DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
FY 2015-16 JOINT BUDGET COMMITTEE HEARING AGENDA

Tuesday, December 9, 2014
1:30 p.m. – 5:00 p.m.

1:30-1:50 COMMISSION ON FAMILY MEDICINE

1:50-2:00 INTRODUCTIONS AND OPENING COMMENTS

2:00-2:05 QUESTIONS COMMON TO ALL DEPARTMENTS

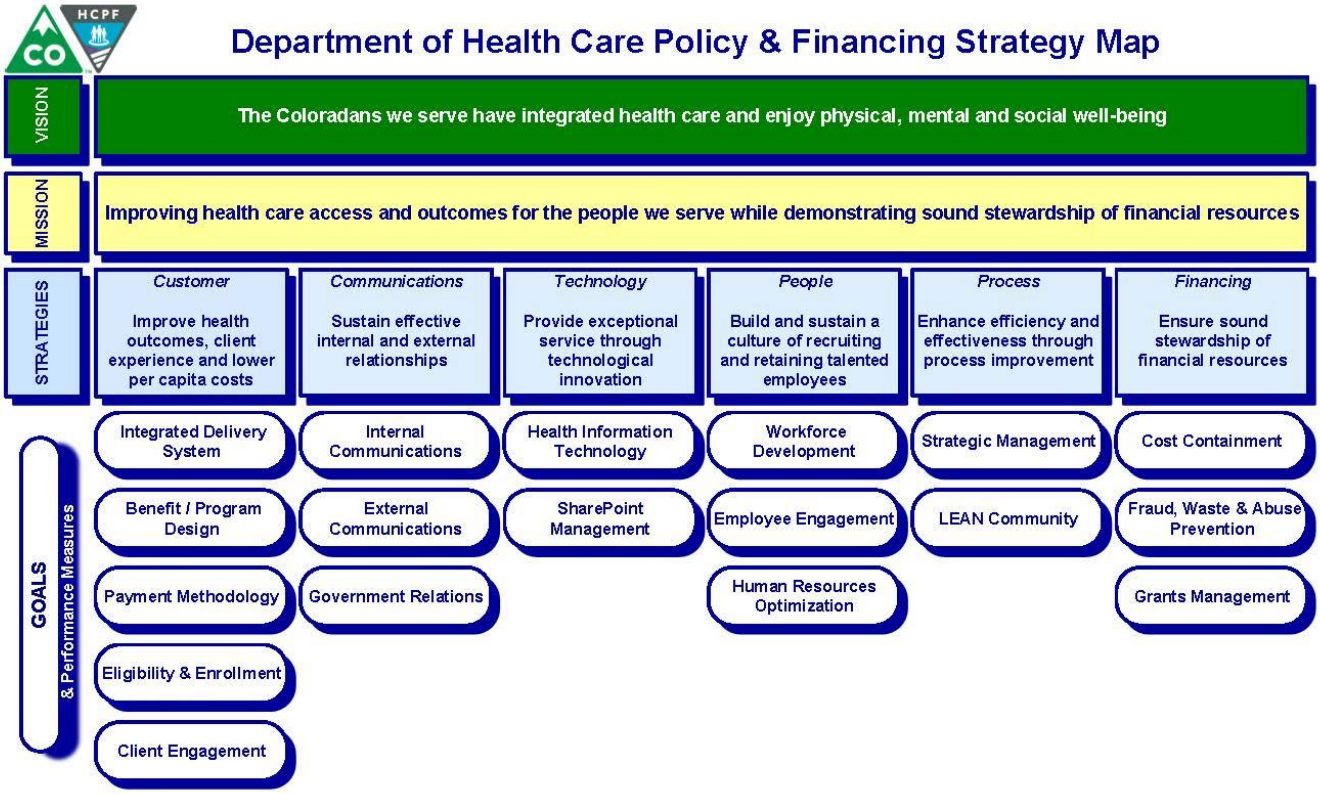
1. **SMART Government Act:**
   a. **Please describe how the SMART Government Act is being integrated into the Department's existing processes (both in terms of service delivery and evaluating performance).**
   b. **How is the data that is gathered for the performance management system used?**
   c. **Please describe the value of the act in the Department.**

The Department has integrated the SMART Government Act into its culture and routine business practices through a strategic management process. This process facilitates collaboration among managers and staff who work together to establish performance measures, set goals, and evaluate and report on progress. Using a strategy map as an employee engagement tool, the Department provides structure and cohesion for implementing and prioritizing projects that align with its strategic goals.

With respect to service delivery integration of SMART Government principles, the Department is committed to its strategic initiative to deliver a customer-focused Medicaid program that improves health outcomes and client experience while delivering services in a cost-effective manner. Managers review performance data monthly, quarterly or semi-annually as needed. Data gathered for the performance management system are used to shape policy and implementation efforts. For example, performance measures are a critical component of Department contracts with Regional Care Collaborative Organizations in the Accountable Care Collaborative. These performance measures are tied to recurring evaluations, which enhance performance through structured incentive payments.

The SMART Government Act is valued by growing numbers of managers and staff within the Department. With the strategy map as an overarching guide, staff have developed greater appreciation for their individual roles in helping the Department succeed through specific projects that support strategic initiatives. Further enhancing the value of the SMART Government Act, the Department established a Lean Community for process improvement in 2012. The Lean Community empowers employees to eliminate waste and maximize value in their daily work activities, and fosters a culture of continuous improvement through training and project management. The Department uses training, coaching, Lean projects and rapid improvement sessions called "Quick Hits" to deploy Lean throughout the Department. In doing so, the Department has created a growing Lean culture that is customer-centric and focused on continuous

improvement and data-driven decision-making. By raising the profile of performance planning and Lean, the SMART Government Act has helped the Department achieve a meaningful way to communicate, both internally and externally, about its mission, vision and goals.



2. **Do you have infrastructure needs (roads, real property, and information technology) beyond the current infrastructure request? If so, how do these needs fit in with the Department's overall infrastructure priorities that have been submitted to the Capital Development Committee or Joint Technology Committee? If infrastructure should be a higher priority for the Department, how should the Department's list of overall priorities be adjusted to account for it?**

The Department has not identified any infrastructure needs beyond the current request. If necessary, the Department would use the regular budget process to submit any request for adjustments to current appropriations to account for variations in implementation of previously approved initiatives.

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

    a. **Was the training adequate?**

The Department received substantial general training related to the major functional areas of CORE. These areas included General Accounting, Accounts Receivable, Accounts Payable, Asset Management, Procurement, Budgeting, Performance Budgeting, Cost Accounting and Cost Allocation. Department staff attended these trainings in classroom style settings where they were able to directly work on the system and process test transactions. Trainings were offered in various locations and at multiple times to provide different options for staff to attend.

In addition to this training, there are numerous job aids such as step-by-step procedures that are available on the CORE website. The Department used this information to reinforce the training received when processing transactions and doing other work. Staff hired subsequent to the initial courses are provided instruction and guidance by existing personnel. The Department believes the training received in the above noted areas allowed it to successfully navigate the transition from COFRS to CORE.

Initially, reporting training was not provided to all system users. Courses were given to a group of "super users" from each department in June 2013. Now that the system is operational, additional training would be beneficial in the area of reporting.

b. Has the transition gone smoothly?

Although no system implementation is perfect, the Department believes the transition has been successful. Staff devoted numerous hours to the project serving as trainers, testers, and functional team members and leads to ensure payments could be processed as soon as allowed after system go-live. On July 7, CORE successfully processed the first Medicaid Management Information System (MMIS) cycle of FY 2014-15 resulting in $82 million of provider payments issued. All required federal reports for Federal Fiscal Year 2013-14 were certified by the October 30 deadline resulting in the claiming of over $1 billion of federal financial participation.

The current reporting available in CORE, however, has provided a challenge to staff. Although a large amount of baseline reports are available in the InfoAdvantage package, many of these are not useful in providing the information management that certain users require. The Department has managed around these issues through the use of the limited amount of staff members who can create reports and through receiving a nightly CORE extract that is loaded into an SQL database. Staff are participating in reporting forums and user's groups with the Office of the State Comptroller and CGI to help improve reporting capability.

c. How has the implementation of CORE affected staff workload during the transition?

Staff workload has not changed dramatically during the transition. The month of July is the close of the fiscal year for Accounting and always results in additional hours worked. Prior to CORE implementation, it was necessary for professional staff to work extra hours to prepare for the transition and to set up all the necessary CORE coding to allow for processing of payments. The Department strongly believes that this preparatory work allowed for the successes noted in the responses to part (b) above.

Workload currently appears similar to that under COFRS. Staff go home on time and are not required to come in on weekends. Additional hours are necessary as certain deadlines approach (for example, quarterly federal reporting) but this was the case when using COFRS as well.

d. Do you anticipate that CORE will increase the staff workload on an ongoing basis? If so, describe the nature of the workload increase and indicate whether the Department is requesting additional funding for FY 2015-16 to address it.

The Department recognizes that the implementation of such a substantial new system will drive additional short-term workload as employees adjust to new ways of doing business. As employees adjust to new business processes and become more familiar with the CORE system, it is expected that this short-term workload increase will dissipate. Any long-term staffing changes resulting from CORE -- whether increases or decreases -- will not be known before the system reaches a steady operational state. At this time, the Executive Branch is not submitting any requests for FY 2015-16 to address the impact of CORE on normal departmental financial services operations.

2:05-2:20 CLIENT ENGAGEMENT

4. Please describe how the Department is using technology to address the surge in inquiries to the Customer Service Center. What options are available for people to get answers to their questions other than calling the Customer Service Center?

The Department is continually improving technology to address the increase in inquiries to the Customer Service Center that save agent time. In FY 2013-14, the Department requested, and the Joint Budget Committee approved, new technology for the Customer Service Center (November 1, 2013, R-12 "Customer Service Technology Improvement"). In October 2013, the Center implemented an Interactive Voice Response (IVR) System and Customer Relationship Management (CRM) System. Both of these systems are cloud-based, highly flexible solutions with robust features that have been used to more efficiently handle client inquiries and call management.

Interactive Voice Response (IVR) System

The IVR allows the Department to deploy self-service options for clients by automating functions such as Medicaid ID card requests. This improvement frees the time of the agent to handle more complex questions. The Center is able to mine data within the system to determine why clients are calling and to create self-service options when appropriate.

