Colorado Commission on Family Medicine
Training Family Physicians for the State's Health Care Needs

Presenters:
- James Helgoth, Congressional District 2 Representative, COFM Chair
- Janell Wozniak, M.D., Director, Fort Collins Family Medicine Residency, CAFMR Chair
- Kim Marvel, Ph.D., Executive Director, COFM/CAFMR

The Commission on Family Medicine supports the education of family physicians in Colorado.

Colorado has a shortage of primary care physicians (PCPs), especially in rural areas.
- The Colorado Health Institute identified wide regional variation in the primary care workforce, requiring an additional 258 PCPs in nine regions of the state; 34 of 64 counties are short PCPs.
- The Graham Center reported Colorado needs 444 additional PCPs to maintain current rates of utilization.

The General Assembly has committed funds to increase the training of family physicians. Beginning in 2013, additional state funds have enabled the residency programs to expand the number of family physicians being trained and to place them in areas of highest need: rural and underserved communities.

State funds are matched by federal Medicaid dollars, effectively doubling the state investment.

In the 2015-16 fiscal year, state funding for training family physicians in Colorado (allocated to the Commission on Family Medicine) is divided into three areas:

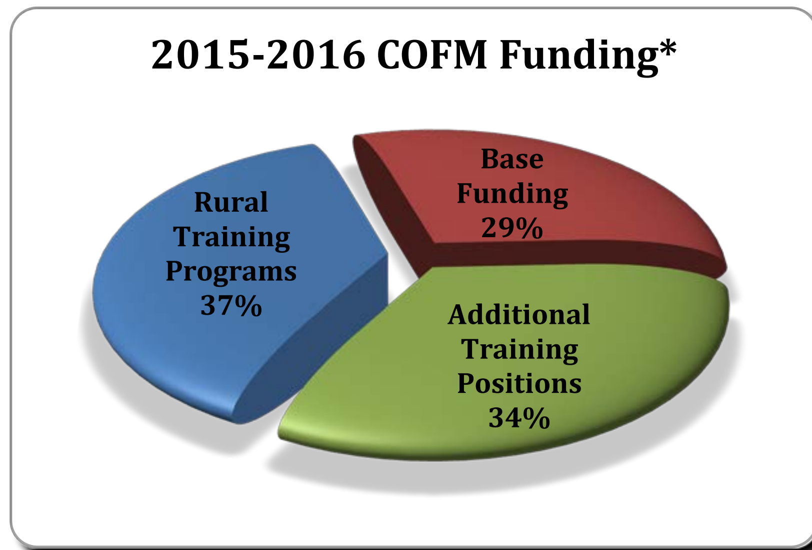
Base Funding: ($1,167,578)
- These funds are distributed directly from HCPF to the nine family medicine residency programs.
- The funds are used for training expenses, especially to advance team-based care and care coordination within the Patient-Centered Medical Home model.
- State funding is combined with patient care revenue and federal Medicare GME funds to pay the expenses of training family physicians.

Rural Training Programs: ($1,500,000)
- Rural training programs are being established in Alamosa, Fort Morgan, and Sterling.
- Once established, these new programs *will graduate six family physicians each year* (two per program), graduates of rural programs are much more likely to practice in rural areas.
- Progress for the rural training programs is on track.
- Two programs (Alamosa and Sterling) were approved for accreditation in October, 2015 and are recruiting medical students to begin residency in July, 2016. The Ft. Morgan program will be accredited soon and will begin training residents in July 2017.
- Rural training programs are long-term investments that require sustained funding.
- A rural "pipeline" is used by recruiting medical students with rural backgrounds and those participating in the rural tracks of the University of Colorado and Rocky Vista University.

Adding training positions in existing family medicine residency programs: ($1,350,000)
- Five family medicine residency programs have the capacity to add more training positions.
- Trainees in these new positions will commit to practice in rural/undeserved locations in the state for three years following graduation.
- In return, the graduates will receive a loan repayment award.
- The additional trainees are being recruiting now and will begin in July, 2016.
- State funds for the additional positions ($1.35M) are matched by federal Medicaid funds ($1.35M)

Colorado Family Medicine Residencies

Colorado Commission on Family Medicine



*State funds ($4,017,578) are matched by federal Medicaid funds ($4,084,265)

Results of recent increases in state funding for training family physicians:

- The total number of family physicians in residency training is increasing from 204 to 237.
- The number of family physicians graduating each year will increase from 68 to 79.
- The additional graduates will help ease the shortage of primary care physicians in rural and underserved areas of the state because the added graduates have loan repayment commitments or are training in rural communities.

Importance of sustained funding to build the primary care physician workforce:

- Recent funding increases to expand residency training are long-term investments that require sustained funding.
- Base funding: The base funding has enabled the nine residency programs to produce 68 highly qualified family physicians capable of team-based, integrated, coordinated care for patients and families.
    - Last year, 73% of graduating residents stayed in the state.
    - 47% of graduates that stayed in Colorado practice in rural or underserved communities.
- Rural training programs (will add 6 more graduates per year): The timeline to develop rural training programs is 3-4 years; ongoing funds are necessary to maintain the programs.
    - Development: To find appropriate rural communities; become accredited; recruit students.
    - Maintenance: State funds combined with patient care revenue allow programs to continue.
- Additional positions (will add 5 more graduates per year): Funding is required for a minimum of three years to complete at least one cycle of trainees to the point of graduation.
- Timeline for increasing the number of residents in family medicine programs:

Academic Year	Number in training	Graduates per year
2015-2016:	204	68
2016-2017:	213	68
2017-2018:	224	68
2018-2019:	235	77
2019-2020:	237	79

- Ongoing funding will be required to maintain the increased numbers of graduates after 2020; eliminating the current state funding will return productivity to 2015-2016 levels.

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
FY 2016-17 JOINT BUDGET COMMITTEE HEARING AGENDA

Wednesday, December 16, 2015
1:30 p.m. – 5:00 p.m.

1:30-1:45 **COMMISSION ON FAMILY MEDICINE**

1:45-2:00 **INTRODUCTION AND OPENING REMARKS**

HCPF Presenters:
Susan Birch, Executive Director
Gretchen Hammer, Medicaid Director
Dr. Judy Zerzan, Chief Medical Officer
John Bartholomew, Chief Financial Officer
Chris Underwood, Health Information Office Director

2:00-2:20 **MEDICAID ELIGIBILITY**

1. **Under what circumstances (including presumptive eligibility) can noncitizens and refugees receive Colorado Medicaid benefits?**

RESPONSE

Colorado covers all required and statutorily authorized optional Medicaid eligibility categories of lawful permanent residents, including refugees. Other than having different citizenship documentation requirements, these individuals are eligible for the same Medicaid categories as U.S. citizens as long as they meet all other eligibility criteria to qualify for a specific program (such as income and assets limits) which includes presumptive eligibility for pregnant women and children.

Individuals who do not meet citizenship or residency requirements (such as undocumented or lawful permanent residents who have not been residents for five years excluding pregnant women and children) are eligible for Emergency Medicaid as long as they meet all other eligibility criteria to qualify (such as income).

Under federal law, refugees are initially given access to Medicaid via the Refugee Medical Assistance Program (RMA) which is federally funded through the U.S. Department of Health and Human Services' Office of Refugee Resettlement and administered by the Colorado Department of Human Services (CDHS). The eligibility criteria for these individuals is that their income must be under 200 percent FPL at initial determination and it is time limited. They are exempted from the five-year bar (a provision that excludes certain individuals who recently gained certain legal status from receiving Medicaid coverage for five years) and Medicaid coverage is provided for eight months from the date of entry into the U.S. They remain enrolled for the entirety of the eight months even if their income increases beyond the 200 percent FPL during these eight months. After the eight months, these individuals must qualify under a standard Medicaid eligibility criteria to continue coverage. Once RMA coverage expires, refugees will continue to qualify for Medicaid if they meet Medicaid eligibility criteria, with the exception of the five-year bar. Pursuant to federal law, these individuals are eligible for up to seven years (8 U.S.C. § 1612). The Department receives the standard federal match depending on the eligibility category.

Refugees do not have any special requirements in order to apply for Medicaid benefits. The various standard options for applying for benefits (paper, telephone, or online through PEAK) may also be used by refugees to provide the information necessary (including their legal/refugee status) to make an eligibility determination for Medicaid. Original documents are not required to be provided; however, specific information should be provided on the application in order to electronically verify legal status and income. Pregnant women and children who are refugees are also eligible to apply for presumptive eligibility through approved presumptive eligibility sites.

Additional in-person services for help with the application may be obtained through either Certified Application Assistance Sites (CAAS), Medical Assistance (MA) Sites, Presumptive Eligibility (PE) sites, or through local county departments of social/human services. Specific locations may be found through the directory by "Site Type" at http://www.colorado.gov/apps/maps/hcpf.map.

a. What are the benefits they are eligible to receive?

Lawful permanent residents who have met the five-year bar and refugees are eligible for full Medicaid benefits based on their eligibility for a specific Medicaid category. Individuals who do not meet citizenship or other legal residency requirements are only eligible for benefits associated to the specific emergency.

b. Is this coverage for noncitizens optional or required by the federal government for participation in Medicaid?

The coverage given to refugees is federally required for the first seven years. Coverage for lawful permanent residents who have met the five-year bar is optional. It is also an option to provide coverage to pregnant women and children who have not met the five-year bar. Emergency Medicaid is a federal mandate for individuals who do not meet citizenship requirements (such as undocumented or lawful permanent residents subject to the five-year bar).

c. How much does the state spend on services for noncitizens?

During FY 2014-15, caseload for non-citizens receiving Emergency Medicaid was 2,722 with total expenditures of $40,549,623. The Department's claims data does not indicate whether individuals in other statutorily authorized-eligibility categories are non-citizens, and thus the Department cannot provide total expenditure for all non-citizens.

2. Under what circumstances are people required to meet an asset test to receive Medicaid benefits and what are the asset standards?

RESPONSE

The people that have an asset test for eligibility are the Aged, Blind and Disabled Supplemental Security Income (SSI) related groups, the Medicare Savings Programs (Programs that cover Medicare premiums, co-pays and deductibles) and the 300 percent group which is the primary eligibility category that pays for Long-Term Care (LTC) in nursing facilities or Long-Term Services and Supports (LTSS) which help aged and disabled people remain in the community through the Home and Community Based Services (HCBS) Waivers. The asset standard for the Aged, Blind and Disabled groups is $2,000 for an individual or $3,000

for a couple. For the Medicare Savings Programs, the asset standards are $8,780 for an individual and $13,930 for a couple. For the 300 percent Long-Term Care group the asset standards are $2,000 for an individual or $3,000 for a couple if both are eligible and receiving LTC in a nursing facility and/or LTSS in the community. If only one spouse is eligible and receiving LTC or LTSS then the non-eligible spouse that is remaining in the community can have assets on his/her own of $119,220 in addition to the eligible spouse who is able to have the $2,000 individual limit.

a. Are the asset tests based on state policy or required by the federal government?

In general, federal law requires states to follow the eligibility methodology of the closest related cash assistance program, which is SSI for these groups. The SSI rules are the base set of eligibility rules for which the state cannot be more restrictive. Since the SSI related Aged, Blind and Disabled groups are mandatory, the methodology must be the same as SSI. However, under the 300 percent LTC group (which is an optional group) and the Medicare Savings Programs, the state can choose to exempt certain assets or not apply an asset test at all through State Plan Amendments.

b. Should/could asset tests be eliminated or reduced to remove disincentives for work?

Eliminating the asset test, or reducing the type of assets that are counted, is possible through State Plan Amendments for the 300 percent LTC group and/or the Medicare Savings Programs. Since many of the individuals in the 300 percent LTC group are under age 65 and disabled, eliminating the asset test or allowing an increase in the amount of certain assets would help in removing disincentives to work. Removing the asset test or reducing the type of assets that are counted would require a statute change and an appropriation increase by the General Assembly, as either action is an expansion of Medicaid eligibility.

c. Should/could asset tests be changed to make them more consistent and equitable across eligibility categories?

The asset test could be changed for the 300 percent LTC group and/or the Medicare Savings Programs. Since the non-SSI related categories do not have an asset test, changing the asset test would help make the eligibility requirements more consistent and equitable across the eligibility categories. Removing the asset test or reducing the types of assets that are counted would require a statute change and an appropriation increase by the General Assembly, as either action is an expansion of Medicaid eligibility.

3. Does Colorado Medicaid cover prenatal care (if the client accesses it) in all circumstances where Medicaid covers the delivery? Are there any areas where it might make sense to expand prenatal coverage in order to reduce high cost deliveries that are covered by Medicaid?

RESPONSE

Colorado Medicaid covers benefits that include prenatal, labor and delivery, and post-partum care for pregnant women within the eligibility categories of MAGI-Pregnant and Legal Immigrant Prenatal with an income threshold of less than 195 percent Federal Poverty Level (FPL). A pregnant woman who meets all other eligibility criteria and is a U.S. citizen, U.S. National, or a qualified non-citizen (defined at 10 CCR 2505-10 8.100.3.G) is eligible for full Medicaid benefits. Unlike other lawfully present non-citizens, pregnant women do not need to be residents for five years before qualifying for Medicaid (section 25.5-5-201(4), C.R.S.).

Pregnant women who do not have a legal citizen status or have a Deferred Action for Childhood Arrivals (known as DACA) status but meet all other eligibility criteria can be found eligible for Emergency Medicaid Services only. Emergency Medicaid services cover pregnant women for services considered emergent only, such as labor and delivery services. Prenatal care is not considered an emergent service. Coverage by Emergency Medicaid is directed by federal law (42 CFR 435.139 and 440.255) and by Colorado Statute (section 26-2-137, C.R.S.).

Prenatal care as part of Emergency Medicaid service coverage, might make sense and be considered efficacious. Adding prenatal care as an available service for women covered by Emergency Medicaid would require additional state and federal authorization.

4. **How does the number of people enrolled in Medicaid as a proportion of the estimated people eligible for Medicaid (or the Medicaid penetration rate) vary across the state? What are the reasons behind the variation and is the Department doing anything to improve outreach in areas with lower Medicaid penetration rates?**

RESPONSE

The Colorado Health Institute conducts annual analysis determining the number of people eligible for Medicaid or the Child Health Plan *Plus* (CHP+) programs compared to the number of people enrolled in public health insurance programs. This analysis includes regional information and highlights variations. The next analysis by the Colorado Health Institute is expected to be released in early 2016. The Department will share this analysis with the committee when it is available. Analysis by the Colorado Health Institute includes demographic information that can help the Department understand why variations of penetration rates occur.

The Department does not receive funds for outreach unless it receives grant funding specified for this purpose. The Department has previously received federal grant funding from the Health Resources and Services Administration (HRSA) for direct to consumer outreach to enroll HB 09-1293 expansion populations. This federal funding was awarded in 2009 and ended in 2013. The grant funds allowed the Department to raise awareness about improvements to the online application available on Colorado.gov/PEAK, allowed the Department to conduct targeted outreach by conducting regional trainings for community partners to equip them to reach newly eligible populations, and allowed the Department to award Maximizing Outreach Retention and Enrollment (MORE) grants to community partners to reach new populations authorized by HB 09-1293. The targeted populations included pregnant women and children who were eligible but not enrolled in the Child Health Plan *Plus (*CHP+) program, individuals eligible for the Medicaid Buy-In Programs for Working Adults with Disabilities and for the Medicaid Buy-in Program for Children with Disabilities.

In lieu of funding for direct outreach, the Department works closely with community partners and local stakeholders to reach areas with lower Medicaid penetration rates.

5. **How do changes in the federal poverty guidelines over time compare to changes in Colorado's income and cost of living?**

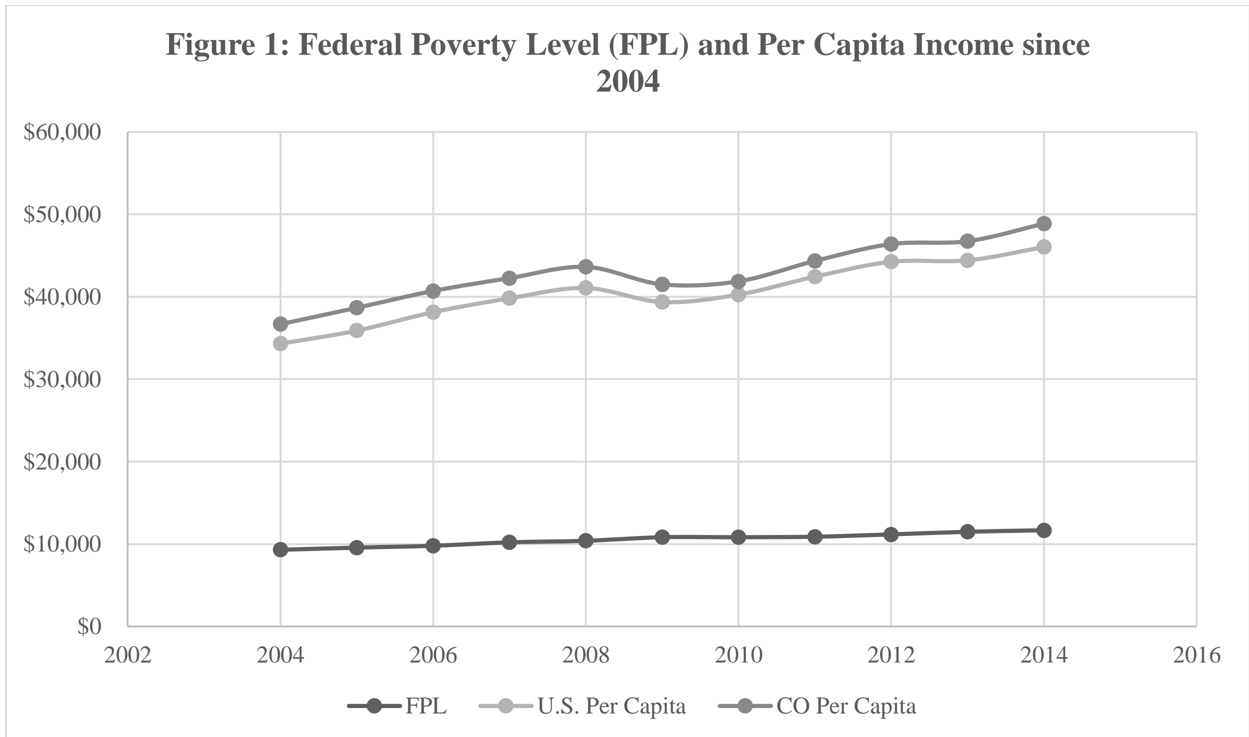
RESPONSE

Table 1 and Figure 1 show changes in the federal poverty level (FPL), the U.S. per capita income, Colorado per capita income, and the consumer price index (CPI) for the Denver-Boulder-Greeley area since 2004. In the last four years, growth in Colorado's per capita income outpaced the growth in the FPL guidelines. In terms of cost of living, the CPI was used to compare year-to-year changes in the cost of purchasing a representative basket of goods. Colorado's average growth in per capita income (3.02 percent) outpaces the average growth in CPI (2.20 percent) since 2004.

Table 1: Changes in Federal Poverty Level (FPL), U.S. Per Capita Income, and CO Per Capita Income since 2004

Year	Federal Poverty Level (FPL) for One Person[1]	% Change from Previous Year in FPL	U.S. Per Capita Income[2]	% Change from Previous Year in U.S. Per Capita	Colorado Per Capita Income[2]	% Change from Previous Year in CO Per Capita	CPI of Denver-Boulder-Greeley[3]	% Change from Previous Year in CPI
2004	$9,310	3.67%	$34,316	4.97%	$36,676	3.57%	187.00	0.11%
2005	$9,570	2.79%	$35,904	4.63%	$38,665	5.42%	190.90	2.09%
2006	$9,800	2.40%	$38,144	6.24%	$40,709	5.29%	197.70	3.56%
2007	$10,210	4.18%	$39,821	4.40%	$42,265	3.82%	202.03	2.19%
2008	$10,400	1.86%	$41,082	3.17%	$43,631	3.23%	209.90	3.90%
2009	$10,830	4.13%	$39,376	-4.15%	$41,508	-4.87%	208.55	-0.65%
2010	$10,830	0.00%	$40,277	2.29%	$41,877	0.89%	212.45	1.87%
2011	$10,890	0.55%	$42,453	5.40%	$44,349	5.90%	220.29	3.69%
2012	$11,170	2.57%	$44,266	4.27%	$46,402	4.63%	224.57	1.94%
2013	$11,490	2.86%	$44,438	0.39%	$46,746	0.74%	230.79	2.77%
2014	$11,670	1.57%	$46,049	3.63%	$48,869	4.54%	237.20	2.78%
Average	$10,561	2.42%	$40,557	3.20%	$42,882	3.02%	211.03	2.20%

(1) Federal Poverty Levels (FPL) are issued by the Department of Health and Human Services on a yearly basis.
(2) The Bureau of Economic Analysis calculates Per Capita Income as Total Personal Income divided by Population.
(3) The Consumer Price Index is a monthly report produced by the Bureau of Labor Statistics that compares a representative basket of goods and services across different regions and years. The base period is an average of the CPIs from 1982-1984 standardized to 100.



Alternatively, the Department also looked at how the poverty rate has changed over time in the state. Poverty rates have decreased but there are more persons living in poverty over time as a function of the state's growing population.

Table 2: Poverty Rate and Persons in Poverty since 1960 in U.S. and Colorado

	Poverty Rate(1)		Population		Persons in Poverty	
Year	U.S.	Colorado	U.S.	Colorado	U.S.	Colorado
1960	22.10%	18.31%	175,034,505	1,706,245	38,684,545	312,413
1970	13.70%	12.30%	198,059,959	2,133,176	27,124,985	263,224
1980	12.40%	10.10%	220,845,766	2,813,861	27,392,580	284,898
1990	13.12%	11.68%	241,977,859	3,212,550	31,742,864	375,214
2000	12.38%	9.26%	273,882,232	4,202,140	33,899,812	388,952
2010	14.90%	12.86%	301,333,410	4,927,283	44,852,527	633,878

Source: U.S. Census Bureau

(1) Poverty rate refers to the percentage of the population living below the poverty threshold. The U.S. Census Bureau defines poverty thresholds in terms of various dollar amounts based on family size and ages of family members. If an individual's household income is below a particular threshold, the individual is considered to be in poverty. The Federal Poverty Level (FPL) is a simplification of poverty thresholds. Please refer to Census website for additional information. https://www.census.gov/hhes/www/poverty/about/overview/measure.html

6. **What safeguards and remedies are in place to ensure that the state does not pay for benefits for people who are not eligible for the benefits?**

RESPONSE

The MMIS only pays claims when the Medicaid Client has a valid eligibility span from the Colorado Benefits Management System (CBMS), which has controls in place to determine eligibility correctly. Within CBMS, most eligibility information is verified against trusted data sources. For example, Lawful Permanent Resident or refugee status is verified with the Department of Homeland Security's Systematic Alien Verification for Entitlement Program (SAVE) trusted data source. If information cannot be verified through this data source or via other evidence such as physical documentation, then an applicant's eligibility will be terminated.

The Department conducts internal reviews of Medicaid and Child Health Plan *Plus* eligibility determinations to evaluate compliance with federal and state regulations. The Department further conducts the federally required Medicaid Eligibility Quality Control studies as well as the Payment Error Rate Measurement Program.

7. In response to legislative request for information #12 the Department identified three ideas for suggested implementation.

a. Who identified these ideas?

RESPONSE

These ideas were identified by subject matter experts within the Department in collaboration with the Colorado Gerontological Society (CGS).

b. Are these priorities of the Department?

The Department provided options for the General Assembly to consider as requested in the legislative request for information and has not established a prioritization of the options. Currently, the Department is not recommending to implement an expansion of Medicaid eligibility as described in the options provided in the legislative request for information.

c. What is the Department doing to pursue these ideas, if anything?

Until there is statutory authority or appropriation by General Assembly, the Department is not pursuing an expansion of Medicaid eligibility as described in the options provided in the legislative request for information. In January 2010, the Department initiated a conversation with Social Security Administration (SSA) to modify the data file as described in the legislative request for information; however, the SSA was not able to accommodate the request at the time. The Department will consult with stakeholders to determine if making another request to the SSA would be beneficial.

2:40-3:00 BENEFITS AND ACCESS

8. What is the availability of specialty care in rural areas? Has there been a shift in where people access specialty care from rural to urban areas?

RESPONSE

Access to specialty care in rural and frontier areas continues to be a challenge for both public and private insurers.[1] Of Colorado's 64 counties, 47 are designated as rural (non-metro) or frontier.[2] Defining availability of specialty care for these areas, however, involves more than identifying the number and location of specialists who are enrolled in Medicaid. Specialty care availability is also impacted by which specialists are accepting new Medicaid patients, wait times for appointments, hours of operation and location within a community, patient access to transportation and child care, and accommodations for people with disabilities and different languages and cultures.

Access to detailed and accurate data regarding specialty care providers is currently one of the Department's major challenges. We anticipate that some of these limitations will be addressed with the implementation of the Department's new MMIS, Colorado interChange, in November 2016. For example:

- Providers are currently encouraged, but not required, to identify a specialty when enrolling.
- Status of providers' willingness to accept new Medicaid patients is unknown.
- Number of hours spent by a specialty provider at each service location is unknown.

To assess the *availability* (i.e. number and location) *of Medicaid specialty care providers in rural/frontier counties*, Department staff analyzed Medicaid enrollment data. The 'Specialist' category includes individual rendering providers that could have been included in the various specialist-specific HEDIS measures in 2015 and are not classified as primary care. Some examples include: Physician, PA, PT/OT/ST, Podiatrist, Optometrist, Audiologist, and Orthodontist.

FY 2014-15 Medicaid Specialists Location	
County Type	Providers
Frontier	87
Rural	689
Urban	6,592
Out of State	277
TOTAL	**7,645**

Anecdotally, psychiatry, pain management, dermatology, urology, orthopedics, rheumatology, oral surgery, and endocrinology are noted as specialties with large service gaps in both rural and urban areas.

To determine *if there has been a shift in where people access specialty care from rural to urban areas*, Department staff reviewed the following data: (1) Medicaid members in rural/frontier counties who received services from a specialty care provider and (2) the location of the specialty service provider (rural vs. urban) that rendered services. Data from FY 2013-14 was compared to data from FY 2014-15 with the following results:

[1] For additional detail, please see the Department's response to Question 39 from the FY 2015-16 Joint Budget Committee hearing and its response to LRFI #2, submitted on November 3, 2014.

[2] Frontier counties are defined as having fewer than six persons per square mile.

Where Clients Received their Specialty Services			
FY 2014-15	Specialist Location		
Client Location	Rural/Frontier	Urban	Out of State
Rural/Frontier	52%	45%	3%
Urban	3%	96%	1%

9. How will the proposed 1.0 percent provider rate reduction affect physical health services?

RESPONSE

From July 2009 to July 2010, the Department implemented a series of rate reductions that together, added up to a 5.39 percent rate reduction.[3] These reductions affected nearly all providers. After implementing the reductions, the Department continued to see consistent increases in the number of enrolled Medicaid providers. Between November 2008 and November 2010, provider enrollment increased 14 percent. The table below shows the number of participating providers submitting claims by fiscal year for FY 2008-09, FY 2009-10, and FY 2010-11, which shows an increase in participation despite the reductions. There was also no increase in client complaints during that time period regarding access to care. Based on this historical experience with rate reductions, the Department anticipates that any impact of the 1 percent rate reduction requested for FY 2016-17 on provider enrollment or client access to care will likely be minimal.

