered children because of the low rate of Medicaid reimbursement. The ongoing improvement of practitioner rates of payment is an important priority as a method to improve access to services. Primary care rates were increased in FY 93-94 and the Department has requested these rates to be indexed to inflation in future years to avoid erosion of these rates in real dollars.
- Because of a difference in unit definition and pricing methodology, it was not possible to compare Medicaid's reimbursement rates for durable medical equipment to other payers. The Department plans to review the reimbursement methodology and determine if a better method of procurement and reimbursement is feasible to implement.
- County transportation rates cannot be compared to other payers' rates because transportation to medical appointments is not a benefit of Medicare or any other payer.
- Medicaid HMO rates may not be comparable with other payers because Medicaid clients tend to have lower health status and drive more health care expenditures than
other populations. The reimbursement policy is that the established rate will not exceed 95% of fee-for-service expenditures.

Long Term Care Services Program Rates and Reimbursements

Long term care services generally consist of two large groups: community-based and institutional. The Division of Long Term Care’s 1994 Rate Study made the following findings:

Home and Community-Based Services (HCBS) for the Elderly, Blind, and Disabled (EBD), Mentally III (MI), and Persons Living With Aids (PLWA). HCBS-EBD, MI, and PLWA services include personal care, homemaker services, and adult day care. The EBD and MI programs also include respite care, electronic monitoring, home modification, nonmedical transportation, and alternative care facility (ACF) services. Since all three programs are delivered by the same types of providers, these findings apply to all programs.

- Personal care/homemaker services account for the bulk of HCBS expenditures (69% in EBD), but there is no mechanism for regular rate adjustment. These providers have received only one rate increase in eight years. Current reimbursement is $8.45 per hour, which is more than $2.00 less than the private pay rate. The number of participating personal care agencies has been declining, and HCBS case managers are reporting that many of the remaining providers are reluctant to take on additional Medicaid clients.
- Alternative Care Facilities offer 24-hour residential, assisted-living services in licensed Personal Care Boarding Homes (PCBHs). ACF is a cost-effective alternative to nursing facility placement, especially for clients without strong support systems. The current rate is $907 per month, while costs are estimated at $1,200. As a result, only 17% of the 339 licensed PCBHs participate. Access to ACF services for Medicaid clients is therefore limited by the low number of PCBHs available.
- The remaining HCBS services have mechanisms for regular adjustment in their rates. For example, adult day care centers can annually request rate adjustments based upon cost reports, home modification providers are selected by a competitive bid process, and respite care in a nursing facility is annually adjusted to reflect changes in the average Medicaid Class 1 nursing facility rate.

Nursing Facility Rates:
1. The Medicaid rate-setting system for nursing facilities pays fair and equitable rates to nursing facility providers.
   - The Department compared Medicaid rates paid to various nursing facilities to the number of deficiencies cited by the Department of Health in those facilities. There was no correlation between rates paid by Medicaid and the number or severity of deficiencies found in the facilities.
   - In State Fiscal Year 93-94, 53% of the licensed providers had 100% of their allowable cost covered by the rate setting system. The majority of nursing facility providers are able to provide a quality product and still have their full costs covered by Medicaid.

2. Medicaid clients have sufficient access to nursing facilities.
There are 204 nursing facilities in the state and 198 participate in Medicaid. The number of Medicaid persons accepted by nursing facilities remains relatively constant (450-475 Medicaid admissions per month). This high rate of provider participation (higher than Medicare participation) is interpreted as indicating that Medicaid clients have adequate access to nursing facilities.

C. COST CONTAINMENT AND UTILIZATION CONTROLS

Overall Strategy for Managing Medicaid Costs
The rate of growth in Medicaid expenditures has outstripped the growth in the State’s General Fund in recent years. Therefore, controlling the rate of growth in Medicaid costs has become a major goal for Colorado State Government.

There are a limited number of options available at the State level for controlling Medicaid expenditures. Among them are the development, implementation, and refinement of methods to:

- Manage rates of payment
- Limit the utilization of services to those medically necessary
- Limit eligibility for services, including enrollments and benefits
- Improve effectiveness and reduce costs of operations and administration

Colorado Medicaid compares favorably with other states and payers in terms of the effective use of specific cost containment strategies. Through a combination of managed care strategies, cost avoidance mechanisms, utilization controls, and the identification of third parties responsible for financing health care of Medicaid enrollees, Colorado avoided $180 million in FY 93-94 program costs, while meeting its statutory and regulatory obligations to provide care to covered individuals. The management of the "Access, Quality, Cost" relationship is not an exact science, and must be carried out in a complex health care delivery, economic and political environment.

In addition to utilization controls, managed care strategies and reimbursement methods discussed above in the Access, Quality of Care and Rate sections of this report, a number of other cost management techniques are employed by Colorado Medicaid to maximize efficiency and effectiveness. Among these methods are:

1. Provider and client education
2. Utilization Review and Control Systems
3. Co-payments
4. Utilization and Claims Review
5. Identification and recovery of financial liability of other third party payers
6. Avoidance of cost increases driven by over supply of services
7. Competitive Procurement and Selective Contracting

Use of these cost-containment and utilization control strategies is summarized below:

Specific Cost-Containment Methods
1. Provider and Client Education: Providers and clients are informed of the scope and proper use of Medicaid benefits, of the means to receive further information if needed, and of the penalties for misuse of the program. Medicaid provider staff receive training and provider manuals to aid in determining what benefits and services are covered, how to determine whether persons are enrolled in Medicaid, and how to bill Medicaid for services
rendered Medicaid clients. Providers may call the program’s Fiscal Agent contractor, Blue Cross/Blue Shield of Colorado, for consultation on specific problems. Persons enrolling in Medicaid enrollees receive informational brochures and orientation at their county department of social services or outreach site, and are assisted to select a primary care provider. Prepaid Health Plan (PHP) or Health Maintenance Organization (HMO) that will manage and facilitate their access to care. County Department staff, provider staff and other agency personnel attend training sessions offered by the Department and its contractors, statewide.

