DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
FY 2013-14 JOINT BUDGET COMMITTEE HEARING AGENDA

Wednesday, January 7, 2013
1:30 pm– 5:00 pm

1:30 - 1:45 Update from the Advisory Commission on Family Medicine

1:45 – 2:15 Health Care Policy and Financing, Introductions and Opening Comments

QUESTIONS COMMON TO ALL DEPARTMENTS

1. The JBC occasionally hears complaints that base personal services reductions to capture vacancy savings result in more vacancy savings as managers reduce staff to absorb the reduction and then still experience turnover. Some departments refer to this as the "death spiral." Has your department experienced this problem? How does your department attempt to minimize and avoid the "death spiral?"

2:15 – 3:20 Potential eligibility and benefit expansions

AFFORDABLE CARE ACT ELIGIBILITY EXPANSIONS

2. Should Colorado expand Medicaid pursuant to the Affordable Care Act, and why? How would Medicaid and CHP+ enrollment change, and how much would such an expansion cost?

3. What are the Department's intentions regarding involvement of the General Assembly in any expansion decisions?

4. What is the Department's vision for the Hospital Provider Fee in the Affordable Care Act environment?

5. Please compare the size, scope, and uses of Colorado's provider fees -- Hospital Provider Fee, Nursing Facility Fee, and Intermediate Care Facility for People with Intellectual Disabilities (ICF-ID) Fee – to provider fees in other states. How many states have provider fees?

6. Please provide estimates of the underinsured in Colorado, especially in the income ranges potentially impacted by the Affordable Care Act.

7. Please provide a history of optional expansions of Medicaid eligibility, including the year and fund sources, and each expansion's contribution to total enrollment.

8. Please provide a projection of Medicaid enrollment and of CHP+ enrollment through FY 2016-17. When does the Department anticipate that the Medicaid population will reach 1.0 million?

9. More individuals are projected to be covered by Medicaid in the coming years due to the passage of the insurance requirement in the federal Affordable Care Act. Does the Department anticipate that the new enrollees will be more likely than existing enrollees to require behavioral health services? Does the Department anticipate that the new enrollees will have a higher per capita cost than existing enrollees?

10. What have other states experienced with per capita mental health costs when Medicaid eligibility is increased?

11. How much churn does the Department expect between eligibility for Medicaid, CHP+, and tax benefits through the health insurance exchange? What plans does the Department have to minimize disruptions in coverage caused by churn? What is the status of the implementation of continuous eligibility?

12. In the wake of *NFIB v. Sebelius*, what ACA Medicaid expansions are optional versus mandatory, and what is the match rate for each expansion? Specifically, is the expansion for former foster children mandatory or optional?

13. What is Colorado's provider capacity to handle an eligibility expansion? What is the Department doing to ensure providers are sufficient and prepared?

DENTAL BENEFIT

14. How does the proposed dental benefit fit with other payment reforms the Department is implementing? How will the Department track changes in health outcomes and how will the Department attribute those changes to the dental benefit versus other reform initiatives, such as the Affordable Care Collaborative, gainsharing, or payment reforms authorized by H.B. 12-1281?

15. What is the benefit of having an Administrative Services Organization (ASO) manage the children's dental benefit and the proposed new adult benefit? Would the outreach and care management functions of an ASO overlap with the Affordable Care Collaborative (ACC)? Should these functions be merged into the ACC?

16. Please explain the Department's estimate of the costs, savings, and federal match rate associated with the proposed new dental benefit. Especially, please focus on FY 2012-13 and

how the expected wind-down of expenditures for CoverColorado aligns with the expected costs for the Department during the phase-in of the dental benefit.

17. What are the Department's projections of future revenue available from the Unclaimed Property Trust Fund (UPTF)? Will the revenue be enough to sustain funding for the dental benefit from this source in the future?

18. What are the legal limitations on the uses of the Unclaimed Property Trust Fund?

19. How does the proposed dental benefit compare to legislation on dental benefits last year? Why did the Department decide to change the scope and financing?

20. What is Colorado's provider capacity to handle a benefit expansion? What is the Department doing to ensure providers are sufficient and prepared?

3:20 - 3:30 Break

3:30 - 5:00 Other JBC Questions

MEDICAID FORECAST

21. The JBC staff provided a chart comparing Colorado's Medicaid enrollment and Colorado's unemployment rate. Please provide any available information about the number of underemployed in Colorado and their contribution to Medicaid enrollment.

22. How do changes in Medicaid costs compare to changes in general health care costs? Are Medicaid costs rising faster, slower, or about the same as costs in the health care market?

PROVIDER RATES

23. Please compare changes in Medicaid reimbursement rates for various providers for the last several years.

24. How do current appropriations for hospital providers compare to the maintenance of effort requirement contained in Section 25.5-4-402.3 (5) (a) (I), C.R.S.?

LONG-TERM CARE

25. Why has the cost per capita for the elderly and disabled populations been increasing so rapidly? Which services are driving the cost increases? Why have costs per capita for the disabled increased more rapidly than costs per capita for the elderly?

26. What is the Department doing to control long-term care costs? Is the Department putting sufficient emphasis on controlling costs in this area versus other areas of the budget?

27. How do changes in nursing home reimbursement rates compare to changes in rates for other providers?

28. Should the nursing home rate be in statute, and why? If it remains in statute, how could it be fixed to be more transparent and comprehensible, while maintaining the purpose and intent of the statute?

29. Please provide an update on the Program for All-inclusive Care for the Elderly (PACE). As part of the update, please discuss:
    a. What is the status of the PACE expansion in Northern Colorado?
    b. When will the Northern Colorado program open, and what communities will it serve?
    c. What other communities could use PACE?
    d. How can PACE be tailored to rural communities?
    e. How will PACE work with Regional Care Collaborative Organizations (RCCOs)?
    f. Has S.B. 12-023 been implemented?
    g. Have the rules been promulgated to allow PACE providers to contract with an enrollment broker to include the PACE program in its marketing materials to eligible long-term clients?

30. How are rates for home and community based services (HCBS) calculated and how have they changed over time? What would those rates be today if they had been increased for the annual cost of living since 2004? How do changes in HCBS rates compare to changes in nursing home rates?

ADMINISTRATIVE STAFF

31. How do the staffing levels for Colorado's Medicaid and CHP+ programs compare to the staffing levels in other states?

32. Why can't the Department manage staffing needs within existing resources?

PHARMACY

33. Please explain how the Department will calculate pharmacy acquisition costs? Is it average acquisition cost or actual acquisition cost?

34. Are there ways the savings from using the new pharmacy reimbursement methodology could be reinvested in initiatives that promote more effective use of pharmaceuticals to improve health outcomes and reduce long-term costs?

35. What are the Department's concerns about RX Review?

36. What would be the characteristics of an effective drug management therapy program? What does the literature say about the performance of these programs? How much would such a program cost?

37. What are the Department's views on reimbursing pharmacists for providing immunizations?

PAYMENT REFORM

38. Please provide an update on the Department's efforts to implement gainsharing and other payment reform initiatives authorized in FY 2012-13's R-5 and in H.B. 12-1281.

39. Please provide an update on the implementation of the Accountable Care Collaborative (ACC), including a discussion of the performance outcomes.

MISCELLANEOUS

40. How will the Affordable Care Act affect the Medicaid family planning program? What is the federal match rate for this program?

41. Please coordinate with the departments of Education and of Public Health and Environment to discuss whether the funding and administration for school based health clinics should be transferred to the Department of Education.

42. Can local funds for services for people with developmental disabilities, such as Denver's program, be used to match federal Medicaid funds?

43. Does Colorado have a Medicaid administrative claiming process that would allow local governments to get matching funds for administrative functions, and if not, why not?

QUESTIONS FROM NOVEMBER 5, 2012 BRIEFING ON MEDICAID MENTAL HEALTH COMMUNITY PROGRAMS

AFFORDABLE CARE ACT

1. More individuals are projected to be covered by Medicaid in the coming years due to the passage of the insurance requirement in the federal Affordable Care Act. Does the Department anticipate that the new enrollees will be more likely than existing enrollees to require behavioral health services? Does the Department anticipate that the new enrollees will have a higher per capita cost than existing enrollees?

SUBSTANCE USE DISORDER BENEFIT

2. The Department proposes shifting the current Medicaid substance use disorder benefit from a fee-for-service model to a managed care model. Why does the Department propose that the Behavioral Health Organizations (BHOs) should manage the benefit rather than the Managed Service Organizations (MSOs) that already administer the non-Medicaid substance use disorder program for the Department of Human Services?

3. If the Department's request to enhance the existing substance use disorder through the expansion of existing services and the addition of new services is funded, how will the savings in other areas of the budget (e.g. physical health care) be tracked?

4. Does the Department have any preliminary projections for future cost savings in other areas of the budget (e.g. physical health care) if the request is funded?

5. The Department has implemented Regional Care Collaborative Organizations (RCCOs) to connect Medicaid enrollees with providers offering services to Medicaid enrollees and to provide improved communication mechanisms to better coordinate care. If the Department's funding request for the substance use disorder benefit is granted and implemented as part of the BHO contracts, what impact (if any) will it have on the integration of behavioral health services and physical health services as it relates to the RCCOs?

ADDENDUM: OTHER QUESTIONS FOR WHICH SOLELY WRITTEN RESPONSES ARE REQUESTED

Please provide:

1. The Joint Budget Committee has recently reviewed the State Auditor's Office *Annual Report of Audit Recommendations Not Fully Implemented* (October 2012). If this report identifies any recommendations for the Department that have not yet been fully implemented and that fall within the following categories, please provide an update on the implementation status and the reason for any delay.

    a. Financial audit recommendations classified as material weaknesses or significant deficiencies;
    b. Financial, information technology, and performance audit recommendations that have been outstanding for three or more years.

44. Pease provide the number of units provided in the last fiscal year by discipline, in either visits or hours, for home health, private duty nursing and home and community based services programs. These disciplines include RN visits, PT visits, OT visits, speech therapy visits,

home health aide visits by time, personal care provider hours, and private duty nursing and RN and LPN hours.

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
(Medicaid Mental Health Community Programs Only)
FY 2013-14 JOINT BUDGET COMMITTEE HEARING AGENDA

Tuesday, November 27, 2012
10:30 am – 11:00 am

10:30-10:35 INTRODUCTIONS AND OPENING COMMENTS

10:35-10:40 AFFORDABLE CARE ACT

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10:40-11:00 SUBSTANCE USE DISORDER BENEFIT

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HCPF JBC Hearing responses

Medicaid Mental Health Community Programs

November 27, 2012

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(Medicaid Mental Health Community Programs Only)
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1. **More individuals are projected to be covered by Medicaid in the coming years due to the passage of the insurance requirement in the federal Affordable Care Act. Does the Department anticipate that the new enrollees will be more likely than existing enrollees to require behavioral health services? Does the Department anticipate that the new enrollees will have a higher per capita cost than existing enrollees?**

RESPONSE: If the State were to expand Medicaid eligibility for parents and Adults without Dependent Children (AwDC) beyond current categories, the Department does not anticipate that the new enrollees would be more likely to require behavioral services or have a higher per capita cost than existing enrollees. For the most recent expansion of Medicaid Parents from 60% of the federal poverty level (FPL) to 100% FPL, the behavioral health capitation rates for the expansion group were the same as those for the lower income parent categories. The Department anticipates that this would also likely be the case if eligibility for Medicaid Parents were to be further expanded. For Adults without Dependent Children (AwDC) with income at or below 10% FPL, the behavioral health capitation rates are between the existing low-income adult and disabled rates. If AwDC eligibility were to be expanded, the Department believes that the per capita cost may decrease as the higher income individuals are likely to be relatively healthier.

10:40-11:00 SUBSTANCE USE DISORDER BENEFIT

2. **The Department proposes shifting the current Medicaid substance use disorder benefit from a fee-for-service model to a managed care model. Why does the Department propose that the Behavioral Health Organizations (BHOs) should manage the benefit rather than the Managed Service Organizations (MSOs) that already administer the non-Medicaid substance use disorder program for the Department of Human Services?**

RESPONSE: The Department proposes that the Behavioral Health Organizations (BHOs) should manage the Substance Use Disorder (SUD) benefits for a number of reasons. Moving the SUD services into the BHO contract addresses the importance of providing integrated services and does so in a way that is administratively feasible, effective and efficient. The inclusion of these services into the BHO contract is an important and logical step toward improving Colorado Medicaid's behavioral health system as a whole.

On both national and local levels, health care is moving towards integration and coordination of services. Integration efforts focus not only on integration of mental health and substance use disorder services into the comprehensive behavioral health system, but also on integrating behavioral health services with physical health care. Integrating SUD services into the BHO contract ensures that Colorado Medicaid's policy is aligned with national trends and best practices.

Integrating SUD services will also eliminate the need to create yet another siloed managed care entity or "carve out" and will help ensure that we provide more seamless and coordinated care for our clients. Research has shown that a high percentage of clients with mental health conditions have a co-occurring substance use disorder. Similarly, many individuals with a substance use disorder have an undiagnosed mental health condition. Providing integrated treatment for these co-occurring conditions is significantly more effective than treating each in isolation. By integrating SUD services into the BHO contract, treatment may be provided to the whole person in one delivery system, maximizing treatment outcomes, as well as improving our clients' experience of care.

In addition to supporting the goal of integration, moving the full SUD benefit into the BHO contract makes sense from an administrative perspective. BHOs already provide SUD and mental health services to clients with co-occurring conditions and are familiar with the provision of these services. The BHOs' main providers, Community Mental Health Centers (CMHCs), are all certified SUD services providers, and the Department is confident that BHOs could assume this scope of work and expand their contracting to include other SUD providers. BHOs have also been working on integration with physical health services, so it makes sense to align integration of mental health and SUD treatment with these efforts.

Finally, integration makes sense in terms of the Department's contracting and systems capabilities. The Department is currently under contract with the BHOs, so adding the SUD services into the BHO contract scope of work avoids a costly/lengthy procurement process. Technical systems are already set up to process BHO encounter data and can easily be revised to include SUD services. The Department is also working on a Request for Proposals (RFP) for the new behavioral health services contract for FY 2013-14. This RFP will include a strong focus on integration of not only mental health and SUD services, but physical health services, as well. MSOs and SUD providers are actively involved in the RFP stakeholder engagement process for the rebid, and the Department will encourage all qualified MSOs and behavioral health organizations to bid on the new scope of work.

3. **If the Department's request to enhance the existing substance use disorder through the expansion of existing services and the addition of new services is funded, how will the savings in other areas of the budget (e.g. physical health care) be tracked?**

RESPONSE: If the request is approved, the Department would account for any savings through future budget requests for Medical Services Premiums and Medicaid Community Mental Health Programs.

It is not clear if the Department will be able to identify savings specifically attributable to an enhanced substance use disorder treatment benefit. In its November 2010 performance audit on

the existing Medicaid outpatient substance use disorder treatment benefit, the Office of the State Auditor found that it was not "…able to determine whether the reduction in medical costs

was the direct **result of, or 'caused by,'** Substance Abuse Benefit services provided to clients" (**emphasis** original). This finding was in part because state databases, including the Department's Medicaid Management Information System (MMIS) and information available from the Department of Human Services, were not designed "…to collect data on underlying factors impacting clients' medical costs for research or experimental studies." As a result, the Office of the State Auditor was not able to establish a causal relationship between the benefit and reductions in cost.

As was the case at the time of the performance audit, the Department does not have access to the needed information that would allow for this type of analysis, and as a result, the Department may not be able to specifically attribute savings to an enhanced substance use disorder treatment benefit. However, if savings do occur, they would lead to a lower request for Medical Services Premiums in future years.

The Office of the State Auditor did perform a number of additional analyses to examine cost trends for clients who used the existing substance use disorder benefit, and found "…the trends in medical costs for clients who utilized the Medicaid Substance Abuse Benefit are promising and indicate that the benefit may have a positive impact." The Department would be able to perform similar analyses in the future to examine if there was evidence of savings, even if a causal relationship cannot be established.

The Department believes that the implementation of an expanded benefit in a managed care delivery model – specifically, the state's Behavioral Health Organizations – has the potential to provide for better data that may allow for a causal relationship to be established in the future. The Department, in conjunction with its Statewide Data and Analytics Contractor (SDAC), which is primarily focused on analysis related to the Accountable Care Collaborative, are collaborating on finding ways to better measure the impact of programmatic changes. The results to date have been positive; the Department's response to the November 1, 2012 Legislative Request for Information #6, discussing the results of the Accountable Care Collaborative, would not have been possible without the statistical and technical help of the SDAC. If this request is approved, the Department fully intends to evaluate and analyze utilization of services of clients accessing SUD to determine impacts on client's overall health outcomes and utilization, and incorporate any savings achieved in a future budget request.

4. **Does the Department have any preliminary projections for future cost savings in other areas of the budget (e.g. physical health care) if the request is funded?**

RESPONSE: The Department did not include a savings estimate as part of its request. As described in the Department's response to question 3, in the most recent performance audit of the current program, the Office of the State Auditor was unable to determine whether the reduction in costs was a result of the treatment or other factors. Therefore, the Department did not believe that it would be appropriate to prospectively include a savings estimate in the request.

However, the Department believes that providing treatment greatly improves the overall health of the client as it reduces clients' risks for a variety of health conditions and accidents and could therefore reduce costs. This view is supported by research from the National Center for Addiction and Substance Abuse at Columbia University, which has found that untreated addiction alone causes or contributes to more than 70 other diseases requiring hospitalization. In Washington, substance use disorder treatment was shown to save $311 per month in medical costs for Medicaid members. In California, substance use disorder treatment reduced ER visits by 39%, hospital stays by 35% and total medical costs by 26% (Substance Abuse and Mental Health Services Administration (SAMHSA)). Further, beyond direct health outcomes, research by the National Center for Addiction and Substance Abuse at Columbia University has found that health-related costs represent only 26 cents of every dollar spent on substance use disorder. The other 74 cents goes to the justice system, education, child/family services and other costs. By providing appropriate and sufficient treatment to individuals with substance use disorders, the overall burden to State government for related costs may be reduced.

Therefore, while the Department has not provided a preliminary savings estimate in the request, the Department is hopeful that the request will lead to lower costs and better outcomes in the future. As noted in the Department's response to question 3, the Department is optimistic that it will be able to provide a more detailed assessment of savings in the future.

5. **The Department has implemented Regional Care Collaborative Organizations (RCCOs) to connect Medicaid enrollees with providers offering services to Medicaid enrollees and to provide improved communication mechanisms to better coordinate care. If the Department's funding request for the substance use disorder benefit is granted and implemented as part of the BHO contracts, what impact (if any) will it have on the integration of behavioral health services and physical health services as it relates to the RCCOs?**

RESPONSE: Including the current fee for service substance use disorder (SUD) benefit in the Behavioral Health Organization (BHO) contracts will positively impact the Accountable Care Collaborative (ACC) program and support current Department efforts to further integrate behavioral health and physical health care services. The Regional Care Collaborative Organizations (RCCOs) continue to increase their focus on achieving integrated care, and moving all behavioral health services under the BHO contracts will further promote their ability to effectively coordinate services and impact integrated service delivery for their members.

Over the past several years the Department has placed progressively greater emphasis on the integration of behavioral and physical health care services in Medicaid. Prior to the development of the ACC program, the BHOs were responsible for helping clients obtain a focal point of physical health care and coordinating mental health care with other health care services. Over time, the BHOs have pursued additional initiatives focused on integrated care. These integration strategies include co-located behavioral health care in primary care clinics, information sharing and consultation to facilitate better integrated care, and embedded physical care services in behavioral health provider sites.

Under the ACC, the BHOs have continued to make progress in the integration of care by actively working with the RCCOs to integrate behavioral health care with Primary Care Medical

Providers (PCMPs), who serve as medical homes for ACC members. Moving forward, the Department is currently developing the next Request for Proposals (RFP) for the behavioral health services contracts to begin in FY 2013-14. The RFP will include a continued strong focus on integration of behavioral health and physical health services, incorporating a number of new requirements in this area. The new integration requirements will help inform the Department and its BHO and RCCO partners on the most effective ways to further integrate behavioral health and physical health care. Integrating SUD and mental health services in a more robust way under the BHO contract is a significant step towards continuing to build a strong relationship between the behavioral health system and physical health care and towards the Department's long-term goal of a fully integrated health care delivery system.

ADDENDUM: OTHER QUESTIONS FOR WHICH SOLELY WRITTEN RESPONSES ARE REQUESTED

1. **The Joint Budget Committee has recently reviewed the State Auditor's Office Annual Report of Audit Recommendations Not Fully Implemented (October 2012). If this report identifies any recommendations for the Department that have not yet been fully implemented and that fall within the following categories, please provide an update on the implementation status and the reason for any delay.**
    a. **Financial audit recommendations classified as material weaknesses or significant deficiencies;**
    b. **Financial, information technology, and performance audit recommendations that have been outstanding for three or more years.**

RESPONSE: The Department will provide responses to this question at its main hearing on January 7, 2013. The Department's outstanding audit recommendations do not pertain to the Department's Medicaid Mental Health Community Programs.

HCPF JBC HEARING RESPONSES

January 7, 2013

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QUESTIONS COMMON TO ALL DEPARTMENTS

1) The JBC occasionally hears complaints that base personal services reductions to capture vacancy savings result in more vacancy savings as managers reduce staff to absorb the reduction and then still experience turnover. Some departments refer to this as the "death spiral." Has your department experienced this problem? How does your department attempt to minimize and avoid the "death spiral?"

RESPONSE:

The Department aggressively manages its Personal Services appropriation in an attempt to minimize the effects of the "death spiral" and base personal services reductions in general. As a result, the Department typically expends all of its General Fund Personal Services appropriation each year. Therefore, reductions to the Department's Personal Services appropriations and the resulting "death spiral" create operational issues for the Department.

In order to minimize the effects of reductions to its Personal Services appropriation, the Department uses multiple strategies to help contain costs. When a position is vacated, the Department evaluates the position and similar positions in the division to determine if job duties can be absorbed by existing staff. Where possible, the Department also temporarily downgrades positions for training purposes. By doing so, new staff can be brought in at lower salaries, creating additional flexibility in the Department's Personal Services appropriation. However, this approach is not sustainable in the long term. Existing staff cannot typically absorb many additional job duties for a significant period of time. Downgrading positions discourages highly qualified candidates from applying, as the initial salary offered is lower.

As the Department has grown in size and scope over the last decade, vacancies create a considerable burden for those who continue to work at the Department, and the length of time needed to hire employees into the State personnel system can create workload and morale issues. To alleviate this burden, the Department attempts to supplement staff with temporary employees when vacancies occur, which reduces the potential amount of vacancy savings. However, this, too, is not an ideal solution. Temporary employees may only be employed for a limited amount of time in each 12-month period (previously six months per year; nine months per year effective January 1, 2013). Therefore, temporary employees cannot work on long-term assignments. This places an additional burden on existing staff who must assume additional responsibilities created by the vacancy and also creates additional training responsibilities. At the end of the temporary employee's assignment, the knowledge the employee has gained is lost to the Department. As a result, although temporary employees are less expensive in the short run, they are not a sustainable way for the Department to manage its personnel needs.

Overall, because the Department frequently spends its entire General Fund Personal Services appropriation, base personal services reductions made in an attempt to capture vacancy savings put significant additional pressure on the Department's ability to manage FTE levels. Further reductions to the Department's Personal Services appropriation would

likely result in reduced overall staffing at the Department and ultimately impair the Department's ability to perform its core operations and work on health care reform initiatives.

MEDICAID ELIGIBILITY EXPANSION

2) Should Colorado expand Medicaid pursuant to the Affordable Care Act, and why? How would Medicaid and CHP+ enrollment change, and how much would such an expansion cost?

RESPONSE:

The Department believes Colorado should expand Medicaid. While Colorado expands Medicaid coverage, the Department must also strengthen programs that improve quality, make the system easier to navigate for clients, and contain costs.

By expanding Medicaid, the Department can leverage existing federal and State dollars to improve Coloradans health coverage at a lower cost to the State. The availability of 100% federal match from 2014 through 2016, along with the federal match tapering down to 90% in the later years, is a strong incentive to expand Medicaid.

Studies have shown that having health insurance has a profound impact on health. When people aren't well, they have difficulty working. By increasing the number of insured through Colorado's Medicaid program, it will have a positive impact on the health of those individuals, which benefits the State economy.

The Department took a measured and analytical approach in determining the fiscal impact of this choice. The Department looked at the:

- cost of newly eligibles;
- cost of currently eligible but not enrolled (EBNE) – an impact regardless of expansion decision;
- administrative costs;
- savings from reduction in state programs for the uninsured;
- other revenue gains and savings; and
- fiscal impact of not expanding.

After evaluating these factors, the Department determined the Affordable Care Act (ACA) expansion allows Colorado to enroll nearly 161,000 additional people. This enhanced match will also allow provider fee dollars to go further. The current federal medical assistance percentage (FMAP) for the expansion populations authorized in the Colorado Health Care Affordability Act (HB 09-1293) is only 50%, and population expansions to 100% of the federal poverty level (FPL) have been dependent on available funds, which has limited the Department's ability to provide coverage under this legislation.

The following table shows a preliminary 10-year estimate of caseload and expansion projections with the expansion. The HB 09-1293 column identifies funding and caseload related to its required expansion and ACA refers to the expansion between 100%-133% FPL.

Preliminary 10-Year Estimate* **Caseload and Cumulative Expenditure Projections, 2013-2022** (Representing Net Change, Costs in Millions)			
	09-1293	**ACA**	**Total****
Caseload[1]	220,300	59,500	271,000
Total Cost	$11,709.7	$2,039.2	$13,548.3
State Share: Provider Fee/Other[2]	$1,267.3	**$128.3**	$1,395.6
State Share: General Fund/Other[2]	$0	$0	**($179.5)**
Federal	$10,382.3	$1,910.9	$12,280

** This is a preliminary estimate of caseload and expenditures and does not include administrative costs or effects of other programs.*

*** The Total column above takes into account calculations for eligible but not enrolled individuals and changes to CHP+ costs and caseload.*

(1) The total caseload includes 110,200 parents and adults without dependent children currently authorized under the provider fee. More than 160,000 Coloradans will be enrolled as a result of the expansion.

(2) As federal funding tapers, the Department anticipates savings, provider fees and other public funding will cover the additional caseload.

The Affordable Care Act created the exchange subsidies affecting everyone above the allowable FPL rate of Medicaid. With the current FMAP under the provider fee, the State would not be able to fully implement coverage levels intended in the legislation. If Colorado opted out of the Medicaid expansion, it would leave over 100,000 people below 100% FPL uninsured and excluded from access to health insurance in Medicaid or through the exchange.

3) What are the Department's intentions regarding involvement of the General Assembly in any expansion decisions?

RESPONSE:

The Department plans to collaborate with the legislature on any expansion efforts.

4) What is the Department's vision for the Hospital Provider Fee in the Affordable Care Act environment?

RESPONSE:

The Department's vision for the Hospital Provider Fee is to allow the State to move forward with expansion under the Affordable Care Act with little to no General Fund impact.

The passage of HB 09-1293, the Colorado Health Care Affordability Act, created Colorado's hospital provider fee. The provider fee is a fee assessed on Colorado hospitals, the size of which is based on the size of the facility. The fees collected from hospitals are then matched by the federal government.

The provider fee has enabled the State to increase reimbursements under Medicaid and the Colorado Indigent Care Program (CICP). By increasing reimbursements, the provider fee helps to reduce the rate of rising health care costs that results from underpayment. In addition, the provider fee expanded eligibility to thousands of uninsured Coloradans through Medicaid and the Child Health Plan *Plus* (CHP+); many of the covered would be eligible under the Affordable Care Act. Because of the hospital provider fee, both the increase to reimbursement and expansion of eligibility were able to be performed without relying on General Fund dollars or shifting costs to other health care consumers.

According to the Colorado Hospital Association, levels of uncompensated care at Colorado hospitals were reduced by approximately $300 million statewide, due in large part to increased reimbursement rates for Medicaid.

5) Please compare the size, scope, and uses of Colorado's provider fees – Hospital Provider Fee, Nursing Facility Fee, and Intermediate Care Facility for People with Intellectual Disabilities (ICF-ID) Fee – to provider fees in other states. How many states have provider fees?

RESPONSE:

Colorado has three, provider-fee programs with various objectives. The federal government limits fee assessments to 6% of Net Patient Revenue (NPR) for the service type.

Hospital Provider Fee
The Hospital Provider Fee was established by HB 09-1293. The Department assesses two distinct fees, one on inpatient services and the other on outpatient services. Combined inpatient and outpatient fees collections totaled $585.7 million in FY 2011-12, with the inpatient fee at 5.9% of NPR and outpatient fee at 0.9% of NPR. These fees generated $526.8 million in federal matching dollars in FY 2011-12.

Hospital-fee revenue and federal matching funds are used to:

- increase hospital reimbursement for inpatient and outpatient services under Medicaid up to the federal Upper Payment Limits;
- increase hospital reimbursement under the Colorado Indigent Care Program up to 100% of costs;
- create hospital quality incentive payments;
- increase coverage for Medicaid parents with incomes up to 100% of the federal poverty level (FPL) and for Child Health Plan *Plus* (CHP+) children and pregnant women up to 250% FPL;
- implement health coverage for adults without dependent children up to 100% FPL;
- create a Medicaid buy-in program for individuals with disabilities up to 450% FPL;
- implement 12-month continuous eligibility for Medicaid children;
- cover the Department's related administrative costs; and
- pursuant to SB 10-169 and SB 11-212, provide temporary General Fund budget relief in the Medicaid program.

Nursing Facility Provider Fee

The Nursing Facility Provider Fee was established by HB 08-1114. Pursuant to statute, fees are collected on non-Medicare service days for qualifying facilities at $12.00 per day, adjusted for inflation. Nursing facility fees totaled $42.7 million in FY 2011-12 and are at 4.2% of NPR. Along with federal matching dollars, the program funded $84.5 million in supplemental payments to nursing facilities without any increase in General Fund expenditures.

Nursing facility-fee revenue and federal matching funds allow the Department to make supplemental payments to nursing facilities above the per diem rate subject to the General Fund growth cap. These supplemental payments are funded as provider-fee revenue and federal matching funds allow according to a hierarchy established in statute as follows:

- Paying administrative costs and offsetting the Medicaid cost of the provider fee
- Payment for acuity or case-mix of residents
- Payment for higher quality performance
- Payment for residents with moderate to severe mental health conditions, cognitive dementia, or acquired brain injury
- Payment for the difference between the state-wide per diem rate and the General Fund share

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) Fee

Colorado established a provider fee for ICF/IID facilities under 25.5-6-204 C.R.S. through the enactment of HB 03-1292. The ICF/IID provider fee is assessed at 5% of costs (approximately 5% of NPR) for the two state-owned regional centers and the privately-owned ICF/IID. The fee amount is $1.8 million per year and, with federal matching funds, is used to offset General Fund expenditures.

Use of Provider Fees in Other States

According to the National Conference of State Legislatures, for FY 2012, the number of states with some type of Medicaid-related provider fees has increased to 47 states plus

Washington, D.C. The three states without provider fees are Alaska, Delaware, and Hawaii. At least 34 states currently assess a fee on hospitals, 34 states charge a fee on ICF/IID, and 38 states assess nursing facilities. A number of states also charge fees on ambulatory services, insurance and managed-care organizations, pharmacies, and day rehab facilities. A majority of states' assessments on Nursing Facilities and ICF/IID are at or near the federal NPR limit.

There is considerably more variation in the assessment amount on hospital services. Some states' assessments on hospital services are only a percent or two of NPR, while others approach the maximum-allowable 6% NPR limit.

Fee revenues are used in a variety of ways in other states. Some states use cash fund revenue to supplant general fund in Medicaid claims or managed care payments. Other states' fee programs fund expansion populations, supplemental payment programs, or a combination of these mechanisms.[1] In Colorado, fees must show a direct benefit to the entity being assessed a fee and cannot be used for just any purpose. Specifically, section 25.5-4-402.3 (5) (a) (I), C.R.S. (2012), states that the intention of the hospital provider fee is to supplement, not supplant, General Fund supported hospital reimbursement.

The table on the following page shows provider fee and provider tax types by state for FY 2010-11 and uses information published in May 2011 by the Kaiser Commission on Medicaid and the Uninsured.[2] After this table was developed, Wyoming added fee programs for hospitals and nursing facilities. Under federal regulations, these programs are referred to as "provider taxes." According to analysis by Legislative Legal Services (LLS), Colorado's programs are defined as "fees" under Colorado law. In a memo to Senator Keller dated December 22, 2008, LLS specifically stated in regard to whether the hospital provider fee is a tax for purposes of section 20 (4) (a) of article X of the Colorado constitution:

> "The intent of the hospital provider fee would be to increase reimbursements to the hospitals paying the fee, not to increase revenue for general governmental purposes. Therefore, the hospital provider fee would not be a tax requiring prior voter approval under 20(4)(a) of article X of the State constitution."

[1] Information on fee programs in other states was obtained from the National Conference of State Legislatures (http://www.ncsl.org/issues-research/health/health-provider-and-industry-state-taxes-and-fees.aspx)

[2] Table and additional information on fees are from Kaiser Commission on Medicaid and the Uninsured, Publication Number: 8193, Publish Date: 2011-05-31 (http://www.kff.org/medicaid/8193.cfm)

Provider Fees and Taxes in the 50 States and the District of Columbia: FY 2010-2011												
States	Hospitals		ICF/IID		Nursing Facilities		Managed Care Organizations		Other		Any Provider Tax/Fee	
	2010	2011	2010	2011	2010	2011	2010	2011	2010	2011	2010	2011
Alabama	X	X			X	X			X	X	X	X
Alaska												
Arizona							X	X			X	X
Arkansas	X	X	X	X	X	X					X	X
California		X	X	X	X	X			X	X	X	X
Colorado	X	X	X	X	X	X					X	X
Connecticut					X	X					X	X
Delaware												
District of Columbia	X	X	X	X	X	X	X	X			X	X
Florida	X	X	X	X	X	X					X	X
Georgia		X			X	X					X	X
Hawaii												
Idaho	X	X			X	X					X	X
Illinois	X	X	X	X	X	X					X	X
Indiana			X	X	X	X					X	X
Iowa		X	X	X	X	X					X	X
Kansas	X	X				X					X	X
Kentucky	X	X	X	X	X	X			X	X	X	X
Louisiana			X	X	X	X			X	X	X	X
Maine	X	X	X	X	X	X			X	X	X	X
Maryland	X	X	X	X	X	X	X	X			X	X
Massachusetts	X	X			X	X			X	X	X	X
Michigan	X	X			X	X				X	X	X
Minnesota	X	X	X	X	X	X	X	X	X	X	X	X
Mississippi	X	X	X	X	X	X					X	X
Missouri	X	X	X	X	X	X			X	X	X	X
Montana	X	X	X	X	X	X					X	X
Nebraska			X	X							X	X
Nevada					X	X					X	X
New Hampshire	X	X			X	X					X	X
New Jersey	X	X	X	X	X	X	X	X	X	X	X	X
New Mexico							X	X	X	X	X	X
New York	X	X	X	X	X	X			X	X	X	X
North Carolina			X	X	X	X					X	X
North Dakota			X	X							X	X
Ohio	X	X	X	X	X	X					X	X
Oklahoma					X	X					X	X
Oregon	X	X			X	X	X		X	X	X	X
Pennsylvania	X	X	X	X	X	X	X	X			X	X
Rhode Island	X	X	X	X	X	X	X	X			X	X
South Carolina	X	X	X	X							X	X
South Dakota			X	X							X	X
Tennessee		X	X	X	X	X	X	X			X	X
Texas			X	X			X	X			X	X
Utah		X	X	X	X	X					X	X
Vermont	X	X	X	X	X	X			X	X	X	X
Virginia				X								X
Washington	X	X	X	X			X	X			X	X
West Virginia	X	X	X	X	X	X					X	X
Wisconsin	X	X	X	X	X	X			X	X	X	X
Wyoming												
Total	**29**	**34**	**33**	**33**	**37**	**38**	**12**	**11**	**14**	**15**	**46**	**47**

6) Please provide estimates of the underinsured in Colorado, especially in the income ranges potentially impacted by the Affordable Care Act.

RESPONSE:

The following is a chart from the Colorado Health Institute of self-reported insurance status of Coloradans covered under expansions of the Affordable Care Act.

Table 1. Colorado Adults (ages 19-64) with Family Incomes Less Than 138 Percent of the Federal Poverty Level (FPL) by Parental Status and Health Insurance Status,[2] 2011

Insurance Status	Adults without Dependent Children (AwDC)		Parents	
	Number	Percent	Number	Percent
Employer*	179,547	34.0	49,204	25.4
Medicare	30,547	5.8	5,778	3.0
Medicaid**	68,450	13.0	61,092	31.6
Individual Purchase	62,952	11.9	7,345	3.8
Uninsured	187,036	35.4	70,059	36.2
Total	528,532	100.0	193,478	100.0

*Includes military coverage
** Please note that these are estimates based on self-reported data and will differ from administrative figures. Many of the AwDC reporting Medicaid are likely eligible based on disability.
Source: CHI analysis of the 2011 American Community Survey

It is difficult to gauge how many of the insured adults without dependents and parents are underinsured. A person is typically considered underinsured if limits on their coverage hinder them from obtaining medically necessary care or if high out-of-pocket payments constitute a serious financial burden or outright barrier to care.

According to a report by the Colorado Health Foundation on Benefit Adequacy, those most likely to be underinsured include:

- people with low incomes or who have medical deductibles exceeding 5% of their income;
- individuals with health problems;
- people with individual or public, as opposed to employer-sponsored, health insurance;
- women and adults age 55 to 64 or 19 to 24;
- farm families; and
- rural and inner-city residents.

7) Please provide a history of optional expansions of Medicaid eligibility, including the year and fund sources, and each expansion's contribution to total enrollment.

RESPONSE:

Population	Description	Year of Implementation	Fund Source	Caseload (November 2012)
Breast and Cervical Cancer Program	Women under this optional coverage group were screened using the Centers for Disease Control's national breast and cervical cancer early detection and prevention guidelines, and found to have breast or cervical cancer.	FY 2002-03	General Fund, Prevention, Early Detection, and Treatment Fund, Tobacco Settlement Funds	615
Presumptive Eligibility for Pregnant Women on Medicaid	Allows pregnant women to apply for Medicaid benefits and receive them immediately for a period of 45 days if they pass an initial eligibility screening at a certified clinic. Legislative authority for this population was reauthorized by House Bill 05-1025 and the program was reintroduced on July 1, 2005, after having legislative authority inadvertently removed in 1991.	FY 2005-06	Health Care Expansion Fund	456
Expansion Adults to 60% FPL	Extended eligibility under Medicaid to the parents of any Medicaid or Children's Basic Health Plan eligible child from approximately 23% to at least 60% of the federal poverty level.	FY 2006-07	Health Care Expansion Fund	29,076
Removal of the Medicaid Asset Test	Removed the Medicaid asset test as part of its eligibility criteria.	FY 2006-07	Health Care Expansion Fund	N/A
Medicaid for Legal Immigrants	Reinstated Medicaid benefits for optional legal immigrants.	FY 2006-07	Health Care Expansion Fund	5,386
Expansion of Medicaid Eligibility for Foster Care Children	Expanded Medicaid eligibility to young adults less than 21 years of age and who were in the foster care system immediately prior to their 18th birthday.	FY 2007-08	Health Care Expansion Fund	1,402
Children's Extensive Support Waiver increase	Increased the number of resources to enroll eligible clients in the program.	FY 2006-07	Health Care Expansion Fund	79

Population	Description	Year of Implementation	Fund Source	Caseload (November 2012)
Children's Home and Community Based Services Waiver Increase	Increased the number of resources to enroll eligible clients in the program.	FY 2006-07	Health Care Expansion Fund	678
Expansion Adults to 100% FPL	Increased the eligibility level for parents of children who are eligible for medical assistance or the children's basic health plan to up to 100% of the federal poverty line.	FY 2009-10	Hospital Provider Fee	41,895
Adults without Dependent Children	Provided Medicaid benefits for adults who do not have dependent children receiving Medicaid, and who are at or below 100% of the Federal Poverty Level.[1]	FY 2011-12	Hospital Provider Fee	9,972
Medicaid Buy-In Program for Working Adults with Disabilities Medicaid Buy-In Program for Children with Disabilities	Provided working adults with disabilities and children who are under age 19, who earn too much income or have too many resources to qualify for Medicaid, the opportunity to purchase Medicaid.	FY 2011-12 (Working Adults) FY 2012-13 (Children)	Hospital Provider Fee	753

[1]*Due to fiscal constraints, the Department has only implemented this population up to 10% of the Federal Poverty Level, with a cap of 10,000 clients.*

8) Please provide a projection of Medicaid enrollment and of CHP+ enrollment through FY 2016-17. When does the Department anticipate that the Medicaid population will reach 1.0 million?

RESPONSE:

Assuming there are no significant changes in the economic outlook and that Medicaid eligibility is expanded to 133% of the federal poverty level (FPL) pursuant to the Affordable Care Act (ACA), the Department estimates that average monthly enrollment in FY 2016-17 in Medicaid and CHP+ will be 1,038,710 and 91,919, respectively. This includes estimates of caseload increases from currently eligible but not enrolled (EBNE) individuals seeking Medicaid or CHP+ enrollment beginning in 2014.

Based on similar assumptions, the Department anticipates the Medicaid population will reach 1.0 million during FY 2015-16.

9) More individuals are projected to be covered by Medicaid in the coming years due to the passage of the insurance requirement in the federal Affordable Care Act. Does the Department anticipate that the new enrollees will be more likely than existing enrollees to require behavioral health services? Does the Department anticipate that the new enrollees will have a higher per capita cost than existing enrollees?

RESPONSE:

If the State were to expand Medicaid eligibility for parents and adults without dependent children beyond current categories, the Department does not anticipate the new enrollees would be more likely to require behavioral services or have a higher per capita cost than existing enrollees. For the most recent expansion of Medicaid parents from 60% of the federal poverty level (FPL) to 100% FPL, the behavioral health capitation rates for the expansion group were the same as those for the lower-income parent categories. The Department anticipates this would also likely be the case if eligibility for Medicaid parents were to be further expanded. For Adults without Dependent Children (AwDC) with income at or below 10% FPL, the behavioral health capitation rates are between those for existing low-income adult and disabled individuals.

Academic research indicates that, among low-income populations, there is a negative correlation between income and health care cost. Recent analysis performed by The Urban Institute indicates that adults currently eligible for Medicaid are more expensive than those who would be newly eligible for Medicaid under the ACA expansion to 133% FPL.[3]

10) What have other states experienced with per capita mental health costs when Medicaid eligibility is increased?

RESPONSE:

The Department has been unable to obtain enough information to provide a useful comparison of other states' experience with per capita mental health costs during periods of Medicaid eligibility expansions; the Department does not believe that such information is readily available in published documents from other states. In order to accurately compare Colorado's Medicaid mental health costs to those for other states, additional resources would be needed to hire a contractor to research states' per capita mental health costs. Each state offers a unique Medicaid program and corresponding mental health program where components such as the services covered, the type of program through which services are provided (i.e., fee-for-service, managed care, etc.), and the risk profile of the eligible and newly eligible enrollees varies. Therefore, the impact from expansions experienced in other states can vary based on the unique characteristics of the states and their Medicaid mental health programs.

[3] John Holahan, Matthew Buettgens, Caitlin Carroll, and Stan Dorn, *The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis*, The Urban Institute, November 2012.

11) How much churn does the Department expect between eligibility for Medicaid, CHP+, and tax benefits through the health insurance exchange? What plans does the Department have to minimize disruptions in coverage caused by churn? What is the status of the implementation of continuous eligibility?

RESPONSE:

The Department does not yet know the full extent of churn in Colorado but is working with other states and data institutes to better identify the population most likely to churn and potential policy solutions. The following key program design considerations to minimize churn will be explored:

- Benefit alignment between Medicaid and the exchanges
- Health plan participation in both Medicaid and the exchanges
- Enrollment and eligibility systems designed to facilitate transitions
- Provider engagement and network requirements for Regional Care Collaborative Organizations (RCCOs) and Qualified Health Plans (QHPs)

Churn occurs when individuals become eligible and then ineligible for Medicaid and CHP+. There are two main reasons why people churn: 1) income fluctuations, and 2) family size/household composition changes. At the income levels in which one qualifies for Medicaid and CHP+, families are much more likely to have inconsistent and unstable income. The phenomenon of churn between public and private coverage is not a new problem, though it is complicated by the future coverage continuum that creates new programmatic breaking points between Medicaid and the future health insurance exchanges, as well as between existing federal and state-funded coverage programs.

The Department is continually looking at ways to ensure that all uninsured individuals who are eligible for Medicaid and CHP+ maintain coverage for as long as they qualify. The Department has already adopted nationally recommended[4] practices into its procedures and operations.

Over the past several years, the Department has:

- simplified the re-enrollment process by automatically re-enrolling qualified individuals using information obtained from other public assistance programs;
- expanded community-based outreach to over 400 sites statewide;
- implemented technologies to automate verifications and reduce the burden for both the worker and the applicant; and
- engaged leaders and partners to articulate a clear vision and benefits to enrolling children.

The Department is preparing to minimize the impacts of churn by guiding consumers through unavoidable changes in coverage. Guidance will occur through well-trained

[4] Maximizing Kids' Enrollment in Medicaid and SCHIP: What Works in Reaching, Enrolling and Retaining Eligible Children. V. Wachino, A. Weiss. National Academy for State Health Policy and Robert Wood Johnson Foundation. February 2009.

eligibility site staff, consumer-friendly websites, upgrades and enhancements to its application and eligibility determination processes (PEAK and CBMS), a state-of-the-art call center, and assistors who provide outreach. In addition, the exchange plans to provide a call center and navigators to assist consumers.

Status of Implementation of Continuous Eligibility
The Oversight and Advisory Board of the Hospital Provider Fee prioritized the expansion populations and then continuous eligibility. Within the available funding, the Department successfully and fully expanded eligibility to parents and to children and pregnant women in CHP+; expanded the buy-in for people with disabilities; and expanded eligibility to adults without dependents to 10% FPL or the first 10,000 adults.

The Department continues work on the expansion for adults without dependent children but is also re-evaluating the original fiscal note related to continuous eligibility. Because of the work to reduce barriers for enrolling and retaining coverage for qualified individuals, as identified above, and what the Department has learned about utilization working with other states and stakeholders, the Department anticipates the costs of continuous eligibility may be less than originally estimated in the 2009 fiscal note. The Department continues to research continuous eligibility and work with stakeholders to determine a possible implementation date.

12) In the wake of *NFIB v. Sebelius,* what ACA Medicaid expansions are optional versus mandatory, and what is the match rate for each expansion? Specifically, is the expansion for former foster children mandatory or optional?

RESPONSE:

Former Foster Children
This population continues to be mandatory; the foster care expansion was not addressed in *NFIB v. Sebelius* and, therefore, remains in effect as Congress intended. Because the Affordable Care Act limits the enhanced federal match to "newly eligible individuals" as defined in subclause (VIII) of Section 1902(a)(10)(A)(i) of the Social Security Act, which does not include "former foster children," this expansion population receives the standard 50% federal match.

Low-Income Adults and Children to 133% FPL
While the Affordable Care Act still requires expansion to this population, under *NFIB v. Sebelius*, there is no penalty for failure to comply with the federal legislation. Therefore, states have the choice of expanding to 133% FPL. The federal match for this population varies over time as follows:

Calendar Year	Enhanced Federal Match Rate for Newly Eligible Populations
2014-2016	100%
2017	95%
2018	94%
2019	93%
2020+	90%

Following *NFIB v. Sebelius*, CMS provided guidance to states[5], indicating that a partial eligibility expansion would not qualify for an enhanced federal match. Consequently, if the State opts not to extend eligibility for adults to 133% FPL, existing Medicaid populations that would have otherwise received an enhanced federal match will not be eligible; this includes both the State's "Adults without Dependent Children" population and "Expansion Adults to 100% FPL."

13) What is Colorado's provider capacity to handle an eligibility expansion? What is the Department doing to ensure providers are sufficient and prepared?

RESPONSE:

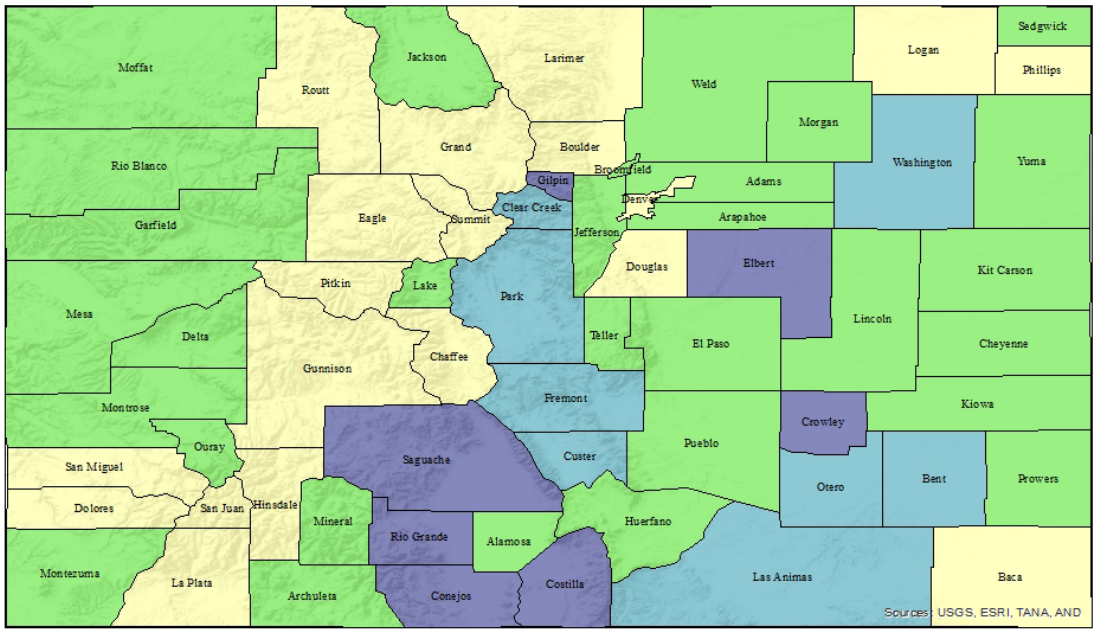
The Colorado Health Institute (CHI) published a brief on this topic in December 2011 that estimated Colorado will need approximately 83 to 141 additional physicians, nurse practitioners, and physician assistants to cover newly insured individuals under the Affordable Care Act. CHI estimated in 2011 that approximately 510,000 Coloradans would become newly insured; currently the Department estimates that 161,000 low-income adults will gain Medicaid coverage due to the Affordable Care Act expansion. The Department, the Department of Public Health and Environment, funders, and local physician and stakeholder groups are aware of this shortfall and are working on strategies.

The Department has mapped the number of Medicaid clients per primary care provider, and a copy of the map is provided on the following page.

[5] December 10, 2012 Governors' letter from Secretary Sebelius. http://cciio.cms.gov/resources/files/exchanges-faqs-12-10-2012.pdf

Number of Colorado Medicaid Clients Per Primary Care Provider by County, State Fiscal Year 2011-12

Total average number of Colorado Medicaid clients per month represented in the data/map: 619,963
Total number of Colorado Medicaid primary care providers (PCP) represented in the data/map: 21,391
State-wide number of Colorado Medicaid clients per primary care provider: 29



As expected, there is variation in primary care availability, and the areas where there exists a need in Medicaid primary care providers correspond to areas where there is a shortage of primary care providers statewide.

The Department is working on several strategies to ensure an adequate and prepared provider network. First, the Accountable Care Collaborative is changing the way that health care is delivered. Coordinated care, which is a primary role of the seven Regional Care Collaborative Organizations (RCCOs), will minimize time-consuming efforts that a practitioner would have previously needed to provide. For example, RCCOs can assist practitioners in meeting a client's non-medical needs that might impact a client's health, such as transportation or housing. Care coordinators, electronic health records, and the Statewide Data Analytics Contractor (SDAC) are all tools being implemented for practices to eliminate uncoordinated, duplicative care. Additionally, RCCOs are providing practice support in an effort to streamline and enhance the protocols within each practice, allowing providers to focus on patient care rather than administratively burdensome processes like billing questions or helping navigate a denied prior-authorization request.

Second, the Department currently has over 33,000 providers statewide. Between January 2010 and December 2012, the Department increased the number of actively enrolled primary care-like providers by 26% and the number of all other types of providers by 38%. This resulted in a 30% overall increase in the number of providers available to service

Medicaid clients despite the rate cuts implemented over the past few fiscal years. The Department believes this trend will continue as the Department continually works to enroll as many providers as possible. To ensure an adequate network of providers to serve the future expansions under the Affordable Care Act, the Department's Client Service, Eligibility, and Enrollment Office is conducting additional provider outreach activities through a contracted provider recruitment firm with funding from the Health Resources Services Administration (HRSA) grant. The HRSA grant expires in August 2013, and the provider recruitment contract expires in June 2013.

Third, the Affordable Care Act provides for a two-year payment increase for Medicaid primary-care providers to match Medicare payment rates for qualified physicians and advanced-practice nurses. The exact amount of the increase is not known at this time because Medicare has not established a rate for 2013. The Department estimates paying providers approximately $16 million per year, mostly federal funds. There is excitement in the physician community about this new reimbursement, and the Department expects new providers to enroll and existing providers to consider taking new Medicaid clients. This will especially benefit small, rural communities with a disproportionate percentage of Medicaid clients. There are other Affordable Care Act provisions not directly related to Medicaid that are also expected to support providers, such as enhanced funding to Federally Qualified Health Centers to increase capacity and increased student loan repayments for primary care.

Finally, the Department's Chief Medical Officer meets every four to six weeks with provider groups, including the Colorado Medical Society, the American Academy of Family Practice, the American Academy of Pediatrics, and the RCCO Medical Directors. These meetings are designed to discuss issues of mutual interest, which includes ensuring an adequate provider network.

DENTAL BENEFIT

14) How does the proposed dental benefit fit with other payment reforms the Department is implementing? How will the Department track changes in health outcomes and how will the Department attribute those changes to the dental benefit versus other reform initiatives, such as the Affordable Care Collaborative, gainsharing, or payment reforms authorized by H.B. 12-1281?

RESPONSE:

The proposed change to the children's dental benefit aligns with the work the Department is doing on both benefit redesign and payment reform. The implementation of an Administrative Services Organization (ASO) model for the Children's dental benefit aligns directly with the Accountable Care Collaborative (ACC), the Department's delivery system reform model for other services. The goal is to have a dental care delivery system using a similar delivery system and payment model as the ACC. Like the ACC, the dental ASO will manage the fee-for-service dental benefit, which includes utilization management,

improving and enhancing the provider network, and coordinating care delivery. The payment of a per-member per-month (PMPM) to incent appropriate utilization and care management is a step toward payment reform. The dental ASO model would not only increase access to care and improve the care delivered through proper management of the provider network, it also lends flexibility to implement additional payment reform measures going forward. Any possible dental payment reform measures will align with existing payment reform measures that have demonstrated success in Department models like the ACC. A dental benefit that is functioning purely as fee-for-service does not fit in with the other payment and delivery system reforms the Department is implementing. Ultimately, the Department envisions the integration of the dental ASO with the ACC, which is a constantly evolving model for care delivery. The alignment of the dental ASO and ACC models will lay the foundation to integrate both models in the future. While now is not the time to integrate dental into the ACC, the dental ASO will help bring appropriate dental expertise to the ACC.

The alignment of the dental ASO and ACC models supports the Department's goal of improving overall health outcomes and the client experience, as well as lowering per capita costs. While all Department efforts support this goal, it is difficult to attribute cost savings to a specific intervention. However, the Department is committed to continued tracking and reporting on process measures that look at trends over time and access to care. Current process measures examined by the Department are found within the Department's Healthy Living oral health initiatives and the dental performance measures, as well as measures examined by the Department over the past four years, including utilization of dental treatment and prevention services and sealants. These measures align with the clearly defined measures identified by the Centers for Medicare and Medicaid Services (CMS), which has required Colorado, along with all states, to develop a Medicaid/Child Health Plan *Plus* (CHP+) dental action plan, which outlines the Department's roadmap for reaching CMS' goal for each state to increase its respective prevention services and dental sealants by 10 percentage points from FFY 2012-13 through FFY 2017-18.