The Department expects the impact of the 1.0 percent provider rate reduction to be $30,375,797 total funds for Medical Services Premiums for FY 2016-17.

Average Number of Distinct Rendering Providers with Claims Paid Per Month by Fiscal Year

Fiscal Year	All Practitioner Providers	Physician/Osteopath	Mid-Level Practitioner
FY 2008-09	10,652	7,808	1,109
FY 2009-10	11,698	8,375	1,298
Percentage Change	**9.81%**	**7.25%**	**17.04%**
FY 2010-11	12,552	8,790	1,460
Percentage Change	**7.30%**	**4.96%**	**12.47%**

10. In the response to legislative request for information #5 the Department identified many strategies for improving the transportation benefit.

a. What are the Department's priorities with regard to improving the transportation benefit and where is the Department actively working on changes?

b. What is the Department's implementation time frame for these changes?

[3] This was not the total rate reduction applied to Medicaid providers during the recession; reductions in subsequent fiscal years further increased the total rate reductions.

c. Which improvement strategies might require additional resources?

RESPONSE

The Department currently is focusing on four priorities to help improve the Colorado Medicaid Non-Emergency Transportation (NEMT) benefit. The first is to assess the current state of the administration of the NEMT program. The program administration varies by county. Currently the Department administers a broker contract operated by Total Transit that serves the following nine front-range metro counties: Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, Jefferson, Larimer and Weld. In the other 55 counties, the program is county administered. The Department commissioned a study in April 2015 to better understand how the counties were administering the NEMT program and give the Department concrete suggestions and options to improve NEMT services statewide. This study has already been completed and culminated in the Department's response to legislative request for information #5.

The second priority is to improve access to transportation providers for Medicaid clients. The Department requires that NEMT providers be licensed by the Public Utilities Commission (PUC). PUC licensing requirements at Title 40, Article 10.1, C.R.S., govern the PUC's role in regulating NEMT transportation providers (and other types of transportation for hire). Since NEMT providers are not specifically listed in a licensing category, the PUC requires NEMT to be regulated as a "common carrier." This level of regulation has hindered licensing new providers because it allows existing providers the opportunity to file objections that delay the PUC licensing process. The PUC estimated that at least two thirds of all new NEMT applications are protested. The Department is currently working with the PUC to pursue statutory changes that would make it easier for providers to get licensed. The Department has included these statutory changes in its 2016 legislative agenda.

The third priority is to analyze the actual transportation costs to determine whether changes in State Medicaid transportation billing policies and reimbursement rates are warranted. The Department requested Medicaid transportation rates be reviewed in the first cycle of rate reviews required by SB15-228. Using the criteria outlined in SB15-228, the Department will look at how Colorado's rates compare to other Medicaid programs, Medicare, and other available benchmarks. The review will also allow the Department to better understand how Medicaid transportation rates impact client access to this important service. This analysis will be included in a report submitted to the Medicaid Provider Rate Review Advisory Committee and the Joint Budget Committee in May 2016.

The fourth priority is to determine whether structural changes in the administration of the program are needed. The study the Department commissioned in April 2015 informed the Department that program administration varies by county. Lack of standardization is inefficient and provides inconsistent services and compliance. Multi-county collaboratives appear to have more consistency in administration and service delivery, which helps clients, providers, and administrators, and reduces duplication. Also, the study indicated 75 percent of the counties currently administering the program would like the state to consider a regional brokered model similar to what exists in the metro counties. The Department will be issuing a Request for Information (RFI) early in 2016, to help inform the Department on the possible options and designs that could be incorporated into a statewide transformation strategy. This strategy would then inform and lead to the development of a Request for Proposal (RFP) that would procure the delivery model(s) necessary to achieve a much broader improvement in the NEMT program statewide. The earliest

that the Department could foresee implementation of the model procured through the RFP would be July 1, 2017.

Two of the strategies outlined above may require additional resources. Should the Rate Review analysis reveal that payment for NEMT services is not sufficient for adequate access and high quality, additional funding may be required. The Department also assumes that moving to a regional brokered model would be cost positive since the counties do not have a specific NEMT administrative line item of funding that they can forfeit to fund a separate entity, whether that would be the Department, a broker, or another county collaborative, to provide the NEMT administration. The Department will use the regular budget process if necessary to implement any of the strategies listed above.

11. **What is the long-term outlook for the Children's Basic Health Plan, including federal authority and funding? What is the Department's plan to ensure successful transitions for clients currently on the Children's Basic Health Plan, if it is not renewed at the federal level?**

RESPONSE

The Affordable Care Act (ACA) authorized the Children's Health Insurance Program (CHIP) through federal fiscal year (FFY) 2019 and increased the Federal Medical Assistance Percentage (FMAP) by 23 percentage points, which took effect on October 1, 2015. For Colorado, this means that the federal CHIP match is currently over 88 percent. Federal funding for CHIP allotments runs through FFY 2017 (September 30, 2017). Congress has not yet authorized funding for FFY 2018 or FFY 2019.

Under the ACA, states are required to maintain the same eligibility levels for children in Medicaid and CHIP until FFY 2019. This requirement is known as "maintenance of effort" (MOE). If CHIP funding is not reauthorized beyond FFY 2017, Colorado is required to continue to cover children in the Medicaid-expansion CHIP program authorized by SB11-008 through FFY 2019 at the regular federal Medicaid match rate. Colorado's separate CHIP program, however, is no longer subject to the MOE in the absence of federal funding for CHIP.

While there have been discussions regarding extending federal funding for CHIP through FFY 2019, it is unclear whether Congress will consider or approve this option. Therefore, the Department has been using this time to explore other viable coverage options for the children and pregnant women currently covered by the Children's Basic Health Plan in case federal funding is not renewed. So far, the Department has drafted future of Child Health Plan *Plus* (CHP+) goals, held several stakeholder meetings to gather feedback, explored policy issues and coverage options and discussed issues and opportunities with other states. Ongoing stakeholder engagement is planned in 2016.

12. **For the top 1 percent of utilizers accounting for 23 percent of expenditures, how much of the costs are related to pharmaceuticals?**

RESPONSE

The Department paid $131,285,197 for pharmaceuticals for the top 1 percent of utilizers.[4] This amount is approximately 9 percent of total expenditures for the top 1 percent of utilizers.

Rank	Therapeutic Class Code Description	Total Payments
1	ANTI-CONVULSANTS (seizures, pain, mood disorders)	$11,386,279
2	ANTI-HEMOPHILIC FACTORS (bleeding problems)	$9,501,526
3	ANTINEOPLASTIC SYSTEMIC ENZYME (cancer)	$9,042,894
4	AGENTS TO TREAT MULTIPLE SCLEROSIS	$8,517,304
5	ADRENOCORTICOTROPHIC HORMONES (endocrine problems)	$4,156,050
6	ANTIPSYCHOTICS, ATYP, D2 PARTI (atypical antipsychotics)	$4,038,110
7	HEPATITIS C VIRUS NUCLEOTIDE ANALOG NS5B (newer hepatitis C)	$3,394,182
8	GROWTH HORMONES	$3,292,697
9	ANALGESICS, NARCOTICS	$3,144,599
10	ANTIPSYCHOTICS, ATYPICAL	$2,926,634
11	INSULINS	$2,823,256
12	MUCOLYTICS (cystic fibrosis)	$2,717,294
13	ANTI-INFLAMMATORY TUMOR NECROSIS (rheumatoid arthritis and other auto-immune problems/disorders?)	$2,562,724
14	HEPATITIS C VIRUS NEUCLEOTIDE ANALOG (newer hepatitis C)	$2,528,612
15	ANTIVIRAL MONOCLONAL ANTIBODIE (Synagis for RSV)	$2,497,198
	All Other Therapeutic Classes	$58,756,329
	GRAND TOTAL	**$131,285,687**

13. Regarding Planned Parenthood's participation in the Colorado Medicaid program and during the last three fiscal years please answer the following questions for the following four items: (1) oral contraceptives, (2) emergency contraceptives, (3) LARCs, and (4) LARCs paid for by the Department's Family Planning Program:

- **a. How many patients have been prescribed the item by Planned Parenthood?**
- **b. What were Planned Parenthood's actual acquisition costs for the item?**
- **c. What is the State's reimbursement rate for each item?**
- **d. What is the State's dispensing fee for each item?**

RESPONSE

The Department’s response is limited by the following factors:

[4] This figure represents the Department’s gross cost for pharmaceuticals, and does not incorporate the effect of drug rebates, as the Department does not have drug rebate information on a claim-by-claim basis.

- The Department's data does not identify whether any item has been prescribed by Planned Parenthood.
- The Department's data does not contain Planned Parenthood's actual acquisition cost of any item;
- Because Planned Parenthood is not a pharmacy, the Department does not pay a dispensing fee for services provided.

The reimbursement rate for each item is provided in the following table.

Procedure Code	Procedure Cost Description	FY 2012-13	FY 2013-14	FY 2014-15
11981	Insert drug implant device	$84.43	$86.11	$86.55
57170	Diaphragm or cervical cap fit w/instruction	$23.18	$23.64	$23.76
58300	Insertion of intra-uterine device (IUD)	$49.67	$50.66	$50.91
A4266	Diaphragm	$30.05	$30.64	$30.80
J1050	Injection, medroxprogesterone acetate 1mg	N/A	$0.43	$0.43
J7300	Intrauterine copper contraceptive (t38a)	$617.54	$629.65	$742.70
J7302	Levonorgestrel iu 52 mg	$717.32	$731.38	$892.99
J7303	Contraceptive vaginal ring	$34.88	$35.57	$40.31
J7304	Contraceptive hormone patch	$16.44	$16.76	$19.00
J7307	Etonogestrel implant system	$672.61	$685.80	$777.37
S4993	Contraceptive pills for birth control	$13.68	$13.95	$35.19

The Department's fee schedule can be found here: https://www.colorado.gov/pacific/hcpf/provider-rates-fee-schedule

2:40-3:00 BREAK

3:00-3:30 IMPLEMENTATION OF LEGISLATIVE INITIATIVES

14. The Centers for Medicare and Medicaid Services (CMS) is requiring Colorado to cover the autism services authorized in H.B. 15-1186 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit rather than the Children with Autism waiver.

a. Based on discussions with CMS to date, how does the Department expect this will be different than what was contemplated in the bill for families, providers, and the budget?

RESPONSE

Providing autism services authorized in HB15-1186 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit rather than the Children with Autism Waiver will be different for families, providers and the budget in the following ways:

- Clients enrolled in Medicaid who require medically necessary treatment for autism spectrum disorder will receive those services through the State Plan pursuant to the EPSDT requirements.

- The Department does not have federal approval to implement the new requirements from HB 15-1186, including allowing access to waiver services for clients who are ages 7 and 8, or who have not been on the waiver for three full years; removing the annual dollar limit of $25,000; eliminating the waitlist for enrollment in the waiver.
- Some providers who provide services under the waiver are not currently able to provide services via EPSDT. The Department is working with interested service providers to complete the provider enrollment process.
- The Department does not yet know how the direction from CMS will cause a change from the projected expenditures in HB 15-1186 (and its current appropriation in the Long Bill). The Department will use the regular budget process to account for any change experienced from the projections.

b. When does the Department anticipate more definitive guidance?

At this time no further guidance is anticipated from CMS concerning the EPSDT benefit.

c. Will changes be needed to the statutes or rules regarding autism services to implement the Centers for Medicare and Medicaid Services (CMS) guidance?

The Department has the authority to comply with CMS' directive to authorize services through the EPSDT benefit pursuant to Section 25.5-5-102(g), C.R.S. This statute requires that "the program for the categorically needy shall include… (g) Early and periodic screening, diagnosis, and treatment, as required by federal law."

The Department will meet with stakeholders the first week of January and discuss a plan for the Children with Autism waiver. The Department intends to decide on a plan regarding the Children with Autism waiver shortly after that meeting. Currently the Children with Autism waiver is operating the same as it was prior to the denial of the Children with Autism waiver expansion from CMS. It is not yet clear what changes to statute or rule will be needed, or whether changes will be needed in the current legislative session. The Department continues to work with CMS, legislators, and stakeholders, to determine the proper course of action. Changes may need to be made to title 25.5, article 6, part 8, authorizing Home-And Community –Based Services for Children with Autism.

15. Describe the Department's communication with the Centers for Medicare and Medicaid Services (CMS).

RESPONSE

The Department is in constant communication with CMS. Leadership from the Department and the Regional Office have a standing monthly meeting to discuss current issues. In addition, staff from each of the Department's offices work frequently with staff at both the Regional and Central Offices. The areas of frequent engagement include amendments to the State Plan and Waivers, managed care and technology contracts, rate calculations, quality measures and other program requirements.

The formal communication process is dictated by regulation for the submission, discussion and approval of state plan amendments (SPAs) and waiver amendments. This process is lengthy and must be followed exactly; any misstep by either the Department or CMS can delay the process by months. The formal process

requires approval for submission by the Medicaid Director, tribal consultation, public notice, CMS review, a 90 day approval clock and opportunities for CMS to request additional information from the Department which stops the 90 day approval clock. More detailed information about these requirements are included in the Technical Appendix A.

The Department often communicates informally with CMS before submitting an amendment to assess the chances for approval and ensure that the Department is following all regulations, such as public notice regulations. However, there is no process for informal communication with the CMS central office, and sometimes the Department must begin the formal submission process before it can get any guidance at all from CMS. As described above, this is not the most efficient way to get initial guidance and input, but sometimes it is the only option given.

a. How did it occur that the Department requested a change to the Children with Autism waiver that worked all the way through the legislative process only to be denied by CMS?

CMS guidance in 2014 outlined several options on providing services to children with autism; CMS specifically allowed for a section 1915(c) waiver. Treatment of autism is an evolving field, and new evidence of effective treatment changed CMS' view of what should be provided through EPSDT. Colorado already had a waiver with these services and the guidance stated 1915(c) was an appropriate avenue for the services.

b. What is the Department doing to reduce the potential for similar surprises in the future where the position of CMS is so unexpected?

The Department researches the likelihood of amendment approval by reviewing existing CMS guidance, health policy analysis and other states' programs. The Department also uses the informal communication process with CMS as soon as it knows that an amendment may be forthcoming. This process works well when there is existing guidance from CMS or health policy analysis on the issue. When the Department suggests new or innovative solutions, or when there is a shifting federal framework on an issues, it will continue to engage in informal communications, but continues to be limited by CMS's willingness and ability to have those conversations informally. Sometimes CMS itself is not sure of what it will or will not approve until late in the process.

16. What are the issues causing delays in federal approval of the targeted rate increase for personal care and homemaker services and when does the Department expect they will be resolved? Does the Department expect it will be able to implement the increase as approved by the General Assembly?

RESPONSE

In March 2014, CMS issued new regulations for submitting waiver amendments. This regulation created new requirements regarding public noticing and effective date timelines for waiver renewals and amendments. The General Assembly approved targeted rate increases to traditional personal care and homemaker that decoupled the rates from the Consumer Directed Attendant Support Services (CDASS) delivery model. Because the rate increase affected similar services disparately, CMS required the

Department to develop an entirely new rate methodology for both traditional and CDASS delivery options for personal care and homemaker.

This change was considered substantive by CMS. Requests for waiver amendments that include substantive changes may only take effect on or after the date when the amendment is approved by CMS. 42 CFR §441.304(d)(2). Substantive changes include, but are not limited to, revisions to services available under the waiver including elimination or reduction of services, or reduction in the scope, amount, and duration of any service, a change in the qualifications of service providers, changes in rate methodology, or a constriction in the eligible population. 42 CFR §441.304(d)(1).

Therefore, in order for the targeted rate increases for personal care and homemaker services to be effective they must have prospective approval from CMS.

The Department has submitted the required waiver amendments to implement these changes and continues to collaborate with CMS in order to gain approval for these rate increases. The Department does not have an expected date of resolution.

The Department has had recent conversations with CMS on this issue, but at this time the Department does not know if CMS will approve the rate changes. Although CMS' technical guidance on consumer directed services suggests that best practice is to have the same rate basis for consumer directed and agency based services, the Department is unsure whether CMS has a clear regulatory basis to legally enforce its technical guidance.

17. Is decoupling the rates for consumer directed attendant support services from the rates for personal care and homemaker services good public policy?

RESPONSE

The Department received authorization from the General Assembly to increase agency based home care rates. This increase did not extend to the consumer directed attendant support services delivery option. CMS technical guidance suggests the best practice would be to use the same rate for consumer directed services and traditional agency based services. If directed by the General Assembly with the corresponding federal approval to increase the consumer directed services rates the Department would implement the change.

18. Did funding a second increase in the lifetime cap on home modifications before the first increase was approved by the Centers for Medicaid and Medicare Services (CMS) slow down federal approval?

RESPONSE

No. Delays in federal approval resulted from the March 2014 federal regulation that amended public noticing procedures and effective date timeline requirements for waiver renewals and waiver amendments.

19. How have enrollments and expenditures changed for the Program for All-inclusive Care for the Elderly (PACE) over time and how do the trends compare to other services?

RESPONSE

PACE enrollment and expenditures have been increasing over time, particularly with the opening of new facilities and the introduction of new PACE organizations. The table below shows the 3-year average expenditure and caseload/enrollment growth for PACE. These growth rates are compared to growth in Class I Nursing Facilities and the Elderly, Blind, and Disabled waiver. The Class I Nursing Facility rates are one of the factors used to set the rates for PACE. Many of the clients participating in PACE would use the Elderly, Blind, and Disabled waiver if they were receiving services in the community rather than through PACE.

Comparison of Growth between PACE and Other Services	**PACE**	**Class I Nursing Facilities**	**HCBS - EBD Waiver**
3-Year Average Expenditure Growth (FY 2012-13 through FY 2014-15)	16.46%	3.59%	10.04%
3-Year Average Caseload/Enrollment Growth (FY 2012-13 through FY 2014-15)	12.48%	-0.12%	4.93%
Definitions PACE: Program of All-Inclusive Care for the Elderly; C1NF: Class I Nursing Facilities; HCBS - EBD Waiver: Home- and Community-Based Services - Elderly, Blind, and Disabled Waiver			

a. Is the PACE program a sound financial investment for the state?

Measuring whether PACE is a sound financial investment requires evaluating the benefits for clients relative to the cost of the program. There is limited literature evaluating the PACE program. The Department has reviewed the few national studies that indicate PACE improves care quality and access to services, with strong evidence in a decrease of inpatient hospitalization. In January 2014, the federal Department of Health and Human Services commissioned a study[5] that showed PACE had no significant effect on Medicare costs, but is associated with higher Medicaid costs. However, the Department is aware of another study conducted by Duke University showing savings to both Medicare and Medicaid.

As with all programs, the Department aims to use the best available information to set payment rates and evaluate impact of programs. Programs like PACE have a long-term impact on clients' lives and the budget so it is important that the Department evaluate the investments in PACE over time, not in short term intervals. The Department is actively working with PACE providers to collect detailed service and administrative cost data for use in rate setting. This data will help ensure that governmental payments are aligned with the actual costs of program operation. Additionally, the Department is conducting a preliminary policy review to determine whether a medical loss ratio, which provides a ceiling on payments for administrative costs and operating surplus, should be applied to the PACE program.

For reference, the table below shows enrollment in PACE and expenditure by fiscal year.

PACE Expenditure and Client Counts by Fiscal Year

5 http://www.mathematica-mpr.com/our-publications-and-findings/publications/evaluating-pace-a-review-of-the-literature

Fiscal Year	Average Monthly Enrollment	Percent Change	Expenditure	Percent Change
FY 2007-08	1,240		$49,418,856	
FY 2008-09	1,422	14.68%	$61,049,835	23.54%
FY 2009-10	1,619	13.85%	$69,256,028	13.44%
FY 2010-11	1,846	14.02%	$84,414,278	21.89%
FY 2011-12	2,054	11.27%	$85,480,585	1.26%
FY 2012-13	2,402	16.94%	$97,346,358	13.88%
FY 2013-14	2,257	-6.04%	$100,474,817	3.21%
FY 2014-15	2,856	26.54%	$132,904,767	32.28%
Estimated FY 2015-16	2,898	1.47%	$133,853,042	0.71%
Estimated FY 2016-17	3,188	10.01%	$156,900,991	17.22%
Estimated FY 2017-18	3,466	8.72%	$174,713,989	11.35%
Estimated values were originally provided in the Department's November 1, 2015 Budget Request, R-1 "Medical Services Premiums."				

b. How did the waiver allowing for-profit PACE providers get approved so quickly and how is it expected to change enrollment and expenditure trends?

Federal and Colorado State law authorizes for-profit PACE providers, so a federal waiver is not required. Federal law mandated that CMS allow PACE providers to be for-profit as long as a study showed that the pilot for-profit providers did not fail four requirements, which was demonstrated in CMS' study[6,7]. The Colorado legislature passed SB15-137, effective August 2015, authorizing for-profit PACE providers.

The Colorado Attorney General's Office must approve any conversion of non-profit PACE providers to for-profit status. The Attorney General's Office currently has one pending application for a PACE non-profit to for-profit conversion. Unlike waivers, conversions are not required to go through an intricate and complex federal approval process.

The Department is strictly following both Colorado and federal law on PACE conversions. Further, the Department is coordinating with the Centers for Medicare and Medicaid Services (CMS) and is awaiting guidance on the procedural actions the Department will have to take in the conversion processes.

There are two circumstances under which a for-profit PACE organization can emerge in Colorado: a current non-profit organization can convert to a for-profit organization, or a new for-profit organization can open. As one non-profit PACE organization has already begun the process required to convert to a for-profit

[6] The four qualifications that the pilot for-profit PACE providers could not fail included: (i) the for-profit entities had more than 800 enrollees, (ii) the enrollees of the for-profit providers were not less frail than the enrollees of other PACE organizations, (iii) the enrollees of the for-profit entities did not receive lower access to or quality of care than enrollees of other PACE organizations, and (iv) the application of the non-profit status did not result in an increase in expenditures under the Medicare or Medicaid programs above expenditures that would have been made if such status did not apply.

[7] https://innovation.cms.gov/Files/reports/RTC_For-Profit_PACE_Report_to_Congress_051915_Clean.pdf

PACE organization, the Department assumes that at least one for-profit PACE organization would exist in Colorado in the near future. To remain conservative, the Department has estimated the impact of two new PACE locations opening in FY 2016-17, due to the conversion to for-profit. This assumption is based on indications by PACE organizations in Colorado that conversion to a for-profit entity would allow PACE organizations to acquire the necessary capital to build new facilities.

The Department assumes that PACE rates would not significantly change due to a PACE organization converting to a for-profit entity. This assumption is based on the CMS study of its for-profit PACE pilot[2] and the qualifications required for CMS' determination to allow for-profit PACE organizations without a pilot or waiver.

The Department also assumes that any for-profit PACE organization conversions would require time for the conversion process, as well as time to build new facilities and begin enrolling Medicaid clients. As such, the Department assumes that there would be no additional costs associated with for-profit PACE organizations until FY 2016-17.

The below table outlines the costs of for-profit PACE organizations that the Department estimates based on the assumptions above:

Estimated Medical Services Premiums Impact of PACE For-Profit Organizations					
Row	**Component**	**FY 2016-17**	**FY 2017-18**	**FY 2018-19**	**Notes/Calculations**
A	Projection of Annual Average New Enrollment Attributed to For-Profit PACE Organizations	60	152	210	Based on enrollment ramp-up experiences in new PACE locations; assumes two new locations.
B	Current PACE Aggregate Annual Cost Per Enrollee Estimates	$49,216.12	$50,407.96	$51,629.85	November 1, 2015 R-1 "Medical Services Premiums"; FY 2018-19 projected based on growth rate of FY 2016-17 to FY 2017-18.
C	Impact of New Enrollment to For-Profit PACE Organizations	$2,952,967	$7,662,010	$10,842,269	Row A * Row B
D	Estimated Savings to Acute Care due to New Enrollment in PACE	($636,502)	($1,647,752)	($2,316,253)	Estimated based on expected savings percentage by eligibility category.
E	Estimated Savings to Home- and Community-Based Services due to New Enrollment in PACE	($950,386)	($2,505,262)	($3,601,553)	Estimated based on per capita cost on the Elderly, Blind, and Disabled Waiver.
F	**Total Impact**	**$1,366,079**	**$3,508,996**	**$4,924,463**	**Row C + Row D + Row E**

20. What is the implementation status of the services financed with additional funding provided by Proposition BB?

RESPONSE

The Department published a Request for Applications (RFA) to the statewide procurement website on December 9, 2015. Proposals from interested vendors are due on January 15, 2016. The Department anticipates awarding the grant by the first part of February 2016, and a contract no later than March 1, 2016. Work funded by the grant must be completed by June 30, 2016.

3:30-4:00 PRIMARY CARE

21. What conclusions does the Department draw from the evaluation of the primary care rate bump? How did those conclusions influence the Department's decision to not request funding to continue the primary care rate bump beyond the scheduled end date? How confident is the Department in the evaluation of the primary care rate bump?

RESPONSE

The initial evaluation analysis reveals that the four client-based access to care measures remained stable despite rapid growth in the Medicaid population. This suggests the primary care system was able to accommodate the growth without reductions in access to care, though this cannot be attributed directly to the bump payments.

Two provider-based measures suggest that more providers served Medicaid patients in direct relationship to the increasing number of Medicaid clients. Providers who attested to receive the bump delivered approximately 3 additional "bump-eligible" visits per month, or an approximate 10 percent increase over the expected number of bump-eligible visits per month without the higher payment. This increased number of visits resulted in approximately 11,000 to 13,000 additional bump-eligible visits between January 2013 and June 2014. The absence of a significant increase after January or July 2013 suggests that the increased payments did not increase the number of bump-eligible primary care encounters. Therefore, the association between increases in visits and the increase in payment rates is uncertain.

This difficult budget year did not allow the administration to propose extending the bump payments into FY 2016-17 and was not influenced by the findings of this initial evaluation. The source of funding to continue the bump between January 1, 2015 and June 30, 2016 came from savings as a result of the increase to the Federal Medical Assistance Percentage (FMAP). As described in Figure Setting from that year there was "uncertainty about the future of the FMAP and the initiatives proposed in BA-10 to spend the saving from the higher FMAP are for short-duration projects." As evidenced in R-11, Decreased FMAP, the FMAP beginning on October 1, 2016 will have lower federal share and higher state share. The Department values and is committed to continue supporting primary care providers. Several initiatives, including the Accountable Care Collaborative, State Innovation Model and Transforming Clinical Practice Initiative (TCPI) are underway to provide direct support to primary care practices.

The evaluation of the initial impact of the bump utilized widely-recognized measures and followed recommendations contained in a recent report by NORC at the University of Chicago about claims-based measures of realized access to care.[8] Access to care measures within a state that are based on claims data can provide a reliable, valid, and unbiased alternative to survey data in measuring changes over time in access to care for Medicaid clients. Among the claims-based measures suggested in this report are Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators, two Healthcare Effectiveness Data and Information Set (HEDIS) measures, the Usual Provider Continuity Index, the percentage of eligible beneficiaries with at least one primary care visit, and the number of providers participating in Medicaid.

22. Please describe and provide examples of the services affected by the end of the primary care rate bump in layman's terms. What are the most commonly used codes, what services are those codes for, and how much are the rates for those commonly used codes changing?

RESPONSE

The Department continued the 1202 payment bump with all the services that were included by CMS. This included all Evaluation and Management codes, including those at facilities. The most common services affected are routine office visits for established patients (32 percent of bump eligible services), visits in the

[8] NORC University of Chicago. Study Brief: Recommendations for Monitoring Access to Care among Medicaid Beneficiaries at the State-level. 2013. https://aspe.hhs.gov/sites/default/files/pdf/122651/rpt_MedicaidAccessStudy_0.pdf (Accessed December 14, 2015).