Customer Relationship Management (CRM) System

The CRM increases agent efficiency by obtaining real-time eligibility data and delivering that information to the agent's desktop. This integration saves the agent time as the agent does not have to search multiple systems for basic client information. It also saves the agent time in data entry. The CRM also contains a knowledge management function, a unique database of information delivered to the agent during the call through keyword prompting. The knowledge articles quickly provide agents accurate information so they can handle calls more effectively and efficiently.

Chat

The most recent technology improvement is the introduction of an online chat function implemented within PEAK, the online eligibility portal available at Colorado.gov/PEAK, in June 2014. Clients are able to 'chat' with agents directly which carves out calls that clients need to make to the Center for resolution. The Department is averaging 550-600 chats per month. The chat function is especially efficient because one agent can handle up to 5 chats at a time.

Other Options

Those applying for Medicaid have many options to get their questions answered including in person or phone assistance at county offices, Medicaid Assistance sites and Presumptive Eligibility sites located across the state. Once clients are enrolled in Medicaid's Accountable Care Collaborative, they can also seek assistance or benefit information from the local Regional Care Collaborative Organization. Children enrolled in Medicaid and the Child Health Plan *Plus* (CHP+) can work with their local Family Health Coordinator for in person or phone assistance.

Beyond in person and phone assistance, the Department launched a more consumer friendly website in August 2014. The new site offers a more user accessible layout for clients to obtain answers to their questions through published frequently asked questions (FAQs). From launch on August 20 through December 4, 2014, the site had 249,000 unique visitors and had 2.1 million page views. For Coloradans who have general questions about health coverage but may not know which department to seek information from, the Department developed an interdepartmental consumer focused website, Colorado.gov/health.

Additionally, clients can contact the Center by e-mail, PEAK Online Chat (agents are available daily from 12:30 p.m. – 4:00 p.m.) and PEAK E-mail.

Because of increased caseload and complexity of questions, even with these technology improvements, the Department has not experienced a decrease in call center volume demand. The Customer Service Center remains inadequately staffed to handle the volume of calls received.

5. Please provide statistics on the performance of the Customer Service Center, such as call duration, staff turnover rates, and the results of satisfaction surveys.

The Department experiences an average weekly call volume of 20,000 calls to the Customer Service Center. The call duration over the past calendar year averages at about 7 minutes and the call abandonment rate averages at 40%. The Department blocks, at minimum, 20% of all incoming calls daily to reduce hold times to as low as 7 minutes and to reduce the Department cost of paying for minutes on hold.

The Department call center staff experiences a 21% staff turnover rate.

The newly implemented technology now allows the Department the tools to offer surveys. The first survey implemented was through the PEAK online chat forum. The results of the survey are

overwhelmingly positive with 72.2% of all respondents indicating a Very/Extremely response to the questions asked.

Chat Survey Summary Chart

Chat question	Extremely	Very	Moderately	Slightly	Not at All
1. How convenient was the Chat session?	58	22	10	6	9
2. How well did the Chat Agent understand your concern?	49	21	13	8	14
3. How satisfactory was the Chat Agent responses?	57	22	18	3	5
4. How many of your questions or concerns were addressed?	59	6	3	4	33
5. How likely are you to use Chat again?	53	18	9	10	15

The Department is now in the process of developing a survey to evaluate customer satisfaction with the services offered through the call center to complement the chat survey.

Impact of Additional Temporary Staff

In November 2014, the Department added 15 temporary staff and experienced a 77% increase in the number of calls answered as more previously blocked calls can be answered.

Calls Answered Week Prior and Week After Adding Temporary Staff

Week	Calls Answered	Percent Increase
11/10–11/14	3,864	
11/17–11/21[(1)]	**6,831**	**76.79%**

6. How do the activities of the Customer Service Center overlap and interact with county offices?

The Department supports a no wrong door approach by resolving approximately 70% of client eligibility issues that come into the Customer Service Center. The most frequent reason for calls to the Customer Service Center is about a client's eligibility for Medicaid. Counties are responsible for the administration of the eligibility process for Medicaid and other human service programs, and some counties currently offer call center services to its clients. Clients receive county-specific phone numbers on their eligibility letters.

a. Is the technology to address client inquiries shared?

Beginning with the October 1, 2013 launch of the new call center technology, the Department offered to extend this technology to the county offices and is currently in a pilot phase with Arapahoe County for eligibility issues and phone applications. It is anticipated that other county offices offering call center services will use the Department's technology solution and the Department continues to offer this as a solution for counties to participate at any time.

b. Could better coordination between the Department and counties help in addressing the volume of calls to the Customer Service Center?

Potentially. The Department has already begun to explore avenues for technology coordination through the pilot study with Arapahoe County and continues to discuss with counties how to ensure calls are answered in a timely and effective way.

c. Are counties experiencing a similar surge in call volume?

Yes. As a result of the implementation of the Affordable Care Act and increased caseload realized throughout the state, call volumes for questions regarding health coverage have increased across all call centers around the state, including counties. Counties have reported more than 50% increase in their call centers and lobby traffic from before open enrollment to the peak service months, which were January, February and March.

d. Are counties sufficiently funded for their call volume?

The county administration appropriation pays counties for eligibility determination and case maintenance, which includes payment for answering client queries over the phone. The Department worked collaboratively with the counties to determine the appropriate funding based on the increase in federal funds through the enhanced matching rate made available through the Affordable Care Act and Maintenance and Operations Advanced Planning Document. The appropriation for county administration for Medicaid and CHP+ was able to fully support the higher than expected Medicaid enrollment and call activities during FY 2013-14. Additionally, the Department transferred $1,587,348 of unspent General Fund in the Department's County Administration line item to the Department of Human Services to help cover reimbursement for county administration costs in other human services programs.

The Department believes that county administration appropriation is sufficient for FY 2015-16 and following years and has not requested an increase in the November 3 budget request. Counties have also not requested an increase from the Department. The Department will continue to closely monitor expenditure to appropriation and will utilize the normal budget process should any shortfalls be perceived.

7. How do the operations of the Department's Customer Service Center compare to the activities of other large call centers operated by the state?

The Department contacted the Departments of Labor and Employment, Revenue, Personnel and Administration, Office of Information Technology and Human Services. Each state agency call

center contacted communicated a program-specific level of expertise to handle issues related to their respective programs. The services provided by the Department's Customer Service Center are most comparable to that of a private insurance carrier and to the counties that offer call center services. The Department handles issues related to Medicaid and CHP+ eligibility, health benefits, coverage, prior authorizations, provider network and referrals, and benefits coordination for people with other insurance coverage.

There is a great deal of variation in terms of the operations of the call centers operated by the state. The Department has not been able to determine if there is a call center that closely matches the call volume and type of call of the Customer Service Center.

The Colorado Department of Labor and Employment (CDLE), Division of Worker's Compensation currently staffs a client facing call center between the hours of 8:00 a.m. and 5:00 p.m. daily, with six staff members to manage an annual call volume of 45,000 calls; this is an average of 7,500 calls taken per agent per year.

The CDLE Unemployment Insurance Call Center answered more than 36,000 calls at its peak in March 2014 with an average of more than 27,000 calls per month. Wait times to the center can be long with the longest average of 53 minutes, 20 seconds in January 2014. The average call handling time is between 12 and 14 minutes. Staffing levels vary depending on available funding.

The Department averages 20,00 calls per week to the Customer Service Center. In order to estimate the number of FTE needed to improve customer service the Department utilized the output of the Erlang calculator, an industry standard used to estimate how many agents are needed for each hour in an eight hour day in order to hit a certain level of customer service. The calculator evaluates call centers based upon three main factors: average call duration, average wrap up time, and call answering target, based upon the hourly call volume input by the Department. Based on the calculator's output, the Department would need 28 representatives in order to meet the industry standard of 80% of calls, which would require 18 additional representatives. This would allow the call center to answer 80% of calls within five minutes, have adequate staffing to respond to online forms and real time chat, and reduce frustration for customers.

8. **What is the federal match rate for the Customer Service Center? Has the Department ever had a problem with not receiving the expected level of federal matching funds for the Customer Service Center?**

The federal matching rate for the Customer Service Center is 50%. The Department has not had issues receiving the match rate for the services provided by the Customer Service Center.

2:20-2:40 AUTISM TREATMENT

9. **If the General Assembly adopts the changes to the Children with Autism waiver proposed in R8, discuss the expected implementation timeline and the anticipated pace of enrollment from the waitlist. How confident is the Department that this schedule is achievable? What assurances can the Department provide that families waiting for services will gain access according to this schedule?**

The Department intends to begin enrolling eligible children into the Children with Autism waiver on July 1, 2015, assuming approval from both the General Assembly and our federal partners, the Centers for Medicare and Medicaid Services (CMS). The Department will seek CMS approval by submitting a waiver amendment prior to final General Assembly approval. The submission of a waiver amendment is not binding and the Department may withdraw the submission prior to implementation. If the General Assembly makes changes to the request, the Department will need to submit a new amendment to CMS which could result in a delayed implementation past July 1, 2015. While the Department believes July 1 is a realistic timeframe, it cannot ensure approval from CMS by that date.

The anticipated pace of enrollment is 41 children per month in the first year, and then 5-7 per month in the years following. At this pace the Department expects all enrollments on the waitlist to be complete within eight months. This will allow the Community Centered Boards (CCB) time to hire additional staff needed and provide them with required training. The Department will monitor the rate of CCB enrollment and follow up with any CCB that appears to be having trouble with enrollments. This pace will allow the Department time to recruit and enroll additional providers across the state to ensure adequate service availability once a child is enrolled.

10. Compare the services provided through the Children with Autism waiver with those available through Early Periodic Screening, Diagnosis, and Treatment (EPSDT).

All services provided under the EPSDT benefit must be both medically necessary and listed within section 1905(a) of the Social Security Act. All children receiving Medicaid are eligible for EPSDT benefits.

Waiver services for children are those services that are either not listed within section 1905(a) or not covered by the state plan. The Department has conducted a regulatory review and has determined that behavioral intervention is not mandated as an EPSDT benefit. The Children with Autism waiver specifically provides behavioral intervention provided by professionals with specific training and/or experience in behavioral therapies for people with autism. The waiver provides children with autism the opportunity to receive services, such as behavioral interventions, which would otherwise not be available under EPSDT.

a. Should some of the Children with Autism waiver services be part of the state plan, rather than a waiver?

No. The Department purposefully submitted budget action (R-8) that requested expansion of waiver services rather than requesting creating a new state plan benefit.