15) What is the benefit of having an Administrative Services Organization (ASO) manage the children's dental benefit and the proposed new adult benefit? Would the outreach and care management functions of an ASO overlap with the Affordable Care Collaborative (ACC)? Should these functions be merged into the ACC?

RESPONSE:

The benefits of a fee-for-service model managed by an ASO include:

- proper management of the provider network – enhanced provider recruitment efforts and strategies, a robust provider credentialing system that ensures client access to an adequate provider network, the provision of provider support, and Medicaid education to increase provider satisfaction;
- guidance and recommendations on an enhanced claims adjudication process;
- client outreach and education to improve overall access to the dental benefit;
- utilization management to ensure provision clinically appropriate services;

- benefit management that may consist of guidance about evidence-based dentistry guided by best practices and recommendations on benefit limitations and exclusions; and
- infrastructure to comply with CMS' goals for the states and meet the Department's oral health performance measures and Healthy Living initiatives.

While the outreach and care management functions of an ASO align with the ACC, and do not overlap, now is not the time to integrate dental into the ACC. The outreach and case management functions would be complementary and synergistic with the work of the RCCOs. Ultimately, the Department envisions the integration of the dental ASO with the ACC. The synergies would be a result of the appropriate dental expertise the dental ASO will help bring to the ACC in the future.

In order to realize these benefits of a dental ASO model, the Department must consider a comprehensive systems approach and model that not only maximizes health outcomes but bends the cost curve. Due to economies of scale and specific dental expertise, it is the Department's opinion that an ASO that delivers and manages dental services is the best model to improve health outcomes and client experiences as well as lower per capita costs. This aligns with the ACC model, which has shown positive results in the delivery of physical health services.

16) Please explain the Department's estimate of the costs, savings, and federal match rate associated with the proposed new dental benefit. Especially, please focus on FY 2012-13 and how the expected wind-down of expenditures for CoverColorado aligns with the expected costs for the Department during the phase-in of the dental benefit.

RESPONSE:

Costs

In its November 1, 2012 Budget Request R-8, "Medicaid Dental Benefit for Adults," the Department proposed a dental benefit for adults that would cover preventive care up to a cost of $1,000 per year. Based on data available from North Carolina, the Department assumed that not all clients would receive the full $1,000 of services that the benefit permits but would instead receive an average of $600 of services per client. The Department selected North Carolina as a model because it has the most comprehensive Medicaid dental benefit information available. In addition, CMS singled out North Carolina as one of eight states with innovative practices and the adult dental benefit that might be used as a prototype for stakeholder discussion in Colorado.

Based on data available from other states and studies, the Department estimated that 27.0% of eligible clients would receive services each year (see Table 4 of the R-8 request). However, the Department also assumed that not all of the clients who would eventually utilize the benefit would do so immediately, as it would take time for them to become aware of the benefit and schedule appointments with providers; therefore, the Department's estimates for the overall utilization rate are lower in the first year of the program's implementation.

The Department assumes the administrative costs of managing this benefit would be between $1 and $3 per member per month (PMPM). It is important to note that a PMPM would be applied to all clients eligible for the benefit rather than only clients who actually utilize services. This estimate is based on current knowledge of administrative rates and could increase or decrease, depending on the vendor selected through the request for proposal (RFP) process. The Department may pay the vendor a fixed price per year, as opposed to a monthly fee, based on the number of clients served; this would be determined through the RFP process. To simplify these undetermined administrative costs, the Department estimated a $2.00 PMPM for each client eligible for the benefit.

Savings

The Department assumed coverage of preventive treatments would reduce the volume of emergency care and extractions, as regular access to preventive care can prevent the development of acute dental conditions. In order to estimate the potential decrease in emergency care, the Department reviewed other states' Medicaid programs. No states have recently implemented or expanded their adult dental benefits; therefore, the Department examined the dental-related emergency service utilization that other states reported after reducing or eliminating their adult dental benefits in Medicaid. The following states reported an increase in dental-related emergency visits after reducing or eliminating their adult dental benefits: Michigan (11% increase after six months); Massachusetts (30% increase after six months); Maryland (21% increase after 12 months); and Iowa (224.7% increase over seven years, despite only a 16.3% increase in caseload). Based upon these findings, the Department considered it reasonable to assume a 15% reduction in FY 2013-14 and a 30% reduction in FY 2014-15 in emergency dental services after implementing an adult dental benefit that provides preventive services aimed to reduce more-costly restorative services in the future. The Department notes this dental benefit may produce other potential savings and benefits that cannot be readily measured. For instance, clients who receive treatments that enhance the appearance of their teeth may be able to secure employment more readily than those who have not received any dental treatment.

Federal Match Rates

Providing dental coverage to adults is allowable under the Social Security Act. Therefore, the Department assumes services provided would qualify for the standard federal medical assistance percentage (FMAP) of 50%. Costs for system changes to the Medicaid Management Information System (MMIS) would qualify for 75% federal financial participation.

CoverColorado Wind-Down and Dental Benefit Phase-In

According to the Joint Budget Committee staff briefing document for the Department of Treasury (page 14), the Unclaimed Property Trust Fund (UPTF) is expected to receive $34.0 million in revenue in each year through FY 2014-15. This amount does not include interest earnings and does not account for any available fund balance. The Department estimates that a fully operational dental benefit would require $21.9 million annually from the UPTF by FY 2014-15; therefore, the Department believes revenue from the UPTF would exceed projected costs for the program by a substantial amount. The Department

notes this amount would be less in the first year of the program because of program ramp-up. For example, with an assumed start date of April 1, 2014, the Department calculated it would need $12.8 million from the UPTF in FY 2013-14.

The Department's requested implementation date of April 1, 2014, assumed CoverColorado would cease operations by that date and would require no further funding from the UPTF. However, information provided during the Department of Treasury's Joint Budget Committee staff briefing on December 20, 2012, indicates that CoverColorado will end coverage by April 2014 and cease operations by the end of CY 2014. Based on these dates, Joint Budget Committee staff estimated the FY 2013-14 available balance of the UPTF to be $8.3 million, or $4.5 million less than the Department projected for the estimated costs of the program in FY 2013-14. As a result, the proposed implementation date of the adult dental benefit may need to be modified to account for the available balance of the UPTF.

The UPTF is projected to have enough incoming revenue to sustain the proposed adult dental program; however, the reserve requirement for the CoverColorado program (projected to be $103.6 million in FY 2014-15) would decrease the available balance to less than the $22.8 million that the Department estimates is needed in cash funds to fund the dental benefit in FY 2014-15. However, the Department anticipates the reserve requirement will diminish over time as CoverColorado ceases operation and a portion of that funding will become available to fund the proposed adult dental benefit. Once the reserve requirement is eliminated, the Department believes the annual revenue into the UPTF will fully support the adult dental benefit without any need to use the fund balance.

17) What are the Department's projections of future revenue available from the Unclaimed Property Trust Fund (UPTF)? Will the revenue be enough to sustain funding for the dental benefit from this source in the future?

RESPONSE:

The Department is basing its estimate for the Unclaimed Property Trust Fund (UPTF) revenue and fund balance on the Joint Budget Committee's staff briefing document for the Department of Treasury (page 14). In FY 2014-15, the UPTF's $34.0 million in projected net revenue would exceed the $21.9 million in funding the Department estimates would be needed to fund the adult dental benefit during that fiscal year. The Department believes the incoming revenue to the UPTF would support the program for the foreseeable future.

18) What are the legal limitations on the uses of the Unclaimed Property Trust Fund?

RESPONSE:

Per section 38-13-116.5 (1)(b) and (d), C.R.S. (2012), the principal of the trust fund shall not be expended except to pay CoverColorado health insurance claims or the Unclaimed Property Trust Fund's (UPTF) administration, and the principal is not subject to

appropriation by the General Assembly. The funds in the UPTF do not revert to the General Fund at the end of any fiscal year.

Given these provisions, the General Assembly would need to amend the existing statute to allow the Department to utilize UPTF monies to fund the proposed dental benefit.

19) How does the proposed dental benefit compare to legislation on dental benefits last year? Why did the Department decide to change the scope and financing?

RESPONSE:

SB 12-108, "Concerning providing oral health care to pregnant women who are enrolled in Medicaid," would have provided a dental benefit only to pregnant women and would have placed a specific list of covered services in statute, including a single comprehensive examination, prophylaxis, debridement, cariostatic agents, radiographs as needed, and up to five restorations. SB 12-108 was financed using General Fund revenue to cover the State cost of the program.

The Department's proposed Medicaid dental benefit for adults, as proposed in R-8 of the Department's November 1, 2012 Budget Request, would cover all adults in Medicaid including pregnant women. To ensure that clients have access to the proper services, the services covered would be determined through the Department's Benefits Collaborative process. In order to track each client's service costs and ensure proper utilization, the Department anticipates the benefit would be managed by a third-party administrator under an administrative services organization (ASO) structure.

To finance the services, the Department requested funding from the Unclaimed Property Trust Fund (UPTF) which will become available when many of the CoverColorado members are transitioned to private insurance available through the Colorado Health Benefits Exchange. The Department anticipates the UPTF will generate revenue of $34 million annually; therefore, due to the finite amount of funding available from the UPTF, the benefit would employ an annual per-client cap of $1,000. The Department's request would not require any General Fund to provide services but would result in an estimated savings to the General Fund in the amount of $747,621 in FY 2013-14 due to a reduction in emergency dental services.

SB 12-108 was not a Department-initiated bill; therefore, the Department does not consider its proposed dental benefit in the budget request to be a change in scope or financing. This request represents the first time the Department has independently proposed a dental benefit for adults. The availability of funding through the UPTF provides a unique opportunity to serve an unmet medical need that will have an impact on health and save money currently being spent on emergency dental services with no impact to the General Fund.

20) What is Colorado's provider capacity to handle a benefit expansion? What is the Department doing to ensure providers are sufficient and prepared?

RESPONSE:

The Department has the capability to increase the capacity of the provider network to support a benefit expansion. There are many initiatives and collaborations underway that have helped increase the number of dental providers enrolled from 1,484 in FY 2008-09 to 2,087 in FY 2011-12, a 40.6% increase. In addition, a dental benefit expansion could, in fact, alleviate a dental provider shortage, as it would make it more financially feasible to serve areas with dental provider shortages.

Initiatives to increase provider capacity include a contract the Department awarded to a vendor to perform provider retention and recruitment functions, including dental providers through July 2013. Additionally, the Department works collaboratively with Cavity Free at Three, a grant-funded, statewide initiative of dentists, physicians, public health professionals, foundations, and child-health advocates that is currently engaged in a statewide effort to recruit pediatric dentists for the Medicaid program.

Colorado experiences dental provider shortages in the rural areas. To combat this problem, the Department is collaborating with the Colorado Dental Association (CDA) and the Oral Health Colorado coalition (OHCO) to develop a dental practice satellite model in areas of limited dental access. The stated goals of the satellite model are to: 1) identify rural counties for a pilot program; 2) connect dentists with rural communities by offering incentives; and 3) assist independent hygienists serving the community with a business model. The Department will collaborate with CDA and OHCO to evaluate the use of and billing for tele-dentistry in rural areas. Tele-health is increasingly being used to serve clients in rural areas as a cost-effective alternative to delivering face-to-face care and ensuring that clients in rural areas have access to care.

Building on current initiatives and collaborations identified above, the Department expects the dental Administrative Services Organization (ASO) to ensure providers are sufficient and prepared. As a core element of the dental ASO contract, the dental ASO is responsible for developing and managing the provider network and ensuring the provider network is delivering appropriate, evidence-based dentistry through efficient practice models.

MEDICAID FORECAST

21) The JBC staff provided a chart comparing Colorado's Medicaid enrollment and Colorado's unemployment rate. Please provide any available information about the number of underemployed in Colorado and their contribution to Medicaid enrollment.

RESPONSE:

The U.S. Bureau of Labor Statistics (BLS) calculates various measures of labor underutilization for states, ranging from U-1 to U-6, with each statistic accounting for an additional category of labor underutilization. The U-6 statistic is the most inclusive measure of unemployment, as it includes total unemployed plus all persons marginally attached to the labor force and total employed part-time for economic reasons (the "underemployed"). According to the most recent BLS estimates, the "Alternative Measures of Labor Underutilization for States, Fourth Quarter of 2011 through Third Quarter of 2012 Averages," approximately 15% of Colorado's work force is underemployed (including the unemployed). For more information on the various measures of labor underutilization, please visit http://www.bls.gov/lau/stalt12q3.htm.

Despite the fact that U-6 unemployment is widely considered to be a more broad measure of unemployment, the Department believes the U-3 unemployment rate – which is the official unemployment rate and includes all persons unemployed 15 weeks or longer, job losers, and persons who completed temporary jobs – is a more reliable indicator of expected Medicaid caseload. An underemployed individual can be either eligible or ineligible for Medicaid, depending on their income level relative to Medicaid thresholds. During a recovery, previously unemployed individuals may become employed part-time, which results in an increase in underemployment as well as increased income. However, this change in income may or may not move a family's income over the Medicaid-eligibility threshold, depending on what this income level is. If the individual's income is still very low and below Medicaid thresholds (for example, very few hours at a minimum-wage job), the family will remain eligible for Medicaid; if the income is relatively high and is above the Medicaid threshold, the family will be ineligible for Medicaid (for example, a higher-wage job or more hours worked). As a result, the U-6 unemployment measure's relationship to Medicaid caseload is uncertain.

Additionally, there are other technical considerations why the Department uses the U-3 measure instead of the U-6 measure. First, the BLS publishes the U-6 unemployment data on a four-quarter, moving-average basis, whereas U-3 data is available on a monthly basis. This increases the sample size that the Department can use in its forecasts, which increases the reliability of the model. Second, the Department's forecast modeling requires monthly projections of U-3 unemployment rates throughout the forecast period, and a similar monthly forecast for U-6 unemployment rates is not available.

Finally, the Department does not believe that, even if the obstacles to using the U-6 measure could be overcome, the use of this measure would materially improve its Medicaid

caseload forecast. In the Department's forecast models, the absolute level of unemployment is irrelevant; rather, it is the relative change between data points that matters. In any forecast modeling, if two variables have a very similar pattern over time, both will yield very similar forecasts regardless of differences in absolute value. As the moving averages of U-3 and U-6 unemployment have displayed very similar trends since the first quarter of 2008, using U-6 unemployment would yield results that are very similar to the Department's official forecast if a forecast for U-3 was available for the Department to use.

22) How do changes in Medicaid costs compare to changes in general health care costs? Are Medicaid costs rising faster, slower, or about the same as costs in the health care market?

RESPONSE:

Although certain comparisons are provided below, the Department cautions that Medicaid costs are not directly comparable to measures of health care inflation or rates of increase in private insurance premiums. The Department does not generally adjust reimbursement rates for changes in actual provider costs, and so changes in Medicaid costs do not necessarily reflect the change in cost for practitioners providing health care. Rather, per capita Medicaid costs are generally a function of actual utilization and changes in Medicaid caseload; this contrasts with measures such as the medical care consumer price index (CPI), which are derived from a broader calculation of health care-related expenses, including insurance premiums and administrative costs.

In recent years, Medicaid per capita costs have generally decreased for most services, while general health care costs have increased. In most cases, Medicaid reimbursement does not change in response to changes in cost in the health care market. The majority of Medicaid providers are reimbursed based on a set fee schedule, and the Department does not generally update the fee schedule without additional appropriations for that purpose from the General Assembly. Since FY 2008-09, the Department has reduced reimbursement to the majority of Medicaid providers by 6.10%, whereas health care costs, as measured by the consumer price index, have increased by approximately 10.83% during that time.[6] The Department's response to question 23 contains additional information on recent changes in Medicaid reimbursement rates.

In general, costs in the health care market rise faster than Medicaid costs. Since FY 2008-09, per capita costs for the Department's relatively high-cost categories (elderly and disabled) have increased slightly, while per capita costs for the Department's relatively low-cost categories (adults and children) have decreased. During the same period, the average annual total for employer-provided health care premiums has increased by nearly 25% (see the following table).

[6] Consumer Price Index for All Urban Consumers: Medical care in Denver-Boulder-Greeley, CO (CMSA) (CUUSA433SAM), 2009-2012 (comparisons based on June data)

Annual Growth in Per-Capita Costs by Medicaid Category[(a)]: FY 2008-09 through FY 2012-13*					
	Adults 65 and Older (OAP-A)	**Disabled Individuals to 59 (AND/AB)**	**Categorically Eligible Low-Income Adults (AFDC-A)**	**Eligible Children (AFDC-C/BC)**	**Average Annual Total Premiums for Family Coverage[(b)]**
FY 2009-10	-4.41%	-3.23%	-10.22%	-7.93%	5.48%
FY 2010-11	1.31%	3.51%	-5.59%	-2.00%	2.95%
FY 2011-12	1.36%	-0.33%	-1.83%	-5.34%	9.46%
FY 2012-13[(c)]	2.67%	2.01%	-0.70%	-4.60%	4.46%
Since FY 2008-09	**0.78%**	**1.84%**	**-17.37%**	**-18.52%**	**24.17%**

(a) Historical per capita costs can be found in Department's November 1, 2012 Budget Request R-1, Exhibit C

(b) These figures include physical health and long-term care costs. Kaiser Family Foundation, Employer Health Benefits 2012 Annual Survey, Exhibit 6.4: Average Annual Worker and Employer Contributions to Premiums and Total Premiums for Family Coverage, 1999-2012 (calendar-year data is matched with fiscal year beginning during calendar year – i.e., CY 2009 data is matched with FY 2009-10)

(c) FY 2012-13 figures are projections from the Department's November 1, 2012 Budget Request R-1.

PROVIDER RATES

23) Please compare changes in Medicaid reimbursement rates for various providers for the last several years.

RESPONSE:

The majority of Medicaid providers were subject to the same rate reductions between FY 2009-10 and FY 2011-12. A small number of providers have more complicated rate methodologies and received different reductions. The Department compares the reductions applied to the majority of providers with two particular types of providers: pharmacies and nursing facilities.

Across-the-board Rate Reductions

The majority of fee-for-service providers in Medicaid are reimbursed on a fee schedule. Adjustments to the fee schedule are typically addressed through the normal budget process. Most notably, during the recession, multiple rate reductions were implemented as the State shared the financial burden with Medicaid providers. Beginning in FY 2009-10, the Department has reduced rates for most acute-care providers (e.g., hospitals, physicians, specialists, and home-health agencies) by a cumulative 6.10% and has reduced rates for community-based long-term care providers (primarily home- and community-based services providers) by a cumulative 5.86%. See the following table for additional details.

Across-the-board Reductions	Rate Reduction
FY 2009-10	
July 2009	2.00%
September 2009	1.50%
December 2009	1.00%
Total FY 2009-10[(1)]	**4.44%**
FY 2010-11	
July 2010	1.00%
Total FY 2010-11	**1.00%**
FY 2011-12	
July 2011	0.75% (Acute Care) 0.5% (Community-Based Long-Term Care)
Total FY 2011-12	0.75% (Acute Care) 0.5% (Community-Based Long-Term Care)
Total Rate Cuts to Date[(1)]	**6.10% (Acute Care)** **5.86% (Community-Based Long-Term Care)**

(1) Please note that rate cuts are multiplicative, and individual rate reductions will not add to the total. For example: If a rate is reduced from $100.00 to$ 99.00 in one year, and in the following year the rate is reduced by 1%, the new rate would be $98.01. The cumulative percentage change would therefore be -1.99% (multiplicative result), not -2.00% (additive result).

Pharmacy

Medicaid pharmacy reimbursement has been subject to a combination of across-the-board rate reductions as well as targeted policy changes that impacted specific drug classes. Greater utilization of the State Maximum Allowable Cost (SMAC) reimbursement methodology has been the primary policy mechanism for achieving savings other than across-the-board rate reductions. The SMAC reimbursement methodology brought prices closer in-line with actual acquisition cost for targeted drug classes where a clear disparity between pharmacy acquisition cost and Department reimbursement was evident.

For comparison purposes across provider types, the following table shows major impacts to pharmacy reimbursement since FY 2009-10.

Impacts to Pharmacy Reimbursement Since FY 2009-10			
Fiscal Year	**Budget Action**	**Estimated Impact as a Percentage of Total Expenditure**	**Mechanism of Change**
FY 2009-10			
	BRI-1	-0.02%	SMAC
	ES-2	-1.50%	Rate Reduction
Total FY 2009-10		**-1.52%**	
FY 2010-11			
	BRI-3	-0.77%	SMAC
	BRI-6	-1.00%	Rate Reduction
Total FY 2010-11		**-1.77%**	
FY 2011-12			
	BRI-5	-0.73%	SMAC
Total FY 2011-12		**-0.73%**	
FY 2012-13			
	R-6[(1)]	-1.13%	Methodology Change
	R-1[(2)]	-0.85%	Methodology Change
Total FY 2012-13		**-1.98%**	
Total Rate Cuts to Date[(3)]		**-5.87%**	

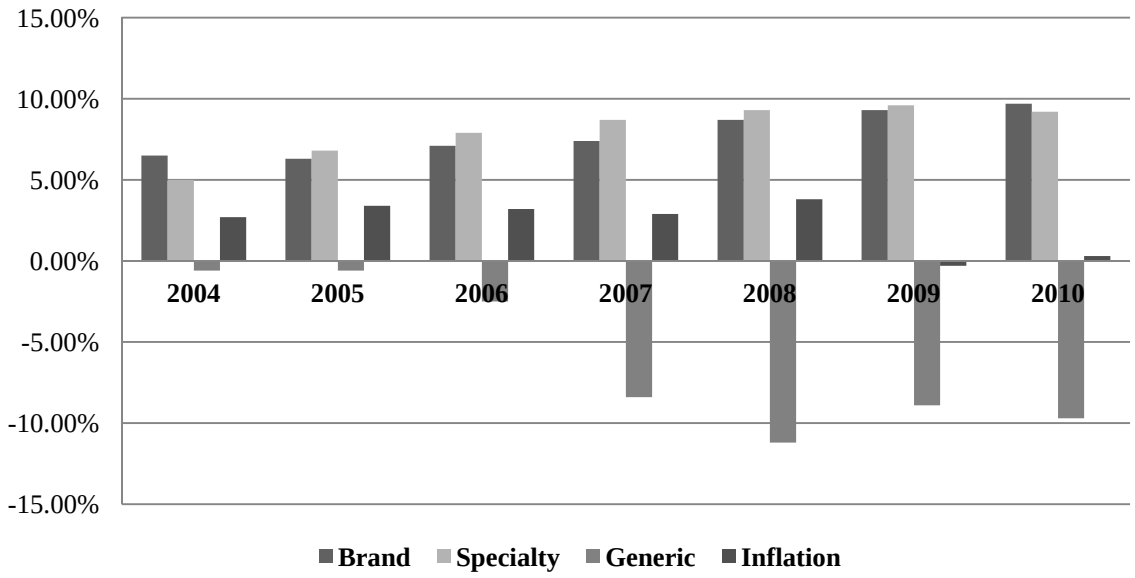
(1) Percentage based on $4 million reduction originally presented in the FY 2012-13 R-6 and an estimated $354.3 million in gross pharmacy expenditure in FY 2012-13.
(2) Percentage based on incremental revision to the estimated fiscal impact in the FY 2012-13 R-6, or an additional $3 million reduction in expenditure in FY 2012-13.
(3) Pharmacy rate impacts are calculated additively within fiscal years and multiplicatively between fiscal years. Impacts will not sum to the total as a result. See the example in the "Across-the-board Rate Reductions" table.

However, despite the reductions, pharmacy reimbursement, particularly for brand and specialty drugs, continues to grow. The pharmacy reimbursement methodology is unique in that rates have historically been tied to national pricing statistics that change over time (wholesale acquisition cost, state maximum allowable cost, etc.). This means that, as pharmacies' costs of acquiring drugs increases or decreases, the reimbursement rates change accordingly. For example, Synagis, a drug used to reduce the risk of hospitalization due to respiratory virus for certain high-risk children, is one of Medicaid's greatest sources of pharmaceutical expenditure. Reimbursement rates have increased as manufacturer prices increased and have consequently seen between 7.49% and 12.65% annual growth since 2008. These figures include rate reductions. While this is not true for every drug, for most brand name and specialty drugs, reimbursement rates have continued to increase despite rate reductions.

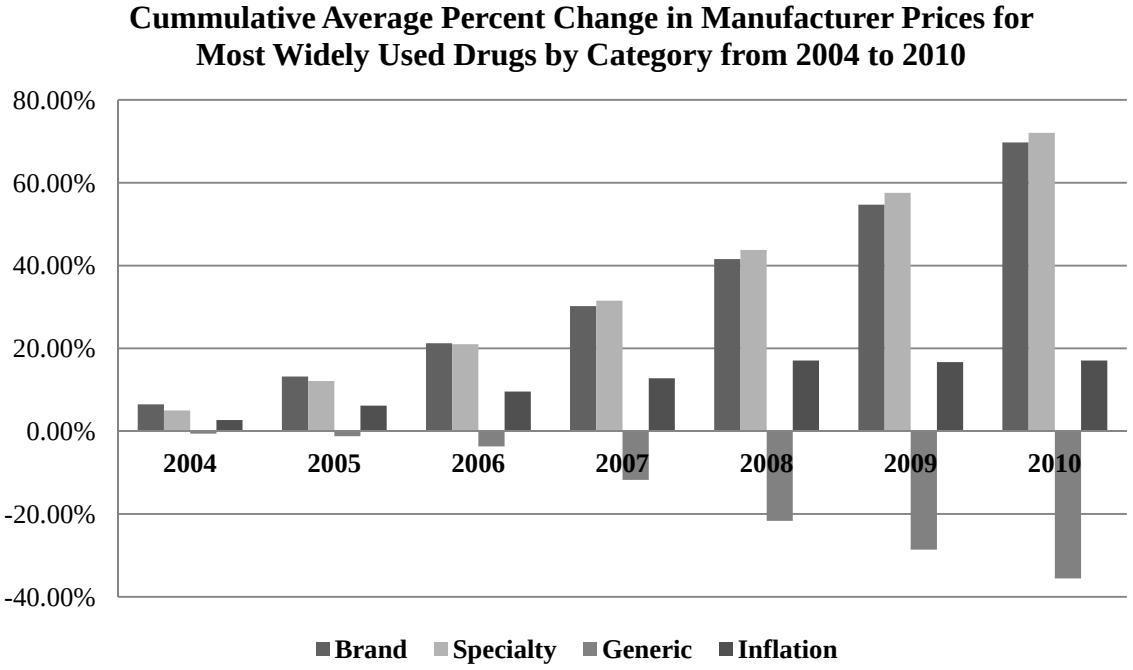
Synagis 50 mg: Average Reimbursement per Unit		
Date	**Average Reimbursement**	**Percentage Change**
November 2008	$1,829.18	N/A
November 2009	$1,966.22	7.49%
November 2010	$2,095.82	6.59%
November 2011	$2,264.42	8.04%
November 2012	$2,550.84	12.65%

The following tables show the average annual percent change in wholesale acquisition cost pricing for the most widely used brand name drugs, specialty drugs, and generic drugs as reported in the AARP Public Policy Institute's annual *Rx Watchdog Report*.[7] Please note that the report uses Medicare Part D drug utilization to establish an average; Medicaid drug utilization will differ. Under the pharmaceutical reimbursement methodology, pharmacy reimbursement rates are a function of manufacturer prices and will move similarly to what is reflected in the following graphs.

Average Annual Percent Change in Manufacturer Prices for Most Widely Used Drugs by Category



[7] http://www.aarp.org/health/medicare-insurance/info-04-2009/rx_watchdog.html



Although approximately 78.6% of Medicaid pharmaceutical utilization is generic drugs, approximately 71.4% of expenditure is on brand and specialty drugs. Because rates for generics have been decreasing but rates for brand and specialty have been increasing, the aggregate impact on rates is not immediately evident. However, it is clear that increasing total pharmaceutical reimbursement is being significantly impacted by increasing rates for brand name drugs.

Class I Nursing Facilities

Class I Nursing Facility reimbursement is complex but is essentially cost-based. As costs grow, so does reimbursement up to a maximum-allowable amount. In a sense, this is similar to pharmaceutical reimbursement, with the exception that growth in reimbursement to pharmacies is not capped.

In aggregate, the General Fund portion of nursing facility per diem rates (net of patient payment) is allowed to grow by 3% annually. Allowable costs for facilities beyond this amount – including the portion attributable to rate reductions – is funded through supplemental payments to the extent possible. Additionally, whereas rate reductions for other providers have been cumulative, rate reductions for nursing facilities have been applied as one-time reductions that do not impact future years' rates. Consequently, rate reductions have impacted Class I Nursing Facility rates differently than other provider types; because nursing facilities' costs have been growing over time and the reimbursement methodology is cost-based, rate reductions for Class I Nursing Facilities slowed the rate of growth in reimbursement rates rather than decrease them.

Impacts to Class I Nursing Facility Reimbursement since FY 2009-10			
Fiscal Year	**Legislative Action**	**Rate Reduction[(1)]**	**Note**
FY 2009-10	HB 10-1324	-1.50%	Effective March 1, 2010 – partial year impact
FY 2010-11	HB 10-1379	-2.50%	Also limited General Fund growth in rate from FY 2009-10 to FY 2010-11 to 1.9%
FY 2011-12	SB 11-125	-1.50%	
FY 2012-13	HB 12-1340	-1.50%	
FY 2013-14	N/A	0%	All rate reductions expire and rates return to what they would have been absent the policy changes in the preceding years.

(1) Unlike previous examples for other provider types, these figures are not cumulative; they are instead, one-time impacts.

Despite the rate reductions, total nursing facility rates have risen since FY 2009-10. Annual increases in rates due to the reimbursement methodology have resulted in an estimated increase of 5.1% from FY 2009-10 to FY 2012-13, even after accounting for rate reductions over the same period.

24) How do current appropriations for hospital providers compare to the maintenance of effort requirement contained in Section 25.5-4-402.3 (5) (a) (I), C.R.S.?

RESPONSE:

Section 25.5-4-402.3 (5) (a) (I), C.R.S. states that the intention of the Hospital Provider Fee is to supplement, not supplant, General Fund-supported hospital reimbursement. The statute requires that "General Fund appropriations for hospital reimbursements shall be maintained at the level of appropriations in the Medical Services Premium (sic) line item made for the fiscal year commencing July 1, 2008." While there is no specific appropriation for hospitals in the Medical Services Premiums line item, total expenditure for hospital claims have increased from $510.5 million in FY 2008-09 to $595.0 million in FY 2011-12.

Additionally, the statute allows for General Fund appropriations for hospital reimbursements to be reduced if General Fund appropriations are reduced for certain other providers, including home health providers, physician services, and outpatient pharmacies. During the economic downturn, the Department complied with the intent of the statute by reducing hospitals' Medicaid rates by the same percentage as other Medicaid providers. In the Department's FY 2013-14 November 1, 2012 budget request R-13, the Department is requesting the same 1.5% rate increase for hospitals as it is for other Medicaid providers.

25) Why has the cost per capita for the elderly and disabled populations been increasing so rapidly? Which services are driving the cost increases? Why have costs per capita for the disabled increased more rapidly than costs per capita for the elderly?

RESPONSE:

Medical Services Premiums expenditures (physical health) for the elderly and disabled have been important cost drivers in the budget. Annual expenditures for the elderly have increased by over $100 million per year compared to the budget from five years prior (FY 2011-12 compared to FY 2007-08). Expenditures for the disabled have grown even more quickly, increasing by almost $200 million in that same time frame. For both populations, caseload growth drove the majority of the spending increase.

Total Payment Amount and Caseload: FY 2007-08 and FY 2011-12				
Fiscal Year	**Adults 65 and Older (OAP-A) Total Payment Amount**	**Adults 65 and Older (OAP-A) Caseload**	**Disabled Individuals to 59 (AND/AB) Total Payment Amount**	**Disabled Individuals to 59 (AND/AB) Caseload**
FY 2007-08	$704,602,839	36,284	$653,062,382	49,933
FY 2011-12	$806,748,259	39,740	$844,556,448	59,434
Percent Change	**14.50%**	**9.52%**	**29.32%**	**19.03%**
Compound Annual Growth Rate	**3.44%**	**2.30%**	**6.64%**	**4.45%**

The Department disaggregated the overall per capita cost by examining each service on a cost per capita basis to determine which services were driving these increases. As can be seen from the following table, average per capita growth has been relatively low for the last five fiscal years; per capita costs for the elderly population have increased by an average of 1.12%, and the average per capita cost increase for the disabled population has been 2.10% over the same period. The following table compares per capita costs for both populations from FY 2007-08 to FY 2011-12 for select service categories.[8]

[8] "Per capita" cost is defined as the total expenditure divided by the total caseload. In instances where only a small proportion of the total caseload uses each service (e.g. the Program of All-Inclusive Care for the Elderly), large per capita changes do not necessarily reflect an increase or decrease in the cost of the service. Rather, per capita changes can also reflect a change in utilization of service. This concept is discussed further below, as the Department breaks out the cost drivers for these populations.

Service Category	Adults 65 and Older (OAP-A) Cost per Capita by Service Category FY 2007-08 and FY 2011-12			Disabled Individuals to 59 (AND/AB) Cost per Capita by Service Category FY 2007-08 and FY 2011-12		
	FY 2007-08	FY 2011-12	Compound Annual Growth Rate	FY 2007-08	FY 2011-12	Compound Annual Growth Rate
Durable Medical Equipment	$526.39	$464.25	-3.09%	$809.51	$841.70	0.98%
Home Health	$629.85	$560.18	-2.89%	$1,759.18	$1,960.30	2.74%
Acute Care - Other	$1,357.92	$1,350.94	-0.13%	$6,455.83	$6,549.43	0.36%
Community Based Long Term Care	$3,423.65	$3,815.19	2.74%	$1,896.02	$2,664.17	8.88%
Nursing Facility	$10,734.05	$10,347.28	-0.91%	$1,439.47	$1,312.44	-2.28%
Program of All-Inclusive Care for the Elderly	$1,220.16	$1,853.83	11.02%	$31.98	$63.20	18.57%
Other Costs	$1,527.08	$1,908.99	5.74%	$686.79	$818.74	4.49%
Total Cost	**$19,419.11**	**$20,300.66**	**1.12%**	**$13,078.77**	**$14,209.99**	**2.10%**
Percent Change		**4.54%**			**8.65%**	

Although other populations, particularly low-income adults and eligible children, have experienced per capita decreases in the past several years, the Department does not believe a comparison of the per capita costs between different types of populations is useful. The Department has seen per capita declines for adults and children because of a dramatic increase in caseload during the recession. This type of caseload increase did not occur in the elderly and disabled populations because age and disability are not affected by economic conditions.

For the purpose of this question, the remainder of the Department's response focuses on select major areas of cost growth for these populations: community-based long-term care and the Program for All-Inclusive Care for the Elderly.[9]

Community-Based Long-Term Care

In its budget requests, the Department defines community-based long-term care services to include home- and community-based services (HCBS) waivers, private duty nursing, and hospice.[10] Among these, the most important expenditure driver for the elderly and disabled populations is the HCBS waiver for Elderly, Blind, and Disabled (HCBS-EBD). Since FY 2007-08, the Department has experienced significant cost increases for this waiver program, with expenditures growing from $141.2 million in FY 2007-08 to $225.2 million in FY 2011-12, an increase of over 59%. The Department has identified two primary drivers for the HCBS-EBD waiver program: increases in caseload, and increases in the usage of consumer-directed care.

[9] Nursing facility cost growth is also a key component of the overall expenditure for these populations; the Department addresses nursing facility cost growth in questions 23 and 27 of these responses.

[10] Please note that the Department's budget for Medical Services Premiums does not include HCBS costs for waiver programs administered by the Department of Human Services, which are primarily waiver programs for individuals with developmental and intellectual disabilities.

Caseload

Since FY 2007-08, the Department has seen a large increase in the number of recipients of home- and community-based services (HCBS), with waiver enrollment growing from 19,112 in FY 2007-08 to 23,651 in FY 2011-12, an increase of 23.75%, equaling a 5.47% compound growth rate. At the same time, total caseload for the likely recipients of HCBS (the elderly and disabled) increased from 86,217 in FY 2007-08 to 99,174, an increase of 15.03%, equaling a 3.56% compound growth rate. The growth in the disabled and elderly caseload, along with the growth in the waiver enrollment, has been a major factor in the increase in costs for both populations.

The following table depicts the increase in waiver enrollment in Adults 65 and Older and Disabled Individuals to 59:

Total HCBS Waiver Enrollment and Total Adults 65 and older (OAP–A) and Disabled Individuals to 59 (AND/AB), Percent Change, and Compound Annual Growth Rate: FY 2007-08 and FY 2010-12		
	Total Waiver Enrollment	**Total OAP-A and AND/AB Enrollment**
FY 2007-08	19,112	86,217
FY 2011-12	23,651	99,174
Percent Change	23.75%	15.03%
Compound Annual Growth Rate	5.47%	3.56%

Consumer-Directed Services

The fastest-growing area of expenditure within the HCBS-EBD wavier during this period was payments for consumer-directed attendant support services (CDASS). CDASS is a person-centered benefit that allows clients to maintain their own budget for attendant services (personal care, homemaker, and health maintenance activities) and pay their attendant the rate they chose (within the wage cap). CDASS is a client-directed alternative for agency-based skilled (long-term home health) and unskilled (waiver) attendant services. Since the CDASS benefit was added to the HCBS-EBD waiver in FY 2007-08, there has been significant program growth. Since FY 2008-09, HCBS-EBD expenditure for CDASS has grown by over $30 million.[11] These costs represent over 69% of the increase in the HCBS-EBD waiver program during that time.

HCBS – Elderly, Blind, and Disabled Waiver Program Growth: FY 2008-09 to FY 2011-12		
Total Program Growth	**CDASS Growth**	**Percent**
$43,421,128	$30,064,313	69.24%

The following table breaks down CDASS growth in total cost by population:

[11] For this portion of the response, the Department uses FY 2008-09 as the comparison point. CDASS was added to the HCBS EBD waiver program in FY 2007-08, which creates a skewed comparison.

Elderly, Blind, and Disabled Waiver, Consumer Directed Attendant Support Services (CDASS) Total Cost, Percent Change, and Compound Annual Growth: FY 2008-09 and FY 2011-12			
	Adults 65 and Older (OAP-A)	**Disabled Individuals to 59 (AND/AB)**	**Total**
FY 2008-09	$4,307,035	$22,736,708	$27,043,743
FY 2011-12	$14,912,993	$42,195,064	$57,108,056
Total Increase	**$10,605,958**	**$19,458,356**	**$30,064,313**
Percent Change	**246.25%**	**85.58%**	**111.17%**
Compound Annual Growth Rate	**51.28%**	**22.89%**	**28.30%**

Although the total CDASS expenditures for Adults 65 and Older have increased at a faster rate than Disabled Individuals, the majority of the increase in expenditures is due to increased utilization of CDASS by Disabled Individuals. The overall increase in expenditure is being driven both by an increase in enrollment and higher costs per enrollee for clients who utilize CDASS.

The following table below breaks down CDASS year-by-year recipients and cost per recipient by population:

Elderly, Blind, and Disabled Waiver Adults 65 and Older (OAP-A) and Disabled Individuals (AND/AB) CDASS Recipient Cost Per Capita FY 2008-09 through FY 2011-12						
Fiscal Year	**Adults 65 and Older (OAP-A)**		**Disabled Individuals to 59 (AND/AB)**		**Total EBD**	
	Enrollees	**Cost Per Enrollee**	**Enrollees**	**Cost Per Enrollee**	**Enrollees**	**Cost Per Enrollee**
FY 2008-09	182	$23,697.58	537	$42,333.67	719	$37,621.72
FY 2009-10	277	$25,329.26	686	$39,379.52	963	$35,340.84
FY 2010-11	493	$24,724.09	1,012	$39,467.95	1,505	$34,640.95
FY 2011-12	702	$21,253.67	1,286	$32,819.60	1,987	$28,736.02

Increased participation in CDASS is not, in and of itself, necessarily an overall cost driver for the HCBS-EBD waiver. As described, CDASS is a substitute for other HCBS-EBD and long-term home health services. If these clients were not enrolled in CDASS, they would be generating additional costs for other services.

The per recipient cost, however, is significantly higher for clients enrolled in CDASS, as compared to clients who are not enrolled in a client-directed program. Because of the size difference in the non-CDASS population compared to the CDASS population, more analysis is needed to compare CDASS clients and a similar population within the same waiver who have similar acuity and needs.

The following table depicts the number of EBD-CDASS recipients, their costs, and cost per enrollee compared to the non-CDASS EBD population in FY 2011-12.

Elderly, Blind, and Disabled (EBD) Home And Community Based Services (HCBS) Waiver Consumer Directed Attendant Support Services (CDASS) Recipients and EBD Non-CDASS Recipients Total Cost, Enrollees, cost per enrollee						
	EBD - CDASS Costs	**EBD - CDASS Enrollees**	**EBD - CDASS Cost Per Enrollee**	**Non-CDASS EBD Costs**	**Non-EBD CDASS Enrollees**	**Non-CDASS Cost Per Enrollee**
FY 2011-12	$57,108,056	1,987	$28,740.84	$168,077,655	17,665	$9,514.73

The Department believes there are valid reasons for the cost per enrollee in CDASS to be higher than that of other clients. For example, in analysis the Department has completed thus far, the CDASS population costs trend with acuity, thus leading to higher costs for clients with higher needs. This could also be indicative of provider capacity, when clients receive CDASS they are actually receiving the services they need, whereas outside of CDASS they were having difficulties finding access to the care they need. However, the Department is actively working on ensuring that expenditures for the CDASS program are necessary and appropriate. In an effort to balance client's health care needs while containing costs and increasing health outcomes, the Department has implemented a wage cap for attendants, moved the fiscal intermediary administrative service fee from a portion of each CDASS clients monthly budget to a monthly per member per month fee, implemented a protocol designed prevent overspending , and has developed a multi-stakeholder and departmental workgroup to help the benefit evolve and maintain its importance to participant freedom and service selection, as well as maintain client health outcomes and bending the cost curve.

As a result of these efforts, the Department has seen substantive reductions in the cost per enrollee for clients enrolled in CDASS since FY 2008-09.

Elderly, Blind, and Disabled Waiver, Consumer Directed Attendant Support Services (CDASS) Cost Per Enrollee, FY 2008-09 and FY 2011-12			
	Adults 65 and Older (OAP-A)	**Disabled Individuals to 59 (AND/AB)**	**Total**
FY 2008-09	$23,697.58	$42,333.67	$37,621.72
FY 2011-12	$21,253.67	$32,819.60	$28,736.02
Total Decrease	**($2,443.91)**	**($9,514.07)**	**($8,885.70)**
Percent Change	**-10.31%**	**-22.47%**	**-23.62%**
Compound Annual Growth Rate	**-3.56%**	**-8.14%**	**-8.59%**

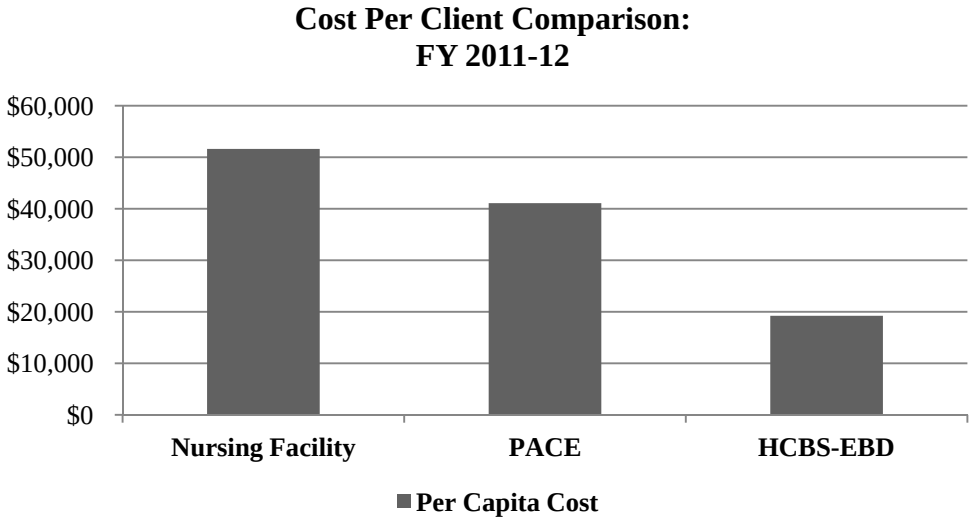
The Department believes continued action will be necessary to maintain budget stability in per capita spending in the disabled and elderly eligibility categories. While there is no causal link or definitive evidence, it is possible the growth in consumer-directed services is now resulting in reductions in nursing facility and home health per capita costs. The Department continues to analyze data for these programs to ensure that appropriate cost controls are in place.

The Program of All-Inclusive Care for the Elderly
The Program of All-Inclusive Care for the Elderly, known as PACE, is a risk-based, fully capitated program. The Department pays a single organization a capitation rate that covers all medical costs, including acute care, long-term services and supports, and mental health.

PACE is different from traditional managed care in how it shares risk between the payer (the Department) and the provider. Traditional managed care (such as a health maintenance organization or the Department's behavioral health organizations) share financial risk on a short time period. The monthly capitation rate paid to the managed care organization is an estimate of what that organization's costs will be in that month. For a PACE provider, however, this is different. When a client typically enters PACE, that client generally has fewer long-term care needs and might otherwise be placed in an HCBS waiver program. As the client ages, however, that client's needs change and the client may eventually require placement in a nursing facility. During this time period – from when a client enters the PACE program through when a client enters a nursing facility – the Department pays the PACE organization the same rate regardless of the client's current needs. Thus, PACE shares financial risk over a much longer time period than traditional managed care organizations. As a result, the Department pays a PACE organization above their expected costs when the client enters the program, and below the expected cost when the client ages and enters a nursing facility. A PACE organization is responsible for managing its finances to account for the long-term risk window; when a client requires placement in a nursing facility, the client cannot be disenrolled from PACE.

In short, when a client is enrolled in PACE, the State makes an upfront investment; the Department pays higher costs on the front end in order to have cost stability at the end of a client's life, when expenditure is typically the highest.

Accordingly, costs per client for PACE clients generally falls between that of clients enrolled in a nursing facility and clients enrolled in the Department's HCBS-EBD waiver.



Since FY 2007-08, the Department has seen significant growth in PACE expenditure:

Program of All-Inclusive Care for the Elderly (PACE)				
	Adults 65 and Older		Disabled Individuals to 59	
Fiscal Year	Expenditure	Cost Per Enrollee	Expenditure	Cost Per Enrollee
FY 2007-08	$44,272,143	$39,496.37	$1,596,904	$43,453.17
FY 2011-12	$73,671,387	$41,994.90	$3,756,277	$38,957.82
Percent Change	66.41%	6.33%	135.22%	-10.35%

PACE expenditure has seen rapid growth in the last five years, primarily as a result of increased caseload growth. In FY 2007-08, 1,240 clients were enrolled in PACE. By FY 2011-12, enrollment had grown to 2,055 clients. During that time, existing PACE providers built additional capacity, and several new providers began to operate, further increasing enrollment. PACE rates, the driving factor behind cost per recipient, have been contained in recent years by rate reductions and cost-containment measures, such as the 3% nursing facility General Fund growth cap. New providers operating outside the Denver-metro area also have lower costs and have contributed to the decline in cost per enrollee during this period.

26) What is the Department doing to control long-term care costs? Is the Department putting sufficient emphasis on controlling costs in this area versus other areas of the budget?

RESPONSE:

Improving Long-Term Services and Supports (LTSS) is a major focus for the Department. The Department is simultaneously pursuing control of costs, improving quality of services, and increasing client satisfaction with services. This is critically important because of the aging of the population and the increase in the number of individuals with disabilities. In FY 2012-13, the Department estimates it will expend approximately $1.88 billion for physical health services on approximately 110,000 clients who are elderly or disabled. Although this population on comprises approximately 16% of the total Medicaid caseload, it accounts for over 58% of the Department's total expenditure for physical health services.

Because of the complex needs of clients utilizing LTSS, improving long-term care requires the simultaneous pursuit of three aims: improving the experience of care, improving the health of populations, and reducing per capita costs of health care. In order to effectively control costs without causing detrimental effects to clients, these three aims must be addressed simultaneously and with careful thought and strong partnership with clients, advocates and providers.

The Department has multiple efforts underway designed to meet these three objectives. Over the past 18 months, the Department has:

- Reallocated additional management and staff to the LTSS division so the Department can appropriately manage, analyze, and improve services and costs.

Staff are analyzing expenditures by waiver and program, identifying variances, and identifying areas where improved program operations can improve service quality and appropriately manage costs.

- Implemented a wage cap for attendants, moved the fiscal intermediary administrative service fee from a portion of each CDASS clients monthly budget to a monthly per member per month fee, implemented a protocol designed to prevent overspending, and developed a multi-stakeholder and departmental workgroup to help the benefit evolve and maintain its importance to participant freedom and service selection, as well as maintain client health outcomes and bending the cost curve. These are all efforts to balance clients' health care needs while containing costs and increasing health outcomes for the consumer-directed attendant support services program.
- Conducted enhanced data analysis utilizing claims data to better understand cost drivers and utilization within LTSS. This data has been made available to the public on the Department's website and has been widely disseminated to LTSS stakeholders, the Long Term Care Advisory Committee (LTCAC), and the Community Living Advisory Group. Most recently, analysis of non-medical transportation led to a restructuring of the service, which the Department believes has the potential to result in significant savings and enhanced access to services for clients.[12]
- Created a team of finance, data, rates, and program staff to collaborate on the analysis of key programmatic data points.
- Utilized the Benefits Collaborative to define and provide clear guidance on the type and quantity of long-term services and supports covered by Medicaid. The largest accomplishment of 2012 has been creation of the Home Health Benefits Standard, which will ensure equity and appropriateness of home health services.
- Begun development of training and guidance to Single Entry Points (SEPs) and Community Centered Boards (CCBs) that develop service plans for clients. This will help to ensure the appropriateness of service utilization and reduce variation in how SEPs and CCBs develop service plans. The Department will work with SEPs and CCBs to define best practices and approaches for service plan development.
- Partnered with clients, providers, and advocates to identify improvement areas that will better meet client needs and reduce costs without negatively impacting critical services needed by clients. The input of clients, providers, and advocates is absolutely essential to effectively improve services while controlling costs. This partnership has included extensive collaboration on the following work groups:
    - Participant-Directed Programs Policy Collaborative (PDPPC)
    - Long-Term Care Advisory Committee (LTCAC)
    - Community Living Advisory Group
- Begun defining system enhancements that will provide enhanced data and operational management capabilities. For example, implementation of a new MMIS system will provide greater controls to ensure appropriate utilization of services. The new MMIS system will include a new benefits-utilization system

[12] Any savings achieved will be accounted for during the regular budget process.

(BUS), which is the primary system used for LTSS service plans and client tracking.

- Identified the need for a new, functional assessment tool and service planning process. The Department has contracted with a vendor to assist with analysis of a new assessment tool. This will be conducted under the guidance of the LTCAC, which includes broad representation of clients, providers, and stakeholders.
- Begun the process of analyzing LTSS waivers with the goal of identifying which waivers could be combined. Again, this work will be conducted under the oversight of the LTCAC. The Department anticipates the benefits of fewer waivers will be include improved service quality, client satisfaction, and improved cost management.
- Begun the process of integrating the work of the Accountable Care Collaborative (ACC) with LTSS. For example, the Regional Care Collaborative Organizations (RCCOs) are beginning to partner with SEPs and CCBs to improve client health and utilization. Acute care spending is an important component of client costs in the elderly and disabled eligibility categories. RCCOs, SEPs, and CCBs are working with high-cost clients to ensure better health and lower costs for those clients.
- Worked to develop an approach to integrate care for clients who are dually eligible for Medicaid and Medicare. This is a population with complex needs and high costs. The Department plans to implement an integrated care program inside the ACC for these clients in the second quarter of 2013, depending upon CMS approval.
- Strengthened its support and focus on consumer direction through creation of the Participant-Directed Programs Policy Collaborative (PDPPC) and the Community First Choice Council.
- Implemented Colorado Choice Transitions (CCT). The CCT program offers short-term, intensive supports that enable clients to transition successfully from an institutional setting to a less-costly or more appropriate community-based setting.

All of the efforts described above are being informed by the work of the Long-Term Care Advisory Committee (LTCAC) and the Community Living Advisory Group. The work being done by these groups has played an important role in assisting the Department in redesigning and modernizing LTSS in Colorado, and the Department anticipates these groups will continue to provide critical input regarding this process in the future. The current long-term care system is administratively and programmatically complex, frequently does not provide access to services in ways that successfully meet needs, and is costly without consistently demonstrating positive health outcomes or satisfaction for clients. The four subcommittees of the LTCAC (Care Coordination, Entry-Point Eligibility, Consumer Direction, and Waiver Modernization) are charged with making recommendations to the Community Living Advisory Group aimed at developing systems that better support clients across a continuum by improving client choice and access to services, eliminating duplication while also identifying gaps, simplifying processes, and reducing costs.

27) How do changes in nursing home reimbursement rates compare to changes in rates for other providers?

RESPONSE:

Please see the Department's response to Question 23.

28) Should the nursing home rate be in statute, and why? If it remains in statute, how could it be fixed to be more transparent and comprehensible, while maintaining the purpose and intent of the statute?

RESPONSE:

The Department believes the extent to which the nursing facility rate methodology is described in statute is problematic. There have been a number of conflicts generated by the statute that the Department is unable to resolve without additional legislative action. For example, as the result of a nursing facility rate appeal settlement regarding appraisal of fair rental value, the Department has incurred a financial obligation to 31 nursing facility providers. Due to conflicting statutory obligations, there is no apparent funding source to support this legal obligation.[13]

While the level to which the rate methodology is prescribed in statute has created operational difficulties for the Department, it is important to note that nursing facility rates are not the only rates provided for in Colorado statutes. The intent of the General Assembly is defined in statute for many sets of Medicaid provider rates. For example, statute requires that community mental health centers be reimbursed based upon reported costs and that inpatient hospitals be paid based upon a system of diagnosis-related groups. What is unusual about nursing facility rates is there is much more detail about the operation of the rate methodology than for other provider groups. The Department finds it is better able to perform its administrative duties in a statutory context that provides broad policy guidance and allows flexibility in terms of the operational details. Furthermore, having the nursing facility reimbursement methodology in statute constrains policy direction of the Department. Because of the prescriptive nature of the statute, alternative payment methodologies – including provider incentives, efficiencies, or payments tied to outcomes – cannot be implemented. For example, the reimbursement methodology reflects an "institutional" model of care that delineates between "institutional" and "community-based" care. This makes it difficult to establish an integrated, long-term services and supports system that is responsive to the needs of the beneficiaries and the State.

Because of their statutory complexity, nursing facility rates are unusually opaque to stakeholders. Also, nursing facility rates comprise a highly disproportionate share of the Department's provider rate appeals. The Department believes this is at least partially due to the legal complexity that arises by putting an unusual amount of detail in statute.

[13] The Department has requested funding for this issue in its January 2, 2013 supplemental request S-16, "Nursing Facility Rate Appeal Settlement".

The Department does believe statute needs to be adjusted to make technical corrections. Over the last decade, it has become common for the General Assembly to consider some type of technical bill concerning nursing facility rates during each legislative session. This is not the norm for other provider groups and is a clear consequence of the level of rate detail that is currently in statute. Without statutory simplification, the need for the General Assembly to clarify or revise the rate-setting methodology is likely to continue.

29) Please provide an update on the Program for All-inclusive Care for the Elderly (PACE). As part of the update, please discuss:

RESPONSE:

The Program of All-Inclusive Care for the Elderly (PACE) is an important part of the Department's continuum of managed-care services and programs. PACE currently serves almost 2,000 clients, costing approximately $80 million per year, with an annual per capita cost of $42,000. Throughout 2012, the Department strengthened its management of the program, including increased analysis of PACE in a number of areas to better quantify PACE service outcomes and to align it with other Department initiatives.