ER (22 percent of services), and vaccine administration (4percent of services). (Office visits - 99213, 99124; ER services - 99283, 99284, 99285; vaccine administration - 90460).
Routine office visits are for treatment of acute issues, chronic issues, and occasionally preventive services. Office visit treatment usually includes an initial visit and follow up visit(s) to assess changes in the acute condition. ER visits are for care at the emergency room. ER visits cover diagnosis and treatment of severe issues.

Most conditions are resolved in one or two visits. The rates for the most common codes are going to be reduced by $13-$35 per visit (a reduction of 20-33 percent). Vaccine administration will be reduced by $15, a reduction of 71 percent.

Service	New Rate	Bump Rate	Change	Percent Change
Office or Outpatient Visit Established Patient, Low Complexity	$51.32	$76.52	($25.19)	(32.9%)
Office or Outpatient Visit Established Patient, Moderate Complexity	$77.10	$112.43	($35.33)	(31.4%)
ER Department Visit, Moderate Severity	$50.09	$62.87	($12.78)	(20.3%)
ER Department Visit, High Severity	$92.59	$119.88	($27.29)	(22.8%)
ER Department Visit, High Severity, Significant Threat To Life	$138.05	$175.99	($37.95)	(21.6%)
Immunization administration	$6.33	$21.68	($15.35)	(70.8%)

23. How many providers does the Department believe will reduce or eliminate the number of Medicaid patients they see due to the end of the primary care rate bump?

RESPONSE

The Department cannot fully predict how this change will impact provider behavior. Decisions about reductions or elimination of Medicaid patients from provider practices will be made by providers on an individual basis.

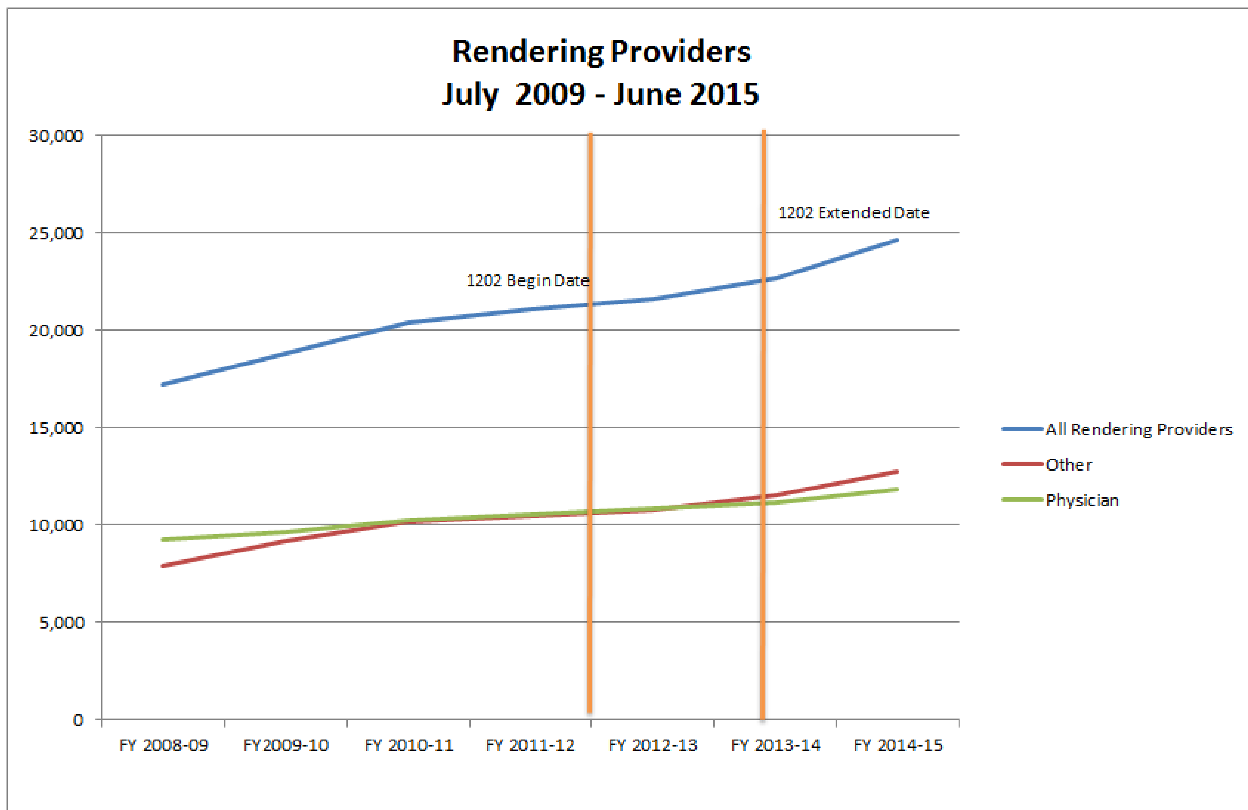
According to a recent Health Affairs Health Policy Brief,[9] after the federal bump ended in December 2014, 16 states and the District of Columbia decided to continue paying the bump while 34 states had declined. Research has not firmly established a positive correlation between Medicaid payment rates and access, and the debate about the bump's effectiveness continues. Evidence is limited and recognizes that results could be due to factors other than the bump. A recent "secret shopper" study found that appointment availability for Medicaid clients increased after the bump was implemented. Some stakeholders argue that the program mostly benefited providers already participating in Medicaid. Qualitative interviews with Medicaid officials conducted by the federal Medicaid and CHIP Payment and Access Commission (MACPAC) suggested that

[9] Health Affairs. Health Policy Brief: Medicaid Primary Care Parity. Updated May 15, 2015. http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_137.pdf

few physicians completing attestation were new to Medicaid, indicating little to no effect on Medicaid provider participation rates. Six of the eight states interviewed reported no change in primary care service use after the program's implementation.

The Health Affairs article cites an April 2014 survey of members of the American College of Physicians regarding providers' plans to accept fewer Medicaid patients or stop participation in Medicaid all together if the bump expired. The Colorado Chapter of American Academy of Pediatrics, Colorado Children's Healthcare Access Program, Colorado Academy of Family Physicians, Colorado Medical Society, and Colorado Rural Health Center recently engaged their members to participate in a similar survey, and the Department will work with these stakeholders to understand the findings.

In addition, the analysis conducted by the CU School of Medicine indicates that historically the number of providers delivering primary care services to Medicaid clients has paralleled the increase in the number of Medicaid clients. At this time, 70 percent of Colorado's licensed physicians are currently enrolled in Medicaid.



24. Please provide information about where the providers and expenditures affected by the end of the primary care rate bump are regionally, perhaps on a map. Will the end of the primary care rate bump disproportionately affect rural communities?

RESPONSE

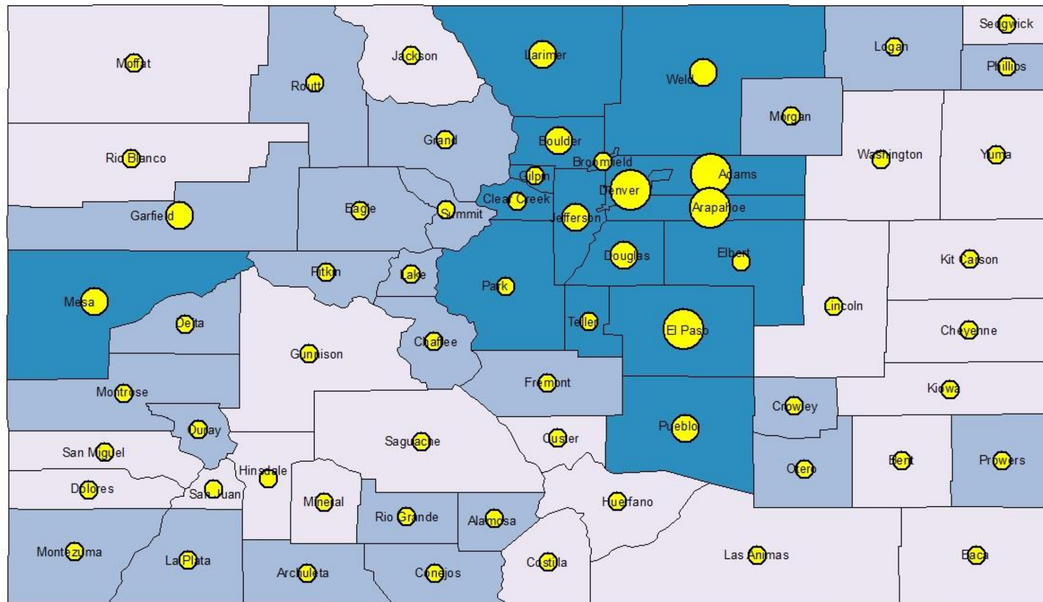
There will be a not be a disproportionate effect on rural providers by ending the 1202 bump. The table below is the estimate of the difference in reimbursement for FY 2016-17 between the increased payment

and the rate that would have been applicable without the bump. Appendix B includes this information by county.

Estimated 1202 Bump Payment Impacts to Providers and Expenditures		
County Group	FY 2014-15 Number of Providers	Estimated FY 2016-17 Expenditure
Frontier	206	$2,820,286
Rural	1,348	$10,934,105
Urban	13,023	$131,321,243
Total:	14,577	$145,075,634

Note:
The number of providers is based on claims paid in January-June 2015.

Dollar Impact of 1202 by County
FY2014 -15



Minimum: $0 **Maximum: $11,122,594**
Average: $897,158 **Median: $92,715**

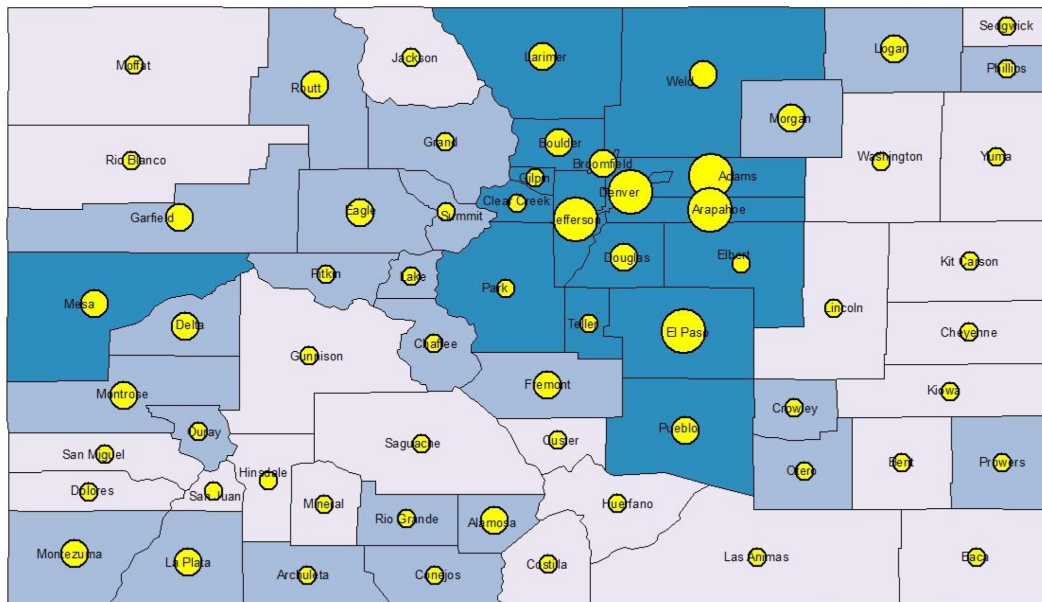
1202 Provider Cost by County
- $0 - $500,000
- $500,001 - $5,000,000
- $5,000,001 - $12,000,000

Urban, Rural or Frontier County
- Frontier
- Rural
- Urban

Project Tracking #: 5852 Map Created on: 12/10/2015

HCPF COLORADO Department of Health Care Policy & Financing

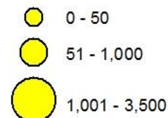
1202 Providers by County
FY2014 -15



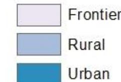
Minimum: 0 **Maximum: 3,206**
Average: 228 **Median: 29**

Project Tracking #: 5853 Map Created on: 12/10/2015

1202 Provider Count



Urban, Rural or Frontier County



25. Why has the number of Medicaid clients served by Federally Qualified Health Centers and Rural Health Centers increased so dramatically in recent years? Why is this relevant when interpreting the results of the evaluation of the primary care rate bump?

RESPONSE

The increase in utilizers of Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) can be attributed to expansion of Medicaid, an increase in capacity through Health Resources and Services Administration (HRSA) grants, and an increase in newly designated entities (existing providers converting to FQHCs). The increase of patients seen at these provider types matches the increase in Medicaid enrollees. There has not been a proportional increase in members seen at RHCs or FQHCs.

FQHCs have expanded capacity through existing locations or by adding new locations with the support of HRSA.

- There have been five new FQHC type entities created in the past three years.
- HRSA provided funding for four new locations for existing FQHCs in 2015.

- HRSA provided funding for 86 new FTEs at FQHCs in 2014.
- HRSA provided funding for three new locations for FQHCs in 2014.
- FQHCs received a grant to fund staff for Outreach and Enrollment in 2014 and many of the people they reached became patients at FQHCs.

The primary care bump did not affect payments to FQHC or RHC providers. As these providers are paid on a cost-based encounter basis instead of a claims basis, these providers did not receive bump payments during the federal bump or state extension period. FQHCs and RHCs are supported by other funding mechanisms to expand capacity to serve the Medicaid population. The next phase of primary care analysis conducted by the CU School of Medicine will examine the extent to which expansion and non-expansion clients are seeing FQHCs for bump-eligible services.

26. How will the end of the primary care rate bump affect the health care workforce? Will staff reductions occur?

RESPONSE

The initial analysis conducted by the CU School of Medicine did not speculate on the future impact on the health care workforce. Survey findings from the Colorado Academy of Pediatrics, Colorado Children's Health Access Program, Colorado Academy of Family Practice, Colorado Medical Society and Colorado Rural Health Center and feedback from ClinicNET include anecdotal responses that practices have utilized payments to support behavioral health providers, case managers, care coordinators, navigators, social workers, medical assistants, and support staff to create a medical home and provide integrated care. Many of the providers responding to these surveys indicate that they would re-evaluate staffing and some indicated that there would be staff reductions.

The mission of the Department is to improve health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources. Supporting primary care is foundational to achieving our mission. Colorado has long been a leader in the national primary care medical home arena and continues to make significant and innovative investments in primary care that may mitigate the need for staff reductions. As part of the ACC program, the Department makes per member per month payments directly to practices and the Regional Care Collaborative Organizations (RCCO) to support care coordination. Over the course of the Colorado State Innovation Model (SIM), the Department will make payments directly to 400 practices to support practice transformation and integration of behavioral health. The Comprehensive Primary Care Initiative is a multi-payer effort to support some practices. Through the TCPI grant, the Department will provide practice transformation support to 2,000 primary care and specialty care providers.

27. Please provide a list of the rates excluded from the across-the-board reduction proposed in R12, the reasons why, and the magnitude of the exclusions as a percentage of medical services expenditures.

RESPONSE

Rates Excluded from the Across-the-Board Reduction Proposed in R-12			
Service Area	**Excluded Subset of Service**	**Reason Excluded**	**Magnitude of Exclusion as % of Estimated Medical Services Expenditure in FY 2016-17**
Physician Services & Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)	All	Providers have a significant rate reduction occurring 7/1/2016 (sunset of the continuation of the Affordable Care Act section 1202 primary care rate increases, as approved by the General Assembly). Additional reductions risk loss of access to services for clients.	12.96%
Non-emergency Medical Transportation	Services rendered under a fixed price contract	A portion of expenditure in this service category is not eligible for rate increases or rate decreases, due to services being rendered under a fixed price contract.	0.03%
Dental Services	Dental Administrative Services Only (ASO) costs	Dental ASO administrative costs are not eligible for rate increases or rate decreases (these rates are set in contract).	0.17%
Prescription Drugs	All	Pharmacy reimbursement is not eligible for rate increases or decreases, as it is set by an average acquisition cost.	6.84%
Rural Health Centers (RHCs)	All	RHCs are federally entitled to cost-based reimbursement.	0.42%
Federally Qualified Health Centers (FQHCs)	All	FQHCs are federally entitled to cost-based reimbursement.	2.94%
Home- and Community-Based Services (HCBS) Children with Autism Waiver	All	These services currently have an expenditure cap; these rates have historically been excluded from rate reductions or rate increases, as both changes result in unintended negative consequences for clients or providers.	0.34%
Hospice	Hospice room and board rates	Rates for this portion of hospice services align with nursing facility rates, which are set based on a methodology defined in statute and not affected by across-the-board increases or decreases.	0.64%
Class I Nursing Facilities (C1NF)	All	These rates are set based on a methodology defined in statute and are not affected by across-the-board increases or decreases.	10.57%

Rates Excluded from the Across-the-Board Reduction Proposed in R-12			
Service Area	**Excluded Subset of Service**	**Reason Excluded**	**Magnitude of Exclusion as % of Estimated Medical Services Expenditure in FY 2016-17**
Supplemental Medicare Insurance Benefit	All	Medicare premiums are not affected by Medicaid rate changes.	2.80%
Health Insurance Buy-In Program	All	Third party/private insurance premiums are not affected by Medicaid rate changes.	0.03%
Disease Management	All	This is Tobacco Quitline, which is paid on actual submitted costs by the Colorado Department of Public Health and Environment, and is not eligible for rate increases/decreases.	0.02%
Prepaid Inpatient Health Plan Administration	All	These payments are not eligible for across-the-board rate increases/decreases (these rates are in contracts).	2.80%

4:00-4:15 PROVIDER RATES

28. Does the Medicaid Provider Rate Review Advisory Committee have the capacity at this time to assist the JBC in evaluating the provider rate reductions in the Governor's request, including the one percent across-the-board decrease, the scheduled end of the primary care rate bump, and the $100 million restriction on Hospital Provider Fee revenue? Describe how the Department has engaged providers regarding the proposed rate reductions.

RESPONSE

The Rate Review process that is guided by Section 25.5-4-401.5, C.R.S. (SB15-228) requires the Department to create a Rate Review process, determine the schedule for rates to be reviewed, and work with the established Medicaid Provider Rate Review Advisory Committee. It also allows the Department to exclude some service categories because those rates are based on costs, or have a regular process for updates or processes that are delineated in statute or regulation. Because some of the rate reductions proposed in the Governor's budget are excluded from the Rate Review Process or are only partially included in the Rate Review process, the Department believes the processes that are required for the Assuring Access to Covered Medicaid Services federal rule are the best mechanism to evaluate the impact of the proposed reductions. The Department will be sure to engage the Medicaid Provider Rate Review Advisory Committee in the areas where their work as defined in section 25.5-4-401.5, C.R.S. aligns with the requirements of the new federal rule.

The Assuring Access to Covered Medicaid Services Federal Rule

The Social Security Act requires states to "*assure that payments are consistent with efficiency, economy and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such services are available to the general population in the geographic area.*" The rule, published in the Federal Register on Monday, November 2, 2015

(http://www.gpo.gov/fdsys/pkg/FR-2015-11-02/pdf/2015-27697.pdf) creates a standardized, transparent process for states to document whether Medicaid payments are sufficient to enlist providers to assure beneficiary access to covered care and services.

The rule requires all states to develop an Access Monitoring Review Plan that includes:

- Data elements that will support the state's analysis of whether beneficiaries have sufficient access to care
- Analysis of the data elements to determine if beneficiary needs are met across different geographic regions, services and beneficiary populations
- Actual or estimated levels of provider payments available from other payers by provider type and site of service
- Beneficiary and provider input
- Comparison of Medicaid payment rates to other public and private payments rates

The Access Monitoring Review Plan must include analysis for:

- Primary care services
- Physician specialist services
- Behavioral health services
- Pre- and post-natal obstetric services, including labor and delivery
- Home health services
- Additional services for which the state or CMS has received a significantly higher volume of access complaints
- Additional types of services selected by the state

The plan must be published and made available for public review and comment for no less than 30 days prior to being finalized. The plan must be submitted to the Center for Medicare and Medicaid Services for review by July 1, 2016 and updated by July 1 of each subsequent review period. States must have mechanisms for ongoing beneficiary and provider input. If it is determined that there is inadequate access states must submit a corrective action plan to the Center for Medicare and Medicaid Services within 90 days of identifying access issues that includes specific steps and timelines to address the issue within 12 months

The rule includes additional provisions for proposed provider rate reductions or restructuring. The requirements require states to submit an Access Review with a State Plan Amendment that reduces or restructures provider's rates. The Access Review must demonstrate sufficient access for services impacted by the rate reduction and include the most recent Access Review Monitoring Plan for the affected services, an analysis of the effect of the change in payment rates on access, and a specific analysis of the information and concerns expressed by affected stakeholders. States must establish procedures for at least three years following the effective date of the State Plan Amendment to monitor access after implementation of a rate reduction.

The Department has regular communications with providers and provider associations. Senior leadership at the Department have regular meetings with providers and provider associations throughout the year to ensure strong relationships and opportunities for engagement. As the rate reduction was part of the Governor's proposed FY 2016-17 budget, the opportunities to communicate with providers were limited until the release of the budget on November 2. Following the release of the budget, the Department has met with many provider groups and remains committed to ongoing collaboration and communication.

29. In the response to legislative request for information #1, why did the Department choose to compare dental rates to the highest compensating states rather than an average rate in the manner used for Home and Community Based Services and for Home Health/Private Duty Nursing?

RESPONSE

Different service categories require different benchmarking strategies based on what information is available for analysis. Home health and PDN services do not have industry standard rate benchmarks. The American Dental Association (ADA) does publish commercial charges for procedures, but commercial charges do not reflect typical reimbursement.

For Home Health and Private Duty Nursing, the Department was able to limit comparison data sources to states with similar sets of services provided in a fee-for-service environment (and those states that had readily available information). Further, public payers cover a significant percentage of long-term care services; this means that Medicaid rates are a stronger indicator of the general market rate than with other service categories. Because the benefit was verifiably comparable and rates were likely more reflective of the broader market rates, a simple average for the benchmark was utilized. In other words, average Medicaid reimbursement makes sense as a benchmark for these services where it might not for other service categories.

For dental services, the data source was a nation-wide survey of states' Medicaid reimbursement levels relative to average commercial charges. The Department utilized the highest rate because, unlike with Home Health and Private Duty Nursing, Medicaid is less likely to be fully representative of the broader market for dental services. Additionally, private payers are more likely to reimburse at a higher level than Medicaid. Consequently, when selecting a benchmark for dental services, the Department selected the highest Medicaid reimbursement level to account for the potential skew resulting from selecting only Medicaid providers and having incomplete information about the comparability of other states' dental benefit packages. This means that using the highest Medicaid value as a benchmark gets closer to what a composite public/private market benchmark would be. See Appendix C for a comprehensive list of Medicaid reimbursement relative to reported average commercial dental charges by state; the range is 26.7 percent to 81.01 percent for children's dental services and 13.8 percent to 60.5 percent for adult dental services.

As is the case for all service categories in the report, the benchmark is meant to provide insight, but in and of itself is insufficient for determining the appropriate level of reimbursement in Colorado; cost and efficiency differences across delivery systems appropriately drive differences in levels of reimbursement.

30. In the response to legislative request for information #1, how did the Department select the comparison states for Home and Community Based Services and for Home Health/Private Duty Nursing?

RESPONSE

The Department contracted with an actuarial firm to assist with the benchmarking process including identification of states with comparable rates. In order to appropriately benchmark the HCBS, Home Health, and Private Duty Nursing (PDN) rates, the actuary evaluated states that had a similar set of services, the

services were reimbursed under fee-for-service, and the rates and service descriptions were available. Given the variability in benefit packages and availability of data, the viable comparison states were limited to those included in the analysis.

31. Why does the Department believe Colorado pays so much for Home Health/Private Duty Nursing relative to the comparison states and does this indicate that Colorado's rates are too high?

RESPONSE

Many factors contribute to differences in rates across states; consequently, rate benchmarking is useful for providing insight, but in isolation is insufficient for determining whether or not reimbursement levels are appropriate. To determine if these services are appropriately funded, additional analysis would be necessary (client access, quality of services rendered, population need, Colorado-specific costs for rendering services, etc.). Growth in the number of providers can also indicate whether or not a service is appropriately funded.

Quantifiable factors that impact differences in rates across states include variability in salaries, operating costs, administrative and capital expenses. Other factors driving differences in reimbursement rates across states include state policies, service definitions, and provider qualifications and requirements. A comparison of rates across states does not address how rates are affected by these qualitative differences. For example CNAs in Colorado are required to be supervised by a nurse on a periodic basis. Many other states do not have this requirement and consequently, services provided by a CNA should be cheaper in states without the supervision requirement.

Lastly, a rate comparison where reimbursement is benchmarked against other states assumes that other states are appropriately funded. If another state is underfunded then Colorado rates will look higher in comparison even if adjustments are made for all of the factors discussed previously.

Due to all of these considerations, it is unclear whether or not the services are over funded.

4:15-4:35 HOSPITAL PROVIDER FEE

32. What problem was the Hospital Provider Fee trying to solve by increasing hospital reimbursements (i.e. what was the originally intended purpose of the Hospital Provider Fee) and has it achieved that purpose?

RESPONSE

In enacting the hospital provider fee as part of the Colorado Health Care Affordability Act (HB 09-1293), the General Assembly declared that "hospital providers in the state incur significant costs by providing uncompensated emergency department care and other uncompensated medical services to low-income and uninsured populations."

The General Assembly noted that it intended to provide a payer source for some low-income and uninsured populations, reduce underpayment to Colorado hospitals participating in publicly funded health insurance programs, reduce the number of Coloradans who are without health care benefits, reduce the need of health

care providers to shift the cost of providing uncompensated care to other payers, and expand access to high-quality, affordable health care for low-income and uninsured populations.

The hospital provider fee is achieving its intended purposes.

a. Provide a payer source for some low-income and uninsured populations, reduce underpayment to Colorado hospitals participating in publicly funded health insurance programs, and expand access to high-quality, affordable health care for low-income and uninsured populations.

To meet these goals, the legislation calls for increasing reimbursement to hospitals for inpatient and outpatient care provided to Medicaid patients up to a maximum of the federal upper payment limit (UPL), increasing payments to hospitals for services provided to low-income Coloradans through participation in the Colorado Indigent Care Program (CICP), and establishing Hospital Quality Incentive Payments (HQIP) to improve the quality of care provided in Colorado hospitals.

Medicaid Supplemental Inpatient and Outpatient Hospital Payments

The hospital provider fee finances additional reimbursement to hospitals for inpatient and outpatient care provided to Medicaid patients up to a maximum of the federal UPL.

The Department and the Hospital Provider Fee Oversight and Advisory Board are in the process of finalizing the Hospital Provider Fee Annual Report due on January 15, 2016. Pending final review of the upcoming Hospital Provider Fee Annual Report, hospitals received approximately $607 million in supplemental Medicaid inpatient payments and approximately $208 million in supplemental Medicaid outpatient payments between October 2014 and September 2015.

Colorado Indigent Care Program Payments

The hospital provider fee increases payments to hospitals for services provided to low-income Coloradans who do not qualify for Medicaid or the Child Health Plan *Plus* (CHP+) programs through participation in the Colorado Indigent Care Program (CICP). Prior to the hospital provider fee, reimbursement to CICP-participating hospitals was $163 million per year.

Pending final review of the upcoming Hospital Provider Fee Annual Report, hospitals (including CICP-participating and non CICP-participating) were reimbursed $310 million for services provided to CICP and uninsured patients between October 2014 and September 2015.