Customer service publications are distributed to thousands of clients and providers annually, including:

- Medicaid client brochures
- Client appeals procedures
- Provider Manuals
- Medicaid Bulletins
- Program newsletters and reports

Recent developments in provider education are discussed elsewhere in this report. These new programs analyze utilization data against standard criteria, and inform providers of their prescribing and treatment patterns as these compare with standards established by peers. These new automated systems serve both as utilization control and provider education tools.

2. Inpatient Hospital Utilization Review and Control System Development: Inpatient hospital and Managed Care provider services are reviewed for appropriateness of level of care and reimbursement provided, and for quality of care. The State’s system for utilization review and control is operated under contract by the Colorado Foundation for Medical Care, a federally recognized Peer Review Organization (PRO). Two major changes to the acute and ambulatory care utilization control system were implemented in FY 93-94:

- A new inpatient hospital utilization review system uses MMIS paid claim data to provide retrospective review of: 1) medical necessity for admissions; 2) quality of care provided; and 3) appropriateness of DRG. Hospitals that previously applied to the PRO on a case by case basis for prior or concurrent approval of admissions are now at risk for appropriate utilization decisions, in that payment will be denied retrospectively if unnecessary, excessive or inappropriate quality of care was provided. This computerized review system is far more cost-effective for the State to operate, and allows review resources to be focused on admissions that have the highest likelihood of inappropriate or excessive charges.

Under this focused sampling method, CFMC reviewed 74% fewer claims (14,460) in FY 93-94 than the 56,212 reviewed in FY 92-93. The total included 4,897 PPS reviews, 6,334 Non-PPS reviews and 3,229 special reviews. (Data is based solely on cases discharged during FY 93-94 which were not covered by managed care providers.) The CFMC contract resulted in a financial impact of $2,273,848, which constituted a net savings of $1,310,455, after contract costs of $963,393 were deducted. The net savings per review was $90.62, which equals an aggregate savings to cost ratio of 2.36. The State portion of the savings was $1,038,693 and the State cost of the contract $240,848, a savings to cost ratio of 4.31 in State funds. The review effort generated a significant impact in terms of both financial savings and in ensuring high quality care and
appropriate utilization of Medicaid-covered benefits. (Medicaid Acute Care Annual Report, The Colorado Foundation for Medical Care, July 1, 1993 - June 30, 1994.)

- The inpatient hospital utilization review and control contract is now competitively procured and is managed and paid on a performance basis, rather than on a reimbursement of cost basis. The utilization control system has been streamlined and made more effective: the new review and control system is operated at a cost savings of over $600,000 per year, or about 1/3 less than the previous system. Preliminary information indicates that inpatient hospital expenditures are down during the period that the new system has been operating. The Department plans to use the inpatient system of automated, targeted retrospective review as a model for other utilization review and control systems such as outpatient hospital services.

3. Co-Payments: Client co-payments deducted from provider claims amounted to over $3 million in FY 93-94. About 3,300 Medicaid clients paid the maximum annual co-payment amount of $150; most of these clients utilize mental health services on a regular basis, and/or utilize numerous prescription drugs. About 160,000 clients paid co-payments, while 95,000 were exempt from co-payment requirements because they were under 19 years of age, were pregnant, or utilized only emergency services. No changes to the co-payment program were made in the fiscal year.

The Department concurs with the findings of the Medicaid Reform Study last year on Co-payments, summarized recently as follows: "A comprehensive analysis of cost-sharing for a range of Medicaid services -- including inpatient and outpatient hospital and ambulatory surgery centers, emergency department services, physician, lab and x-ray services, prescription drugs, psychotherapy services, home health services and medical equipment -- indicate that cost-sharing generally reduces the use of both necessary and unnecessary care and has a greater negative effect on the lowest income recipients. Patient and provider education, telephone triage, and selective use of cost-sharing hold more promise for reducing unnecessary care than current Medicaid cost-sharing strategies."

Colorado's Medicaid co-payments are among the highest in the nation. However, additional co-payment assessments would be permitted under federal law, including: increasing inpatient and emergency room co-payments, and assessing a co-payment for equipment and supplies. Specific recommendations on co-payments have been made by the Department and by the Medicaid Reform Study over the past several years. Increased co-payments are not recommended because of the cost of system modifications and the probable loss of access to necessary health care services.

Some providers complain that because co-payments are withheld from their claim reimbursements, and many clients are not in a financial position to pay, the co-payments amount to a reduction in provider rates. Administrative burdens on providers and the program are also substantial. Last year, co-payments deducted from provider claims amounted to over $3 million -- the amount actually collected by providers from clients is unknown.

4. Utilization and claims review: The Department's contract with the Medicaid fiscal agent (currently Blue Cross/Blue Shield of Colorado) includes a large data collection, processing and reporting component. Billing information from providers ("claims") entered

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to the Medicaid Management Information System (MMIS) is reviewed for accuracy and
timeliness, edited to assure that the lower of billed charges or maximum allowable payment
is made, and entered into a comprehensive claims data base for further use.

MMIS claims information is reported on state and federal formats for use in managing
the program and accounting for expenditures. Some claims data is extracted for use by the
Department of Health Care Policy and Financing and/or its contractors for utilization review.
For example, the Department's contractor for inpatient hospital utilization review uses an
MMIS hospital claims tape to build its data base for that purpose. The Surveillance and
Utilization Review and Third Party Resource Units use MMIS data to perform their post-
payment review and recovery functions.