In the past year, the Department has focused on key PACE projects including the collection and standardization of PACE data and quality measures. For the first time, the Department is able to analyze and trend PACE performance measures in quality of care, care management, and acuity areas. Formalization and streamlining of the PACE application process has been another focus area and is nearly completed. The Department has developed and chairs a workgroup of PACE states that meets every other month to discuss important PACE issues and trends. PACE state administrators from California, Pennsylvania, Texas, Oklahoma, Missouri, Kansas, New Mexico, and North Dakota participate in these informative meetings.

a) **What is the status of the PACE expansion in Northern Colorado?**

RESPONSE:

On October 6, 2011, the Department approved a Program of All-Inclusive Care for the Elderly (PACE) organization's expansion into Northern Colorado, which included the cities of Fort Collins, Loveland, and Greeley and other parts of Larimer and Weld counties. The following week, the Department submitted that organization's expansion application to the Centers for Medicare and Medicaid Services (CMS) along with a state attestation letter indicating the Department's approval. On October 18, 2011, CMS received and began reviewing this application.

On November 15, 2011, CMS sent a letter to the PACE organization and the Department indicating the need for further information from the PACE organization. CMS is currently awaiting a response from the PACE organization in order to proceed with their review of the organization's application. The Department has offered and provided assistance to the organization to help it supply CMS with the requested

information, including a letter of support to help the organization secure funding for their new PACE center in Northern Colorado.

CMS has requested that: 1) the PACE organization complete construction; and, 2) the Department provide a completed State Readiness Review of this new center before CMS will approve the organization's expansion application into Northern Colorado. The PACE organization anticipates completing construction on its new center in Northern Colorado in October or November of 2013, at which time the Department will conduct its Readiness Review of the new facility. After the Department completes its Review of the new facility and the organization provides CMS with the requested information, CMS has 90 days to review the organization's application. Given this process, the Department does not expect the organization's Northern Colorado PACE program to open until at least the beginning of 2014.

The Northern Colorado program will serve the following zip codes: 80513, 80521, 80523, 80524, 80525, 80526, 80528, 80534, 80537, 80538, 80543, 80550, 80615, 80620, 80631, 80634, and 80639. These zip codes encompass the cities of Fort Collins, Loveland, and Greeley and parts of Larimer and Weld Counties.

b) When will the Northern Colorado program open, and what communities will it serve?

RESPONSE:

Please see the Department's response to Question 29a, above.

c) What other communities could use PACE?

RESPONSE:

Currently, the Department has not conducted analysis to determine which communities could benefit from a PACE program. The Department reviews submitted applications from potential PACE providers and makes determinations based on the providers' analysis regarding the community need for PACE and financial feasibility. As the Department continues to enhance its data and analytic capabilities, it will be able to segment the Medicaid population by client health needs in the future. This will improve efficiency in meeting the needs of Medicaid clients and linking them to the right services from the right providers. As population segmentation becomes more of a reality, the Department anticipates this will be a useful tool for identifying which communities and individuals would benefit from a PACE program.

The Department is currently reviewing an application for PACE services to be provided in Boulder and Weld counties. A PACE organization currently serving Montrose and Delta counties is planning to open an alternative care setting in Olathe, which is already part of its existing service area. This will allow PACE participants in western Colorado to receive limited PACE services in Olathe and alleviate travel to Montrose or Eckert to

receive those same services. Another PACE organization located in Colorado Springs has also expressed interest in expanding its operations.

d) How can PACE be tailored to rural communities?

RESPONSE:

In 2011, the Centers for Medicare and Medicaid Services (CMS) presented a report to Congress on the successes and failures of 15 rural PACE programs that received grants through the Deficit Reduction Act of 2005. This report found that the success of rural PACE organizations "…hinge[d] on a delicate balance between enrollment and the ability of PACE centers to keep their participants healthy and out of hospitals." One rural PACE organization located on the Western Slope of Colorado has been highly successful in keeping participants out of hospitals and was recognized by CMS in its 2011 report. This organization was also recognized by the National PACE Association as having the lowest percentage of acute hospital readmissions within 30 days of all PACE organizations nationwide. The report presented to Congress by CMS also identifies two other important factors for success of rural PACE organizations: 1) successful community relationships, especially with local area agencies on aging; and 2) the ability to contract with and utilize local community-based physicians not only for their services but as a means to increase awareness of the PACE program. The report can be found online at http://www.npaonline.org/website/download.asp?id=3841.

The success of rural PACE organizations can also be attributed to their use of alternative-care sites. Alternative-care sites must be approved by CMS and the Department and allow PACE organizations to provide limited services at a location closer to the participant's home. The Department finds this type of facility is crucial to providing services in rural communities where distances to PACE centers can be challenging. As described above in the Department's response to 29c, the PACE organization on the Western Slope plans to open another alternative care site in Olathe in the near future.

e) How will PACE work with Regional Care Collaborative Organizations (RCCOs)?

RESPONSE:

PACE and the ACC are complementary. As a component of the Medicaid continuum of managed-care services and programs, the Department has focused on creating alignment between the PACE organizations and the ACC program. The RCCOs are intended to create regional collaboration across all providers for the benefit of Medicaid clients. As such, RCCOs will collaborate with PACE. For example, clients enrolled in the ACC may be better served via PACE. RCCOs may identify clients with needs that could be met via PACE. Similarly, PACE and RCCOs could develop common care-coordination approaches.

El Paso County is a useful example of PACE organizations and RCCOs working together. The PACE organization and the RCCO in El Paso county have been collaborating since the RCCO's formation, with the PACE organization playing a critical role in development of the RCCO's care-management plan. PACE's interdisciplinary team approach to care planning and coordination, which is one of the staples of the PACE program, has been studied by the RCCO for potential adaptation. Not only is this PACE organization one of the founding members of this RCCO, but they have contracted with the RCCO as participating providers.

f) Has S.B. 12-023 been implemented?

RESPONSE:

SB 12-023 provides that the state board shall adopt rules: 1) requiring the Department and Single Entry Point Agencies (SEPs) to discuss the option and potential benefits of participating in the PACE program with all eligible long-term care clients; and, 2) allowing PACE providers to contract with an enrollment broker to include the PACE program in its marketing materials to eligible long-term clients.

The provisions of SB 12-023 are already being implemented by the Department and can be pursued without formal rule change. Currently, SEPs are mandated to inform long-term care clients of all available programs and the benefits of those programs including PACE. Long-term care clients sign a form attesting that they were offered these choices. The Department is also working with PACE organizations on providing ongoing trainings to SEPs and their staff regarding PACE. In conversations between PACE organizations and an enrollment broker, the Department has supported the effort to provide PACE materials to eligible long-term care clients.

In its review of SB 12-023 and section 25.5-5-412, C.R.S. (2012), the Department saw a larger charge to not only implement the provisions set forth in SB 12-023 but to write program-wide rules necessary for the governance of PACE in Colorado pursuant to section 25.5-5-412(11) C.R.S. (2012). The Department is scheduled to develop these rules in 2013 with the help of PACE organizations, PACE participants, and advocates. The Department will utilize its formal rule-making process and submit these rules to the Medical Services Board for review and approval.

g) Have the rules been promulgated to allow PACE providers to contract with an enrollment broker to include the PACE program in its marketing materials to eligible long-term clients?

RESPONSE:

PACE organizations are already negotiating with the Department's enrollment broker, as other managed care providers have also done. At the same time, the Department is working to create rules to implement this provision set forth in S.B. 12-023 and section 25.5-5-412(11) C.R.S. (2012). The Department's response to 29f, above, provides

further explanation). The Department has been in communication with PACE organizations regarding their ability to contract with a broker of their choosing to provide marketing materials to long-term care clients. The Department will take an active role in this process, possibly including provision of the data needed to implement the marketing effort.

30) How are rates for home and community based services (HCBS) calculated and how have they changed over time? What would those rates be today if they had been increased for the annual cost of living since 2004? How do changes in HCBS rates compare to changes in nursing home rates?

RESPONSE:

Historically, rates for home- and community-based services (HCBS) were based upon historical data using other Medicaid state rates for comparability of similar services and methodologies focused on wage data for salary expectations from the U.S. Bureau of Labor Statistics (BLS). Beginning in 2011, the Department has revised its methodology for calculating new HCBS rates. Under the new methodology, the Department calculates a new HCBS rate based on the expected cost of providing the service and the accessibility of the service. Typical research on setting service rates includes determining salary expectations, direct and indirect care hours, the full-time equivalent (FTE) required for the delivery of services, other costs, and whether the rate is aligned with other payers in the marketplace. The Department must also ensure that rates set are in compliance with all applicable federal regulations, including upper payment limits. Based on the results of the Department's research, the Department uses that information to establish the unit value (such as the length of time being paid for) and the price. Once the rate has been determined, comparisons of other state Medicaid rates and private pay rates for similar (or identical) services are analyzed to ensure the appropriateness of the determined rate.

Once a rate is established, the Department applies rate increases or decreases when funds are approved through the appropriations process. The following table displays rates for services in the Elderly, Blind, and Disabled HCBS waiver program for FY 2004-05 and FY 2012-13. The table also includes a calculated value based on if the FY 2004-05 rate had been annually adjusted for inflation.

Service	FY 2004-05	FY 2012-13	CPI Adjusted FY 2012-13	Percent Difference between FY 2012-13 Rates and CPI Adjusted 2012-13 Rates
Adult Day - Basic Rate	$21.05	$21.79	$28.56	31.09%
Adult Day - Specialized Rate	$26.90	$27.83	$36.50	31.16%
Alternative Care Facility	$36.03	$46.14	$48.89	5.96%
Homemaker	$3.14	$3.47	$4.26	22.79%
Non-Medical Transportation - Taxi	$47.50	$46.98	$64.46	37.20%
Non-Medical Transportation - Mobility Van	$12.20	$12.07	$16.55	37.16%
Non-Medical Transportation - Wheelchair Van	$15.19	$15.02	$20.61	37.23%
Non-Medical Transport. - Wheelchair Van Mileage	$0.61	$0.62	$0.83	33.51%
Personal Care	$3.14	$3.47	$4.26	22.79%
Relative Personal Care	$3.14	$3.47	$4.26	22.79%
Respite-Alternative Care Facility	$51.84	$51.38	$70.34	36.91%
Respite-In-Home	-	$2.94	$4.04	37.30%
Respite-Nursing Facility	$115.81	$114.57	$157.15	37.16%
Average Percent Change in FY 2012-13 Rates and CPI Adjusted FY 2012-13 Rates				**30.23%**

- *Inflation was calculated using the Consumer Price Index or All Urban Consumers: Medical care in Denver-Boulder-Greeley, CO (CMSA) (CUUSA433SAM)*
- *Prior year inflation factor was used to inflate current year rates. For example, the 2011 inflation factor was used to estimate FY 2012-13 rates.*
- *Unit values differ for each service type. For example, the billing unit for alternative care facilities is a full day, while the billing using for personal care is 15 minutes. Further information is available in the Department's billing manual for HCBS services.*

Table A in Attachment 30 includes a table displaying the yearly rates for the Elderly, Blind, and Disabled HCBS waiver program from FY 2004-05 to FY 2012-13. Table B shows what the rates would have been if an inflationary increase were applied each year. The Department estimates that, on average, rates would be approximately 30% higher than the current FY 2012-13 rates if an inflationary adjustment had been applied each year.

Unlike HCBS rates, rates for skilled nursing facilities are set annually and based on facility submitted cost reports as required by statute. Between FY 2004-05, the actual paid nursing facility per diem has increased by approximately 25%. Nursing Facility Data is shown in Table C of Attachment 30.

Class I Nursing Facility Per Diem Rates and Percent Change: FY 2004-05 and FY 2012-13		
Fiscal Year	**Per-Diem Rate**	**Percent Change**
FY 2004-05	$150.15	N/A
Estimated FY 2012-13	$187.97	**25.19%**

ADMINISTRATIVE STAFF

31) How do the staffing levels for Colorado's Medicaid and CHP+ programs compare to the staffing levels in other states?

RESPONSE:

Please see the following table for a comparison of state agencies responsible for Medicaid and State Children's Health Insurance Program, known in Colorado as the Child Health Plan *Plus* (CHP+). Please note that the structure of the Medicaid program and the administration of the Medicaid program is different in each state, so a direct comparison based on the table alone may be misleading. For example, eligibility determinations are done at the county level in Colorado; however, other states may perform this function within the Department. Also, each state may organize its programs differently than Colorado and have a variety of other programs designed for low-income families, the elderly, and persons with disabilities housed in the same Department as its Medicaid program.

State	Total Medicaid and CHP+ Expenditures (Federal Fiscal Year 2011[1])	Eligibles (Federal Fiscal Year 2011[2])	Current FTE Level
Colorado	$4,546,184,230	560,722	326.2
Arizona	$9,034,050,555	1,324,000	1,407.3
Oregon	$4,591,734,555	566,224	527.8
Kansas	$2,769,606,345	303,770	211
Utah	$1,829,637,309	286,200	213.9
Nebraska	$1,682,739,228	237,047	430

[1] *This information is from http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/MBES/CMS-64-Quarterly-Expense-Report.html, a website managed website by the Centers for Medicare & Medicaid Services.*

[2] *This information is from the Department's November 2012 CMS-37 budget request.*

32) Why can't the Department manage staffing needs within existing resources?

RESPONSE:

The work of the Department has fundamentally shifted over time; as a result, the staffing needs have also fundamentally changed. When the Department was created, the Department's only function was to pay the health care claims of those enrolled in the State's medical assistance programs. The Department was operational in nature, with little emphasis placed on policy and initiatives geared toward increasing quality and containing costs. Over time, the core mission and the purpose of the Department have changed, along with the stakeholder and regulatory environment in which it finds itself. Colorado is now a national leader in health care, and the Department is expected to deliver innovative programs that will dramatically improve how the State delivers and pays for health care.

Over time, as new projects and needs have arisen and existing programs have grown significantly in both size and complexity, the Department has also either fully or partially absorbed the need for resources. For example, during the FY 2009-10 budget process, the Department requested three FTE to implement the Accountable Care Collaborative (ACC); however only 0.5 FTE was appropriated for that purpose. The lack of resources was a major reason that the program took an additional 13 months to implement and was much more difficult for those who did work on the program, many of whom simply absorbed the extra duties.

In order to continue the important work of programs like the ACC, including moving forward with innovation in payment methods, the Department is now in a position where additional resources are required in order to effectively operate and perform as a national leader in today's health care environment.

PHARMACY

33) Please explain how the Department will calculate pharmacy acquisition costs? Is it average acquisition cost or actual acquisition cost?

RESPONSE:

Pharmacy acquisition cost is the ***weighted average acquisition cost*** for like drugs grouped by Generic Code Number (GCN) based on actual acquisition cost data submitted on invoices by Colorado pharmacies. GCN is a standard number used to group drugs with the same ingredients, drug strength, and dosage form. The Department is also weighting each drug within a GCN by invoice purchase records so that drugs more utilized by Colorado pharmacies will be more represented in Medicaid reimbursement.

For pharmacy providers, the survey invoice process will more closely align and maintain a reimbursement that reflects actual current costs. While the cost of providing a service may vary from provider to provider, the reimbursement does not change. Providers are thereby incentivized to provide the service or purchase the product in a more cost-effective manner. The majority of other Medicaid providers are not reimbursed based on their cost, and many providers are paid less than their cost.

To ensure that the average acquisition cost is a fair reimbursement rate, the Department is currently analyzing pharmacy-submitted invoice data to identify whether acquisition cost differs by pharmacy type (independent and retail) or pharmacy size (total prescription volume). If this analysis shows a difference in acquisition cost by either pharmacy type or size, a percentage adjustment will be applied to the calculation of average acquisition cost rates to offset the difference. Similar to Colorado, the Centers for Medicare and Medicaid Services (CMS) has already completed analysis comparing acquisition cost between urban and rural pharmacies as well as chain and independent pharmacies using collected invoice data from all states. CMS's findings concluded that, while there are differences in acquisition cost based on pharmacy type, these differences are negligible.

The alternative of using each pharmacy's actual acquisition cost would require expensive billing system updates, be burdensome for both the State and providers, and be difficult and expensive to audit.

34) Are there ways the savings from using the new pharmacy reimbursement methodology could be reinvested in initiatives that promote more effective use of pharmaceuticals to improve health outcomes and reduce long-term costs?

RESPONSE:

The Department believes that several options exist, which, with expanded funding, could promote more effective use of pharmaceuticals, improved health outcomes, and reduced long-term costs. The expansion of the Department's Rx Review program, authorized by HB 07-1021, to a full Medication Therapy Management program, could serve the Department's clients statewide and would be a promising investment.

Another option is enhanced payments to pharmacies and prescribers that act as "lock-in" providers to select Medicaid clients in the Client Over Utilization Program (COUP). The COUP is a utilization control program designed to rectify client overutilization of medications and services. This program restricts clients to one designated pharmacy and primary care physician. By providing incentive payments to participating providers, the Department anticipates greater overall participation from providers which would lead to greater reductions in the inappropriate use of medications. The Department also sees the potential for meeting these goals by expanding the Department's current Drug Utilization Review (DUR) vendor contract with the University of Colorado, Skaggs School of Pharmacy, to include additional services. By expanding its retrospective claims-review efforts to physician-administered drugs, the Department could target one of its highest expenditure pharmaceutical areas. In addition, the DUR vendor has previously proposed a program which could provide specialist prior-authorization review and/or peer-to-peer consultation for patient-specific prior-authorization medical-necessity requests.

The Department believes additional efforts can be focused under the current structure of the Accountable Care Collaborative (ACC). By incorporating the previously mentioned initiatives into the ACC model for increased collaboration, duplication of effort can be avoided, and overall program savings can be accounted for more easily. Integrating the pharmacist into the collaborative team would be an effective use of resources resulting in overall program benefit and improved health outcome.

35) What are the Department's concerns about RX Review?

RESPONSE:

The Rx Review Program was implemented in 2008, in accordance with HB 07-1021, which sought to promote better medication management for Medicaid clients through consultations with pharmacists. While the program has proven to be beneficial for clients,

the program, as it currently exists, has significant limitations. The Department's primary concerns with the program are related to resource constraints. These constraints have downstream impacts, such as low participation rates, inequitable reimbursement for pharmacists' time and effort, and high administrative burden relative to the overall scope of the program.

Annual program funding of $16,950 severely limits the number of clients who can benefit from the program. At current reimbursement levels and assuming full utilization of funding, the Department anticipates that approximately 220 clients will participate in the program in FY 2012-13. In order to stretch existing funds as far as possible, consultations are limited to only one per year, which reduces program efficacy on a client-specific basis. Further, because of limited pharmacist participation (largely due to low reimbursement levels), the program is not consistently available across the State.

Equitable reimbursement for pharmacists providing medication management in the Rx Review program is also of concern to the Department. Limited program funding prevents the Department from reimbursing pharmacists more than $75 per review. With reviews requiring up to five hours of a pharmacist's time, reimbursement amounts to $15 per hour, which is insufficient, and few pharmacists are willing to participate in the programs (i.e., at five hours, the hourly rate is $15 per hour). In cases where a pharmacist performs initial outreach efforts and the client declines to participate in the program, the pharmacist is not compensated for their efforts.

Lastly, the program is time intensive to both pharmacists and Department staff. The Department's process is primarily manual and includes: contracting with pharmacists, analyzing data to find clients who meet program criteria, matching clients to pharmacists, providing pharmacists with the information needed for the consultation, confirming that the consultation was completed, and paying pharmacists. The documentation and consultation process for pharmacists is predominantly manual as well. Given low participation levels and limited program scope, the administrative burden is not commensurate with the benefits achieved. The program essentially lacks economies of scale and lacks sufficient funding to remedy process, participation, and reimbursement issues.

A more comprehensive program where the aforementioned concerns are addressed could provide access to all qualified clients wherever they are located. Other medication therapy management programs are more automated, which greatly improves the efficiency of the programs. In other medication therapy management programs, the pharmacists meet more regularly, sometimes quarterly, with the clients to follow up on medication changes and recommendations. Through this regular interaction, a pharmacist can develop relationships with the clients, follow up on past recommendations, and continue to monitor the client's medications for further modifications.

The Department notes that if a sizable appropriation is granted for an expansion of the RX Review program to create a more comprehensive program, the Department may be compelled to use the state's competitive procurement process to procure a vendor to

perform these functions. Such a vendor may not necessarily be required to contract with local pharmacists to perform these reviews.

36) What would be the characteristics of an effective drug management therapy program? What does the literature say about the performance of these programs? How much would such a program cost?

RESPONSE:

An effective drug-management therapy program includes: 1) efficient, thorough ways to identify clients who could benefit from the program; 2) efficient methods by which to transfer medication information to and from the consulting pharmacist; 3) a comprehensive review of prescription medications, vitamins, over-the-counter medications, and herbal supplements; 4) an interactive, person-to-person consultation either telephonically or face-to-face; 5) regularly scheduled follow-up consultations; and 6) written reports and assessments regarding the client's medications that are shared with the client's other health care providers.

Through these consultations, the pharmacist would work with the rest of the client's health care providers to identify, resolve, and prevent medication-related problems, including:

- screening for drug-drug and drug-OTC/supplement interactions;
- screening for duplicative drug therapy;
- evaluating the client's response to current therapy, including drug effectiveness and safety;
- using multiple prescribers and/or pharmacies; and
- medication adherence issues.

CMS has established guidelines for Part D medication therapy management programs which, although they do not apply specifically to Medicaid programs, can be helpful when developing an effective drug management therapy program. The guidelines include: 1) enrolling targeted clients using an opt-out method of enrollment only; 2) targeting clients for enrollment in the medication therapy management program at least quarterly during each plan year; and 3) offering a minimum level of services for each client enrolled in the medication therapy management program that includes interventions for both clients and prescribers as well as annual comprehensive medication reviews with written summaries. The comprehensive medication review must include an interactive, person-to-person consultation performed by a pharmacist.[14]

As reported in the literature, the effectiveness of medication therapy management programs varies. One highly successful program in North Carolina is Checkmeds NC, which is a service offered to Part D beneficiaries. Based on an expenditure of less than $1 million through a commercial medication therapy management program, the program has claimed a return on investment (ROI) of $13.1 million in savings. In contrast, a pilot study of a

[14] Medication Therapy Management 42 C.F.R. §423.153(d); Prescription Drug Benefit Manual, Chapter 7 of the 2012 Contract Year Medicare Prescription Drug Benefit Solicitation for Applications for New Prescription Drug Plans Sponsors.

medication therapy management program within the North Carolina State Health Plan utilized one chain's pharmacies to target 88 Medicaid clients to receive quarterly, face-to-face reviews. This program provided $6,720 in reimbursement to pharmacists and yielded an annual net cost avoidance of $2,724. The program did not result in statistically significant improvement in medication management as the ROI was 1.4 to 1 (J Am Pharm Assoc., 2010). Additionally, another pilot program, the North Carolina nursing home Polypharmacy Initiative, was conducted on Medicaid clients residing in 12 nursing homes. This initiative cost the North Carolina Medicaid program $8,700 in payments to physician and pharmacist consultants and yielded an annualized drug cost avoidance of $113,340, based on a one-month savings of $9,445. An estimated ROI of 13 to 1 was assumed (Trygstad, 2006). Similarly, according to an article in Health Affairs, Connecticut Medicaid had a pilot program in which 88 clients participated. Drug claims for those participants totaled $423,387, and total healthcare costs (medical, hospital, pharmacy, and emergency room visits) amounted to $574,817. Based on an extrapolation of the initial success of the program, had the pilot program continued for a year, drug costs would have been $324,553, and the total health care costs would have been $434,465. Per client, the estimated cost avoidance was roughly $1,600 annually. Thus, the estimated total savings were approximately 2.5 times the cost of the fees associated with the program.

Unfortunately, there are flaws in the cost avoidance methodologies. Sample selection details, attrition information, and selection bias are all potential factors. For example, within the Connecticut study, the estimated total costs for the Medicaid participants are aggregate figures based on the previous year with no explanation of the methodology used. The study-year estimates had simply been extrapolated and then subtracted from the actual aggregate costs, then divided by the total number of participants (n=88). The resulting figures are $1,123 in savings per patient on drug claims and $472 in total health expenditures. There is also potential selection bias because the same group that completed the study also calculated these savings.

Measuring the effectiveness of these programs is difficult in part because the savings projections are difficult to quantify. Savings from these programs result from: 1) decreased spending on medications, and 2) better health outcomes. Savings projections based on the decreased spending on medications are further complicated in Medicaid programs because of manufacturer rebates received by Medicaid. Because of these rebates, some medications that are generally more expensive are actually cheaper for the Medicaid program. The rebate information is confidential and cannot be shared with drug therapy contractors. Since the contractors are not aware of the rebate amounts, they sometimes recommend switching medications to what they think would be cheaper, when they are, in fact, not cheaper. As a result, the medication therapy management contractor tries to capture that as savings to the Medicaid program when it actually is not.

It is also difficult to tie changes in medication therapy directly to improved health care outcomes. For example, eliminating a duplicative use of blood pressure medications may avoid a hospital stay for overly low blood pressure. However, calculating the potential savings for that avoided hospital stay has been difficult historically for medication therapy management programs.

The cost of a medication therapy management program could vary significantly, depending on the structure of the program. A contractor that could run a full program and contract with the pharmacists to provide the services might charge between $60,000-$500,000 per year (depending on the number of clients included in the program) for the administrative costs, plus a payment to the pharmacists for their services, ranging from $10 for each client education to $75 for each consultation. Through the administrative fee, the contractor would take care of much of the administrative work that the pharmacists are currently doing under the Rx Review program. Thus, the payment of $75 would be much more in line with the work being done by the pharmacist.

37) What are the Department's views on reimbursing pharmacists for providing immunizations?

RESPONSE:

The Department understands there can be benefits to reimbursing pharmacists for providing immunizations to Medicaid clients. The Department recognizes this service could provide further access for clients to certain immunizations through a trusted, accessible health care provider. However, the Department has concerns whether a current policy change to allow pharmacists to immunize would be cost-effective. The change to allow pharmacists to provide immunizations would require increased coordination between providers, computer system changes that could cost a significant amount of money, and pharmacists to participate, which they may not do based on the reimbursement structure.

For adult clients (ages 19 and older), the current reimbursement rate for covered immunizations across all provider types is the cost of the vaccine plus an administration fee of $6.33. Since all provider types are currently reimbursed the same way, the Department would likely reimburse pharmacies at this same rate as well. To contrast, effective February 1, 2013, pharmacies will be reimbursed $9.31-$14.14 plus the cost of the drug for each medication that is dispensed. For clients 18 and younger, the Department reimburses the administration fee only for most immunizations. The Vaccines for Children (VFC) Program provides a supply of federally purchased vaccines to be administered to eligible children – such as children on Colorado Medicaid – at no cost to any public or private health care provider that participates in the VFC Program. The Department encourages providers that render vaccines to clients ages 18 and under to enroll into the VFC Program. Since providers in the VFC Program can get VFC-covered vaccines free of charge from the VFC Program, the Department does not reimburse providers for the cost of VFC-covered vaccines, although provides do receive (but does reimburse for the $6.33 administration rate fee for the vaccines rendered). Many vaccines, including the flu vaccine, are covered by the VFC program for children 18 years and under.

In order for pharmacies to participate in the VFC program, pharmacies would be required to enroll as a VFC provider. Currently, pharmacies are not listed as eligible providers under the VFC Program. Thus, a change to the VFC Program, which is administered by the Colorado Department of Public Health and Environment, would be necessary in order

for the pharmacies to receive the vaccines through the VFC Program. Given the reimbursement rates for immunizations as compared to medications, the Department is concerned about the actual participation rate that would be realized if pharmacies were allowed to provide immunizations. Additionally, because pharmacists are not currently allowed as billing providers for immunizations, even just to collect the administrative fee, the current Department's claims Medicaid Management Information System (MMIS) would require changes at potentially significant cost. With a full MMIS reprocurement on the horizon, implementation of non-required system changes over the other necessary system changes may be difficult to justify. This is particularly true given the reimbursement rates that would be paid to pharmacists and the question as to how many pharmacies would actually participate.

The flu vaccine is an example of a vaccine that could be administered by pharmacists. Currently, Federally Qualified Health Centers can administer the flu vaccine and are reimbursed for that administration through their encounter rates. Physician offices, various clinics, and hospitals can also administer the flu vaccine. In FY 2011-12, approximately 32,000 clients (about 20,000 of whom were children) received a flu vaccine from these providers, and the Department paid approximately $400,000 for these flu vaccines. If pharmacists could also administer the flu vaccine, some of these clients may choose to receive their vaccines from the pharmacists instead of the provider they used in FY 2011-12. In those cases, the funding would come from money otherwise already paid to other providers. Some additional clients who did not receive a flu vaccine in FY 2011-12 may choose to get one from their pharmacist. The funds for those vaccines could come from reinvestment of the savings from the new pharmacy reimbursement methodology. There are no guarantees that additional clients will opt to receive the flu vaccine. Simply put, it may not be cost-effective to make the necessary changes to allow pharmacists to administer vaccines.

In summary, the Department recognizes the value of pharmacist-provided immunizations. However, consideration must be given to the time and cost of updating the current claims system to allow for this billing, potential difficulties in getting information back to the clients' medical providers, and the likelihood that many pharmacies would not participate.

PAYMENT REFORM

38) Please provide an update on the Department's efforts to implement gainsharing and other payment reform initiatives authorized in FY 2012-13's R-5 and in H.B. 12-1281.

RESPONSE:

R-5 Shared Savings

The Department's FY 2012-13 budget request R-5, "Medicaid Fee-For-Service Reform," included three approved shared-savings, also referred to as "gainsharing," initiatives: Behavioral Health Organization (BHO) shared savings, Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) shared savings, and Accountable Care

Collaborative (ACC) shared savings. BHO shared savings initially intended to measure psychotropic drug utilization for all Medicaid clients enrolled in the BHOs who are seriously and persistently mentally ill. FQHC/RHC shared savings was designed to measure Medicaid FQHC clients' hospital and pharmaceutical expenditure. ACC shared savings was less defined and stated that savings beyond the administrative costs of the ACC would be shared between the Regional Care Collaborative Organizations (RCCOs) and the Primary Care Medical Providers (PCMPs).

The Department has since revised its shared savings proposals. To combine delivery system reform with payment reform, reduce confusion among several separate shared-savings initiatives, support the integration of behavioral and physical health care, leverage existing infrastructure, and support the Department's ACC program, these three individual savings initiatives have been streamlined into one ACC shared-savings program. This strategy aligns the Department's payment reform goals while maintaining shared savings for providers detailed in the Department's initial proposals.

In order to ensure that the shared savings program is successful, the Department has engaged stakeholders – in particular, the BHOs, FQHCs, RHCs, and RCCOs – to design the shared-savings approaches. This process has taken some additional time as stakeholder groups come to an agreement regarding the methodology and distribution of savings with the assistance of the Department. Stakeholder workgroups will continue until the end of April 2013, and the Department anticipates that implementation will occur in the second half of 2013.

In addition, since the approval of R-5, HB 12-1281 was passed, instructing the Department to implement a number of payment reform pilots. Proposals that include shared savings are eligible to be selected as part of the HB 12-1281 payment reform pilots, though the shared savings will be separate from those described above. As a result, the Department is working to ensure alignment and synergy between R-5 and HB 12-1281 payment-reform pilots for the benefit of clients and providers and to ensure that the Department can administer these two initiatives in an effective and efficient manner.

HB 12-1281 Accountable Care Collaborative Payment Reform Initiative
HB 12-1281, referred to as the Accountable Care Collaborative (ACC) Payment Reform Initiative (PRI), allows the Department to accept proposals for innovative payment reform ideas that will demonstrate new ways of paying for improved client outcomes while reducing costs. The ACC program infrastructure will be the vehicle for delivery and payment reforms in Colorado Medicaid, and the Regional Care Collaborative Organizations (RCCOs) may submit proposals to the Department for evaluation and possible selection.

Over the past several months, the Department has worked to develop the solicitation and procurement process, has engaged stakeholders for input and feedback on draft documents, and has hired dedicated staff. The ACC PRI is soliciting proposals for payment reform projects from the contracted RCCOs. Organizations partnering with the RCCOs may collaborate in proposal development and implementation. RCCOs are encouraged to

partner with providers in their region to submit proposals. Providers could include but are not limited to: primary care, hospitals, long-term supports and services, and home- and community-based service providers. Proposals could include various payment reform arrangements, such as shared savings, episodes of care payments, and global payments tied to improved patient outcomes. While the Department is allowing flexibility in order to encourage a wide range of payment reform ideas, the Department is requiring that the proposed payment models neither perpetuate the existing fee-for-service system nor create a managed-care structure that does not add innovative components beyond the traditional health maintenance organization (HMO) model.

The Department has developed and released solicitation documents for the HB 12-1281 pilot. The documents can be found on the PRI webpage under the "Guidelines for Proposals" section at the following URL:
http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1251626415803

Key activities that have been completed for the payment reform initiative include the following:

- September 11, 2012 – The Department requested that interested RCCOs submit two-page abstracts of sample payment reform ideas and projects. The purpose of these abstracts was to help define the scope of potential proposals and inform the official proposal evaluation criteria for the pilot program(s). The Department received 12 abstracts, including at least one abstract from each RCCO.
- November 5, 2012 – The Department hosted a stakeholder meeting to present a draft version of the solicitation criteria for pilot proposals and to hear feedback. Over 50 stakeholders participated in the meeting in person, and approximately 10 stakeholders participated by phone.
- November 16, 2012 – The Department hosted an additional forum to receive stakeholder input on the draft solicitation criteria document. This opportunity was incorporated into a regularly-scheduled meeting – the ACC Payment Reform Subcommittee meeting. Participants included representatives from the RCCOs, Behavioral Health Organizations (BHOs), Federally Qualified Health Centers (FQHCs), and other providers and provider associations.
- December 17, 2012 – The Department released the final solicitation document for the ACC Payment Reform Initiative, titled the Guidelines for Proposals, Solicitation #12-1281-PRI. The document, along with several appendices, outlines the purpose and goals of the PRI, the required contents of and process for submitting proposals, and the general criteria to be used by the Department for evaluation.
- December 31, 2012 – Questions from the RCCOs related to the Guidelines for Proposals (GFP) documents were due to the Department by 5:00 p.m. MST.

The timeline for upcoming activities through the selection of one or more pilot projects is outlined as follows.

- January 14, 2013 – The Department will formally respond to all submitted RCCO questions through a posting on the PRI web page.
- January 18, 2013 – By this date, RCCOs that intend to submit full pilot proposals must submit to the Department a Letter of Intent that summarizes the proposal

design, including the following components: population to be served, the region(s) or county (counties) in which the pilot would operate, the policy innovation that will enhance the current Medicaid program and support the Triple Aim, and the general payment model.

- February 1, 2013 – The Department will submit to the Joint Budget Committee (JBC) a report concerning the design and implementation of the program, including summaries of the payment projects. The Department will use the project summaries collected through the Letters of Intent to complete the report. Because the development of the solicitation design was a complex and time-consuming process requiring substantial research and coordination, the Department chose to allow the RCCOs additional time to develop full proposals. Designing payment reforms for Medicaid requires the consideration of many detailed components of the program, as well as a thorough understanding of the potential real-world impacts of policy decisions.
- April 1, 2013 – Full proposals in response to the ACC Payment Reform Initiative GFP solicitation are due to the Department. The Department plans to utilize a standardized evaluation process with an executive-led committee and subject matter experts to review the submitted proposals and select one or more payment projects for implementation.
- July 1, 2013 – The Department will announce which proposals are selected for a contract. In addition, RCCOs that submitted proposals not selected will be notified in writing of the reasons for which these proposals were not chosen for implementation.

39) Please provide an update on the implementation of the Accountable Care Collaborative (ACC), including a discussion of the performance outcomes.

RESPONSE:

The Accountable Care Collaborative (ACC) program is Colorado Medicaid's predominant platform for reforming the health care delivery system to create better overall value and achieve the Triple Aim. The primary goals of the ACC program are to improve client health, support providers in providing high-quality efficient care, and reduce costs. ACC client enrollment began in May 2011, and initial results of this program are promising; costs, utilization, and client experience are trending in the right direction. Since the last year's Joint Budget Committee hearing, the Department has made significant strides in expanding the ACC provider network and enrollment, using data to drive results, and aligning the program with other efforts.

The potential for the ACC program was illustrated in the November 1, 2012 Accountable Care Collaborative Annual Report. The Department's response to Legislative Request for Information #6 described a reduction in hospital readmissions and high-cost imaging. The rate of emergency room utilization increased at a lower rate for ACC enrollees than non-enrollees. The Department evaluated the total cost of care for ACC clients using a number of statistical methodologies. The various methodologies created a large range of possible

savings; however, the Department believes the reported estimate of $20 million gross cost reduction was a reasonable estimate of the program's impact.

Program Description
The ACC is a managed fee-for-service model with three key components: seven Regional Care Collaborative Organizations (RCCOs); contracted Primary Care Medical Providers (PCMPs), and a Statewide Data Analytics Contractor (SDAC).

The RCCOs' core responsibilities are to ensure that every client receives care coordination or medical management, develop a network of providers, support providers in providing high-quality care, and be accountable to the Department. PCMPs are a client's medical home and provide continuous, comprehensive, client-centered care. The SDAC's core function is to provide unprecedented levels of data and analytics via an interactive web portal.

Expanding Network & Enrollment
As of December, there are over 210,000 ACC enrollees. In contrast to last year, where the majority of enrollees were adults, approximately 56% of current enrollees are children. Beginning May 2012, roughly 10,000 Adults without Dependent Children (AwDC) were enrolled in the program. The percentage of enrollees who have opted out of the program is under 5%.

The number of contracted ACC Primary Care Medical Providers (PCMPs) has kept pace with the increase in enrollees. There are now approximately 350 PCMP sites representing nearly 1,900 individual practitioners.

Using Data to Drive Results
The SDAC web portal went live in February 2012. Since then, the Department, RCCOs, and PCMPs have been able to utilize the web portal to view aggregated population level and client level paid claims data. The population data allows the Department to compare RCCO and PCMP performance and identify areas for system improvement and practice transformation. Users can drill down from the population statistics to individual clients, allowing RCCOS and PCMPs to identify clients in need of additional services and support.

Beginning July 2012, the Department implemented an incentive program to increase the accountability of RCCOs and PCMPs. One dollar of the Per-Member Per-Month (PMPM) payment for RCCOs and PCMPs is withheld and will be paid out based on regional performance on three key performance indicators: high-cost imaging, all cause 30-day readmissions, and emergency room (ER) visits.

The full impact of the web portal and incentive payment program was not realized in the last fiscal year, based on implementation dates and the time needed for users to be trained and to become familiarized with the new systems. The Department anticipates that both will have a positive impact on future program efficacy.

Aligning ACC with other Programs & Department Efforts
One of the Department's goals is to align other Medicaid programs with the ACC to reduce duplication of effort between programs and increase overall efficiency.

One example of this alignment effort is the Department's engagement in the Comprehensive Primary Care Initiative (CPCI). Colorado Medicaid is one of nine payers in Colorado participating in this initiative funded by the Centers for Medicare and Medicaid Services (CMS) to help primary care practices deliver higher-quality, better-coordinated, and more patient-centered care. The Department is participating entirely through the structure of the ACC program. Participating through the ACC with other payers allows providers with a smaller number of Medicaid enrollees to benefit from provider practice supports available from the RCCOs without creating additional administrative burden on the providers.

The Department has also begun working with stakeholders to better align the Children's Medical Home program with the ACC program. The Department is facilitating a stakeholder workgroup that meets twice per month to develop a proposal for this alignment. The workgroup includes representatives from the Colorado Children's Healthcare Access Program (CCHAP), the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), school-based health centers, and behavioral health providers. This workgroup is assisting the Department with considering program adjustments, such as changing the current ACC performance measurements and incentive payments to include more pediatric-focused metrics.

Program Next Steps (Master Plan)
The ACC program has a short-term (12-month) plan and a long-term plan.

Short-Term
The Department is exploring the possibility of enrolling an additional 160,000 clients during calendar year 2013. This enrollment will include a number of current Medicaid populations. First, the Department will work to contract additional Children's Medical Home Providers and enroll clients linked to those providers into the ACC. Second, the Department plans to systematically enroll clients who are Medicare-Medicaid eligible into the ACC program.

The ACC program enables the Department to more effectively leverage current resources and programs. In the next calendar year, the Department will work on alignment with Healthy Communities, local public health agencies, County Medical Assistance sites, and the Department's Utilization Management vendor. The RCCOs' strong connection and communication avenues with providers and clients allow them to connect the right individuals with the right resources.

The ACC program is also the platform for payment reform including gainshairing and the proposals requested as directed in HB 12-1281. On December 17, 2012, Request for Proposals (RFPs) were released, and responses will be submitted to the Department in April 2013.

The Department is developing plans to increase access to the SDAC web portal for other members of a client's health team to promote greater integration. The Department will identify additional data sources to incorporate in the web portal to provide a more complete picture of client health. The Department will also expand program measures to include quality and health outcomes, as well as client and provider experience. These metrics will allow the RCCOs to improve their performance as it relates to how care is provided, not just the volume of care provided.

Long-Term

The Department is working with its partners and stakeholders to begin developing plans for the long-term strategic plan of the program. The resulting plan will begin to explore:

- long-term enrollment strategies;
- behavioral health integration;
- reprocurement of the behavioral health program for 2014;
- reprocurement of the RCCO contracts for 2016;
- payment reform initiatives such as HB 12-1281 pilot programs;
- development of health homes;
- integration of and access to dental services; and
- integration of long-term services and supports.

The ACC program is evolving. System change must occur incrementally to ensure that all members of the system are prepared, willing partners. Ongoing program evaluation identifies opportunities for improvement. The Department is committed to taking these opportunities and continuously implementing positive change in the program.

The next steps for the program will be fully developed in partnership with the Department's stakeholders through the ACC Program Improvement Advisory Committee. The Committee includes providers, behavioral health organization (BHO) representatives, consumers, and advocates. The Committee has four working subcommittees: Payment Reform; Quality and Health Improvement; Provider and Community Relations; and the Medicare-Medicaid Enrollees Demonstration. These groups ensure regular and intensive feedback to the Department.

MISCELLANEOUS

40) How will the Affordable Care Act affect the Medicaid family planning program? What is the federal match rate for this program?

RESPONSE:

The Affordable Care Act will not change Medicaid coverage of family planning services. The federal match rate for the Medicaid family planning program is currently 90% and will continue to be 90% post-Affordable Care Act implementation.

During the FY 2010-11 budget request cycle, the Department worked toward creating an 1115 demonstration waiver that would extend the provision of family planning services to individuals up to 200% FPL. The intent of the waiver was to provide family planning and reproductive health care to individuals who meet established criteria and who otherwise would not have access to these services.

The Department withdrew the waiver application in December 2011 for multiple reasons. The Department determined, with the implementation of health care reform in 2014, it would be more efficient and cost-effective to withdraw the waiver and refocus on other efforts to support family planning infrastructure and sustainability in Colorado. The individuals who would have originally been covered under this waiver will now be covered through the expansion of Medicaid (up to 133% FPL) or will be eligible for a subsidized plan covering all essential benefits, including family planning services, through the Colorado Health Benefit Exchange. Additionally, implementation of the waiver would have required over $800,000 for system changes, and program implementation would not have been completed until late 2013.

41) Please coordinate with the departments of Education and of Public Health and Environment to discuss whether the funding and administration for school based health clinics should be transferred to the Department of Education.

RESPONSE:

There are two programs under the Department's purview that provide funds for health services provided to students: 1) the School-Based Health Center Program, and 2) the School Health Services Program. The departments do not believe the funding or administration for either program should be transferred to the Department of Education. These programs are related to providing health care or reimbursing for health care services, which is within the scope of the Department of Health Care Policy and Financing and not the Department of Education. For reference, the programs are described in detail below.

School-Based Health Center Program
The School-Based Health Center Program was created in 1987 to assist in the establishment, expansion, and ongoing operations of school-based health centers (SBHCs) in Colorado for uninsured and/or low-income children. SBHCs are clinics operated within

a public school building – including charter schools and GED programs – associated with a school district and in collaboration with hospitals, health care organizations, medical providers, public health nurses, community health centers, and mental health providers.

Establishing a school-based health center is a community-driven process that requires multiple partnerships – between school districts, the medical and mental health communities, and local and state funders – to be effective. The Colorado Department of Public Health and Environment does not run these clinics but rather sets standards and provides some funding. SBHCs that enroll as Medicaid or CHP+ providers receive reimbursement from the Department for their Medicaid claims and through CHP+ managed care organizations for their CHP+ services.

The departments believe the SBHC Program is appropriately placed in Department of Public Health and Environment (CDPHE) for the following reasons:

- School-based health centers address topics of concern to public health including immunizations, obesity prevention, depression screening, management of acute illnesses such as diabetes and asthma, primary prevention of communicable illnesses, and oral health. The expertise to address these health concerns resides in the CDPHE.
- Colorado Department of Education's (CDE) mission is to "shape, support, and safeguard a statewide education system that prepares students for success in a globally competitive world." CDE's primary role is to educate children and youth, while CDPHE is primarily responsible for the health of Colorado's people.
- The Prevention Services Division at CDPHE is responsible for managing hundreds of contracts throughout the State. The department has the capacity, expertise, and experience to effectively and efficiently administer the SBHC program. Nationally, the majority of state-run, school-based health center programs are housed in state health agencies.

School Health Services Program

The School Health Services (SHS) Program was established in 1997 and allows public school districts, Boards of Cooperative Educational Services (BOCES), and state K-12 educational institutions to receive federal Medicaid funds for amounts spent providing health services to students who are Medicaid-eligible and have either an Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP).[15] In addition, participating districts and BOCES may receive reimbursement for Medicaid administrative activities that directly support efforts to identify and enroll potentially eligible children and their families into Medicaid.

The district or BOCES incurs the original expenditures using local tax dollars or appropriated General Funds which draw federal matching Medicaid funds through the certification of public expenditures (CPE) mechanism. To draw federal Medicaid funds through CPEs, districts and BOCES must participate in a federally-approved quarterly time study and submit quarterly and annual cost reports.

[15] Note: Health services required in a child's IEP or IFSP are not covered by the SBHC program, which provides primary health care and mental health services.

Under Colorado statute, participating districts and BOCES are required to use the Medicaid funds received to fund student health services for all students. Each participating district and BOCES must develop a local services plan with community input to identify the types of health services needed by its students and must submit an annual report that describes exactly how the Medicaid revenue was spent in accordance with its local services plan.

The SHS Program is administered jointly by the Department and the Colorado Department of Education. The Department draws and disburses the federal Medicaid funds, conducts the federally-approved time study, administers the quarterly and annual cost report and certification processes, and conducts on-site reviews to ensure compliance with federal requirements. The Department of Education provides technical assistance related to the development of the local services plan and annual report and reviews and approves the local services plan.

42) Can local funds for services for people with developmental disabilities, such as Denver's program, be used to match federal Medicaid funds?

RESPONSE:

History
In January 2006, the Centers for Medicare and Medicaid Services (CMS) notified the Department that it was no longer permitted to use certification of public expenditures (CPE) to qualify for a federal Medicaid match for services for the developmentally disabled population. CPE requires that public providers certify their uncompensated costs, but local governments are not the provider of developmental disability services; rather, private Community Centered Boards (CCBs) are. The appropriate mechanism to qualify for a federal match for these services would be an Inter-Governmental Transfer (IGT) from the local government to the Department. The Department would then report legitimate Medicaid expenditures to CMS to obtain the match.

In the fall of 2009, the Department, the Department of Human Services (DHS), and selected stakeholders formed a workgroup to discuss the possibility of obtaining a match through IGT. In February 2010, a letter was sent to county commissioners outlining a possible new process for reinstating the federal match through an IGT process to alleviate waitlists. No interest was expressed, and the Department's workgroup disbanded.

Current Situation
Pursuant to section 27-10.5-104(6) C.R.S. (2012), boards of county commissioners are permitted to levy up to one mill for purchasing services for persons with developmental disabilities. Presently, eight counties in Colorado assess a levy designated for developmental disability services and support: Arapahoe, Boulder, Denver, Douglas, Jefferson, Larimer, Pueblo, and Routt.

This mill levy revenue would need to be transferred to the Department as an IGT in order to receive matching federal Medicaid funds pursuant to 42 CFR § 433.51. These funds

could then be used to provide Medicaid-approved waiver services to persons with developmental disabilities and may not be passed directly back to the local governments that levied the assessment.

Once transferred to the Department, local control over the use of the revenues would be limited. Further research and discussion with CMS would be required to explore this issue and answer many questions. For example, it is unknown if the IGT funding could be targeted to specific waivers, specific individuals, or specific Medicaid services. If the HCBS programs caseload and costs were to grow over time, it is unclear what financial obligations would be borne by the State versus the local governments. Furthermore, the ramifications for those counties that do not designate funds or transfer funds to the State for this purpose are unknown. Lastly, the State must also estimate and study the ramifications this transfer of local government funds would have on its annual TABOR revenue limits.

43) Does Colorado have a Medicaid administrative claiming process that would allow local governments to get matching funds for administrative functions, and if not, why not?

RESPONSE:

Medicaid administrative activities performed by counties are reimbursed through the "County Administration" Long Bill line item. Costs are submitted by counties through the County Financial Management System (CFMS), which is managed by the Colorado Department of Human Services (DHS).

In 2009, the Department formed a workgroup with DHS and Boulder County to study reimbursement through the "County Administration" Long Bill line item. The focus of the study was to determine if counties conducting Medicaid administrative activities were incurring Medicaid costs that were not being reimbursed that could qualify for matching federal Medicaid funds through the certification of public expenditure mechanism. The workgroup concluded that county Medicaid administration costs submitted by the counties through the CFMS are being fully reimbursed. Furthermore, DHS demonstrated that the current cost allocation and year-end pass-through close-out processes in place are designed to maximize funding and accurately reimburse counties. Given this finding, the Department disbanded its research related to certification of public expenditure to qualify for federal funding for uncompensated administrative Medicaid costs. Counties may wish to contact the Settlement Accounting section at DHS to receive detailed coding assistance for administrative claiming and a thorough walk-through of the reimbursement process.

In addition, Medicaid administrative activities performed by school districts and Boards of Cooperative Educational Services (BOCES) are reimbursed through the School Health Services program, which is administered jointly by the Department and the Department of Education. School districts and BOCES that choose to participate in the program may receive reimbursement for Medicaid administrative activities that directly support efforts to identify and enroll potentially eligible children and their families into Medicaid. The reimbursement mechanism is matching federal Medicaid funds through certification of

public expenditures, which requires participation in a federally-approved time study and submission of quarterly cost reports. In FY 2011-12, 39 school districts participated in Medicaid administrative claiming in the School Health Services program and received reimbursement totaling $1,388,203 through the end of the third quarter of that fiscal year.

ADDENDUM: OTHER QUESTIONS FOR WHICH SOLELY WRITTEN RESPONSES ARE REQUIRED

1) The Joint Budget Committee has recently reviewed the State Auditor's Office Annual Report of Audit Recommendations Not Fully Implemented (October 2012). If this report identifies any recommendations for the Department that have not yet been fully implemented and that fall within the following categories, please provide an update on the implementation status and the reason for any delay.

a) **Financial audit recommendations classified as material weaknesses or significant deficiencies;**

b) **Financial, information technology, and performance audit recommendations that have been outstanding for three or more years.**

RESPONSE:

The Department has provided a response and update to all the recommendations in the State Auditor's Office Annual Report of Audit Recommendations Not Fully Implemented in Attachment A1. Most of the implementation dates of the performance audit recommendations in the report have not been outstanding for three or more years. However, the Department is providing a response to all the performance audit recommendations in the report as additional information to the Joint Budget Committee. As summarized in Table A1 of the attachment, the Department is pleased to report that one of the two Material Weaknesses and one of the six Significant Deficiencies have been implemented since the last update provided to the State Auditor's Office that was used generate the report. The JBC request only covered a portion of the total Deficiency in Internal Control recommendations; therefore the Department is providing additional information on all of these low-severity recommendations, of which four of the 12 have since been implemented. Further, the Department has made significant gains in implementing the performance audit recommendations. As provided in Table A1, of the 17 outstanding audit recommendations reporting in October 2012, the Department has since implemented eight of those recommendations.

2) Please provide the number of units provided in the last fiscal year by discipline, in either visits or hours, for home health, private duty nursing and home and community based services programs. These disciplines include RN visits, PT visits, OT visits, speech therapy visits, home health aide visits by time, personal care provider hours, and private duty nursing and RN and LPN hours.

RESPONSE:

The Department has provided a response in Attachment A2.

Table A: Basic HCBS Waiver Service Rates FY 2004-05 through FY 2012-13

Service	HCBS Rates FY 2004-05 through FY 2012-13										
	FY 2004-05	**FY 2005-06**	**FY 2006-07**	**FY 2007-08**	**FY 2008-09**	**FY 2009-10 (July)**	**FY 2009-10 (September)**	**FY 2009-10 (December)**	**FY 2010-11**	**FY 2011-12**	**FY 2012-13**
Adult Day - Basic Rate	$21.05	$21.47	$22.46	$22.80	$23.14	$22.68	$22.34	$22.12	$21.90	$21.79	$21.79
Adult Day - Specialized Rate	$26.90	$27.44	$28.70	$29.13	$29.57	$28.98	$28.54	$28.25	$27.97	$27.83	$27.83
Alternative Care Facility	$36.03	$36.75	$47.58	$48.29	$49.01	$48.03	$47.31	$46.84	$46.37	$46.14	$46.14
Homemaker	$3.14	$3.20	$3.52	$3.57	$3.63	$3.63	$3.57	$3.53	$3.49	$3.47	$3.47
Non-Medical Transportation - Taxi	$47.50	$48.45	$48.45	$49.18	$49.91	$48.92	$48.18	$47.70	$47.22	$46.98	$46.98
Non-Medical Transportation - Mobility Van	$12.20	$12.44	$12.44	$12.63	$12.82	$12.56	$12.37	$12.25	$12.13	$12.07	$12.07
Non-Medical Transportation - Wheelchair Van	$15.19	$15.49	$15.49	$15.72	$15.96	$15.64	$15.40	$15.25	$15.10	$15.02	$15.02
Non-Medical Transportation - Wheelchair Van Mileage	$0.61	$0.62	$0.62	$0.62	$0.62	$0.62	$0.62	$0.62	$0.62	$0.62	$0.62
Personal Care	$3.14	$3.20	$3.52	$3.57	$3.63	$3.63	$3.57	$3.53	$3.49	$3.47	$3.47
Relative Personal Care	$3.14	$3.20	$3.52	$3.57	$3.63	$3.63	$3.57	$3.53	$3.49	$3.47	$3.47
Respite-Alternative Care Facility	$51.84	$52.98	$52.98	$53.77	$54.58	$53.49	$52.69	$52.16	$51.64	$51.38	$51.38
Respite-In-Home	-	$3.03	$3.03	$3.08	$3.06	$3.01	$2.98	$2.95	$2.94	$2.94	$2.94
Respite-Nursing Facility	$115.81	$118.13	$118.13	$119.90	$121.70	$119.27	$117.48	$116.31	$115.15	$114.57	$114.57

The HCBS rates in the table above display the HCBS waiver for the Elderly, Blind, and Disabled, as this waiver contains the largest number of services which are replicated in the Department's other adult waivers. All services for which the rate is client or product specific have been removed.

Unit values differ for each service type. For example, the billing unit for alternative care facilities is a full day, while the billing using for personal care is 15 minutes. Further information is available in the Department's billing manual for HCBS services.