Hospital Quality Incentive Payments

The hospital provider fee legislation established HQIP funded by hospital provider fees to improve the quality of care provided in Colorado hospitals. Pending final review of the upcoming Hospital Provider Fee Annual Report, HQIP payments during the October 2014 to September 2015 timeframe, HQIP payments totaled more than $61 million with 75 hospitals receiving payments. These payments were made for performance in the following five measurement areas:

- Emergency department process

- Postoperative pulmonary embolism or deep vein thrombosis (PPE/DVT)
- Elective delivery between 37 and 39 weeks gestation
- 30 Day all-cause readmissions
- Cesarean Sections for low-risk, first birth women

Net Reimbursement Increase to Hospitals

Through increased Medicaid and CICP reimbursement and quality incentive payments, the Department expects the upcoming Hospital Provider Fee Annual Report to show that hospitals received approximately $335 million in new reimbursement from the hospital provider fee between October 2014 and September 2015 after accounting for CICP payments received prior to the hospital provider fee. See the table below.

Inpatient Hospital Supplemental Payments	$606,802,000
Outpatient Hospital Supplemental Payments	$207,647,000
CICP and Uncompensated Care Payments	$310,302,000
Hospital Quality Incentive Payments	$61,449,000
Total Supplemental Hospital Payments	**$1,186,200,000**
Less total hospital provider fees	($688,448,000)
Less approximate prior CICP payments	($162,876,000)
Net Reimbursement Increase to Hospitals	**$334,876,000**

b. Reduce the number of Coloradans who are without health care benefits.
Hospital provider fees finance health coverage for more than 400,000 Coloradans including children, pregnant women, low-income adults, and adults and children with disabilities. Specifically, hospital provider fees finance the following health care coverage expansions:

- Medicaid parents with incomes from 61 percent to 133 percent of the federal poverty level (FPL);
- Children and pregnant women in the Child Health Plan *Plus* (CHP+) from 205 percent to 250 percent FPL;
- Adults without Dependent Children (AwDC) in the home from 0 percent to 133 percent FPL;
- Medicaid Buy-In Program for individuals with disabilities whose family incomes are too high for Medicaid eligibility but are under 450 percent FPL for working adults or under 300percent FPL for children; and
- Twelve-month continuous eligibility for Medicaid children.

These expansions were implemented between May 2010 and March 2014. The caseload reported as of September 30, 2015 was as follows:

- 91,116 Medicaid parents,
- 15,330 CHP+ children and pregnant women,
- 10,175 working adults and children with disabilities, and

- 293,526 adults without dependent children.

c. **Reduce the need of health care providers to shift the cost of providing uncompensated care to other payers.**

Cost shifting occurs because publicly funded health care (i.e., Medicare and Medicaid) and uninsured care are paid below the cost of providing care. Those uncompensated costs are shifted to private payers.

The hospital provider fee reduces the need for hospital providers to shift uncompensated care costs to private payers by increasing reimbursement to hospitals for inpatient and outpatient care provided for Medicaid and CICP patients and by reducing the number of uninsured Coloradans. Pending final review of the upcoming Hospital Provider Fee Annual Report, from 2009 to 2014, the payment for care provided by hospitals to Medicaid clients has improved overall from 54 percent to 72 percent of costs. In addition, in 2014 the amount of bad debt and charity care decreased by more than 50 percent compared to 2013.

These outcomes follow the implementation of increased reimbursement to hospitals under the hospital provider fee and the reduction in the number of uninsured Coloradans due to the provider fee-financed expansion of health coverage in the state. This significant reduction in hospitals' uncompensated care is evidence of the success of the hospital provider fee.

33. What is the effect of the proposed $100 million reduction in the Hospital Provider Fee by hospital?

a. How is the effect distributed across the state?

RESPONSE

The Department cannot estimate how the $100 million FY 2016-17 fee reduction will impact net reimbursement by hospital or by area of the state at this time.

The Department is in the process of calculating the FFY 2015-16 hospital provider fee and payment calculations, which will reflect the impact of the $100 million reduction in hospital provider fee revenue as proposed in Governor Hickenlooper's FY 2016-17 budget request. The $100 million reduction in hospital provider fee revenue is expected to reduce net reimbursement to all Colorado hospitals by $102 million in federal matching funds.

Distribution of net reimbursement amongst hospitals depends on changes in utilization patterns of all patients, Medicaid patients, and uninsured patients for each hospital relative to all other hospitals. Because of these multiple variables, the distribution of net reimbursement to individual hospitals in FFY 2015-16 may vary greatly compared to the distribution of net reimbursement in FFY 2014-15.

The FFY 2015-16 hospital provider fees and payments must first be reviewed and approved by the Hospital Provider Fee Oversight and Advisory Board. Presentation to the board is scheduled for January 19, 2016. If the Oversight and Advisory Board approves the FFY 2015-16 hospital provider fees and payments at that meeting, the Department can share hospital- and regional- specific impacts of the fee reduction then. (Note:

the FFY 2015-16 hospital provider fee and payment amounts will not be final until approved by the federal Center for Medicare and Medicaid Services, which may take several months.)

b. What information can the Department supply to provide a sense of the magnitude of the proposed reduction compared to the operations of the hospitals that will be affected?

c. In particular, how will the proposed reduction change rural hospitals and access to care in rural areas?

RESPONSE

Because the Department cannot estimate the impact of the reduction on individual hospitals until the FFY 2015-16 hospital provider fee calculations have been completed and reviewed by the Hospital Provider Fee Oversight and Advisory Board, the Department does not know the impact of the reduction on hospital operations or the impact on rural hospitals. Generally, hospitals that serve higher proportions of publicly insured patients compared to privately insured patients will be more sensitive to changes in payments from public insurance programs.

d. Is the Hospital Provider Fee adding to the profits of hospitals that are doing well financially?

RESPONSE

The hospital provider fee reduces, but does not eliminate, hospitals' uncompensated costs for care provided to Medicaid and uninsured patients. Net reimbursement for all Colorado hospitals from the hospital provider fee in the October 2014 through September 2015 timeframe was approximately $335 million. This net reimbursement would be reflected in hospitals' patient revenues.

34. Compare hospital profits with the net benefit hospitals receive from the Hospital Provider Fee. Are the high profit hospitals also recipients of large net benefits from the Hospital Provider Fee?

RESPONSE

The Denver Post article, Colorado Hospitals Make More Money Despite Lower Bed Occupancy Rates, by David Olinger published on October 14, 2015, includes information from Allan Baumgarten's *Colorado Health Market Review 2015*[10]. The article referred to HealthOne, Centura, and University system hospitals, as well as University of Colorado Hospital individually.

The net reimbursement for all Colorado hospitals from the hospital provider fee in the October 2014 through September 2015 timeframe was approximately $335 million. The following table shows net reimbursement and percentages for the six hospitals or hospital systems that receive the largest net reimbursement from the hospital provider fee.

[10] Available at AllenBaumgarten.com.

Select Hospitals and Hospital Systems	FFY 2014-15 Net Reimbursement	Percentage of Total Net Reimbursement
Denver Health Medical Center	$45,651,000	13.6%
Centura Health (13 hospitals) *Avista Adventist Hospital, Littleton Adventist Hospital, Parker Adventist Hospital, Porter Adventist Hospital, Castle Rock Adventist Hospital, Mercy Medical Center, Ortho Colorado, Penrose - St. Francis Health Services, Saint Anthony Central Hospital, Saint Anthony North Hospital, Saint Anthony Summit Hospital, St. Mary-Corwin Medical Center, and St. Thomas More Hospital*	$35,036,000	10.5%
Children's Hospital Colorado	$34,810,000	10.4%
University of Colorado Health System (4 hospitals) *University of Colorado Hospital, Poudre Valley Hospital, Medical Center of the Rockies, and Memorial Hospital*	$29,178,000	8.7%
Banner Health (4 hospitals) *East Morgan County Hospital, North Colorado Medical Center, McKee Medical Center, and Sterling Regional MedCenter*	$24,410,000	7.3%
HealthOne (7 hospitals) *Medical Center of Aurora, North Suburban Medical Center, Presbyterian/St. Luke's Medical Center, Rose Medical Center, Sky Ridge Medical Center, Spalding Rehabilitation Hospital, and Swedish Medical Center*	$22,245,000	6.6%
All Hospitals	**$334,876,000**	

The hospital provider fee reimburses hospitals for care provided to Medicaid and uninsured patients, and the net reimbursement to the above hospitals is in large part due to their higher Medicaid payer mix compared to other hospitals. (See Exhibits 21 and 25 below, extracted from Allan Baumgarten's *Colorado Health Market Review 2015* below.) While the Denver Post article notes that HealthOne has the highest net income of hospitals systems in the Denver area, HealthOne's high Medicaid payer mix (at 25% of its inpatient hospital days) is the factor driving its hospital provider fee net reimbursement.

Exhibit 21

Occupancy and Payer Mix for Denver Metro Area Hospitals, 2014

Hospital	Available Beds	Inpatient Days	Occupancy	% Medicare	% Medicaid	% Other
Centura	**1,027**	**203,529**	**49.8%**	**38.7%**	**16.5%**	**44.8%**
Avista	114	15,713	37.8%	15.9%	36.2%	47.9%
Parker Adventist	124	29,440	65.0%	32.5%	15.9%	51.6%
Porter Adventist	168	33,290	34.1%	53.7%	10.6%	35.7%
Littleton Adventist	184	40,964	61.0%	43.7%	11.6%	44.8%
OrthoColorado	48	4,360	24.9%	28.8%	0.0%	71.2%
St. Anthony North	133	22,910	47.2%	48.1%	26.7%	25.2%
Castle Rock	50	5,930	37.1%	33.2%	10.8%	56.1%
St. Anthony Central	206	50,922	67.7%	32.7%	16.2%	51.2%
HealthOne HCA	**1,619**	**390,060**	**65.5%**	**36.1%**	**25.0%**	**38.9%**
Medical Center of Aurora	295	71,890	65.0%	43.9%	26.0%	30.1%
North Suburban	127	27,774	62.3%	36.5%	35.5%	27.9%
Rose	244	51,980	58.4%	31.8%	22.6%	45.6%
Presbysterian/St. Luke's	344	77,458	60.3%	20.9%	41.1%	38.0%
Sky Ridge	177	53,269	81.7%	33.8%	7.9%	58.3%
Spalding Rehabilitation	100	12,822	35.1%	43.4%	11.9%	44.7%
Swedish	332	94,867	78.4%	45.0%	20.9%	34.1%
SCL/Exempla	**762**	**186,538**	**67.1%**	**41.3%**	**20.0%**	**38.7%**
Samaritan	215	51,884	66.1%	46.1%	9.1%	44.7%
Lutheran	251	50,500	55.1%	42.8%	26.7%	30.5%
St. Joseph	296	84,154	77.9%	37.4%	22.8%	39.8%
Denver Health Medical Center	**336**	**94,872**	**77.4%**	**20.3%**	**60.8%**	**18.9%**
University	**520**	**159,533**	**84.1%**	**30.2%**	**29.3%**	**40.5%**
Children's	**496**	**111,400**	**61.5%**	**0.3%**	**50.4%**	**49.3%**
Other	**371**	**68,076**	**50.2%**	**41.3%**	**22.5%**	**36.2%**
Boulder Community*	133	28,055	57.5%	38.2%	18.0%	43.8%
Longmont United	125	28,653	62.8%	48.2%	22.1%	29.7%
National Jewish Health	24	186	2.1%	4.3%	48.4%	47.3%
Platte Valley	89	11,182	34.4%	31.8%	34.4%	33.7%
2014 TOTAL	**5,131**	**1,214,008**	**63.5%**	**32.3%**	**28.4%**	**39.3%**
2013 TOTAL	**5,195**	**1,200,254**	**64.7%**	**32.4%**	**23.4%**	**44.2%**
2012 TOTAL	**4,930**	**1,172,970**	**65.6%**	**33.6%**	**21.9%**	**44.5%**

Source: Author's analysis of hospital Medicare cost reports for 2014

Exhibit 25

Occupancy and Payer Mix for Largest Outstate Hospitals, 2014

System/ Hospital	Available Beds	Inpatient Days	Occupancy	% Medicare	% Medicaid	% Other
Banner Health	**422**	**65,769**	**42.7%**	**47.0%**	**30.1%**	**22.9%**
East Morgan County	25	2,030	22.2%	75.4%	6.4%	18.3%
McKee Medical Center	115	13,299	31.7%	42.1%	28.1%	29.8%
North Colorado	257	46,770	49.9%	46.5%	32.0%	21.4%
Sterling Regional	25	3,670	40.2%	55.4%	25.9%	18.7%
Centura Health	**672**	**139,625**	**55.3%**	**44.9%**	**20.5%**	**34.6%**
Mercy Regional	82	14,865	49.7%	39.4%	22.7%	37.9%
Penrose-St. Francis	402	90,391	61.6%	44.4%	18.5%	37.1%
St. Anthony Summit	34	3,803	30.6%	12.9%	22.5%	64.7%
St Mary's-Corwin	129	24,163	51.3%	53.3%	25.9%	20.8%
St. Thomas More	25	6,403	39.0%	51.9%	21.9%	26.1%
University of Colorado	**759**	**168,947**	**61.0%**	**38.8%**	**21.1%**	**40.1%**
Medical Center of the Rockies	148	39,177	72.5%	49.7%	13.1%	37.3%
Poudre Valley	197	51,113	71.1%	39.9%	21.3%	38.8%
Memorial	414	78,657	52.1%	32.6%	25.0%	42.4%
Quorum Health	**404**	**90,516**	**61.4%**	**47.1%**	**28.4%**	**24.5%**
Arkansas Valley	54	4,529	23.0%	58.1%	25.4%	16.5%
Montrose Hospital	53	8,772	45.3%	47.3%	23.6%	29.1%
Valley View	49	10,728	60.0%	24.3%	38.3%	37.4%
Parkview	248	66,487	73.4%	50.0%	27.6%	22.4%
San Luis Valley Health	**66**	**6,175**	**25.6%**	**43.2%**	**28.4%**	**28.3%**
San Luis Valley	49	5,569	31.1%	38.6%	30.9%	30.5%
Conejos County	17	606	9.8%	85.5%	5.9%	8.6%
Other	**440**	**77,457**	**48.2%**	**42.7%**	**29.1%**	**28.2%**
Southwest Memorial	25	4,461	48.9%	43.8%	28.2%	28.0%
Colorado Plains Medical Center (Lifepoint)	36	3,754	28.6%	34.3%	27.5%	38.3%
Community Hospital	42	5,464	35.6%	61.1%	7.5%	31.4%
St. Mary's (SCL)	288	58,209	55.4%	41.8%	31.2%	27.0%
TOTAL	**3,111**	**620,971**	**54.3%**	**41.9%**	**24.5%**	**33.6%**

Source: Author's analysis of hospital Medicare cost reports for 2014

35. How do Medicaid reimbursements for hospitals compare to reimbursements for services not provided through hospitals? By investing in hospitals through the Hospital Provider Fee is the state shorting other providers and limiting access to non-hospital care?

RESPONSE

Medicaid payments for services vary depending on the where services are provided and are determined by varying payment methodologies. This makes it difficult to directly compare payments between health care settings for services.

Investing in hospitals through the Hospital Provider Fee does not reduce payment to other providers or limit access to non-hospital care. Instead, the Hospital Provider Fee has directly increased reimbursement to other providers by providing a state funding source for over 396,000 children and adults, most of whom

would not otherwise have access to insurance, as people under 133 percent of the federal poverty level do not qualify for subsidies through Connect for Health Colorado. As a result, the Department is reimbursing primary care doctors, specialists, hospitals, and other health care practitioners for services that were previously only provided as charity care.

The Department further notes that the General Assembly has limited the uses of the Hospital Provider Fee. Pursuant to section 25.5-4-402.3(4)(b), C.R.S., the Hospital Provider Fee can only be used to increase hospital reimbursements, fund a hospital quality incentive program, and expand eligibility for public medical assistance. The statute does not authorize the Hospital Provider Fee to be used for increasing reimbursement rates for any other provider. Therefore, increased payments to hospitals financed through the Hospital Provider Fee are not made at the expense of other providers.

4:35-4:45 HEPATITIS C

36. How will the November 5 Medicaid Drug Rebate Program Notice (release No. 172) regarding assuring Medicaid beneficiaries access to HCV drugs affect Colorado's Medicaid coverage?

RESPONSE

The Department has reviewed the Notice and has obtained additional information from CMS regarding the intent of this Notice. The Department wanted to ensure it understood the intent and scope of the Notice before making any policy decisions. This Notice is not a mandate from CMS. Rather, CMS released the Notice to ensure that states are considering certain factors when making their criteria. CMS encourages states to review their criteria to ensure there is adequate access and coverage. In addition, the Notice describes practices that CMS finds concerning. It was intended to inform states that they should not use criteria to prohibit use based on cost savings, but states can use the criteria to manage the use of the drugs to ensure appropriate use.

The Notice from CMS states that states should "examine their drug benefits to ensure that limitations do not unreasonably restrict coverage of effective treatment." Thus states are tasked with reviewing their criteria to ensure that the limitations do not <u>unreasonably</u> restrict coverage. CMS is not telling states what their criteria must be. For example, in the Notice, CMS mentions requirements regarding specialists. However, mentioning this does not mean that a state cannot use these criteria. Rather, states could look at restricting the prescribing of these medications to specialists if there are adequate specialists available in the state. The CMS concern stemmed from reports that a particular state was requiring a prescription to be written by hepatologists, but that state had no hepatologists available, which essentially resulted in no coverage.

The Department continues to evaluate the criteria based on the safety profile of these drugs as well. There were limited studies done pre-FDA approval on these drugs. In addition, recently both Viekira Pak and Harvoni have had additional side effects with significant health concerns reported. The Department believes that it is important to be cautious when paying for new therapies because new information about the safety profile becomes apparent post release. This applies to this class as well as any other class of new drugs and has proven true in this case.

Based on all of these factors, the Department determined that current criteria is the appropriate balance between access to treatment and appropriate use of taxpayer dollars. The Department does not believe its criteria unreasonably restricts coverage. The criteria allows those who need the drugs the most to receive

them first. Additionally, it ensures that there is the best chance for successful treatment and that members will remain HCV free. With the cost of these medications, it is important to use taxpayer dollars wisely to ensure the most are treated successfully as possible. For example, the Department requires six months of abstinence before treatment because those who are currently abusing alcohol and/or using IV drugs may be less likely to be treated successfully and remain HCV free. This requirement is not a barrier to treatment but rather a way to ensure successful treatment.

In addition, the Notice mentions metavir fibrosis score criteria, which is a way to measure the health of the liver, and asks states to consider what scores will be approved. (The potential scores are F0 through F4, with F0 indicating no fibrosis and F4 indicating cirrhosis, which is a chronic degenerative liver disease state in which normal liver cells are damaged and then replaced by scar tissue.) The Department currently has criteria that allows coverage for members with a score of F3 and F4. In addition, regardless of fibrosis score, the Department also covers members that have other serious extra-hepatic manifestations of HCV. Many other states have similar criteria. Given the expense of these medications and the slow progression of the disease, the Department believes that its criteria allows for treatment for those who are the most sick and need treatment first and then treat the less severe disease later without adverse impact. Expanding the fibrosis score criteria to include F2 would significantly increase the total expenditure on these drugs.

The Department is and will continue to review its criteria and will modify criteria when circumstances change and review new drugs that are expected to come to market. Colorado is looking to start a Project ECHO program related to Hepatitis C where primary care practices would be trained by specialists regarding the diagnosis, treatment, and monitoring of Hepatitis C. The Department is considering changing its criteria to allow primary care practitioners who have gone through this program to be able to prescribe these medications. By providing this training, the program could ensure that these practitioners have the necessary knowledge regarding these drugs to meet the needs of the Department.

37. We heard in a recent presentation to the JBC that hepatitis C is the only disease for which a patient needs to become sicker before HCPF will provide a cure. Why is this the case?

RESPONSE

Hepatitis C is not the only disease where a mild disease severity is not treated until the disease progresses. With each therapeutic drug class and disease state, the Department balances cost with clinical efficacy, safety, and differences in special populations such as children or pregnant women, common medical practice, etc. Some examples of other disease states where treatment differs based on severity include:

- Parkinson's is not treated until the patient becomes symptomatic.
- Cancer has different treatments which are based on the disease progression; some treatment is simply watch and wait with no drug therapy.
- Rheumatoid Arthritis is treated more aggressively with disease progression. Initially the treatment options are lifestyle changes only until progression of disease is found.
- Diabetic patients are not initiated on insulin unless the diagnosis is severe. They may start with lifestyle changes only and progress to different drug therapy and progress to insulin as the disease worsens.
- Pulmonary hypertension monotherapy is the initial treatment and increases to dual and triple therapy as disease progresses.
- Patients with Multiple Sclerosis are allowed the more expensive oral products for more severe disease states.

4:45-5:00 BUDGET AND FINANCING

38. Will Medicaid enrollment decline as the economy improves and when will that happen?

RESPONSE

The Department does not anticipate that Medicaid caseload will decline within its current forecast period (through FY 2017-18). A recent publication by the Colorado Center on Law & Policy[11] (CCLP) titled "State of Working Colorado 2015-16" concluded in part that "[the] jobs that have returned during the recovery have been mostly low-wage jobs" and that "32 percent of all jobless workers were facing long-term unemployment—still significantly above the 2007 rate of 13 percent." In addition, CCLP found that in 2014, the median hourly wage in Colorado was still below the 2007 median wage, and that "…46 percent of Coloradans in poverty are living in deep poverty—that is, living on an income that is half of the poverty line. In 2014, that meant $5,835 per year for an individual and $9,895 for a family of three. And the number of people living in deep poverty increased by nearly 27,200 between 2007 and 2014." Taken together, it appears unlikely that the current economic recovery will induce a meaningful reduction in Medicaid caseload in the near future.

The Department does not, however, anticipate further large increases in Medicaid caseload. Historically, Medicaid enrollment and spending have been driven largely by economic conditions as well as state and federal policy decisions. According to the Kaiser Family Foundation Report on Medicaid Enrollment and Spending, "During economic downturns, when individuals lose their jobs and incomes decline, more people qualify and enroll in Medicaid driving increases in spending. Following economic downturns, Medicaid enrollment and spending growth may slow in the absence of other policy changes."[12] Historically, Colorado's Medicaid growth has remained strong for up to two years after prior recession ended.

Since FY 2013-14, the implementation of the Affordable Care Act (ACA) has been the primary driver of changes in Medicaid enrollment and spending growth. In FY 2016-17 and FY 2017-18, enrollment and spending growth are expected to continue to increase but at a decreasing rate as Medicaid expansion reaches a steady state and as Colorado's personal per capita income continues to grow at a faster rate than national averages. The assumptions of a slowing growth rate in Medicaid caseload is reflected in the Department's FY 2016-17 budget request. See the table below for historical and forecasted caseload growth percentages.

Table 1: Colorado Medicaid Caseload

Fiscal Year	Caseload	Percent Change from Prior Year
FY 2009-10 Actuals	498,797	14.19%
FY 2010-11 Actuals	560,759	12.42%
FY 2011-12 Actuals	619,963	10.56%
FY 2012-13 Actuals	682,994	10.17%
FY 2013-14 Actuals	860,957	26.06%
FY 2014-15 Actuals	1,161,206	34.87%
FY 2015-16 Projection	1,291,471	11.22%
FY 2016-17 Projection	1,352,005	4.69%
FY 2017-18 Projection	1,405,780	3.98%

[11] http://cclponline.org/wp-content/uploads/2015/11/SOWC_2015_FULL_FINAL.pdf
[12] http://kff.org/report-section/medicaid-enrollment-spending-growth-fy-2015-2016-issue-brief/

39. How much is the Medicaid expansion authorized in S.B. 13-200 costing the state, including the "welcome mat" effect, and how does this compare to the estimates in the fiscal note for the bill?

RESPONSE

In FY 2014-15, estimated service costs for implementing the Medicaid expansion authorized in SB13-200 was $1.18 billion total funds, including $38.5 million General Fund, $1.6 million cash funds, and $1.14 billion federal funds.

Of this total, an estimated $1.11 billion total funds, including $9.8 million General Fund, $627,000cash funds, and $1.10 billion federal funds was from the expansions authorized in SB 13-200, including the expansion of MAGI parents/caretakers and adults to 133 percent, foster care eligibility to age 26, and the corresponding increase in eligibility for non-citizen emergency services. An estimated $69.9 million total funds, including $28.7 million General Fund, $951,000 cash funds, and $40.3 million federal funds, was from the "welcome mat" effect, including clients who were eligible but not enrolled prior to Medicaid expansion.

Because there are a large number of components in the Medicaid expansion, the Department has summarized only the major differences between actual FY 2014-15 and the fiscal note for SB 13-200 in the text below. Appendix D at the end of this document provides a detailed breakdown by population and service type, including both caseload and per capita differences, and by fiscal year.

Expansion Populations

The fiscal note for SB 13-200 underestimated expansion population caseload by 90,374 in FY 2014-15. Primarily, this difference was in the MAGI Adults population. The increased caseload appears to be the result of higher take-up rates than expected as a result of the individual mandate and Medicaid expansion.

Actual physical health and behavioral health per capita costs were generally lower than estimated. The Department implemented a risk-sharing mechanism (known as a risk-corridor) to recoup funding if actual costs differ from the rates. The risk-corridor data has a lag time and was not available last year.

Medicaid expansion, authorized in SB 13-200, is primarily federally funded, though the state costs will increase as the federal medical assistance percentage (FMAP) ramps down from 100 percent to 90 percent over time. The state share of costs for these populations is funded through the Hospital Provider Fee cash fund.

Welcome Mat Effect

The fiscal note for SB 13-200 also underestimated the "welcome-mat" caseload (also known as "eligible but not enrolled") by an estimated 29,665 in FY 2014-15. All states, including states that did not expand Medicaid, experienced increased caseload growth for "eligible but not enrolled." The welcome-mat effect was significantly stronger from the expansion than estimated in the fiscal note, and is likely attributable to the individual mandate, particularly for parents and children. The Department notes that prior to implementation, there was significant disagreement about the likely effects of the individual mandate. Many, including the Department and JBC staff, concluded that there would be a relatively slow ramp-up as individuals would be slow to sign up for new health coverage. Instead, there was a large influx of caseload, which began immediately when enrollment was opened.

The Department's most recent estimate of the future impact of the "welcome mat" effect is from the February 2015 budget request, with estimates of 36,747 clients in FY 2015-16 and 39,818 clients in FY 2016-17. However, it is impossible to distinctly identify which clients were eligible for Medicaid prior to enrollment on Medicaid. The Department does not collect information about why a client did not apply

prior to the moment of application. Therefore, the Department has no basis in the data to identify who might have been eligible but not enrolled prior to enrollment.

In the past, the Department made prospective adjustments based on the information received from third parties that estimated the number of uninsured individuals in Colorado. That information showed there was a large number of people who were potentially eligible but not enrolled, indicating that it was appropriate to increase the caseload forecast under the assumption that they would eventually enroll. The most recent report on people who are uninsured[13] indicates that the vast majority of people who are potentially eligible have enrolled in Medicaid or found other insurance, and now in the third year of expansion, the potential size of the remaining eligible but not enrolled population is a lot smaller. Given that evidence, the Department believes there is no longer a reason to expect another large influx of caseload due to individuals eligible but not enrolled, and as such, the Department removed a specific adjustment for the effect from the forecast.