Utilization review and control systems are designed and operated to limit utilization and
reimbursement of care to those services that are medically necessary and appropriate,
while still assuring quality of care and access to necessary care. Following are two
examples of utilization review (U/R) systems in use by Colorado Medicaid other than the
Inpatient Hospital, Managed Care and Drug Utilization Review Systems discussed
previously.

a) Uniform Long Term Care Assessment: Medicaid continues to enhance the
effectiveness of utilization controls on long term care by development of assessment
instruments, procedures and systems. The utilization of nursing facility services is
reduced, when possible, by diverting appropriate recipients to community based care.
Diversion to community care is desirable because:

- Community-based long term care programs such as HCBS, Home Care Allowance
  (HCA), Adult Foster Care (AFC) and the Home Health program cost far less to
deliver than institutional care.
- Clients prefer care at home to institutional care.
- HCBS and home health care are used extensively as alternatives to hospital care,
  both to facilitate earlier discharge and to provide longer-term care.
- A number of home health clients are technology-dependent; children in particular
  benefit from the home care alternative.

Diversion to community-based care is accomplished by making in-home and
community-based care available and accessible. The Department has implemented a
comprehensive community-based care network statewide over the past decade, that
has successfully limited growth in nursing facility utilization and diverted the state's
expanding population of persons of advanced age and disability who are most likely to
require long term care services to community care alternatives. The Single Entry Point
system will further enhance accessibility of community-based long term care
alternatives.

b) The Surveillance and Utilization Review System (SURS) is a computerized claims
review system used by Colorado Medicaid staff to identify questionable claims and
unusual billing patterns.

When excessive or improper utilization or billing of the Medicaid program is identified,
Medicaid staff follow up to investigate, classify and recover or refer to appropriate legal
authorities for possible prosecution. Sanctions for improper use of the Medicaid
program range from educational interventions and recovery of over-payments to
restriction or exclusion from participation in the program. Additionally, civil and/or
criminal sanctions may be imposed by the State. The Surveillance and Utilization
Review Section communicates and coordinates with the federal Office of the Inspector
General and the Medicaid Fraud Control Unit located in the Colorado Attorney General's
Office.

5. Recovery of other Third Party resources: Medicaid, which is by federal and state
regulation the "payer of last resort" for benefit services, will not pay for services for which
any other entity is responsible. Applicants for Medicaid coverage are required to provide
information on any type of resource they have which may pay for health care services.
Other payer sources with liability primary to Medicaid include: Medicare, commercial health
insurance policies or Health Maintenance Organization (HMO) plans which are a benefit of
employment or retirement, liability coverage such as auto insurance and homeowner
policies. In addition to obtaining information directly from Medicaid applicants, Colorado
receives notice of other health care resources through sources such as Social Security
Administration, Worker's Compensation, and the Department of Labor and Employment.

In order to reduce Medicaid costs for covered persons with health insurance eligibility, the
State pays monthly premiums to "buy in" eligible Medicaid recipients to Medicare or to
certain Employer Group Health (Insurance) Plans (EGHP). During FY 93-94, approximately
44,000 Medicaid clients were "bought in" to these two types of primary coverage.

Additional post-payment activities include tort/casualty recoveries. This process identifies
claims for Medicaid clients which are related to accidents or wrongful injury settlements.

Colorado also has established an Estate Recovery program to recover payments made by
Medicaid for nursing facility and other types of care. In addition to recovery from recipients'
estates, the program includes provisions to place liens on real property owned by recipients
of any age who reside in nursing facilities and are unlikely to return home. The Estate
Recovery program was required by federal legislation passed in October 1993 in order to
expand the recipient population from clients age 65 and older to those age 55 and older.

Third Party cost avoidance and post payment recovery saved Colorado $162.2 million in
Medicaid charges during FY 93-94.

6. Avoidance of cost increases driven by over-supply of services: In health care, it is
theorized that the supply of services drives demand for and/or utilization of those services.
For example, cities with a high ratio of hospital beds to general population will usually have
a higher rate of hospitalizations and a higher cost per person for hospital care than a similar
community with fewer beds per capita. Health status is not improved by such increased
utilization, however.

For those services such as inpatient hospital and nursing facility care where Medicaid is
federally required to pay providers their full cost of delivering services to Medicaid enrollees
the over-supply of hospital or nursing facility beds is of particular concern. This concern
arises from the fact that if many beds are empty, the costs for building and maintaining
those empty beds becomes a part of the provider's overhead costs, which can be spread to
payers for the beds in use.

Colorado Medicaid addressed this issue for nursing facilities by placing a limitation (a
"moratorium") on the number of nursing facility beds enrolled in the Colorado Medicaid
program, effective February 1, 1990. Under the moratorium regulations, new nursing facility beds or nursing facility providers only may be enrolled in the Medicaid program if they meet one or more of the following exceptions to the moratorium:

- under-served areas or populations
- existing facilities (as of 2/1/90) may add no more than 10 new beds to the Medicaid contract every two years
- out of state providers
- previously issued certificate of need for projects not yet completed
- substantial investment was made (property was purchased and development begun for the facility prior to 10-1-89)

For hospitals, in addition to the inpatient hospital utilization review system outlined above, the Medicaid program controls psychiatric hospital service utilization and costs by contracting for only the number of inpatient psychiatric beds that are required to serve its enrolled population. Medicaid conducted a needs assessment in 1990 to determine the number of beds that were required to serve children and adolescents, who are the only Medicaid enrollees eligible for inpatient psychiatric treatment. This assessment and limited contracting was necessary because utilization trends for inpatient psychiatric treatment of children and adolescents were apparently being driven upward by the oversupply of hospital beds in the State, rather than by any increase in the need for such inpatient care. The program contracts for inpatient psychiatric services with State-owned facilities and two private free-standing psychiatric providers. This method has moderated the use of psychiatric hospitalizations for Medicaid-financed children, while maintaining appropriate access to necessary inpatient care.

7. Competitive Procurement System Development, Waivers, RFPs

- The Department's Competitive Procurement Project was initiated by competitively bidding and awarding a consultant contract to assist Medicaid staff in the preparation of procurement strategies, applications for waivers of federal regulations, RFI's and RFP's, data bases and contract management systems. Waivers and procurement instruments are being prepared to determine the feasibility of competitively procuring Organ Transplants, Oxygen and Drugs for persons in Nursing Facilities, and various intensive Long Term Care services including Rehabilitation Nursing Facilities.