Table B: Basic HCBS Waiver Service Rates FY 2004-05 through FY 2012-13, Adjusted Yearly by CPI

Service	HCBS Inflation Adjusted Rates FY 2004-05 through FY 2012-13								
	FY 2004-05	**FY 2005-06**	**FY 2006-07**	**FY 2007-08**	**FY 2008-09**	**FY 2009-10**	**FY 2010-11**	**FY 2011-12**	**FY 2012-13**
Adult Day - Basic Rate	$21.05	$21.44	$22.24	$23.89	$25.44	$27.34	$27.97	$28.19	$28.56
Adult Day - Specialized Rate	$26.90	$27.40	$28.42	$30.52	$32.51	$34.94	$35.75	$36.03	$36.50
Alternative Care Facility	$36.03	$36.70	$38.06	$40.88	$43.55	$46.80	$47.88	$48.25	$48.89
Homemaker	$3.14	$3.20	$3.32	$3.56	$3.80	$4.08	$4.17	$4.21	$4.26
Non-Medical Transportation - Taxi	$47.50	$48.38	$50.18	$53.90	$57.41	$61.70	$63.12	$63.62	$64.46
Non-Medical Transportation - Mobility Van	$12.20	$12.43	$12.89	$13.84	$14.75	$15.85	$16.21	$16.34	$16.55
Non-Medical Transportation - Wheelchair Van	$15.19	$15.47	$16.05	$17.24	$18.36	$19.73	$20.19	$20.34	$20.61
Non-Medical Transportation - Wheelchair Van Mileage	$0.61	$0.62	$0.64	$0.69	$0.74	$0.79	$0.81	$0.82	$0.83
Personal Care	$3.14	$3.20	$3.32	$3.56	$3.80	$4.08	$4.17	$4.21	$4.26
Relative Personal Care	$3.14	$3.20	$3.32	$3.56	$3.80	$4.08	$4.17	$4.21	$4.26
Respite-Alternative Care Facility	$51.84	$52.80	$54.76	$58.82	$62.66	$67.33	$68.89	$69.43	$70.34
Respite-In-Home	-	$3.03	$3.14	$3.38	$3.60	$3.86	$3.95	$3.98	$4.04
Respite-Nursing Facility	$115.81	$117.96	$122.34	$131.41	$139.98	$150.42	$153.89	$155.10	$157.15
Inflation Rate (CPI Adjustment)*	**-**	**1.86%**	**3.71%**	**7.41%**	**6.52%**	**7.46%**	**2.31%**	**0.78%**	**1.32%**

*Prior year inflation factor was used to inflate current year rates. For example, the 2011 inflation factor was used to estimate FY 2012-13 rates.
The Inflation factor was calculated using the Consumer Price Index or All Urban Consumers: Medical care in Denver-Boulder-Greeley, CO (CMSA) (CUUSA433SAM)

The Consumer Price Index for All Urban Consumers: Medical care in Denver-Boulder-Greeley, CO was used to determine what the rates would have been had they cost of living adjustments been applied.

Table C: Class I Nursing Facility Per-Diem Rates FY 2004-05 through FY 2012-13 (Estimated)

Class I Nursing Facility Per-Diem Rates FY 2004-05 through FY 2012-13				
Fiscal Year	**Per-Diem Rate**	**Percent Change**	**Final Paid Rate**	**Percent Change**
FY 2004-05	$150.15	N/A	$124.26	N/A
FY 2005-06	$157.34	4.79%	$129.82	4.47%
FY 2006-07	$166.30	5.69%	$136.05	4.80%
FY 2007-08	$169.28	1.79%	$138.08	1.49%
FY 2008-09	$190.34	12.44%	$157.24	13.87%
FY 2009-10	$178.83	-6.04%	$145.25	-7.62%
FY 2010-11	$173.27	-3.11%	$140.06	-3.57%
FY 2011-12	$180.57	4.22%	$149.23	6.55%
Estimated FY 2012-13	$187.97	4.10%	$153.14	2.62%

Data Source: R-1 FY 2013-14 Exhibit H, footnote (1)

Table A1: Number of Outstanding Audit Recommendations

Number of Outstanding Audit Recommendations Summary	Number of Outstanding Audit Recommendations from OSA October 2012 Report	Number of Outstanding Audit Recommendations from Department January 2013 JBC Hearing	Change in the Number of Outstanding Audit Recommendations
Financial Audit Recommendations			
Material Weakness	2	1	-1
Significant Deficiency	6	5	-1
Deficiency in Internal Control	12	8	-4
Total Financial Audit Recommendations	**20**	**14**	**-6**
Performance Audit Recommendations			
Access to Medicaid Home and Community-Based Long-Term Care Services (2009)	7	1	-6
Implementation of the Medicaid Pediatric Hospice Waiver (2011)	7	7	0
Medicaid Eligibility Status for Adult Civil Patients at the Colorado Mental Health Institutes (2012)	3	1	-2
Total Performance Audit Recommendations	**17**	**9**	**-8**

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
Finding Classification: Material Weakness Report: 2011 Single Statewide Financial Audit Published: 2012 Number: 26	The Department of Health Care Policy and Financing should improve its controls over eligibility of Medicaid providers to ensure that it complies with federal regulations. In addition, it should develop, implement, and document a process for removing providers from the Medicaid Management Information System providers who are no longer in compliance with provider eligibility requirements.	In Progress With Replacement MMIS – 2016	Full compliance will be achieved with the implementation of the replacement Medicaid Management Information System (MMIS) in 2016. While the replacement MMIS and Fiscal Agent Operations Services are expected to be operational by July 2016, the Department's implementation of the Affordable Care Act (ACA) Provider Screening Rules needs to be completed by March 2016 under federal regulations. The MMIS and Fiscal Agent Operations Services contractor is expected to work with the Department to implement ACA Provider Screening Rules as a top priority under the Request for Proposals (RFP). However, several initiatives are underway to improve compliance in advance of the replacement MMIS: 1) The Department is implementing changes to the provider enrollment application and process which will improve its compliance with current federal regulations. These changes are expected to be completed by June 2013. 2) The Department is working with the Departments of Public Health and Environment (DPHE) and of Regulatory Agencies (DORA) to improve and automate

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
			the collection of license information provided by these Departments. A number of processes are already in place to ensure that ineligible providers are not enrolled and are terminated if they become ineligible after enrollment. Many of these processes rely on manual validation of provider eligibility information. As a result, a key component of the RFP for the replacement MMIS is to allow the systematic validation of provider credentials via implementation of an online provider enrollment tool. The contractor who will build the replacement MMIS will be required to work with the Department to implement ACA Provider Screening Rules, such that all providers must perform the re-validation by March 2016. The Department is working with the Centers for Medicare and Medicaid Services (CMS) regarding the ACA Provider Screening Rules in order to amend the State Plan in a way that is satisfactory to CMS during the period between now and the implementation of the replacement MMIS.

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
Finding Classification: Material Weakness 2011 Single Statewide Financial Audit Published: 2012 Number: 29	The Department of Health Care Policy and Financing should ensure that requirements are met for the Children's Basic Health Plan (CBHP) program related to determining whether an individual has creditable coverage. In addition, the Department should ensure that the Colorado Benefits Management System is properly programmed to deny CBHP eligibility for individuals who are receiving Medicaid or Children's Health Insurance Program benefits in other states.	Implemented June 30, 2012	The Department has reviewed all three cases and determined that these were a result of data entry errors performed by eligibility site workers. As of February 2012, the errors been addressed with the eligibility site. Other health insurance information has correctly been entered in the Colorado Benefits Management System (CBMS) and the disenrollment of one individual from the Children's Basic Health Plan program has been completed. The Department has a process in place to utilize the Public Assistance Reporting Information System (PARIS) tool to determine if a recipient is receiving public assistance benefits in another state. If it is verified that the recipient is residing out-of-state, the case will be end-dated in CBMS to reflect the effective date that the individual began receiving public assistance in the other state. The Department is currently and will continue to work with its Child Health Plan Plus enrollment vendor to ensure that this process and tool is being utilized. This process will replace the previous plans to implement PARIS in CBMS as an automated process to meet this recommendation.

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
Finding Classification: Significant Deficiency 2011 Single Statewide Financial Audit Published: 2012 Number: 25	The Department of Health Care Policy and Financing should ensure that county departments of human/ social services and Medical Assistance (MA) sites meet program processing time requirements for Medicaid and Children's Basic Health Plan eligibility by using Colorado Benefits Management System (CBMS) reports to identify counties that have the highest number of cases, including long-term care cases, that exceed processing guidelines, and by focusing the Department's resources, such as the Application Overflow Unit, on improving processing time frames at those counties and MA sites. The Department should use the monthly CBMS reports to measure the effectiveness of how these mechanisms are working and make adjustments accordingly.	Partially Implemented January 31, 2014	The Department has implemented the recommendations of the Office of the State Auditor (OSA) on improved controls over eligibility sites since 2009. Errors will always exist in a process that requires manual and human intervention. This is true regardless of whether the errors impact eligibility or not. It is difficult for the Department to ensure 100 percent accuracy, especially when there are more than 400 different eligibility sites and more than 4,275 individual users of the Colorado Benefits Management System (CBMS) statewide. In January 2011, the Department began utilizing a timely processing report for new applications and redeterminations that is provided to eligibility sites. Additionally, the Department provides another report containing cases that have not yet been processed or exceed processing time frames and that reflects cases that are pending. Through these reports, the Department identifies eligibility sites that have a high percentage of untimely processing and refers these sites to the Application Overflow Unit or offers temporary staff assistance, as needed. The Department implemented the Application Overflow Unit in FY 2008-09 to assist eligibility sites with application processing. For FY 2010-11, the Application Overflow Unit

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
			received and processed 6,323 medical applications. In addition to this, the project assisted with processing eligibility for Eligible Needy Newborns. In the FY 2011-12, the Application Overflow Unit also started accepting and processing redeterminations. The Department implemented improved controls over eligibility sites through the Medical Eligibility Quality Improvement Project in FY 2008- 09 and through the Colorado Eligibility Process Improvement Collaborative in FY 2011-10, in compliance with the OSA's recommendations from all prior fiscal year reviews. Through Affordable Care Act, the Department plans to automate more functions and interfaces in CBMS which would lessen the need for worker intervention as well as implement Business Processing Re-engineering statewide to standardize processes across eligibility sites. These incentives and changes will help improve and reduce errors.

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
Finding Classification: Significant Deficiency 2011 Single Statewide Financial Audit Published: 2012 Number: 31	The Department of Health Care Policy and Financing should improve controls over Medicaid and Children's Basic Health Plan program eligibility determinations and data entry into the Colorado Benefits Management System. In addition, the Department should ensure that the data entry errors identified during this audit are corrected and reclassify expenditures, as appropriate.	Partially Implemented January 31, 2014	The Department has implemented the recommendations of the Office of the State Auditor (OSA) on improved controls over eligibility sites since 2009. Errors will always exist in a process that requires manual and human intervention. This is true regardless of whether the errors impact eligibility or not. It is difficult for the Department to ensure 100 percent accuracy, especially when there are more than 400 different eligibility sites and more than 4,275 individual users of the Colorado Benefits Management System (CBMS) statewide. The data entry errors identified during this audit have been corrected. The Department has determined that only $10,053 in claims will need to be reclassified. Internal meetings are being held to determine the appropriate action for these claims. The Department implemented improved controls over eligibility sites through the Medical Eligibility Quality Improvement Plan in 2009 and the Colorado Eligibility Process Improvement Collaborative in 2010, in compliance with the OSA's recommendations from all prior fiscal year reviews. However, eligibility determination errors were identified by the OSA during FY 2011-12. Through Affordable Care Act, the Department

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
			plans to automate more functions and interfaces in CBMS which would lessen the need for worker intervention as well as implement Business Processing Re-engineering statewide to standardize processes across eligibility sites. These incentives and changes will help improve and reduce errors.
Finding Classification: Significant Deficiency 2011 Single Statewide Financial Audit Published: 2012 Number: 33a	The Department of Health Care Policy and Financing should improve its oversight of surveys and certifications required under the Medicaid program for nursing facilities, intermediate care facilities for the mentally retarded (ICF/MRs), and hospitals that provide nursing facility services by: a. Providing appropriate procedural training to staff responsible for monitoring nursing facilities, ICF/MRs, and hospitals that provide nursing facility services.	In Progress July 31, 2013	The Department is working with its state and federal partners to ensure the procedures in the State Operations Manual are being followed. A reassessment of responsibilities and coordination between the Department and the Department of Public Health and Environment is in progress as a result of that work.

Audit Classification, Report, Year, Number	**Audit Recommendation Text**	**Current Implementation Status and Date**	**Department's Implementation Status Update**
Finding Classification: Significant Deficiency 2011 Single Statewide Financial Audit Published: 2012 Number: 33c	The Department of Health Care Policy and Financing should improve its oversight of surveys and certifications required under the Medicaid program for nursing facilities, intermediate care facilities for the mentally retarded (ICF/MRs), and hospitals that provide nursing facility services by: c. Developing and implementing procedures to indicate the dates the Department will input into its database and use for monitoring the required time frames for surveys conducted by the Department of Public Health and Environment.	Partially Implemented July 13, 2013	The Department is working with its state and federal partners to ensure State Plan requirements and Interagency Agreements are being followed. The unannounced basis of facility surveys as documented in the State Plan (Attachment 4.40-C, Revisions HCPF-PM-92-3 – April 1992) makes tracking of the required survey timelines difficult. The Department is evaluating the reporting requirements of the Interagency Agreement with the Department of Public Health and Environment to enhance the value of the reports received to allow for closer and more effective oversight of nursing facilities and Intermediate Care Facilities for Individuals with Intellectual Disabilities.

Audit Classification, Report, Year, Number	**Audit Recommendation Text**	**Current Implementation Status and Date**	**Department's Implementation Status Update**
Finding Classification: Significant Deficiency 2011 Single Statewide Financial Audit Published: 2012 Number: 35b	The Department should improve controls over the processing of medical claims for the Medicaid program by: b. modifying the Medicaid State Plan and Department rules, as necessary, to include the exemptions from Lower of Pricing and submitting the State Plan modifications to the federal government for approval.	In Progress March 31, 2013	The Department initiated contact with the federal Centers for Medicare and Medicaid Services CMS on December 20, 2011, in order to determine what, if any, changes are necessary to the State Plan regarding any exemption from Lower of Pricing logic. The Department is still in the process of exploring internally and with its federal partner what language regarding the exception list to the Lower of Pricing methodology would be acceptable.

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
Finding Classification: Significant Deficiency 2011 Single Statewide Financial Audit for Fiscal Year Published: 2012 Number: 35c	The Department should improve controls over the processing of medical claims for the Medicaid program by: c. Denying claims that are not in accordance with state regulations on timely filing requirements. In addition, clarifying provider guidance when claims extend beyond timely filing deadlines.	Implemented September 30, 2012	State rule 8.043.02.C allows for 'possible exceptions' regarding timely filing. The Department is compliant with the rule and has determined that its guidance is sufficient. No further review or implementation effort is planned for this recommendation.

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
Finding Classification: Deficiency in Internal Control 2011 Single Statewide Financial Audit Published: 2012 Number: 27	The Department of Health Care Policy and Financing should ensure that Income, Eligibility, and Verification System (IEVS) data discrepancies for the Medicaid and Children's Basic Health Plan programs are resolved. In addition, the Department should ensure that the method of resolving IEVS data discrepancies is incorporated into the State Plans and Department rules.	Implemented September 17, 2012	The Department designed Income Eligibility and Verification System (IEVS) changes during FY 2010-11 and the actual system changes were implemented in August 2011. The Department incorporated IEVS requirements within its Department rules in April 2009. In September 2012, the Centers for Medicare and Medicaid Services approved the Department's State Plans and Department rules that incorporated the method of resolving IEVS data discrepancies. The Department has provided the Office of the State Auditor (OSA) with all evidence of implementation for this finding. In October 2012, the OSA confirmed the Department's implementation.

Audit Classification, Report, Year, Number	**Audit Recommendation Text**	**Current Implementation Status and Date**	**Department's Implementation Status Update**
Finding Classification: Deficiency in Internal Control 2011 Single Statewide Financial Audit Published: 2012 Number: 38d	The Department of Health Care Policy and Financing should improve controls over payments to laboratory providers for the Medicaid program by: d. Identifying and recovering any payments made to providers that were not CLIA-certified, as appropriate.	Implemented No date provided as payment is pending; please see agency comments	The Department sent demand letters in FY 2011-12 to providers who did not have proper Clinical Laboratory Improvement Act (CLIA) certificates. The Department will recover payments as applicable through the proper recovery process which may include but is not limited to informal reconsideration, settlements, formal appeal, and referring the overpayment to collections. Some payments are not collectable due to bankruptcy or other issues.

Audit Classification, Report, Year, Number	**Audit Recommendation Text**	**Current Implementation Status and Date**	**Department's Implementation Status Update**
Finding Classification: Deficiency in Internal Control 2010 Single Statewide Financial Audit Published: 2011 Number: 68a	The Department of Health Care Policy and Financing should improve its monitoring of the nursing facility rate-setting process by: a. Using the options available under state rules for enforcing requirements for the submission of cost reports by the nursing facilities in cases where facilities are delinquent in submitting the reports.	Implemented December 1, 2012	The Long Term Services and Support Operations Division has created and implemented rule-based procedures for addressing Med-13 cost report submission concerns.

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
Finding Classification: Deficiency in Internal Control 2009 Single Statewide Financial Audit Published: 2010 Number: 53c	The Department of Health Care Policy and Financing should improve controls over documentation in Medicaid case files to support eligibility by: c. Working with the Department of Human Services to identify and implement revisions to policies and procedures for documenting and monitoring Medicaid eligibility determination/ redetermination for the Title IV-E population. Changes should be communicated to counties and medical assistance sites as appropriate.	In Progress February 28, 2013	As a result of the planning meeting with the Department of Human Services' Division of Child Welfare, the Department revised and finalized the redetermination form. The Department plans to conduct training on this new form. The anticipated date of completion of training will be early 2013.

Audit Classification, Report, Year, Number	**Audit Recommendation Text**	**Current Implementation Status and Date**	**Department's Implementation Status Update**
Finding Classification: Deficiency in Internal Control 2009 Single Statewide Financial Audit Published: 2010 Number: 59c	The Department of Health Care Policy and Financing should reduce eligibility determination errors for CBHP by improving oversight and training of eligibility sites. Specifically, the Department should: c. Investigate the causes of the CBMS errors identified in the audit and modify CBMS as needed to correct them. *[The following response and implementation date was previously reported to the LAC and JBC in November 2011. However, based on an old response in June 2010 in which the Department had reported a 6/30/2013 implementation date, OSA has deferred this finding to test until after that date. For more information, please refer to the Disposition of Prior Audit Recommendations in the 2010 and 2011 single statewide audits]*	Implemented September 1, 2010 and ongoing	The Medical Eligibility Quality Improvement (MEQIP) initiative has been implemented, ensuring that eligibility processing standards are developed, implemented and monitored among county and medical assistance sites. The Department began providing training in September 2010 and continues to provide training, upon request, through phone support, on site or in a computer lab. With information gathered through MEQIP and other audit findings, the Department has begun conducting quality site reviews on eligibility sites to determine the additional trainings, tools and resources needed. The Colorado Eligibility Process Improvement Collaborative (CEPIC) is a joint effort between the Department and the Southern Institute on Children and Families Process Improvement Center to assist county sites on improving the efficiency, effectiveness and quality of processes. CEPIC, which began in January 2010, focuses on eligibility services, specifically the timely processing of applications. The July 2011 results of CEPIC showed that participating counties reduced their processing time averages from 28 days to 13 days. The Department is working toward obtaining additional grant funding to continue CEPIC, which will allow additional medical assistance sites to participate.

Audit Classification, Report, Year, Number	**Audit Recommendation Text**	**Current Implementation Status and Date**	**Department's Implementation Status Update**
Finding Classification: Deficiency in Internal Control 2009 Single Statewide Financial Audit Published: 2010 Number: 73a	The Department of Health Care Policy and Financing should improve MMIS user access controls by immediately implementing our prior year recommendation and strengthening MMIS' operating system, including: a. Evaluating MMIS user access profiles and identifying those profiles, or combinations of profiles, that are appropriate for different system users. This information should be shared with the supervisors of MMIS users.	Partially Implemented March 31, 2013	An improved set of profiles has been defined as part of system change (CSR 2556) in the Department's Medicaid Management Information System but has not yet been implemented. Work has been delayed by higher priority projects and staff limitations.

Audit Classification, Report, Year, Number	**Audit Recommendation Text**	**Current Implementation Status and Date**	**Department's Implementation Status Update**
Finding Classification: Deficiency in Internal Control 2009 Single Statewide Financial Audit Published: 2010 Number: 73c	The Department of Health Care Policy and Financing should improve MMIS user access controls by immediately implementing our prior year recommendation and strengthening MMIS' operating system, including: c. Ensuring that profiles or profile combinations that provide escalated system privileges are identified and tightly controlled, including the establishment of compensating controls.	Partially Implemented June 30, 2013	The recommendation remains in progress and is partially implemented. An improved set of profiles has been defined. The access requirements for most Department users with elevated access were validated with their management. The Department's Fiscal Agent has been directed by transmittal to document its profiles, separation of duties and compensating controls and user access on a quarterly basis and to report this to the Department. Responsibilities for ongoing monitoring and controlling of access profiles that provide escalated system privileges have not been determined.

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
Finding Classification: Deficiency in Internal Control 2009 Single Statewide Financial Audit Published: 2010 Number: 73d	The Department of Health Care Policy and Financing should improve MMIS user access controls by immediately implementing our prior year recommendation and strengthening MMIS' operating system, including: d. Periodically reviewing MMIS user access levels for appropriateness and promptly removing access for terminated users, including comparing active MMIS users to termination information contained in the Colorado Personnel and Payroll System and requiring business managers to annually verify the accuracy and relevance of access levels belonging to the MMIS users they supervise.	Partially Implemented June 30, 2013	Medicaid Management Information System (MMIS) user access data is compared each month to data received from the Colorado Personnel and Payroll System and to the mainframe time share operations data. This monthly analysis has been improved and systematized. The Department's Fiscal Agent has been requested to improve the accuracy and effectiveness of its processes for user suspension and revocation. The Fiscal Agent has been directed to review its profiles on a quarterly basis and report to the Department. Responsibilities to require managers to annually verify the accuracy and relevance of access levels of the MMIS users they supervise have not been defined.

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
Finding Classification: Deficiency in Internal Control 2009 Single Statewide Financial Audit Published: 2010 Number: 75	The Department of Health Care Policy and Financing should review its policy that excludes certain procedures from the Medicare lower of pricing logic to assess the appropriateness of these exclusions, particularly related to cost-control strategies for the Medicaid Program. If the Department decides to continue excluding certain procedures from these pricing requirements, the Department should justify in writing the reasons for these exclusions and periodically reassess their appropriateness. Further, the Department should work with the federal Centers for Medicare and Medicaid Services to determine whether an amendment to Colorado's State Medicaid Plan should have been submitted related to these exclusions and whether any of the payments made for claims falling under these exclusions should be recovered.	In Progress March 31, 2013	The Department initiated contact with the federal Centers for Medicare and Medicaid Services on December 20, 2011, in order to determine what, if any, changes are necessary to the State Plan regarding any exemption from Lower of Pricing logic. The Department is still in the process of exploring internally and with its federal partner what language regarding the exception list to the Lower of Pricing logic would be acceptable.

Audit Classification, Report, Year, Number	**Audit Recommendation Text**	**Current Implementation Status and Date**	**Department's Implementation Status Update**
Finding Classification: Deficiency in Internal Control 2009 Single Statewide Financial Audit Published: 2010 Number: 76a	The Department of Health Care Policy and Financing should improve controls to prevent Medicaid payments for service to deceased individuals by: a. Periodically evaluating the effectiveness of methods used to identify payments made for services provided after a client's death and implementing changes to these methods, as necessary.	Partially Implemented To be determined following ACA verification plan. Please see agency comments.	The Social Security Administration (SSA) and Division of Motor Vehicles interfaces have been implemented. These interfaces will allow information matching for any application that is being processed and will identify when a person at the time of application has deceased. However, the Vital Stats project is on hold due to costly transaction fees. The Department is evaluating other options. It is possible the SSA/SVES SCHIP (State Verification Eligibility System State Children's Health Insurance Program) will be a better avenue to prevent payments for services provided to deceased individuals, so the Department will be conducting further research. The research will be undertaken in tandem with the verification plan for the Affordable Care Act and is estimated to be completed by February 2013. From there, the Department will make a decision on how to move forward.

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
Finding Classification: Deficiency in Internal Control 2009 Single Statewide Financial Audit Published: 2010 Number: 79c	The Department of Health Care Policy and Financing should strengthen contract provisions and its monitoring of contractors responsible for performing prior authorization reviews of durable medical equipment and supplies requested for Medicaid clients by: c. Implementing a formal oversight program for each of its prior authorization contractors, including onsite visits.	In Progress December 31, 2012	The new utilization management vendor assumed all prior authorization reviews as of February 1, 2012. The Department did not conduct an on-site readiness review, but is continuing to work to develop a formal oversight process to assure all contract requirements are met. The Department continues to meet with the vendor multiple times per week to communicate expectations and resolve outstanding issues to continue strengthened oversight and vendor accountability.
Finding Classification: Deficiency in Internal Control 2009 Single Statewide Financial Audit Published: 2010 Number: 81b	The Department of Health Care Policy & Financing should ensure a comprehensive and uniform assessment process for determining functional eligibility and the services necessary to address the needs of individuals seeking long-term care services by: b. Modifying State Medicaid Rules to more clearly define how to score functioning when the individual uses an assistive device and making appropriate corresponding changes to the Department' functional assessment tool.	In Progress August 1, 2013	In response to this audit recommendation, the Department has drafted specific guidance for case managers to assist in determining appropriate scoring for individuals who use assistive devices. This guidance is currently in Department clearance. In addition, the Department will also modify State Medicaid Rules to more clearly define how to score functioning when the individual uses an assistive device. The Department does not agree with the recommendation to make changes to the actual assessment tool as guidance is most appropriately offered through policy and regulation.

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
Access to Medicaid Home and Community-Based Long-Term Care Services Published: 2009 Number: 4c	The Department of Health Care Policy & Financing should ensure an effective and coordinated statewide resource development effort for the Single Entry Point System by: c. Taking a more direct and active role in overseeing and coordinating single entry point agencies' resource development efforts. This should include exploring options for designating a staff position within the Community-Based Long-Term Care Section to serve as a Resource Coordinator for the Single Entry Point System.	Implemented December 1, 2012	In addition to developing a Benefits Utilization System-based mechanism for identifying provider resource concerns geographically, the Department's Provider Relations Specialist has offered Single Entry Point (SEP) agencies assistance in mitigating service availability issues. The Department has also modified SEP contracts to allow for the inclusion of additional activities around resource development.

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
Access to Medicaid Home and Community-Based Long-Term Care Services Published: 2009 Number: 5a	The Department of Health Care Policy & Financing should help ensure the future financial sustainability of the State's community-based long-term care programs by taking a more comprehensive and forward-looking approach to managing and analyzing program costs and evaluating available policy options, such as those under the federal Deficit Reduction Act of 2005. To provide a basis for such policy discussions, at a minimum, the Department should: a. Evaluate available cost control measures for HCBS waiver services, including whether individual cost limits should be used as a denial point in the eligibility process or as a maximum cap when authorizing services for HCBS waiver clients.	Implemented November 15, 2012	The Department has completed a review of the available cost control measures for Home and Community Based Services (HCBS), including whether individual cost limits should be used as a denial point in the eligibility process or as a maximum cap when authorizing services for HCBS waiver clients. While a waiver may be managed in the "aggregate" to assure cost-neutrality or achieve a targeted level of expenditures per waiver participant, entrance determinations must be made on an individual basis. The Centers for Medicare and Medicaid Services (CMS) allow states to limit participation in a waiver based on an individual cost limit. The individual cost limit is specified in relationship to the costs of the institutional services at the level of care that a person requires. In the federally approved waiver application there are four options for implementing individual cost limits. The Department has chosen to implement the Cost Limit Lower than Institutional Services option in the Supported Living Services, Children with Autism and Children's Extensive Support waivers. Additionally, requests for services that exceed $250 per day are required to be submitted to the Department for approval.

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
Access to Medicaid Home and Community-Based Long-Term Care Services Published: 2009 Number: 5b	The Department of Health Care Policy & Financing should help ensure the future financial sustainability of the State's community-based long-term care programs by taking a more comprehensive and forward-looking approach to managing and analyzing program costs and evaluating available policy options, such as those under the federal Deficit Reduction Act of 2005. To provide a basis for such policy discussions, at a minimum, the Department should: b. Examine how expanded availability of HCBS waiver services has affected the demand for long-term care services and, therefore, overall program costs.	Implemented November 30, 2012	The Department has reviewed leading industry research regarding the correlation between the expansion of community-based services and overall Medicaid costs. By reviewing national data, the Department was able to garner a broad and statistically sound analysis of the issue. In short, the preponderance of research suggests a short-term increase in spending associated with community-based services followed by a reduction in institutional spending and long-term cost savings. Largely, the research indicates that mature home and community based programs save states money.

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
Access to Medicaid Home and Community-Based Long-Term Care Services Published: 2009 Number: 5c	The Department of Health Care Policy & Financing should help ensure the future financial sustainability of the State's community-based long-term care programs by taking a more comprehensive and forward-looking approach to managing and analyzing program costs and evaluating available policy options, such as those under the federal Deficit Reduction Act of 2005. To provide a basis for such policy discussions, at a minimum, the Department should: c. Analyze functional assessment data to identify the underlying factors driving the need for long-term care services and how these factors may differ between the HCBS waiver and nursing facility populations.	Implemented December 1, 2012	A study of functional assessment data was completed in December 2011. The Department's current functional assessment tool, the ULTC 100.2, captures information on six functional areas: bathing, toiletry, mobility, transfer, eating, and dressing. Home and Community Based Services waiver clients score notably lower than nursing facility clients in bathing, toiletry and dressing. The Department has only one tool, the ULTC 100.2 that captures functional data. This tool is outdated and not integrated with Medicaid financial claims data causing a gap between functional and cost data. A new fully integrated tool that includes robust data is needed to take a more comprehensive and forward-looking approach to managing and analyzing long term care program costs.

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
Access to Medicaid Home and Community-Based Long-Term Care Services Published: 2009 Number: 5d	The Department of Health Care Policy & Financing should help ensure the future financial sustainability of the State's community-based long-term care programs by taking a more comprehensive and forward-looking approach to managing and analyzing program costs and evaluating available policy options, such as those under the federal Deficit Reduction Act of 2005. To provide a basis for such policy discussions, at a minimum, the Department should: d. Identify the extent to which HCBS waiver clients access other public outlays of non-Medicaid benefits and the cost of these other services to determine the true cost of serving long-term care clients in the community versus in a nursing facility.	Partially Implemented March 31, 2013	The Department is working with our sister agency, Department of Human Services (DHS) to obtain the cost of other public outlays of non-Medicaid benefits for Medicaid Home and Community Based Services (HCBS) waiver clients. Food stamps and adult financial assistance have been identified as some of the non-Medicaid programs that HCBS waiver clients utilize. The Department will provide the waiver client information and DHS will provide the cost information, as the administrator of those programs. Once that information is gathered, the Department will do the cost comparison with nursing facility care.

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
Access to Medicaid Home and Community-Based Long-Term Care Services Published: 2009 Number: 7c	The Department of Health Care Policy & Financing should ensure that HCBS waiver service units authorized in the Medicaid Management Information System better align with clients' needs and utilization by: c. Streamlining the prior authorization process for HCBS waiver services to make it more efficient and less cumbersome for the single entry point agencies. This should include exploring options for single entry point agencies to electronically submit prior authorization requests directly to the Department's Medicaid Fiscal Agent.	Implemented	The Department's Medicaid Management Information System (MMIS) cannot currently accept electronically submitted Prior Authorizations from the Single Entry Points. The Department is reprocuring a replacement MMIS and has included this requirement into the Request for Proposals (RFP). As of October 2011, the Department implemented and continues to operate a portal-based prior authorization request (PAR) development tool for clients receiving Home and Community Based Services with the Consumer Directed Attendant Support Services benefit. This process represents a significant improvement over the approach taken at the time of this finding.

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
Access to Medicaid Home and Community-Based Long-Term Care Services Published: 2009 Number: 10a	The Department of Health Care Policy & Financing should ensure consistent practices among Single Entry Point agencies system wide for the day-to-day administration of Colorado's long-term care program by: a. Issuing a written policy and procedure manual for single entry point agencies and updating the manual on a routine basis.	Implemented December 1, 2012	The Single Entry Point (SEP) Policy and Procedures Manual has been circulated to the SEP agency contractors and will be updated on a routine basis.

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
Implementation of the Medicaid Pediatric Hospice Waiver Published: 2011 Number: 1a	The Department should strengthen care planning for children in the Pediatric Hospice Waiver program to ensure that SEP case managers are identifying and documenting all of a child's waiver service needs. This should include: a. Providing clear, written direction to SEP agencies on care planning, including comprehensive definitions of how Palliative/ Supportive Care waiver services are different from similar services under the standard Medicaid program and a requirement that SEP case managers obtain and use the input of both palliative and curative service providers to assess a child's service needs, plan services to address the needs, and determine the proper source for each service.	Partially Implemented July 1, 2013	The Department and stakeholders have clearly defined services that need to be approved by the Centers for Medicare and Medicaid Services (CMS). Service definition changes require waiver amendment and rule changes. The Department anticipates these to be done and submitted late summer 2012. The rules will be submitted to the Medical Service Board as soon as CMS and the Department have approved both the waiver amendment and proposed rules. Because an understanding of the services is integral to appropriate care planning, and because guidance on care planning cannot be issued until the services are finalized, this recommendation has not been fully implemented yet.

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
Implementation of the Medicaid Pediatric Hospice Waiver Published: 2011 Number: 1b	The Department should strengthen care planning for children in the Pediatric Hospice Waiver program to ensure that SEP case managers are identifying and documenting all of a child's waiver service needs. This should include: b. Providing training on what specific services may be offered under the Palliative/Supportive Care waiver service category. The training should cover the comprehensive definitions of how these waiver services are different from similar services offered through the standard Medicaid program recommended in Part "a," above.	Partially Implemented July 1, 2013	Per the reasons described in recommendation 1a, this recommendation has not been implemented yet. The Department will be able to offer training to single entry points on revised service definitions and care planning for this waiver by July 2013.

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
Implementation of the Medicaid Pediatric Hospice Waiver Published: 2011 Number: 1c	The Department should strengthen care planning for children in the Pediatric Hospice Waiver program to ensure that SEP case managers are identifying and documenting all of a child's waiver service needs. This should include: c. Enforcing federal and state care planning requirements that are in place to ensure that the services a child receives are based on need and are coordinated among resource options to avoid gaps or overlaps in service provision. This should include using the newly implemented review and monitoring process. The Department's review and monitoring processes should ensure that SEP case managers are determining the waiver service needs of enrolled children rather than fully delegating this responsibility to waiver providers; documenting service needs when a provider is not available; and basing the care plan on the child's needs rather than on provider availability.	Partially Implemented July 1, 2013	Per the reasons described in recommendations 1a and 1b, this recommendation has not been implemented yet. In the care planning training to be offered to single entry points (SEPs) by July 2013, the Department will ensure that SEPs understand that care planning must be based on the assessed needs of the client not provider availability, that service plans should be done in collaboration with service providers (not fully delegated to them, but not done in a vacuum either), and that the client's needs should be documented regardless of whether a provider is available. This will be monitored in part through use of the Program Review Tool described in the original responses.

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
Implementation of the Medicaid Pediatric Hospice Waiver Published: 2011 Number: 2b	The Department should increase resource development efforts to help ensure there is an adequate pool of providers for the Pediatric Hospice Waiver program by: b. Reevaluating and changing, if warranted, the current limitations placed on who can become a waiver service provider. This should include an evaluation of whether qualified providers who are not employed by a hospice or home health agency can be enlisted to provide services within the broad Palliative/Supportive Care service category. This should also include assessing whether the requirement that all waiver providers must apply separately for both a Medicaid Provider ID number and a Pediatric Hospice Waiver Provider ID number can be streamlined to require potential providers to go through only one, rather than two, approval processes.	Partially Implemented July 1, 2013	The Department and stakeholder group have discussed the provider qualifications for these services. Both the Department staff and stakeholders felt it was important to limit the provider type for Palliative/Supportive Care services to hospice or home health agencies. The group felt this was important due to the level of care the providers will need to provide to the children for this service. The care is very specialized and requires specific training that only a hospice or home health agency can provide. Provider qualifications for other services have also been reviewed and it was decided that those services would not be limited to hospice and home health providers with hopes of increasing the provider pool for other services. This has not been fully implemented as the newly defined services that include provider qualifications will need to be approved by the Centers for Medicare and Medicaid Services (CMS) and rule changes presented to the Medical Services Board. The provider process for the Pediatric Hospice Waiver is the same as the process for all other waivers. All providers are required to complete an application with the Department and the Department of Public Health and Environment.

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
Implementation of the Medicaid Pediatric Hospice Waiver Published: 2011 Number: 3a	The Department should make improvements to the Pediatric Hospice Waiver program to ensure that families receive bereavement counseling that can continue after the enrolled child has died by: a. Establishing a tracking mechanism to ensure that the Department can differentiate bereavement counseling services from other waiver services, including other counseling services. To accomplish this, the Department should consider making bereavement counseling a separate waiver service category with separate service limitations from the general Counseling waiver service category.	Partially Implemented July 1, 2013	The Department plans to separate post-death bereavement services from anticipatory grief and psychosocial counseling services provided to the client/family while the client is living. This will allow the Department to track this service.

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
Implementation of the Medicaid Pediatric Hospice Waiver Published: 2011 Number: 3b	The Department should make improvements to the Pediatric Hospice Waiver program to ensure that families receive bereavement counseling that can continue after the enrolled child has died by: b. Providing guidance to SEP agencies on how to identify the need for bereavement services in care plans. This guidance should include the requirement that a bereavement plan of care be initiated prior to an enrolled child's death.	Partially Implemented July 1, 2013	As described above in recommendation 3a, once the services and benefit structure has been finalized (including bereavement), the Department will provide training to the Single Entry Points on all aspects of this waiver, including care planning and how to include bereavement services on the care plan when applicable.

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
Implementation of the Medicaid Pediatric Hospice Waiver Program Published: 2011 Number: 4	The Department should evaluate whether revising the design of the Pediatric Hospice Waiver program is warranted to improve the program and ensure enrolled children are able to access needed services. Specifically, the Department should address the problems identified in this report with respect to care planning and access to providers, and use utilization data to determine whether changes should be made to the current frequency requirement or waiver service categories. If the Department chooses to change the frequency requirement or include case management or another service as a waiver service, the Department should submit a waiver application amendment reflecting these changes to the CMS for approval. Regardless of changes to the frequency requirement or waiver services, the Department should enforce the requirements it establishes regarding the frequency of service provision and disenrollment of children who are no longer eligible for the program.	Partially Implemented July 1, 2013	The Department has evaluated the design of the waiver and plans to implement changes to the benefit structure, provide clarifying guidance on client eligibility requirements, and evaluate the reimbursement rate methodologies and provider enrolment processes. The Department has also reevaluated the service frequency requirement for this waiver and maintains that the frequency requirement of at least one wavier service every thirty days is appropriate. Once the revised services are finalized, the Department will conduct Single Entry Point trainings on the waiver including detailed explanations of the services available and frequency requirements. The Department will also be focusing on provider recruitment and ensuring that client level-of-care eligibility criteria are clarified and enforced to ensure that appropriate clients are being approved for the waiver and have access to the needed services, eliminating the concern that clients could be removed from the waiver if service frequency requirements cannot be met due to provider scarcity.

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
Medicaid Eligibility Status for Adult Civil Patients at the Colorado Mental Health Institutes Published: 2012 Number: 1a	The Department should develop controls to ensure that Medicaid does not pay any claims for Fort Logan or Pueblo Institute patients who fall under the federal IMD exclusion. Specifically, HCPF should: a. Work with CDHS to develop a process for receiving data on the dates of admission and discharge for Medicaid-eligible clients, regardless of age, who are inpatients at the Fort Logan and Pueblo Institutes.	Implemented July 1, 2012	The Department began processing mental health institute patient admission/discharge files submitted by the Department of Human Services (DHS) on July 1, 2012. In addition, the Department's Program Integrity Section is maintaining a database containing admission and discharge information from the Fort Logan and Pueblo mental health institutes. This database contains historical data from DHS to the present and is updated on a routine basis.

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
Medicaid Eligibility Status for Adult Civil Patients at the Colorado Mental Health Institutes Published: 2012 Number: 1b	The Department should develop controls to ensure that Medicaid does not pay any claims for Fort Logan or Pueblo Institute patients who fall under the federal IMD exclusion. Specifically, HCPF should: b. Use the patient information obtained through part a to develop a process for identifying and denying, or flagging for further investigation, all Medicaid claims, including capitation payments, for IMD-excluded patients. Additionally, HCPF should pursue a long-term solution as part of the MMIS reprocurement.	Implemented July 1, 2012	The Department began processing mental health institute patient admission/discharge files submitted by the Department of Human Services (DHS) on July 1, 2012 and updates information in the current Medicaid Management Information System (MMIS) to prevent the payment of capitation amounts for clients in the institutions for mental diseases. In addition, the Department has included this requirement in the reprocurement of the MMIS. The MMIS implementation remains on track and therefore, the Department will not update this audit recommendation further as the recommendation has been meet by including the requirement in the reprocurement.

Audit Classification, Report, Year, Number	Audit Recommendation Text	Current Implementation Status and Date	Department's Implementation Status Update
Medicaid Eligibility Status for Adult Civil Patients at the Colorado Mental Health Institutes Published: 2012 Number: 1c	The Department should develop controls to ensure that Medicaid does not pay any claims for Fort Logan or Pueblo Institute patients who fall under the federal IMD exclusion. Specifically, HCPF should: c. Use the patient information obtained through part a to develop a routine process for identifying and reviewing for appropriateness all claims paid for Medicaid clients, regardless of age, who were inpatients at the Fort Logan or Pueblo Institute on the date of service.	Partially Implemented June 2013	The Department's Program Integrity Section is conducting data monitoring for fee-for-service claims paid when clients are institutionalized in the mental health institutes. Using data provided by the Department of Human Services (DHS), The Department's Program Integrity Section and policy staff are analyzing any paid claims for proper recovery actions. In addition, the Department's Rates and Analysis Division will include the federal institution for mental diseases (IMD) capitation recovery in its annual behavioral health organization (BHO) capitation reconciliation process. In the next BHO capitation reconciliation cycle starting January 2013, the Division will recover all capitations paid to IMD clients in FY 2010-11 and will be completed by June 2013.

FY 2011-12 Home Health, Private Duty Nursing, and HCBS Personal Care Costs
Paid dates from July 1, 2011 to June 30, 2012

Acute Home Health							
Description	**Discipline**	**Reimbursed Amount**	**Reimbursed Units**	**Client Count**	**Unit Measure**	**Total Visits/Hours**	**Visits/Hrs per Capita**
Skilled Nursing Visit	RN/LPN	$8,627,254	93,874	4,985	1 Visit	93,874	18.83
Home Health Aide - Basic	HH Aide	$3,981,027	120,356	1,643	1 Hour	120,356	73.25
Home Health Aide - Extended	HH Aide	$1,269,917	128,533	780	15-30 Minutes*	32,133 - 64,267	41.20 - 82.39
Physical Therapy	PT	$2,481,475	24,695	2,945	1 Visit	24,695	8.39
Occupational Therapy	OT	$977,677	9,680	1,714	1 Visit	9,680	5.65
Speech Pathology	ST	$405,505	3,757	543	1 Visit	3,757	6.92
RN Assess and Teach	RN	$6,353	68	63	1 Visit	68	1.08

**Unit measures with an asterisk denote that the unit represents a possible range of values. The minimum and maximum of the range is represented in the total visit/hours and the visit/hours per capita.*

Long-Term Home Health							
Description	**Discipline**	**Reimbursed Amount**	**Reimbursed Units**	**Client Count**	**Unit Measure**	**Result in Visits/Hours**	**Visits/Hrs per Capita**
Home Health Aide - Basic	HH Aide	$73,088,477	2,204,517	3,998	1 Hour	2,204,517	551.40
Home Health Aide - Extended	HH Aide	$37,825,586	3,817,173	2,545	15-30 Minutes*	954,293 - 1,908,587	374.97 - 749.94
Skilled Nursing Visit	RN/LPN	$21,937,994	235,508	4,497	1 Visit	235,508	52.37
RN Brief Visit - 1st of Day	RN	$5,154,767	79,141	531	1 Visit	79,141	149.04
Physical Therapy	PT	$3,613,226	35,908	1,046	1 Visit	35,908	34.33
Occupational Therapy	OT	$3,391,968	33,615	1,069	1 Visit	33,615	31.45
Speech Pathology	ST	$3,374,158	30,779	961	1 Visit	30,779	32.03
RN Brief Visit - 2nd or Greater	RN	$2,767,782	60,681	247	1 Visit	60,681	245.67

**Unit measures with an asterisk denote that the unit represents a possible range of values. The minimum and maximum of the range is represented in the total visit/hours and the visit/hours per capita.*

Acute or Long-Term Home Health							
Description	**Discipline**	**Reimbursed Amount**	**Reimbursed Units**	**Client Count**	**Unit Measure**	**Result in Visits/Hours**	**Visits/Hrs per Capita**
Occupational Therapy Evaluation	OT	$53,461.92	520	485	1 - 2 Visits*	520 - 1040	1.07 - 2.14
Physical Therapy Evaluation	PT	$13,278.68	130	115	1 - 2 Visits*	130 - 260	1.13 - 2.26

**Unit measures with an asterisk denote that the unit represents a possible range of values. The minimum and maximum of the range is represented in the total visit/hours and the visit/hours per capita.*

Private Duty Nursing							
Description	**Discipline**	**Reimbursed Amount**	**Reimbursed Units**	**Client Count**	**Unit Measure**	**Result in Visits/Hours**	**Hours per Capita**
Skilled Nursing Visit	RN	$19,816,985	538,495	262	1 Hour	538,495	2,055.32
Skilled Nursing Visit	LPN	$7,074,364	255,458	186	1 Hour	255,458	1,373.43
Home Health - Other Visit - RN	RN	$2,087,940	75,339	20	1 Hour	75,339	3,766.95
Home Health - Hourly - LPN/RN	RN/LPN	$1,548,015	55,956	24	1 Hour	55,956	2,331.50
Home Health - Other Visit - LPN	LPN	$616,850	29,004	14	1 Hour	29,004	2,071.71

Home- and Community-Based Services							
Description	**Discipline**	**Reimbursed Amount**	**Reimbursed Units**	**Client Count**	**Unit Measure**	**Result in Visits/Hours**	**Hours per Capita**
Personal Care	Unskilled	$90,545,932	26,102,943	12,283	15 Minutes	6,735,005	548.32

Colorado Department of Health Care Policy & Financing





Joint Budget Committee Hearing

January 7, 2013

Hearing Agenda

- Previous Briefings
  - Substance Use Disorder R-7 (from Mental Health Briefing)
  - MMIS Reprocurement R-5 (from Governor's Office Briefing)
- Cost Containment Strategies
- Medicaid Expansion
- Accountable Care Collaborative
- Payment Reform
- Issue Briefings
  - Dental Requests R-8, R-9
  - Changes to Pharmacy Reimbursement
  - Long Term Supports and Services
  - Provider Rates R-11
  - Administrative Staff/Additional FTE R-6
- Unemployment and Medicaid

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Addendum Questions	
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2. Please provide the number of units provided in the last fiscal year by discipline, in either visits or hours, for home health, private duty nursing and home and community based services programs. These disciplines include RN visits, PT visits, OT visits, speech therapy visits, home health aide visits by time, personal care provider hours, and private duty nursing and RN and LPN hours.	126

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R-7 | Substance Use Disorder Benefit

Improving the behavioral health system

- Current behavioral health system is fragmented and difficult to navigate
- Existing limitations on services restrict clients' access to effective and comprehensive treatment plans

Better coordination will support recovery and improve overall health

- Coordinated request between the Department and Department of Human Services
- States with coordinated substance use disorder benefits have seen improved health and reductions in ER visits, hospitalizations, and complications
- Eliminate/modify some caps on services and add some new clinically effective treatment options

Utilizing the expertise of Behavioral Health Organizations (BHOs) to integrate services

- BHOs already provide substance use disorder and mental health services to clients with co-occurring conditions
- Research shows a high percentage of substance abusers have mental health conditions
- Treating both conditions together is much more clinically effective than treating clients in health care silos

FY 2013-14 Request:
General Fund: $1,818,130
Total Funds: $5,788,068

1. **More individuals are projected to be covered by Medicaid in the coming years due to the passage of the insurance requirement in the federal Affordable Care Act. Does the Department anticipate that the new enrollees will be more likely than existing enrollees to require behavioral health services? Does the Department anticipate that the new enrollees will have a higher per capita cost than existing enrollees?**

   RESPONSE:

   If the State were to expand Medicaid eligibility for parents and Adults without Dependent Children (AwDC) beyond current categories, the Department does not anticipate that the new enrollees would be more likely to require behavioral services or have a higher per capita cost than existing enrollees. For the most recent expansion of Medicaid Parents from 60% of the federal poverty level (FPL) to 100% FPL, the behavioral health capitation rates for the expansion group were the same as those for the lower income parent categories. The Department anticipates that this would also likely be the case if eligibility for Medicaid Parents were to be further expanded. For Adults without Dependent Children (AwDC) with income at or below 10% FPL, the behavioral health capitation rates are between the existing low-income adult and disabled rates. If AwDC eligibility were to be expanded, the Department believes that the per capita cost may decrease as the higher income individuals are likely to be relatively healthier.

2. **The Department proposes shifting the current Medicaid substance use disorder benefit from a fee-for-service model to a managed care model. Why does the Department propose that the Behavioral Health Organizations (BHOs) should manage the benefit rather than the Managed Service Organizations (MSOs) that already administer the non-Medicaid substance use disorder program for the Department of Human Services?**

   RESPONSE:

   The Department proposes that the Behavioral Health Organizations (BHOs) should manage the Substance Use Disorder (SUD) benefits for a number of reasons. Moving the SUD services into the BHO contract addresses the importance of providing integrated services and does so in a way that is administratively feasible, effective and efficient. The inclusion of these services into the BHO contract is an important and logical step toward improving Colorado Medicaid's behavioral health system as a whole.

   On both national and local levels, health care is moving towards integration and coordination of services. Integration efforts focus not only on integration of mental health and substance use disorder services into the comprehensive behavioral health system, but also on integrating behavioral health services with physical health care. Integrating SUD services into the BHO contract ensures that Colorado Medicaid's policy is aligned with national trends and best practices.

   Integrating SUD services will also eliminate the need to create yet another siloed managed care entity or "carve out" and will help ensure that we provide more seamless and coordinated care for our clients. Research has shown that a high percentage of clients with mental health

conditions have a co-occurring substance use disorder. Similarly, many individuals with a substance use disorder have an undiagnosed mental health condition. Providing integrated treatment for these co-occurring conditions is significantly more effective than treating each in isolation. By integrating SUD services into the BHO contract, treatment may be provided to the whole person in one delivery system, maximizing treatment outcomes, as well as improving our clients' experience of care.

In addition to supporting the goal of integration, moving the full SUD benefit into the BHO contract makes sense from an administrative perspective. and are familiar with the provision of these services. The BHOs' main providers, Community Mental Health Centers (CMHCs), are all certified SUD services providers, and the Department is confident that BHOs could assume this scope of work and expand their contracting to include other SUD providers. BHOs have also been working on integration with physical health services, so it makes sense to align integration of mental health and SUD treatment with these efforts.

Finally, integration makes sense in terms of the Department's contracting and systems capabilities. The Department is currently under contract with the BHOs, so adding the SUD services into the BHO contract scope of work avoids a costly/lengthy procurement process. Technical systems are already set up to process BHO encounter data and can easily be revised to include SUD services. The Department is also working on a Request for Proposals (RFP) for the new behavioral health services contract for FY 2013-14. This RFP will include a strong focus on integration of not only mental health and SUD services, but physical health services, as well. MSOs and SUD providers are actively involved in the RFP stakeholder engagement process for the rebid, and the Department will encourage all qualified MSOs and behavioral health organizations to bid on the new scope of work.

3. If the Department's request to enhance the existing substance use disorder through the expansion of existing services and the addition of new services is funded, how will the savings in other areas of the budget (e.g. physical health care) be tracked?

RESPONSE:

If the request is approved, the Department would account for any savings through future budget requests for Medical Services Premiums and Medicaid Community Mental Health Programs.

It is not clear if the Department will be able to identify savings specifically attributable to an enhanced substance use disorder treatment benefit. In its November 2010 performance audit on the existing Medicaid outpatient substance use disorder treatment benefit, the Office of the State Auditor found that it was not "…able to determine whether the reduction in medical costs was the direct result of, or 'caused by,' Substance Abuse Benefit services provided to clients" (emphasis original). This finding was in part because state databases, including the Department's Medicaid Management Information System (MMIS) and information available from the Department of Human Services, were not designed "…to collect data on underlying factors impacting clients' medical costs for research or experimental studies." As a result, the Office of the State Auditor was not able to establish a causal relationship between the benefit and reductions in cost.

As was the case at the time of the performance audit, the Department does not have access to the needed information that would allow for this type of analysis, and as a result, the Department may not be able to specifically attribute savings to an enhanced substance use disorder treatment benefit. However, if savings do occur, they would lead to a lower request for Medical Services Premiums in future years.

The Office of the State Auditor did perform a number of additional analyses to examine cost trends for clients who used the existing substance use disorder benefit, and found "…the trends in medical costs for clients who utilized the Medicaid Substance Abuse Benefit are promising and indicate that the benefit may have a positive impact." The Department would be able to perform similar analyses in the future to examine if there was evidence of savings, even if a causal relationship cannot be established.

The Department believes that the implementation of an expanded benefit in a managed care delivery model – specifically, the state's Behavioral Health Organizations – has the potential to provide for better data that may allow for a causal relationship to be established in the future. The Department, in conjunction with its Statewide Data and Analytics Contractor (SDAC), which is primarily focused on analysis related to the Accountable Care Collaborative, are collaborating on finding ways to better measure the impact of programmatic changes. The results to date have been positive; the Department's response to the November 1, 2012 Legislative Request for Information #6, discussing the results of the Accountable Care Collaborative, would not have been possible without the statistical and technical help of the SDAC. If this request is approved, the Department fully intends to evaluate and analyze utilization of services of clients accessing SUD to determine impacts on client's overall health outcomes and utilization, and incorporate any savings achieved in a future budget request.

4. Does the Department have any preliminary projections for future cost savings in other areas of the budget (e.g. physical health care) if the request is funded?

RESPONSE:

The Department did not include a savings estimate as part of its request. As described in the Department's response to question 3, in the most recent performance audit of the current program, the Office of the State Auditor was unable to determine whether the reduction in costs was a result of the treatment or other factors. Therefore, the Department did not believe that it would be appropriate to prospectively include a savings estimate in the request.

However, the Department believes that providing treatment greatly improves the overall health of the client as it reduces clients' risks for a variety of health conditions and accidents and could therefore reduce costs. This view is supported by research from the National Center for Addiction and Substance Abuse at Columbia University, which has found that untreated addiction alone causes or contributes to more than 70 other diseases requiring hospitalization. In Washington, substance use disorder treatment was shown to save $311 per month in medical costs for Medicaid members. In California, substance use disorder treatment reduced ER visits by 39%, hospital stays by 35% and total medical costs by 26% (Substance Abuse and Mental Health Services Administration (SAMHSA)). Further, beyond direct health outcomes, research by the National Center for Addiction and Substance Abuse at Columbia University has found that health-related costs represent only 26 cents of every dollar spent on substance use disorder. The other 74 cents goes to the justice system, education, child/family services and other

costs. By providing appropriate and sufficient treatment to individuals with substance use disorders, the overall burden to State government for related costs may be reduced.

Therefore, while the Department has not provided a preliminary savings estimate in the request, the Department is hopeful that the request will lead to lower costs and better outcomes in the future. As noted in the Department's response to question 3, the Department is optimistic that it will be able to provide a more detailed assessment of savings in the future.

5. **The Department has implemented Regional Care Collaborative Organizations (RCCOs) to connect Medicaid enrollees with providers offering services to Medicaid enrollees and to provide improved communication mechanisms to better coordinate care. If the Department's funding request for the substance use disorder benefit is granted and implemented as part of the BHO contracts, what impact (if any) will it have on the integration of behavioral health services and physical health services as it relates to the RCCOs?**

   RESPONSE:

   Including the current fee for service substance use disorder (SUD) benefit in the Behavioral Health Organization (BHO) contracts will positively impact the Accountable Care Collaborative (ACC) program and support current Department efforts to further integrate behavioral health and physical health care services. The Regional Care Collaborative Organizations (RCCOs) continue to increase their focus on achieving integrated care, and moving all behavioral health services under the BHO contracts will further promote their ability to effectively coordinate services and impact integrated service delivery for their members.