Primarily, the reason for the budget action request is the desire by the Department to quickly provide needed services to children. Amending a new waiver is significantly quicker operationally than creating and implementing a new state plan service. To provide one example, a new state plan service would require extensive MMIS changes. Making significant changes to the current MMIS would not happen in a timely manner and is not cost-effective. Therefore, a state plan amendment could not be implemented operationally prior to November 2016, at the earliest, when the new MMIS will be operational.

There were budget considerations as well. The administrative cost of amending a current waiver is low relative to the administrative cost of creating a new state plan benefit. In terms of service cost, while a state plan amendment creates an entitlement, a waiver expansion can be capped. The R8 budget request proposes to keep a ceiling on cost per child and also retain an age limit of children served, although in both cases the limits are at higher amounts than current policy. Neither limitation would be allowable under a state plan framework. Under a waiver structure, Colorado has the choice in the future to re-institute a cap on the number of children served. However, state plan services cannot have caps on the number of people served.

b. How does the proposed expansion of the Children with Autism waiver fit with the Department's efforts around consolidating waivers and the Community First Choice initiative?

Significant work has occurred with stakeholders on consolidation of the waivers and Community First Choice. While the Department is committed to moving forward with this work, we anticipate it will take several years to fully implement. The Department has made the policy decision to expand the waiver due to the extensive waitlist and needs of children currently on the waitlist. Stakeholders active in the Waiver Simplification Subcommittee of the Community Living Advisory Group expressed a desire for the Children with Autism waiver to expand. The Department believes it can quickly build on its existing infrastructure and increase the number of children who receive needed services without disrupting the efforts of waiver consolidation or Community First Choice.

11. What is the Department's rationale for a three-year cap on services through the Children with Autism waiver? What happens if a child needs services beyond the three years? Please estimate the additional cost if the service duration was not capped at three years.

There is limited research and consensus on the length of time behavioral intervention is needed to provide a lasting impact to a child with an autism diagnosis. The waiver currently limits waiver interventions to three years aligning with limited published definitions of intensive intervention. Reviews of the literature of research describe effective treatment to be "early and intensive." Early is defined as prior to age three and intensive is defined as 25 hours or more per week. Autism Speaks, a leading autism science and advocacy organization, describes intensive as 25 to 40 hours per week for one to three years. If a child needs services beyond the three years, the Department is authorized by CMS to approve a one-year extension based on documentation from the child's provider and physician.

If the three-year service duration cap is altered or removed, the Department estimates that the incremental cost of each additional year would be approximately $6,000,000 total funds for waiver, state plan and behavioral health services, under the assumption that all children would utilize at least one additional year of services under the waiver. The validity of this assumption depends on the specific policy authorized by the General Assembly; for example, if an additional year of services is only authorized in certain circumstances, the cost would likely be lower.

12. How would the proposed changes to the Children with Autism waiver affect services provided through schools?

The proposed changes to the Children with Autism waiver would not change funding to schools.

School districts can bill Medicaid for some, but not all, of the services in the child's Individualized Educational Plan. However, school districts cannot bill for services in the waiver, and the waiver plan of care cannot authorize services that are necessary to support a child's education.

Although there is no direct overlap between waiver and school services, clients would receive greater benefits from the services when there is consistency and coordination between school and home based services.

13. Provide an overview of the Autism Treatment Cash Fund, including the sources of revenue, projected revenues and expenditures and the legislative history. Is this a declining source of revenue? Is there a connection between tobacco usage and the prevalence of autism? Are tobacco settlement moneys the best source of revenue to support the Children with Autism waiver?

Autism Treatment Cash Fund Revenue Source

The source of revenue for the Autism Treatment Cash Fund is the Tobacco Master Settlement Agreement (MSA). Section 24-75-1104.5(1)(l), C.R.S. directs $1 million per year from the MSA to the Autism Treatment Cash Fund. The $1 million per year in revenue for the Autism Treatment Cash Fund is a fixed amount in statute, and thus is not a declining source of revenue.

The current revenue to the Autism Treatment Cash Fund is insufficient to fully fund the program; given that MSA funds are declining overall, the Department believes that tobacco settlement moneys are not the best source of revenue to support the Children with Autism waiver program. With the available funding, the Department is only authorized to serve 75 clients, which has resulted in a waitlist of over 300 clients. On November 3, 2014, the Department submitted a budget request (R-8) in order to fully fund the waitlist and make critically needed changes to the program. If approved, the expansion of the Children with Autism waiver would require General Fund after the first year of expansion as the balance in the Colorado Autism Treatment Fund is insufficient to fully fund the balance of projected expenditures under the expansion.

Summary of Projected Revenues and Expenditures

Please see the table below for a summary of projected revenue and expenditure for the Colorado Autism Treatment Cash Fund. Please note that revenue and expenditure projections assume approval of the FY 2015-16 R-8 request.

Colorado Autism Treatment Fund Cash Funds Summary, FY 2012-13 - FY 2016-17							
Row	**Item**	**Actual FY 2012-13**	**Actual FY 2013-14**	**Projected FY 2014-15**	**Projected FY 2015-16**	**Projected FY 2016-17**	**Notes/Calculation**
A	Year Beginning Fund Balance	$2,574,382	$3,131,317	$3,709,876	$4,304,507	$0	Schedule 9: Cash Funds Report FY
B	Projected Revenue	$1,035,454	$1,037,493	$1,044,420	$1,006,466	$1,000,000	2015-16 Budget Request Fund 18A0 -
C	Projected Expenditure	($478,519)	($458,910)	($449,789)	($470,770)	($491,434)	"Colorado Autism Treatment Fund"
D	R-8 CWA Expansion	$0	$0	$0	($4,840,203)	($508,566)	
E	**Ending Cash Fund Balance**	**$3,131,317**	**$3,709,900**	**$4,304,507**	**$0**	**$0**	**Row A + Row B + Row C + Row D**

Legislative History

The Colorado Autism Treatment Fund was created by SB 04-177 with the purpose of providing services for eligible children with autism enrolled in the Home and Community-Based Services Program, and specified a transfer of up to $1,000,000 into the fund. HB 06-1310 made minor changes to the funding distribution, specifying that exactly $1,000,000 would be placed in the fund each year. SB 12-159 required the Department to perform an annual evaluation of the fund to determine if the fund can sustain an increase to the waiver enrollment cap.

Connection between Tobacco and Autism Spectrum Disorder

Researchers have discovered a large genetic component for autism spectrum disorders (ASD), however there is ongoing exploration of other environmental factors. Prenatal exposure to tobacco smoke is suggested as a potential risk factor for ASD. There have been a number of epidemiological studies on this topic that have yielded mixed findings. It is not clear if smoking is a risk factor or not.

14. To qualify for the Children with Autism waiver a child must be at risk of institutionalization. What does that term mean and how does the Department evaluate whether a client is at risk of institutionalization?

The Social Security Act requires all individuals served on a 1915(c) waiver to be at risk of institutionalization in one of three types of institutions: Hospital, Nursing Facility or Intermediate Care Facility for Individuals with Intellectual and Developmental Disabilities (ICF/IID). To qualify for the Children with Autism waiver a child must be at risk of institutionalization in an ICF/IID. This means without the supports of the waiver and without primary caregiver support, the child would be at risk of placement in an ICF/IID. To evaluate a child's risk for institutionalization case managers conduct a Uniform Long-Term Care (ULTC) 100.2 assessment in the child's home with the child and primary caregivers. The score on the ULTC 100.2 and case management assessment determine if the child is at risk of institutionalization.

15. For children at risk of institutionalization parental income is not considered when determining Medicaid eligibility. Discuss the policy ramifications of children from families with income above the standard Medicaid eligibility thresholds qualifying for the Children with Autism waiver.

While autism treatment benefits are growing in the private health insurance market, a significant gap remains for many Colorado families whose employer-sponsored health plans do not have an autism treatment benefit. Colorado's Health Insurance Mandate for Autism Treatment is not

required in health plans that are regulated by the Employee Retirement Income Security Act which make up a significant portion of the private health plans in Colorado. Without the current policy of disregarding parents' income for this waiver, it would leave those families to pay out-of-pocket for autism services. Even when behavioral services are covered, families report the co-payments for behavioral services can cost a family upwards of $150 per week.

The Department agrees that this policy should be revisited over the next few years as the gap in autism treatment in private plans narrows. Until that time, there are kids whose parents cannot afford to pay out-of-pocket for these behavioral services and research shows that the benefit of receiving behavioral services for these children is time sensitive. The children that would benefit from the expansion of this waiver, both current Medicaid enrollees and people with family income above Medicaid eligibility income thresholds, cannot wait until the private health insurance gaps are reduced.

16. Some of the statutory changes proposed in R8 to the Children with Autism waiver go beyond budgetary issues. Why does the Department propose that the JBC carry the legislation, rather than members of the House and Senate health committees?

Only one of the five proposed statute changes in the request could be considered non-budgetary but would still have a significant fiscal impact if implemented. The five items in statute that would be changed under the request are:

- Increase the statutory defined annual limit of services to $30,000 (currently set a $25,000) and allow the service limit to be amended through the Long Bill so that providers that serve clients in this waiver can be included in the rate increases without reducing the amount of services clients are able to receive. 25.5-6-804(2) C.R.S.
- Allow the Autism Treatment Fund to finance state plan services for existing and new enrollees once waiver service expenditure is exhausted, and in the subsequent years after expansion, allow General Fund to supplement the cost of waiver and state plan services after the fund is depleted. The Autism Treatment Fund receives a fixed amount of funding from the Tobacco Master Settlement each year. 25.5-6-803(3)(a) C.R.S.
- Strike the requirement that the Department annually review the available balance of the Autism Treatment Fund to determine if new clients can be added to the waiver since the fund would no longer be required to fully support all of the clients on the waiver as described in the above bullet. 25.5-6-804(9) C.R.S.
- Change the frequency of the program evaluation to an annual basis to determine the efficacy of the program. The request includes $62,000 total funds to hire an independent evaluator for this annual report. 25.5-6-806(2)(c) C.R.S.
- Change the age limit in statute to age eight and guarantee up to three years of services as long as the child enrolled in the waiver by age eight. 25.5-6-802(1)(b) C.R.S.

While changing the age limit of the waiver could be considered non-budgetary, the Department believes that it would be appropriate for the Joint Budget Committee to carry this legislation due to the policy's significant fiscal impact, the overall policy to change how the Autism Treatment Fund is used, and the Committee's experience providing resources to eliminate the waitlists of the

Department's other Home and Community-Based waivers. The Children with Autism waiver is the last children's waiver with a waitlist.