- Competitive procurement of HMO and global obstetric services present many issues and challenges in the rapidly changing managed care environment. Therefore, the Department is pursuing a longer-range strategy of developing models and tools for capitated services procurement. DME and other services are also under consideration, and will be addressed by the project in FY 95.

- The Department's procurement strategy is to proceed on a pilot basis to develop the necessary skills, models and tools for competitive procurements on a larger scale. Colorado is among a handful of states innovating in this area. The Department is concerned that systems be in place to procure Medicaid services responsibly, with full accountability for costs, access and quality of care.

D. FINANCING

Health Plans and Medical Services programs in the Department of Health Care Policy and Financing are financed by four distinct funding streams: Medicaid (Title XIX of the Social
Security Act); the Colorado Indigent Care Program (often called the "Medically Indigent program"); Old Age Pension Health and Medical Fund; and Home Care Allowance and Adult Foster Care. Medicaid financing is discussed first below, followed by other Health Plans and Medical Services financing.

Medicaid is a state/federal partnership, funded under a federally-determined formula that allocates federal match to states according to the percentage of the state's citizens with incomes below the federal poverty line. Colorado's federal match percentage has been declining slightly over the past few years, since the State's economy has been improving compared to the rest of the country's. Medicaid revenue sources for health care services in FY 93-94 are shown in the following chart:

![Chart 9, Medicaid Funding Sources]

State 47%
Federal 53%
Other <1%

SOURCE: Medicaid Budget Request & Narrative

Notes: Federal Financial Participation (FFP) at 10/1/93 = 54.30%
FFP at 10/1/94 = 53.10%
2 months at earlier rate + 10 months at later = 53.30% FFP for FY 93-94

Federal funds made up 53.3% of total Colorado Medicaid service funds in FY 93-94, except for Family Planning services, which are 90% federal funded. Federal reimbursements for State and County administration of Medicaid are mostly at the 50% level, except for higher federal funding (75% or 90%) of some computerized claims processing and information reporting systems development. The State pays the rest of Medicaid expenditures, except for 20% of each county's administrative costs which are paid by the county, and a small amount (one-tenth of a percent of total expenditures) received from grants and other cash funding.
Old Age Pension Health and Medical program is financed 100% by the General Fund, and provides reimbursements to Medicaid providers for services rendered to persons receiving the Colorado Old Age Pension who are not eligible for Medicaid or Medicare.

Health care providers participate in the Colorado Indigent Care Program (CICP) through one of four programs:

- Denver Indigent Care Program (DHH)
- University Hospital Indigent Care Program (University Hospital)
- Outstate Indigent Care Program (Outstate)
- Specialty Indigent Care Program (Specialty)

Each CICP program has its own appropriation. DHH, University Hospital, one Outstate provider and two Specialty providers receive CICP payments that are matched by Medicaid, which includes federal funds. The remaining Outstate and Specialty providers are paid through CICP state-only funds.

E. COSTS OF CARE - COST PER PERSON

Medicaid budgets are constructed using a "premium" method. Average cost per person in each eligibility category for each service is tracked, analyzed and projected forward, with caseload information, to estimate the amount that is likely to be paid to providers for care per person (the "premium"). Average Medicaid expenditures for each covered person varies widely among eligibility categories because health care utilization varies according to enrollee's age, health status, and other circumstances associated with the reason for Medicaid eligibility.

On the following pages, Charts 10 and 11, and detail charts 10a, b and c, show the variation in Medicaid cost per enrolled person by category of eligibility, and the effect of the Medicaid Consumer Price Index upon cost per person. Overall, these charts show that the rise in the amounts Medicaid pays per person for health care is consistent with or below the general rise in medical costs nationally. Increases in health care costs have been moderate over the past four years.
Chart 10,
Medicaid Cost Per Person --Weighted Averages of Eligibility Group Subtotals

Chart 11,
MCPI-Adjusted Medicaid Cost Per Person -- FY 94 Constant Dollar
SOURCES for Charts 10, 10 a, b and c, and 11: Budget Office; "Medicaid Caseload History & Projections," "Comparison of Cost per Eligible for FY 89-90 through 92-93 Actual & FY 93-94 through 95-96 Estimates," and (DOL) CPI/MCPI spreadsheet - Program Development sourcefile P:\ANREP\PCCB\ELIG.XLS
Per Capita Cost Analysis -- Charts 10, 10a, 10b, and 10c
Overall Medicaid cost per person (Chart 10) shows a very slight rise in FY 94. The increase in Medicaid cost per enrolled person has slowed to around 2% per year over the past three fiscal years. Acute and ambulatory services costs per person actually declined in FY 94, in part as a result of decreased utilization of physician services and inpatient hospital. (The unexpected decline in inpatient hospital expenditures is discussed above in Section III. A., Utilization.) Continued increased long term care expenditures per person (driven by statutory requirements to compensate within certain limits audited costs in nursing facilities) more than offsets the decrease in acute and ambulatory services costs.

The one-year decline in acute care expenditures was not considered sufficiently strong to represent a counter-trend to the general rise in costs over recent years. The decline in acute and ambulatory costs per capita and in the hospital line was unprecedented except for FY 89-90; and that year’s cost decline was followed the next year by a double-digit cost inflation which re-established the multi-year upward cost trend. For that reason, FY 95-96 estimates were conservatively projected to be consistent with multi-year upward cost trends, rather than to repeat the declines seen in FY 93-94.