Based on the Department's February 2015 estimates of client counts for the "welcome mat" effect, and assuming that these clients have similar expenditure levels as clients who were already enrolled prior to Medicaid expansion (since the Department cannot differentiate between the two populations), the Department has calculated a very rough estimate of potential expenditure that may be attributed to the "welcome mat" effect.

40. Describe cost avoidances as a result of increased insurance.

RESPONSE

The Department is achieving cost avoidance while we have added more enrollees into Medicaid. One example of cost avoidance is the savings achieved through the Accountable Care Collaborative (ACC) program. The program has saved more than $285 million (gross) and $77 million (net) over past 4 years. The increased savings occurred at the same time we have increased enrollment in the program from about 500 enrollees in May 2011 to 899,596 enrollees at the end of FY 2014-15.

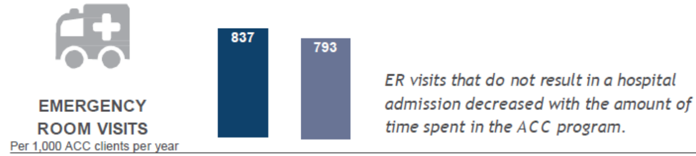
In FY 2014-15 alone, the ACC program achieved $121 million (gross) and $37 million (net) in savings. The net savings amount is after administrative costs including payments to providers and regional care organizations are taken into account. The ACC program allows providers to earn extra payments by meeting key performance indicators and enhanced care factors such as offering weekend or evening hours or having behavioral health services onsite.

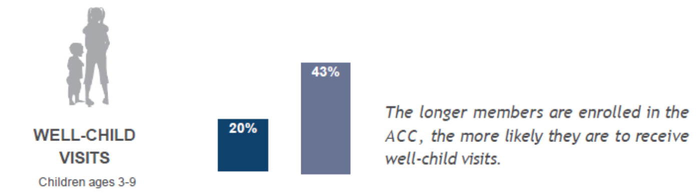
The ACC's key performance indicator results indicate that as enrollees are in the program longer, the use of high value services increases while the use of the emergency room decreases.

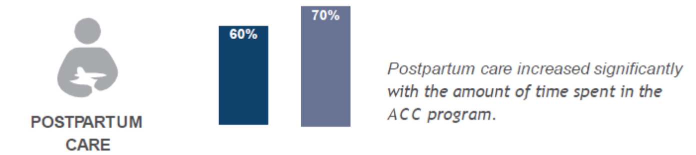
[13] http://www.coloradohealthinstitute.org/uploads/postfiles/CHAS/2015_CHAS_for_Web_.pdf

2015 KEY PERFORMANCE INDICATOR RESULTS*

0-6 Months
7-10 Months





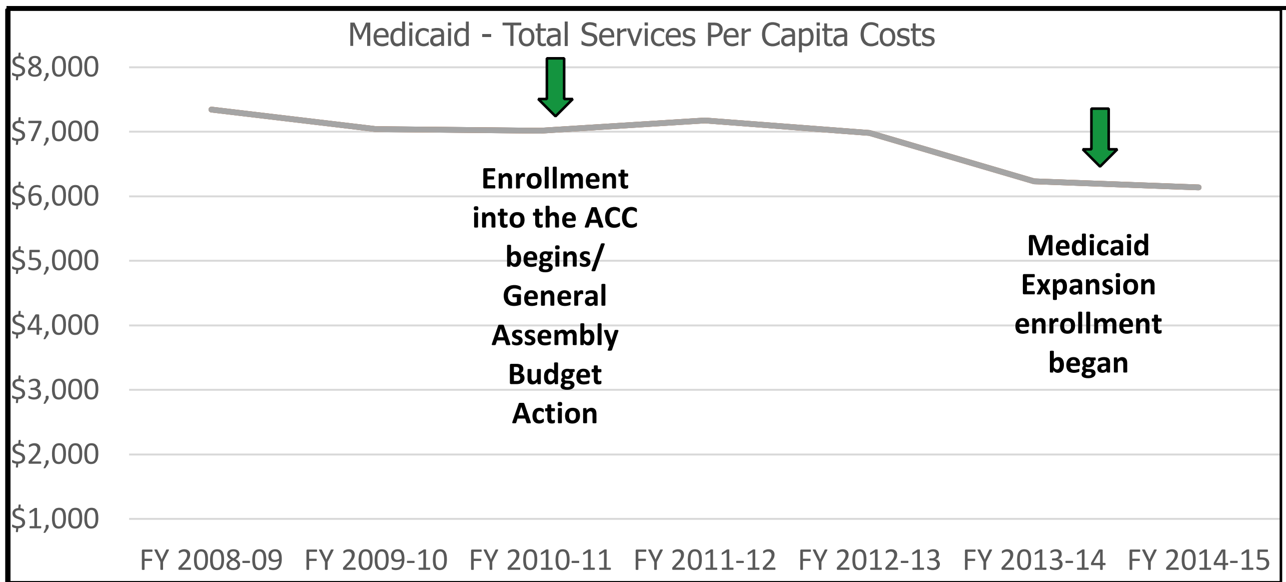


*For further information on these metrics, please see the Department's report to the Joint Budget Committee at http://tinyurl.com/pbnubnu.

Colorado Medicaid has had recent coverage expansions through HB 09-1293 and SB 13-200. This expanded health care coverage to more than 400,000 Coloradans as of September 30, 2015:

- 91,116 Medicaid parents
- 15,330 CHP+ children and pregnant women
- 10,175 working adults and children with disabilities
- 293,526 adults without dependent children

As the State has expanded coverage, the Department has seen the cost per Medicaid enrollee level off as shown in the chart below.



Source: Exhibit Q, Health Care Policy & Financing FY 2015-16 Budget Request, November 2015.

The Department's outcomes in the ACC are also being reflected in improvements in national health system rankings. Due to increased enrollment in the ACC program, Colorado was recently recognized in the Commonwealth Health System Rankings as a top state in its 2015 Scorecard on State Health System Performance, rising in the rankings from 12th in 2014 to 8th in 2015. Colorado was 5th best in the nation in the Avoidable Hospital Use & Cost. This factor looked at rates of potentially avoidable and expensive hospital care. Colorado was in the top quartile of states in the focus areas of Prevention & Treatment, Healthy Lives and Equity.

41. Describe the adequacy of County Administration funding.

RESPONSE

Prior to FY 2014-15, the Department of Health Care Policy and Financing's (HCPF) county administration funding was adequate and fully covered the state and federal share of county costs. In most prior years, the Department had remaining General Fund appropriation which was transferred to the Department of Human Services (CDHS) to help cover county administration costs for their programs, as allowed by Section 24-75-106(1), C.R.S. In FY 2014-15, with approval of the 1331 supplemental request for over expenditure of federal funds, the Department was able to mostly reimburse the state and federal share of county costs for Medicaid activities; however, there were still $175,530 of uncovered costs.

In FY 2015-16 and beyond, more funding is available to counties due to the transition of additional workload from the prior centralized eligibility vendor (MAXIMUS) and due to the final annualization from SB 13-200 "Expand Medicaid Eligibility" to help with the expected increases in caseload.

Given the current trajectory of county expenditure, without approval of the request for additional federal funding, it is likely the Department would not be able to reimburse counties the full state and federal share of Medicaid costs in FY 2016-17.

During the Joint Budget Committee's (JBC) briefing for HCPF on December 8, 2015, JBC staff indicated that they would recommend against the Department's request to remove the (M) headnote from the appropriation for county administration. The JBC has approved "emergency" supplemental requests in each of the last two fiscal years[14] in order to override the restriction, provide additional federal funds spending authority, and allow the Department to reimburse counties the General Fund that the General Assembly had already appropriated in the Long Bill each year. The (M) headnote causes unnecessary uncertainty for counties because they do not know whether their costs will be reimbursed; this can cause reductions in staff and other eligibility activities, ultimately delaying timely eligibility processing and leading to gaps in coverage which can impact health outcomes.

The appropriation of additional federal funds and removing the (M) headnote would give the Department flexibility to reimburse counties as much of their costs as possible within the bounds of the appropriated state funds.

a. Should the county workload study be updated and how much would it cost?

The Department recognizes that the results of the 2007 workload study may be out of date and may not accurately reflect how county workers and administrators currently work with the Department's programs. Since the study, numerous changes including population expansions, changes in business processes and technology advancements may have impacted business operations in counties.

Caseload Changes

In July 2007, there were a total of 383,563 Medicaid members and 54,238 Children's Basic Health Plan (CBHP)[15] members enrolled in the Department's programs; as of October 2015 that number is 1,272,951 Medicaid members and 47,027 Children's Health Plan *Plus* (CHP+) members. This represents an overall increase of nearly 890,000 members over the past eight years.

	July 2007	October 2015
Medicaid Members	383,563	1,272,951
Children's Health Insurance Program[1]	54,238	47,027

Technological Advances

With the implementation of the Affordable Care Act (ACA), Colorado expanded eligibility to new populations. To improve the capacity of the Colorado Benefits Management System (CBMS) and to accommodate expanded caseload, technology initiatives were funded by the General Assembly and implemented. These include the creation and expansion of the Program Eligibility Application Kit (PEAK), a web-based client portal, the utilization of electronic interfaces with the Social Security Administration (SSA) and Colorado Department of Labor and Employment (CDLE), and the implementation of Real Time Eligibility (RTE).

[14] In September 2013 and June 2015

[15] CBHP/CHP+ both represent the Department's programs under the Children's Health Insurance Program (CHIP) per State Plan Amendment CO-CSPA-12 "Medicaid Expansion and State Employees Expansion"

Many of the technological advances the Department has implemented are targeted at reducing the need for manual labor by eligibility technicians. These include the use of electronic interfaces and Real Time Eligibility (RTE). The Children's Health Insurance Program Reauthorization Act of 2009 allowed for the Department to utilize an electronic interface with the SSA in order to verify an applicant's citizenship. This reduced the need for eligibility technicians to manually request paper copies of citizenship documentation. The advent of RTE through PEAK allowed for applicants to apply online and receive a real-time eligibility determination, without the need for an eligibility technician to review the case. These technological advancements implemented in recent years (RTE was implemented in October 2013) have altered how counties and workers interact with the state eligibility determination system.

Other Workload Impacts to Consider
In addition to a workload study helping to gain a better understanding of how these changes in technology and caseload have impacted county workload, other areas can be included in an updated workload study. As shared in the Department's response to the 2015 Legislative Request for Information #5 regarding emergency and nonemergency medical transportation services (NEMT), the Department is interested in expanding the scope of a future workload study to include options for revising the County Administrative allocation methodology to improve NEMT including an analysis of:

- Mandated administrative activities included in the Regular Administrative Allocation line item;
- Inequities where allocations do not differentiate between the nine counties who are part the state managed broker contract and the remaining 55 counties that operate under a state-supervised/county- administrated structure; and
- County concerns that their currently stretched administrative allocations will be further reduced to pay for regionalization of NEMT.

The Department continues to work on cost estimates for a new workload study taking into account the above and has found that a new study would cost, at a minimum, $500,000 total funds based on a project of similar scope.

b. Could some of the additional $7.1 million in federal funding for County Administration identified in R7 be used to finance an update to the county workload study?

Only the Medicaid federal funds portion of the contract could be paid for with a portion of the additional $7.1 million. If the General Assembly appropriated funding for a county administration workload study, the Department expects that the portion of the cost related to Medicaid would qualify for 50 percent Federal Financial Participation (FFP).

However, county administration for Medical Assistance is closely tied to county administration for CDHS programs, including Supplemental Nutritional Assistance Program, some child welfare, child care administration and Temporary Assistance for Needy Families. Depending upon the county choice, CDHS county administration funding also funds administrative costs for the Low Income Energy Assistance Program and child support enforcement. Federal regulations at 42 CFR Part 95, Subpart F require administrative costs, which would include the study, to be allocated between HCPF and CDHS programs. Based on the method used for cost allocation described in both Departments' Public Assistance Cost

Allocation Plan (PACAP) the Department anticipates that Medicaid funding could cover 40 percent of the costs for the study.

c. Have the needs identified in the previous county workload study been fully funded and implemented?

Based on the results of the 2007 workload study completed by Deloitte Consulting, LLC, the Department was provided with three short-term, three medium-term, and three long-term recommendations. The Department has worked diligently to implement the recommendations, as seen below:

Recommendation	Implementation Strategy	Implementation Status
Web Enabled Access, Phase 1	Initial implementation of PEAK system	Completed and Ongoing
Change Management and Training Strategy	Creation of Staff Development Center (SDC)	Ongoing
Oversight and Quality Assurance Advisory Committee, Phase 1	Folded into existing committee structures	Ongoing
Web Enabled Access, Phase 2	PEAK Apply for Benefits (AFB) module	Ongoing
Oversight and Quality Assurance Advisory Committee, Phase 2	Folded into existing committee structures	Ongoing
Customer Contact Center, Phase 1	Medicaid Customer Contact Center	Ongoing
Web Enabled Access, Phase 3	PEAK Report My Changes (RMC) and Recertification modules	Ongoing
Customer Contact Center, Phase 2	Medicaid Customer Contact Center	Ongoing
Oversight and Quality Assurance Advisory Committee, Phase 3	Folded into existing committee structures	Ongoing

Funding for recommendations was requested through the regular budget process and is subject to annual appropriation

With the implementation of the ACA, the Department was able to utilize increased federal funding, such as the enhanced federal match for certain qualifying eligibility and enrollment activities, in order to implement some of these recommendations.

42. What is the fiscal impact of the projected changes in the federal match rate for:

RESPONSE

a. Medicaid

The additional expenditure for Medicaid programs in FY 2016-17 resulting from a reduction in the federal medical assistance percentage (FMAP) from 50.72 percent to 50.42 percent is $15.5 million General Fund, $1.33 million cash funds, and $9,000 reappropriated funds. For every 0.1 percentage point decrease in FMAP in FY 2016-17, the State's expenditure will increase by approximately $5.2 million General Fund. The Department's estimates are incorporated into its various change requests in the November 2, 2015 budget submission.

b. The "newly eligible" under the Affordable Care Act

In FY 2016-17 the federal match rate for clients newly eligible under the Affordable Care Act will decrease by 2.5 percent from 100 percent to an average of 97.5percent. The Department estimates that this will result in expenditures of approximately $42.5 million in Hospital Provider Fee cash funds. In FY 2017-18 the federal match for clients newly eligible under the Affordable Care Act will decrease by an additional 3 percent to an average of 94.5 percent. The Department estimates that this will result in total expenditures of approximately $95.4 million in Hospital Provider Fee cash funds for those populations. The Department's estimates are incorporated into its various change requests in the November 2, 2015 budget submission.

c. The Children's Basic Health Plan?

The Department estimates that the additional expenditure for the Child Health Plan *Plus* Program in FY 2016-17 resulting from a reduction in the federal match rate from 88.5 percent to 88.13 percent is $0 General Fund and $540,000 cash funds. The Department's estimates are incorporated into its various change requests in the November 2, 2015 budget submission.

43. The Governor set aside $25 million General Fund for a potential increase in Medicare premiums and deductibles paid by Medicaid and "opportunities presented by the update to the prison utilization study and the findings from the Results First project." How much of the $25 million was expected to be needed for Medicare premiums and deductibles and is the recent Congressional action on Medicare premiums and deductibles a savings compared to the Governor's request?

RESPONSE

The Department estimates that the increased Medicare premiums and deductibles will result in increased expenditures of $5.1 million General Fund in FY 2015-16 and $10.8 million General Fund in FY 2016-17. In its November 2, 2015 Budget Request, the Department submitted an informational-only budget request, prioritized as R-1I, indicating that there may be a need of approximately $20.1 million General Fund in FY 2015-16 and $42.5 million General Fund in FY 2016-17 beyond what was being requested in the budget. This was based on preliminary information and provided a 'worst-case scenario' for planning purposes. However, after the budget was published, the Centers for Medicare and Medicaid Services provided new information indicating that the Medicare premiums and deductibles would not be as high as initially projected. On November 12, 2015, the Department provided a revised projection to Joint Budget Committee staff indicating the revised estimates of $5.1 million General Fund in FY 2015-16 and $10.8 million General Fund in FY 2016-17. The Department will provide further updates in its final projection for Medical Services Premiums in February 2016.

44. If the General Assembly had to reduce the optional benefits or eligibility to balance the budget, how would the Department recommend making reductions? What would be the Department's priorities?

RESPONSE

The Governor submitted a balanced budget on November 2, 2015, which contained the Executive Branch's priorities for reductions. The Department cannot provide additional recommendations for budget reductions outside of the established budget process.

The Department notes, however, that reductions to optional benefits or eligibility for the purpose of current year budget balancing are likely to have long-term financial consequences for the state. Optional benefits include all home and community based waiver services, pharmacy, durable medical equipment, and dental care for adults. Reductions in optional services could have impacts on quality of care and could result in higher costs. For example, eliminating pharmacy benefits could have serious impacts on an enrollee's health and result in increased use of the emergency room and hospitalizations.

As noted by Joint Budget Committee staff during the briefing for the Department[16], the eligibility reductions that are possible would either not save a significant amount of General Fund, or would have drastic consequences for the people affected. For example:

- The eligibility expansions authorized under SB 13-200 are funded via the Hospital Provider Fee, not the General Fund, and have disproportionately high federal match rates. To illustrate the consequences: If the General Assembly eliminated eligibility for MAGI Adults[17] in FY 2016-17, state savings would only be 2.5 percent of the total fund reduction; a reduction of $1 billion[18] would achieve only $25 million in savings to the hospital provider fee, and forgo $975,000,000 in federal funds.
- The state optionally covers the elderly and individuals with disabilities above the Supplemental Security Income limit to 300 percent of FPL; to qualify for this category, individuals must qualify for services in a nursing facility (although services can be provided at an individual's home). If this eligibility category were eliminated, these individuals would be responsible for procuring their own services and supports, which would be difficult as most insurance plans do not cover these services. These individuals would be required to liquidate and spend their remaining assets (such as their homes), potentially forcing spouses or dependent children into poverty. Ultimately, it is likely that these individuals would then qualify for Medicaid again after their assets are depleted.

ADDENDUM: OTHER QUESTIONS FOR WHICH SOLELY WRITTEN RESPONSES ARE REQUESTED

1. **Provide a list of any legislation that the Department has: (a) not implemented or (b) partially implemented. Explain why the Department has not implemented or has only partially implemented the legislation on this list.**

RESPONSE

Please see Appendix E.

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[16] See page 80: http://www.tornado.state.co.us/gov_dir/leg_dir/jbc/2015-16/hcpbrf1.pdf

[17] Referred to as "Expansion Adults without Dependent Children to 133 percent FPL" by Joint Budget Committee staff

[18] Roughly, this would be eliminating the MAGI Adults category; JBC staff noted during the briefing that the Department's FY 2014-15 expenditure for this population was $1.04 billion. The Department is using round numbers for illustrative purposes.

2. **Please provide a detailed description of all program hotlines administered by the Department, including:**

   a. **The purpose of the hotline;**

RESPONSE

Colorado Medicaid has one hotline. The Colorado Medicaid Nurse Advice Line provides all Medicaid clients free around-the-clock access to medical information and advice.

   b. **Number of FTE allocated to the hotline;**

RESPONSE

The Colorado Medicaid Nurse Advice Line is subcontracted to Denver Health by the utilization management contractor, eQHealth Solutions. The Nurse Advice Line is staffed with a mixture of Health Information Aids (HIAs) and Registered Nurses (RNs), who are trained to respond to medical triage inquiries from callers 24 hours per day, seven days per week, 365 days per year, including holidays and weekends. The Denver Health NurseLine is managed by seven FTEs: RN Service Leader, Operations Manager, Nurse Manager, HIA Supervisor, Clinical Nurse Educator, and two Charge Nurses. These positions oversee operations of the Nurse Advice Line contract in addition to other contracts. The NurseLine staff (excluding management) consists of 31 RNs and 13 HIAs, including 6.3 FTEs dedicated to the Nurse Advice Line contract. All staff members handle Nurse Advice Line calls.

   c. **The line item through which the hotline is funded; and**

(1) Executive Director's Office (E) Utilization and Quality Review Contracts; Professional Services Contracts.

The Department contract is approximately $80,000 per month, and includes incentive payments for call volume.

   d. **All outcome data used to determine the effectiveness of the hotline.**

RESPONSE

The Nurse Advice Line aids clients in determining the appropriate level of care and resources based on their needs. Outcomes include: 1) reduced unnecessary visits to the emergency room, urgent care centers, and primary care physicians, 2) minimized risk for those clients who did not realize the urgency of their condition and thus warranted more emergent care, and 3) cost-savings because clients sought less costly/lower levels of care or sought more urgent or emergent care as advised, which may have otherwise resulted in more costly care at a later date. Additionally, the Nurse Advice Line provides information and referral for clients to utilize available services to best meet their needs (e.g., Nurse Family Partnership), as well as medical information and education for clients (e.g., diabetes education). This supports a holistic integrated care to improve health factors directly and indirectly impacts health outcomes.

<u>FY 2014-15 Nurse Advice Line Data Summary</u>

VOLUME METRICS

RN TRIAGE CALLS	18,049
HIA NON-TRIAGE CALLS	14,153
TOTAL HANDLED CALLS	32,202

During FY 2014-15, the Nurse Advice Line handled 32,202 calls. This is an increase of 32 percent over FY 2013-14. Registered Nurses triaged 18,049 clients, including medical triage and medical information. Another 14,153 calls were handled by Health Information Aides (HIA); ranging from caller referrals to the Medicaid Customer Service for benefit clarification to resource referrals (e.g. where to obtain oxygen supplies, receive smoking cessation information, how to schedule an appointment, etc.).

QUALITY METRICS

CUSTOMER SERVICE	97%
GUIDELINE ACCURACY	99%
DISPOSITION ACCURACY	99%

All Medicaid calls were reviewed for quality assurance to validate the completeness and accuracy of the data entered into the case record. In addition, an in-depth review of the clinical quality of the record was completed on randomly selected samples of at least 10 percent of the triaged cases. Finally, the case audio recording is reviewed in full to assess customer service, as well as guideline and disposition accuracy. The quality ratings consistently scored between 97 percent and 99 Percent.

METRICS SUMMARY

AVERAGE RN HANDLE TIME	9m:21s
AVERAGE SPEED TO ANSWER	11 sec
ABANDONMENT RATE	3.3%
PENETRATION RATE	3.1%

The Denver Health NurseLine managed the Colorado Medicaid Nurse Advice Line to URAC Healthcare Call Center Standards throughout the fiscal year. The average speed to answer averaged 11 seconds with the URAC standard being 30 seconds. The average abandonment rate was 3.3 percent which is below the URAC standard of 5 Percent. The average RN handle time for RN triage calls reached 9 minutes and 21 seconds and the penetration rate averaged 3.1 percent in FY 2014-15. These metrics meet the service level goals established by the Nurse Advice Line and demonstrate the efficiency of the service.

CALL SOURCE

MEDICAID CARD	16,654
Online	3,843
WALLET CARD	3,598
BENEFIT INFO/ MAILING	819
MAGNET	106

Medicaid clients may receive Nurse Advice Line information from multiple sources. The most successful marketing strategy to date, and a source of 16,654 calls to the Nurse Advice Line in FY 2014- 15, was the inclusion on the back of the Medicaid card. This has been the case since implementation in mid-2011. Prior to this time, the Nurse Advice Line phone number was only distributed through mailings, wallet cards, word of mouth, magnets, and online, each with only moderate effectiveness.

Caller Outcomes

Nurse recommendations for callers' follow-up care are noted in the diagram below: 32 percent of all callers were advised to seek home care (HK); 29 percent were advised to seek an appointment (AP) with a healthcare professional; 14 percent were directed to urgent care (UC); and the remaining 25 percent were directed to the emergency department (ER). When applicable, all triaged clients were offered additional information through the HIPAA secure web-based message portal. This service promotes better health education of clients and contributes to cost avoidance.

Caller information is collected to identify what clients planned to do before calling (predisposition) and what they now plan to do after receiving medical advice (outcome). Based on the information collected below you can see that 5,554 clients called with the intent to seek emergency care with 52 percent of clients instead choosing to utilize a more appropriate avenue for care.

Additionally, 2,091 clients called with the intent to visit an urgent care clinic and 53 percent of clients instead chose a lower level of care that was more appropriate and cost-effective.

Thirty-five percent of the 5,441 callers who planned to make an appointment chose to provide self-care in the home, while 23 percent of callers chose a higher level of care based on medical advice provided during the call.

Fifty percent of the 4,963 callers chose a higher level of care than home care after receiving medical advice during the call.

FY 2014-15 TOTAL - Predisposition vs. Outcome							
Predisposition of Clients		Outcome of Clients				Downgrade	Upgrade
		ER	Urgent Care	Appt.	Home Care		
ED/911	5554	2685	785	1103	981	2869	N/A
Urgent Care	2091	345	641	630	475	1105	345
Appointment	5441	642	633	2259	1907	1907	1275
Home Care	4963	835	504	1142	2482	N/A	2481
Total	**18049**	**4507**	**2563**	**5134**	**5845**	**5881**	**4101**

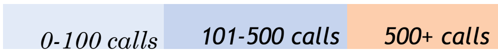
Age and Gender Summary

In FY 2014-15, the Colorado Medicaid clients utilizing the Colorado Medicaid Nurse Advice Line services were 66 percent female and 34 percent male. The largest proportion of clients were in the 18-29 year old age group, representing 29 percent of callers.

County of Origin

The Nurse Advice Line tracks caller residency and utilization among the 64 counties in Colorado. The highest Nurse Advice Line utilization has been in El Paso, Denver, and Adams counties over the past 4 years.

TOP COUNTIES IN COLORADO



EL PASO	3,927
DENVER	2,599
ADAMS	2,491
ARAPAHOE	2,180
JEFFERSON	1,855

3. **Describe the Department's experience with the implementation of the new CORE accounting system.**

    a. **How has the implementation improved business processes in the Department?**

    b. **What challenges has the Department experienced since implementation and how have they been resolved (i.e. training, processes, reports, payroll)?**

    c. **What impact have these challenges had on the Department's access to funding streams?**

    d. **How has the implementation of CORE affected staff workload?**

    e. **Do you anticipate that CORE implementation will result in the need for a permanent increase in staff? If so, indicate whether the Department is requesting additional funding for FY 2016-17 to address it.**

RESPONSE

Please refer to the Office of State Planning and Budgeting's letter to the Joint Budget Committee dated November 30, 2015.

4. **If the Department receives federal funds of any type, please provide a detailed description of any federal sanctions for state activities of which the Department is already aware. In addition, please provide a detailed description of any sanctions that MAY be issued against the Department by the federal government during FFY 2015-16.**

RESPONSE

When discussing Medicaid, the term "sanction" is understood to mean a penalty for having done something that falls outside of the activities allowed by the Social Security Act (SSA). The federal Centers for Medicare and Medicaid Services (CMS) has the power to reduce the state's Federal Financial Participation or to fine the state as a sanction for these violations. CMS has not penalized or sanctioned the Department in its operation of the Medicaid program in at least the past 10 years.

Federal disallowances can be somewhat equated to overpayments for activities allowed by the SSA, but that CMS requires the Department to pay back. Disallowances the Department typically encounters are due to disagreements over the administration of various activities. The Department actively challenges and engages with CMS regarding any disallowances by appealing disallowance to Health and Human Services Departmental Appeals Board (DAB). However, it is unusual for the DAB to rule against CMS' disallowances, even when CMS applies current guidance retroactively or disallows funding for legitimate services provided to eligible clients. The Department stresses that it fully disagrees with the below disallowances.