17. Is the Children with Autism waiver a candidate for a cost/benefit analysis through the Results First initiative? What data can the Department provide about the long-term effect on state expenditures of an investment in autism services for children?

The Children with Autism waiver is outside the current project scope of Results First. The first year of the program is focused on juvenile justice, child welfare and adult criminal justice. After the first year, and depending on the success of the program, the Governor may use the regular budget process to seek funding to expand the scope of Results First; however, that is unknown at this time.

It is reasonable to believe that investment in early intervention services treating autism would create long-term savings. However, the literature base is thin and the Department has found no definitive or quantifiable answer to this question. If savings were to occur, the Department is certain that they would not be material in either this budget year or the next.

The Department performed research in the spring of 2013 modeling cost offsets of autism treatment. The research suggested that investment in autism treatment would be offset in the long run by savings in special education spending. However, the model was sensitive to assumptions, and in some scenarios savings did not offset costs.

2:40-2:55 ACCOUNTABLE CARE COLLABORATIVE

18. The Department's R11 proposes to better connect the activities of the Regional Care Collaborative Organizations (RCCOs) and Local Public Health Agencies (LPHAs). Please describe in more detail these improved connections and how they benefit the state. Would some of the benefits apply to people who are not Medicaid clients?

Health is not just limited to physical wellbeing, but also includes social, emotional and environmental factors. As a result, health services extend beyond medical services to include education support, social services and prevention. The primary purview of Colorado Medicaid currently is the delivery of medical services. To fully address the total health of Medicaid clients, the Department relies on collaboration with other state agencies and organizations to deliver preventive and education services.

The Local Public Health Agencies (LPHAs) are an important resource for Regional Care Collaborative Organizations (RCCOs) in providing preventive and disease management services to ACC clients. Most LPHAs are enrolled Medicaid providers; however, they also receive funding to deliver many services that are not directly reimbursable by Medicaid. These non-reimbursed services include chronic disease self-management education, health literacy education and preventive screenings that are intrinsically linked to the RCCO's efforts to treat the whole client.

There is a natural alignment of the work of RCCOs and LPHAs, and R-11 is designed to provide an incentive for RCCOs and LPHAs to build sustaining partnerships and explore creative ways to

improve the effectiveness of RCCO, LPHA and Medicaid services. The request provides an opportunity for RCCOs and LPHAs to jointly obtain funding to support innovative collaborative projects in their communities. These projects may offer essential services that can increase a client's engagement and ability to manage their own health.

For example, projects might include a RCCO/LPHA chronic disease self-management education program for clients with diabetes, hypertension and obesity. This is one important way to reduce the need for expensive services such as emergency room visits and hospital admissions. Or, RCCOs and LPHAs could seek funding to support collaborative work designed to improve the health literacy of clients through LPHA educational programs that would be included in RCCO-developed care plans. Funding could be provided to assist LPHAs with billing for preventive services, allowing them to expand access to preventive care for Medicaid clients which could mitigate access challenges.

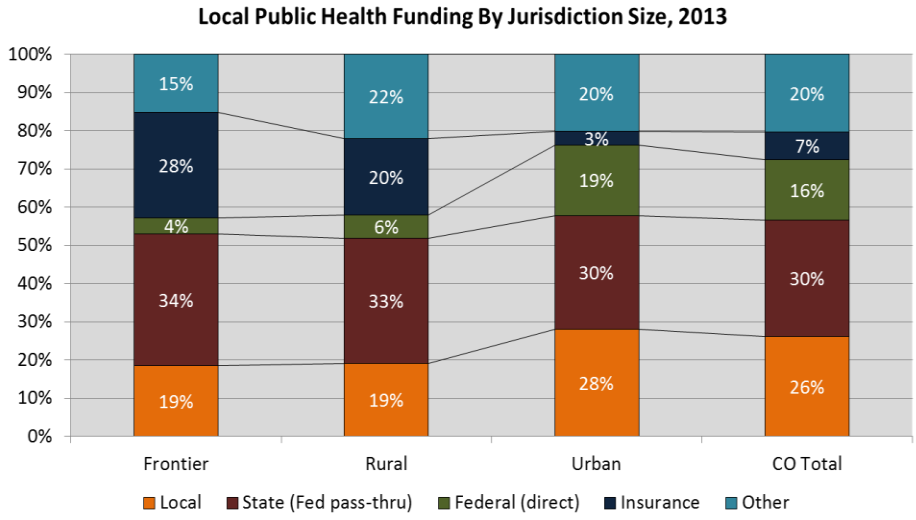
Project proposals will be customized to address both the needs of Medicaid clients and the needs identified in the LPHA's Community Health Improvement Plan. Direct services will be delivered only to Medicaid clients but the best practices and successes will benefit all Coloradans.

19. What are the typical sources of revenue to Local Public Health Agencies?

The primary sources of revenue to Local Public Health Agencies (LPHAs) are state General Fund and master settlement dollars provided by the Colorado Department of Public Health and Environment (CDPHE). Counties are required to match the state funds with at least a $1.50 per capita. Additional money to support programs and services comes from state grants, general funds, local funds, federal pass through (e.g. emergency preparedness) inspection fees, clinical fees, foundation grants and Medicaid (which accounts for approximately 3%).

a. Why can't these revenue sources be used to forge the improved connections with Regional Care Collaborative Organizations proposed in R11?

The figure on the following page details the funding sources by jurisdiction size.



With these dollars, Colorado's 54 LPHAs provide statutorily and regulatory required Core Public Health services. These services include: Assessment, Planning and Communication; Vital Records and Statistics; Communicable Disease Prevention, Investigation and Control; Prevention and Population Health Promotion; Emergency Preparedness and Response; Environmental Health; and Administration and Governance. Many LPHAs also provide direct services to Coloradans such as immunizations, cancer screenings, tobacco cessation counseling and chronic condition management and education. Each LPHA offers different services, based on local needs and the availability of funding and other resources. Much of the funding, including federal dollars provided by the Centers for Disease Control, is dedicated to specific programs, offering limited flexibility to repurpose funding.

This inflexibility regarding resources does appear to impair the development of strong connections with the Regional Care Collaborative Organizations (RCCOs). Results from a 2014 CDPHE sponsored survey suggest that more than half of responding LPHAs said they needed time, funding, personnel and a better understanding of RCCO priorities in order to better align activities. Funding was the most frequently reported need.

b. Please specifically address how R11 relates to the Cancer, Cardiovascular and Chronic Pulmonary Disease (CCPD) Grants Program.

R-11 will not fund the decade-old Cancer, Cardiovascular, and Chronic Pulmonary Disease (CCPD) Grants Program. However, both grant programs are incentivizing and encouraging inter-agency work to improve the health outcomes of Coloradans. This year, for the first time, CDPHE has included criteria to the CCPD grants where LPHAs can receive priority for RCCO/LPHA collaboration alignment. Together, these grants will support improved interagency work and enhanced LPHA/RCCO collaboration.

20. In R13 the Department requests funding to prepare for the re-procurement of contracts with the Regional Care Collaborative Organizations (RCCOs) responsible for the implementation of the Accountable Care Collaborative (ACC). How is the ACC performing and what are the Department's goals for the future of the ACC?

The Accountable Care Collaborative (ACC) is achieving its goal of improving the overall health of clients while lowering costs. The ACC achieved gross savings in medical costs between $98 million and $102 million with net savings totaling $29 million to $33 million after ACC program expenses. In its third year, the ACC continued to make changes to the way health care is delivered and paid for that added up to results like fewer emergency room visits, a decrease in the use of expensive imaging, and better access to primary and behavioral health care. Some of the program performance highlights are below:

- **Reduction in emergency room (ER) visits**: Children and adults who were enrolled in the ACC for more than six months had a lower rate of ER visits than children and adults who were not enrolled, or had been in the ACC for less than six months.

- **Reduction in 30 day, all-cause hospital readmissions**: Hospital readmissions rates were lower for all children and adults who had been in the ACC for six months or longer.

- **Reduction in high cost imaging**: Consistently lower utilization of these services for all members who have been enrolled in the ACC for six months or longer as compared to those not enrolled and those enrolled for less than six months.

- **Progress on health care delivery system transformation**: Regional Care Collaborative Organizations across the state have improved communication, referrals and relationships among both medical and non-medical providers.

The Department goals for the future of the ACC include:

- Taking major steps toward medical services, preventive services, community-based services, public health, human services and behavioral health integration.

- Pursuing payment reforms that will continue to transition from a volume-based model to one that is more value-based.

- Creating efficiencies across the state budget allowing for closer coordination, cross-agency program evaluation, and the move towards whole-state savings. Initial partnerships would likely include the Colorado Department of Public Health and Environment, the Colorado Department of Human Services and the Colorado Department of Corrections.

More detailed information can be found in the Department's response to the Joint Budget Committee's FY2013-14 Legislative Request for Information #3 submitted on November 3, 2014.

21. The Departments 2013-14 ACC by the Numbers Fact Sheet showed that the program's successes are not as good for the disability community -- for example adults with disabilities enrolled in the ACC have more emergency room visits than those not enrolled whereas adults without disabilities have 8% fewer ER visits. Does the performance vary by Regional Care Collaborative Organization (RCCO)? What is the Department doing to address the performance of the ACC for people with disabilities? What is the Department doing to ensure that RCCOs engage with the disability community?

The Department believes that the difference in ER visits between the enrolled and not-enrolled populations may be the result of the selection process for enrollment into the Accountable Care Collaborative (ACC). As a result, the comparison of ER visits between the two populations does not indicate that there is a problem with the ACC, but rather that there is a substantial difference in the needs and utilization of the two populations that would exist even without the ACC. Specifically, during FY 2013-14, the Department was not actively enrolling individuals living in an institution. This means that those individuals with disabilities in the ACC are generally living in the community, and may rely more on the emergency room when they need care for their multiple conditions outside of usual office hours than those in an institution do.

There is performance variation among RCCOs for individuals with disabilities, just as there is variation across the RCCOs for all ACC clients. For example, individuals with disabilities enrolled

in RCCOs 1 and 6 have lower rates of ER visits than individuals with disabilities in those regions that are not enrolled. For 30 day readmission rates, individuals with disabilities enrolled in the ACC had lower rates in RCCOs 1, 4 and 6 than individuals with disabilities in those regions that are not enrolled in the ACC. Since 2012, there has been a 6% increase in the rate of professional visits for children with disabilities and a 7% decrease in emergency room visits.