The detail charts show a wide variation in cost per person by eligibility group. Cost per enrollee in FY 94 ranged from less than $1000 per person per year (AFDC-Children) to almost $10,000 per person per year (Old Age Pension-A). Further, the cost trends vary by group; some groups’ costs per person are fairly stable, while others (such as OAP-A) are rising year-to-year, and some groups’ costs (Baby Care-Children and Adults) have been declining. (The decline in costs for the Foster Care Children’s group, although a high-cost group because of high utilization of mental health services, is not considered to be a reliable trend. Because of the small number of clients in the group, annual variation in cost per person is expected.)

MCPI-Adjusted Medicaid Cost per Person -- FY 94 Constant Dollar -- Chart 11:
Chart 11 shows the four-year history (and one projected year) of Medicaid cost per person, adjusted by the Medical Consumer Price Index (MCPI). The US Department of Labor’s national MCPI data was applied to the figures shown in Chart 10, backward and forward from FY 94, to show costs in “94 health care constant dollars”.

The MCPI-adjusted cost per person for Medicaid enrollees overall declined in recent years, which indicates that Colorado Medicaid costs are rising at a slower rate than health care costs for all persons in the country. All groups except OAP-A show a decline in “constant dollar” costs; the OAP-A increase is driven by increased nursing facility costs in this group with high utilization of long term care services.

The rise in cost per person between FY 90 and FY 91 is attributable to the settlement of an inpatient hospital law suit that required the State to substantially increase reimbursement rates paid to hospitals.
SECTION IV
OPERATIONS AND FUTURE DIRECTIONS

A. ADMINISTRATION

Who Manages the Colorado Medicaid Program?
The Colorado Medicaid program is administered by Department of Health Care Policy and Financing staff, working with State Department of Human Services and local agencies including 63 County Departments of Social Services, 10,000 health care providers (both in and outside the state), and contractors including the Fiscal Agent (Blue Cross/Blue Shield of Colorado) and the Colorado Foundation for Medical Care (Medicaid’s Peer Review and Utilization Review Contractor).

Administrative costs at the state and county levels, including contracted services, account for approximately 2.9% of the Medicaid budget. Of that amount, $5.6 million is expended for State staffing and operations, $19.5 million is paid to contractors, and about $5.5 million is paid to counties for eligibility determination functions.

Operations at state and county levels, and contracted operations, are summarized below:

STATE-LEVEL OPERATIONS

The State Department of Health Care Policy and Financing, created July 1, 1994, manages Medicaid program operations, policy, regulation, financing, monitoring and reporting, to comply with federal and State law and regulations. Staff of the Department’s Health Plans and Medical Services Divisions administer (directly or through contracts) the program’s financing and cost containment systems, information and bill paying systems, coverage and benefits, access and quality of care assurance programs, and delivery systems for both fee-for-service and managed health care.

The Colorado Medicaid agency is a highly diversified work force with a broad range of skills: 106 staff manage health care financing and delivery systems that cover over a quarter million persons, with expenditures of $1.3 billion. Less than one-half of one percent of Medicaid program funding is used by State government for its own staffing and operations costs of providing program administration, management, planning and evaluation. This level of management and administrative financing is below that utilized by other public and private health care financing and management entities.
Federal regulations require the designation of a "Single State Medicaid Agency," which is the Colorado Department of Health Care Policy and Financing. The State Medicaid Agency is responsible for supervising the following administrative functions:

- Eligibility determination -- promulgating and interpreting regulations, training and monitoring staff who determine the eligibility of applicants for Medicaid coverage.

- Provider enrollment and certification -- establishing and applying standards of enrollment and certification of providers in order to qualify them to provide health care and medical services to Medicaid clients and receive Medicaid reimbursement.

- Claims processing -- reimbursing providers for appropriate services rendered eligible persons. Ensuring Medicaid is the "payer of last resort" when providing health care services.

- Program policy and operations -- ensuring proper administration of the program through:
  - Monitoring and controlling the accessibility, appropriateness and quality of services delivered to Medicaid-eligible persons.
  - Quality control systems focused on minimizing errors in eligibility determination and claims processing.
  - Providing information on program performance, utilization and expenditures, including federal and other required reports to the state General Assembly and to the federal government.
  - Providing training, technical assistance and oversight to operational and administrative units, including county departments of social services and contractors.
  - General program monitoring, reporting and accountability, including rate negotiations and rate setting, budgeting and reimbursement systems.
  - Implementing and staffing the Medical Assistance and Services Advisory Committee (MAC) to advise the Medicaid Agency Director. The MAC membership includes practitioners and representatives of health care facilities, providers and the public.
  - Staffing the State Medical Services Board, whose members are appointed by the Governor to hold public hearings and adopt State regulations that apply to Medicaid.

- Supervision of specific county and Single Entry Point Agency operations, including:
  - client assessment, care planning and quality assurance
  - payment authorization
  - provider recruitment, training and supervision

The Department of HCPF's Health Plans & Medical Services Divisions also administer the following programs:
- Home Care Allowance and Adult Foster Care
- Old Age Pension Health and Medical Services Fund
- In FY 93-94, Health Plans and Medical Services assumed management of the Colorado Indigent Care Program (CICP), including the following functions:
  - reimbursing participating health care providers a percentage of their costs of serving medically indigent patients
  - researching alternatives to achieve equitable reimbursement for providers
  - assuring the most efficient and effective methods are used to operate the program
  - developing managed care opportunities
COUNTY OPERATIONS

County Department of Human Services staff, and some eligibility technicians "outstationed" in clinics, hospitals and single entry points, determine eligibility and provide referral and other related services. Eligibility staff accept applications and help clients maneuver through the complicated eligibility requirements to gain access to Medicaid and other Health and Medical Services benefits. Medicaid clients are assisted by eligibility staff to select a primary care provider and apply for other benefits to which they may be entitled.

Approximately 600 (Full Time Equivalent) staff are employed by the 63 County Departments of Social Services and assigned to Medicaid and other Health and Medical Services eligibility functions. The State Department of Human Services provides training, oversight, and administrative assistance to County Department operations.