   Over the past several years the Department has placed progressively greater emphasis on the integration of behavioral and physical health care services in Medicaid. Prior to the development of the ACC program, the BHOs were responsible for helping clients obtain a focal point of physical health care and coordinating mental health care with other health care services. Over time, the BHOs have pursued additional initiatives focused on integrated care. These integration strategies include co-located behavioral health care in primary care clinics, information sharing and consultation to facilitate better integrated care, and embedded physical care services in behavioral health provider sites.

   Under the ACC, the BHOs have continued to make progress in the integration of care by actively working with the RCCOs to integrate behavioral health care with Primary Care Medical Providers (PCMPs), who serve as medical homes for ACC members. Moving forward, the Department is currently developing the next Request for Proposals (RFP) for the behavioral health services contracts to begin in FY 2013-14. The RFP will include a continued strong focus on integration of behavioral health and physical health services, incorporating a number of new requirements in this area. The new integration requirements will help inform the Department and its BHO and RCCO partners on the most effective ways to further integrate behavioral health and physical health care. Integrating SUD and mental health services in a more robust way under the BHO contract is a significant step towards continuing to build a strong relationship between the behavioral health system and physical health care and towards the Department's long-term goal of a fully integrated health care delivery system.

9) More individuals are projected to be covered by Medicaid in the coming years due to the passage of the insurance requirement in the federal Affordable Care Act. Does the Department anticipate that the new enrollees will be more likely than existing enrollees to require behavioral health services? Does the Department anticipate that the new enrollees will have a higher per capita cost than existing enrollees?

RESPONSE:

If the State were to expand Medicaid eligibility for parents and adults without dependent children beyond current categories, the Department does not anticipate the new enrollees would be more likely to require behavioral services or have a higher per capita cost than existing enrollees. For the most recent expansion of Medicaid parents from 60% of the federal poverty level (FPL) to 100% FPL, the behavioral health capitation rates for the expansion group were the same as those for the lower-income parent categories. The Department anticipates this would also likely be the case if eligibility for Medicaid parents were to be further expanded. For Adults without Dependent Children (AwDC) with income at or below 10% FPL, the behavioral health capitation rates are between those for existing low-income adult and disabled individuals.

Academic research indicates that, among low-income populations, there is a negative correlation between income and health care cost. Recent analysis performed by The Urban Institute indicates that adults currently eligible for Medicaid are more expensive than those who would be newly eligible for Medicaid under the ACA expansion to 133% FPL.[1]

10) What have other states experienced with per capita mental health costs when Medicaid eligibility is increased?

RESPONSE:

The Department has been unable to obtain enough information to provide a useful comparison of other states' experience with per capita mental health costs during periods of Medicaid eligibility expansions; the Department does not believe that such information is readily available in published documents from other states. In order to accurately compare Colorado's Medicaid mental health costs to those for other states, additional resources would be needed to hire a contractor to research states' per capita mental health costs. Each state offers a unique Medicaid program and corresponding mental health program where components such as the services covered, the type of program through which services are provided (i.e., fee-for-service, managed care, etc.), and the risk profile of the eligible and newly eligible enrollees varies. Therefore, the impact from expansions experienced in other states can vary based on the unique characteristics of the states and their Medicaid mental health programs.

[1] John Holahan, Matthew Buettgens, Caitlin Carroll, and Stan Dorn, *The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis*, The Urban Institute, November 2012.

R-5 | Rebuilding the Medicaid Management Information System

The MMIS primary function is to pay providers

- In FY 2011-12, the MMIS processed millions of claims totaling over $3.5 billion
- Also enrolls providers, completes client management functions, and is used for analytics and reporting

Source: http://www.computersciencelab.com/ComputerHistor

(1970's computer mainframe)

Current system is outdated and workarounds are unsustainable

- Based on 1970's general mainframe design
- System changes (from initiatives, federal mandates, legislation) are costly and take years to complete

A Medicaid payment system for the 21st century

- Dramatically faster system changes leading to quicker implementation of legislation and Department initiatives
- Lower costs for system changes
- More user-friendly interfaces for Medicaid providers
- An interface linking the Colorado Benefits Management System (CBMS), the state's accounting system (COFRS), and the Department's long term case management system (BUS)

Four year investment

- 90% federal match on build with 75% federal match for ongoing maintenance
- Rebuild will be split over four fiscal years ending in FY 2016-17

FY 2013-14 Request:
General Fund: $1,439,072
Total Funds: $15,624,403

23. Please describe the roles and responsibilities of the Department of Health Care Policy and Financing and the Governor's Office of Information Technology in the reprocurement of MMIS and the overall management of MMIS during the implementation and operational phases.

The Department collaborates with OIT on many Information Technology (IT) projects, including service contracts that use supporting IT systems such as the upcoming new MMIS and Fiscal Agent Services contract. In fact, IT Security personnel from OIT were involved in writing the cyber security requirements for the MMIS and Fiscal Agent Services solicitation and have been asked to review two drafts of the solicitation. Also, the Department has requested for OIT to provide staff to join the Evaluation Committee for this solicitation. Furthermore, reprocurement staff at the Department regularly participate in the OIT Project Managers Users Group and provide monthly updates on the MMIS reprocurement project to OIT's Executive Governance Committee and respond to their questions. Lastly, the Department and the MMIS and Fiscal Agent Operations Services vendor will work with OIT as required to ensure successful interfacing of the MMIS with necessary systems maintained by OIT such as CBMS.

Besides collaborating with OIT on the project, the Department is also soliciting an Independent Verification and Validation (IV&V) vendor, which is essentially an IT project "auditor" that will follow well-defined standards for scrutinizing the organizational, management, and technical IT aspects of the MMIS and Fiscal Agent Services reprocurement. The IV&V vendor will be independent of both the Department and the MMIS and Fiscal Agent Services vendor and will verify adherence to industry standards and best practices, identify risks, and make recommendations for corrective action when appropriate. The Centers for Medicare and Medicaid Services (CMS) requires an IV&V vendor for the reprocurement and has emphasized to the Department the value that such a vendor will bring to the project.

While the Department is utilizing the expertise and assistance of OIT and an IV&V vendor for this reprocurement, due to the federal guidance discussed in response to Question #24, the Department is ultimately responsible for drafting the solicitation and contract for the MMIS and Fiscal Agent Operations Services vendor. Also, during the implementation and operational phases of the contract, the Department is held solely responsible by CMS for the overall management of the MMIS and its related systems.

The Department does not view the MMIS and Fiscal Agent Services contract as an IT contract, but rather as a service contract with an IT infrastructure that the vendor brings under the contract to support that service. The MMIS and Fiscal Agent Operations Services solicitation does not contain system specifications or IT language, but rather describes a service needed to administer the Medicaid program. The vendor will propose a solution that will assist in providing that service. A majority of the annual operating expenses under the contract is for Fiscal Agent Operations Services, which includes claims processing and provider support services. In this context, claims processing is defined as support of the Department's claims receipt, entry, and reporting processes and the use of industry standard and Department-specific claim forms. Provider support services for the Colorado Medical Assistance Provider community include, but are not limited to, communication on Medical Assistance program, training, and provider management services.

24. Do federal regulations and/or rules exist that would preclude the Governor's Office of Information Technology from participating in the reprocurement of MMIS and the overall management of MMIS during the implementation and operational phases? If so, please discuss the

exact federal rules and regulations that govern the participation of agencies outside of the Department of Health Care Policy and Financing in MMIS implementation and operation.

The Department often consults with OIT regarding IT matters, however, CMS regulations and guidance have made clear that the Department, as the single state agency for the Medicaid program (see section 25.5-4-104 (1), C.R.S. (2012)), must oversee the MMIS and Fiscal Agent Services contract. As the single state agency, the Department *"…must not be impaired if any of its rules, regulations, or decisions are subject to review, clearance, or similar action by other offices or agencies of the state"* (42 C.F.R. §431.10 (e)(2)). In guidance from CMS dated January 15, 2009 (attached), CMS states that the MMIS must be "…under the direct control of the single state Medicaid agency and the state Medicaid Director" or else the enhanced federal funding (90% federal financial participation for MMIS development work and 75% federal financial participation for operations) is not available. Therefore, based on the position of CMS, the MMIS and related Medicaid systems and their operations remain under the control of the Department.

25. Please explain the certification process. Is the current MMIS vendor certified? If so, what advantages does this bring to the process? If not, how does this detract from the process?

CMS completes an MMIS certification review process defined in detail in Section 11240 of the State Medicaid Manual (SMM) for a new MMIS. This process includes a preliminary evaluation by CMS of system documentation, an onsite observation of ongoing operations, and a post-site visit evaluation report. Per 42 CFR §433, Subpart C, successful completion of the CMS certification review process (and any periodic reviews after the initial one) is required for the MMIS to continuously receive enhanced federal funding rates. Due to the significant cost of operating an MMIS, the enhanced federal funding rates are a key advantage to having a certified system.

The Department's current MMIS has been certified by CMS; CMS certifies a state's MMIS, and does not certify the vendor that operates the system. Through the RFP process, all proposed solutions will be required to meet CMS certification requirements within twelve (12) months of implementation in order to maintain enhanced federal funding. However, not all vendors who will respond to the solicitation will provide a solution that is currently certified by CMS, and the Department is not requiring proposed solutions to be currently CMS certified. This approach does not distract from the process and instead allows for more competition and better product once in production.

There are several advantages to the Department by not requiring that the vendor's proposed solution be a currently certified system. The Department's approach allows for a flexible solution that maximizes the use of industry-related and application-ready commercial off-the-shelf technologies that support the existing health benefit programs under the direction of the State Medicaid Director and that can be expanded to support future health benefit programs in a cost-effective and timely manner. The Department encourages vendors to propose creative, innovative solutions for a suite of applications or components to serve as a "best of breed" MMIS.

The proposed solution will need to provide the Department the ability to administer and modernize the Medical Assistance program without changes to the underlying technology and coding that take significant time to complete. To create a modern program that delivers cost-effective health care services that are population specific, the Department will continue to adapt and make progress on how services to clients are delivered and how payments to providers are paid. In addition, the Department will need to modify payments (or rates) to providers and adapt payment methodologies that encourage quality services and healthy outcomes. The solution cannot serve as a cost, time, or resource constraint to implementing these evolving delivery systems and provider payments.

Where practical, proposed solutions will leverage existing components and/or components that can be transferred from an existing, CMS certified system. In addition, the Department expects vendors to propose a solution that leverages technology and resources across states to reduce implementation and operating costs. The proposed solution should provide a benefit to the Department and other states as future changes in technology and federal regulations can be shared across all partners. Further, the proposed solution should include technology refreshes that allow the system and operations to remain up-to-date.

As a result, the solicitation is focused on objectives, outcomes, achieving CMS certification criteria, and performance measurements rather than dictating the exact IT technology requirements or specification that the vendor offer a currently "certified" system.

26. The State Controller reviews high risk contracts. Is the State Controller planning to review the MMIS contracts associated with the reprocurement?

Yes, the Office of the State Controller will review the resulting contract from this solicitation. The Department has already consulted with the Office of the State Controller to clarify contract language that will be included with the solicitation so vendor concerns are addressed prior to submitting their responses to the solicitation. This approach will decrease the effort and time to negotiate the final contract.

27. Senate Bill 12-096 (Lambert/Levy) dictates that the Governor's Office of Information Technology has authority to review existing information technology contracts and negotiate contract amendments through June 30, 2014. Additionally, amendments to existing contracts are exempted from the requirements of the procurement code during that time period. Is the MMIS reprocurement eligible for review under this statutory authority?

No, the MMIS reprocurement is not exempt from the procurement code through this statute. CMS requires a competitive procurement process every eight to ten years and CMS requires MMIS contracts to be competitively bid and procured (SMM Section 2080.4), meaning the Department must reprocure the MMIS by the end of the current contract to maintain federal approval and FFP. The state must follow either its procurement code or the federal government procurement code during the process. In addition, the Department believes it would be inappropriate to issue a service contract of this magnitude without a competitive procurement process. To date, the Department has held a vendor fair, performed a best practices and market research study, released two drafts of the solicitation, and held two pre-bidder vendor meetings to discuss comments directly from the vendors. The Department has received several comments from vendors that our procurement process has been the most inclusive and transparent they have been involved with and as a result will encourage vendors to submit bids. Traditionally states have not followed a process of releasing draft solicitations and openly responded to vendor comments, which has caused numerous failed procurements.

28. The State Auditor's Office has several outstanding recommendations related to MMIS deficiencies. Will the MMIS reprocurement address the deficiencies?

Audit Recommendation: Provider Eligibility (most recently appearing as Recommendation #26 in the 2011 Single Statewide Audit): The Department of Health Care Policy and Financing should improve its controls over eligibility of Medicaid providers to ensure that it complies with

federal regulations. In addition, it should develop, implement, and document a process for removing providers from the Medicaid Management Information System providers who are no longer in compliance with provider eligibility requirements.

Department Response: Full compliance will be achieved with the implementation of the replacement MMIS system in 2016. While the replacement MMIS and Fiscal Agent Operations Services is expected to be operational by July 2016, the Department's implementation of the Affordable Care Act (ACA) Provider Screening Rules needs to be completed by March 2016 under federal regulations. The MMIS and Fiscal Agent Operations Services contractor is expected to work with the Department to implement ACA Provider Screening Rules as a top priority under the RFP.

However, several initiatives are underway to improve compliance in advance of the replacement MMIS:

1) The Department is implementing changes to the provider enrollment application and process which will improve its compliance with current federal regulations. These changes are expected to be completed by June 2013.
2) The Department is working with the Departments of Public Health and Environment (DPHE) and of Regulatory Agencies (DORA) to improve and automate the collection of license information provided by these Departments.

A number of processes are already in place to ensure that ineligible providers are not enrolled and are terminated if they become ineligible after enrollment. Many of these processes rely on manual validation of provider eligibility information. As a result, a key component of the RFP for the replacement MMIS is to allow the systematic validation of provider credentials via implementation of an online provider enrollment tool. The contractor who will build the replacement MMIS will be required to work with the Department to implement ACA Provider Screening Rules, such that all providers must perform the re-validation by March 2016.

The Department is working with CMS regarding the ACA Provider Screening Rules in order to amend the State Plan in a way that is satisfactory to CMS during the period between now and the implementation of the replacement MMIS.

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Expansion and Cost Containment Strategies

Cost Containment Strategies

1. Benefit Redesign & Value-Based Services
2. Delivery System Reform
3. Payment Reform
4. Improve Health Technology and Information
5. Redesigning Administrative Infrastructure & Reducing Fraud, Waste, Abuse

Medicaid Expansion: The Right Choice for Colorado

Expansion allows Medicaid to cover more than 160,000 additional Coloradans

- Expansion allows us to cover more people with the right services at the right time and drive value in the system
- 58,000 additional parents and adults likely to enroll between 100%-133% of FPL (138% with an automatic 5% income disregard)
  - In 2012, 133 percent of the FPL was $30,657 for a family of four and $14,856 for an individual
- Supports Colorado's health and economy by helping people stay healthier over the long term

Maximizing enhanced federal funding is the best option for Colorado

- Allows provider fee dollars to stretch further with the enhanced federal matching funds
- The Medicaid expansion is expected to have little to no impact on the state General Fund

Expansion Match Rates

Eligibility Category	Match Rate (Federal/State)
Existing Medicaid[1]	50/50
Existing CHP+	65/35 88/12 (FFY 2015-2019)
Parents & AwDC (HB 09-1293)	100/0 (CY2014-16) [2] 90/10 (2020+) [2]
ACA Medicaid	100/0 (CY2014-16) 90/10 (2020+)

Match Rates for Expansion Populations Over Time (Federal/State)				
2014	2017	2018	2019	2020+
100/0	95/5	94/6	93/7	90/10

[1] Includes those currently eligible but not enrolled who subsequently enroll

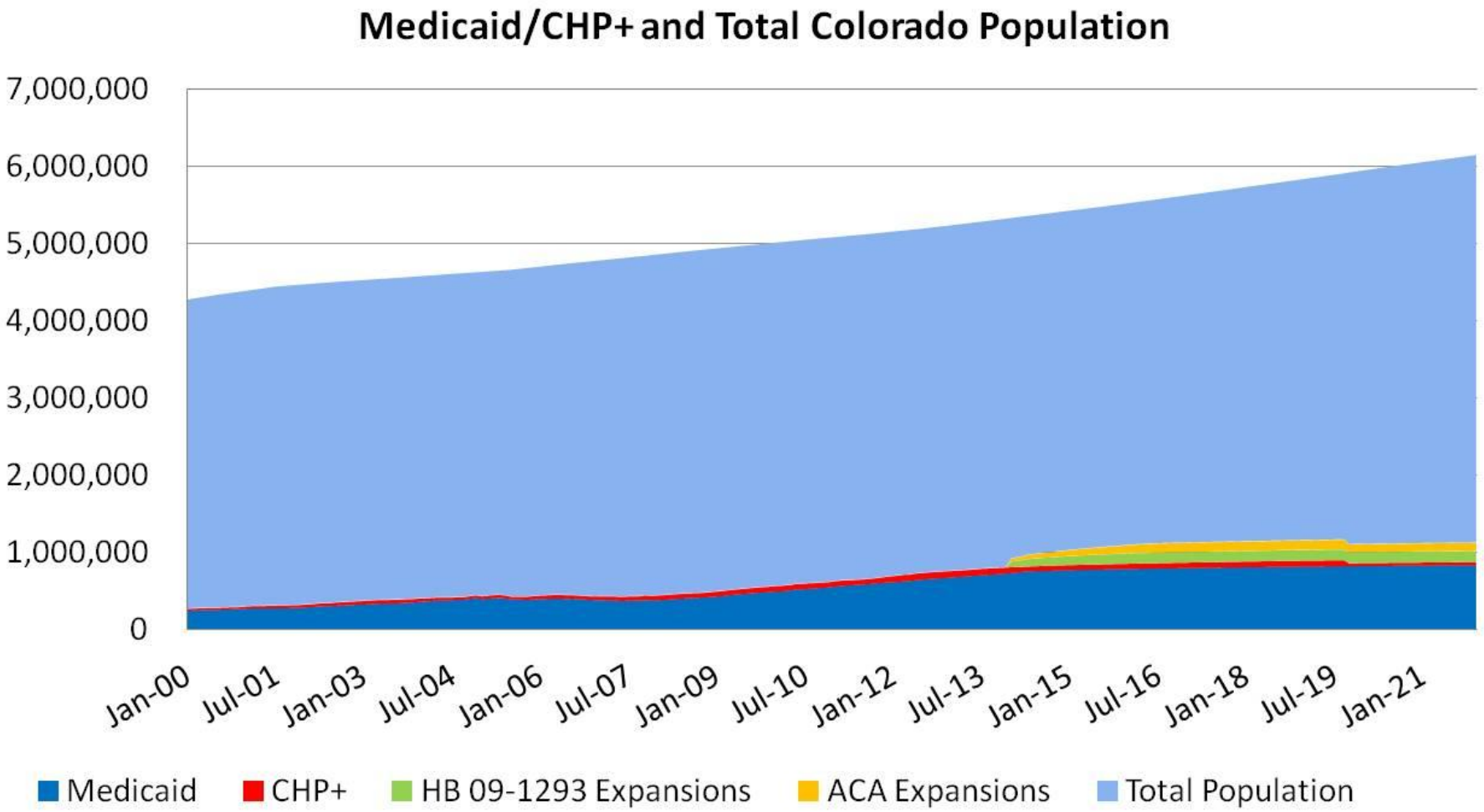
[2] Match rate for parents and AwDC under the 09-1293 expansion will be 50/50 if the state does not expand these categories to 133%

Expansion Financing

Preliminary 10-YEAR ESTIMATE* Caseload and Cumulative Expenditure Projections, 2013-2022 (Representing Net Change, Costs in Millions)			
	HB 09-1293	ACA	**Total
Caseload[1]	220,300	59,500	271,000
Total Cost	$11,709.7	$2,039.2	$13,548.3
State Share: Provider Fee/ Other[2]	*$1,267.3*	***$128.3***	*$1,395.6*
State Share: GF/Other[2]	*$0*	*$0*	***($179.5)***
Federal	*$10,382.3*	*$1,910.9*	*$12,280*

*This is a preliminary estimate of caseload and expenditures and does not include administrative costs or effects of other programs.
**The total estimates column above takes into account calculations for eligible but not enrolled individuals and changes to the CHP+ costs and caseload.
[1] Its estimated that more than 160,000 Coloradans will be enrolled as a result of the expansion. This is the difference between 271,000 (above) and an estimated 110,200 parents and adults without dependent children currently authorized under the provider fee.
[2] As federal funding tapers, we anticipate savings, provider fees and other public funding will cover the additional caseload.

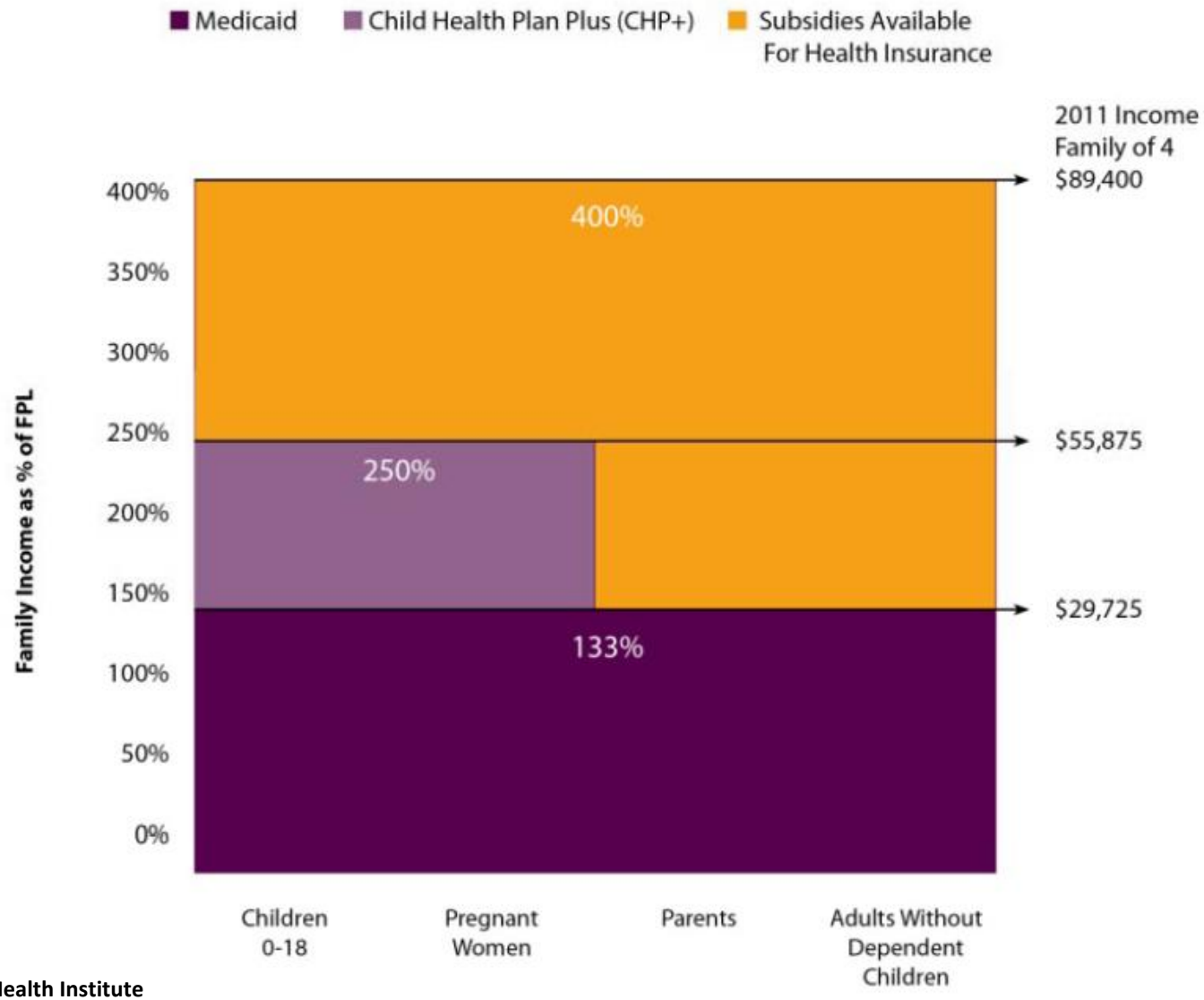
Caseload Forecast with Expansion



*Population estimate from the Department of Local Affairs, State Demography Office.

** Eligible But Not Enrolled caseload included in the "ACA Expansions" category.

“Churn” between Medicaid and the Exchange



Courtesy: Colorado Health Institute

Summary

Churn:
Occurs when individuals become eligible and then ineligible for Medicaid and CHP+. There are two main reasons why people churn:

- Income fluctuations
- Family size/household composition changes

Key Program design considerations to minimize churn:

- Benefit alignment between Medicaid and the exchanges
- Health plan participation in both Medicaid and the exchanges
- Enrollment and eligibility systems designed to facilitate transitions
- Provider engagement and network requirements for RCCOs and QHPs

Department policy changes to address churn:

- Simplified the re-enrollment process by automatically re-enrolling qualified individuals using information obtained from other public assistance programs
- Expanded community-based outreach to over 400 sites statewide
- Implemented technologies to automate verifications and reduce the burden for both the worker and the applicant
- Engaged leaders and partners to articulate a clear vision and benefits to enrolling children

2) Should Colorado expand Medicaid pursuant to the Affordable Care Act, and why? How would Medicaid and CHP+ enrollment change, and how much would such an expansion cost?

RESPONSE:

The Department believes Colorado should expand Medicaid. While Colorado expands Medicaid coverage, the Department must also strengthen programs that improve quality, make the system easier to navigate for clients, and contain costs.

By expanding Medicaid, the Department can leverage existing federal and State dollars to improve Coloradans health coverage at a lower cost to the State. The availability of 100% federal match from 2014 through 2016, along with the federal match tapering down to 90% in the later years, is a strong incentive to expand Medicaid.

Studies have shown that having health insurance has a profound impact on health. When people aren't well, they have difficulty working. By increasing the number of insured through Colorado's Medicaid program, it will have a positive impact on the health of those individuals, which benefits the State economy.

The Department took a measured and analytical approach in determining the fiscal impact of this choice. The Department looked at the:

- cost of newly eligibles;
- cost of currently eligible but not enrolled (EBNE) – an impact regardless of expansion decision;
- administrative costs;
- savings from reduction in state programs for the uninsured;
- other revenue gains and savings; and
- fiscal impact of not expanding.

After evaluating these factors, the Department determined the Affordable Care Act (ACA) expansion allows Colorado to enroll nearly 161,000 additional people. This enhanced match will also allow provider fee dollars to go further. The current federal medical assistance percentage (FMAP) for the expansion populations authorized in the Colorado Health Care Affordability Act (HB 09-1293) is only 50%, and population expansions to 100% of the federal poverty level (FPL) have been dependent on available funds, which has limited the Department's ability to provide coverage under this legislation.

The following table shows a preliminary 10-year estimate of caseload and expansion projections with the expansion. The HB 09-1293 column identifies funding and caseload related to its required expansion and ACA refers to the expansion between 100%-133% FPL.

Preliminary 10-Year Estimate* Caseload and Cumulative Expenditure Projections, 2013-2022 (Representing Net Change, Costs in Millions)			
	09-1293	**ACA**	**Total****
Caseload[1]	220,300	59,500	271,000
Total Cost	$11,709.7	$2,039.2	$13,548.3
State Share: Provider Fee/Other[2]	$1,267.3	**$128.3**	$1,395.6
State Share: General Fund/Other[2]	$0	$0	**($179.5)**
Federal	$10,382.3	$1,910.9	$12,280

** This is a preliminary estimate of caseload and expenditures and does not include administrative costs or effects of other programs.*

*** The Total column above takes into account calculations for eligible but not enrolled individuals and changes to CHP+ costs and caseload.*

(1) The total caseload includes 110,200 parents and adults without dependent children currently authorized under the provider fee. More than 160,000 Coloradans will be enrolled as a result of the expansion.

(2) As federal funding tapers, the Department anticipates savings, provider fees and other public funding will cover the additional caseload.

The Affordable Care Act created the exchange subsidies affecting everyone above the allowable FPL rate of Medicaid. With the current FMAP under the provider fee, the State would not be able to fully implement coverage levels intended in the legislation. If Colorado opted out of the Medicaid expansion, it would leave over 100,000 people below 100% FPL uninsured and excluded from access to health insurance in Medicaid or through the exchange.

3) What are the Department's intentions regarding involvement of the General Assembly in any expansion decisions?

RESPONSE:

The Department plans to collaborate with the legislature on any expansion efforts.

4) What is the Department's vision for the Hospital Provider Fee in the Affordable Care Act environment?

RESPONSE:

The Department’s vision for the Hospital Provider Fee is to allow the State to move forward with expansion under the Affordable Care Act with little to no General Fund impact.

The passage of HB 09-1293, the Colorado Health Care Affordability Act, created Colorado's hospital provider fee. The provider fee is a fee assessed on Colorado hospitals, the size of which is based on the size of the facility. The fees collected from hospitals are then matched by the federal government.

The provider fee has enabled the State to increase reimbursements under Medicaid and the Colorado Indigent Care Program (CICP). By increasing reimbursements, the provider fee helps to reduce the rate of rising health care costs that results from underpayment. In addition, the provider fee expanded eligibility to thousands of uninsured Coloradans through Medicaid and the Child Health Plan *Plus* (CHP+); many of the covered would be eligible under the Affordable Care Act. Because of the hospital provider fee, both the increase to reimbursement and expansion of eligibility were able to be performed without relying on General Fund dollars or shifting costs to other health care consumers.

According to the Colorado Hospital Association, levels of uncompensated care at Colorado hospitals were reduced by approximately $300 million statewide, due in large part to increased reimbursement rates for Medicaid.

5) Please compare the size, scope, and uses of Colorado's provider fees – Hospital Provider Fee, Nursing Facility Fee, and Intermediate Care Facility for People with Intellectual Disabilities (ICF-ID) Fee – to provider fees in other states. How many states have provider fees?

RESPONSE:

Colorado has three, provider-fee programs with various objectives. The federal government limits fee assessments to 6% of Net Patient Revenue (NPR) for the service type.

Hospital Provider Fee
The Hospital Provider Fee was established by HB 09-1293. The Department assesses two distinct fees, one on inpatient services and the other on outpatient services. Combined inpatient and outpatient fees collections totaled $585.7 million in FY 2011-12, with the inpatient fee at 5.9% of NPR and outpatient fee at 0.9% of NPR. These fees generated $526.8 million in federal matching dollars in FY 2011-12.

Hospital-fee revenue and federal matching funds are used to:

- increase hospital reimbursement for inpatient and outpatient services under Medicaid up to the federal Upper Payment Limits;
- increase hospital reimbursement under the Colorado Indigent Care Program up to 100% of costs;
- create hospital quality incentive payments;
- increase coverage for Medicaid parents with incomes up to 100% of the federal poverty level (FPL) and for Child Health Plan *Plus* (CHP+) children and pregnant women up to 250% FPL;
- implement health coverage for adults without dependent children up to 100% FPL;
- create a Medicaid buy-in program for individuals with disabilities up to 450% FPL;
- implement 12-month continuous eligibility for Medicaid children;
- cover the Department's related administrative costs; and
- pursuant to SB 10-169 and SB 11-212, provide temporary General Fund budget relief in the Medicaid program.

Nursing Facility Provider Fee

The Nursing Facility Provider Fee was established by HB 08-1114. Pursuant to statute, fees are collected on non-Medicare service days for qualifying facilities at $12.00 per day, adjusted for inflation. Nursing facility fees totaled $42.7 million in FY 2011-12 and are at 4.2% of NPR. Along with federal matching dollars, the program funded $84.5 million in supplemental payments to nursing facilities without any increase in General Fund expenditures.

Nursing facility-fee revenue and federal matching funds allow the Department to make supplemental payments to nursing facilities above the per diem rate subject to the General Fund growth cap. These supplemental payments are funded as provider-fee revenue and federal matching funds allow according to a hierarchy established in statute as follows:

- Paying administrative costs and offsetting the Medicaid cost of the provider fee
- Payment for acuity or case-mix of residents
- Payment for higher quality performance
- Payment for residents with moderate to severe mental health conditions, cognitive dementia, or acquired brain injury
- Payment for the difference between the state-wide per diem rate and the General Fund share

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) Fee

Colorado established a provider fee for ICF/IID facilities under 25.5-6-204 C.R.S. through the enactment of HB 03-1292. The ICF/IID provider fee is assessed at 5% of costs (approximately 5% of NPR) for the two state-owned regional centers and the privately-owned ICF/IID. The fee amount is $1.8 million per year and, with federal matching funds, is used to offset General Fund expenditures.

Use of Provider Fees in Other States

According to the National Conference of State Legislatures, for FY 2012, the number of states with some type of Medicaid-related provider fees has increased to 47 states plus Washington, D.C. The three states without provider fees are Alaska, Delaware, and Hawaii. At least 34 states currently assess a fee on hospitals, 34 states charge a fee on ICF/IID, and 38 states assess nursing facilities. A number of states also charge fees on ambulatory services, insurance and managed-care organizations, pharmacies, and day rehab facilities. A majority of states' assessments on Nursing Facilities and ICF/IID are at or near the federal NPR limit.

There is considerably more variation in the assessment amount on hospital services. Some states' assessments on hospital services are only a percent or two of NPR, while others approach the maximum-allowable 6% NPR limit.

Fee revenues are used in a variety of ways in other states. Some states use cash fund revenue to supplant general fund in Medicaid claims or managed care payments. Other states' fee programs fund expansion populations, supplemental payment programs, or a combination of these mechanisms.[1] In Colorado, fees must show a direct benefit to the entity being assessed a fee and cannot be used for just any purpose. Specifically, section 25.5-4-402.3 (5) (a) (I), C.R.S. (2012), states that the intention of the hospital provider fee is to supplement, not supplant, General Fund supported hospital reimbursement.

[1] Information on fee programs in other states was obtained from the National Conference of State Legislatures (http://www.ncsl.org/issues-research/health/health-provider-and-industry-state-taxes-and-fees.aspx)

The table on the following page shows provider fee and provider tax types by state for FY 2010-11 and uses information published in May 2011 by the Kaiser Commission on Medicaid and the Uninsured.[2] After this table was developed, Wyoming added fee programs for hospitals and nursing facilities. Under federal regulations, these programs are referred to as "provider taxes." According to analysis by Legislative Legal Services (LLS), Colorado's programs are defined as "fees" under Colorado law. In a memo to Senator Keller dated December 22, 2008, LLS specifically stated in regard to whether the hospital provider fee is a tax for purposes of section 20 (4) (a) of article X of the Colorado constitution:

> "The intent of the hospital provider fee would be to increase reimbursements to the hospitals paying the fee, not to increase revenue for general governmental purposes. Therefore, the hospital provider fee would not be a tax requiring prior voter approval under 20(4)(a) of article X of the State constitution."

Provider Fees and Taxes in the 50 States and the District of Columbia: FY 2010-2011

		Alabama	Alaska	Arizona	Arkansas	California	Colorado	Connecticut	Delaware	DC	Florida	Georgia	Hawaii	Idaho	Illinois	Indiana	Iowa	Kansas	Kentucky	Louisiana	Maine	Maryland	Massachusetts	Michigan	Minnesota	Mississippi	Missouri	Montana	Nebraska	Nevada	New Hampshire	New Jersey	New Mexico	New York	North Carolina	North Dakota	Ohio	Oklahoma	Oregon	Pennsylvania	Rhode Island	South Carolina	South Dakota	Tennessee	Texas	Utah	Vermont	Virginia	Washington	West Virginia	Wisconsin	Wyoming	**Total**
Hospitals	2010	X			X		X			X	X			X	X			X	X		X	X	X	X	X	X	X	X			X	X		X			X		X	X	X	X				X		X	X	X		**29**
	2011	X			X	X	X			X	X	X		X	X		X	X	X		X	X	X	X	X	X	X	X			X	X		X			X		X	X	X	X		X		X	X		X	X	X		**34**
ICF/IID	2010				X	X	X			X	X				X	X	X		X	X	X	X			X	X	X	X	X			X		X	X	X	X		X	X	X	X	X	X		X		X	X	X		**33**
	2011				X	X	X			X	X				X	X	X		X	X	X	X			X	X	X	X	X			X		X	X	X	X		X	X	X	X	X	X	X	X	X	X	X	X		**33**
Nursing Facilities	2010	X			X	X	X	X		X	X	X		X	X	X	X		X	X	X	X	X	X	X	X	X	X		X	X	X		X	X		X	X	X	X			X		X	X			X	X		**37**
	2011	X			X	X	X	X		X	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		X	X	X		X	X		X	X	X	X			X		X	X			X	X		**38**
Managed Care Organizations	2010			X						X												X			X							X	X							X	X	X			X	X				X				**12**
	2011			X						X												X			X							X	X							X	X	X			X	X				X				**11**
Other	2010	X				X													X	X	X		X		X		X					X	X	X					X								X			X		**14**
	2011	X				X													X	X	X		X	X	X		X					X	X	X					X								X			X		**15**
Any Provider Tax/Fee	2010	X		X	X	X	X	X		X	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		X	X	X		**46**
	2011	X		X	X	X	X	X		X	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		**47**

[2] Table and additional information on fees are from Kaiser Commission on Medicaid and the Uninsured, Publication Number: 8193, Publish Date: 2011-05-31 (http://www.kff.org/medicaid/8193.cfm)

6) Please provide estimates of the underinsured in Colorado, especially in the income ranges potentially impacted by the Affordable Care Act.

RESPONSE:

The following is a chart from the Colorado Health Institute of self-reported insurance status of Coloradans covered under expansions of the Affordable Care Act.

Table 1. Colorado Adults (ages 19-64) with Family Incomes Less Than 138 Percent of the Federal Poverty Level (FPL) by Parental Status and Health Insurance Status,[2] 2011

Insurance Status	Adults without Dependent Children (AwDC)		Parents	
	Number	Percent	Number	Percent
Employer*	179,547	34.0	49,204	25.4
Medicare	30,547	5.8	5,778	3.0
Medicaid**	68,450	13.0	61,092	31.6
Individual Purchase	62,952	11.9	7,345	3.8
Uninsured	187,036	35.4	70,059	36.2
Total	528,532	100.0	193,478	100.0

*Includes military coverage

** Please note that these are estimates based on self-reported data and will differ from administrative figures. Many of the AwDC reporting Medicaid are likely eligible based on disability.

Source: CHI analysis of the 2011 American Community Survey

It is difficult to gauge how many of the insured adults without dependents and parents are underinsured. A person is typically considered underinsured if limits on their coverage hinder them from obtaining medically necessary care or if high out-of-pocket payments constitute a serious financial burden or outright barrier to care.

According to a report by the Colorado Health Foundation on Benefit Adequacy, those most likely to be underinsured include:

- people with low incomes or who have medical deductibles exceeding 5% of their income;
- individuals with health problems;
- people with individual or public, as opposed to employer-sponsored, health insurance;
- women and adults age 55 to 64 or 19 to 24;
- farm families; and
- rural and inner-city residents.

7) Please provide a history of optional expansions of Medicaid eligibility, including the year and fund sources, and each expansion's contribution to total enrollment.

RESPONSE:

Population	Description	Year of Implementation	Fund Source	Caseload (November 2012)
Breast and Cervical Cancer Program	Women under this optional coverage group were screened using the Centers for Disease Control's national breast and cervical cancer early detection and prevention guidelines, and found to have breast or cervical cancer.	FY 2002-03	General Fund, Prevention, Early Detection, and Treatment Fund, Tobacco Settlement Funds	615
Presumptive Eligibility for Pregnant Women on Medicaid	Allows pregnant women to apply for Medicaid benefits and receive them immediately for a period of 45 days if they pass an initial eligibility screening at a certified clinic. Legislative authority for this population was reauthorized by House Bill 05-1025 and the program was reintroduced on July 1, 2005, after having legislative authority inadvertently removed in 1991.	FY 2005-06	Health Care Expansion Fund	456
Expansion Adults to 60% FPL	Extended eligibility under Medicaid to the parents of any Medicaid or Children's Basic Health Plan eligible child from approximately 23% to at least 60% of the federal poverty level.	FY 2006-07	Health Care Expansion Fund	29,076
Removal of the Medicaid Asset Test	Removed the Medicaid asset test as part of its eligibility criteria.	FY 2006-07	Health Care Expansion Fund	N/A
Medicaid for Legal Immigrants	Reinstated Medicaid benefits for optional legal immigrants.	FY 2006-07	Health Care Expansion Fund	5,386
Expansion of Medicaid Eligibility for Foster Care Children	Expanded Medicaid eligibility to young adults less than 21 years of age and who were in the foster care system immediately prior to their 18th birthday.	FY 2007-08	Health Care Expansion Fund	1,402
Children's Extensive Support Waiver increase	Increased the number of resources to enroll eligible clients in the program.	FY 2006-07	Health Care Expansion Fund	79
Children's Home and Community Based Services Waiver Increase	Increased the number of resources to enroll eligible clients in the program.	FY 2006-07	Health Care Expansion Fund	678
Expansion Adults to 100% FPL	Increased the eligibility level for parents of children who are eligible for medical assistance or the children's basic health plan to up to 100% of the federal poverty line.	FY 2009-10	Hospital Provider Fee	41,895
Adults without Dependent Children	Provided Medicaid benefits for adults who do not have dependent children receiving Medicaid, and who are at or below 100% of the Federal Poverty Level.[1]	FY 2011-12	Hospital Provider Fee	9,972
Medicaid Buy-In Program for Working Adults with Disabilities Medicaid Buy-In Program for Children with Disabilities	Provided working adults with disabilities and children who are under age 19, who earn too much income or have too many resources to qualify for Medicaid, the opportunity to purchase Medicaid.	FY 2011-12 (Working Adults) FY 2012-13 (Children)	Hospital Provider Fee	753

[1]*Due to fiscal constraints, the Department has only implemented this population up to 10% of the Federal Poverty Level, with a cap of 10,000 clients.*

8) Please provide a projection of Medicaid enrollment and of CHP+ enrollment through FY 2016-17. When does the Department anticipate that the Medicaid population will reach 1.0 million?

RESPONSE:

Assuming there are no significant changes in the economic outlook and that Medicaid eligibility is expanded to 133% of the federal poverty level (FPL) pursuant to the Affordable Care Act (ACA), the Department estimates that average monthly enrollment in FY 2016-17 in Medicaid and CHP+ will be 1,038,710 and 91,919, respectively. This includes estimates of caseload increases from currently eligible but not enrolled (EBNE) individuals seeking Medicaid or CHP+ enrollment beginning in 2014.

Based on similar assumptions, the Department anticipates the Medicaid population will reach 1.0 million during FY 2015-16.

11) How much churn does the Department expect between eligibility for Medicaid, CHP+, and tax benefits through the health insurance exchange? What plans does the Department have to minimize disruptions in coverage caused by churn? What is the status of the implementation of continuous eligibility?

RESPONSE:

The Department does not yet know the full extent of churn in Colorado but is working with other states and data institutes to better identify the population most likely to churn and potential policy solutions. The following key program design considerations to minimize churn will be explored:

- Benefit alignment between Medicaid and the exchanges
- Health plan participation in both Medicaid and the exchanges
- Enrollment and eligibility systems designed to facilitate transitions
- Provider engagement and network requirements for Regional Care Collaborative Organizations (RCCOs) and Qualified Health Plans (QHPs)

Churn occurs when individuals become eligible and then ineligible for Medicaid and CHP+. There are two main reasons why people churn: 1) income fluctuations, and 2) family size/household composition changes. At the income levels in which one qualifies for Medicaid and CHP+, families are much more likely to have inconsistent and unstable income. The phenomenon of churn between public and private coverage is not a new problem, though it is complicated by the future coverage continuum that creates new programmatic breaking points between Medicaid and the future health insurance exchanges, as well as between existing federal and state-funded coverage programs.

The Department is continually looking at ways to ensure that all uninsured individuals who are eligible for Medicaid and CHP+ maintain coverage for as long as they qualify. The Department has already adopted nationally recommended[3] practices into its procedures and operations.

[3] Maximizing Kids' Enrollment in Medicaid and SCHIP: What Works in Reaching, Enrolling and Retaining Eligible Children. V. Wachino, A. Weiss. National Academy for State Health Policy and Robert Wood Johnson Foundation. February 2009.

Over the past several years, the Department has:

- simplified the re-enrollment process by automatically re-enrolling qualified individuals using information obtained from other public assistance programs;
- expanded community-based outreach to over 400 sites statewide;
- implemented technologies to automate verifications and reduce the burden for both the worker and the applicant; and
- engaged leaders and partners to articulate a clear vision and benefits to enrolling children.

The Department is preparing to minimize the impacts of churn by guiding consumers through unavoidable changes in coverage. Guidance will occur through well-trained eligibility site staff, consumer-friendly websites, upgrades and enhancements to its application and eligibility determination processes (PEAK and CBMS), a state-of-the-art call center, and assistors who provide outreach. In addition, the exchange plans to provide a call center and navigators to assist consumers.

Status of Implementation of Continuous Eligibility

The Oversight and Advisory Board of the Hospital Provider Fee prioritized the expansion populations and then continuous eligibility. Within the available funding, the Department successfully and fully expanded eligibility to parents and to children and pregnant women in CHP+; expanded the buy-in for people with disabilities; and expanded eligibility to adults without dependents to 10% FPL or the first 10,000 adults.

The Department continues work on the expansion for adults without dependent children but is also re-evaluating the original fiscal note related to continuous eligibility. Because of the work to reduce barriers for enrolling and retaining coverage for qualified individuals, as identified above, and what the Department has learned about utilization working with other states and stakeholders, the Department anticipates the costs of continuous eligibility may be less than originally estimated in the 2009 fiscal note. The Department continues to research continuous eligibility and work with stakeholders to determine a possible implementation date.

12) In the wake of *NFIB v. Sebelius*, what ACA Medicaid expansions are optional versus mandatory, and what is the match rate for each expansion? Specifically, is the expansion for former foster children mandatory or optional?

RESPONSE:

Former Foster Children

This population continues to be mandatory; the foster care expansion was not addressed in *NFIB v. Sebelius* and, therefore, remains in effect as Congress intended. Because the Affordable Care Act limits the enhanced federal match to "newly eligible individuals" as defined in subclause (VIII) of Section 1902(a)(10)(A)(i) of the Social Security Act, which does not include "former foster children," this expansion population receives the standard 50% federal match.

Low-Income Adults and Children to 133% FPL

While the Affordable Care Act still requires expansion to this population, under *NFIB v. Sebelius*, there is no penalty for failure to comply with the federal legislation. Therefore, states have the choice of expanding to 133% FPL. The federal match for this population varies over time as follows:

Calendar Year	Enhanced Federal Match Rate for Newly Eligible Populations
2014-2016	100%
2017	95%
2018	94%
2019	93%
2020+	90%

Following *NFIB v. Sebelius*, CMS provided guidance to states[4], indicating that a partial eligibility expansion would not qualify for an enhanced federal match. Consequently, if the State opts not to extend eligibility for adults to 133% FPL, existing Medicaid populations that would have otherwise received an enhanced federal match will not be eligible; this includes both the State's "Adults without Dependent Children" population and "Expansion Adults to 100% FPL."

13) What is Colorado's provider capacity to handle an eligibility expansion? What is the Department doing to ensure providers are sufficient and prepared?

RESPONSE:

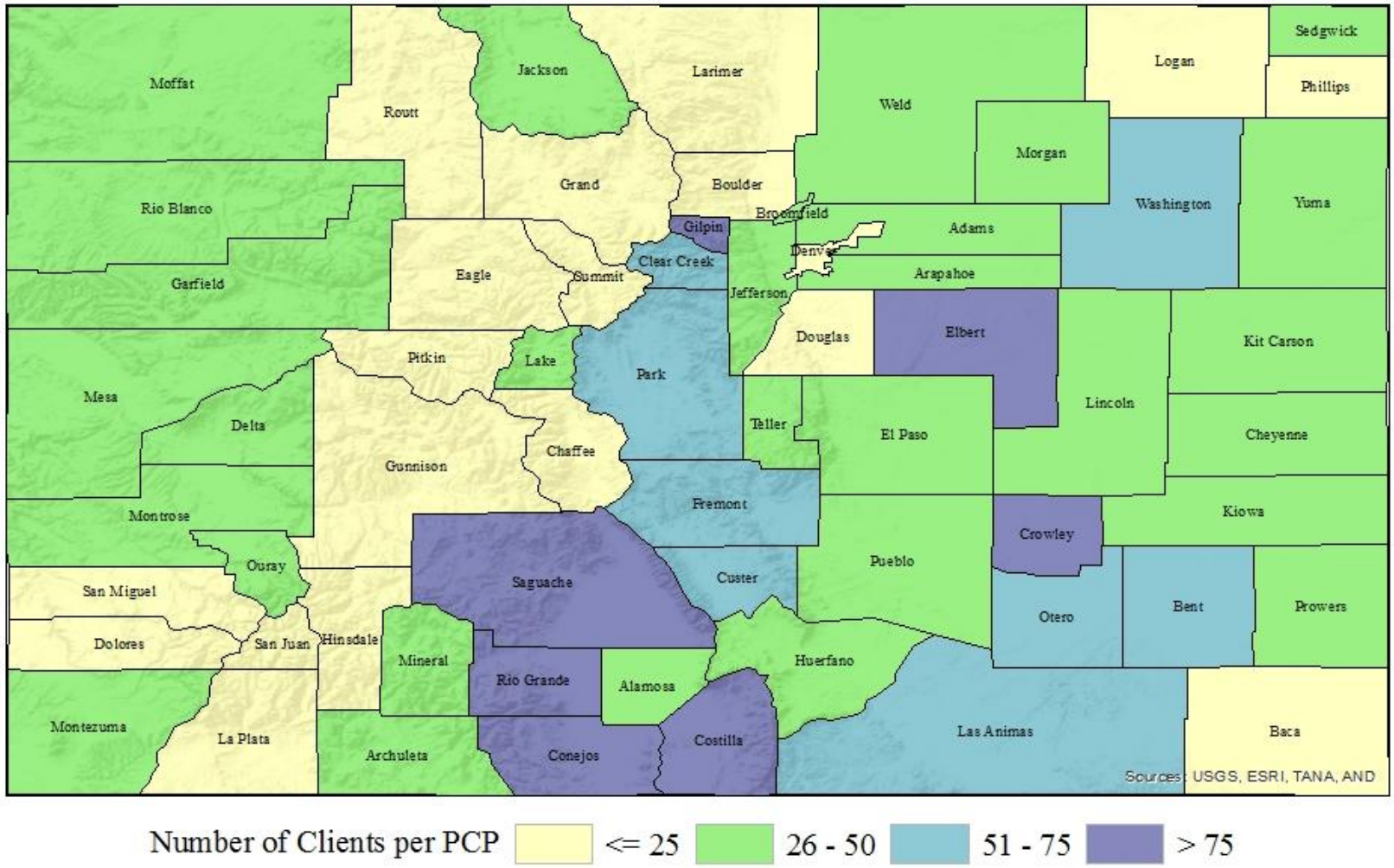
The Colorado Health Institute (CHI) published a brief on this topic in December 2011 that estimated Colorado will need approximately 83 to 141 additional physicians, nurse practitioners, and physician assistants to cover newly insured individuals under the Affordable Care Act. CHI estimated in 2011 that approximately 510,000 Coloradans would become newly insured; currently the Department estimates that 161,000 low-income adults will gain Medicaid coverage due to the Affordable Care Act expansion. The Department, the Department of Public Health and Environment, funders, and local physician and stakeholder groups are aware of this shortfall and are working on strategies.

The Department has mapped the number of Medicaid clients per primary care provider, and a copy of the map is provided on the following page.

[4] December 10, 2012 Governors' letter from Secretary Sebelius. http://cciio.cms.gov/resources/files/exchanges-faqs-12-10-2012.pdf

Number of Colorado Medicaid Clients Per Primary Care Provider
by County, State Fiscal Year 2011-12

Total average number of Colorado Medicaid clients per month represented in the data/map: 619,963
Total number of Colorado Medicaid primary care providers (PCP) represented in the data/map: 21,391
State-wide number of Colorado Medicaid clients per primary care provider: 29



As expected, there is variation in primary care availability, and the areas where there exists a need in Medicaid primary care providers correspond to areas where there is a shortage of primary care providers statewide.

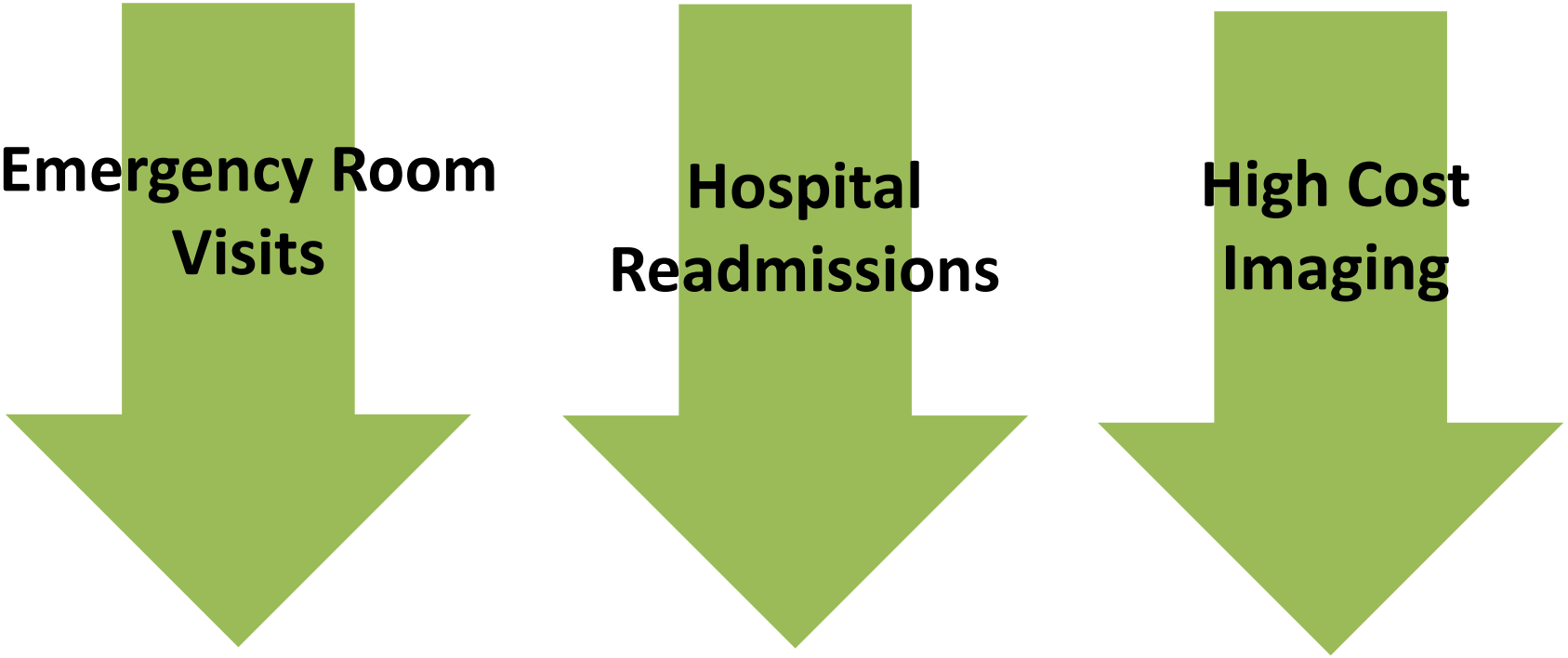
The Department is working on several strategies to ensure an adequate and prepared provider network. First, the Accountable Care Collaborative is changing the way that health care is delivered. Coordinated care, which is a primary role of the seven Regional Care Collaborative Organizations (RCCOs), will minimize time-consuming efforts that a practitioner would have previously needed to provide. For example, RCCOs can assist practitioners in meeting a client's non-medical needs that might impact a client's health, such as transportation or housing. Care coordinators, electronic health records, and the Statewide Data Analytics Contractor (SDAC) are all tools being implemented for practices to eliminate uncoordinated, duplicative care. Additionally, RCCOs are providing practice support in an effort to streamline and enhance the protocols within each practice, allowing providers to focus on patient care rather than administratively burdensome processes like billing questions or helping navigate a denied prior-authorization request.