The purpose of the ACC is to redesign the Medicaid delivery system to be person-centered and fully integrated so Medicaid clients have the best possible health outcomes while the state controls costs. The ACC has expanded each year and the Department has used an incremental approach to health system transformation to allow for progress and evolution across the delivery system. Preliminary transformations in the ACC focused on innovations in the medical care system. More recently, the Department began working with RCCOs to start collaborating with long-term services and supports providers. RCCOs are now charged with coordinating care for clients with more complex conditions, including clients with a disability. To support this, the Department and the RCCOs are taking multiple steps to address the performance of the ACC for people with disabilities, including but not limited to interventions and activities being developed as part of the ACC: Medicare-Medicaid Program (ACC: MMP). The Department believes that these specific interventions (described below) will support improved care to the ACC: MMP clients and to all ACC enrollees. Specifically:

- Service Coordination Plan is a standard care assessment and coordination tool that RCCOs use for all ACC: MMP clients. RCCOs meet with clients to understand their goals and then arrange and coordinate their services to reduce duplication and fragmentation of services, and address any gaps in care. Several RCCOs have indicated they intend to use the Service Coordination Plan for all ACC clients.
- Cross-Provider Communication Agreements require RCCOs to strengthen relationships with providers across the continuum of care and document how they will work together to meet the client's goals.
- Disability-Competent tools and trainings help providers know how to meet the needs of persons with disabilities, and helps clients know where to find accessible care. The Department is working with nationally recognized disability competent care experts to create this tool. Colorado is only the second state in the nation to develop such a tool, which establishes an inventory of disability-accessible providers and resources.
- Strategies and models to reach out to clients with multiple conditions who use the emergency room or have high prescription drug utilization, and connect them to the services they need to change behaviors.
- Meetings with disability advocacy organizations in their communities to connect with existing services and learn how to support clients with disabilities.

22. The Department procures and re-procures contracts all the time with the base funding provided for administration. Why is the re-procurement of the ACC different, requiring new and specifically dedicated funding?

The request for dedicated funding for re-procurement is not unprecedented. The Department has submitted, and received approval for, four other budget requests since FY 2013-14 for contract re-

procurement funding. The request for proposals (RFPs) process is critical to ensuring the Department can maximize the value of taxpayer dollars spent on services and administration of public benefits. Consequently, the Department has historically requested additional funding to accommodate complex or critical vendor transitions and RFP processes that could not be otherwise absorbed with existing resources.

The original Accountable Care Collaborative (ACC) procurement, the recent re-procurement of the Medicaid Management Information System (MMIS), and several other procurements (see table at the end of this response) are all examples of procurements that received additional funding from the General Assembly based on the scope and complexity of the project. Given the importance of the ACC program in Colorado and the complex nature of the re-procurement, the Department believes additional resources are necessary to successfully design and re-procure the next phase of the ACC.

The ACC is Colorado Medicaid's delivery system reform and the primary vehicle for implementing broad, comprehensive care system reforms. Therefore, the re-procurement for the ACC requires new, dedicated funding to ensure the most effective policies and payment reforms for improving the health outcomes of Medicaid clients and achieving the greatest cost efficiencies are included.

The Department anticipates that the re-procurement of the ACC will be complex. For example, the Department is currently exploring options that may require a federal demonstration waiver. Such a waiver would allow Colorado new authority and flexibility in the administration of its Medicaid program. Specifically, it would allow the State to take major steps towards behavioral health integration, payment reform, cross-agency savings and rapid-cycle quality-improvement projects.

While a demonstration waiver offers considerable flexibility for Colorado, receiving approval of a waiver from the Centers for Medicare and Medicaid Services (CMS) is significantly more complicated and time-consuming than receiving approval of State Plan Amendments. Final approval of a demonstration waiver is contingent upon substantial stakeholder engagement work, detailed financial analysis, clearly articulated program goals and policies, and months and sometimes years of negotiations with CMS. These activities necessitate additional expertise and resources. The requested dollars would enable the Department to secure national expertise and technical assistance in the following three key domains:

- **Program and policy analysis**: additional national perspective and research capacity is needed to identify best practices, areas for savings, and specific contractual options.

- **Financial analysis and payment reform research:** moving towards purchasing value and away from an inefficient "volume-driven" system requires extensive knowledge of current payment methodologies, best practices in payment from other states, and opportunities for cross-agency savings.

- **Stakeholder engagement**: meaningful and lasting change will require the partnership of the various entities and individuals in the health care system. Developing these partnerships

is a time-consuming and complex process and using an external, neutral convener often helps stakeholders engage and provide useful, robust input.

Examples of Approved Funding Requests for Re-Procurements

Year	Request
FY 2013-14	R-5: MMIS Re-procurement
FY 2014-15	R-12: Administrative Contract Re-procurements
FY 2014-15	BA-13: Disability Determinations Contract Re-procurement
FY 2014-15	S-9: Behavioral Health Services Contracts Re-procurement

2:55-3:05 PHARMACY

23. Please discuss the most expensive drugs covered by Medicaid and the Department's cost containment efforts related to them.

The tables below represent the most expensive fee-for-service outpatient drugs based on total expenditures per drug and average cost per drug. It should be noted that drugs are also covered as a medical benefit, the tables below do not reflect costs associated with those drugs. Totals do not include drug rebates.

10 Most Expensive Fee-for-Service Outpatient Drugs based on Total Expenditure FY2013-14			
Rank	**Drug**	**Therapeutic Description**	**Total Expenditure**
1	Abilify	Antipsychotic	$29,797,549
2	Advair	Respiratory Agent	$8,718,211
3	Proair	Respiratory Agent	$8,662,111
4	Norditropin	Growth Hormone	$8,114,717
5	Synagis	Antiviral	$6,977,747
6	Oxycodone(1)	Analgesic	$6,901,163
7	Humira	Anti-inflammatory	$6,609,098
8	Methylphenidate(1)	ADHD Agent	$6,542,975
9	Lyrica	Anticonvulsant	$6,244,015
10	Sovaldi(2)	Hepatitis C Agent	$6,101,208

(1) Generic products only
(2) The total expenditure for Solvaldi is also included in the response to question 26. That figure is different from the total reported on this table because it reflects expenditures for a different time period.

Average Cost Per Unit FY 2013-14			
Rank	**Drug**	**Therapeutic Description**	**Average Cost Per Unit**
1	Stelara	Immunotherapy	$14,406.88

2	Somatuline	Growth Hormone	$11,104.43
3	HP Acthar Gel	Endocrine Disorders	$6,164.09
4	Neulasta	Immune Stimulator	$5,676.76
5	Simponi	Immunotherapy	$5,235.09
6	Kynamro	Antihyperlipidemic	$4,799.71
7	Mozobil	Non-Hodgkin's Lymphoma/Multiple Sclerosis	$4,282.89
8	Kalbitor	Immunotherapy	$3,546.67
9	Avonex	Multiple Sclerosis Agent	$3,655.26
10	Actimmune	Immunotherapy	$3,477.91

Cost Containment Strategies

The Department uses several cost containment strategies for fee-for-service outpatient drugs: drugs may require prior authorization to ensure that utilization is clinically appropriate and/or that more cost-effective alternatives are not available; the Department may enter into supplemental rebate contracts with drug manufacturers for preferred drugs which reduce a drug's net cost; quantity limits may be implemented; and, pursuant to section 25.5-5-501(1)(a), C.R.S., the Department covers only the generic equivalent of a drug unless one of the specified exceptions is applicable (e.g., the brand name drug is more cost-effective).

a. Why are these drugs so expensive? Are there common characteristics?

The cost of a drug is largely based on the price set by the drug manufacturer. In the absence of reduced demand (e.g., due to generic or therapeutic equivalents), there really are no other forces in the marketplace which work to reduce drug prices on a national scale. The federal government does not regulate drug prices and is barred from negotiating prices for Medicare. Medicaid programs receive federally mandated rebates from drug manufacturers, and sometimes state-negotiated supplemental rebates. Medicaid does not purchase drugs; pharmacies acquire the medications then Medicaid reimburses the pharmacies, therefore Medicaid is not in a position to directly negotiate drug prices.

The most expensive drugs often share some or all of the following characteristics: they are brand name drugs with no generic and/or therapeutic equivalents; they treat rare diseases for a relatively small portion of the population; they are specialty drugs such as biologics which are more expensive to manufacture; and, they treat diseases or symptoms which may be life-threatening or severely debilitating.

b. Are the drugs under patent? When will the patents expire?

Most drugs on this list are under patent. Drugs may be protected from competition through exclusive marketing rights and/or patents. Drug patents and exclusivity work in a similar fashion but are distinctly different from one another. Patents are granted by the Patent and Trademark Office anywhere along the development lifeline of a drug and can encompass a wide range of claims. Exclusivity is exclusive marketing rights granted by the Food and Drug Administration

upon approval of a drug and can run concurrently with a patent or not. Some drugs have both patent and exclusivity protection while others have just one or none.

Patents expire 20 years from the date of filing which happens during drug development but many other factors can affect the duration of a patent. The length of exclusivity depends on the type granted but generally lasts from 3 to 7 years. The Department anticipates that a generic equivalent for Abilify will be available in the marketplace in calendar year 2015.

c. What is the availability of generic options?

For the drugs listed in the tables above, only oxycodone and methylphenidate are generic products and these are widely available.

d. Are any of these drugs manufactured in Colorado?

Sandoz manufactures oxycodone products and has a manufacturing facility located in Colorado. The Department has not been able to confirm whether oxycodone is actually manufactured at their Broomfield location. Amgen manufactures Neulasta and has manufacturing facilities in Colorado but an Amgen document from 2011 indicates that Neulasta is manufactured in Puerto Rico.

e. Could/should the state provide incentives for production in Colorado, either through the Department of Health Care Policy and Financing or some other state agency, and what sort of incentives would be effective?

Colorado currently has programs set in place to incentivize business such as drug manufacturers to operate in the state. One of the programs includes the Colorado Innovation Investment Tax Credit (CIITC). This is a tax credit created in 2009 (HB 09-1105) to stimulate investments in Colorado businesses primarily involved in the research and development or manufacturing of new technologies, products or processes. Another program is the Biotechnology Research and Development Sales and Use Tax Refund. Under this program, Colorado's biotechnology industry has the ability to recover the sales and uses of taxes paid in the preceding year on equipment and supplies purchased to conduct biotechnology research and development. The Department does not administer these incentive programs or have data on their effectiveness.