CONTRACTED OPERATIONS

One-half of the Medicaid program's total administrative dollars are paid to contractors for specific administrative, research and evaluation, and regulatory functions. Twelve major contractors receive reimbursements totaling over $19 million per year to deliver such services as processing providers' claims and payments, performing audits and program evaluations, developing and operating utilization review systems, inspecting care facilities and certifying providers.

Health Plans and Medical Services staff are responsible for determining contractor work plans, soliciting proposals and bids from potential contractors, negotiating and administering contracts, and monitoring and evaluating contractor performance. In addition to the twelve major administrative services contractors, numerous contracts with direct service providers such as hospitals and Health Maintenance Organizations are also directly managed by the Department.
B. Future Directions

The Colorado Medicaid program operates in a multi-faceted health care financing and delivery environment. The program must interact with and respond to influences in public and private health care delivery, and to the political and financing realities of federal, State and local government. The program must plan for and adapt to major changes underway in all of those spheres. Medicaid must balance a complex of mandates ranging from assuring access to health care for low income people, to participating as a major payer in health care financing and system development.

At the same time, Medicaid staff and managers, executive managers, the Legislature, and the Governor share accountability for managing the growth of state general fund expenditures for the program. Medicaid management and program development is often a challenge of conflicting priorities and mandates. Some of the Medicaid issues and innovations now being addressed by the Department are summarized below:

THE MEDICAID REFORM STUDY

The Medicaid Reform Study was initiated as a result of legislation introduced in both the 1992 and 1993 legislative sessions. Senate Bill 92-65 called for the development of an alternative to Medicaid but contained a provision that could have terminated Colorado's participation in the Program. As a result, Governor Romer vetoed the bill but directed the Office of State Budget and Planning (OSPB) to conduct the study called for in the bill. OSPB contracted with the University of Colorado Health Sciences Center, and Phase I of the study was published in September 1993. Senate Bill 93-122, signed into law on June 30, 1993, called for a study of a cost-effective means of providing a medical care delivery system that would not reduce services to the Medicaid population and would allow the continuation of federal funding. Phase II of the Medicaid Reform Study, the results of which were published in the Interim Report, December 1994, addresses Medicaid's coverage for persons over 65 years of age, and for persons with mental illness, developmental disabilities, and physical disabilities.

The following is a summary of findings in the Interim Report, as interpreted by Department staff who reviewed Phases I and II of the Medicaid Reform Study:

- The Colorado Medicaid program is designed and operated logically and effectively, within the constraints of:
  - federal and State laws and regulation,
  - State funding availability,
  - the need for health care coverage for low income persons, and
  - the health care delivery and financing systems extant in the State.
• In FY 92-93, Colorado Medicaid covered 353,665 individuals at some time during the year and covered an average of 265,219 persons per month. (Heitler and Yondorf, 1992). Medicaid thus covered about 10% of the State’s population for part or all of FY 92-93, and paid about 8% of health care costs in the state that year.

• If no programmatic changes occur at the State or federal level, the number of Medicaid enrollees is expected to grow at between 4.7 and 6.7 percent per year. Overall expenditures will increase about 8.8 percent per year. (Barton et al., 1993)

• Medicaid expenses constituted 16% of the General Fund in FY 93-94. Any expansion of access to health care coverage for uninsured Coloradans would potentially cause the State’s public health care expenditures to increase both as a dollar amount and as a percentage of the State’s budget.

• Only about 40% of Colorado citizens who live at or below the federal poverty level are likely to be served by Medicaid because of the income standards for assistance. (The federal poverty level for a family of four in 1993 was $14,763 while the income level for general Medicaid eligibility was less than half that amount.)

• Eligibility to Medicaid is linked to welfare payments from AFDC or SSI for many clients. This link can discourage people from remaining in the work force, since the family’s health care coverage may be lost when AFDC or SSI eligibility is terminated as a result of the income received from work. Attempts have been and are being made to rectify this problem, but barriers still remain.

• Reimbursement rates are a disincentive to some providers. However, even if rates were raised to Medicare’s payment levels, only a slight increase in physician participation would be likely for a sizable increase in expenditures.

• Waivers granted by HCFA relieve states of certain federal requirements and increase Medicaid program flexibility. Programmatic waivers allow new services to special populations that are otherwise at risk of more costly institutionalization. Other waivers permit restructuring of Medicaid programs to better serve eligible populations and contain expenditures. Colorado Medicaid has successfully used federal waivers program to enroll clients with primary care physicians, PHPs or HMOs; to offer PACE to the frail elderly; and to provide home and community based services.
- **Mental Health Services:** Medicaid reimburses Mental Health (MH) Services including inpatient and outpatient care, physician and practitioner services, prescription drugs and clinic services. Historically, the federal government has declined to participate financially in reimbursement for most inpatient or HCBS services to individuals aged 22 to 65. Beginning 7/1/94, however, Colorado received approval for persons with mental illness to be admitted to HCBS if they meet admission requirements.

In FY 92-93, 24,412 Medicaid enrollees (9% of the total Medicaid population) received mental health services through the mental health system, not including the population served by State-operated psychiatric facilities and community mental health providers.

About 73% of recipients receiving mental health services receive some from the state mental health system; this drives two-thirds of all mental health expenditures. The Medicaid population (receiving MH services) represents one-third of the population served by community mental health clinics and 23% of the population served in the State's two mental hospitals. Community mental health clinics were established to serve a broad range of clients and problems but have grown increasingly dependent on Medicaid funds. This reliance is more evident in outpatient services where 87% of all expenditures are provided by CMHCs and clinics; conversely, Medicaid expenditures for inpatient psychiatric care are spent primarily in non-state hospitals.

- **Developmental Disabilities (DD):** The movement away from institution-based and toward community-based services began in 1983 and currently most persons with developmental disabilities receive needed services outside the nursing facility. People receive Medicaid-reimbursed services in 1) one of the regional centers (three) for the most severely disabled, 2) in the home or community setting through one of 20 Community Centered Boards, or 3) as part of a Community Supported Living arrangement. The majority is provided through the CCBs.