Second, the Department currently has over 33,000 providers statewide. Between January 2010 and December 2012, the Department increased the number of actively enrolled primary care-like providers by 26% and the number of all other types of providers by 38%. This resulted in a 30% overall increase in the number of providers available to service Medicaid clients despite the rate cuts implemented over the past few fiscal years. The Department believes this trend will continue as the Department continually works to enroll as many providers as possible. To ensure an adequate network of providers to serve the future expansions under the Affordable Care Act, the Department's Client Service, Eligibility, and Enrollment Office is conducting additional provider outreach activities through a contracted provider recruitment firm with funding from the Health Resources Services Administration (HRSA) grant. The HRSA grant expires in August 2013, and the provider recruitment contract expires in June 2013.

Third, the Affordable Care Act provides for a two-year payment increase for Medicaid primary-care providers to match Medicare payment rates for qualified physicians and advanced-practice nurses. The exact amount of the increase is not known at this time because Medicare has not established a rate for 2013. The Department estimates paying providers approximately $16 million per year, mostly federal funds. There is excitement in the physician community about this new reimbursement, and the Department expects new providers to enroll and existing providers to consider taking new Medicaid clients. This will especially benefit small, rural communities with a disproportionate percentage of Medicaid clients. There are other Affordable Care Act provisions not directly related to Medicaid that are also expected to support providers, such as enhanced funding to Federally Qualified Health Centers to increase capacity and increased student loan repayments for primary care.

Finally, the Department's Chief Medical Officer meets every four to six weeks with provider groups, including the Colorado Medical Society, the American Academy of Family Practice, the American Academy of Pediatrics, and the RCCO Medical Directors. These meetings are designed to discuss issues of mutual interest, which includes ensuring an adequate provider network.

Accountable Care Collaborative: Initial Results



Summary

The Accountable Care Collaborative Program (ACC) is Medicaid's platform for reforming the health care delivery system to improve client health outcomes, improve client and provider experience, reduce costs, and create better value for Colorado tax payers.

The program consists of three core components:

- **Regional Care Collaborative Organizations (RCCOs):** Seven RCCOs are responsible for the overall health outcomes of enrolled clients; provider network development and practice support; medical management and care coordination; and accountability/reporting for quality and financial outcomes.

- **Primary Care Medical Providers (PCMPs):** PCMPs serve as medical homes for ACC clients and are responsible for ensuring timely access to comprehensive primary care that is whole-person oriented, coordinated, and culturally/linguistically sensitive.

- **Statewide Data and Analytics Contractor (SDAC):** The SDAC serves as a data repository, provides data analytics and reporting, supports a provider web portal, and provides the Department, RCCOs, and PCMPs with actionable data at both the population and client level. This unprecedented level of data supports accountability and continuous quality improvement.

Accountable Care Collaborative: Future Vision

2012	2013	2014	2015	2016
Duals Proposal to CMS	**Enrollment 200,000**	**Enrollment 350-400,000**	**Enrollment 470-520,000**	**Enrollment 620-670,000**
AwDC Implementation	**Shared savings Implementation**	**ACA Expansion**		**RCCO RFP**
CPCI	**Duals Implementation with CMS approval**	**BHO Rebid Implementation**		
	1281 Implementation			

Accountable Care Collaborative Next Steps

Short Term

- Additional enrollment during calendar year 2013. This enrollment will include a number of current Medicaid populations.
    - First, the Department will work to contract additional children's medical home providers and enroll clients linked to those providers into the ACC
    - Second, the Department plans to systematically enroll clients who are Medicare-Medicaid eligible into the ACC program
- Move toward collaboration across different provider types and functions
    - Healthy communities
    - Local public health agencies
    - County medical assistance sites
- Payment reform initiatives including shared savings and HB 12-1281.
- Development of plans to increase access to the SDAC web portal for other members of a client's health team to promote greater integration

Long Term

Work with partners and stakeholders to begin developing plans for the long-term strategic plan of the program. The resulting plan will begin to explore:

- long-term enrollment strategies;
- behavioral health integration;
- reprocurement of the behavioral health program for 2014;
- reprocurement of the RCCO contracts for 2016;
- on-going payment reform
- development of health homes;
- integration of and access to dental services; and
- integration of long-term services and supports.
- on-going improvement and evaluation of program

39) Please provide an update on the implementation of the Accountable Care Collaborative (ACC), including a discussion of the performance outcomes.

RESPONSE:

The Accountable Care Collaborative (ACC) program is Colorado Medicaid's predominant platform for reforming the health care delivery system to create better overall value and achieve the Triple Aim. The primary goals of the ACC program are to improve client health, support providers in providing high-quality efficient care, and reduce costs. ACC client enrollment began in May 2011, and initial results of this program are promising; costs, utilization, and client experience are trending in the right direction. Since the last year's Joint Budget Committee hearing, the Department has made significant strides in expanding the ACC provider network and enrollment, using data to drive results, and aligning the program with other efforts.

The potential for the ACC program was illustrated in the November 1, 2012 Accountable Care Collaborative Annual Report. The Department's response to Legislative Request for Information #6 described a reduction in hospital readmissions and high-cost imaging. The rate of emergency room utilization increased at a lower rate for ACC enrollees than non-enrollees. The Department evaluated the total cost of care for ACC clients using a number of statistical methodologies. The various methodologies created a large range of possible savings; however, the Department believes the reported estimate of $20 million gross cost reduction was a reasonable estimate of the program's impact.

Program Description
The ACC is a managed fee-for-service model with three key components: seven Regional Care Collaborative Organizations (RCCOs); contracted Primary Care Medical Providers (PCMPs), and a Statewide Data Analytics Contractor (SDAC).

The RCCOs' core responsibilities are to ensure that every client receives care coordination or medical management, develop a network of providers, support providers in providing high-quality care, and be accountable to the Department. PCMPs are a client's medical home and provide continuous, comprehensive, client-centered care. The SDAC's core function is to provide unprecedented levels of data and analytics via an interactive web portal.

Expanding Network & Enrollment
As of December, there are over 210,000 ACC enrollees. In contrast to last year, where the majority of enrollees were adults, approximately 56% of current enrollees are children. Beginning May 2012, roughly 10,000 Adults without Dependent Children (AwDC) were enrolled in the program. The percentage of enrollees who have opted out of the program is under 5%.

The number of contracted ACC Primary Care Medical Providers (PCMPs) has kept pace with the increase in enrollees. There are now approximately 350 PCMP sites representing nearly 1,900 individual practitioners.

Using Data to Drive Results

The SDAC web portal went live in February 2012. Since then, the Department, RCCOs, and PCMPs have been able to utilize the web portal to view aggregated population level and client level paid claims data. The population data allows the Department to compare RCCO and PCMP performance and identify areas for system improvement and practice transformation. Users can drill down from the population statistics to individual clients, allowing RCCOS and PCMPs to identify clients in need of additional services and support.

Beginning July 2012, the Department implemented an incentive program to increase the accountability of RCCOs and PCMPs. One dollar of the Per-Member Per-Month (PMPM) payment for RCCOs and PCMPs is withheld and will be paid out based on regional performance on three key performance indicators: high-cost imaging, all cause 30-day readmissions, and emergency room (ER) visits.

The full impact of the web portal and incentive payment program was not realized in the last fiscal year, based on implementation dates and the time needed for users to be trained and to become familiarized with the new systems. The Department anticipates that both will have a positive impact on future program efficacy.

Aligning ACC with other Programs & Department Efforts
One of the Department's goals is to align other Medicaid programs with the ACC to reduce duplication of effort between programs and increase overall efficiency.

One example of this alignment effort is the Department's engagement in the Comprehensive Primary Care Initiative (CPCI). Colorado Medicaid is one of nine payers in Colorado participating in this initiative funded by the Centers for Medicare and Medicaid Services (CMS) to help primary care practices deliver higher-quality, better-coordinated, and more patient-centered care. The Department is participating entirely through the structure of the ACC program. Participating through the ACC with other payers allows providers with a smaller number of Medicaid enrollees to benefit from provider practice supports available from the RCCOs without creating additional administrative burden on the providers.

The Department has also begun working with stakeholders to better align the Children's Medical Home program with the ACC program. The Department is facilitating a stakeholder workgroup that meets twice per month to develop a proposal for this alignment. The workgroup includes representatives from the Colorado Children's Healthcare Access Program (CCHAP), the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), school-based health centers, and behavioral health providers. This workgroup is assisting the Department with considering program adjustments, such as changing the current ACC performance measurements and incentive payments to include more pediatric-focused metrics.

Program Next Steps (Master Plan)
The ACC program has a short-term (12-month) plan and a long-term plan.

Short-Term
The Department is exploring the possibility of enrolling an additional 160,000 clients during calendar year 2013. This enrollment will include a number of current Medicaid populations. First, the Department will work to contract additional Children's Medical Home

Providers and enroll clients linked to those providers into the ACC. Second, the Department plans to systematically enroll clients who are Medicare-Medicaid eligible into the ACC program.

The ACC program enables the Department to more effectively leverage current resources and programs. In the next calendar year, the Department will work on alignment with Healthy Communities, local public health agencies, County Medical Assistance sites, and the Department's Utilization Management vendor. The RCCOs' strong connection and communication avenues with providers and clients allow them to connect the right individuals with the right resources.

The ACC program is also the platform for payment reform including gainshairing and the proposals requested as directed in HB 12-1281. On December 17, 2012, Request for Proposals (RFPs) were released, and responses will be submitted to the Department in April 2013.

The Department is developing plans to increase access to the SDAC web portal for other members of a client's health team to promote greater integration. The Department will identify additional data sources to incorporate in the web portal to provide a more complete picture of client health. The Department will also expand program measures to include quality and health outcomes, as well as client and provider experience. These metrics will allow the RCCOs to improve their performance as it relates to how care is provided, not just the volume of care provided.

Long-Term

The Department is working with its partners and stakeholders to begin developing plans for the long-term strategic plan of the program. The resulting plan will begin to explore:

- long-term enrollment strategies;
- behavioral health integration;
- reprocurement of the behavioral health program for 2014;
- reprocurement of the RCCO contracts for 2016;
- payment reform initiatives such as HB 12-1281 pilot programs;
- development of health homes;
- integration of and access to dental services; and
- integration of long-term services and supports.

The ACC program is evolving. System change must occur incrementally to ensure that all members of the system are prepared, willing partners. Ongoing program evaluation identifies opportunities for improvement. The Department is committed to taking these opportunities and continuously implementing positive change in the program.

The next steps for the program will be fully developed in partnership with the Department's stakeholders through the ACC Program Improvement Advisory Committee. The Committee includes providers, behavioral health organization (BHO) representatives, consumers, and advocates. The Committee has four working subcommittees: Payment Reform; Quality and Health Improvement; Provider and Community Relations; and the Medicare-Medicaid Enrollees Demonstration. These groups ensure regular and intensive feedback to the Department.

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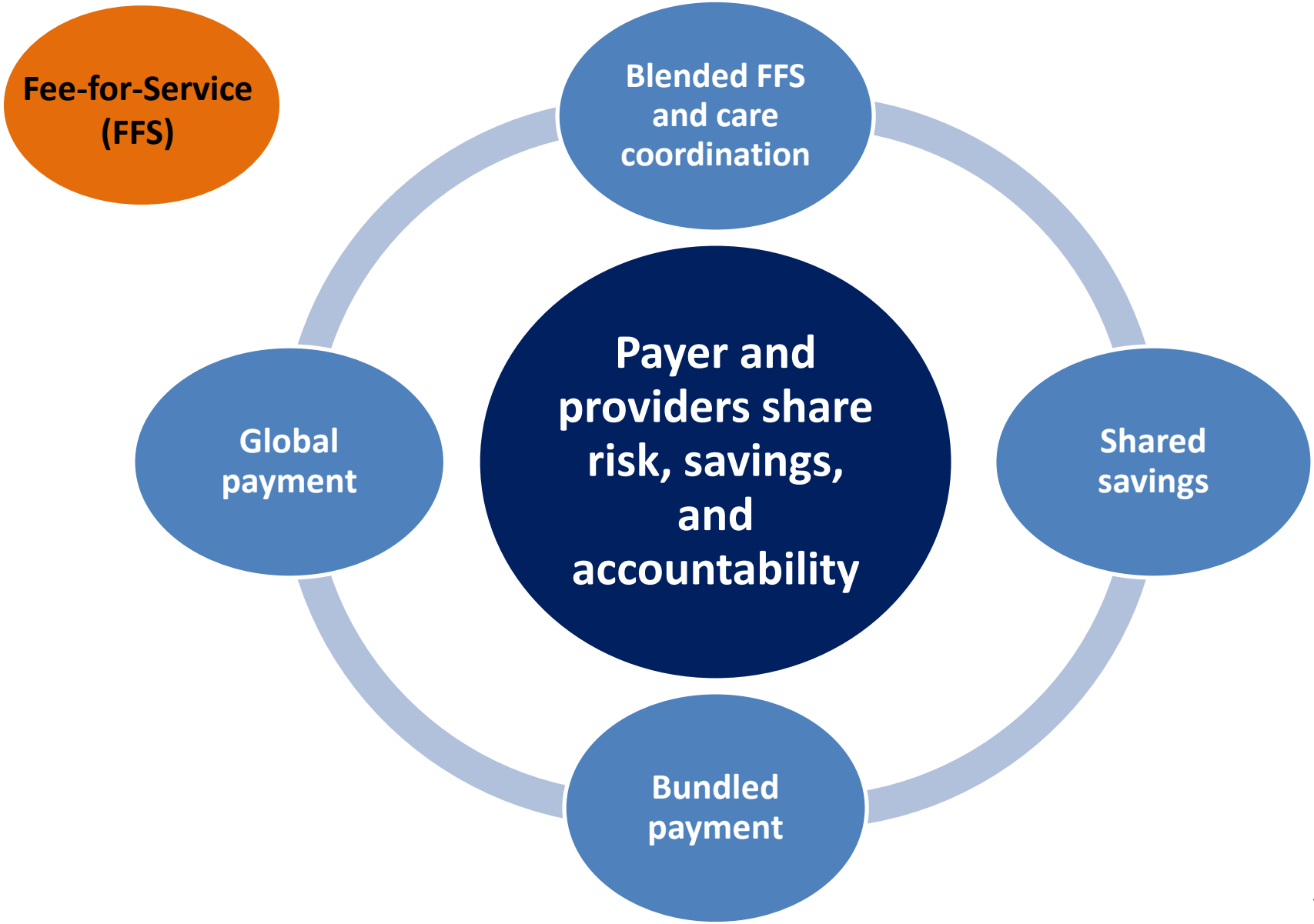
Payment Reform through the ACC



Payment Reform Goals:

- Move toward a value-based purchasing system
- Improve the delivery of care with quality health outcomes
- Reduce medical services costs
- Promote accountability at every level
- Integrate physical and behavioral health services

Shared Savings Update

- Several shared savings initiatives will be streamlined into one program under the ACC
- The Department is engaging stakeholders in a collaborative process to determine the distribution of savings between RCCOs, primary care providers, and the BHOs. The need for further discussions has pushed the implementation date to July 1, 2013

HB 12-1281 Update

- The ACC Program will be the vehicle for the 1281 payment reform pilot project
- The proposals must include an alternate payment methodology, continuing policy innovations that support improved health, reduced cost, and promote client centered care

38) Please provide an update on the Department's efforts to implement gainsharing and other payment reform initiatives authorized in FY 2012-13's R-5 and in H.B. 12-1281.

RESPONSE:

R-5 Shared Savings

The Department's FY 2012-13 budget request R-5, "Medicaid Fee-For-Service Reform," included three approved shared-savings, also referred to as "gainsharing," initiatives: Behavioral Health Organization (BHO) shared savings, Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) shared savings, and Accountable Care Collaborative (ACC) shared savings. BHO shared savings initially intended to measure psychotropic drug utilization for all Medicaid clients enrolled in the BHOs who are seriously and persistently mentally ill. FQHC/RHC shared savings was designed to measure Medicaid FQHC clients' hospital and pharmaceutical expenditure. ACC shared savings was less defined and stated that savings beyond the administrative costs of the ACC would be shared between the Regional Care Collaborative Organizations (RCCOs) and the Primary Care Medical Providers (PCMPs).

The Department has since revised its shared savings proposals. To combine delivery system reform with payment reform, reduce confusion among several separate shared-savings initiatives, support the integration of behavioral and physical health care, leverage existing infrastructure, and support the Department's ACC program, these three individual savings initiatives have been streamlined into one ACC shared-savings program. This strategy aligns the Department's payment reform goals while maintaining shared savings for providers detailed in the Department's initial proposals.

In order to ensure that the shared savings program is successful, the Department has engaged stakeholders – in particular, the BHOs, FQHCs, RHCs, and RCCOs – to design the shared-savings approaches. This process has taken some additional time as stakeholder groups come to an agreement regarding the methodology and distribution of savings with the assistance of the Department. Stakeholder workgroups will continue until the end of April 2013, and the Department anticipates that implementation will occur in the second half of 2013.

In addition, since the approval of R-5, HB 12-1281 was passed, instructing the Department to implement a number of payment reform pilots. Proposals that include shared savings are eligible to be selected as part of the HB 12-1281 payment reform pilots, though the shared savings will be separate from those described above. As a result, the Department is working to ensure alignment and synergy between R-5 and HB 12-1281 payment-reform pilots for the benefit of clients and providers and to ensure that the Department can administer these two initiatives in an effective and efficient manner.

HB 12-1281 Accountable Care Collaborative Payment Reform Initiative

HB 12-1281, referred to as the Accountable Care Collaborative (ACC) Payment Reform Initiative (PRI), allows the Department to accept proposals for innovative payment reform ideas that will demonstrate new ways of paying for improved client outcomes while reducing costs. The ACC program infrastructure will be the vehicle for delivery and payment reforms in Colorado Medicaid, and the Regional Care Collaborative Organizations (RCCOs) may submit proposals to the Department for evaluation and possible selection.

Over the past several months, the Department has worked to develop the solicitation and procurement process, has engaged stakeholders for input and feedback on draft documents, and has hired dedicated staff. The ACC PRI is soliciting proposals for payment reform projects from the contracted RCCOs. Organizations partnering with the RCCOs may collaborate in proposal development and implementation. RCCOs are encouraged to partner with providers in their region to submit proposals. Providers could include but are not limited to: primary care, hospitals, long-term supports and services, and home- and community-based service providers. Proposals could include various payment reform arrangements, such as shared savings, episodes of care payments, and global payments tied to improved patient outcomes. While the Department is allowing flexibility in order to encourage a wide range of payment reform ideas, the Department is requiring that the proposed payment models neither perpetuate the existing fee-for-service system nor create a managed-care structure that does not add innovative components beyond the traditional health maintenance organization (HMO) model.

The Department has developed and released solicitation documents for the HB 12-1281 pilot. The documents can be found on the PRI webpage under the "Guidelines for Proposals" section at the following URL:
http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1251626415803

Key activities that have been completed for the payment reform initiative include the following:

- September 11, 2012 – The Department requested that interested RCCOs submit two-page abstracts of sample payment reform ideas and projects. The purpose of these abstracts was to help define the scope of potential proposals and inform the official proposal evaluation criteria for the pilot program(s). The Department received 12 abstracts, including at least one abstract from each RCCO.
- November 5, 2012 – The Department hosted a stakeholder meeting to present a draft version of the solicitation criteria for pilot proposals and to hear feedback. Over 50 stakeholders participated in the meeting in person, and approximately 10 stakeholders participated by phone.
- November 16, 2012 – The Department hosted an additional forum to receive stakeholder input on the draft solicitation criteria document. This opportunity was incorporated into a regularly-scheduled meeting – the ACC Payment Reform Subcommittee meeting. Participants included representatives from the RCCOs, Behavioral Health Organizations (BHOs), Federally Qualified Health Centers (FQHCs), and other providers and provider associations.
- December 17, 2012 – The Department released the final solicitation document for the ACC Payment Reform Initiative, titled the Guidelines for Proposals, Solicitation #12-1281-PRI. The document, along with several appendices, outlines the purpose and goals of the PRI, the required contents of and process for submitting proposals, and the general criteria to be used by the Department for evaluation.
- December 31, 2012 – Questions from the RCCOs related to the Guidelines for Proposals (GFP) documents were due to the Department by 5:00 p.m. MST.

The timeline for upcoming activities through the selection of one or more pilot projects is outlined as follows.

- January 14, 2013 – The Department will formally respond to all submitted RCCO questions through a posting on the PRI web page.
- January 18, 2013 – By this date, RCCOs that intend to submit full pilot proposals must submit to the Department a Letter of Intent that summarizes the proposal design, including the following components: population to be served, the region(s) or county (counties) in which the pilot would operate, the policy innovation that will enhance the current Medicaid program and support the Triple Aim, and the general payment model.
- February 1, 2013 – The Department will submit to the Joint Budget Committee (JBC) a report concerning the design and implementation of the program, including summaries of the payment projects. The Department will use the project summaries collected through the Letters of Intent to complete the report. Because the development of the solicitation design was a complex and time-consuming process requiring substantial research and coordination, the Department chose to allow the RCCOs additional time to develop full proposals. Designing payment reforms for Medicaid requires the consideration of many detailed components of the program, as well as a thorough understanding of the potential real-world impacts of policy decisions.
- April 1, 2013 – Full proposals in response to the ACC Payment Reform Initiative GFP solicitation are due to the Department. The Department plans to utilize a standardized evaluation process with an executive-led committee and subject matter experts to review the submitted proposals and select one or more payment projects for implementation.
- July 1, 2013 – The Department will announce which proposals are selected for a contract. In addition, RCCOs that submitted proposals not selected will be notified in writing of the reasons for which these proposals were not chosen for implementation.

Issue Briefings

R-8 | A Limited Dental Benefit for Adults in Medicaid

Preventive dental care improves health and reduces emergency costs

- Currently adults in Medicaid have no access to preventive dental care
- Clients have limited options (e.g. extractions) for dental emergencies
- Adults who work in lower-paying industries who have no access to preventative dental care lose 2-4 times more work hours due to oral health related issues than adults who have professional positions (National Institutes of Health)

A limited benefit

- Benefits would be determined through a stakeholder process and would likely include basic preventive and restorative treatments (e.g. cleanings and filling cavities)
- There would be an annual $1,000 cap on dental services per client

The cost of providing preventive dental care is potentially

10 times

less than the cost of managing symptoms of dental disease in emergency room

Funding from the Unclaimed Property Trust Fund (UPTF)

- Benefit would be funded by a portion of the incoming revenue to the UPTF
- The UPTF is currently used to pay for CoverColorado – the state's high risk health insurance pool
- CoverColorado is phasing down as a result of federal requirements in the Affordable Care Act
- Lower emergency dental costs funded from UPTF will reduce the General Fund by over $747,000

FY 2013-14 Request:
General Fund: ($747,620)
Total Funds: $32,959,416
FTE: 1.2

16) Please explain the Department's estimate of the costs, savings, and federal match rate associated with the proposed new dental benefit. Especially, please focus on FY 2012-13 and how the expected wind-down of expenditures for CoverColorado aligns with the expected costs for the Department during the phase-in of the dental benefit.

RESPONSE:

Costs

In its November 1, 2012 Budget Request R-8, "Medicaid Dental Benefit for Adults," the Department proposed a dental benefit for adults that would cover preventive care up to a cost of $1,000 per year. Based on data available from North Carolina, the Department assumed that not all clients would receive the full $1,000 of services that the benefit permits but would instead receive an average of $600 of services per client. The Department selected North Carolina as a model because it has the most comprehensive Medicaid dental benefit information available. In addition, CMS singled out North Carolina as one of eight states with innovative practices and the adult dental benefit that might be used as a prototype for stakeholder discussion in Colorado.

Based on data available from other states and studies, the Department estimated that 27.0% of eligible clients would receive services each year (see Table 4 of the R-8 request). However, the Department also assumed that not all of the clients who would eventually utilize the benefit would do so immediately, as it would take time for them to become aware of the benefit and schedule appointments with providers; therefore, the Department's estimates for the overall utilization rate are lower in the first year of the program's implementation.

The Department assumes the administrative costs of managing this benefit would be between $1 and $3 per member per month (PMPM). It is important to note that a PMPM would be applied to all clients eligible for the benefit rather than only clients who actually utilize services. This estimate is based on current knowledge of administrative rates and could increase or decrease, depending on the vendor selected through the request for proposal (RFP) process. The Department may pay the vendor a fixed price per year, as opposed to a monthly fee, based on the number of clients served; this would be determined through the RFP process. To simplify these undetermined administrative costs, the Department estimated a $2.00 PMPM for each client eligible for the benefit.

Savings

The Department assumed coverage of preventive treatments would reduce the volume of emergency care and extractions, as regular access to preventive care can prevent the development of acute dental conditions. In order to estimate the potential decrease in emergency care, the Department reviewed other states' Medicaid programs. No states have recently implemented or expanded their adult dental benefits; therefore, the Department examined the dental-related emergency service utilization that other states reported after reducing or eliminating their adult dental benefits in Medicaid. The following states reported an increase in dental-related emergency visits after reducing or eliminating their adult dental benefits: Michigan (11% increase after six months); Massachusetts (30% increase after six months); Maryland (21% increase after 12 months); and Iowa (224.7% increase over seven years, despite only a 16.3% increase in caseload). Based upon these findings, the Department considered it reasonable to assume a 15% reduction in FY 2013-14 and a 30% reduction in FY 2014-15 in emergency dental services after implementing an adult dental benefit that provides preventive services aimed to reduce more-costly restorative services in the future. The Department notes this dental benefit may produce other potential savings and benefits that cannot be readily measured. For

instance, clients who receive treatments that enhance the appearance of their teeth may be able to secure employment more readily than those who have not received any dental treatment.

Federal Match Rates
Providing dental coverage to adults is allowable under the Social Security Act. Therefore, the Department assumes services provided would qualify for the standard federal medical assistance percentage (FMAP) of 50%. Costs for system changes to the Medicaid Management Information System (MMIS) would qualify for 75% federal financial participation.

CoverColorado Wind-Down and Dental Benefit Phase-In
According to the Joint Budget Committee staff briefing document for the Department of Treasury (page 14), the Unclaimed Property Trust Fund (UPTF) is expected to receive $34.0 million in revenue in each year through FY 2014-15. This amount does not include interest earnings and does not account for any available fund balance. The Department estimates that a fully operational dental benefit would require $21.9 million annually from the UPTF by FY 2014-15; therefore, the Department believes revenue from the UPTF would exceed projected costs for the program by a substantial amount. The Department notes this amount would be less in the first year of the program because of program ramp-up. For example, with an assumed start date of April 1, 2014, the Department calculated it would need $12.8 million from the UPTF in FY 2013-14.

The Department's requested implementation date of April 1, 2014, assumed CoverColorado would cease operations by that date and would require no further funding from the UPTF. However, information provided during the Department of Treasury's Joint Budget Committee staff briefing on December 20, 2012, indicates that CoverColorado will end coverage by April 2014 and cease operations by the end of CY 2014. Based on these dates, Joint Budget Committee staff estimated the FY 2013-14 available balance of the UPTF to be $8.3 million, or $4.5 million less than the Department projected for the estimated costs of the program in FY 2013-14. As a result, the proposed implementation date of the adult dental benefit may need to be modified to account for the available balance of the UPTF.

The UPTF is projected to have enough incoming revenue to sustain the proposed adult dental program; however, the reserve requirement for the CoverColorado program (projected to be $103.6 million in FY 2014-15) would decrease the available balance to less than the $22.8 million that the Department estimates is needed in cash funds to fund the dental benefit in FY 2014-15. However, the Department anticipates the reserve requirement will diminish over time as CoverColorado ceases operation and a portion of that funding will become available to fund the proposed adult dental benefit. Once the reserve requirement is eliminated, the Department believes the annual revenue into the UPTF will fully support the adult dental benefit without any need to use the fund balance.

17) What are the Department's projections of future revenue available from the Unclaimed Property Trust Fund (UPTF)? Will the revenue be enough to sustain funding for the dental benefit from this source in the future?

RESPONSE:

The Department is basing its estimate for the Unclaimed Property Trust Fund (UPTF) revenue and fund balance on the Joint Budget Committee's staff briefing document for the Department of Treasury (page 14). In FY 2014-15, the UPTF's $34.0 million in projected net

revenue would exceed the $21.9 million in funding the Department estimates would be needed to fund the adult dental benefit during that fiscal year. The Department believes the incoming revenue to the UPTF would support the program for the foreseeable future.

18) What are the legal limitations on the uses of the Unclaimed Property Trust Fund?

RESPONSE:

Per section 38-13-116.5 (1)(b) and (d), C.R.S. (2012), the principal of the trust fund shall not be expended except to pay CoverColorado health insurance claims or the Unclaimed Property Trust Fund's (UPTF) administration, and the principal is not subject to appropriation by the General Assembly. The funds in the UPTF do not revert to the General Fund at the end of any fiscal year.

Given these provisions, the General Assembly would need to amend the existing statute to allow the Department to utilize UPTF monies to fund the proposed dental benefit.

19) How does the proposed dental benefit compare to legislation on dental benefits last year? Why did the Department decide to change the scope and financing?

RESPONSE:

SB 12-108, "Concerning providing oral health care to pregnant women who are enrolled in Medicaid," would have provided a dental benefit only to pregnant women and would have placed a specific list of covered services in statute, including a single comprehensive examination, prophylaxis, debridement, cariostatic agents, radiographs as needed, and up to five restorations. SB 12-108 was financed using General Fund revenue to cover the State cost of the program.

The Department's proposed Medicaid dental benefit for adults, as proposed in R-8 of the Department's November 1, 2012 Budget Request, would cover all adults in Medicaid including pregnant women. To ensure that clients have access to the proper services, the services covered would be determined through the Department's Benefits Collaborative process. In order to track each client's service costs and ensure proper utilization, the Department anticipates the benefit would be managed by a third-party administrator under an administrative services organization (ASO) structure.

To finance the services, the Department requested funding from the Unclaimed Property Trust Fund (UPTF) which will become available when many of the CoverColorado members are transitioned to private insurance available through the Colorado Health Benefits Exchange. The Department anticipates the UPTF will generate revenue of $34 million annually; therefore, due to the finite amount of funding available from the UPTF, the benefit would employ an annual per-client cap of $1,000. The Department's request would not require any General Fund to provide services but would result in an estimated savings to the General Fund in the amount of $747,621 in FY 2013-14 due to a reduction in emergency dental services.

SB 12-108 was not a Department-initiated bill; therefore, the Department does not consider its proposed dental benefit in the budget request to be a change in scope or financing. This request represents the first time the Department has independently proposed a dental benefit for adults.

The availability of funding through the UPTF provides a unique opportunity to serve an unmet medical need that will have an impact on health and save money currently being spent on emergency dental services with no impact to the General Fund.

20) What is Colorado's provider capacity to handle a benefit expansion? What is the Department doing to ensure providers are sufficient and prepared?

RESPONSE:

The Department has the capability to increase the capacity of the provider network to support a benefit expansion. There are many initiatives and collaborations underway that have helped increase the number of dental providers enrolled from 1,484 in FY 2008-09 to 2,087 in FY 2011-12, a 40.6% increase. In addition, a dental benefit expansion could, in fact, alleviate a dental provider shortage, as it would make it more financially feasible to serve areas with dental provider shortages.

Initiatives to increase provider capacity include a contract the Department awarded to a vendor to perform provider retention and recruitment functions, including dental providers through July 2013. Additionally, the Department works collaboratively with Cavity Free at Three, a grant-funded, statewide initiative of dentists, physicians, public health professionals, foundations, and child-health advocates that is currently engaged in a statewide effort to recruit pediatric dentists for the Medicaid program.

Colorado experiences dental provider shortages in the rural areas. To combat this problem, the Department is collaborating with the Colorado Dental Association (CDA) and the Oral Health Colorado coalition (OHCO) to develop a dental practice satellite model in areas of limited dental access. The stated goals of the satellite model are to: 1) identify rural counties for a pilot program; 2) connect dentists with rural communities by offering incentives; and 3) assist independent hygienists serving the community with a business model. The Department will collaborate with CDA and OHCO to evaluate the use of and billing for tele-dentistry in rural areas. Tele-health is increasingly being used to serve clients in rural areas as a cost-effective alternative to delivering face-to-face care and ensuring that clients in rural areas have access to care.

Building on current initiatives and collaborations identified above, the Department expects the dental Administrative Services Organization (ASO) to ensure providers are sufficient and prepared. As a core element of the dental ASO contract, the dental ASO is responsible for developing and managing the provider network and ensuring the provider network is delivering appropriate, evidence-based dentistry through efficient practice models.

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R-9 | Better Managing the Dental Benefit for Children in Medicaid

Need for a more focused benefit management

- Dental benefits for children in Medicaid are federally mandated
- Current benefit is in fee-for-service – this incentivizes volume, not value
- Expenditures for this benefit have increased by 93% from FY 2007-08 to FY 2011-12
- Nearly 180,000 children in Medicaid did not receive preventive dental care in FY 2010-11

Leveraging private sector experience

- Utilize a dental administrative services organization (ASO) to better manage the benefit
- ASOs offer multiple benefits:
  - Utilize a dental care coordinator to call parents and set up cleanings
  - Expand the current provider network
  - Provide the Department with data analysis and recommendations on benefit modifications
  - Moving to an ASO would align with the Governor's 10 winnable battles and CDPHE efforts
- ASO contract would be competitively bid
- Contract would require costs to be budget neutral with the possibility of savings

FY 2013-14 Request:
General Fund: $0
Total Funds: $576,072

14) How does the proposed dental benefit fit with other payment reforms the Department is implementing? How will the Department track changes in health outcomes and how will the Department attribute those changes to the dental benefit versus other reform initiatives, such as the Affordable Care Collaborative, gainsharing, or payment reforms authorized by H.B. 12-1281?

RESPONSE:

The proposed change to the children's dental benefit aligns with the work the Department is doing on both benefit redesign and payment reform. The implementation of an Administrative Services Organization (ASO) model for the Children's dental benefit aligns directly with the Accountable Care Collaborative (ACC), the Department's delivery system reform model for other services. The goal is to have a dental care delivery system using a similar delivery system and payment model as the ACC. Like the ACC, the dental ASO will manage the fee-for-service dental benefit, which includes utilization management, improving and enhancing the provider network, and coordinating care delivery. The payment of a per-member per-month (PMPM) to incent appropriate utilization and care management is a step toward payment reform. The dental ASO model would not only increase access to care and improve the care delivered through proper management of the provider network, it also lends flexibility to implement additional payment reform measures going forward. Any possible dental payment reform measures will align with existing payment reform measures that have demonstrated success in Department models like the ACC. A dental benefit that is functioning purely as fee-for-service does not fit in with the other payment and delivery system reforms the Department is implementing. Ultimately, the Department envisions the integration of the dental ASO with the ACC, which is a constantly evolving model for care delivery. The alignment of the dental ASO and ACC models will lay the foundation to integrate both models in the future. While now is not the time to integrate dental into the ACC, the dental ASO will help bring appropriate dental expertise to the ACC.

The alignment of the dental ASO and ACC models supports the Department's goal of improving overall health outcomes and the client experience, as well as lowering per capita costs. While all Department efforts support this goal, it is difficult to attribute cost savings to a specific intervention. However, the Department is committed to continued tracking and reporting on process measures that look at trends over time and access to care. Current process measures examined by the Department are found within the Department's Healthy Living oral health initiatives and the dental performance measures, as well as measures examined by the Department over the past four years, including utilization of dental treatment and prevention services and sealants. These measures align with the clearly defined measures identified by the Centers for Medicare and Medicaid Services (CMS), which has required Colorado, along with all states, to develop a Medicaid/Child Health Plan *Plus* (CHP+) dental action plan, which outlines the Department's roadmap for reaching CMS' goal for each state to increase its respective prevention services and dental sealants by 10 percentage points from FFY 2012-13 through FFY 2017-18.

15) What is the benefit of having an Administrative Services Organization (ASO) manage the children's dental benefit and the proposed new adult benefit? Would the outreach and care management functions of an ASO overlap with the Affordable Care Collaborative (ACC)? Should these functions be merged into the ACC?

RESPONSE:

The benefits of a fee-for-service model managed by an ASO include:

- proper management of the provider network – enhanced provider recruitment efforts and strategies, a robust provider credentialing system that ensures client access to an adequate provider network, the provision of provider support, and Medicaid education to increase provider satisfaction;
- guidance and recommendations on an enhanced claims adjudication process;
- client outreach and education to improve overall access to the dental benefit;
- utilization management to ensure provision clinically appropriate services;
- benefit management that may consist of guidance about evidence-based dentistry guided by best practices and recommendations on benefit limitations and exclusions; and
- infrastructure to comply with CMS' goals for the states and meet the Department's oral health performance measures and Healthy Living initiatives.

While the outreach and care management functions of an ASO align with the ACC, and do not overlap, now is not the time to integrate dental into the ACC. The outreach and case management functions would be complementary and synergistic with the work of the RCCOs. Ultimately, the Department envisions the integration of the dental ASO with the ACC. The synergies would be a result of the appropriate dental expertise the dental ASO will help bring to the ACC in the future.

In order to realize these benefits of a dental ASO model, the Department must consider a comprehensive systems approach and model that not only maximizes health outcomes but bends the cost curve. Due to economies of scale and specific dental expertise, it is the Department's opinion that an ASO that delivers and manages dental services is the best model to improve health outcomes and client experiences as well as lower per capita costs. This aligns with the ACC model, which has shown positive results in the delivery of physical health services.

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Changes to Pharmacy Reimbursement

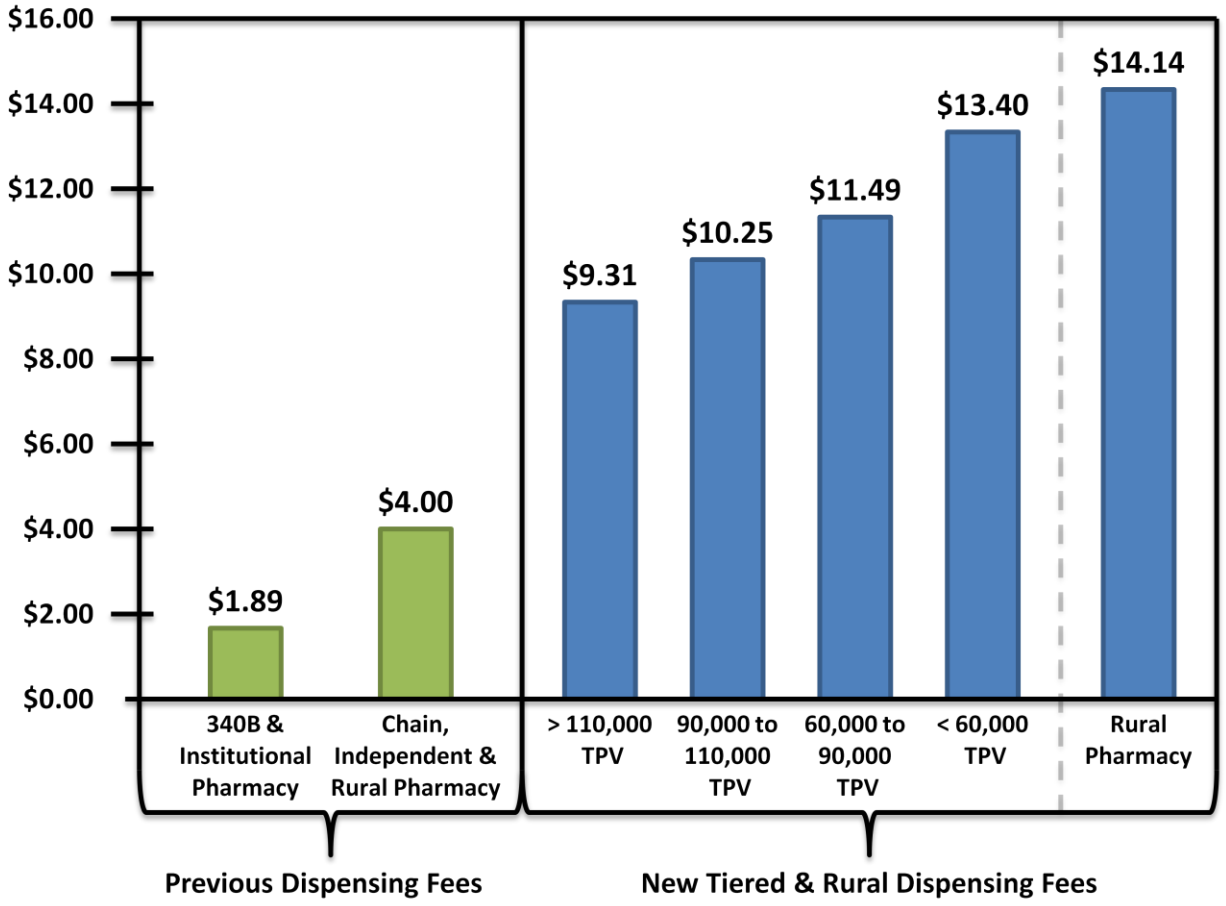
Changing to a fair, transparent reimbursement methodology

- Old reimbursement methodology was based on an artificially inflated pricing index
- The new reimbursement methodology is the weighted average acquisition cost based on actual acquisition cost data submitted by Colorado pharmacies

Potential pharmacy initiatives to improve health and reduce costs

- Expand the Rx Review program to a full Medication Therapy Management program
- Incentivize providers to participate in the Department's Client Over Utilization Program
- Expand the Department's current Drug Utilization Review vendor contract to:
  - review physician administered drugs, one of the highest expenditure areas and largely unmanaged currently
  - provide specialist prior authorization review and/or peer to peer consultation on complex cases
- Reimburse pharmacists for providing immunizations

- **AAC and dispensing fees:**
  - Effective February 1, 2013, pharmacy reimbursement will be based on Average Acquisition Cost + dispensing fee
  - AAC will be determined using the actual acquisition costs incurred by pharmacies
  - Dispensing fees will be set based on the pharmacy's total prescription volume and status as a rural pharmacy



TPV: Total Prescription Volume

  - There is a direct correlation between total prescription volume and the costs associated with dispensing medications
  - CMS approves of the AAC methodology and the tiered dispensing fees

33) Please explain how the Department will calculate pharmacy acquisition costs? Is it average acquisition cost or actual acquisition cost?

RESPONSE:

Pharmacy acquisition cost is the ***weighted average acquisition cost*** for like drugs grouped by Generic Code Number (GCN) based on actual acquisition cost data submitted on invoices by Colorado pharmacies. GCN is a standard number used to group drugs with the same ingredients, drug strength, and dosage form. The Department is also weighting each drug within a GCN by invoice purchase records so that drugs more utilized by Colorado pharmacies will be more represented in Medicaid reimbursement.

For pharmacy providers, the survey invoice process will more closely align and maintain a reimbursement that reflects actual current costs. While the cost of providing a service may vary from provider to provider, the reimbursement does not change. Providers are thereby incentivized to provide the service or purchase the product in a more cost-effective manner. The majority of other Medicaid providers are not reimbursed based on their cost, and many providers are paid less than their cost.

To ensure that the average acquisition cost is a fair reimbursement rate, the Department is currently analyzing pharmacy-submitted invoice data to identify whether acquisition cost differs by pharmacy type (independent and retail) or pharmacy size (total prescription volume). If this analysis shows a difference in acquisition cost by either pharmacy type or size, a percentage adjustment will be applied to the calculation of average acquisition cost rates to offset the difference. Similar to Colorado, the Centers for Medicare and Medicaid Services (CMS) has already completed analysis comparing acquisition cost between urban and rural pharmacies as well as chain and independent pharmacies using collected invoice data from all states. CMS's findings concluded that, while there are differences in acquisition cost based on pharmacy type, these differences are negligible.

The alternative of using each pharmacy's actual acquisition cost would require expensive billing system updates, be burdensome for both the State and providers, and be difficult and expensive to audit.

34) Are there ways the savings from using the new pharmacy reimbursement methodology could be reinvested in initiatives that promote more effective use of pharmaceuticals to improve health outcomes and reduce long-term costs?

RESPONSE:

The Department believes that several options exist, which, with expanded funding, could promote more effective use of pharmaceuticals, improved health outcomes, and reduced long-term costs. The expansion of the Department's Rx Review program, authorized by HB 07-1021, to a full Medication Therapy Management program, could serve the Department's clients statewide and would be a promising investment.

Another option is enhanced payments to pharmacies and prescribers that act as "lock-in" providers to select Medicaid clients in the Client Over Utilization Program (COUP). The COUP is a utilization control program designed to rectify client overutilization of medications and services. This program restricts clients to one designated pharmacy and primary care physician. By providing incentive payments to participating

providers, the Department anticipates greater overall participation from providers which would lead to greater reductions in the inappropriate use of medications. The Department also sees the potential for meeting these goals by expanding the Department's current Drug Utilization Review (DUR) vendor contract with the University of Colorado, Skaggs School of Pharmacy, to include additional services. By expanding its retrospective claims-review efforts to physician-administered drugs, the Department could target one of its highest expenditure pharmaceutical areas. In addition, the DUR vendor has previously proposed a program which could provide specialist prior-authorization review and/or peer-to-peer consultation for patient-specific prior-authorization medical-necessity requests.

The Department believes additional efforts can be focused under the current structure of the Accountable Care Collaborative (ACC). By incorporating the previously mentioned initiatives into the ACC model for increased collaboration, duplication of effort can be avoided, and overall program savings can be accounted for more easily. Integrating the pharmacist into the collaborative team would be an effective use of resources resulting in overall program benefit and improved health outcome.

35) What are the Department's concerns about RX Review?

RESPONSE:

The Rx Review Program was implemented in 2008, in accordance with HB 07-1021, which sought to promote better medication management for Medicaid clients through consultations with pharmacists. While the program has proven to be beneficial for clients, the program, as it currently exists, has significant limitations. The Department's primary concerns with the program are related to resource constraints. These constraints have downstream impacts, such as low participation rates, inequitable reimbursement for pharmacists' time and effort, and high administrative burden relative to the overall scope of the program.

Annual program funding of $16,950 severely limits the number of clients who can benefit from the program. At current reimbursement levels and assuming full utilization of funding, the Department anticipates that approximately 220 clients will participate in the program in FY 2012-13. In order to stretch existing funds as far as possible, consultations are limited to only one per year, which reduces program efficacy on a client-specific basis. Further, because of limited pharmacist participation (largely due to low reimbursement levels), the program is not consistently available across the State.

Equitable reimbursement for pharmacists providing medication management in the Rx Review program is also of concern to the Department. Limited program funding prevents the Department from reimbursing pharmacists more than $75 per review. With reviews requiring up to five hours of a pharmacist's time, reimbursement amounts to $15 per hour, which is insufficient, and few pharmacists are willing to participate in the programs (i.e., at five hours, the hourly rate is $15 per hour). In cases where a pharmacist performs initial outreach efforts and the client declines to participate in the program, the pharmacist is not compensated for their efforts.

Lastly, the program is time intensive to both pharmacists and Department staff. The Department's process is primarily manual and includes: contracting with pharmacists, analyzing data to find clients who meet program criteria, matching clients to pharmacists, providing pharmacists with the information needed for the consultation, confirming that the consultation was completed, and paying pharmacists. The documentation and consultation process for pharmacists is predominantly manual as well. Given low participation levels and limited program scope, the

administrative burden is not commensurate with the benefits achieved. The program essentially lacks economies of scale and lacks sufficient funding to remedy process, participation, and reimbursement issues.

A more comprehensive program where the aforementioned concerns are addressed could provide access to all qualified clients wherever they are located. Other medication therapy management programs are more automated, which greatly improves the efficiency of the programs. In other medication therapy management programs, the pharmacists meet more regularly, sometimes quarterly, with the clients to follow up on medication changes and recommendations. Through this regular interaction, a pharmacist can develop relationships with the clients, follow up on past recommendations, and continue to monitor the client's medications for further modifications.

The Department notes that if a sizable appropriation is granted for an expansion of the RX Review program to create a more comprehensive program, the Department may be compelled to use the state's competitive procurement process to procure a vendor to perform these functions. Such a vendor may not necessarily be required to contract with local pharmacists to perform these reviews.

36) What would be the characteristics of an effective drug management therapy program? What does the literature say about the performance of these programs? How much would such a program cost?

RESPONSE:

An effective drug-management therapy program includes: 1) efficient, thorough ways to identify clients who could benefit from the program; 2) efficient methods by which to transfer medication information to and from the consulting pharmacist; 3) a comprehensive review of prescription medications, vitamins, over-the-counter medications, and herbal supplements; 4) an interactive, person-to-person consultation either telephonically or face-to-face; 5) regularly scheduled follow-up consultations; and 6) written reports and assessments regarding the client's medications that are shared with the client's other health care providers.

Through these consultations, the pharmacist would work with the rest of the client's health care providers to identify, resolve, and prevent medication-related problems, including:

- screening for drug-drug and drug-OTC/supplement interactions;
- screening for duplicative drug therapy;
- evaluating the client's response to current therapy, including drug effectiveness and safety;
- using multiple prescribers and/or pharmacies; and
- medication adherence issues.

CMS has established guidelines for Part D medication therapy management programs which, although they do not apply specifically to Medicaid programs, can be helpful when developing an effective drug management therapy program. The guidelines include: 1) enrolling targeted clients using an opt-out method of enrollment only; 2) targeting clients for enrollment in the medication therapy management program at least quarterly during each plan year; and 3) offering a minimum level of services for each client enrolled in the medication therapy management program that includes interventions for both clients and prescribers as well as annual comprehensive medication reviews with

written summaries. The comprehensive medication review must include an interactive, person-to-person consultation performed by a pharmacist.[1]

As reported in the literature, the effectiveness of medication therapy management programs varies. One highly successful program in North Carolina is Checkmeds NC, which is a service offered to Part D beneficiaries. Based on an expenditure of less than $1 million through a commercial medication therapy management program, the program has claimed a return on investment (ROI) of $13.1 million in savings. In contrast, a pilot study of a medication therapy management program within the North Carolina State Health Plan utilized one chain's pharmacies to target 88 Medicaid clients to receive quarterly, face-to-face reviews. This program provided $6,720 in reimbursement to pharmacists and yielded an annual net cost avoidance of $2,724. The program did not result in statistically significant improvement in medication management as the ROI was 1.4 to 1 (J Am Pharm Assoc., 2010). Additionally, another pilot program, the North Carolina nursing home Polypharmacy Initiative, was conducted on Medicaid clients residing in 12 nursing homes. This initiative cost the North Carolina Medicaid program $8,700 in payments to physician and pharmacist consultants and yielded an annualized drug cost avoidance of $113,340, based on a one-month savings of $9,445. An estimated ROI of 13 to 1 was assumed (Trygstad, 2006). Similarly, according to an article in Health Affairs, Connecticut Medicaid had a pilot program in which 88 clients participated. Drug claims for those participants totaled $423,387, and total healthcare costs (medical, hospital, pharmacy, and emergency room visits) amounted to $574,817. Based on an extrapolation of the initial success of the program, had the pilot program continued for a year, drug costs would have been $324,553, and the total health care costs would have been $434,465. Per client, the estimated cost avoidance was roughly $1,600 annually. Thus, the estimated total savings were approximately 2.5 times the cost of the fees associated with the program.

Unfortunately, there are flaws in the cost avoidance methodologies. Sample selection details, attrition information, and selection bias are all potential factors. For example, within the Connecticut study, the estimated total costs for the Medicaid participants are aggregate figures based on the previous year with no explanation of the methodology used. The study-year estimates had simply been extrapolated and then subtracted from the actual aggregate costs, then divided by the total number of participants (n=88). The resulting figures are $1,123 in savings per patient on drug claims and $472 in total health expenditures. There is also potential selection bias because the same group that completed the study also calculated these savings.

Measuring the effectiveness of these programs is difficult in part because the savings projections are difficult to quantify. Savings from these programs result from: 1) decreased spending on medications, and 2) better health outcomes. Savings projections based on the decreased spending on medications are further complicated in Medicaid programs because of manufacturer rebates received by Medicaid. Because of these rebates, some medications that are generally more expensive are actually cheaper for the Medicaid program. The rebate information is confidential and cannot be shared with drug therapy contractors. Since the contractors are not aware of the rebate amounts, they sometimes recommend switching medications to what they think would be cheaper, when they are, in fact, not cheaper. As a result, the medication therapy management contractor tries to capture that as savings to the Medicaid program when it actually is not.

[1] Medication Therapy Management 42 C.F.R. §423.153(d); Prescription Drug Benefit Manual, Chapter 7 of the 2012 Contract Year Medicare Prescription Drug Benefit Solicitation for Applications for New Prescription Drug Plans Sponsors.

It is also difficult to tie changes in medication therapy directly to improved health care outcomes. For example, eliminating a duplicative use of blood pressure medications may avoid a hospital stay for overly low blood pressure. However, calculating the potential savings for that avoided hospital stay has been difficult historically for medication therapy management programs.

The cost of a medication therapy management program could vary significantly, depending on the structure of the program. A contractor that could run a full program and contract with the pharmacists to provide the services might charge between $60,000-$500,000 per year (depending on the number of clients included in the program) for the administrative costs, plus a payment to the pharmacists for their services, ranging from $10 for each client education to $75 for each consultation. Through the administrative fee, the contractor would take care of much of the administrative work that the pharmacists are currently doing under the Rx Review program. Thus, the payment of $75 would be much more in line with the work being done by the pharmacist.

37) What are the Department's views on reimbursing pharmacists for providing immunizations?

RESPONSE:

The Department understands there can be benefits to reimbursing pharmacists for providing immunizations to Medicaid clients. The Department recognizes this service could provide further access for clients to certain immunizations through a trusted, accessible health care provider. However, the Department has concerns whether a current policy change to allow pharmacists to immunize would be cost-effective. The change to allow pharmacists to provide immunizations would require increased coordination between providers, computer system changes that could cost a significant amount of money, and pharmacists to participate, which they may not do based on the reimbursement structure.

For adult clients (ages 19 and older), the current reimbursement rate for covered immunizations across all provider types is the cost of the vaccine plus an administration fee of $6.33. Since all provider types are currently reimbursed the same way, the Department would likely reimburse pharmacies at this same rate as well. To contrast, effective February 1, 2013, pharmacies will be reimbursed $9.31-$14.14 plus the cost of the drug for each medication that is dispensed. For clients 18 and younger, the Department reimburses the administration fee only for most immunizations. The Vaccines for Children (VFC) Program provides a supply of federally purchased vaccines to be administered to eligible children – such as children on Colorado Medicaid – at no cost to any public or private health care provider that participates in the VFC Program. The Department encourages providers that render vaccines to clients ages 18 and under to enroll into the VFC Program. Since providers in the VFC Program can get VFC-covered vaccines free of charge from the VFC Program, the Department does not reimburse providers for the cost of VFC-covered vaccines, although provides do receive (but does reimburse for the $6.33 administration rate fee for the vaccines rendered). Many vaccines, including the flu vaccine, are covered by the VFC program for children 18 years and under.

In order for pharmacies to participate in the VFC program, pharmacies would be required to enroll as a VFC provider. Currently, pharmacies are not listed as eligible providers under the VFC Program. Thus, a change to the VFC Program, which is administered by the Colorado Department of Public Health and Environment, would be necessary in order for the pharmacies to receive the vaccines through the VFC Program. Given the reimbursement rates for immunizations as compared to medications, the Department is concerned about the actual participation rate that would be realized if pharmacies were allowed to provide immunizations. Additionally, because pharmacists are not currently allowed as billing providers for immunizations, even just to collect the administrative fee, the current Department's claims Medicaid Management Information System (MMIS) would require changes at potentially significant cost. With a full MMIS reprocurement on the

horizon, implementation of non-required system changes over the other necessary system changes may be difficult to justify. This is particularly true given the reimbursement rates that would be paid to pharmacists and the question as to how many pharmacies would actually participate.