24. How is the medically necessary standard applied to determine coverage of Sovaldi (and other expensive drugs)?

When creating prior authorization criteria for drugs, regardless of costs, the Department considers a number of factors including drug safety and effectiveness, clinical evidence, standards of practice, appropriate utilization and cost-effectiveness. The Department's established criteria is designed to allow coverage for drugs that are effective, clinically appropriate and cost-effective, which meets the medically necessary standard.

The Department understands that there may be situations where a Medicaid client may need a medication outside of the established coverage list and the provider believes it is medically necessary for the individual to receive the medication. The Department allows for a second review

whereby the provider may submit a letter of medical necessity and any other clinical evidence to establish the medical need for the medication.

A similar process is also applied for new drugs when there are not yet established prior authorization criteria developed through the Department's public process. This process includes the Department requesting a letter of medical necessity along with any supporting documentation the provider believes will help substantiate medical necessity. In this case, approval is generally based on whether the client cannot wait to receive the medication until there is established prior authorization criteria and existing evidence on the medication. In order to treat all Medicaid client's equitably, the Department prefers to wait to approve prior authorization requests until there is established, published criteria that all providers and clients can see and use. However, the Department recognizes that there are cases where the client cannot wait, and this process allows for those clients and their providers to make a request to receive the drug before criteria is finalized.

25. What is the prior authorization criteria for Hepatitis C mono-infected and HCV/HIV co-infected patients for access to Sovaldi and Harvoni? Please explain the rationale for the criteria?

HCV/HIV co-infection

The prior authorization criteria for the mono-infected and HCV/HIV co-infected individuals is the same. HCV/HIV co-infected clients are afforded the same access to Sovaldi and Harvoni as mono-infected clients. However, there is limited data on the effectiveness of treatment in HCV/HIV co-infected patients. According to the Sovaldi prescribing information, efficacy has been established in subjects with HCV/HIV-1 co-infection, but there were no published Sovaldi studies that included any HCV/HIV co-infected patients at the time of Sovaldi's FDA approval. The Harvoni prescribing information does not address treatment for patients co-infected with HCV/HIV. There are no published Harvoni studies that address co-infected patients. The prior authorization criteria for Hepatitis C per the Preferred Drug List is as follows:

Requests for Sovaldi will be prior authorized if the following criteria are met:

1. Client must have chronic Hepatitis C (HCV) genotype 1, 2, 3 (on transplant list only) or 4 AND
2. Client is 18 years of age and older AND
3. Women of childbearing potential and their male partners must use two forms of effective (non-hormonal) contraception during treatment. Initial pregnancy test must be performed prior to beginning therapy. AND
4. Sofosbuvir is prescribed by or in conjunction with an infectious disease specialist, gastroenterologist, or hepatologist AND
5. Client meets one of the following categories based on liver biopsy, symptoms or other accepted test:
    - Client with serious extra-hepatic manifestations of HCV such as leukocytoclastic vasculitis, membranoproliferative glomerulonephritis, or symptomatic cryoglobulinemia despite mild liver disease;
    - Client with cirrhosis with evidence of hepatic dysfunction as defined by one of the following: Child-Turcotte Pugh (CTP) class A or B (Score 5-9), ascites, hepatic

encephalopathy, or variceal bleeding, and on the liver transplant list with a projected time to transplant of < 1 year;
- Client is listed on the liver transplant list with a projected time to transplant of < 1 year (genotype: 1 naïve, 1 experienced, 2, 3, and 4);
- Client has hepatocellular carcinoma meeting Milan criteria; or
- Client has a fibrosis score equivalent to METAVIR 3-4. AND

6. For clients with Genotype 1, must be Hepatitis C treatment naïve AND
7. Client does not have severe renal impairment (eGFR<30 ml/min/1.73m2) or end stage renal disease requiring hemodialysis AND
8. Client must be 6 months free of: alcohol and Schedule I controlled substances (including marijuana); and cocaine, opiate, benzodiazepine, and barbiturate misuse/abuse as documented by appropriate alcohol/drug screens. Client must also be counseled about the importance of refraining from alcohol use and drug misuse/abuse. Routine alcohol/drug screens must be conducted monthly for clients that have a history (within the past 2 years) of alcohol/drug abuse AND
9. Client must have a baseline HCV ribonucleic acid (RNA) level within 30 days of anticipated start date AND
10. If client is receiving concomitant treatment with a hepatitis protease inhibitor (e.g. simeprevir) this will be reviewed based on medical necessity AND
11. All approvals will initially be for an 8 week time period, with further approvals dependent on the submission of the HCV RNA level at 4, at week 12, and week 24 to justify continuing drug therapy (see discontinuation criteria) AND
12. If the week 4 HCV RNA is detectable while on sofobuvir therapy, HCV RNA will be reassessed in 2 weeks. If the repeated HCV RNA level has not decreased (i.e. >1 log10 IU/ml from nadir) all treatment will be discontinued unless documentation is provided to support continuation of therapy AND
13. Must be in accordance to approved regimens and duration (see Table 1) AND
14. Must be adherent to treatment regimen (see discontinuation criteria) AND
15. Must be Sofosbuvir naïve

Note*:* Once treated, the Department will only cover a once per lifetime treatment with Sofosbuvir.

Discontinuation Criteria:

- Clients receiving a Sofosbuvir based regimen should have HCV RNA levels assessed at weeks, 4, 6 (if applicable), and 12 (if applicable); if the HCV RNA is above the lower limit of quantification by a validated test at any of these time points, all treatment will be discontinued.
- The Department will prospectively evaluate medication adherence based on prescription fills. If a client is non-adherent in filling their Sofosbuvir prescription (e.g. not filled within 7 days of the end of the previous fill), all treatment will be discontinued.

Table 1. Recommended Regimens and Treatment Duration for Sofosbuvir

HCV Genotype	Treatment	Duration
Genotype 1: interferon eligible	Sofosbuvir + peginterferon alfa + ribavirin	12 weeks

Genotype 1: interferon ineligible	Sofosbuvir + ribavirin	24 weeks
Genotype 2:	Sofosbuvir + ribavirin	12 weeks
Genotype 3: on transplant list	Sofosbuvir + ribavirin	24 weeks
Genotype 4: interferon eligible	Sofosbuvir + peginterferon alfa + ribavirin	12 weeks
Genotype 4: interferon ineligible	Sofosbuvir + ribavirin	24 weeks
Note: Post-transplant clients follow the same treatment regimen as described above.		

Quantity and Refill Limits:

Quantity Limit: one 400mg tablet per day (28 tablets/28days)
Length of authorization: Based on HCV subtype
Refills: Should be reauthorized in order to continue the appropriate treatment plan. The client MUST receive refills within one week of completing the previous fill.

Interferon Alpha Ineligible defined:

- Platelet count <75,000mm3
- Decompensated liver cirrhosis (CTP Class B or C or CTP score ≥ 7)
- Documented history of depression or mood disorder, which are not stable on current drug regimen
- Autoimmune hepatitis and another autoimmune disorder
- Inability to complete a prior treatment course due to a documented interferon-related adverse event.

Requests for Harvoni are currently reviewed for medical necessity on a case-by-case basis. Harvoni was approved by the FDA in October of 2014. The Department looks to its Drug Utilization Review (DUR) Board to advise and make recommendations regarding issues of drug utilization, provider education interventions and prior authorization criteria. Hepatitis C drugs were reviewed by the DUR Board in August 2014 and as such, they are not scheduled to be reviewed again until August 2015. At that time, the Board can make recommendations to the Department regarding coverage criteria on existing and new Hepatitis C agents. The Department will continue to evaluate the drug class to determine whether it will request the DUR Board to review these drugs before August 2015. Currently, the Department will manually review each request for new agents for medical necessity. Consideration for approval requires a letter of medical necessity from the individual's health care provider.

Rationale for criteria

The criteria developed for new agents is a process followed in accordance with the Department's rules associated with covering new drugs. This process is very involved and numerous stakeholders provide public testimony and recommendations including the Pharmacy and Therapeutics (P&T) Committee, the Drug Utilization Review (DUR) Board, medical specialists, drug manufacturer representatives, advocacy groups, and any other comments from the public. The criteria development process begins with the P&T Committee reviewing a drug for safety and efficacy, and providing recommendations to the Department based on in depth analysis of the evidence by the Center for Evidence Based Policy, published studies, other sources of evidence

including the California Technology Assessment Forum. The DUR Board is tasked with reviewing drugs the Department considers in need of prior authorization criteria. This Board recommends specific criteria to the Department's pharmacists and Chief Medical Officer, who consider these recommendations along with available cost-effectiveness data.

Please refer to Question 27 of this document for a detailed explanation of the drug review process.

26. For the time period between December 2013 through October 2014 how many people were approved and declined for Sovaldi?
   a. What was their fibrosis score, genotype, age, gender, and race?
   b. What other co-morbidities did they have?
   c. What was the total cost for Sovaldi treatment?
   d. How many achieved SVR?
   e. For patients who were declined Sovaldi, how is their fibrosis being monitored to ensure it is not escalating?

Between December 2013 and October 2014, prior authorization requests were approved for 89 Medicaid clients and prior authorization requests were denied for 157 clients.

a. The table below provides the statistics requested; however, the Department is limited in reporting in a number of key ways.

- Information such as fibrosis score and genotype are not provided on claims data; therefore the Department does not have a consistent way to track this information. Despite that challenge, the Department began informally tracking this information, where possible, due to the growing interest in Sovaldi.
- In certain cases, the Department's ability to report totals is limited due to federal privacy laws. When specific totals are not shown, the Department has provided the maximum detail permitted.