Currently, Colorado's waiver program for persons with developmental disabilities provides services to a maximum of 2,862 through HCSS-DD and a maximum of 200 through the Children's Medical Waiver; there are 2,500 people on the waiting list.

- **Medicaid Long-Term Care and the aged and disabled populations:** The second Medicaid Reform Study projects enrollment and expenditures to the year 2030, in order to capture the initial effects of the aging of the post-World War II baby boom. In 1994-95, expenditures for elderly, physically disabled, developmentally disabled and mentally ill persons requiring long-term care are projected to account for about 38% of expenditures:

  - In the year 2000 the elderly (over age 65) are projected to increase from 12.6% (1990) to 13.2% of the population and by 2020, 17.1 (Rice and Feldman, 1983). Another model estimates 14.3% by 2020 (Rivlin and Wiener, 1988). In the 85 or older population, the growth and change in proportion is startling: From 1.2% in 1990, this population is expected to grow to 2.5% in 2020 (Rice and Feldman, 1983).
ALTERNATIVE PLAN FOR PROVIDING MEDICAL ASSISTANCE

Senate Bill 122, "Concerning Amendments to the State Medical Assistance Program", effective July 1, 1993, includes provisions to amend the Medical Assistance Act by adding a new Section 7, titled the "Alternative Plan for Providing Medical Assistance." This section directs the Medicaid program to:

- Contract with the State Office of Planning and Budgeting (OSPB) to "develop an alternative plan for a nontraditional medical assistance program," and

- In consultation with advisory and affected groups, and as any federal waivers and state legislation in this regard may allow, pursue certain cost-containment and utilization control measures, including:
  - reallocation of Medically Indigent program monies,
  - adjustment or addition of specific client co-payments and service limits,
  - competitive procurement, and
  - adjustments to timely filing of claims requirements.

A Medical Assistance Reform Advisory Committee is established with representation specified from the General Assembly, Medicaid vendors and consumers, and the general public. Prior to July 1, 1996 the General Assembly shall consider legislation to adopt an alternative Medical Assistance program, allowing the state as much self-direction and oversight as possible.

SUMMARY -- FUTURE DIRECTIONS

Based on legislation passed during the 1993 legislative session, Colorado's health and human services systems were restructured at the State level. Effective July 1, 1994, most Health and Medical Services functions and personnel were transferred to the new State Department of Health Care Policy and Financing, and other Department of Social Services functions and staff were merged with Department of Institutions and some Department of Health programs to form the new State Department of Human Services. The Colorado Department of Health became the Department of Public Health and Environment.

The new Department of Health Care Policy and Financing includes staff from Health and Medical Services, the Health Data Commission, the Medically Indigent program, and the Colorado Care initiative. The Division of Health Plans and Medical Services is responsible for administration of the Medicaid program.