The Department is currently repaying the following disallowances:

- $12.1 million (covering costs from CY 2000 – CY 2006) related to administrative expenditures for outstationed Medicaid eligibility workers at Denver Health & Hospital Authority. Denver Health

is repaying half of the disallowed amount. The Department paid Denver Health for federally required Medicaid administrative eligibility services, but CMS found technical flaws in the payment methodology by retroactively applying guidance that wasn't traditionally enforced at the time when the Department originally notified CMS of the payment methodology in 2005. The Department has not yet requested a budgetary adjustment for this disallowance as the details were not available in time for the November 2, 2015 budget request. The Department will account for this repayment in a forthcoming budget action.

- $7.4 million (covering claims from April 2010 – December 2012) related to claims in the "Adult Prenatal Coverage in CHP+ and Premium Assistance Pilot Program" demonstration waiver. This is a technical finding following a review the Department's waiver authority, which allowed CMS to recover funds from the Department for services properly rendered by providers to CHP+ eligible clients. The Department notified the Joint Budget Committee of this in its February 15, 2015 Cost and Caseload Estimates binder and then requested funding for this disallowance as part of its November 2, 2015 Budget Request R-3, "CHP+".

The following are pending or potential disallowances from CMS. The Department is currently in discussions and negotiations with CMS on the following:

- $600,000 (covering costs from SFY 2008-09) related to a technical finding related to the random moment sampling methodology and reconciliation of School Health Medicaid Service program related to payments for services properly rendered by school districts to Medicaid eligible children.

- $91,000 (covering costs from March 2012) related to the "Medicaid Adults without Dependent Children" demonstration waiver, which was used to properly prepare counties to process additional client applications prior to the waiver effective date. CMS may declare that proper planning and preparing with the Department's county partners for a waiver implementation are not allowable costs.

- $1.5 million related to the timeframe surrounding a provider settlement and payment for services rendered to Medicaid eligible clients that was authorized by the Department within our authority to administer the Medicaid program.

- $1.6 million (covering claims from FFY 2011 and FFY 2012) related to payments for Medicare Part B deductibles and coinsurance. This is a technical finding following a review the Department's state plan that determined the plan was vague enough to allow CMS to potentially retroactively recover funds for services properly rendered by providers to Medicaid eligible clients.

5. **"Does the Department have any outstanding high priority recommendations as identified in the ""Annual Report of Audit Recommendations Not Fully Implemented"" that was published by the State Auditor's Office and dated October 2015 (link below)? What is the Department doing to resolve the outstanding high priority recommendations?**

   http://www.leg.state.co.us/OSA/coauditor1.nsf/All/4735187E6B48EDF087257ED0007FE8CA/$FILE/1542S%20Annual%20Report.%20Status%20of%20Outstanding%20Audit%20Recommendations,%20As%20of%20June%2030,%202015.%20Informational%20Report.%20October%202015.pdf"

RESPONSE

In reference to the outstanding audit recommendations identified in the Office of the State Auditor's "Annual Report of Audit Recommendations Not Fully Implemented", the Department takes all of these outstanding audit recommendations seriously.

The Department has two recommendations that are considered "high priority" in the OSA report. Recommendation 2014-035 relates to monitoring health and safety surveys and certifications and Recommendation 2014-036B relates to Medicaid claims processing. These two recommendations are in the table below. For both recommendations the Department is delaying full implementation for some of the requirements until the upgraded Medicaid Management Information System (MMIS) is in place. The Department is making the best use of available resources to implement a long-term solution rather than a costly short-term fix that must be re-built in the replacement MMIS. The Department has implemented interim processes for both recommendations.

(See table below for recommendation language and the Department's status update)

Rec No.	Audit Recommendation	Department's Implementation Status Update	Implementation Date
2014-35/2013-24	The Department of Health Care Policy and Financing (Department) should work with the Department of Public Health and Environment (DPHE) to improve internal controls over the monitoring of nursing facilities, intermediate care facilities for the intellectually disabled (ICF/IIDs), and hospitals that provide nursing facility services to ensure payments are only made to certified providers. This should include creating reports to monitor survey dates, maintaining accurate tracking of survey dates, keeping information and documentation current, following up with DPHE for missing documentation, and modifying the Medicaid Management Information System to deny claims for facilities without current certifications in place.	Full implementation will be accomplished with the new MMIS in November 2016. The Department currently receives monthly reports from the Colorado Department of Public Health and Environment on the dates of the surveys it has conducted. This allows the Department to manually identify facilities that have not been surveyed and take appropriate actions.	Partially Implemented - Manual process has been implemented while the full implementation of the system changes has been deferred to November 2016.

Rec No.	Audit Recommendation	Department's Implementation Status Update	Implementation Date
2014-36	The Department of Health Care Policy and Financing (Department) should improve controls over the processing of medical claims for the Medicaid program by: a) Leveraging the results of the federal Office of Inspector General's report to complete its research of claims coding as it applies to the lower-of-price logic and work with the federal Centers for Medicare and Medicaid Services to determine whether changes are needed to the State Plan. Ensuring that claims delayed by third-party insurers are denied if the claim is submitted beyond 365 days from the date of service and ensuring guidance to providers accurately reflects requirements of Department rules. In addition, ensuring the new Medicaid Management Information System is programmed to deny payments delayed by third-part insurers if a claim is submitted beyond 365 days from the date of service.	The Department worked with the federal Centers for Medicare & Medicaid Services (CMS) to make changes to the State Plan based on the results of the federal Office of Inspector General's (OIG) report as it applies to the lower-of-pricing logic for Medicare cross-over claims. The Department submitted a State Plan Amendment to CMS in December 2014 to clarify pricing logic for Medicare cross-over claims. The Department had updated the Department's provider publications related to this finding to clarify that providers should not submit or resubmit claims which will be received by the fiscal agent later than 365 days from the date of service. Further, during the requirement sessions for the new MMIS, the Department will include requirements related to this recommendation to enforce the federal and state regulations.	Partially Implemented – The Department's State Plan has been updated and providers notified, while the full implementation of the system changes has been deferred to November 2016.

6. Is the department spending money on public awareness campaigns related to marijuana? How is the department working with other state departments to coordinate the campaigns?

RESPONSE

The Department is not currently involved in any public awareness campaigns related to marijuana.

7. Based on the Department's most recent available record, what is the FTE vacancy rate by department and by division? What is the date of the report?

RESPONSE

Please refer to the Office of State Planning and Budgeting's letter to the Joint Budget Committee dated November 30, 2015.

8. For FY 2014-15, do any line items in your Department have reversions? If so, which line items, which programs within each line item, and for what amounts (by fund source)? What are the reasons for each reversion? Do you anticipate any reversions in FY 2015-16? If yes, in which programs and line items do you anticipate this reversions occurring? How much and in which fund sources do you anticipate the reversion being?

RESPONSE

Please refer to the Office of State Planning and Budgeting's letter to the Joint Budget Committee dated November 30, 2015.

9. Are you expecting an increase in federal funding with the passage of the FFY 2015-16 federal budget? If yes, in which programs and what is the match requirement for each of the programs?

RESPONSE

Please refer to the Office of State Planning and Budgeting's letter to the Joint Budget Committee dated November 30, 2015.

10. For FY 2014-15, did your department exercise a transfer between lines that is allowable under state statute? If yes, between which line items and programs did this transfer occur? What is the amount of each transfer by fund source between programs and/or line items? Do you anticipate transfers between line items and programs for FY 2015-16? If yes, between which line items/programs and for how much (by fund source)?

RESPONSE

Please refer to the Office of State Planning and Budgeting's letter to the Joint Budget Committee dated November 30, 2015.

Appendix A -Reference Sheet – Approval Timeline Rules and Regulations

State Plan Amendments (SPAs)

Department Internal Clearance

- For significant program changes, it can take up to six months to draft a State Plan Amendment (SPA) and clear it internally. This includes the time required to resolve any budget and policy concerns with the SPA. In addition, the drafting process oftentimes involves a lot of informal communications with the Centers for Medicare and Medicaid Services (CMS) concerning the content of the SPA. If CMS voices initial concerns with the SPA, the drafting process can take longer than it would otherwise. Amendments with less significant changes, such as rate increases and technical changes, can be drafted and cleared much more quickly – most are cleared within one to two weeks.
- Prior to submission to the CMS, SPAs and formal Request for Additional Information (RAI) responses must be approved by the Medicaid Director. *42 CFR §430.12(b).*

Tribal Consultation

- Must be issued at least 30 days prior to submission to CMS. *§1902(a)(73) Social Security Act; Colorado state plan amendment CO 11-001.*

Public Notice

- Public notice must be provided for the SPA. *42 CFR §447.205(a).*
  - Notice must be published before the proposed effective date. *42 CFR §447.205(d)(1).*
  - Publication of this notice must appear as a public announcement in the Colorado Register or in the newspaper of widest circulation for each city with a population of 50,000 or more. *42 CFR §447.205(d)(2).*
    - The Colorado Register is published on the 10th and 25th of each month.
    - Filing deadlines for publication are the 15th and last day of each month. Because it must be submitted to the Secretary of State's office at least 10 days prior to the desired publication date (e.g., to be published on the 25th, the draft public notice must be submitted by no later than the 15th of the same month), the public notice usually must be filed in the month prior to the effective date of the amendment.

CMS Review

- Upon submission, CMS regional staff review the SPA, discuss issues with Department, and consult with CMS central office staff. *42 CFR §430.14.*

90-day Approval Clock

- CMS has 90 days from date of SPA submission to formally notify the Department either that the SPA is disapproved or that additional information is needed in order to make a final determination. If neither of these actions is taken within 90 days, the SPA will be considered approved. *42 CFR §430.16(a)(1).*

Request for Additional Information (RAI)

- If CMS has questions or concerns with the submitted SPA, CMS staff will either notify the Department informally or issue a formal RAI.
    - **Informal RAI** – This generally takes the form of emails and phone calls between CMS regional staff and Department staff. An informal RAI does not stop the 90-day clock.
    - **Formal RAI** – This is issued in a formal letter typically addressed to the Medicaid Director, setting forth the questions or concerns CMS has with the submitted SPA. A formal RAI stops the 90-day clock, which then restarts upon CMS receipt of the Department's formal response. *42 CFR §430.16(a)(2).*

Department Rules

Department Internal Clearance

- The Department must draft and compile a packet of information for the proposed rule. This contains the proposed rule or amendment language, regulatory analysis, fiscal impact analysis, executive director memo, and summary of stakeholder engagement. On average, it takes two to six months to draft the components and clear them internally. Upon completion of internal clearance, the proposed rule packet is submitted to the Department's Medical Services Board (MSB) Coordinator.

Rule-Making Process

- A non-emergency rule can be effective no sooner than 3½ months after the date that the proposed rule or rule amendment has been submitted to the Department's MSB Coordinator. The rule-making process includes the following requirements:
    - Public notice must be published in the Colorado Register. *C.R.S. §24-4-103(3)(a); C.R.S. §24-4-103(11)(a).*
    - A public rule review meeting must be held three weeks prior to MSB first reading as an additional opportunity for stakeholder input and questions.
    - The Attorney General's (AG's) office must provide an initial review prior to MSB first reading. The AG's office returns reviewed copy with comments to Department within two weeks of initial receipt. The AG's office completes a final review of the rule following its adoption by the MSB. *C.R.S. §24-4-103(8)(b).*
    - Readings at two MSB meetings. MSB meetings occur on the second Friday of every month. *C.R.S. §25.5-1-303(4); C.R.S. §25.5-1-302; and Medical Services Board By-Laws.*

- If proposed rule/amendment is approved by the MSB, the earliest possible effective date is the last day of the month following the month of the MSB vote.

Home and Community Based Services Waiver Amendments

Department Internal Clearance

- Depending on the complexity and scope of proposed waiver changes, the time to draft and clear an amendment application can range from four weeks to a number of months. On average, the Department estimates two to four months to draft a waiver amendment, engage stakeholders, incorporate all policy revisions, revise waiver utilization and expenditure estimates, and clear the application internally.
- Prior to submission to CMS, amendments and formal RAI responses must be submitted to the Medicaid Director or designee for review and signature. *42 CFR §430.25(e).*

Tribal Consultation

- Must be issued at least 60 days prior to submission to CMS and must provide Tribal Governments with at least 30 days to respond. *§1902(a)(73) Social Security Act; Colorado state plan amendment CO 11-001; State Medicaid Director Letter #01-024.*

Public Input

- Waiver amendments must include a public input process. *42 CFR §441.304(f).*
    - Public input process must include at least two statements of public notice and input procedures, with one in a non-electronic and one in a web-based format, and include electronic and non-electronic methods of comment. The Department must share the entirety of the waiver and provide paper copies upon request.
    - Public notice and comment period must be at least 30 days in length and be completed at least 30 days prior to implementation of proposed change or submission to CMS, whichever comes first.
    - Public input process must be sufficient in light of the scope of the changes proposed and ensure meaningful opportunities for input for individuals served or eligible to be served, as determined by CMS.
- Public notice must be provided for requests for significant changes to the rate methodology, as determined by CMS. *42 CFR §447.205(a).*
    - Notice must be published before the proposed effective date of the change to rate methodology. *42 CFR §447.205(d)(1).*
    - Publication of this notice must appear as a public announcement in the Colorado Register or in the newspaper of widest circulation for each city with a population of 50,000 or more. *42 CFR §447.205(d)(2).*
    - CMS has stated that significant changes to the rate methodology must follow the public input requirements as described in 42 CFR §441.304(f) as well, which includes publishing two forms of notice, one in a non-electronic and one in a web-based format. CMS reviews each wavier action

independently to determine if the input process was sufficient to reach the individuals receiving or eligible to receive services, and the allowable format can vary depending on the type of action. In general, the Colorado Register is not considered sufficient non-electronic notice for a substantive waiver action. *Letter from CMS regarding the Department's public notice plan, dated July 31, 2015.*

CMS Review

- Upon submission, CMS regional staff review waiver amendment, discuss issues with Department, and consult with CMS central office staff. *42 CFR §430.25(f)(2).*

90-day Approval Clock

- CMS has 90 days from date of submission to formally notify the Department either that the amendment is disapproved or that additional information is needed in order to make a final determination. If neither of these actions is taken within 90 days, the amendment will be considered approved. *42 CFR §430.25(f)(3).*

Request for Additional Information (RAI)

- If CMS has questions or concerns with the submitted amendment, CMS staff will either notify the Department informally or issue a formal RAI.
    - **Informal RAI –** This generally takes the form of emails and phone calls between CMS regional staff and Department staff. An informal RAI does not stop the 90-day clock.
    - **Formal RAI –** This is issued in a formal letter typically addressed to the Medicaid Director, setting forth the questions or concerns CMS has with the submitted amendment. The original 90-day clock does not stop upon receipt of a formal RAI. However, a new 90-day clock begins when CMS receives the Department's response. *42 CFR §430.25(f)(3).*

Limitations on Retroactive Waiver Amendment Effective Dates

- Requests for waiver amendments may be made retroactive to the date on or after the first day of the current waiver year, unless the request includes substantive changes, as determined by CMS. *42 CFR §441.304(d).*
- Requests for waiver amendments that include substantive changes may only take effect on or after the date when the amendment is approved by CMS. *42 CFR §441.304(d)(2).*
    - Substantive changes include, but are not limited to, revisions to services available under the waiver including elimination or reduction of services, or reduction in the scope, amount, and duration of any service, a change in the qualifications of service providers, changes in rate methodology, or a constriction in the eligible population. *42 CFR §441.304(d)(1).*

Appendix B - Estimated 1202 Bump Payment Impacts to Providers and Dollars			
County	**Urban/ Rural/ Frontier designation**	**FY 2014-15 Number of Providers**	**Estimated FY 2016-17 Expenditure**
Adams	Urban	1,930	$28,102,939
Alamosa	Rural	73	$505,846
Arapahoe	Urban	1,636	$18,145,055
Archuleta	Rural	32	$426,641
Baca	Frontier	10	$73,488
Bent	Frontier	4	$2,476
Boulder	Urban	988	$5,407,915
Broomfield	Urban	79	$592,053
Chaffee	Rural	44	$390,661
Cheyenne	Frontier	3	$5,291
Clear Creek	Urban	0	$0
Conejos	Rural	11	$269,766
Costilla	Frontier	3	$4,947
Crowley	Rural	0	$0
Custer	Frontier	2	$90,790
Delta	Rural	72	$598,913
Denver	Urban	3,206	$22,406,662
Dolores	Frontier	7	$14,756
Douglas	Urban	458	$3,614,709
Eagle	Rural	104	$791,858
Elbert	Urban	3	$14,109
El Paso	Urban	1,338	$22,495,047
Fremont	Rural	71	$571,281
Garfield	Rural	153	$1,407,922
Gilpin	Urban	0	$0
Grand	Rural	27	$618,626
Gunnison	Frontier	39	$190,171
Hinsdale	Frontier	0	$0
Huerfano	Frontier	15	$163,098
Jackson	Frontier	0	$0
Jefferson	Urban	1,047	$7,763,615
Kiowa	Frontier	1	$7,625
Kit Carson	Frontier	6	$42,380
Lake	Rural	9	$204,042
La Plata	Rural	203	$1,184,728
Larimer	Urban	848	$9,259,002

Appendix B - Estimated 1202 Bump Payment Impacts to Providers and Dollars			
County	**Urban/ Rural/ Frontier designation**	**FY 2014-15 Number of Providers**	**Estimated FY 2016-17 Expenditure**
Las Animas	Frontier	28	$746,199
Lincoln	Frontier	4	$129,928
Logan	Rural	62	$226,027
Mesa	Urban	493	$3,105,765
Mineral	Frontier	1	$11,580
Moffat	Frontier	31	$697,056
Montezuma	Rural	65	$520,223
Montrose	Rural	106	$910,017
Morgan	Rural	62	$754,878
Otero	Rural	30	$191,798
Ouray	Rural	8	$26,969
Park	Urban	5	$29,908
Phillips	Rural	8	$72,288
Pitkin	Rural	21	$179,248
Prowers	Rural	47	$242,488
Pueblo	Urban	492	$5,117,607
Rio Blanco	Frontier	10	$206,407
Rio Grande	Rural	36	$89,259
Routt	Rural	64	$369,690
Saguache	Frontier	4	$37,117
San Juan	Frontier	6	$1,665
San Miguel	Frontier	13	$67,297
Sedgwick	Frontier	2	$1,018
Summit	Rural	40	$380,936
Teller	Urban	30	$471,385
Washington	Frontier	0	$0
Weld	Urban	470	$4,795,472
Yuma	Frontier	17	$326,997
Totals		**14,577**	**$145,075,634**

Note:
The number of providers is based on claims paid for in January-June 2015.

Appendix C - Summary of Medicaid Agency Reimbursement as a Percentage of Commercial Billed Charges		
State	**Pediatric Dental Services (2013)**	**Adult Dental Services (2014)**
Alabama	53.60%	N/A
Alaska	61.50%	58.40%
Arizona	54.70%	N/A
Arkansas	67.20%	60.50%
California	29.00%	29.00%
Colorado	45.10%	36.60%
Connecticut	66.80%	34.20%
Delaware	81.10%	N/A
District of Columbia	58.40%	51.90%
Florida	36.60%	N/A
Georgia	54.00%	N/A
Hawaii	47.10%	N/A
Idaho	44.80%	N/A
Illinois	32.50%	13.80%
Indiana	55.70%	48.60%
Iowa	41.80%	43.60%
Kansas	47.20%	N/A
Kentucky	44.00%	41.40%
Louisiana	61.00%	N/A
Maine	43.60%	N/A
Maryland	47.80%	N/A
Massachusetts	57.90%	43.70%
Michigan	32.50%	20.30%
Minnesota	26.70%	27.10%
Mississippi	47.60%	N/A
Missouri	40.20%	N/A
Montana	52.90%	54.10%
Missouri	40.20%	N/A
Montana	52.90%	N/A
Nebraska	43.00%	N/A
Nevada	48.40%	N/A
New Hampshire	39.50%	N/A
New Jersey	68.80%	17.80%
New Mexico	49.30%	49.80%

New York	37.10%	37.10%
North Carolina	48.20%	45.80%
North Dakota	62.70%	60.20%
Ohio	40.50%	41.50%
Oklahoma	54.50%	N/A
Oregon	32.60%	33.40%
Pennsylvania	42.80%	43.10%
Rhode Island	38.60%	29.20%
South Carolina	74.10%	N/A
South Dakota	51.30%	51.60%
Tennessee	53.90%	N/A
Texas	59.50%	N/A
Utah	42.50%	N/A
Vermont	49.70%	54.10%
Virginia	47.40%	43.60%
Washington	40.90%	28.70%
West Virginia	69.90%	N/A
Wisconsin	31.50%	29.60%
Wyoming	61.20%	52.50%
Source:		
http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_1014_3.ashx		
Notes: Source documentation includes additional detail by state, historical data, and methodology.		

APPENDIX D: QUESTION 39 – SB13-200 COMPARISON

Question 39 Appendix
Table 1 - SB 13-200 Medicaid Expansion Populations Estimates
Physical and Behavioral Health Expenditure

FY	Estimate		MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	MAGI Eligible Children	SB 11-008 Eligible Children	Foster Care	Non-Citizens- Emergency Services	TOTAL
FY 2013-14	SB 13-200	Caseload	369	6,534	54,834	768	0	76	26	62,607
		Expenditure	$722,779	$16,375,445	$286,263,742	$593,554	$0	$425,841	$458,958	$304,840,319
	November 2015 Estimate	Caseload	4,802	8,957	68,564	10,190	693	432	184	93,822
		Expenditure	$11,586,845	$21,747,260	$324,238,163	$14,040,731	$878,823	$2,422,012	$2,856,160	$377,769,994
	Difference	*Caseload*	*(4,433)*	*(2,423)*	*(13,730)*	*(9,423)*	*(693)*	*(356)*	*(158)*	*(31,215)*
	(SB 13-200 - Nov 2015 Estimate)	***Expenditure***	***($10,864,066)***	***($5,371,815)***	***($37,974,421)***	***($13,447,177)***	***($878,823)***	***($1,996,171)***	***($2,397,202)***	***($72,929,675)***
FY 2014-15	SB 13-200	Caseload	2,300	17,189	144,244	4,783	0	553	92	169,161
		Expenditure	$4,806,287	$47,896,117	$842,625,970	$3,990,135	$0	$3,108,297	$1,651,705	$904,078,511
	November 2015 Estimate	Caseload	11,343	32,902	221,508	19,122	1,998	1,800	526	289,199
		Expenditure	$28,644,669	$89,537,634	$1,013,498,778	$29,686,410	$2,601,043	$12,142,728	$7,835,822	$1,183,947,084
	Difference	*Caseload*	*(9,043)*	*(15,713)*	*(77,264)*	*(14,340)*	*(1,998)*	*(1,247)*	*(434)*	*(120,039)*
	(SB 13-200 - Nov 2015 Estimate)	***Expenditure***	***($23,838,382)***	***($41,641,517)***	***($170,872,808)***	***($25,696,275)***	***($2,601,043)***	***($9,034,431)***	***($6,184,117)***	***($279,868,573)***
FY 2015-16	SB 13-200	Caseload	5,213	19,870	166,748	10,840	0	1,116	159	203,946
		Expenditure	$11,087,321	$56,348,538	$991,336,063	$9,204,678	$0	$6,304,373	$2,926,912	$1,077,207,885
	November 2015 Estimate	Caseload	12,597	38,123	273,841	20,476	2,256	1,744	539	349,576
		Expenditure	32,185,773	$105,931,825	$1,308,749,123	33,236,006	3,048,341	$12,473,454	$7,839,184	$1,503,463,706
	Difference	*Caseload*	*(7,384)*	*(18,253)*	*(107,093)*	*(9,636)*	*(2,256)*	*(628)*	*(380)*	*(145,630)*
	(SB 13-200 - Nov 2015 Estimate)	***Expenditure***	***($21,098,452)***	***($49,583,287)***	***($317,413,060)***	***($24,031,328)***	***($3,048,341)***	***($6,169,081)***	***($4,912,272)***	***($426,255,821)***

Question 39 Appendix
Table 2.1 - SB 13-200 Medicaid Expansion Populations Estimates
Physical Health Expenditure

FY	Estimate		MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	MAGI Eligible Children	SB 11-008 Eligible Children	Foster Care	Non-Citizens- Emergency Services	TOTAL
FY 2013-14	SB 13-200	Caseload		6,534	54,834			76	26	61,470
		Per Capita		$2,242.74	$4,653.67			$3,466.00	$17,652.24	$4,401.43
		Expenditure		$14,654,074	$255,179,457			$263,416	$458,958	$270,555,905
	November 2015 Estimate	Caseload		7,144	68,564			432	184	76,324
		Per Capita		$2,301.74	$3,667.49			$3,475.76	$15,522.61	$3,567.15
		Expenditure		$16,443,631	$251,455,951			$1,501,528	$2,856,160	$272,257,270
	Difference (Dept Estimate - Nov 2015 Estimate)	*Caseload*		*(610)*	*(13,730)*			*(356)*	*(158)*	*(14,854)*
		Per Capita		*($59.00)*	*$986.18*			*($9.76)*	*$2,129.63*	*$834.28*
		Expenditure		*($1,789,557)*	*$3,723,506*			*($1,238,112)*	*($2,397,202)*	*($1,701,365)*
FY 2014-15	SB 13-200	Caseload		17,189	144,244			553	92	162,078
		Per Capita		$2,480.39	$5,179.50			$3,399.32	$17,953.32	$4,894.43
		Expenditure		$42,635,373	$747,112,180			$1,879,824	$1,651,705	$793,279,082
	November 2015 Estimate	Caseload		28,618	221,508			1,800	526	252,452
		Per Capita		$2,486.74	$3,884.89			$4,193.72	$14,897.00	$3,751.54
		Expenditure		$71,165,525	$860,534,214			$7,548,696	$7,835,822	$947,084,257
	Difference (Dept Estimate - Nov 2015 Estimate)	*Caseload*		*(11,429)*	*(77,264)*			*(1,247)*	*(434)*	*(90,374)*
		Per Capita		*($6.35)*	*$1,294.61*			*($794.40)*	*$3,056.32*	*$1,142.89*
		Expenditure		*($28,530,152)*	*($113,422,034)*			*($5,668,872)*	*($6,184,117)*	*($153,805,175)*
FY 2015-16	SB 13-200	Caseload		19,870	166,748			1,116	159	187,893
		Per Capita		$2,524.38	$5,271.22			$3,393.08	$18,408.25	$4,980.70
		Expenditure		$50,159,409	$878,965,590			$3,786,677	$2,926,912	$935,838,588
	November 2015 Estimate	Caseload		33,634	273,841			1,744	539	309,758
		Per Capita		$2,510.00	$4,044.11			$4,537.04	$14,543.94	$3,898.58
		Expenditure		$84,421,340	$1,107,443,127			$7,912,598	$7,839,184	$1,207,616,249
	Difference (Dept Estimate - Nov 2015 Estimate)	*Caseload*		*(13,764)*	*(107,093)*			*(628)*	*(380)*	*(121,865)*
		Per Capita		*$14.38*	*$1,227.11*			*($1,143.96)*	*$3,864.31*	*$1,082.12*
		Expenditure		*($34,261,931)*	*($228,477,537)*			*($4,125,921)*	*($4,912,272)*	*($271,777,661)*

Question 39 Appendix
Table 2.2 - SB 13-200 Welcome-Mat Effect Estimates
Physical Health Expenditure

FY	Estimate		MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	MAGI Eligible Children	SB 11-008 Eligible Children	Foster Care	Non-Citizens- Emergency Services	TOTAL
FY 2013-14	SB 13-200	Caseload	369	0		768	0			1,137
		Per Capita	$1,752.85	$0.00		$671.95	$0.00			$1,022.89
		Expenditure	$646,801	$0		$515,719	$0			$1,162,520
	November 2015 Estimate [1]	Caseload	4,802	1,813		10,190	693			17,498
		Per Capita	$2,174.28	$1,743.09		$1,207.94	$1,044.37			$1,522.10
		Expenditure	$10,440,708	$3,160,509		$12,308,919	$723,749			$26,633,885
	Difference (SB 13-200 - Nov 2015 Estimate)	*Caseload*	*(4,433)*	*(1,813)*		*(9,423)*	*(693)*			*(16,362)*
		Per Capita	*($421.43)*	*($1,743.09)*		*($535.99)*	*($1,044.37)*			*($499.21)*
		Expenditure	*($9,793,907)*	*($3,160,509)*		*($11,793,200)*	*($723,749)*			*($25,471,365)*
FY 2014-15	SB 13-200	Caseload	2,300	0		4,783	0			7,083
		Per Capita	$1,860.17	$0.00		$718.02	$0.00			$1,088.92
		Expenditure	$4,278,381	$0		$3,433,925	$0			$7,712,306
	November 2015 Estimate [1]	Caseload	11,343	4,284		19,122	1,998			36,747
		Per Capita	$2,287.17	$1,893.37		$1,370.87	$1,120.47			$1,701.01
		Expenditure	$25,943,324	$8,111,211		$26,213,814	$2,238,692			$62,507,041
	Difference (SB 13-200 - Nov 2015 Estimate)	*Caseload*	*(9,043)*	*(4,284)*		*(14,340)*	*(1,998)*			*(29,665)*
		Per Capita	*($427.00)*	*($1,893.37)*		*($652.85)*	*($1,120.47)*			*($612.09)*
		Expenditure	*($21,664,943)*	*($8,111,211)*		*($22,779,889)*	*($2,238,692)*			*($54,794,735)*
FY 2015-16	SB 13-200	Caseload	5,213	0		10,840	0			16,053
		Per Capita	$1,893.253	$0.00		$730.77	$0.00			$1,108.27
		Expenditure	$9,869,528	$0		$7,921,579	$0			$17,791,107
	November 2015 Estimate [1]	Caseload	12,597	4,489		20,476	2,256			39,818
		Per Capita	$2,289.60	$1,908.34		$1,443.75	$1,171.71			$1,748.31
		Expenditure	$28,842,072	$8,566,526		$29,562,226	$2,643,375			$69,614,199
	Difference (SB 13-200 - Nov 2015 Estimate)	*Caseload*	*(7,384)*	*(4,489)*		*(9,636)*	*(2,256)*			*(23,765)*
		Per Capita	*($396.35)*	*($1,908.34)*		*($712.98)*	*($1,171.71)*			*($640.04)*
		Expenditure	*($18,972,544)*	*($8,566,526)*		*($21,640,647)*	*($2,643,375)*			*($51,823,092)*

(1) This estimate of per-capita for FY 2013-14 assumes the original Department estimates were correct that per capita for EBNE clients would be 75% of the cost of the standard population. The Department has maintained these assumptions through FY 2014-15 and FY 2015-16.