The flu vaccine is an example of a vaccine that could be administered by pharmacists. Currently, Federally Qualified Health Centers can administer the flu vaccine and are reimbursed for that administration through their encounter rates. Physician offices, various clinics, and hospitals can also administer the flu vaccine. In FY 2011-12, approximately 32,000 clients (about 20,000 of whom were children) received a flu vaccine from these providers, and the Department paid approximately $400,000 for these flu vaccines. If pharmacists could also administer the flu vaccine, some of these clients may choose to receive their vaccines from the pharmacists instead of the provider they used in FY 2011-12. In those cases, the funding would come from money otherwise already paid to other providers. Some additional clients who did not receive a flu vaccine in FY 2011-12 may choose to get one from their pharmacist. The funds for those vaccines could come from reinvestment of the savings from the new pharmacy reimbursement methodology. There are no guarantees that additional clients will opt to receive the flu vaccine. Simply put, it may not be cost-effective to make the necessary changes to allow pharmacists to administer vaccines.

In summary, the Department recognizes the value of pharmacist-provided immunizations. However, consideration must be given to the time and cost of updating the current claims system to allow for this billing, potential difficulties in getting information back to the clients' medical providers, and the likelihood that many pharmacies would not participate.

Vision for Long Term Services and Supports

Improve the experience of care, improve client health, and reduce per capita costs

Quality Programs

Client-centered

Cost-effective

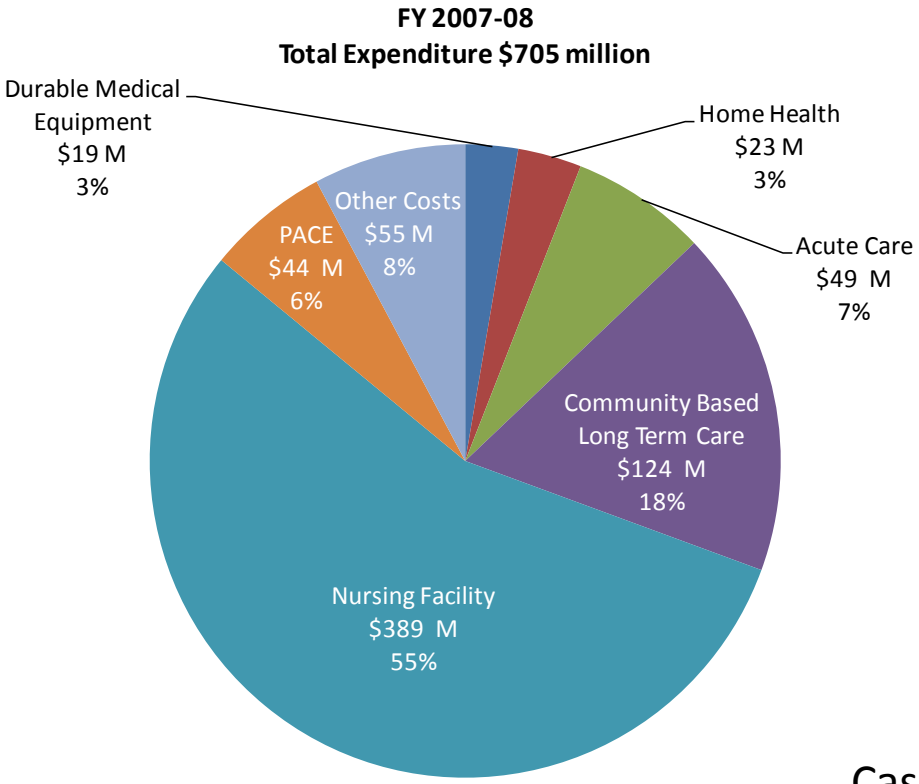
Long Term Services and Supports

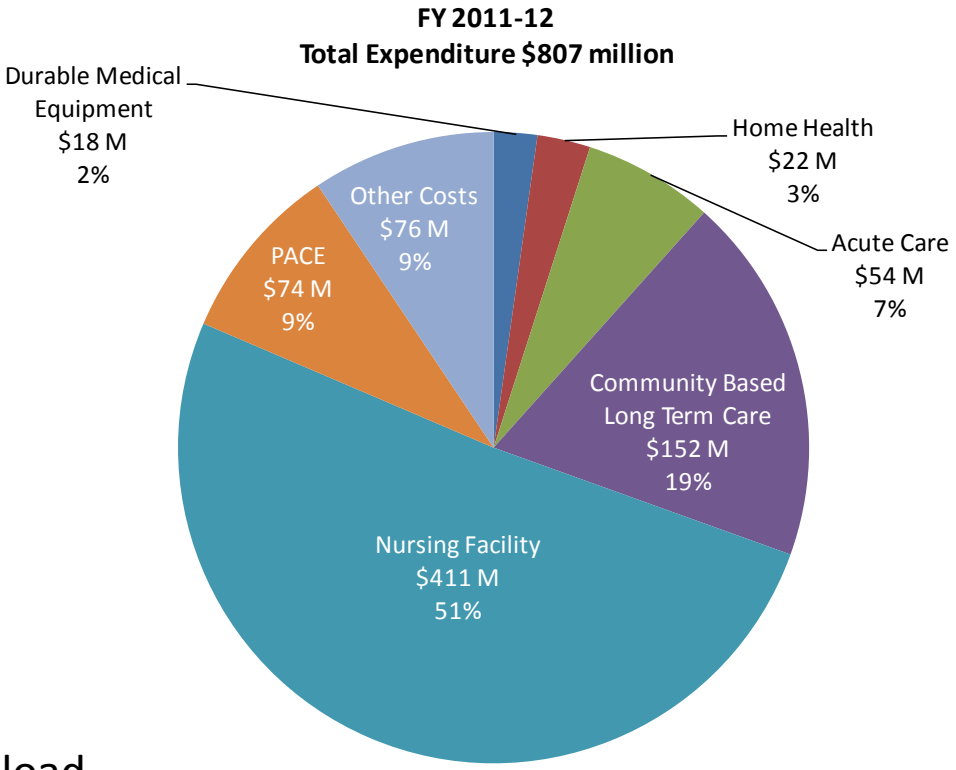
- Major component of the budget
  - $1.8 billion spent for 110,000 clients
  - 58% of physical health services costs and 16% of caseload
  - Fragmented and complex service delivery

- Significant efforts underway to improve
  - Program operations and management
  - Data analysis
  - Benefit Management
  - Partnership with clients, providers, and stakeholders

Adults 65 and Older

FY 2007-08 Expenditures vs. FY 2011-12



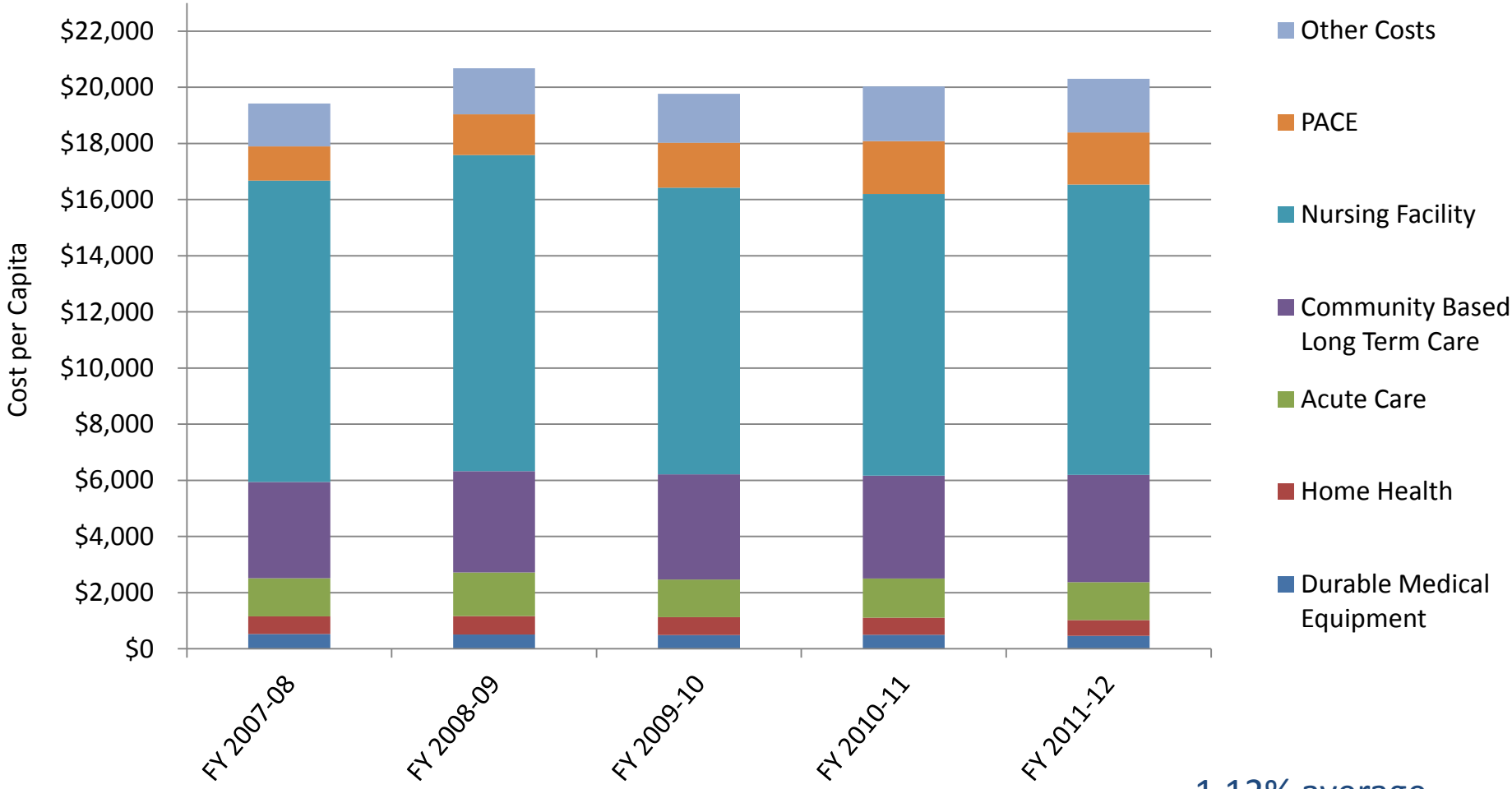


Caseload

FY 2007-08: 36,284

FY 2011-12: 39,740

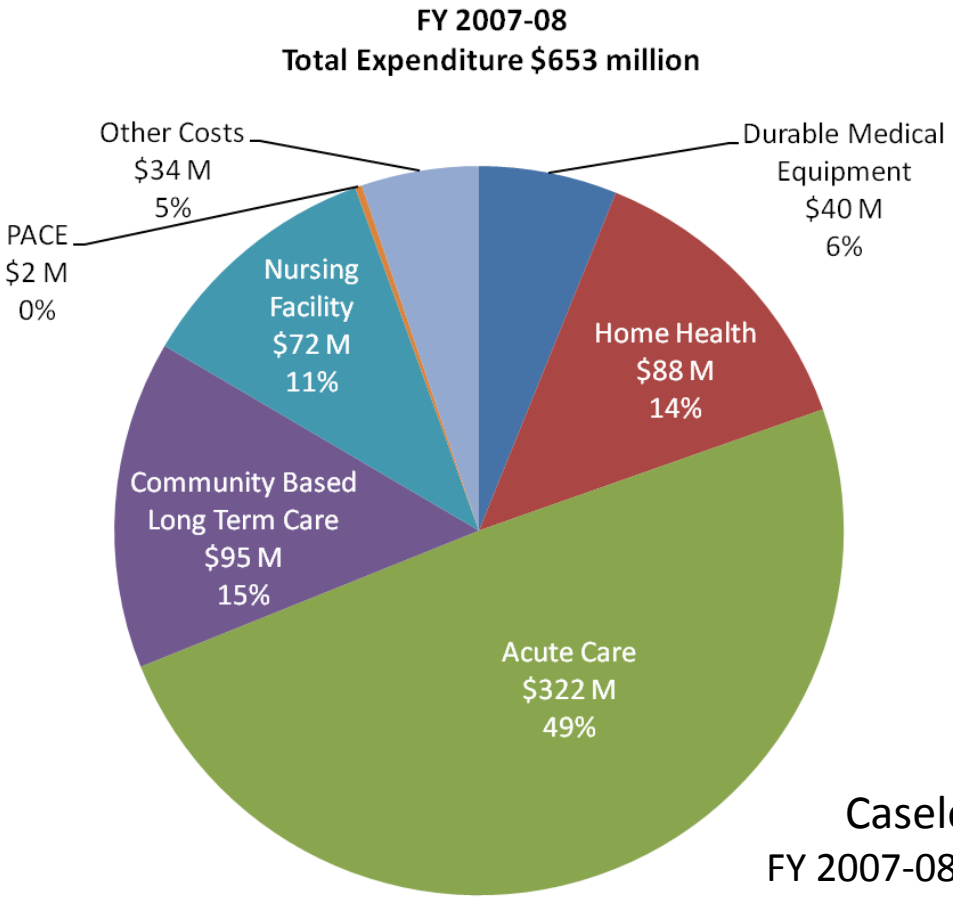
Adults 65 and Older
Per Capita Expenditures

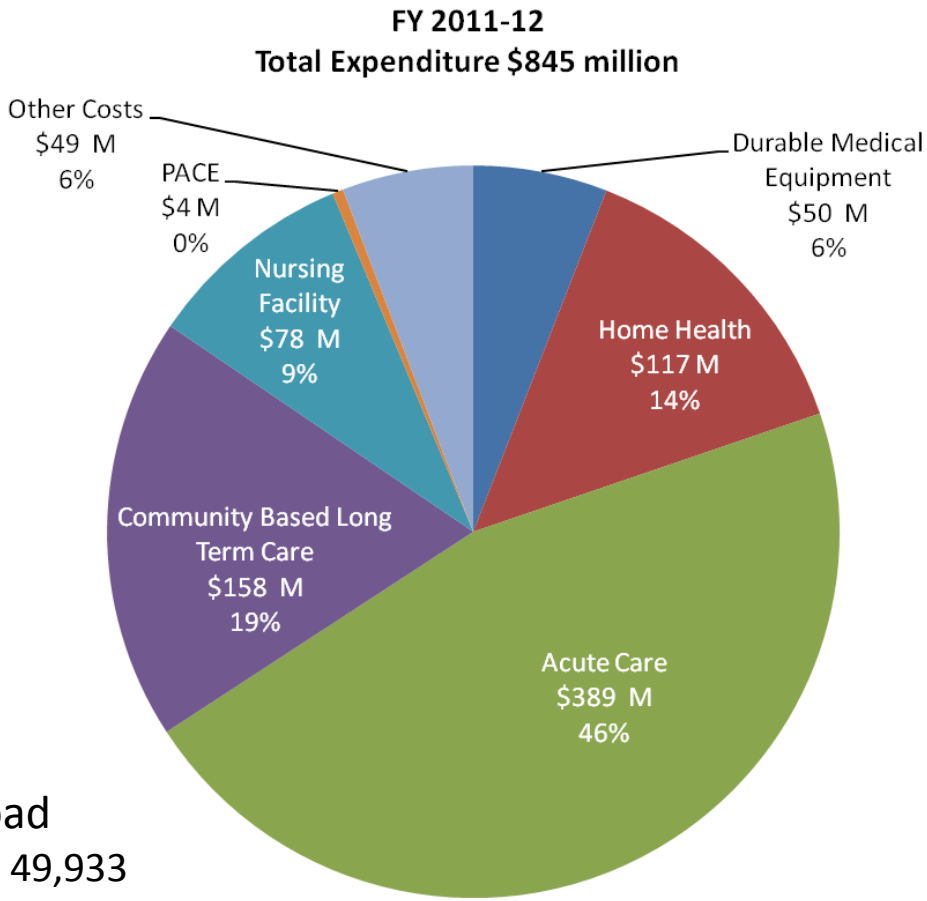


1.12% average annual growth

Individuals with Disabilities to 59

FY 2007-08 Expenditures vs. FY 2011-12



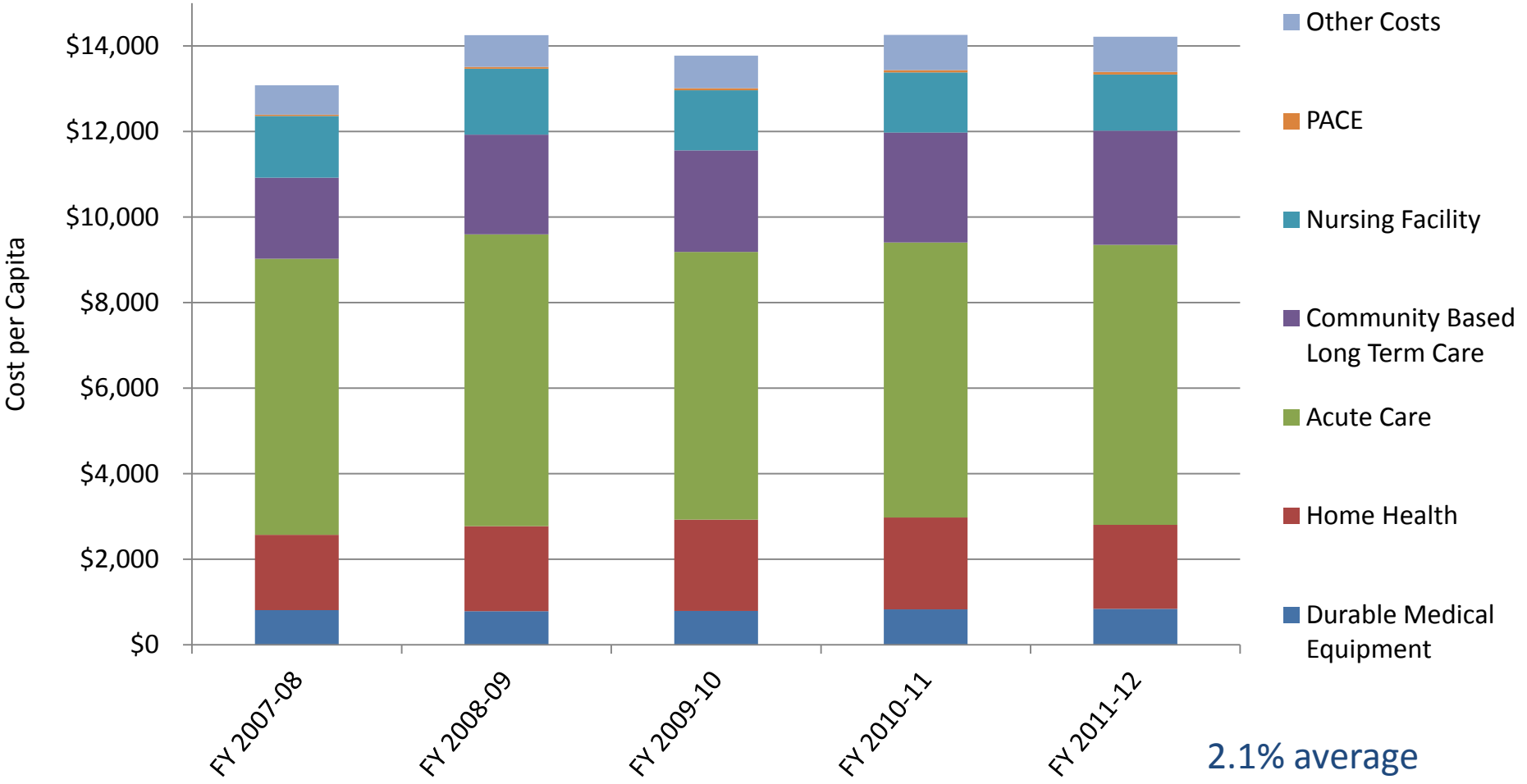


Caseload

FY 2007-08: 49,933

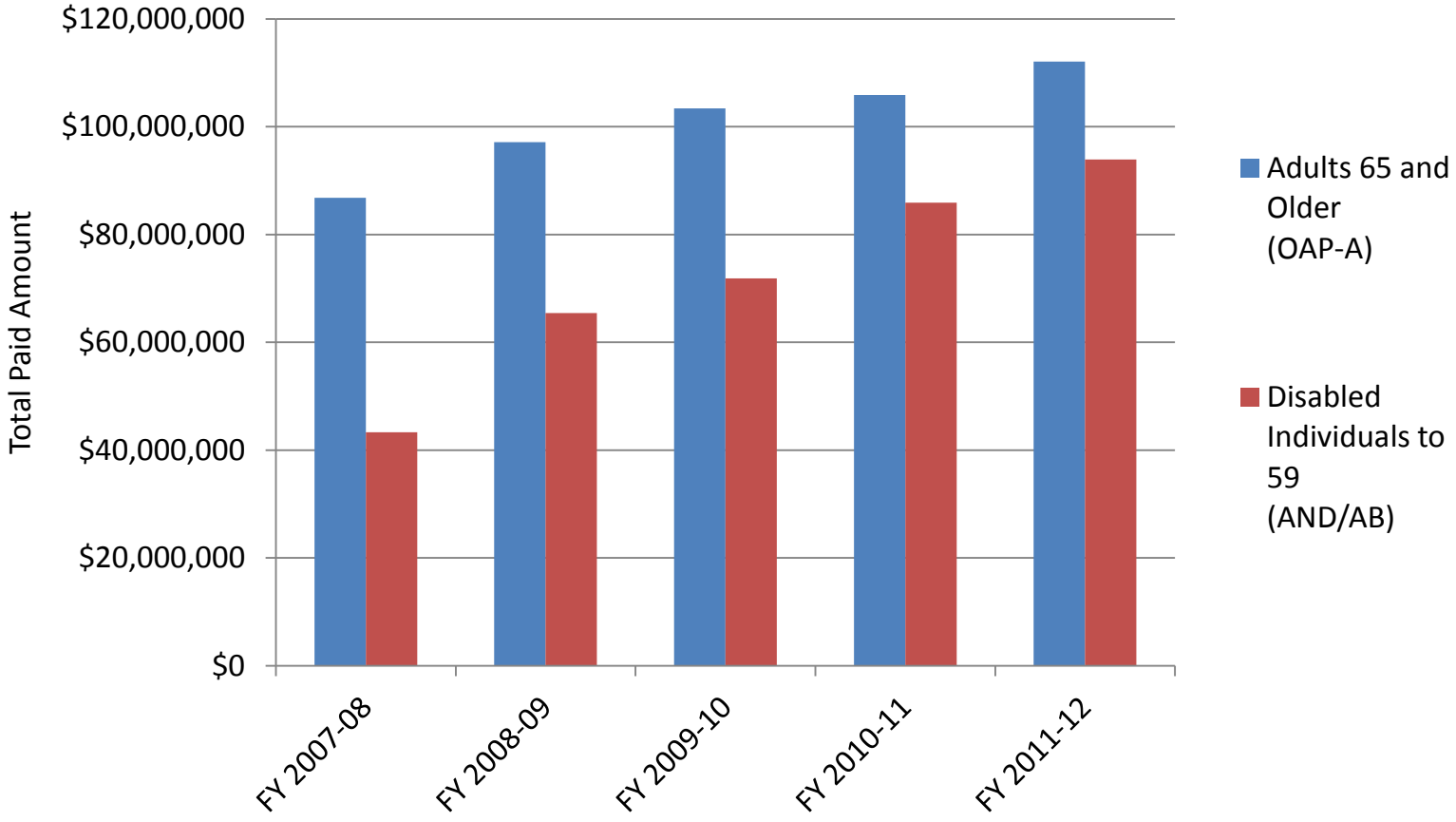
FY 2011-12: 59,434

Individuals with Disabilities to 59
Per Capita Expenditures



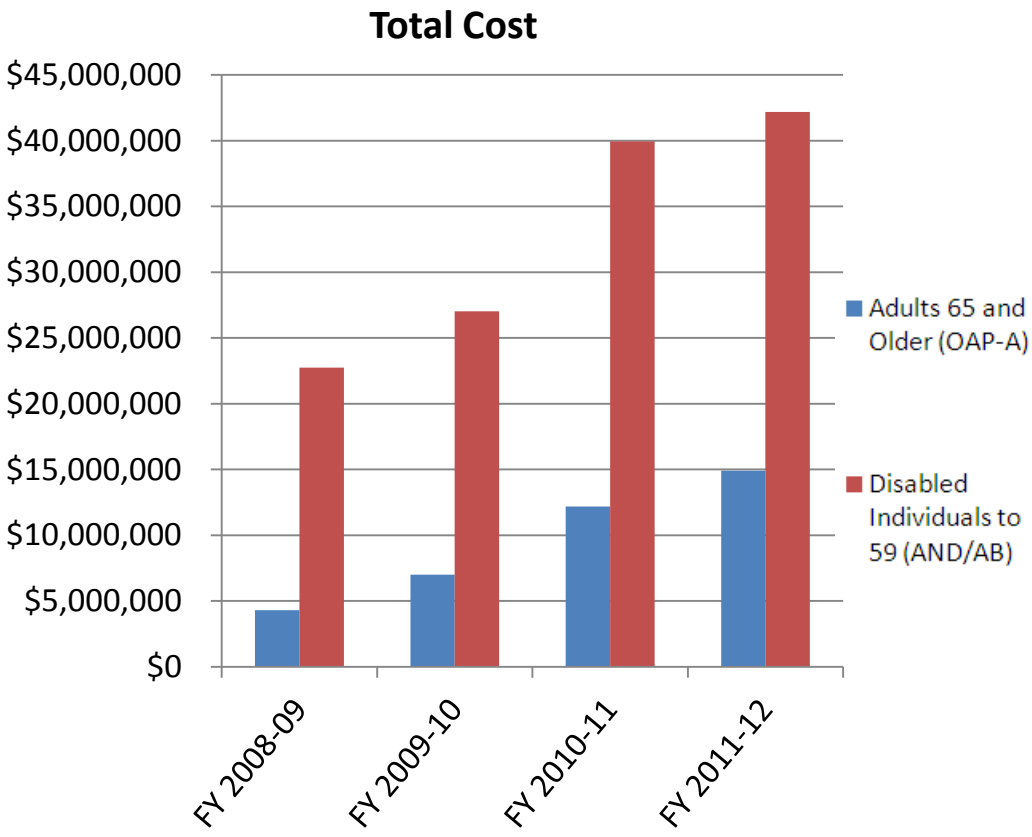
2.1% average annual growth

Elderly, Blind, and Disabled Waiver Expenditures



- EBD waiver expenditures for the above categories was $206 million in FY 2011-12
- EBD expenditures are growing at 6.5% for adults 65 and older and 21% for individuals with disabilities on average each year

Consumer Directed Attendant Support and Services (CDASS) Expenditures



$57 million total in FY 2011-12
28% of EBD expenditures

$28,736 average in FY 2011-12
24% decrease from FY 2008-09

Improving Long Term Supports and Services

Strong program management

Transparent stakeholder partnerships

Rigorous data analysis

Consumer direction

Improving LTSS

- Strengthened program management
- Increased transparency and stakeholder partnerships through workgroups
    - Long Term Care Advisory Committee and subcommittees
        - Consumer Direction, Entry Point Eligibility, Care Coordination, Waiver Modernization
    - Participant Directed Programs Policy Collaborative
    - Community First Choice Council
    - Community Living Advisory Group
- Increased data analysis and transparency
    - Making programmatic and financial data available on website
- Re-engineering and automating manual processes

Home and Community Based Services (HCBS) Waivers

- Assessed waiver eligibility to ensure appropriate utilization
- Renewed Community Mental Health Supports waiver
- Passed new Brain Injury waiver rules
- Initiated Aging in Place Communities
- Expanded Adult Buy-In to Elderly, Blind and Disabled and Community Mental Health Supports waivers
- Launched Spinal Cord Injury waiver
- Improved quality assurance measures: HCBS waivers off global corrective action plan with CMS

Consumer Directed Attendant Support and Services (CDASS)

- Partnered with stakeholder community to identify and make recommendations for improved programmatic and fiscal stability and sustainability of CDASS option
    - Developed and implemented allocation management protocol
    - Implemented attendant wage program and over-spending protocol

25) Why has the cost per capita for the elderly and disabled populations been increasing so rapidly? Which services are driving the cost increases? Why have costs per capita for the disabled increased more rapidly than costs per capita for the elderly?

RESPONSE:

Medical Services Premiums expenditures (physical health) for the elderly and disabled have been important cost drivers in the budget. Annual expenditures for the elderly have increased by over $100 million per year compared to the budget from five years prior (FY 2011-12 compared to FY 2007-08). Expenditures for the disabled have grown even more quickly, increasing by almost $200 million in that same time frame. For both populations, caseload growth drove the majority of the spending increase.

Total Payment Amount and Caseload:

FY 2007-08 and FY 2011-12

Fiscal Year	Adults 65 and Older (OAP-A) Total Payment Amount	Adults 65 and Older (OAP-A) Caseload	Disabled Individuals to 59 (AND/AB) Total Payment Amount	Disabled Individuals to 59 (AND/AB) Caseload
FY 2007-08	$704,602,839	36,284	$653,062,382	49,933
FY 2011-12	$806,748,259	39,740	$844,556,448	59,434
Percent Change	**14.50%**	**9.52%**	**29.32%**	**19.03%**
Compound Annual Growth Rate	**3.44%**	**2.30%**	**6.64%**	**4.45%**

The Department disaggregated the overall per capita cost by examining each service on a cost per capita basis to determine which services were driving these increases. As can be seen from the following table, average per capita growth has been relatively low for the last five fiscal years; per capita costs for the elderly population have increased by an average of 1.12%, and the average per capita cost increase for the disabled population has been 2.10% over the same period. The following table compares per capita costs for both populations from FY 2007-08 to FY

2011-12 for select service categories.[1]

Service Category	Adults 65 and Older (OAP-A) Cost per Capita by Service Category FY 2007-08 and FY 2011-12			Disabled Individuals to 59 (AND/AB) Cost per Capita by Service Category FY 2007-08 and FY 2011-12		
	FY 2007-08	**FY 2011-12**	**Compound Annual Growth Rate**	**FY 2007-08**	**FY 2011-12**	**Compound Annual Growth Rate**
Durable Medical Equipment	$526.39	$464.25	-3.09%	$809.51	$841.70	0.98%
Home Health	$629.85	$560.18	-2.89%	$1,759.18	$1,960.30	2.74%
Acute Care - Other	$1,357.92	$1,350.94	-0.13%	$6,455.83	$6,549.43	0.36%
Community Based Long Term Care	$3,423.65	$3,815.19	2.74%	$1,896.02	$2,664.17	8.88%
Nursing Facility	$10,734.05	$10,347.28	-0.91%	$1,439.47	$1,312.44	-2.28%
Program of All-Inclusive Care for the Elderly	$1,220.16	$1,853.83	11.02%	$31.98	$63.20	18.57%
Other Costs	$1,527.08	$1,908.99	5.74%	$686.79	$818.74	4.49%
Total Cost	**$19,419.11**	**$20,300.66**	**1.12%**	**$13,078.77**	**$14,209.99**	**2.10%**
Percent Change		**4.54%**			**8.65%**	

Although other populations, particularly low-income adults and eligible children, have experienced per capita decreases in the past several years, the Department does not believe a comparison of the per capita costs between different types of populations is useful. The Department has seen per capita declines for adults and children because of a dramatic increase in caseload during the recession. This type of caseload increase did not occur in the elderly and disabled populations because age and disability are not affected by economic conditions.

For the purpose of this question, the remainder of the Department's response focuses on select major areas of cost growth for these populations: community-based long-term care and the Program for All-Inclusive Care for the Elderly.[2]

[1] "Per capita" cost is defined as the total expenditure divided by the total caseload. In instances where only a small proportion of the total caseload uses each service (e.g. the Program of All-Inclusive Care for the Elderly), large per capita changes do not necessarily reflect an increase or decrease in the cost of the service. Rather, per capita changes can also reflect a change in utilization of service. This concept is discussed further below, as the Department breaks out the cost drivers for these populations.

Community-Based Long-Term Care

In its budget requests, the Department defines community-based long-term care services to include home- and community-based services (HCBS) waivers, private duty nursing, and hospice.[3] Among these, the most important expenditure driver for the elderly and disabled populations is the HCBS waiver for Elderly, Blind, and Disabled (HCBS-EBD). Since FY 2007-08, the Department has experienced significant cost increases for this waiver program, with expenditures growing from $141.2 million in FY 2007-08 to $225.2 million in FY 2011-12, an increase of over 59%. The Department has identified two primary drivers for the HCBS-EBD waiver program: increases in caseload, and increases in the usage of consumer-directed care.

Caseload

Since FY 2007-08, the Department has seen a large increase in the number of recipients of home- and community-based services (HCBS), with waiver enrollment growing from 19,112 in FY 2007-08 to 23,651 in FY 2011-12, an increase of 23.75%, equaling a 5.47% compound growth rate. At the same time, total caseload for the likely recipients of HCBS (the elderly and disabled) increased from 86,217 in FY 2007-08 to 99,174, an increase of 15.03%, equaling a 3.56% compound growth rate. The growth in the disabled and elderly caseload, along with the growth in the waiver enrollment, has been a major factor in the increase in costs for both populations.

The following table depicts the increase in waiver enrollment in Adults 65 and Older and Disabled Individuals to 59:

Total HCBS Waiver Enrollment and Total Adults 65 and older (OAP–A) and Disabled Individuals to 59 (AND/AB), Percent Change, and Compound Annual Growth Rate:

FY 2007-08 and FY 2010-12

	Total Waiver Enrollment	**Total OAP-A and AND/AB Enrollment**
FY 2007-08	19,112	86,217
FY 2011-12	23,651	99,174
Percent Change	23.75%	15.03%
Compound Annual Growth Rate	5.47%	3.56%

[2] Nursing facility cost growth is also a key component of the overall expenditure for these populations; the Department addresses nursing facility cost growth in questions 23 and 27 of these responses.

[3] Please note that the Department's budget for Medical Services Premiums does not include HCBS costs for waiver programs administered by the Department of Human Services, which are primarily waiver programs for individuals with developmental and intellectual disabilities.

Consumer-Directed Services

The fastest-growing area of expenditure within the HCBS-EBD wavier during this period was payments for consumer-directed attendant support services (CDASS). CDASS is a person-centered benefit that allows clients to maintain their own budget for attendant services (personal care, homemaker, and health maintenance activities) and pay their attendant the rate they chose (within the wage cap). CDASS is a client-directed alternative for agency-based skilled (long-term home health) and unskilled (waiver) attendant services. Since the CDASS benefit was added to the HCBS-EBD waiver in FY 2007-08, there has been significant program growth. Since FY 2008-09, HCBS-EBD expenditure for CDASS has grown by over $30 million.[4] These costs represent over 69% of the increase in the HCBS-EBD waiver program during that time.

HCBS – Elderly, Blind, and Disabled Waiver Program Growth:
FY 2008-09 to FY 2011-12

Total Program Growth	CDASS Growth	Percent
$43,421,128	$30,064,313	69.24%

The following table breaks down CDASS growth in total cost by population:

Elderly, Blind, and Disabled Waiver, Consumer Directed Attendant Support Services (CDASS)
Total Cost, Percent Change, and Compound Annual Growth:
FY 2008-09 and FY 2011-12

	Adults 65 and Older (OAP-A)	Disabled Individuals to 59 (AND/AB)	Total
FY 2008-09	$4,307,035	$22,736,708	$27,043,743
FY 2011-12	$14,912,993	$42,195,064	$57,108,056
Total Increase	**$10,605,958**	**$19,458,356**	**$30,064,313**
Percent Change	**246.25%**	**85.58%**	**111.17%**
Compound Annual Growth Rate	**51.28%**	**22.89%**	**28.30%**

Although the total CDASS expenditures for Adults 65 and Older have increased at a faster rate than Disabled Individuals, the majority of the increase in expenditures is due to increased utilization of CDASS by Disabled Individuals. The overall increase in expenditure is being driven both by an increase in enrollment and higher costs per enrollee for clients who utilize CDASS.

[4] For this portion of the response, the Department uses FY 2008-09 as the comparison point. CDASS was added to the HCBS EBD waiver program in FY 2007-08, which creates a skewed comparison.

The following table below breaks down CDASS year-by-year recipients and cost per recipient by population:

Elderly, Blind, and Disabled Waiver Adults 65 and Older (OAP-A) and Disabled Individuals (AND/AB) CDASS Recipient Cost Per Capita FY 2008-09 through FY 2011-12						
Fiscal Year	**Adults 65 and Older (OAP-A)**		**Disabled Individuals to 59 (AND/AB)**		**Total EBD**	
	Enrollees	**Cost Per Enrollee**	**Enrollees**	**Cost Per Enrollee**	**Enrollees**	**Cost Per Enrollee**
FY 2008-09	182	$23,697.58	537	$42,333.67	719	$37,621.72
FY 2009-10	277	$25,329.26	686	$39,379.52	963	$35,340.84
FY 2010-11	493	$24,724.09	1,012	$39,467.95	1,505	$34,640.95
FY 2011-12	702	$21,253.67	1,286	$32,819.60	1,987	$28,736.02

Increased participation in CDASS is not, in and of itself, necessarily an overall cost driver for the HCBS-EBD waiver. As described, CDASS is a substitute for other HCBS-EBD and long-term home health services. If these clients were not enrolled in CDASS, they would be generating additional costs for other services.

The per recipient cost, however, is significantly higher for clients enrolled in CDASS, as compared to clients who are not enrolled in a client-directed program. Because of the size difference in the non-CDASS population compared to the CDASS population, more analysis is needed to compare CDASS clients and a similar population within the same waiver who have similar acuity and needs.

The following table depicts the number of EBD-CDASS recipients, their costs, and cost per enrollee compared to the non-CDASS EBD population in FY 2011-12.

Elderly, Blind, and Disabled (EBD) Home And Community Based Services (HCBS) Waiver Consumer Directed Attendant Support Services (CDASS) Recipients and EBD Non-CDASS Recipients Total Cost, Enrollees, cost per enrollee						
	EBD - CDASS Costs	**EBD - CDASS Enrollees**	**EBD - CDASS Cost Per Enrollee**	**Non-CDASS EBD Costs**	**Non-EBD CDASS Enrollees**	**Non-CDASS Cost Per Enrollee**
FY 2011-12	$57,108,056	1,987	$28,740.84	$168,077,655	17,665	$9,514.73

The Department believes there are valid reasons for the cost per enrollee in CDASS to be higher than that of other clients. For example, in analysis the Department has completed thus far, the CDASS population costs trend with acuity, thus leading to higher costs for clients with higher needs. This could also be indicative of provider capacity, when clients receive CDASS they are actually receiving the services they need, whereas outside of CDASS they were having difficulties finding access to the care they need. However, the Department is actively working on ensuring that expenditures for the CDASS program are necessary and appropriate. In an effort to balance client's health care needs while containing costs and increasing health outcomes, the Department has implemented a wage cap for attendants, moved the fiscal intermediary administrative service fee from a portion of each CDASS clients monthly budget to a monthly per member per month fee, implemented a protocol designed prevent overspending , and has developed a multi-stakeholder and departmental workgroup to help the benefit evolve and maintain its importance to participant freedom and service selection, as well as maintain client health outcomes and bending the cost curve.

As a result of these efforts, the Department has seen substantive reductions in the cost per enrollee for clients enrolled in CDASS since FY 2008-09.

Elderly, Blind, and Disabled Waiver, Consumer Directed Attendant Support Services (CDASS) Cost Per Enrollee, FY 2008-09 and FY 2011-12			
	Adults 65 and Older (OAP-A)	**Disabled Individuals to 59 (AND/AB)**	**Total**
FY 2008-09	$23,697.58	$42,333.67	$37,621.72
FY 2011-12	$21,253.67	$32,819.60	$28,736.02
Total Decrease	**($2,443.91)**	**($9,514.07)**	**($8,885.70)**
Percent Change	**-10.31%**	**-22.47%**	**-23.62%**
Compound Annual Growth Rate	**-3.56%**	**-8.14%**	**-8.59%**

The Department believes continued action will be necessary to maintain budget stability in per capita spending in the disabled and elderly eligibility categories. While there is no causal link or definitive evidence, it is possible the growth in consumer-directed services is now resulting in reductions in nursing facility and home health per capita costs. The Department continues to analyze data for these programs to ensure that appropriate cost controls are in place.

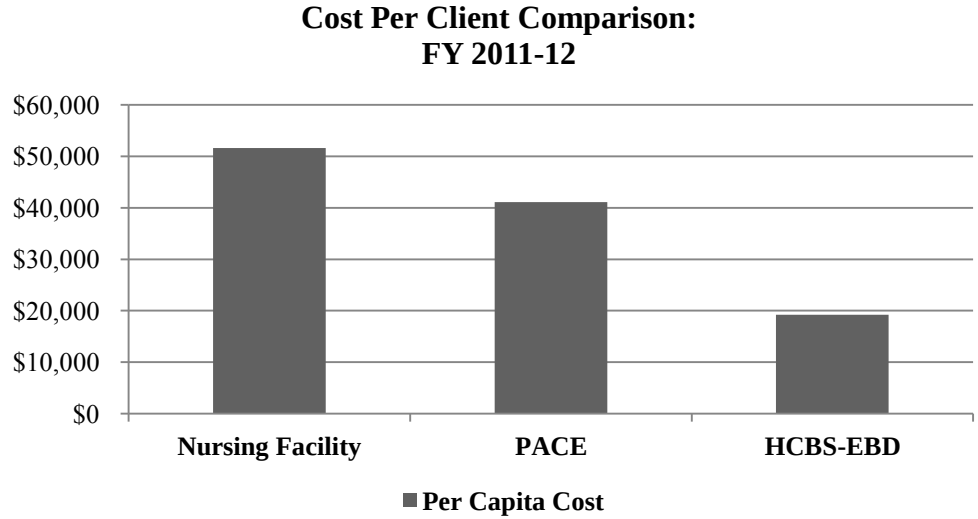
The Program of All-Inclusive Care for the Elderly

The Program of All-Inclusive Care for the Elderly, known as PACE, is a risk-based, fully capitated program. The Department pays a single organization a capitation rate that covers all medical costs, including acute care, long-term services and supports, and mental health.

PACE is different from traditional managed care in how it shares risk between the payer (the Department) and the provider. Traditional managed care (such as a health maintenance organization or the Department's behavioral health organizations) share financial risk on a short time period. The monthly capitation rate paid to the managed care organization is an estimate of what that organization's costs will be in that month. For a PACE provider, however, this is different. When a client typically enters PACE, that client generally has fewer long-term care needs and might otherwise be placed in an HCBS waiver program. As the client ages, however, that client's needs change and the client may eventually require placement in a nursing facility. During this time period – from when a client enters the PACE program through when a client enters a nursing facility – the Department pays the PACE organization the same rate regardless of the client's current needs. Thus, PACE shares financial risk over a much longer time period than traditional managed care organizations. As a result, the Department pays a PACE organization above their expected costs when the client enters the program, and below the expected cost when the client ages and enters a nursing facility. A PACE organization is responsible for managing its finances to account for the long-term risk window; when a client requires placement in a nursing facility, the client cannot be disenrolled from PACE.

In short, when a client is enrolled in PACE, the State makes an upfront investment; the Department pays higher costs on the front end in order to have cost stability at the end of a client's life, when expenditure is typically the highest.

Accordingly, costs per client for PACE clients generally falls between that of clients enrolled in a nursing facility and clients enrolled in the Department's HCBS-EBD waiver.



Since FY 2007-08, the Department has seen significant growth in PACE expenditure:

Program of All-Inclusive Care for the Elderly (PACE)				
	Adults 65 and Older		Disabled Individuals to 59	
Fiscal Year	Expenditure	Cost Per Enrollee	Expenditure	Cost Per Enrollee
FY 2007-08	$44,272,143	$39,496.37	$1,596,904	$43,453.17
FY 2011-12	$73,671,387	$41,994.90	$3,756,277	$38,957.82
Percent Change	66.41%	6.33%	135.22%	-10.35%

PACE expenditure has seen rapid growth in the last five years, primarily as a result of increased caseload growth. In FY 2007-08, 1,240 clients were enrolled in PACE. By FY 2011-12, enrollment had grown to 2,055 clients. During that time, existing PACE providers built additional capacity, and several new providers began to operate, further increasing enrollment. PACE rates, the driving factor behind cost per recipient, have been contained in recent years by rate reductions and cost-containment measures, such as the 3% nursing facility General Fund growth cap. New providers operating outside the Denver-metro area also have lower costs and have contributed to the decline in cost per enrollee during this period.

26) What is the Department doing to control long-term care costs? Is the Department putting sufficient emphasis on controlling costs in this area versus other areas of the budget?

RESPONSE:

Improving Long-Term Services and Supports (LTSS) is a major focus for the Department. The Department is simultaneously pursuing control of costs, improving quality of services, and increasing client satisfaction with services. This is critically important because of the aging of the population and the increase in the number of individuals with disabilities. In FY 2012-13, the Department estimates it will expend approximately $1.88 billion for physical health services on approximately 110,000 clients who are elderly or disabled. Although this population on comprises approximately 16% of the total Medicaid caseload, it accounts for over 58% of the Department's total expenditure for physical health services.

Because of the complex needs of clients utilizing LTSS, improving long-term care requires the simultaneous pursuit of three aims: improving the experience of care, improving the health of populations, and reducing per capita costs of health care. In order to effectively control costs without causing detrimental effects to clients, these three aims must be addressed simultaneously and with careful thought and strong partnership with clients, advocates and providers.

The Department has multiple efforts underway designed to meet these three objectives. Over the past 18 months, the Department has:

- Reallocated additional management and staff to the LTSS division so the Department can appropriately manage, analyze, and improve services and costs. Staff are analyzing expenditures by waiver and program, identifying variances, and identifying areas where improved program operations can improve service quality and appropriately manage costs.
- Implemented a wage cap for attendants, moved the fiscal intermediary administrative service fee from a portion of each CDASS clients monthly budget to a monthly per member per month fee, implemented a protocol designed to prevent overspending, and developed a multi-stakeholder and departmental workgroup to help the benefit evolve and maintain its importance to participant freedom and service selection, as well as maintain client health outcomes and bending the cost curve. These are all efforts to balance clients' health care needs while containing costs and increasing health outcomes for the consumer-directed attendant support services program.
- Conducted enhanced data analysis utilizing claims data to better understand cost drivers and utilization within LTSS. This data has been made available to the public on the Department's website and has been widely disseminated to LTSS stakeholders, the Long Term Care Advisory Committee (LTCAC), and the Community Living Advisory Group. Most recently, analysis of non-medical

transportation led to a restructuring of the service, which the Department believes has the potential to result in significant savings and enhanced access to services for clients.[5]

- Created a team of finance, data, rates, and program staff to collaborate on the analysis of key programmatic data points.
- Utilized the Benefits Collaborative to define and provide clear guidance on the type and quantity of long-term services and supports covered by Medicaid. The largest accomplishment of 2012 has been creation of the Home Health Benefits Standard, which will ensure equity and appropriateness of home health services.
- Begun development of training and guidance to Single Entry Points (SEPs) and Community Centered Boards (CCBs) that develop service plans for clients. This will help to ensure the appropriateness of service utilization and reduce variation in how SEPs and CCBs develop service plans. The Department will work with SEPs and CCBs to define best practices and approaches for service plan development.
- Partnered with clients, providers, and advocates to identify improvement areas that will better meet client needs and reduce costs without negatively impacting critical services needed by clients. The input of clients, providers, and advocates is absolutely essential to effectively improve services while controlling costs. This partnership has included extensive collaboration on the following work groups:
    - Participant-Directed Programs Policy Collaborative (PDPPC)
    - Long-Term Care Advisory Committee (LTCAC)
    - Community Living Advisory Group
- Begun defining system enhancements that will provide enhanced data and operational management capabilities. For example, implementation of a new MMIS system will provide greater controls to ensure appropriate utilization of services. The new MMIS system will include a new benefits-utilization system (BUS), which is the primary system used for LTSS service plans and client tracking.
- Identified the need for a new, functional assessment tool and service planning process. The Department has contracted with a vendor to assist with analysis of a new assessment tool. This will be conducted under the guidance of the LTCAC, which includes broad representation of clients, providers, and stakeholders.
- Begun the process of analyzing LTSS waivers with the goal of identifying which waivers could be combined. Again, this work will be conducted under the oversight of the LTCAC. The Department anticipates the benefits of fewer waivers will be include improved service quality, client satisfaction, and improved cost management.
- Begun the process of integrating the work of the Accountable Care Collaborative (ACC) with LTSS. For example, the Regional Care Collaborative Organizations (RCCOs) are beginning to partner with SEPs and CCBs to improve client health and utilization. Acute care spending is an important component of client costs in the elderly and disabled eligibility categories. RCCOs, SEPs, and CCBs are working with high-cost clients to ensure better health and lower costs for those clients.
- Worked to develop an approach to integrate care for clients who are dually eligible for Medicaid and Medicare. This is a population with complex needs and high costs. The Department plans to implement an integrated care program inside the ACC for these clients in the second quarter of 2013, depending upon CMS approval.
- Strengthened its support and focus on consumer direction through creation of the Participant-Directed Programs Policy Collaborative (PDPPC) and the Community First Choice Council.

[5] Any savings achieved will be accounted for during the regular budget process.

- Implemented Colorado Choice Transitions (CCT). The CCT program offers short-term, intensive supports that enable clients to transition successfully from an institutional setting to a less-costly or more appropriate community-based setting.

All of the efforts described above are being informed by the work of the Long-Term Care Advisory Committee (LTCAC) and the Community Living Advisory Group. The work being done by these groups has played an important role in assisting the Department in redesigning and modernizing LTSS in Colorado, and the Department anticipates these groups will continue to provide critical input regarding this process in the future. The current long-term care system is administratively and programmatically complex, frequently does not provide access to services in ways that successfully meet needs, and is costly without consistently demonstrating positive health outcomes or satisfaction for clients. The four subcommittees of the LTCAC (Care Coordination, Entry-Point Eligibility, Consumer Direction, and Waiver Modernization) are charged with making recommendations to the Community Living Advisory Group aimed at developing systems that better support clients across a continuum by improving client choice and access to services, eliminating duplication while also identifying gaps, simplifying processes, and reducing costs.

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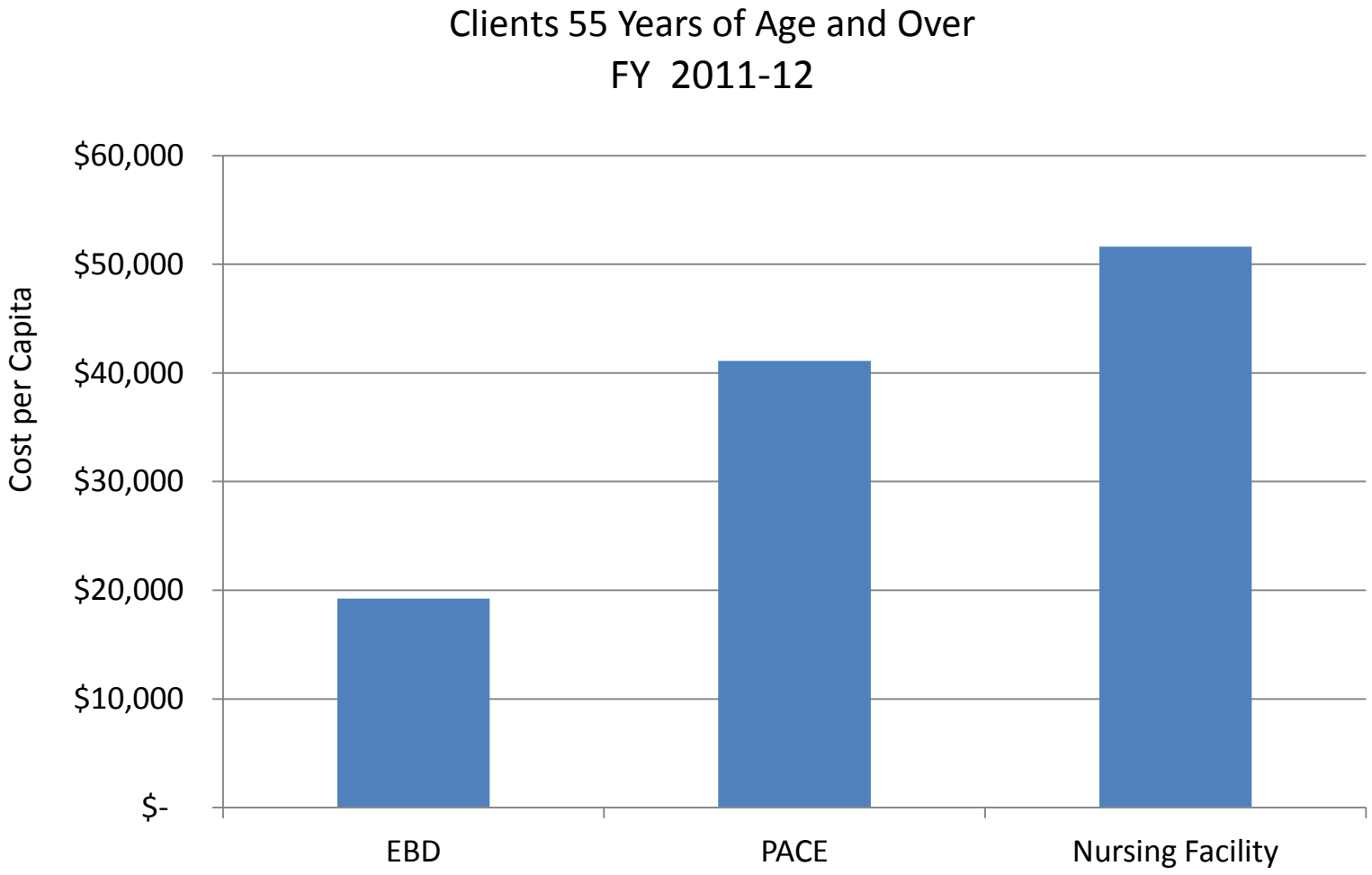
Program for All Inclusive Care for the Elderly (PACE) Status

- Key Stats: $85 million per year, 2,000 clients, $41,000 per year per PACE client (FY 2011-12)
- Program improvements underway
  - Consistency in data and quality measurement
  - Formalization and streamlining of PACE applications
  - Updating PACE rules

PACE Costs Compared to Other Programs



29) Please provide an update on the Program for All-inclusive Care for the Elderly (PACE). As part of the update, please discuss:

RESPONSE:

The Program of All-Inclusive Care for the Elderly (PACE) is an important part of the Department's continuum of managed-care services and programs. PACE currently serves almost 2,000 clients, costing approximately $80 million per year, with an annual per capita cost of $42,000. Throughout 2012, the Department strengthened its management of the program, including increased analysis of PACE in a number of areas to better quantify PACE service outcomes and to align it with other Department initiatives.

In the past year, the Department has focused on key PACE projects including the collection and standardization of PACE data and quality measures. For the first time, the Department is able to analyze and trend PACE performance measures in quality of care, care management, and acuity areas. Formalization and streamlining of the PACE application process has been another focus area and is nearly completed. The Department has developed and chairs a workgroup of PACE states that meets every other month to discuss important PACE issues and trends. PACE state administrators from California, Pennsylvania, Texas, Oklahoma, Missouri, Kansas, New Mexico, and North Dakota participate in these informative meetings.

a) What is the status of the PACE expansion in Northern Colorado?

RESPONSE:

On October 6, 2011, the Department approved a Program of All-Inclusive Care for the Elderly (PACE) organization's expansion into Northern Colorado, which included the cities of Fort Collins, Loveland, and Greeley and other parts of Larimer and Weld counties. The following week, the Department submitted that organization's expansion application to the Centers for Medicare and Medicaid Services (CMS) along with a state attestation letter indicating the Department's approval. On October 18, 2011, CMS received and began reviewing this application.

On November 15, 2011, CMS sent a letter to the PACE organization and the Department indicating the need for further information from the PACE organization. CMS is currently awaiting a response from the PACE organization in order to proceed with their review of the organization's application. The Department has offered and provided assistance to the organization to help it supply CMS with the requested information, including a letter of support to help the organization secure funding for their new PACE center in Northern Colorado.