The task that lies before the Department of Health Care Policy and Financing is to address the design and operation of Colorado's public health care systems in a more coordinated and comprehensive manner than was possible when policy and financing functions of State Government were divided among various agencies. The Medicaid program will continue to provide coverage and services, analyze and develop its program, and carry out its accountability and coordination mandates in the context of a rapidly changing health care system. Preparing for and constructively adapting to rapid change has become an important part of Medicaid's responsibility and business.
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>A</td>
<td>Aid to the Blind</td>
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<tr>
<td>ACF</td>
<td>Alternative Care Facility</td>
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<tr>
<td>AFC</td>
<td>Adult Foster Care</td>
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<td>AFDC</td>
<td>Aid to Families with Dependent Children</td>
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<tr>
<td>AMPS</td>
<td>Automated Medical Payment System</td>
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<tr>
<td>AND</td>
<td>Aid to the Needy Disabled</td>
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<tr>
<td>CFMC</td>
<td>The Colorado Foundation for Medical Care, Medicaid's PRO (Peer Review Organization)</td>
</tr>
<tr>
<td>CFR</td>
<td>Code of Federal Regulations</td>
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<tr>
<td>CICP</td>
<td>Colorado Indigent Care Program</td>
</tr>
<tr>
<td>CRS</td>
<td>Colorado Revised Statutes</td>
</tr>
<tr>
<td>DD</td>
<td>Developmentally Disabled</td>
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<tr>
<td>DHS</td>
<td>(Colorado) Department of Human Services, formerly the Department of Social Services</td>
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<tr>
<td>DME</td>
<td>Durable Medical Equipment</td>
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<tr>
<td>DRG</td>
<td>Diagnosis Related Group (see PPS)</td>
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<tr>
<td>DUR</td>
<td>Drug Utilization Review</td>
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<tr>
<td>EPSDT</td>
<td>Early and Periodic Screening, Diagnosis and Treatment (preventive care for children)</td>
</tr>
<tr>
<td>FFP</td>
<td>Federal Financial Participation</td>
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<tr>
<td>FQHC</td>
<td>Federally Qualified Health Clinic</td>
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<tr>
<td>FY</td>
<td>Fiscal Year</td>
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<tr>
<td>HCA</td>
<td>Home Care Allowance</td>
</tr>
<tr>
<td>HCBS</td>
<td>Home and Community Based Services - alternatives to Nursing Facility services</td>
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<tr>
<td>HCBS-DD</td>
<td>HCBS for the Developmentally Disabled</td>
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<td>HCBS-EBD</td>
<td>HCBS for the Elderly, Blind and Disabled</td>
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<td>HCBS-MI</td>
<td>HCBS for the Mentally Ill</td>
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<td>HCBS-PLWA</td>
<td>HCBS for Persons Living with Aids</td>
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<td>HCFA</td>
<td>Health Care Financing Administration (of the US Department of HHS)</td>
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<td>HCPF</td>
<td>(Colorado) Department of Health Care Policy &amp; Financing</td>
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<tr>
<td>HIBI</td>
<td>Health Insurance Buy-In</td>
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<tr>
<td>HIV</td>
<td>Human Immune-Deficiency Virus</td>
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<td>HHS</td>
<td>Health and Human Services Department (Federal Office)</td>
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<td>HMO</td>
<td>Health Maintenance Organization</td>
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<tr>
<td>ICF</td>
<td>Intermediate Care Facility</td>
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<tr>
<td>JBC</td>
<td>Joint Budget Committee (of the Colorado General Assembly)</td>
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<tr>
<td>LAN</td>
<td>Local Area (Computer) Network</td>
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<tr>
<td>LTC</td>
<td>Long Term Care</td>
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<tr>
<td>MAC</td>
<td>Medical Assistance and Services Advisory Council - or Maximum Allowable (Drug)Cost or Medical Assistance Card, depending upon context</td>
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<tr>
<td>MAP</td>
<td>Maximum Allowable Price (Drug Reimbursement)</td>
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<td>MAUDE</td>
<td>Medicaid Automated Data Extract</td>
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<tr>
<td>MCPI</td>
<td>Medical Consumer Price Index (US Department of Labor statistics)</td>
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<tr>
<td>MDC</td>
<td>Major Diagnostic Category</td>
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<tr>
<td>MMIS</td>
<td>Medicaid Management Information System</td>
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<tr>
<td>MR</td>
<td>Mentally Retarded</td>
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<tr>
<td>NF</td>
<td>Nursing Facility</td>
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<tr>
<td>NON-PPS</td>
<td>Non-Prospective Payment System (Inpatient Hospitals paid on a per diem basis)</td>
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<tr>
<td>OAP-A</td>
<td>Old Age Pension A - 65 years or older</td>
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<tr>
<td>OAP-B</td>
<td>Old Age Pension B - 60 to 64 years of age</td>
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<tr>
<td>OASDI</td>
<td>Old Age Survivors Disability Insurance</td>
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<td>OSPB</td>
<td>Office of State Planning and Budget</td>
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<td>PACE</td>
<td>Program of All-Inclusive Care for the Elderly</td>
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<td>PASARR</td>
<td>Pre-Admission Screening and Annual Resident Review (Nursing Facility)</td>
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<td>PCP</td>
<td>Primary Care Physician</td>
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<td>PDN</td>
<td>Private Duty Nursing</td>
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<tr>
<td>PHP</td>
<td>Prepaid Health Plan</td>
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<tr>
<td>PPS</td>
<td>Prospective Payment System (for Inpatient Hospitals)</td>
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<td>PRO</td>
<td>Peer Review Organization (CFMC)</td>
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<td>QDWI</td>
<td>Qualified Disabled Working Individual</td>
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<tr>
<td>QMB</td>
<td>Qualified Medicare Beneficiary</td>
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<tr>
<td>RFP</td>
<td>Request for Proposal</td>
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<td>RTC</td>
<td>Residential Treatment Center</td>
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<tr>
<td>SEP</td>
<td>Single Entry Point (for Long Term Care)</td>
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<tr>
<td>SLMB / SMIB</td>
<td>Special Low-Income Medicare Beneficiaries / Supplementary Medical Insurance Benefits</td>
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<tr>
<td>SNF</td>
<td>Skilled Nursing Facility</td>
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<tr>
<td>SSA / SSI</td>
<td>Social Security Administration / Supplemental Security Income</td>
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<td>SURS</td>
<td>Surveillance and Utilization Review</td>
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<td>Title XVIII</td>
<td>(of the Social Security Act) Medicare</td>
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<td>Title XIX</td>
<td>(of the Social Security Act) Medicaid</td>
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<tr>
<td>TPL</td>
<td>Third Party Liability</td>
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THE COLORADO MEDICAID ANNUAL REPORT: 
MANDATE, SOURCES AND AVAILABILITY

The Colorado Medicaid Annual Report is provided to the General Assembly as part of the Comprehensive Annual Plan, required under the COLORADO MEDICAL ASSISTANCE ACT; HUMAN SERVICES CODE, CRS 26-4-107, "COMPREHENSIVE PLAN FOR OTHER SERVICES AND BENEFITS." Other parts of the Comprehensive Plan are the Health and Medical Services Budget documents, the Management Action Plans for the Department, and the Title XIX (Medicaid) State Plan that is submitted to the federal government. Copies of these Comprehensive Plan and Supporting Documents are available as stated below.

All data contained in the Annual Report are obtained from the Department of Health Care Policy and Financing Office of Budget and Planning and/or from management reports of the Medicaid Management Information System (MMIS), except as otherwise noted. Policy and program information was provided by the staff of the Colorado Medicaid program, except as otherwise noted. The Medical Advisory Council of the Colorado Medicaid program assisted in the development and preparation of the FY 92-93 Annual Report; however, the Colorado Department of Health Care Policy and Financing is solely responsible for the content of the 1995 report. Cost of printing and distributing this report, at approximately $1.50 per copy, is an administrative expense of the Medicaid program.

CITATIONS
State and Federal Statutory and Regulatory Citations relevant to Health and Medical Services programs:
- Medical Assistance Act, C.R.S. 26-4-100, et seq, 26-4-704, et seq
- Titles XVIII and XIX, Social Security Act
- 42 Code of Federal Regulations, Part 400-429 and Part 430 to End
- Home Care Allowance C.R.S. 26-2-114, 26-2-203, 26-2-119
- Adult Foster Care C.R.S. 26-2-119, 26-2-114
- Staff Manual of the Colorado Department of Human Services, including Volume 8 (Medical Assistance programs), Volume 7 (Eligibility for Home Care Allowance and Adult Foster Care) and Volume 3 (Eligibility)

No person may be excluded from participation in Colorado Medicaid, or denied benefits, or discriminated against, because of: sex, race or color, national origin or citizenship, mental or physical impairment, or religion.

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