Question 39 Appendix
Table 3.1 - SB 13-200 Medicaid Expansion Populations Estimates
Behavioral Health Expenditure

FY	Estimate		MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	MAGI Eligible Children	SB 11-008 Eligible Children	Foster Care	Non-Citizens- Emergency Services	TOTAL
FY 2013-14	SB 13-200	Caseload		6,534	54,834			76	26	61,470
		Per Capita		$263.45	$566.88			$2,137.17	$0.00	$536.33
		Expenditure		$1,721,371	$31,084,285			$162,425	$0	$32,968,081
	November 2015 Estimate	Caseload		7,144	68,564			432	184	76,324
		Per Capita		$215.56	$1,061.53			$2,130.75	$0.00	$985.84
		Expenditure		$1,539,961	$72,782,212			$920,484	$0	$75,242,657
	Difference (SB 13-200 - Nov 2015 Estimate)	*Caseload*		*(610)*	*(13,730)*			*(356)*	*(158)*	*(14,854)*
		Per Capita		*$47.89*	*($494.65)*			*$6.42*	*$0.00*	*($449.51)*
		Expenditure		*$181,410*	*($41,697,927)*			*($758,059)*	*$0*	*($42,274,576)*
FY 2014-15	SB 13-200	Caseload		17,189	144,244			553	92	162,078
		Per Capita		$306.05	$662.17			$2,221.47	$0.00	$629.35
		Expenditure		$5,260,744	$95,513,790			$1,228,473	$0	$102,003,007
	November 2015 Estimate	Caseload		28,618	221,508			1,800	526	252,452
		Per Capita		$329.30	$690.56			$2,552.24	$0.00	$661.44
		Expenditure		$9,423,907	$152,964,564			$4,594,032	$0	$166,982,503
	Difference (SB 13-200 - Nov 2015 Estimate)	*Caseload*		*(11,429)*	*(77,264)*			*(1,247)*	*(434)*	*(90,374)*
		Per Capita		*($23.25)*	*($28.39)*			*($330.77)*	*$0.00*	*($32.10)*
		Expenditure		*($4,163,163)*	*($57,450,774)*			*($3,365,559)*	*$0*	*($64,979,496)*
FY 2015-16	SB 13-200	Caseload		19,870	166,748			1,116	159	187,893
		Per Capita		$311.48	$673.89			$2,256.00	$0.00	$644.39
		Expenditure		$6,189,129	$112,370,473			$2,517,696	$0	$121,077,298
	November 2015 Estimate	Caseload		33,634	273,841			1,744	539	309,758
		Per Capita		$349.49	$735.12			$2,615.17	$0.00	$702.55
		Expenditure		$11,754,747	$201,305,996			$4,560,856	$0	$217,621,599
	Difference (SB 13-200 - Nov 2015 Estimate)	*Caseload*		*(13,764)*	*(107,093)*			*(628)*	*(380)*	*(121,865)*
		Per Capita		*($38.01)*	*($61.23)*			*($359.17)*	*$0.00*	*($58.16)*
		Expenditure		*($5,565,618)*	*($88,935,523)*			*($2,043,160)*	*$0*	*($96,544,301)*

Question 39 Appendix
Table 3.2 - SB 13-200 Welcome-Mat Effect Estimates
Behavioral Health Expenditure

FY	Estimate		MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	MAGI Eligible Children	SB 11-008 Eligible Children	Foster Care	Non-Citizens-Emergency Services	TOTAL
FY 2013-14	SB 13-200	Caseload	369	0		768	0			1,137
		Per Capita	$205.90	$0.00		$101.41	$0.00			$135.34
		Expenditure	$75,978	$0		$77,835	$0			$153,813
	November 2015 Estimate [1]	Caseload	4,802	1,813		10,190	693			17,498
		Per Capita	$238.68	$332.66		$169.95	$223.77			$207.80
		Expenditure	$1,146,137	$603,159		$1,731,812	$155,074			$3,636,182
	Difference (SB 13-200 - Nov 2015 Estimate)	*Caseload*	*(4,433)*	*(1,813)*		*(9,423)*	*(693)*			*(16,362)*
		Per Capita	*($32.78)*	*($332.66)*		*($68.54)*	*($223.77)*			*($72.47)*
		Expenditure	*($1,070,159)*	*($603,159)*		*($1,653,977)*	*($155,074)*			*($3,482,369)*
FY 2014-15	SB 13-200	Caseload	2,300	0		4,783	0			7,083
		Per Capita	$229.52	$0.00		$116.30	$0.00			$153.07
		Expenditure	$527,906	$0		$556,210	$0			$1,084,116
	November 2015 Estimate [1]	Caseload	11,343	4,284		19,122	1,998			36,747
		Per Capita	$238.15	$195.38		$181.60	$181.36			$200.65
		Expenditure	$2,701,345	$836,991		$3,472,596	$362,351			$7,373,283
	Difference (SB 13-200 - Nov 2015 Estimate)	*Caseload*	*(9,043)*	*(4,284)*		*(14,340)*	*(1,998)*			*(29,665)*
		Per Capita	*($8.63)*	*($195.38)*		*($65.30)*	*($181.36)*			*($47.58)*
		Expenditure	*($2,173,439)*	*($836,991)*		*($2,916,386)*	*($362,351)*			*($6,289,167)*
FY 2015-16	SB 13-200	Caseload	5,213	0		10,840	0			16,053
		Per Capita	$233.61	$0.00		$118.37	$0.00			$155.79
		Expenditure	$1,217,793	$0		$1,283,099	$0			$2,500,892
	November 2015 Estimate [1]	Caseload	12,597	4,489		20,476	2,256			39,818
		Per Capita	$265.44	$264.92		$179.42	$179.51			$216.28
		Expenditure	$3,343,701	$1,189,212		$3,673,780	$404,966			$8,611,659
	Difference (SB 13-200 - Nov 2015 Estimate)	*Caseload*	*(7,384)*	*(4,489)*		*(9,636)*	*(2,256)*			*(23,765)*
		Per Capita	*($31.83)*	*($264.92)*		*($61.05)*	*($179.51)*			*($60.49)*
		Expenditure	*($2,125,908)*	*($1,189,212)*		*($2,390,681)*	*($404,966)*			*($6,110,767)*

(1) This estimate of per-capita for FY 2013-14 assumes the original Department estimates were correct that per capita for EBNE clients would be 75% of the cost of the standard population. The Department has maintained these assumptions through FY 2014-15 and FY 2015-16.

APPENDIX E: LEGISLATION NOT FULLY IMPLEMENTED 2008-2015

Total HCPF Related Bills 2008-2015: 184
Not Fully Implemented 2008-2015: 12

The Department has records of the status of implementation for legislation dating back to 2008. Over the last six years, the Department has successfully implemented over 160 bills. Since Medicaid is governed as a partnership between the states and the federal government, any new Medicaid programs or changes to the current program that requires federal funding must be approved by the Centers for Medicare and Medicaid Services (CMS). Several bills passed during this period were contingent upon federal approval which was denied. Without federal financial participation, the Department was unable to implement these bills.

Many of the bills also require system changes to the Department's claims system, the Medicaid Management Information System (MMIS). Built in the 1970s, any changes to the system required manual workarounds and prioritization since the system cannot handle multiple changes at once. While the Department often made note of the system change timeline in its fiscal note response to Legislative Council, the feasibility of implementing a system change was not always aligned with the implementation date of the bill. In 2013, the Joint Budget Committee approved funding to rebuild the MMIS system that would allow for faster modifications as programs are created and changed. Some of the bills have not been implemented because the restrictions on the current MMIS system. Once operational in 2016, the new MMIS will allow for all of those affected bills to be implemented.

Legislation	Legislation Summary	Barriers to Implementation	FTE
HB15-1186 Services for Children with Autism (Young / Steadman)	This bill expands eligibility for the Autism Waiver Program by increasing the age limit from 6 years of age to 8 years of age. If a child enrolls prior to his or her eighth birthday, he or she is eligible to receive services for a total of three full years. The bill removes the existing per child spending cap of $25,000 per year and instead directs the Medical Services Board to set the per child spending cap each year based on available appropriations. The bill eliminates the program waiting list.	The Department cannot implement this bill as written because it was contingent on approval from the federal Centers Medicare and Medicaid Services (CMS). CMS denied the waiver amendment on September 14, 2015. The Department sent communication to parents and a broad scope of stakeholders. The communications informed parents and stakeholders how to access the services available in the Children w/ Autism Waiver through the Early Periodic Screening, Diagnostic, and Treatment Waiver (EPSDT).	0.8 (Temp)
SB15-011 Pilot Prog Spinal Cord Injury Alternative Medicine (Todd / Primavera)	This bill continues the Medicaid Spinal Cord Injury Alternative Medicine Pilot Program through September 1, 2020, and expands the program to serve additional clients. Under the pilot, Medicaid clients with spinal cord injuries who are eligible for home- and community-based services (HCBS) are allowed to receive complementary or alternative medicines. Under Senate Bill 15-011, the existing cap of 67 clients would be raised to at least 100 clients, subject to available appropriations and matching federal funds. Other provisions of the bill direct HCPF to	Full implementation of SB15-011 is delayed pending federal approval of the 5-year HCBS-SCI waiver renewal from the Centers for Medicare and Medicaid Services (CMS) and matching federal funds. The Department is actively working with our federal partners at CMS to gain approval but does not currently have an estimated implementation date. Although this bill has not yet been fully implemented, some elements of the bill have been implemented such as frequent collaboration with the volunteer outreach coordinator, monthly SCI Advisory Committee meetings, the selection of a third-party vendor to conduct the independent evaluation, and the initiation of the enrollment process for two new Complementary and Integrative	1

Legislation	Legislation Summary	Barriers to Implementation	FTE
	continue using a volunteer outreach coordinator and extends the deadline for an independent evaluation of the pilot to no later than January 1, 2020. The authority to seek gifts, grants, and donations for the program is repealed.	Health service providers account for the pending increase to the client cap.	
HB14-1357 In-home Support Services in Medicaid Program (Young/Aguilar)	The bill makes changes to the IHSS delivery model for HCBS. The changes include: * Expanding IHSS to include persons enrolled in the spinal cord injury waiver pilot program; * Clarifying that IHSS may be provided in the home or in the community; * Clarifying that the person receiving services, or his or her authorized representative, may schedule, manage, supervise and direct the work of the attendant providing services; * Requiring the MSB promulgate rules for IHSS to include rules relating to nurse oversight that permit the person receiving services, or his or her representative, in conjunction with the in-home support services agency to determine the amount of nursing oversight; * Removing the limit of IHSS personal care hours family members can be reimbursed to provide and requiring the MSB to promulgate rules, as necessary, regarding reimbursement for services; and, *Require the Department to submit a plan to expand the provision of IHSS to the CMHS, BI, SLS, and CES waivers.	CMS has not yet approved the proposed waiver amendments to the Elderly, Blind, and Disabled, Children's Home- and Community-Based Services, and Spinal Cord Injury waivers. If and when the Department receives CMS approval, the Department will implement the changes to those waivers immediately. The Department submitted a plan to expand the provision of IHSS to the Community Mental Health Supports, Brain Injury, Supported Living Services, and Children's Extensive Support waivers to the General Assembly on April 20, 2015. HB 14-1357 aligned statute with practice in regards to offering IHSS to clients enrolled in the SCI waiver.	
SB 10-061 Medicaid Hospice Room and Board Charges (Tochtrop, Williams/Soper, Riesberg)	Nursing facilities are to be paid directly for inpatient services provided to a Medicaid recipient who elects to receive hospice care; reimburse inpatient hospice facilities for room and board.	The Department cannot implement this bill as written because it is contingent upon federal financial participation. In order for the State to receive federal financial participation, hospice providers must bill for all services and 'pass-through' the room-and-board payment to the nursing facility. CMS has indicated to the Department that there is no mechanism through State Plan or waiver to reimburse class I nursing facilities directly for room-and-board, or to pay a provider licensed as a hospice as if they were a licensed class I nursing facility. Although licensed inpatient hospice facilities are a hospice provider type recognized by the Colorado Department of Public Health and	0

Legislation	Legislation Summary	Barriers to Implementation	FTE
		Environment for the provision of residential and inpatient hospice care, they must be licensed as a class I nursing facility to be reimbursed by the state for room-and-board with federal financial participation.	
SB 10-117 Over-the-Counter Medications (Foster/Primavera)	This bill adds over-the-counter medications identified through the drug utilization review process to services provided under Medicaid when the medications are prescribed by a licensed practitioner or a qualified licensed pharmacist	In order to implement the bill, system changes are needed in the Pharmacy Benefit Management System (PBMS) which will be completed in 2016. The Department did not anticipate the amount of hours it would require to make the necessary system changes in 2010. The Department was also restricted by the current system that would require pharmacists to enroll individually as providers. Given the extra burden of enrolling twice, the Department assumed low participation among pharmacists and decided to wait until the PBMS was reprocured to eliminate these barriers to participation.	0
HB 09-1103 Presumptive Eligibility Long-Term Care (Riesberg/Newell)	Persons in need of long-term care who declare all of the information necessary to determine eligibility under the Medicaid program shall be presumptively eligible for benefits.	The bill authorized the Department to seek federal approval to allow people who are in need of long-term care to be presumptively eligible for Medicaid. The bill directed the Department to seek federal approval from CMS, which was denied. Without federal approval, the Department was not able to implement the legislation.	0
HB 09-1252 Local Access to Health Care (Roberts/Isgar)	This bill expands the "Local Access to Health Care Pilot Program Act" to allow the creation of a pilot program in the San Luis valley.	The bill was permissive and dependent upon gifts, grants, and donations. Not enough funds were collected to expand the program.	0
HB 08-1072 Medicaid Buy-In for Persons with Disabilities (Soper/Williams)	This bill establishes a Medicaid Buy-in Program for people with disabilities who earn too much to qualify for Medicaid and for those whose medical condition improves while participating in the program.	The Medicaid Buy-in Program for people with disabilities has been implemented. The Department has not implemented a buy-in for the “medically improved” group. The goal of the buy-in for the medically improved was to allow clients with improved but preexisting conditions to access health care. Under federal rule, the earliest any of these potential clients could have been covered was March 2013. With SB 13-200 and SB 11-200 these clients will either qualify for Medicaid as part of the expansion population or be able to seek subsidies on private health insurance through Connect for Health regardless of a preexisting condition.	2

Legislation	Legislation Summary	Barriers to Implementation	FTE
SB 08-003 Medicaid Family Planning (Boyd/Riesberg)	This bill provides flexibility in the income eligibility level for the Family Planning Pilot Program. Currently, the income eligibility level is set in statute at 150 percent of the federal poverty level (FPL), but this bill allows the level to be established in the federal waiver sought for the program.	The Department worked extensively with CMS and stakeholders to submit a waiver in order to implement the program. In December 2011, the Department withdrew its application for a waiver after learning that it would cost over $800,000 to make system changes to the MMIS and the earliest the changes could take effect would be January 1, 2014 due to national code freezes. As of January 1, 2014 this population would be covered under the expansion or could access subsidized private insurance through Connect for Health Colorado.	0
SB 08-006 Suspend Medicaid for Confined Persons (Boyd/Solano)	Confined persons will continue to be eligible for Medicaid benefits, if Medicaid benefits were being received immediately prior to designation as a confined person, provided availability of Federal funds	CMS requires that clients who became incarcerated have their eligibility re-determined. Once incarcerated, the client would become a household of one - making them ineligible for Medicaid as Medicaid does not traditionally cover single adults. Until the recent Adults without Dependent Children (AwDC) expansion created by HB 09-1293, there was no category for single adults. Prior to January 1, 2014, there was a cap on the amount of clients covered under the AwDC program at 10,000 clients. The Department could implement this legislation now that childless adults can qualify for Medicaid under the Medicaid expansion. However, the Department cannot fully implement this bill due to the high cost to implement in CBMS and the current MMIS. The Department plans to implement this functionality in the new MMIS, which is scheduled for implementation in November 2016.	0
SB 08-214 Local Government Medicaid Provider Fees (Shaffer/Frangas)	This bill made changes to legislation enacted in 2006 via SB 06-145, which authorized local governments to implement a provider fee on hospital and home health care agencies to draw federal matching funds to increase reimbursement for services provided to Medicaid clients.	As noted in both bills, imposition and collection of a provider fee by a local government is prohibited without federal approval of a Medicaid State Plan Amendment (SPA) authorizing federal financial participation. The Department filed two SPAs with the federal Centers for Medicare and Medicaid Services (CMS) in 2006 and worked with CMS for more than two years for approval. Ultimately, CMS denied the Department's SPAs, concluding that the Department's reimbursement methodology did not meet the requirements of federal regulations [42 CFR §433.68 (f)] addressing hold harmless arrangements.	0
HB 05-1243 Consumer Directed Care Under Medicaid*	This bill extends the option of receiving Home and Community Based Services (HCBS) through the Consumer Directed Attendant Support Services (CDASS) delivery model to all Medicaid recipients who are enrolled in an HCBS waiver for which the Department of Health Care Policy and	CDASS is available in the following Home and Community Based Services (HCBS) waivers: Elderly Blind and Disabled (EBD), Community Mental Health Services (CMHS), Brain Injury and Spinal Cord Injury (SCI). The legislation authorized the Department to seek federal approval to expand Consumer Directed Attendant Support Services (CDASS) to all the HCBS waivers but the fiscal note	0.5

Legislation	Legislation Summary	Barriers to Implementation	FTE
	Financing has federal waiver authority. The bill specifies that an eligible person shall not be required to disenroll from the person's current HCBS waiver in order to receive services through the consumer-directed care service model.	assumed significant savings in out years in order to expand. While a valuable and important delivery model, research and data show that clients in CDASS do not produce net savings. The current structure of CDASS allows clients to direct their own personal care, homemaker, and health maintenance activities. There are four waivers that do not offer these distinct services: Children with Autism, Children with Life Limiting Illness, Persons with Developmental Disabilities, and Children's Residential Habilitation Program. There is additional work that must happen prior to expanding CDASS, as it is currently structured, into waivers where these services are not in the federally approved waivers. Additionally, the participant directed care advisory group (PDPPC) has not examined the policy and operational implications of offering consumer direction to children when the parent or other legally responsible adult might be the person providing services as well as the one responsible for directing the care. Due to the General Assembly's targeted rate increase to personal care and homemaker services, CMS is requesting the Department to submit the new rate methodology for CDASS since it was previously tied to agency based rates. The Department is currently developing that methodology.	

*While the Department does not have record of the implementation status of bills prior to 2008, HB05-1243 was included because the Department is aware that this bill was not fully implemented and would have been included on this list if the Department had a comprehensive record of legislative implementation.

Joint Budget Committee Hearing: Executive Director's Office

December 16, 2015

Susan E. Birch, RN, BSN, MBA
Executive Director

Our Mission

Improving health care access and outcomes for the **people** we serve while demonstrating sound stewardship of financial **resources**

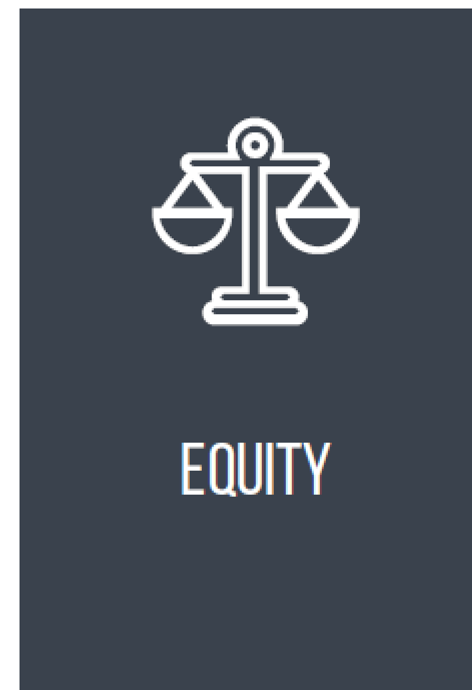
Colorado is Leading

Colorado is ranked 8th overall, up from 12th in 2014

Ranked #9

Ranked #5

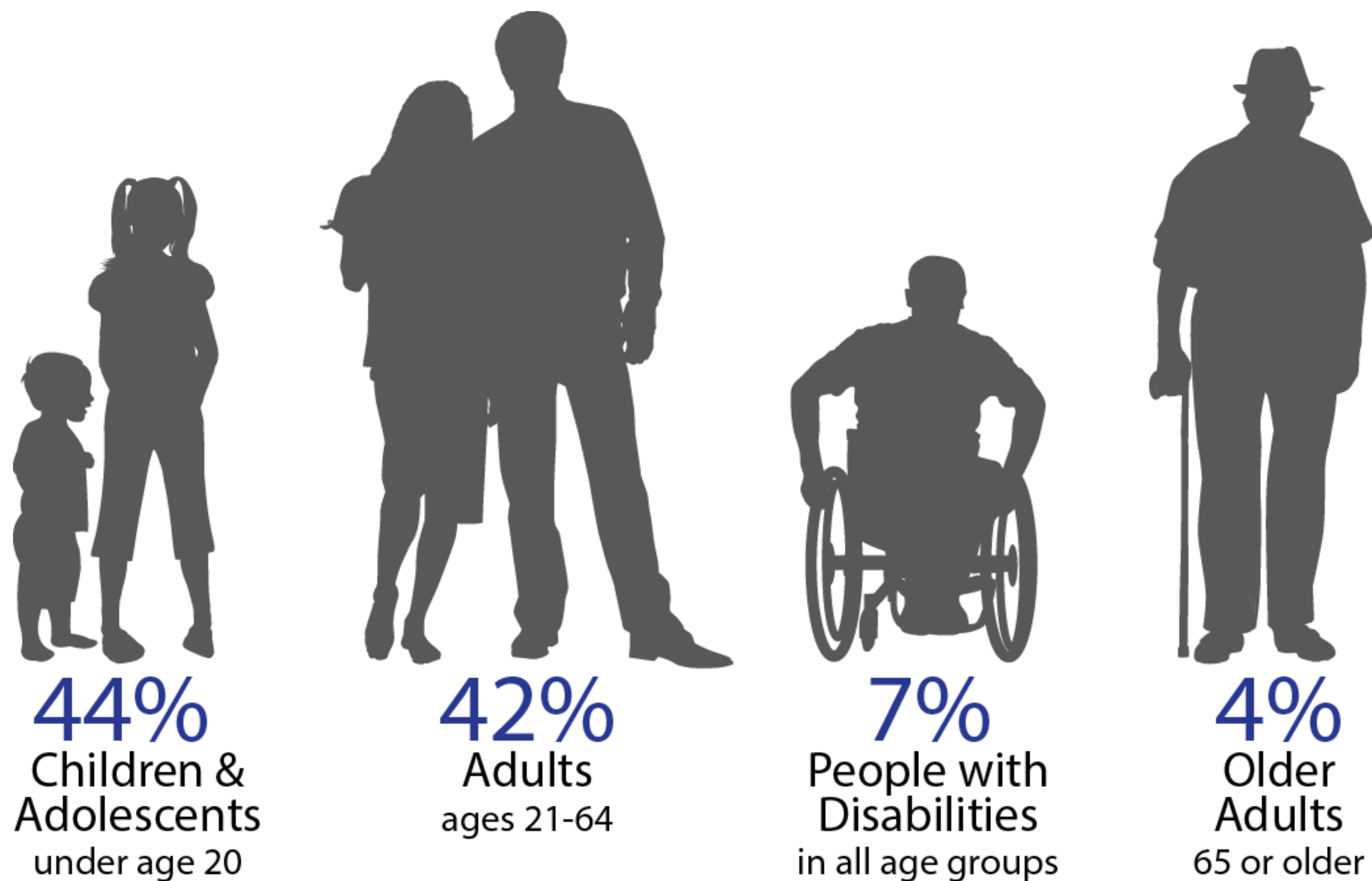
Ranked #2



Ranked #11

Ranked #26

Medicaid Population



FY 2014-15 Medicaid Caseload

Eligibility Category	Match Rate (Federal/State)
*Existing Medicaid	50/50
Existing CHP+	65/35 88/12 (Federal FY 2015-2019)
HB09-1293	50/50, some are eligible for ACA enhanced match
ACA Medicaid SB 13-200	100/0 (CY 2014-2016) 90/10 (2020+)

*Existing Medicaid includes kids and people with disabilities.