Solvaldi Approvals December 2013 - October 2014		
Item	**Approved**	**Denied**
Fibrosis Score	Insufficient Data to Report	Not Tracked
Genotype 1	32	64
Genotype 2	< 30	47
Genotype 3	< 30	37
Genotype 4	< 30	< 30
Average Age	53 (s.d. 8.5)	51 (s.d. 9.3)
Gender	Male: 49 Female: 40	Male: 98 Female 59

Race	White: 44 All Other: < 30	White: 78 All Other < 30

b. The Department has tracked certain co-morbidities related to liver disease and HIV because they are the more common co-morbidities in this population; however, the number of clients for any particular co-morbidity is less than 30 and cannot be reported individually due to federal privacy laws. The Department found that the distribution of co-morbidities for both approved and denied populations are similar.

c. The approximate costs incurred for Sovaldi® claims from December 2013 through October 2014 is $8,138,000. This number does not represent the total cost for all of the approved prior authorizations because some clients have completed treatment within this time period while others are mid-treatment as the typical treatment duration ranges from 3 to 6 months. In addition, a small percent of clients approved for Sovaldi® treatment have not received any medication based on the Department's claims data and may have not initiated their treatment in the requested time period.

d. Sustained Virologic Response (SVR) occurs when the Hepatitis C (HCV) RNA levels are undetectable for a period of time. Beginning June 1, 2014, the prior authorization criteria included requiring providers to supply HCV RNA levels, a measure of disease activity, at pre-treatment, treatment at 4 weeks and 12 weeks of treatment, and 12 weeks post-treatment. The Department's pharmacists initiate calls to providers to obtain the relevant HCV RNA levels at 4 and 12 weeks of treatment, and 12 weeks post-treatment. The HCV RNA levels are used to verify medication adherence and efficacy of treatment. Refills are authorized for 8 weeks at a time and are authorized after RNA levels are provided to the pharmacist at treatment weeks 4 and 12. The post-treatment RNA levels have not yet been obtained due to the fact that very few have reached the 12 week post-treatment point, or the RNA levels have not been provided despite the Department pharmacists' efforts.

e. The fibrosis stage of patients infected with Hepatitis C should be monitored by their physician. At any time, a physician may submit a new prior authorization request if the patient's fibrosis stage has changed or there is any other change in circumstance that the physician believes warrants another review for medical necessity. Hepatitis C is a slow progressing disease so a fibrosis stage does not usually change quickly and most people infected do not progress to cirrhosis.

27. Who makes the case-by-case decisions on prior authorization requests for Sovaldi? Is a Colorado hepatologist, gastroenterologist, or infections disease physician part of the decision making body?

The Department's pharmacists review Sovaldi prior authorization requests in conjunction with the Department's Chief Medical Officer on a case-by-case basis according to established criteria developed with input from multiple hepatologists.

In December 2013 when Sovaldi was FDA approved for treatment of Hepatitis C, Solvadi was added as a non-preferred agent to the Preferred Drug List (PDL) in accordance with the Department's rules. Each drug class on the PDL is reviewed on an annual basis. The Hepatitis C drugs are reviewed during July/August of each year. When the drug was first approved, the Department reviewed requests for medical necessity on a case-by-case basis until criteria was established. Sovaldi was reviewed for interim criteria in May 2014 at the Drug Utilization Review (DUR) Board meeting in order to develop a standardized manner in which Sovaldi prior authorization requests would be reviewed prior to the scheduled July/August meeting. At this time there were few studies published and little information available to help refine criteria. The Department then reviewed all of the current Hepatitis C agents at the July/August meetings and developed final criteria pursuant to its rules.

The current criteria was created through a robust process involving an extensive review of medical literature and input from numerous stakeholders, including specialists involved in the treatment of hepatitis C. Hepatitis C drugs are in a drug class that is included on the Department's PDL. As described in the Department's rules, the class goes through an extensive clinical review every year, which includes creating the prior authorization criteria.

The Pharmacy and Therapeutics (P&T) Committee, which is comprised of 7 physicians, 4 pharmacists, and 2 client representatives, reviews the class for safety and efficacy. As a part of the process, the Committee accepts testimony from any interested party, including pharmaceutical manufacturers, advocates, clients, and physicians. With regard to the Hepatitis C drugs, the drug manufacturer and an advocate on behalf of a hepatologist testified and responded to questions asked by the Committee. After reviewing the clinical evidence and all submitted testimony, the Committee voted that Sovaldi should be subject to prior authorization based its recent FDA approval and limited number of published studies about the safety and effectiveness of the drug. The Committee also recommended that during the prior authorization process, the prescriber should be asked if they specialize in hepatitis or if he/she consulted with someone who does. In accordance with the Department's rules, the Department then determines preferred and non-preferred drugs based on the P&T Committee's recommendations, drug safety, drug effectiveness, public comments, cost-effectiveness and scientific evidence. Based on all of this information, the Department made all of the drugs in the Hepatitis C drug class, including Sovaldi, non-preferred. The non-preferred products are then referred to the DUR Board to make recommendations on prior authorization criteria based on clinical information, public testimony and drug utilization. The DUR Board consists of 4 physicians, 4 pharmacists, and 1 non-voting pharmaceutical industry representative. The DUR Board solicits comments from any interested party and considers clinical evidence in order to make its recommendations. With regard to the Hepatitis C drugs, the DUR Board reviewed clinical studies, guidelines and reports as well as heard testimony from several hepatologists. The DUR Board made recommendations on prior authorization criteria, which was then considered by the Department when creating the final prior authorization criteria.

The Department also took additional steps to ensure that the input from specialists was included in the consideration process for Hepatitis C agents. The Medical Director met with hepatologists from across the state, considered written information provided by various hepatologists, and consulted with hepatologists from Denver Health. The Department also reviewed the Medication

Evidence Based Review Project (MED Project) report regarding Sovaldi. The Center for Evidence Based Policy, which runs the MED Project, is a national leader in evidence-based decision making and policy design. The MED Project members consists of outcomes researchers, health care professionals, and for this report, also contracted with a nationally recognized hepatologist who specializes in Hepatitis C treatment. The result was a comprehensive review of all of the clinical studies related to Sovaldi.

The Department consulted and invited specialists to participate throughout the process of creating the prior authorization criteria and were instrumental in the creation of the criteria.

28. Please estimate the cost of expanding the Sovaldi prior authorization criteria to include people with a fibrosis score of F2?

From December 2013 through October 2014, the Department spent approximately $8,138,000 on Sovaldi for the treatment of Hepatitis C. Currently the Department's prior authorization criteria includes fibrosis stages 3 and above. The costs are estimated to significantly increase if the Department were to expand the prior authorization criteria to include clients having fibrosis stages of 2 and above.

According to a meta-analysis that was completed in 2008, approximately 22% of the Hepatitis C population has a fibrosis stage of 2 whereas approximately 14% of the population has a fibrosis stage of 3.[1] Based on this figure, approximately 2,055 Colorado Medicaid clients have a fibrosis stage of 2. If the criteria was expanded to include all clients with a fibrosis stage of 2, the potential additional costs would range from $172,620,000 to $345,240,000 total funds. If current criteria remains in place with the sole exception of changing the required fibrosis score from 3 to 2, it is unclear how many of these estimated 2,055 clients would receive Sovaldi. Even if it were just 10% of that additional population, the budget would increase by approximately $17,260,000 to $34,520,000.

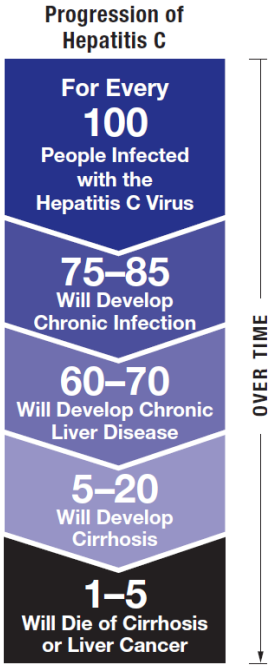
These estimates are based on an analysis performed as of May 31, 2014 where the Department found that over 5,100 clients have a known diagnosis of Hepatitis C. Treatment with Sovaldi costs approximately $84,000 to $168,000 per treatment (depending on the number of weeks of treatment and the Department has about half of treated clients in each category). If all clients with a known diagnosis of Hepatitis C received Sovaldi, it could almost triple the state's annual expenses on pharmaceuticals to approximately $1.2 billion. This number does not take into account existing Medicaid clients who have undiagnosed Hepatitis C infections. The latest estimate using epidemiological statistics published by the U.S. Preventative Services Task Force finds there may be as many as 9,343 clients with Hepatitis C enrolled in Colorado's Medicaid program. Based on those numbers, Colorado could spend as much as $1.8 billion on Hepatitis C related treatments.

The Medicaid Evidence Based Decisions collaboration run by The Center for Evidence Based Policy has collected information about other Medicaid programs and their policies. They have information regarding 27 states that have prior authorization criteria for Sovaldi. Of those states, 24 include disease severity (fibrosis stage) as part of their prior authorization criteria. Of these 24

[1] Thein HH, Yi Q, Dore G., and Krahn M., Estimation of Stage-Specific Fibrosis Progression Rates in Chronic Hepatitis C Virus Infections: A Meta-Analysis and Meta-Regression. Hepatology. 2008;48(2):418-31.

states, 19 require a fibrosis stage of 3 or above. Only three states cover fibrosis stages 2 or above and two states do not clearly specify fibrosis stage requirements. Thus the Department's current policy of requiring a fibrosis score of 3 or more is consistent with the policies of many other states.

In addition, it is important to note that the disease is a slowly progressing disease and many people who are infected with Hepatitis C do not progress to serious liver disease. According to the Centers for Disease Control and Prevention, out of every 100 people infected with the Hepatitis C virus, about 75 to 85 people will develop chronic Hepatitis C virus infection. Of those, 60 to 70 people will develop chronic liver disease, 5 to 20 people will develop cirrhosis over a period of 20 to 30 years, and 1 to 5 people will die from cirrhosis or liver cancer. This is illustrated in the image below. Thus the Department believes that it is clinically appropriate to only allow usage when clients have reached a fibrosis score of 3 or more



3:05-3:15 ELIGIBILITY AND ENROLLMENT

29. In R6 the Department proposes to provide a one-month grace period for people to pay the CHP+ enrollment fee. What information does the Department have about why some people who meet the income eligibility criteria are not currently paying the enrollment fee?

The Department does not currently collect data to identify why applicants are not paying the enrollment fee. Clients that are eligible for CHP+ with incomes 157% above the Federal Poverty Level or higher are responsible for paying an enrollment fee. These clients are not enrolled immediately and benefits cannot be accessed until the enrollment fee is paid and processed. Anecdotally, feedback has been that applicants were not able to meet the deadline to pay on time or they were not able to afford the enrollment fee amount.

The Department's R-6 request focuses on the fact that individuals that qualify for CHP+ cannot receive a real-time determination when they apply online because a determination requires

additional manual processing, noticing, and the payment of the enrollment fee, which occurs after the client is otherwise eligible. By allowing a one-month grace period for CHP+, clients can receive immediate access to benefits upon being determined eligible.