CMS has requested that: 1) the PACE organization complete construction; and, 2) the Department provide a completed State Readiness Review of this new center before CMS will approve the organization's expansion application into Northern Colorado. The PACE organization anticipates completing construction on its new center in Northern Colorado in October or November of 2013, at which time the Department will conduct its Readiness Review of the new facility. After the Department completes its Review of the new facility and the

organization provides CMS with the requested information, CMS has 90 days to review the organization's application. Given this process, the Department does not expect the organization's Northern Colorado PACE program to open until at least the beginning of 2014.

The Northern Colorado program will serve the following zip codes: 80513, 80521, 80523, 80524, 80525, 80526, 80528, 80534, 80537, 80538, 80543, 80550, 80615, 80620, 80631, 80634, and 80639. These zip codes encompass the cities of Fort Collins, Loveland, and Greeley and parts of Larimer and Weld Counties.

b) When will the Northern Colorado program open, and what communities will it serve?

RESPONSE:

Please see the Department's response to Question 29a, above.

c) What other communities could use PACE?

RESPONSE:

Currently, the Department has not conducted analysis to determine which communities could benefit from a PACE program. The Department reviews submitted applications from potential PACE providers and makes determinations based on the providers' analysis regarding the community need for PACE and financial feasibility. As the Department continues to enhance its data and analytic capabilities, it will be able to segment the Medicaid population by client health needs in the future. This will improve efficiency in meeting the needs of Medicaid clients and linking them to the right services from the right providers. As population segmentation becomes more of a reality, the Department anticipates this will be a useful tool for identifying which communities and individuals would benefit from a PACE program.

The Department is currently reviewing an application for PACE services to be provided in Boulder and Weld counties. A PACE organization currently serving Montrose and Delta counties is planning to open an alternative care setting in Olathe, which is already part of its existing service area. This will allow PACE participants in western Colorado to receive limited PACE services in Olathe and alleviate travel to Montrose or Eckert to receive those same services. Another PACE organization located in Colorado Springs has also expressed interest in expanding its operations.

d) How can PACE be tailored to rural communities?

RESPONSE:

In 2011, the Centers for Medicare and Medicaid Services (CMS) presented a report to Congress on the successes and failures of 15 rural PACE programs that received grants through the Deficit Reduction Act of 2005. This report found that the success of rural PACE organizations "…hinge[d] on a delicate balance between enrollment and the ability of PACE centers to keep their participants healthy and

out of hospitals." One rural PACE organization located on the Western Slope of Colorado has been highly successful in keeping participants out of hospitals and was recognized by CMS in its 2011 report. This organization was also recognized by the National PACE Association as having the lowest percentage of acute hospital readmissions within 30 days of all PACE organizations nationwide. The report presented to Congress by CMS also identifies two other important factors for success of rural PACE organizations: 1) successful community relationships, especially with local area agencies on aging; and 2) the ability to contract with and utilize local community-based physicians not only for their services but as a means to increase awareness of the PACE program. The report can be found online at http://www.npaonline.org/website/download.asp?id=3841.

The success of rural PACE organizations can also be attributed to their use of alternative-care sites. Alternative-care sites must be approved by CMS and the Department and allow PACE organizations to provide limited services at a location closer to the participant's home. The Department finds this type of facility is crucial to providing services in rural communities where distances to PACE centers can be challenging. As described above in the Department's response to 29c, the PACE organization on the Western Slope plans to open another alternative care site in Olathe in the near future.

e) How will PACE work with Regional Care Collaborative Organizations (RCCOs)?

RESPONSE:

PACE and the ACC are complementary. As a component of the Medicaid continuum of managed-care services and programs, the Department has focused on creating alignment between the PACE organizations and the ACC program. The RCCOs are intended to create regional collaboration across all providers for the benefit of Medicaid clients. As such, RCCOs will collaborate with PACE. For example, clients enrolled in the ACC may be better served via PACE. RCCOs may identify clients with needs that could be met via PACE. Similarly, PACE and RCCOs could develop common care-coordination approaches.

El Paso County is a useful example of PACE organizations and RCCOs working together. The PACE organization and the RCCO in El Paso county have been collaborating since the RCCO's formation, with the PACE organization playing a critical role in development of the RCCO's care-management plan. PACE's interdisciplinary team approach to care planning and coordination, which is one of the staples of the PACE program, has been studied by the RCCO for potential adaptation. Not only is this PACE organization one of the founding members of this RCCO, but they have contracted with the RCCO as participating providers.

f) Has S.B. 12-023 been implemented?

RESPONSE:

SB 12-023 provides that the state board shall adopt rules: 1) requiring the Department and Single Entry Point Agencies (SEPs) to discuss the option and potential benefits of participating in the PACE program with all eligible long-term care clients; and, 2) allowing PACE providers to contract with an enrollment broker to include the PACE program in its marketing materials to eligible long-term clients.

The provisions of SB 12-023 are already being implemented by the Department and can be pursued without formal rule change. Currently, SEPs are mandated to inform long-term care clients of all available programs and the benefits of those programs including PACE. Long-term care clients sign a form attesting that they were offered these choices. The Department is also working with PACE organizations on providing ongoing trainings to SEPs and their staff regarding PACE. In conversations between PACE organizations and an enrollment broker, the Department has supported the effort to provide PACE materials to eligible long-term care clients.

In its review of SB 12-023 and section 25.5-5-412, C.R.S. (2012), the Department saw a larger charge to not only implement the provisions set forth in SB 12-023 but to write program-wide rules necessary for the governance of PACE in Colorado pursuant to section 25.5-5-412(11) C.R.S. (2012). The Department is scheduled to develop these rules in 2013 with the help of PACE organizations, PACE participants, and advocates. The Department will utilize its formal rule-making process and submit these rules to the Medical Services Board for review and approval.

g) Have the rules been promulgated to allow PACE providers to contract with an enrollment broker to include the PACE program in its marketing materials to eligible long-term clients?

RESPONSE:

PACE organizations are already negotiating with the Department's enrollment broker, as other managed care providers have also done. At the same time, the Department is working to create rules to implement this provision set forth in S.B. 12-023 and section 25.5-5-412(11) C.R.S. (2012). The Department's response to 29f, above, provides further explanation). The Department has been in communication with PACE organizations regarding their ability to contract with a broker of their choosing to provide marketing materials to long-term care clients. The Department will take an active role in this process, possibly including provision of the data needed to implement the marketing effort.

R-13 | 1.5% Provider Rate Increase

Reductions during the recession

- Since FY 2008-09 the state has implemented five budget reductions items that have reduced reimbursement rates
- Maintaining these rate reductions would exacerbate the financial strain on Medicaid providers

Increasing rates to maintain clients access to health care

- It is increasingly difficult to retain current providers or attract new providers with current reimbursement rates
- Access to health care in rural areas is already a challenge

FY 2013-14 Request:
General Fund: $14,578,983
Total Funds: $33,116,630

23) Please compare changes in Medicaid reimbursement rates for various providers for the last several years.

RESPONSE:

The majority of Medicaid providers were subject to the same rate reductions between FY 2009-10 and FY 2011-12. A small number of providers have more complicated rate methodologies and received different reductions. The Department compares the reductions applied to the majority of providers with two particular types of providers: pharmacies and nursing facilities.

Across-the-board Rate Reductions

The majority of fee-for-service providers in Medicaid are reimbursed on a fee schedule. Adjustments to the fee schedule are typically addressed through the normal budget process. Most notably, during the recession, multiple rate reductions were implemented as the State shared the financial burden with Medicaid providers. Beginning in FY 2009-10, the Department has reduced rates for most acute-care providers (e.g., hospitals, physicians, specialists, and home-health agencies) by a cumulative 6.10% and has reduced rates for community-based long-term care providers (primarily home- and community-based services providers) by a cumulative 5.86%. See the following table for additional details.

Across-the-board Reductions	Rate Reduction
FY 2009-10	
July 2009	2.00%
September 2009	1.50%
December 2009	1.00%
Total FY 2009-10[(1)]	**4.44%**
FY 2010-11	
July 2010	1.00%
Total FY 2010-11	**1.00%**
FY 2011-12	
July 2011	0.75% (Acute Care) 0.5% (Community-Based Long-Term Care)
Total FY 2011-12	0.75% (Acute Care) 0.5% (Community-Based Long-Term Care)
Total Rate Cuts to Date[(1)]	**6.10% (Acute Care)** **5.86% (Community-Based Long-Term Care)**

(1) Please note that rate cuts are multiplicative, and individual rate reductions will not add to the total. For example: If a rate is reduced from $100.00 to$ 99.00 in one year, and in the following year the rate is reduced by 1%, the new rate would be $98.01. The cumulative percentage change would therefore be -1.99% (multiplicative result), not -2.00% (additive result).

Pharmacy

Medicaid pharmacy reimbursement has been subject to a combination of across-the-board rate reductions as well as targeted policy changes that impacted specific drug classes. Greater utilization of the State Maximum Allowable Cost (SMAC) reimbursement methodology has been the primary policy mechanism for achieving savings other than across-the-board rate reductions. The SMAC reimbursement methodology brought prices closer in-line with actual acquisition cost for targeted drug classes where a clear disparity between pharmacy acquisition cost and Department reimbursement was evident.

For comparison purposes across provider types, the following table shows major impacts to pharmacy reimbursement since FY 2009-10.

Impacts to Pharmacy Reimbursement Since FY 2009-10			
Fiscal Year	**Budget Action**	**Estimated Impact as a Percentage of Total Expenditure**	**Mechanism of Change**
FY 2009-10			
	BRI-1	-0.02%	SMAC
	ES-2	-1.50%	Rate Reduction
Total FY 2009-10		**-1.52%**	
FY 2010-11			
	BRI-3	-0.77%	SMAC
	BRI-6	-1.00%	Rate Reduction
Total FY 2010-11		**-1.77%**	
FY 2011-12			
	BRI-5	-0.73%	SMAC
Total FY 2011-12		**-0.73%**	
FY 2012-13			
	R-6[(1)]	-1.13%	Methodology Change
	R-1[(2)]	-0.85%	Methodology Change
Total FY 2012-13		**-1.98%**	
Total Rate Cuts to Date[(3)]		**-5.87%**	

(1) Percentage based on $4 million reduction originally presented in the FY 2012-13 R-6 and an estimated $354.3 million in gross pharmacy expenditure in FY 2012-13.

(2) Percentage based on incremental revision to the estimated fiscal impact in the FY 2012-13 R-6, or an additional $3 million reduction in expenditure in FY 2012-13.

(3) Pharmacy rate impacts are calculated additively within fiscal years and multiplicatively between fiscal years. Impacts will not sum to the total as a result. See the example in the "Across-the-board Rate Reductions" table.

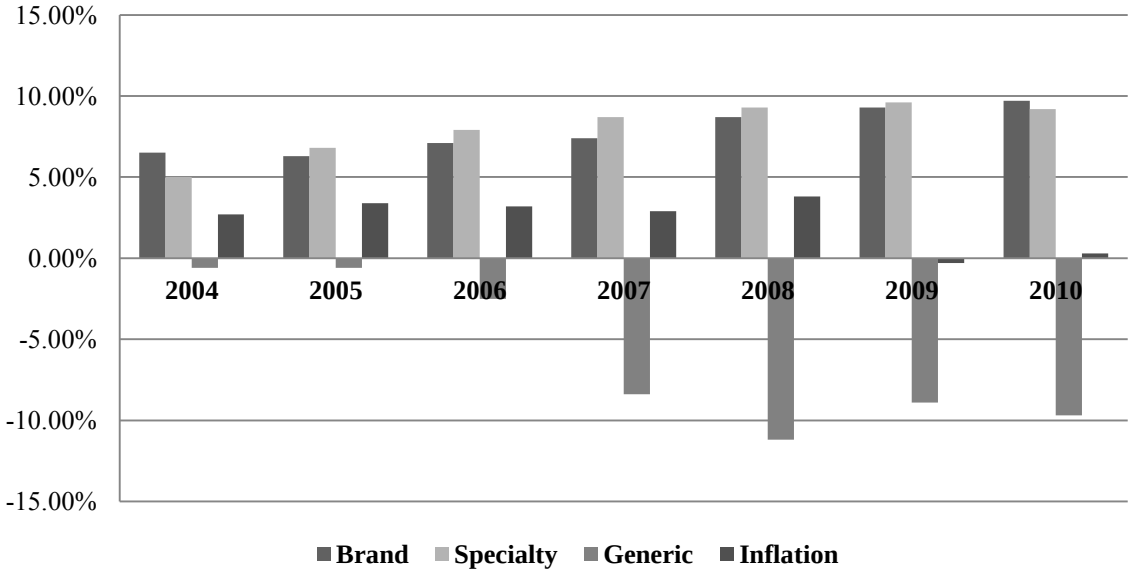
However, despite the reductions, pharmacy reimbursement, particularly for brand and specialty drugs, continues to grow. The pharmacy reimbursement methodology is unique in that rates have historically been tied to national pricing statistics that change over time (wholesale acquisition cost, state maximum allowable cost, etc.). This means that, as pharmacies' costs of acquiring drugs increases or decreases, the reimbursement rates change accordingly. For example, Synagis, a drug used to reduce the risk of hospitalization due to respiratory virus for certain high-risk children, is one of Medicaid's greatest sources of pharmaceutical expenditure. Reimbursement rates have increased as manufacturer prices increased and have consequently seen between 7.49% and 12.65% annual growth since 2008. These figures include rate reductions. While this is not true for every drug, for most brand name and specialty drugs, reimbursement rates have continued to increase despite rate reductions.

Synagis 50 mg: Average Reimbursement per Unit		
Date	**Average Reimbursement**	**Percentage Change**
November 2008	$1,829.18	N/A
November 2009	$1,966.22	7.49%
November 2010	$2,095.82	6.59%
November 2011	$2,264.42	8.04%
November 2012	$2,550.84	12.65%

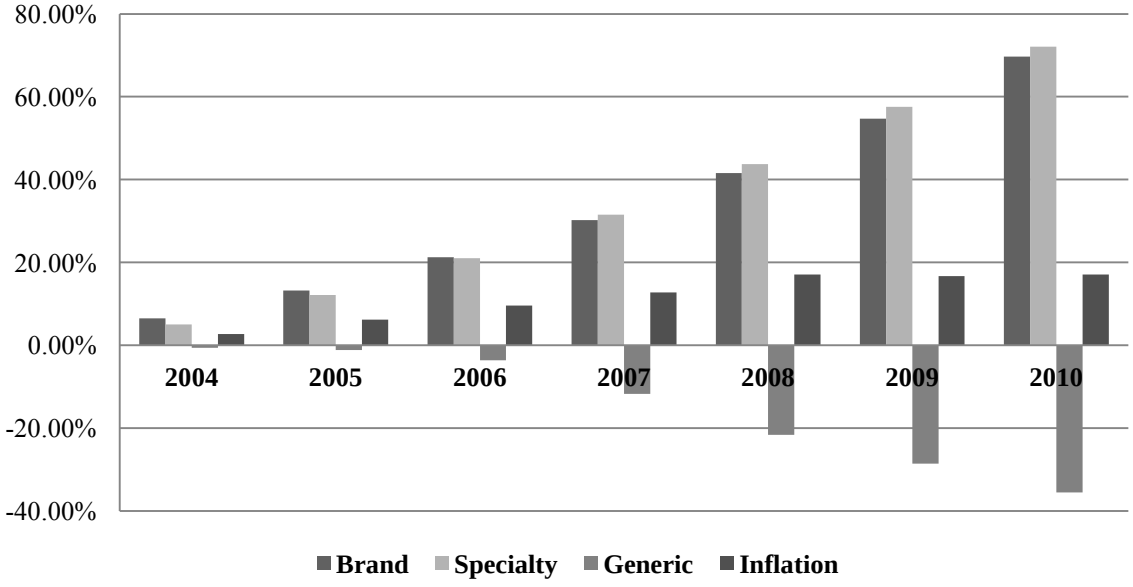
The following tables show the average annual percent change in wholesale acquisition cost pricing for the most widely used brand name drugs, specialty drugs, and generic drugs as reported in the AARP Public Policy Institute's annual *Rx Watchdog Report*.[1] Please note that the report uses Medicare Part D drug utilization to establish an average; Medicaid drug utilization will differ. Under the pharmaceutical reimbursement methodology, pharmacy reimbursement rates are a function of manufacturer prices and will move similarly to what is reflected in the following graphs.

[1] http://www.aarp.org/health/medicare-insurance/info-04-2009/rx_watchdog.html

Average Annual Percent Change in Manufacturer Prices for Most Widely Used Drugs by Category



Cummulative Average Percent Change in Manufacturer Prices for Most Widely Used Drugs by Category from 2004 to 2010



Although approximately 78.6% of Medicaid pharmaceutical utilization is generic drugs, approximately 71.4% of expenditure is on brand and specialty drugs. Because rates for generics have been decreasing but rates for brand and specialty have been increasing, the aggregate impact on rates is not immediately evident. However, it is clear that increasing total pharmaceutical reimbursement is being significantly impacted by increasing rates for brand name drugs.

Class I Nursing Facilities

Class I Nursing Facility reimbursement is complex but is essentially cost-based. As costs grow, so does reimbursement up to a maximum-allowable amount. In a sense, this is similar to pharmaceutical reimbursement, with the exception that growth in reimbursement to pharmacies is not capped.

In aggregate, the General Fund portion of nursing facility per diem rates (net of patient payment) is allowed to grow by 3% annually. Allowable costs for facilities beyond this amount – including the portion attributable to rate reductions – is funded through supplemental payments to the extent possible. Additionally, whereas rate reductions for other providers have been cumulative, rate reductions for nursing facilities have been applied as one-time reductions that do not impact future years' rates. Consequently, rate reductions have impacted Class I Nursing Facility rates differently than other provider types; because nursing facilities' costs have been growing over time and the reimbursement methodology is cost-based, rate reductions for Class I Nursing Facilities slowed the rate of growth in reimbursement rates rather than decrease them.

Impacts to Class I Nursing Facility Reimbursement since FY 2009-10			
Fiscal Year	**Legislative Action**	**Rate Reduction[(1)]**	**Note**
FY 2009-10	HB 10-1324	-1.50%	Effective March 1, 2010 – partial year impact
FY 2010-11	HB 10-1379	-2.50%	Also limited General Fund growth in rate from FY 2009-10 to FY 2010-11 to 1.9%
FY 2011-12	SB 11-125	-1.50%	
FY 2012-13	HB 12-1340	-1.50%	
FY 2013-14	N/A	0%	All rate reductions expire and rates return to what they would have been absent the policy changes in the preceding years.

(1) Unlike previous examples for other provider types, these figures are not cumulative; they are instead, one-time impacts.

Despite the rate reductions, total nursing facility rates have risen since FY 2009-10. Annual increases in rates due to the reimbursement methodology have resulted in an estimated increase of 5.1% from FY 2009-10 to FY 2012-13, even after accounting for rate reductions over the same period.

24) How do current appropriations for hospital providers compare to the maintenance of effort requirement contained in Section 25.5-4-402.3 (5) (a) (I), C.R.S.?

RESPONSE:

Section 25.5-4-402.3 (5) (a) (I), C.R.S. states that the intention of the Hospital Provider Fee is to supplement, not supplant, General Fund-supported hospital reimbursement. The statute requires that "General Fund appropriations for hospital reimbursements shall be maintained at the level of appropriations in the Medical Services Premium (sic) line item made for the fiscal year commencing July 1, 2008." While there is no specific appropriation for hospitals in the Medical Services Premiums line item, total expenditure for hospital claims have increased from $510.5 million in FY 2008-09 to $595.0 million in FY 2011-12.

Additionally, the statute allows for General Fund appropriations for hospital reimbursements to be reduced if General Fund appropriations are reduced for certain other providers, including home health providers, physician services, and outpatient pharmacies. During the economic downturn, the Department complied with the intent of the statute by reducing hospitals' Medicaid rates by the same percentage as other Medicaid providers. In the Department's FY 2013-14 November 1, 2012 budget request R-13, the Department is requesting the same 1.5% rate increase for hospitals as it is for other Medicaid providers.

27) How do changes in nursing home reimbursement rates compare to changes in rates for other providers?

RESPONSE:

Please see the Department's response to Question 23.

28) Should the nursing home rate be in statute, and why? If it remains in statute, how could it be fixed to be more transparent and comprehensible, while maintaining the purpose and intent of the statute?

RESPONSE:

The Department believes the extent to which the nursing facility rate methodology is described in statute is problematic. There have been a number of conflicts generated by the statute that the Department is unable to resolve without additional legislative action. For example, as the result of a nursing facility rate appeal settlement regarding appraisal of fair rental value, the Department has incurred a financial obligation to 31 nursing facility providers. Due to conflicting statutory obligations, there is no apparent funding source to support this legal obligation.[2]

While the level to which the rate methodology is prescribed in statute has created operational difficulties for the Department, it is important to note that nursing facility rates are not the only rates provided for in Colorado statutes. The intent of the General Assembly is defined in statute

[2] The Department has requested funding for this issue in its January 2, 2013 supplemental request S-16, "Nursing Facility Rate Appeal Settlement".

for many sets of Medicaid provider rates. For example, statute requires that community mental health centers be reimbursed based upon reported costs and that inpatient hospitals be paid based upon a system of diagnosis-related groups. What is unusual about nursing facility rates is there is much more detail about the operation of the rate methodology than for other provider groups. The Department finds it is better able to perform its administrative duties in a statutory context that provides broad policy guidance and allows flexibility in terms of the operational details. Furthermore, having the nursing facility reimbursement methodology in statute constrains policy direction of the Department. Because of the prescriptive nature of the statute, alternative payment methodologies – including provider incentives, efficiencies, or payments tied to outcomes – cannot be implemented. For example, the reimbursement methodology reflects an "institutional" model of care that delineates between "institutional" and "community-based" care. This makes it difficult to establish an integrated, long-term services and supports system that is responsive to the needs of the beneficiaries and the State.

Because of their statutory complexity, nursing facility rates are unusually opaque to stakeholders. Also, nursing facility rates comprise a highly disproportionate share of the Department's provider rate appeals. The Department believes this is at least partially due to the legal complexity that arises by putting an unusual amount of detail in statute.

The Department does believe statute needs to be adjusted to make technical corrections. Over the last decade, it has become common for the General Assembly to consider some type of technical bill concerning nursing facility rates during each legislative session. This is not the norm for other provider groups and is a clear consequence of the level of rate detail that is currently in statute. Without statutory simplification, the need for the General Assembly to clarify or revise the rate-setting methodology is likely to continue.

30) How are rates for home and community based services (HCBS) calculated and how have they changed over time? What would those rates be today if they had been increased for the annual cost of living since 2004? How do changes in HCBS rates compare to changes in nursing home rates?

RESPONSE:

Historically, rates for home- and community-based services (HCBS) were based upon historical data using other Medicaid state rates for comparability of similar services and methodologies focused on wage data for salary expectations from the U.S. Bureau of Labor Statistics (BLS). Beginning in 2011, the Department has revised its methodology for calculating new HCBS rates. Under the new methodology, the Department calculates a new HCBS rate based on the expected cost of providing the service and the accessibility of the service. Typical research on setting service rates includes determining salary expectations, direct and indirect care hours, the full-time equivalent (FTE) required for the delivery of services, other costs, and whether the rate is aligned with other payers in the marketplace. The Department must also ensure that rates set are in compliance with all applicable federal regulations, including upper payment limits. Based on the results of the Department's research, the Department uses that information to establish the unit value (such as the length of time being paid for) and the price. Once the rate has been determined, comparisons of other state Medicaid rates and private pay rates for similar (or identical) services are analyzed to ensure the appropriateness of the determined rate.

Once a rate is established, the Department applies rate increases or decreases when funds are approved through the appropriations process. The following table displays rates for services in the Elderly, Blind, and Disabled HCBS waiver program for FY 2004-05 and FY 2012-13. The table also includes a calculated value based on if the FY 2004-05 rate had been annually adjusted for inflation.

Service	FY 2004-05	FY 2012-13	CPI Adjusted FY 2012-13	Percent Difference between FY 2012-13 Rates and CPI Adjusted 2012-13 Rates
Adult Day - Basic Rate	$21.05	$21.79	$28.56	31.09%
Adult Day - Specialized Rate	$26.90	$27.83	$36.50	31.16%
Alternative Care Facility	$36.03	$46.14	$48.89	5.96%
Homemaker	$3.14	$3.47	$4.26	22.79%
Non-Medical Transportation - Taxi	$47.50	$46.98	$64.46	37.20%
Non-Medical Transportation - Mobility Van	$12.20	$12.07	$16.55	37.16%
Non-Medical Transportation - Wheelchair Van	$15.19	$15.02	$20.61	37.23%
Non-Medical Transport. - Wheelchair Van Mileage	$0.61	$0.62	$0.83	33.51%
Personal Care	$3.14	$3.47	$4.26	22.79%
Relative Personal Care	$3.14	$3.47	$4.26	22.79%
Respite-Alternative Care Facility	$51.84	$51.38	$70.34	36.91%
Respite-In-Home	-	$2.94	$4.04	37.30%
Respite-Nursing Facility	$115.81	$114.57	$157.15	37.16%
Average Percent Change in FY 2012-13 Rates and CPI Adjusted FY 2012-13 Rates				**30.23%**

- *Inflation was calculated using the Consumer Price Index or All Urban Consumers: Medical care in Denver-Boulder-Greeley, CO (CMSA) (CUUSA433SAM)*
- *Prior year inflation factor was used to inflate current year rates. For example, the 2011 inflation factor was used to estimate FY 2012-13 rates.*
- *Unit values differ for each service type. For example, the billing unit for alternative care facilities is a full day, while the billing using for personal care is 15 minutes. Further information is available in the Department's billing manual for HCBS services.*

Table A in Attachment 30 includes a table displaying the yearly rates for the Elderly, Blind, and Disabled HCBS waiver program from FY 2004-05 to FY 2012-13. Table B shows what the rates would have been if an inflationary increase were applied each year. The Department estimates that, on average, rates would be approximately 30% higher than the current FY 2012-13 rates if an inflationary adjustment had been applied each year.

Unlike HCBS rates, rates for skilled nursing facilities are set annually and based on facility submitted cost reports as required by statute. Between FY 2004-05, the actual paid nursing facility per diem has increased by approximately 25%. Nursing Facility Data is shown in Table C of Attachment 30.

Class I Nursing Facility Per Diem Rates and Percent Change: FY 2004-05 and FY 2012-13

Fiscal Year	Per-Diem Rate	Percent Change
FY 2004-05	$150.15	N/A
Estimated FY 2012-13	$187.97	**25.19%**

R-6 | FTE for Understaffed Programs

Demands on the Department have grown

- Created in 1993, the Department's function has transitioned from simply being a payer of claims to becoming an innovator that focuses on policy and initiatives to transform how the state delivers and pays for health care
- Increasing Demands:
  - Greater stakeholder engagement
  - Increased caseload
  - Need for innovative cost savings measures to reduce expenditures
  - Implementation of the Affordable Care Act
  - More strict federal guidelines

Department efforts to increase efficiency

- The Department utilized LEAN to conduct 12 process improvement projects
- Stakeholder groups have been used to develop and communicate new policy

FY 2013-14 Request:
General Fund: $352,172
Total Funds: $704,341
FTE: 7.4

Supported by our stakeholders

Colorado Coalition for the Medically Underserved

COLORADO CENTER on LAW & POLICY
Justice and Economic Security for *all* Coloradans

CCDC

COLORADO CHILDREN'S CAMPAIGN
Creating hope and opportunity in Colorado, more than one million kids at a time.

ALL KIDS COVERED
Healthy Kids A Healthy Colorado

Alliance
Colorado Communities United for People with Developmental Disabilities

31) How do the staffing levels for Colorado's Medicaid and CHP+ programs compare to the staffing levels in other states?

RESPONSE:

Please see the following table for a comparison of state agencies responsible for Medicaid and State Children's Health Insurance Program, known in Colorado as the Child Health Plan *Plus* (CHP+). Please note that the structure of the Medicaid program and the administration of the Medicaid program is different in each state, so a direct comparison based on the table alone may be misleading. For example, eligibility determinations are done at the county level in Colorado; however, other states may perform this function within the Department. Also, each state may organize its programs differently than Colorado and have a variety of other programs designed for low-income families, the elderly, and persons with disabilities housed in the same Department as its Medicaid program.

State	Total Medicaid and CHP+ Expenditures (Federal Fiscal Year 2011[1])	Eligibles (Federal Fiscal Year 2011[2])	Current FTE Level
Colorado	$4,546,184,230	560,722	326.2
Arizona	$9,034,050,555	1,324,000	1,407.3
Oregon	$4,591,734,555	566,224	527.8
Kansas	$2,769,606,345	303,770	211
Utah	$1,829,637,309	286,200	213.9
Nebraska	$1,682,739,228	237,047	430

[1] *This information is from http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/MBES/CMS-64-Quarterly-Expense-Report.html, a website managed website by the Centers for Medicare & Medicaid Services.*

[2] *This information is from the Department's November 2012 CMS-37 budget request.*

32) Why can't the Department manage staffing needs within existing resources?

RESPONSE:

The work of the Department has fundamentally shifted over time; as a result, the staffing needs have also fundamentally changed. When the Department was created, the Department's only function was to pay the health care claims of those enrolled in the State's medical assistance programs. The Department was operational in nature, with little emphasis placed on policy and initiatives geared toward increasing quality and

containing costs. Over time, the core mission and the purpose of the Department have changed, along with the stakeholder and regulatory environment in which it finds itself. Colorado is now a national leader in health care, and the Department is expected to deliver innovative programs that will dramatically improve how the State delivers and pays for health care.

Over time, as new projects and needs have arisen and existing programs have grown significantly in both size and complexity, the Department has also either fully or partially absorbed the need for resources. For example, during the FY 2009-10 budget process, the Department requested three FTE to implement the Accountable Care Collaborative (ACC); however only 0.5 FTE was appropriated for that purpose. The lack of resources was a major reason that the program took an additional 13 months to implement and was much more difficult for those who did work on the program, many of whom simply absorbed the extra duties.

In order to continue the important work of programs like the ACC, including moving forward with innovation in payment methods, the Department is now in a position where additional resources are required in order to effectively operate and perform as a national leader in today's health care environment.

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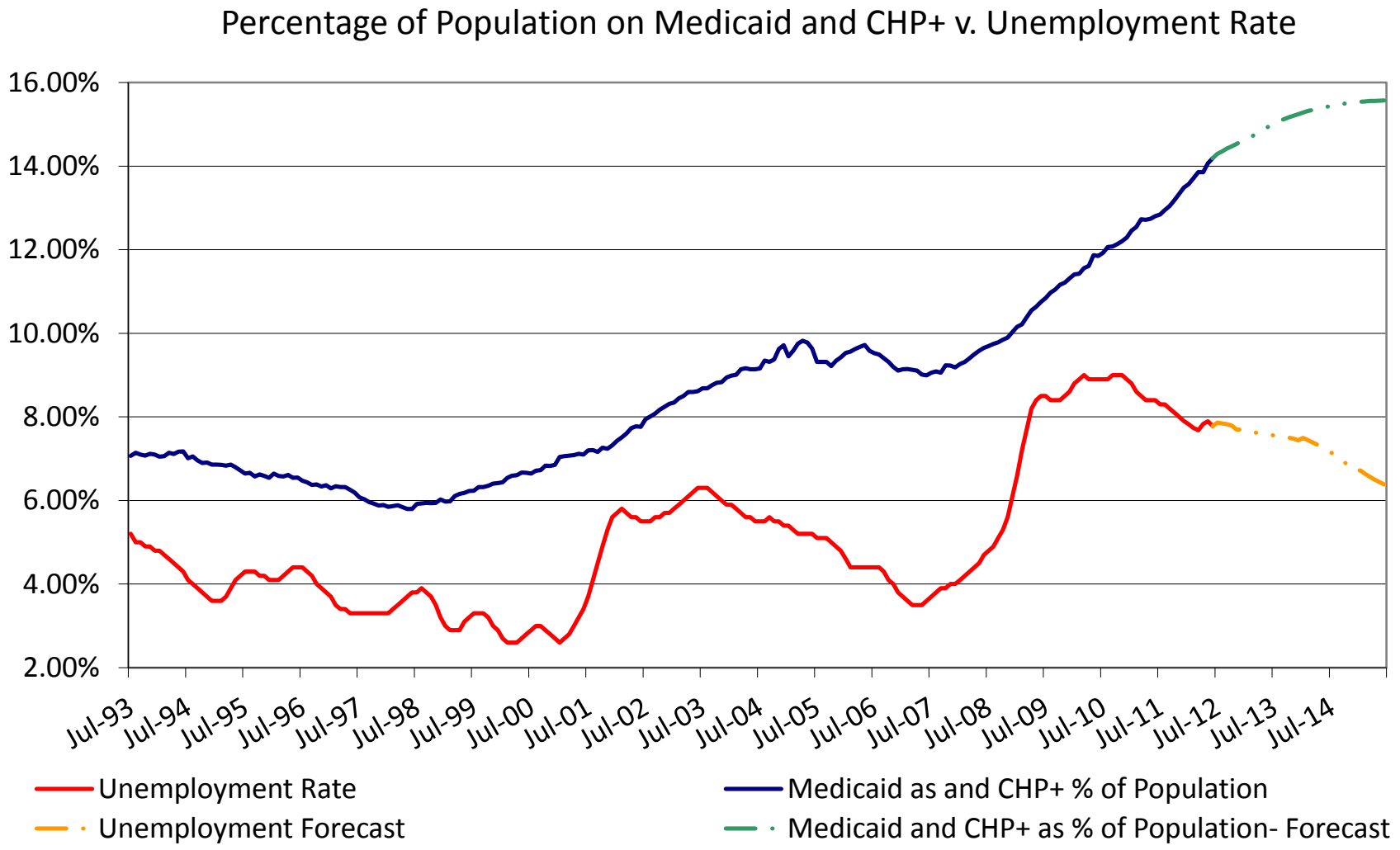
Unemployment and Caseload



21) The JBC staff provided a chart comparing Colorado's Medicaid enrollment and Colorado's unemployment rate. Please provide any available information about the number of underemployed in Colorado and their contribution to Medicaid enrollment.

RESPONSE:

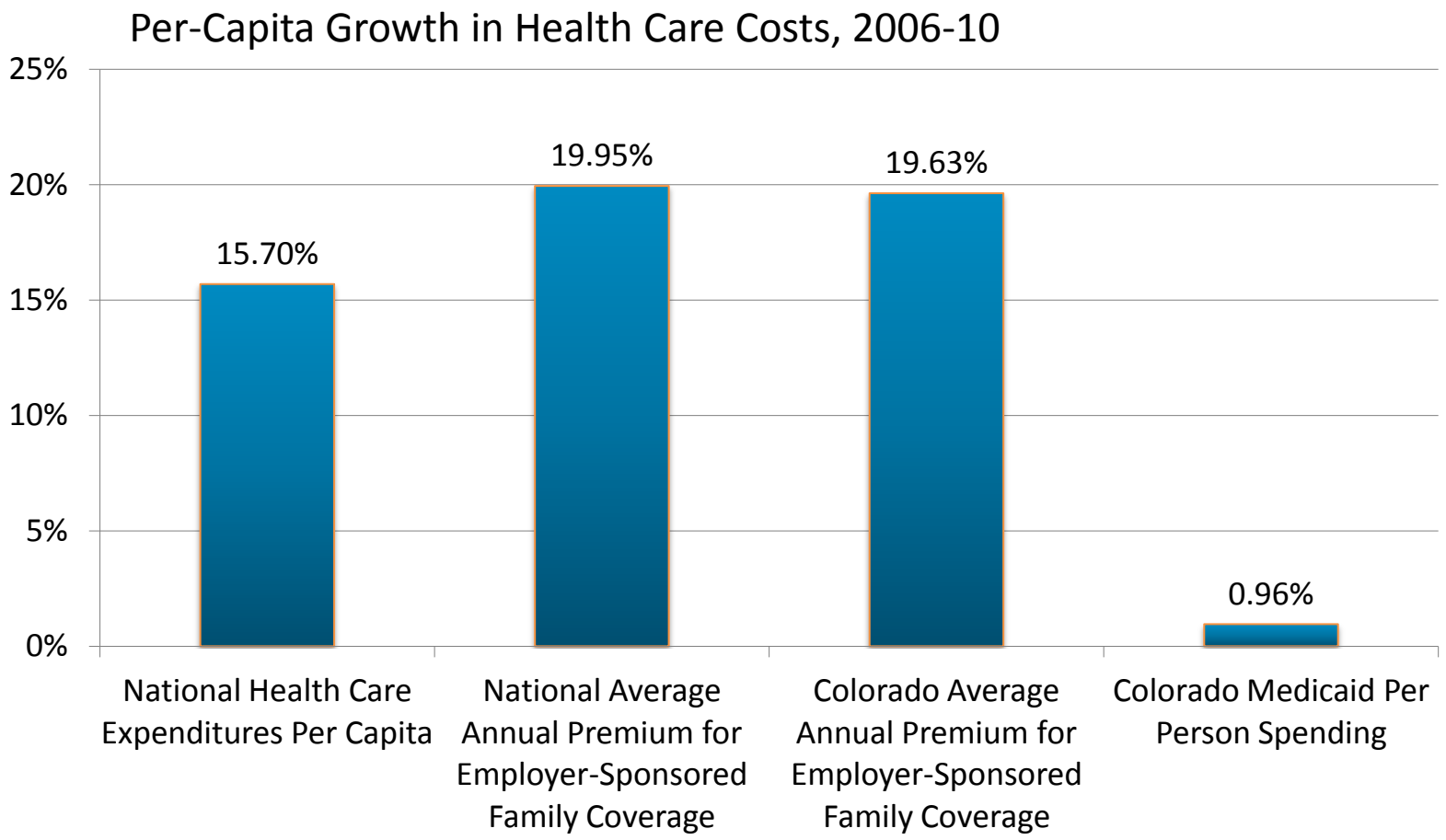
The U.S. Bureau of Labor Statistics (BLS) calculates various measures of labor underutilization for states, ranging from U-1 to U-6, with each statistic accounting for an additional category of labor underutilization. The U-6 statistic is the most inclusive measure of unemployment, as it includes total unemployed plus all persons marginally attached to the labor force and total employed part-time for economic reasons (the "underemployed"). According to the most recent BLS estimates, the "Alternative Measures of Labor Underutilization for States, Fourth Quarter of 2011 through Third Quarter of 2012 Averages," approximately 15% of Colorado's work force is underemployed (including the unemployed). For more information on the various measures of labor underutilization, please visit http://www.bls.gov/lau/stalt12q3.htm.

Despite the fact that U-6 unemployment is widely considered to be a more broad measure of unemployment, the Department believes the U-3 unemployment rate – which is the official unemployment rate and includes all persons unemployed 15 weeks or longer, job losers, and persons who completed temporary jobs – is a more reliable indicator of expected Medicaid caseload. An underemployed individual can be either eligible or ineligible for Medicaid, depending on their income level relative to Medicaid thresholds. During a recovery, previously unemployed individuals may become employed part-time, which results in an increase in underemployment as well as increased income. However, this change in income may or may not move a family's income over the Medicaid-eligibility threshold, depending on what this income level is. If the individual's income is still very low and below Medicaid thresholds (for example, very few hours at a minimum-wage job), the family will remain eligible for Medicaid; if the income is relatively high and is above the Medicaid threshold, the family will be ineligible for Medicaid (for example, a higher-wage job or more hours worked). As a result, the U-6 unemployment measure's relationship to Medicaid caseload is uncertain.

Additionally, there are other technical considerations why the Department uses the U-3 measure instead of the U-6 measure. First, the BLS publishes the U-6 unemployment data on a four-quarter, moving-average basis, whereas U-3 data is available on a monthly basis. This increases the sample size that the Department can use in its forecasts, which increases the reliability of the model. Second, the Department's forecast modeling requires monthly projections of U-3 unemployment rates throughout the forecast period, and a similar monthly forecast for U-6 unemployment rates is not available.

Finally, the Department does not believe that, even if the obstacles to using the U-6 measure could be overcome, the use of this measure would materially improve its Medicaid caseload forecast. In the Department's forecast models, the absolute level of unemployment is irrelevant; rather, it is the relative change between data points that matters. In any forecast modeling, if two variables have a very similar pattern over time, both will yield very similar forecasts regardless of differences in absolute value. As the moving averages of U-3 and U-6 unemployment have displayed very similar trends since the first quarter of 2008, using U-6 unemployment would yield results that are very similar to the Department's official forecast if a forecast for U-3 was available for the Department to use.

Growth in Health Care Costs



22) How do changes in Medicaid costs compare to changes in general health care costs? Are Medicaid costs rising faster, slower, or about the same as costs in the health care market?

RESPONSE:

Although certain comparisons are provided below, the Department cautions that Medicaid costs are not directly comparable to measures of health care inflation or rates of increase in private insurance premiums. The Department does not generally adjust reimbursement rates for changes in actual provider costs, and so changes in Medicaid costs do not necessarily reflect the change in cost for practitioners providing health care. Rather, per capita Medicaid costs are generally a function of actual utilization and changes in Medicaid caseload; this contrasts with measures such as the medical care consumer price index (CPI), which are derived from a broader calculation of health care-related expenses, including insurance premiums and administrative costs.

In recent years, Medicaid per capita costs have generally decreased for most services, while general health care costs have increased. In most cases, Medicaid reimbursement does not change in response to changes in cost in the health care market. The majority of Medicaid providers are reimbursed based on a set fee schedule, and the Department does not generally update the fee schedule without additional appropriations for that purpose from the General Assembly. Since FY 2008-09, the Department has reduced reimbursement to the majority of Medicaid providers by 6.10%, whereas health care costs, as measured by the consumer price index, have increased by approximately 10.83% during that time.[1] The Department's response to question 23 contains additional information on recent changes in Medicaid reimbursement rates.

In general, costs in the health care market rise faster than Medicaid costs. Since FY 2008-09, per capita costs for the Department's relatively high-cost categories (elderly and disabled) have increased slightly, while per capita costs for the Department's relatively low-cost categories (adults and children) have decreased. During the same period, the average annual total for employer-provided health care premiums has increased by nearly 25% (see the following table).

[1] Consumer Price Index for All Urban Consumers: Medical care in Denver-Boulder-Greeley, CO (CMSA) (CUUSA433SAM), 2009-2012 (comparisons based on June data)

Annual Growth in Per-Capita Costs by Medicaid Category[(a)]: FY 2008-09 through FY 2012-13*					
	Adults 65 and Older (OAP-A)	**Disabled Individuals to 59 (AND/AB)**	**Categorically Eligible Low-Income Adults (AFDC-A)**	**Eligible Children (AFDC-C/BC)**	**Average Annual Total Premiums for Family Coverage[(b)]**
FY 2009-10	-4.41%	-3.23%	-10.22%	-7.93%	5.48%
FY 2010-11	1.31%	3.51%	-5.59%	-2.00%	2.95%
FY 2011-12	1.36%	-0.33%	-1.83%	-5.34%	9.46%
FY 2012-13[(c)]	2.67%	2.01%	-0.70%	-4.60%	4.46%
Since FY 2008-09	**0.78%**	**1.84%**	**-17.37%**	**-18.52%**	**24.17%**

(a) Historical per capita costs can be found in Department's November 1, 2012 Budget Request R-1, Exhibit C

(b) These figures include physical health and long-term care costs. Kaiser Family Foundation, Employer Health Benefits 2012 Annual Survey, Exhibit 6.4: Average Annual Worker and Employer Contributions to Premiums and Total Premiums for Family Coverage, 1999-2012 (calendar-year data is matched with fiscal year beginning during calendar year – i.e., CY 2009 data is matched with FY 2009-10)

(c) FY 2012-13 figures are projections from the Department's November 1, 2012 Budget Request R-1.

Our Mission:

Improving health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources

1) The JBC occasionally hears complaints that base personal services reductions to capture vacancy savings result in more vacancy savings as managers reduce staff to absorb the reduction and then still experience turnover. Some departments refer to this as the "death spiral." Has your department experienced this problem? How does your department attempt to minimize and avoid the "death spiral?"

RESPONSE:

The Department aggressively manages its Personal Services appropriation in an attempt to minimize the effects of the "death spiral" and base personal services reductions in general. As a result, the Department typically expends all of its General Fund Personal Services appropriation each year. Therefore, reductions to the Department's Personal Services appropriations and the resulting "death spiral" create operational issues for the Department.

In order to minimize the effects of reductions to its Personal Services appropriation, the Department uses multiple strategies to help contain costs. When a position is vacated, the Department evaluates the position and similar positions in the division to determine if job duties can be absorbed by existing staff. Where possible, the Department also temporarily downgrades positions for training purposes. By doing so, new staff can be brought in at lower salaries, creating additional flexibility in the Department's Personal Services appropriation. However, this approach is not sustainable in the long term. Existing staff cannot typically absorb many additional job duties for a significant period of time. Downgrading positions discourages highly qualified candidates from applying, as the initial salary offered is lower.

As the Department has grown in size and scope over the last decade, vacancies create a considerable burden for those who continue to work at the Department, and the length of time needed to hire employees into the State personnel system can create workload and morale issues. To alleviate this burden, the Department attempts to supplement staff with temporary employees when vacancies occur, which reduces the potential amount of vacancy savings. However, this, too, is not an ideal solution. Temporary employees may only be employed for a limited amount of time in each 12-month period (previously six months per year; nine months per year effective January 1, 2013). Therefore, temporary employees cannot work on long-term assignments. This places an additional burden on existing staff who must assume additional responsibilities created by the vacancy and also creates additional training responsibilities. At the end of the temporary employee's assignment, the knowledge the employee has gained is lost to the Department. As a result, although temporary employees are less expensive in the short run, they are not a sustainable way for the Department to manage its personnel needs.

Overall, because the Department frequently spends its entire General Fund Personal Services appropriation, base personal services reductions made in an attempt to capture vacancy savings put significant additional pressure on the Department's ability to manage FTE levels. Further reductions to the Department's Personal Services appropriation would likely result in reduced overall staffing at the Department and ultimately impair the Department's ability to perform its core operations and work on health care reform initiatives.

40) How will the Affordable Care Act affect the Medicaid family planning program? What is the federal match rate for this program?

RESPONSE:

The Affordable Care Act will not change Medicaid coverage of family planning services. The federal match rate for the Medicaid family planning program is currently 90% and will continue to be 90% post-Affordable Care Act implementation.

During the FY 2010-11 budget request cycle, the Department worked toward creating an 1115 demonstration waiver that would extend the provision of family planning services to individuals up to 200% FPL. The intent of the waiver was to provide family planning and reproductive health care to individuals who meet established criteria and who otherwise would not have access to these services.

The Department withdrew the waiver application in December 2011 for multiple reasons. The Department determined, with the implementation of health care reform in 2014, it would be more efficient and cost-effective to withdraw the waiver and refocus on other efforts to support family planning infrastructure and sustainability in Colorado. The individuals who would have originally been covered under this waiver will now be covered through the expansion of Medicaid (up to 133% FPL) or will be eligible for a subsidized plan covering all essential benefits, including family planning services, through the Colorado Health Benefit Exchange. Additionally, implementation of the waiver would have required over $800,000 for system changes, and program implementation would not have been completed until late 2013.

41) Please coordinate with the departments of Education and of Public Health and Environment to discuss whether the funding and administration for school based health clinics should be transferred to the Department of Education.

RESPONSE:

There are two programs under the Department's purview that provide funds for health services provided to students: 1) the School-Based Health Center Program, and 2) the School Health Services Program. The departments do not believe the funding or administration for either program should be transferred to the Department of Education. These programs are related to providing health care or reimbursing for health care services, which is within the scope of the Department of Health Care Policy and Financing and not the Department of Education. For reference, the programs are described in detail below.

School-Based Health Center Program

The School-Based Health Center Program was created in 1987 to assist in the establishment, expansion, and ongoing operations of school-based health centers (SBHCs) in Colorado for uninsured and/or low-income children. SBHCs are clinics operated within a public school building – including charter schools and GED programs – associated with a school district and in collaboration with hospitals, health care organizations, medical providers, public health nurses, community health centers, and mental health providers.

Establishing a school-based health center is a community-driven process that requires multiple partnerships – between school districts, the medical and mental health communities, and local and state funders – to be effective. The Colorado Department of Public Health and Environment does not run these clinics but rather sets standards and provides some funding. SBHCs that enroll as Medicaid or CHP+ providers receive reimbursement from the Department for their Medicaid claims and through CHP+ managed care organizations for their CHP+ services.

The departments believe the SBHC Program is appropriately placed in Department of Public Health and Environment (CDPHE) for the following reasons:

- School-based health centers address topics of concern to public health including immunizations, obesity prevention, depression screening, management of acute illnesses such as diabetes and asthma, primary prevention of communicable illnesses, and oral health. The expertise to address these health concerns resides in the CDPHE.
- Colorado Department of Education's (CDE) mission is to "shape, support, and safeguard a statewide education system that prepares students for success in a globally competitive world." CDE's primary role is to educate children and youth, while CDPHE is primarily responsible for the health of Colorado's people.
- The Prevention Services Division at CDPHE is responsible for managing hundreds of contracts throughout the State. The department has the capacity, expertise, and experience to effectively and efficiently administer the SBHC program. Nationally, the majority of state-run, school-based health center programs are housed in state health agencies.

School Health Services Program

The School Health Services (SHS) Program was established in 1997 and allows public school districts, Boards of Cooperative Educational Services (BOCES), and state K-12 educational institutions to receive federal Medicaid funds for amounts spent providing health services to students who are Medicaid-eligible and have either an Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP).[1] In addition, participating districts and BOCES may receive reimbursement for Medicaid administrative activities that directly support efforts to identify and enroll potentially eligible children and their families into Medicaid.

The district or BOCES incurs the original expenditures using local tax dollars or appropriated General Funds which draw federal matching Medicaid funds through the certification of public expenditures (CPE) mechanism. To draw federal Medicaid funds through CPEs, districts and BOCES must participate in a federally-approved quarterly time study and submit quarterly and annual cost reports.

Under Colorado statute, participating districts and BOCES are required to use the Medicaid funds received to fund student health services for all students. Each participating district and BOCES must develop a local services plan with community input to identify the types of health services needed by its students and must submit an annual report that describes exactly how the Medicaid revenue was spent in accordance with its local services plan.

The SHS Program is administered jointly by the Department and the Colorado Department of Education. The Department draws and disburses the federal Medicaid funds, conducts the federally-approved time study, administers the quarterly and annual cost report and certification processes, and conducts on-site reviews to ensure compliance with federal requirements. The Department of Education provides technical assistance related to the development of the local services plan and annual report and reviews and approves the local services plan.

42) Can local funds for services for people with developmental disabilities, such as Denver's program, be used to match federal Medicaid funds?

[1] Note: Health services required in a child's IEP or IFSP are not covered by the SBHC program, which provides primary health care and mental health services.

RESPONSE:

History
In January 2006, the Centers for Medicare and Medicaid Services (CMS) notified the Department that it was no longer permitted to use certification of public expenditures (CPE) to qualify for a federal Medicaid match for services for the developmentally disabled population. CPE requires that public providers certify their uncompensated costs, but local governments are not the provider of developmental disability services; rather, private Community Centered Boards (CCBs) are. The appropriate mechanism to qualify for a federal match for these services would be an Inter-Governmental Transfer (IGT) from the local government to the Department. The Department would then report legitimate Medicaid expenditures to CMS to obtain the match.

In the fall of 2009, the Department, the Department of Human Services (DHS), and selected stakeholders formed a workgroup to discuss the possibility of obtaining a match through IGT. In February 2010, a letter was sent to county commissioners outlining a possible new process for reinstating the federal match through an IGT process to alleviate waitlists. No interest was expressed, and the Department's workgroup disbanded.

Current Situation
Pursuant to section 27-10.5-104(6) C.R.S. (2012), boards of county commissioners are permitted to levy up to one mill for purchasing services for persons with developmental disabilities. Presently, eight counties in Colorado assess a levy designated for developmental disability services and support: Arapahoe, Boulder, Denver, Douglas, Jefferson, Larimer, Pueblo, and Routt.

This mill levy revenue would need to be transferred to the Department as an IGT in order to receive matching federal Medicaid funds pursuant to 42 CFR § 433.51. These funds could then be used to provide Medicaid-approved waiver services to persons with developmental disabilities and may not be passed directly back to the local governments that levied the assessment.

Once transferred to the Department, local control over the use of the revenues would be limited. Further research and discussion with CMS would be required to explore this issue and answer many questions. For example, it is unknown if the IGT funding could be targeted to specific waivers, specific individuals, or specific Medicaid services. If the HCBS programs caseload and costs were to grow over time, it is unclear what financial obligations would be borne by the State versus the local governments. Furthermore, the ramifications for those counties that do not designate funds or transfer funds to the State for this purpose are unknown. Lastly, the State must also estimate and study the ramifications this transfer of local government funds would have on its annual TABOR revenue limits.

43) Does Colorado have a Medicaid administrative claiming process that would allow local governments to get matching funds for administrative functions, and if not, why not?

RESPONSE:

Medicaid administrative activities performed by counties are reimbursed through the "County Administration" Long Bill line item. Costs are submitted by counties through the County Financial Management System (CFMS), which is managed by the Colorado Department of Human Services (DHS).

In 2009, the Department formed a workgroup with DHS and Boulder County to study reimbursement through the "County Administration" Long Bill line item. The focus of the study was to determine if counties conducting Medicaid administrative activities were incurring Medicaid costs that were not being reimbursed that could qualify for matching federal Medicaid funds through the certification of public expenditure mechanism. The workgroup concluded that county Medicaid administration costs submitted by the counties through the CFMS are being fully reimbursed. Furthermore, DHS demonstrated that the current cost allocation and year-end pass-through close-out processes in place are designed to maximize funding and accurately reimburse counties. Given this finding, the Department disbanded its research related to certification of public expenditure to qualify for federal funding for uncompensated administrative Medicaid costs. Counties may wish to contact the Settlement Accounting section at DHS to receive detailed coding assistance for administrative claiming and a thorough walk-through of the reimbursement process.

In addition, Medicaid administrative activities performed by school districts and Boards of Cooperative Educational Services (BOCES) are reimbursed through the School Health Services program, which is administered jointly by the Department and the Department of Education. School districts and BOCES that choose to participate in the program may receive reimbursement for Medicaid administrative activities that directly support efforts to identify and enroll potentially eligible children and their families into Medicaid. The reimbursement mechanism is matching federal Medicaid funds through certification of public expenditures, which requires participation in a federally-approved time study and submission of quarterly cost reports. In FY 2011-12, 39 school districts participated in Medicaid administrative claiming in the School Health Services program and received reimbursement totaling $1,388,203 through the end of the third quarter of that fiscal year.

1) The Joint Budget Committee has recently reviewed the State Auditor's Office Annual Report of Audit Recommendations Not Fully Implemented (October 2012). If this report identifies any recommendations for the Department that have not yet been fully implemented and that fall within the following categories, please provide an update on the implementation status and the reason for any delay.

a) Financial audit recommendations classified as material weaknesses or significant deficiencies;

b) Financial, information technology, and performance audit recommendations that have been outstanding for three or more years.

RESPONSE:

The Department has provided a response and update to all the recommendations in the State Auditor's Office Annual Report of Audit Recommendations Not Fully Implemented in Attachment A1. Most of the implementation dates of the performance audit recommendations in the report have not been outstanding for three or more years. However, the Department is providing a response to all the performance audit recommendations in the report as additional information to the Joint Budget Committee. As summarized in Table A1 of the attachment, the Department is pleased to report that one of the two Material Weaknesses and one of the six Significant Deficiencies have been implemented since the last update provided to the State Auditor's Office that was used generate the report. The JBC request only covered a portion of the total Deficiency in Internal Control recommendations; therefore the Department is providing additional information on all of these low-severity recommendations, of which four of the 12 have since been implemented. Further, the Department has made significant gains in implementing the performance audit recommendations. As provided in Table A1, of the 17 outstanding audit recommendations reporting in October 2012, the Department has since implemented eight of those recommendations.

2) Please provide the number of units provided in the last fiscal year by discipline, in either visits or hours, for home health, private duty nursing and home and community based services programs. These disciplines include RN visits, PT visits, OT visits, speech therapy visits, home health aide visits by time, personal care provider hours, and private duty nursing and RN and LPN hours.

RESPONSE:

The Department has provided a response in Attachment A2.