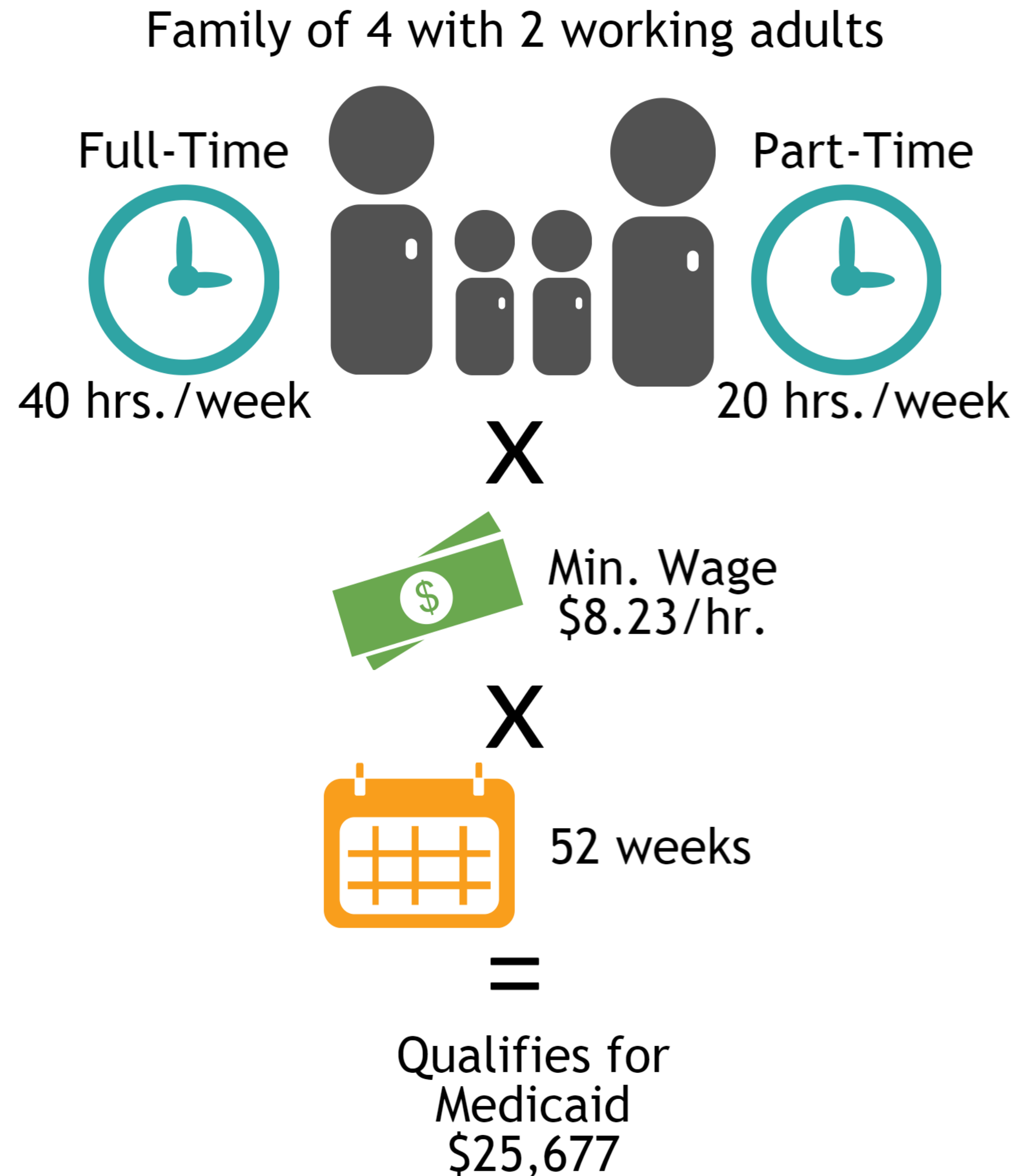
Income Levels & Family Example

Approximately **74% of adults** on Medicaid **are working**

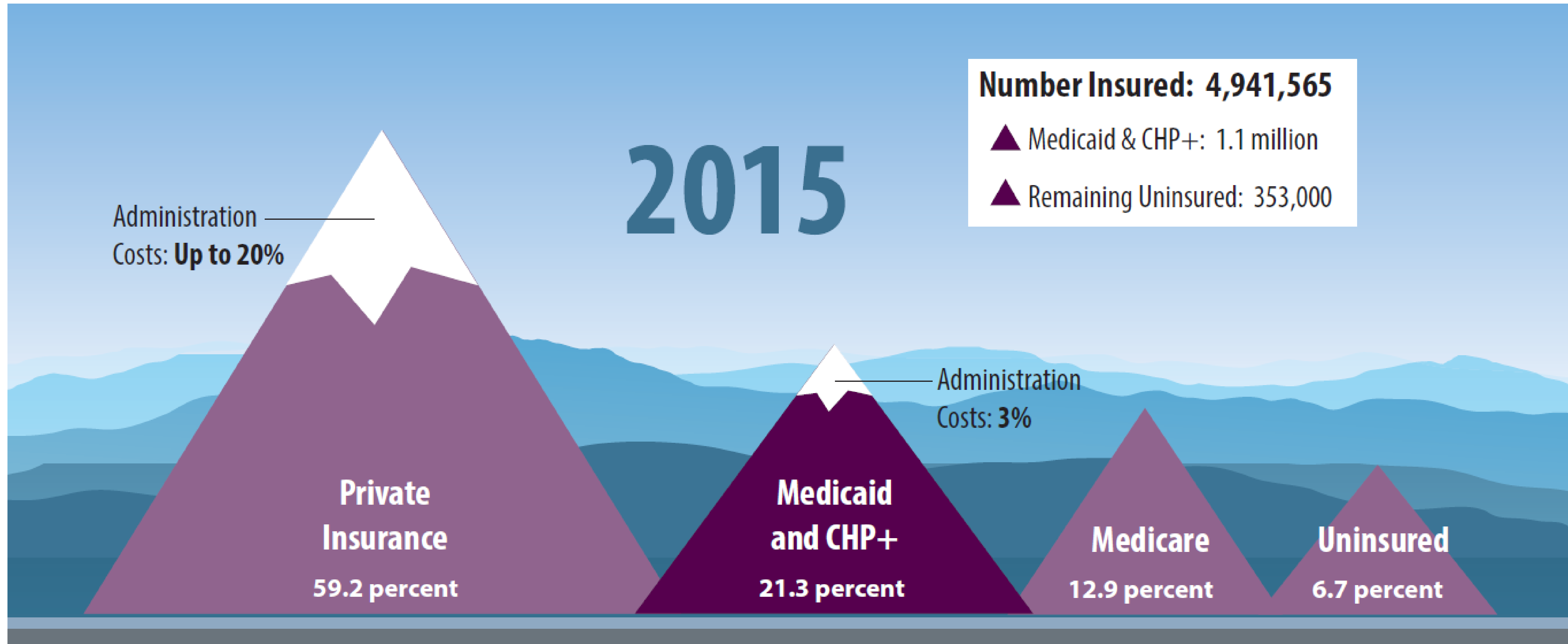
Bureau of Labor & Statistics, 2014 data

FPL Levels by Family Size		
	1	4
133%	$15,654	$32,252
260% (CHP+)	NA	$60,625

**Some earning more may still qualify.*



Medicaid & the Colorado Coverage Landscape



Source: Insured percentages and uninsured estimates from Colorado Health Institute's (CHI) 2015 Colorado Health Access Survey. Infographic by CHI.

Bending the Cost Curve

Medicaid - Total Services Per Capita Costs

	FY 2008-09	FY 2009-10	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15

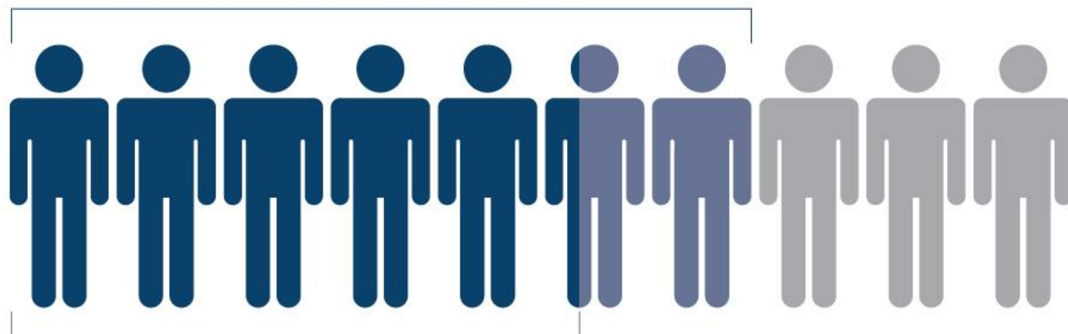
Source: Exhibit Q, Health Care Policy & Financing FY 2015-16 Budget Request, November 2015.

Accountable Care Collaborative

FY 2014-15

MEDICAL EXPENSES SAVINGS		ADMINISTRATIVE COSTS*		NET SAVINGS
$121 MILLION		**$84** MILLION		**$37** MILLION

*Administrative costs include per member per month payments, SDAC and incentive payments to providers for meeting performance measures.



Since 2011...

$285 million
in Gross Savings

$77 million
in Net Savings

Improving Health Outcomes

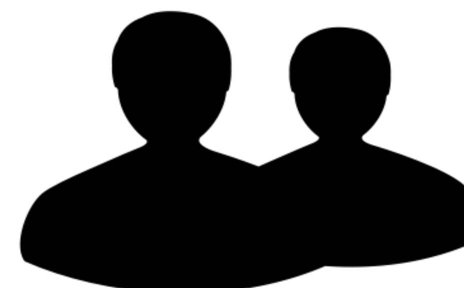
Physical Health

More than 73% of those eligible received physicals

Nearly doubled flu shots

Utilization information from claims data comparing 2013 and 2014

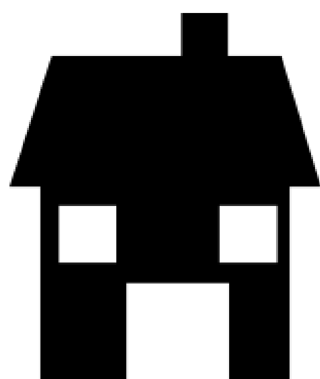
Behavioral Health



The suicide rate of Medicaid clients is nearly 1/2 that of the state average.

Comparison of 2012-13 CDPHE death certificate data

Long Term Services & Supports



Nearly 74% of clients live in place in the community

Comparison of FY 2014-15 waiver enrollments & clients receiving facility-based care

Accountable Care Collaborative

Well-child visits are more than double for children in the ACC for 7-10 months, as compared to those enrolled for 6 months or less.

ACC Annual Report, FY 2014-15

COLORADO
Department of Health Care Policy & Financing

Medicaid Eligibility Questions 1-7

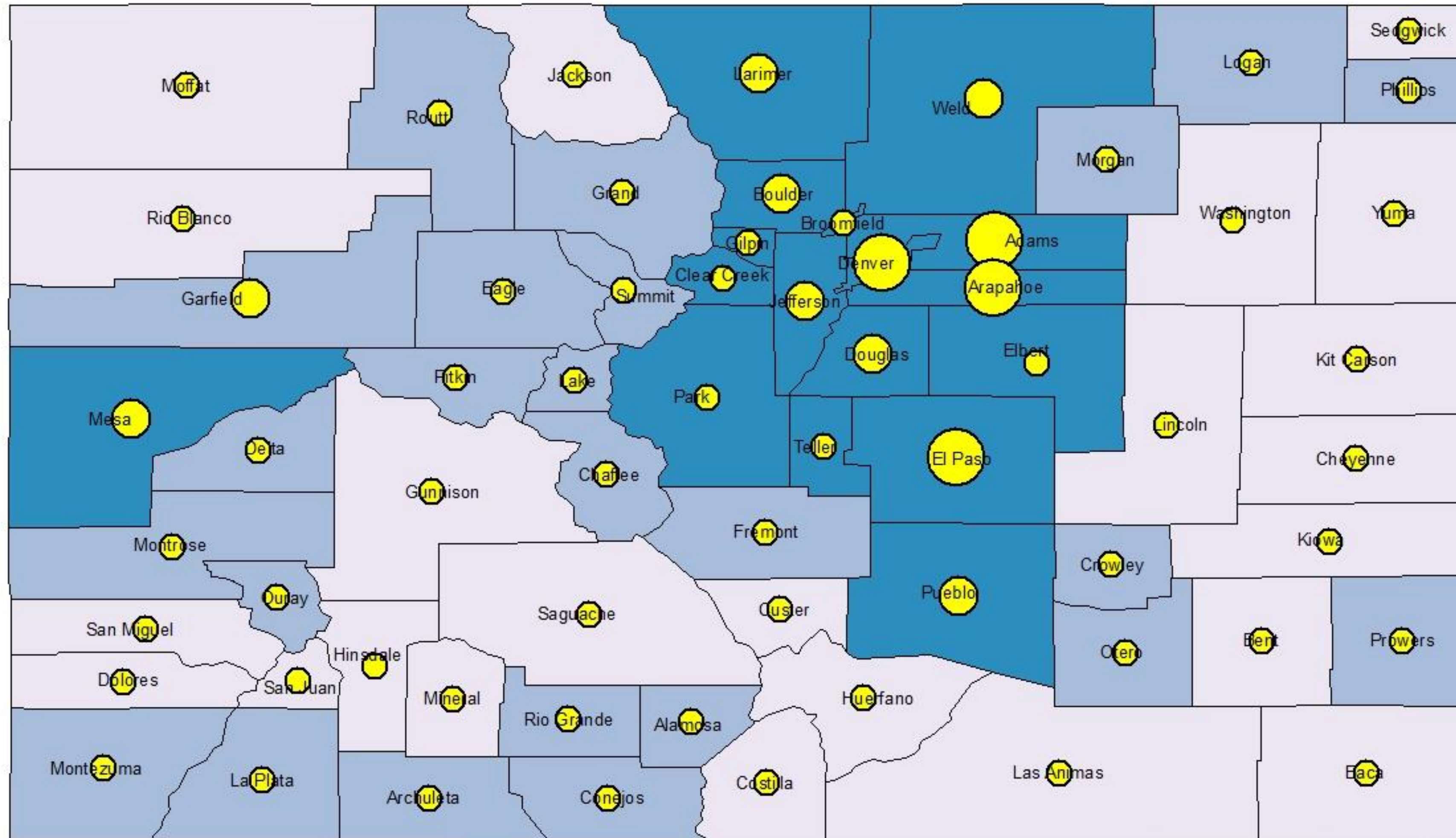
Benefits and Access Questions 8-13

Infographic data from the HCPF 2014 annual report (calendar year data).
Rural includes frontier in the graphic above.

Implementation of Legislative Initiatives
Questions 14-20

Primary Care, Questions 21-27

Dollar Impact of 1202 by County FY2014 -15



Minimum: $0 **Maximum: $11,122,594**
Average: $897,158 **Median: $92,715**

1202 Provider Cost by County
- $0 - $500,000
- $500,001 - $5,000,000
- $5,000,001 - $12,000,000

Urban, Rural or Frontier County
- Frontier
- Rural
- Urban

Project Tracking #: 5852 Map Created on: 12/10/2015

Better, Smarter, Healthier: Aligning Transformation Efforts

Provider Rates Questions 28-31

Hospital Provider Fee Questions 32-35

Hepatitis C
Questions 36-37

Budget & Financing Questions 38-44

Thank You

Susan E. Birch, RN, BSN, MBA
Executive Director
Health Care Policy & Financing

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
FY 2016-17 JOINT BUDGET COMMITTEE HEARING AGENDA

Wednesday, December 16, 2015
1:30 pm – 5:00 pm

1:30-1:45 Commission on Family Medicine

1:45-2:00 INTRODUCTIONS AND OPENING COMMENTS

2:00-2:20 MEDICAID ELIGIBILITY

1. Under what circumstances (including presumptive eligibility) can noncitizens and refugees receive Colorado Medicaid benefits?
   a. What are the benefits they are eligible to receive?
   b. How much does the state spend on services for noncitizens?
   c. Is this coverage for noncitizens optional or required by the federal government for participation in Medicaid?

2. Under what circumstances are people required to meet an asset test to receive Medicaid benefits and what are the asset standards?
   a. Are the asset tests based on state policy or required by the federal government?
   b. Should/could asset tests be eliminated or reduced to remove disincentives for work?
   c. Should/could asset tests be changed to make them more consistent and equitable across eligibility categories?

3. Does Colorado Medicaid cover prenatal care (if the client accesses it) in all circumstances where Medicaid covers the delivery? Are there any areas where it might make sense to expand prenatal coverage in order to reduce high cost deliveries that are covered by Medicaid?

4. How does the number of people enrolled in Medicaid as a proportion of the estimated people eligible for Medicaid (or the Medicaid penetration rate) vary across the state? What are the reasons behind the variation and is the Department doing anything to improve outreach in areas with lower Medicaid penetration rates?

5. How do changes in the federal poverty guidelines over time compare to changes in Colorado's income and cost of living?

6. What safeguards and remedies are in place to ensure that the state does not pay for benefits for people who are not eligible for the benefits?

7. In response to legislative request for information #12 the Department identified three ideas for suggested implementation.
   a. Who identified these ideas?
   b. Are these priorities of the Department?
   c. What is the Department doing to pursue these ideas, if anything?

2:20-2:40 BENEFITS AND ACCESS

8. What is the availability of specialty care in rural areas? Has there been a shift in where people access specialty care from rural to urban areas?

9. How will the proposed 1.0 percent provider rate reduction affect physical health services?

10. In the response to legislative request for information #5 the Department identified many strategies for improving the transportation benefit.
    a. What are the Department's priorities with regard to improving the transportation benefit and where is the Department actively working on changes?
    b. What is the Department's implementation time frame for these changes?
    c. Which improvement strategies might require additional resources?

11. is the long-term outlook for the Children's Basic Health Plan, including federal authority and funding? What is the Department's plan to ensure successful transitions for clients currently on the Children's Basic Health Plan, if it is not renewed at the federal level?

12. For the top 1 percent of utilizers accounting for 23 percent of expenditures, how much of the costs are related to pharmaceuticals?

13. Regarding Planned Parenthood's participation in the Colorado Medicaid program and during the last 3 fiscal years please answer the following questions for the following four items: (1) oral contraceptives, (2) emergency contraceptives, (3) LARCs, and (4) LARCs paid for by the Department's Family Planning Program:
    a. How many patients have been prescribed the item by Planned Parenthood?
    b. What were Planned Parenthood's actual acquisition costs for the item?
    c. What is the State's reimbursement rate for each item?
    d. What is the State's dispensing fee for each item?

2:40-3:00 BREAK

3:00-3:30 IMPLEMENTATION OF LEGISLATIVE INITIATIVES

14. The Centers for Medicaid and Medicare Services (CMS) is requiring Colorado to cover the autism services authorized in H.B. 15-1186 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit rather than the Children with Autism waiver.
    a. Based on discussions with CMS to date, how does the Department expect this will be different than what was contemplated in the bill for families, providers, and the budget?
    b. When does the Department anticipate more definitive guidance?
    c. Will changes be needed to the statutes or rules regarding autism services to implement the CMS guidance?

15. Describe the Department's communication with the Centers for Medicaid and Medicare Services (CMS).
    a. How did it occur that the Department requested a change to the Children with Autism waiver that worked all the way through the legislative process only to be denied by CMS?
    b. What is the Department doing to reduce the potential for similar surprises in the future where the position of CMS is so unexpected?

16. What are the issues causing delays in federal approval of the targeted rate increase for personal care and homemaker services and when does the Department expect they will be resolved? Does the Department expect it will be able to implement the increase as approved by the General Assembly?

17. Is decoupling the rates for consumer directed attendant support services from the rates for personal care and homemaker services good public policy?

18. Did funding a second increase in the lifetime cap on home modifications before the first increase was approved by the Centers for Medicaid and Medicare Services (CMS) slow down federal approval?

19. How have enrollments and expenditures changed for the Program for All-inclusive Care for the Elderly (PACE) over time and how do the trends compare to other services?
    a. Is the PACE program a sound financial investment for the state?
    b. How did the waiver allowing for-profit PACE providers get approved so quickly and how is it expected to change enrollment and expenditure trends?

20. What is the implementation status of the services financed with additional funding provided by Proposition BB?

3:30-4:00 PRIMARY CARE

21. What conclusions does the Department draw from the evaluation of the primary care rate bump? How did those conclusions influence the Department's decision to not request funding to continue the primary care rate bump beyond the scheduled end date? How confident is the Department in the evaluation of the primary care rate bump?

22. Please describe and provide examples of the services affected by the end of the primary care rate bump in layman's terms. What are the most commonly used codes, what services are those codes for, and how much are the rates for those commonly used codes changing?

23. How many providers does the Department believe will reduce or eliminate the number of Medicaid patients they see due to the end of the primary care rate bump?

24. Please provide information about where the providers and expenditures affected by the end of the primary care rate bump are regionally, perhaps on a map. Will the end of the primary care rate bump disproportionately affect rural communities?

25. Why has the number of Medicaid clients served by Federally Qualified Health Centers and Rural Health Centers increased so dramatically in recent years? Why is this relevant when interpreting the results of the evaluation of the primary care rate bump?

26. How will the end of the primary care rate bump affect the health care workforce? Will staff reductions occur?

27. Please provide a list of the rates excluded from the across-the-board reduction proposed in R12, the reasons why, and the magnitude of the exclusions as a percentage of medical services expenditures.

4:00-4:15 PROVIDER RATES

28. Does the Medicaid Provider Rate Review Advisory Committee have the capacity at this time to assist the JBC in evaluating the provider rate reductions in the Governor's request, including the one percent across-the-board decrease, the scheduled end of the primary care rate bump, and the $100 million restriction on Hospital Provider Fee revenue? Describe how the Department has engaged providers regarding the proposed rate reductions.

29. In the response to legislative request for information #1, why did the Department choose to compare dental rates to the highest compensating states rather than an average rate in the

manner used for Home and Community Based Services and for Home Health/Private Duty Nursing?

30. In the response to legislative request for information #1, how did the Department select the comparison states for Home and Community Based Services and for Home Health/Private Duty Nursing?

31. Why does the Department believe Colorado pays so much for Home Health/Private Duty Nursing relative to the comparison states and does this indicate that Colorado's rates are too high?

4:15-4:35 HOSPITAL PROVIDER FEE

32. What problem was the Hospital Provider Fee trying to solve by increasing hospital reimbursements (i.e. what was the originally intended purpose of the Hospital Provider Fee) and has it achieved that purpose?

33. What is the effect of the proposed $100 million reduction in the Hospital Provider Fee by hospital?
    a. How is the effect distributed across the state?
    b. What information can the Department supply to provide a sense of the magnitude of the proposed reduction compared to the operations of the hospitals that will be affected?
    c. In particular, how will the proposed reduction change rural hospitals and access to care in rural areas?
    d. Is the Hospital Provider Fee adding to the profits of hospitals that are doing well financially?

34. Compare hospital profits with the net benefit hospitals receive from the Hospital Provider Fee. Are the high profit hospitals also recipients of large net benefits from the Hospital Provider Fee?

35. How do Medicaid reimbursements for hospitals compare to reimbursements for services not provided through hospitals? By investing in hospitals through the Hospital Provider Fee is the state shorting other providers and limiting access to non-hospital care?

4:35-4:45 HEPATITIS C

36. How will the November 5 Medicaid Drug Rebate Program Notice (release No. 172) regarding assuring Medicaid beneficiaries access to HCV drugs affect Colorado's Medicaid coverage?

37. We heard in a recent presentation to the JBC that hepatitis C is the only disease for which a patient needs to become sicker before HCPF will provide a cure. Why is this the case?

4:45-5:00 BUDGET AND FINANCING

38. Will Medicaid enrollment decline as the economy improves and when will that happen?

39. How much is the Medicaid expansion authorized in S.B. 13-200 costing the state, including the "welcome mat" effect, and how does this compare to the estimates in the fiscal note for the bill?

40. Describe cost avoidances as a result of increased insurance.

41. Describe the adequacy of County Administration funding.
    a. Should the county workload study be updated and how much would it cost?
    b. Could some of the additional $7.1 million in federal funding for County Administration identified in R7 be used to finance an update to the county workload study?
    c. Has the needs identified in the previous county workload study been fully funded and implemented?

42. What is the fiscal impact of the projected changes in the federal match rate for:
    a. Medicaid
    b. The "newly eligible" under the Affordable Care Act
    c. The Children's Basic Health Plan?

43. The Governor set aside $25 million General Fund for a potential increase in Medicare premiums and deductibles paid by Medicaid and "opportunities presented by the update to the prison utilization study and the findings from the Results First project." How much of the $25 million was expected to be needed for Medicare premiums and deductibles and is the recent Congressional action on Medicare premiums and deductibles a savings compared to the Governor's request?

44. If the General Assembly had to reduce the optional benefits or eligibility to balance the budget, how would the Department recommend making reductions? What would be the Department's priorities?

ADDENDUM: OTHER QUESTIONS FOR WHICH SOLELY WRITTEN RESPONSES ARE REQUESTED

1. Provide a list of any legislation that the Department has: (a) not implemented or (b) partially implemented. Explain why the Department has not implemented or has only partially implemented the legislation on this list.

2. Please provide a detailed description of all program hotlines administered by the Department, including:
   a. The purpose of the hotline;
   b. Number of FTE allocated to the hotline;
   c. The line item through which the hotline is funded; and
   d. All outcome data used to determine the effectiveness of the hotline.

3. Describe the Department's experience with the implementation of the new CORE accounting system.
   a. How has the implementation improved business processes in the Department?
   b. What challenges has the Department experienced since implementation and how have they been resolved (i.e. training, processes, reports, payroll)?
   c. What impact have these challenges had on the Department's access to funding streams?
   d. How has the implementation of CORE affected staff workload?
   e. Do you anticipate that CORE implementation will result in the need for a permanent increase in staff? If so, indicate whether the Department is requesting additional funding for FY 2016-17 to address it.

4. If the Department receives federal funds of any type, please provide a detailed description of any federal sanctions for state activities of which the Department is already aware. In addition, please provide a detailed description of any sanctions that MAY be issued against the Department by the federal government during FFY 2015-16.

5. Does the Department have any outstanding high priority recommendations as identified in the "Annual Report of Audit Recommendations Not Fully Implemented" that was published by the State Auditor's Office and dated October 2015 (link below)? What is the department doing to resolve the outstanding high priority recommendations?

   http://www.leg.state.co.us/OSA/coauditor1.nsf/All/4735187E6B48EDF087257ED0007FE8CA/$FILE/1542S%20Annual%20Report.%20Status%20of%20Outstanding%20Audit%20Recommendations,%20As%20of%20June%2030,%202015.%20Informational%20Report.%20October%202015.pdf

6. Is the department spending money on public awareness campaigns related to marijuana? How is the department working with other state departments to coordinate the campaigns?

7. Based on the Department's most recent available record, what is the FTE vacancy rate by department and by division? What is the date of the report?

8. For FY 2014-15, do any line items in your Department have reversions? If so, which line items, which programs within each line item, and for what amounts (by fund source)? What are the reasons for each reversion? Do you anticipate any reversions in FY 2015-16? If yes, in which programs and line items do you anticipate this reversions occurring? How much and

in which fund sources do you anticipate the reversion being?

9. Are you expecting an increase in federal funding with the passage of the FFY 2015-16 federal budget? If yes, in which programs and what is the match requirement for each of the programs?

10. For FY 2014-15, did your department exercise a transfer between lines that is allowable under state statute? If yes, between which line items and programs did this transfer occur? What is the amount of each transfer by fund source between programs and/or line items? Do you anticipate transfers between line items and programs for FY 2015-16? If yes, between which line items/programs and for how much (by fund source)?