30. In R6 the Department proposes an option for using annualized income, rather than monthly income, to determine Medicaid eligibility. In states that have implemented annualized income has it reduced churn?

Three states were identified that have implemented annualized income determinations (California, Michigan, and Vermont). The Department has researched this topic and at this time has not found any information that specifically addresses if these states have seen a reduction in churn based upon implementation of this policy. However a 2014 study published in Health Affairs states that this policy is an option that "could reduce rates of eligibility changes, particularly for workers whose earnings vary seasonally". The Department has reached out to these states to find out more information around their implementation of this policy and if they have seen a reduction in churn due to the implementation of this policy. Thus far, the Department has only received a response from officials in Michigan, who have indicated that it is still too early to determine if this policy has caused a reduction in churn, but they do expect that this policy will reduce churn.

31. How did the last open enrollment period for health plans offered through Connect for Health Colorado affect enrollment in Medicaid and the Children's Basic Health Plan (CHP+)? How is the open enrollment period accounted for in the Department's projections for FY 2014-15 and FY 2015-16? Is the Department expecting a surge in enrollment during this period?

Total caseload for Medicaid and CHP+ experienced a surge of enrollment beginning in January 2014, after the open enrollment period. High growth rates continued through the remainder of the fiscal year. Average monthly caseload for both programs in FY 2013-14 was 21.12% higher than the average monthly caseload in FY 2012-13. The Department does expect a second surge during the open enrollment period in FY 2014-15, and has accounted for it in its November 2014 budget requests for Medicaid and CHP+. The Department estimates that total caseload will increase nearly 30% in FY 2014-15, but that growth will slow to less than 9% in FY 2015-16 as most of the expansion and eligible but not enrolled ("welcome-mat") populations will have enrolled by that time.

32. What is the percentage of teen births covered by Medicaid? What data does the Department have on the percentage of complicated births covered by Medicaid?

The table below shows the percentage of teen births covered by Medicaid:

Colorado Teen Births Compared to Medicaid Teen Births			
Item	**FY 2011-12**	**FY 2012-13**	**FY 2013-14**
Medicaid Teen Deliveries (Ages 15-19) [(1)]	3,399	3,351	2,963
Total Colorado Teen Births (Ages 15-19) [(2)]	4,687	4,123	3,807

Percent of Teen Births Covered by Medicaid	72.5%	81.3%	77.8%
Note: Medicaid data are for fiscal years. CDPHE-based total Colorado data are for calendar years 2011, 2012, and 2013.			
(1) From FY 2013-14, 2014-15, 2015-16 Budget Request: Department Description.			
(2) CDPHE Publications 'Colorado Births and Deaths' for 2011, 2012, and 2013.			

The Department does not have data showing the number of complicated births covered by other insurers; the percentage of Medicaid births considered complicated can be found in the table below.

Percentage of Colorado Medicaid Births Considered Complicated			
Item	**FY 2011-12**	**FY 2012-13**	**FY 2013-14 (July-Dec)**
Number of Medicaid Fee-for-Service Inpatient Deliveries (1)	21,398	21,606	11,599
Number of Caesarian Section Deliveries with Complicating Diagnoses (1)	2,137	2,170	1,009
Number of Vaginal Deliveries with Complicating Diagnoses (1)	2,941	2,779	1,492
Percentage of Medicaid Fee-for-Service Inpatient Deliveries Considered Complicated (2)	23.73%	22.91%	21.56%
(1) From FY 2013-14, 2014-15, 2015-16 Budget Request: Department Description.			
(2) Calculation derived from adding caesarian section deliveries and vaginal deliveries with complicating diagnoses and dividing by total CMS-DRG inpatient deliveries.			

For additional context, the table below shows the percentage of low birth weight infant births covered by Medicaid as a percentage of the statewide total.

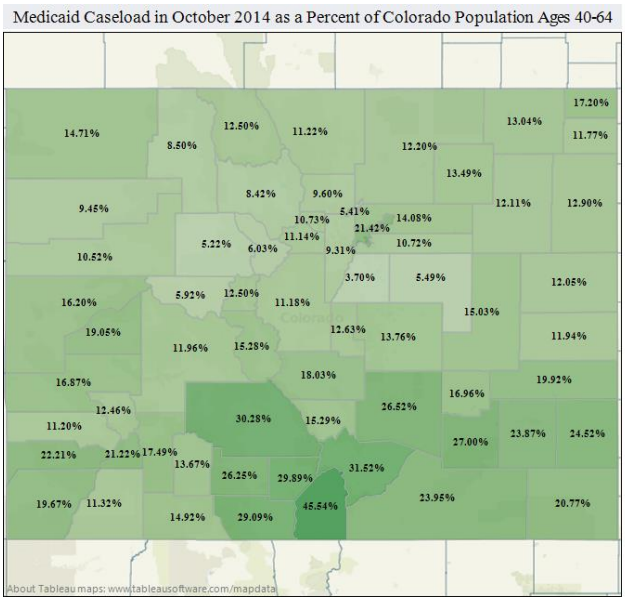
Percentage of Low Birth Weight Infants in Colorado Covered by Medicaid			
Item	**FY 2011-12**	**FY 2012-13**	**FY 2013-14**
Medicaid Low Birth Weight Infants (< 2500 grams) (1)	3,137	3,385	3,752
Colorado Low Birth Weight Infants (< 2500 grams) (2)	5,659	5,762	5,728

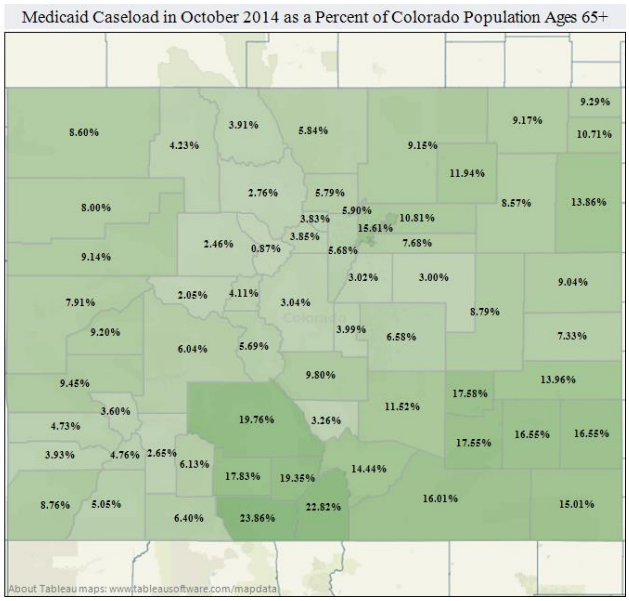
Percent of Low Birth Weight Infants in CO	55.43%	58.75%	65.50%
(1) From FY 2013-14, 2014-15, 2015-16 Budget Request: Department Description.			
(2) CDPHE Publications 'Colorado Births and Deaths' for 2011, 2012, and 2013.			

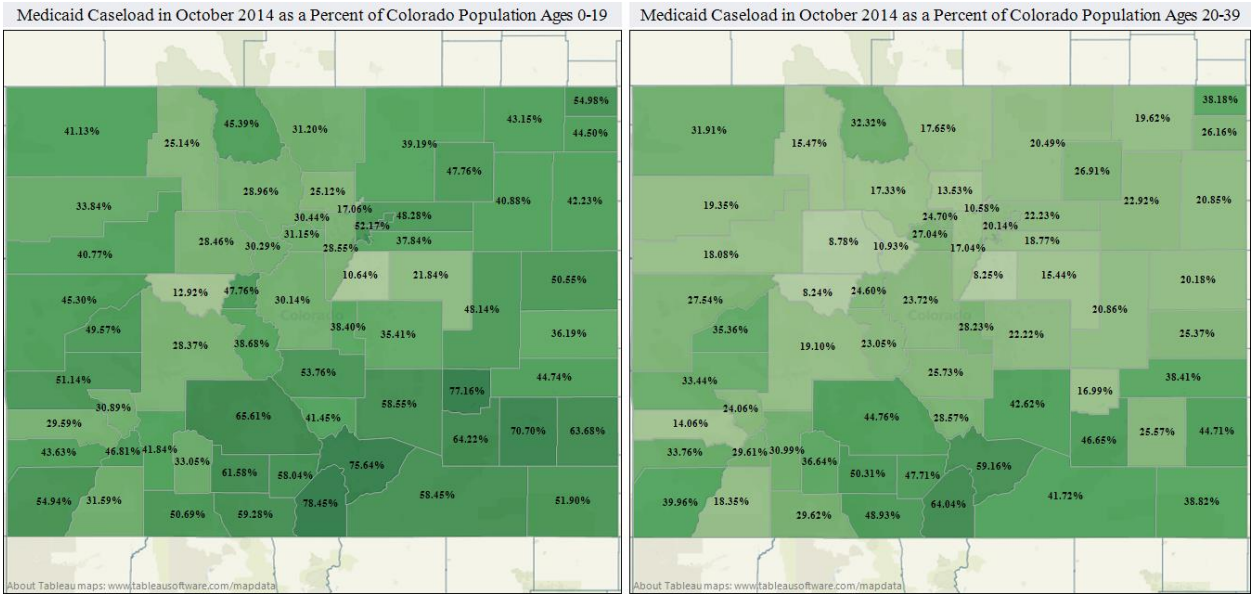
33. The JBC staff provided a map showing the percentage of Colorado's population enrolled in Medicaid by county. Is there significant variation for subsets of the population, such as the percentage of children or the percentage of elderly covered by Medicaid by county?

The Department has provided four additional maps showing Medicaid caseload as a percent of the Colorado population divided into age groupings. The age groupings include 0-19 for children, 20-39 for young/middle adults, 40-64 for older adults, and 65+ for the elderly.

The maps indicate that penetration rates as a percentage of Colorado population are highest for children and lowest for the elderly population; there are intermediate penetration rates for adults. With limited exception, counties with higher enrollment rates as a percentage of population compared to other counties in the state for children also have a higher penetration rate for older individuals.







34. Why has the removal of the five-year bar for children and pregnant women been delayed?

In order to implement this policy, funding was required to program the new eligibility rules into the Colorado Benefits Management System (CBMS). Both the Department of Human Services (DHS) and the Department rely on CBMS to operate their programs. Because there is a limit on the amount of system changes that can happen per quarter, the departments created a work plan to prioritize all of the needed system changes. Due to the amount of system changes requested by both departments, there is currently a prioritized work plan for changes going into 2016.

The required system changes to eliminate the five year bar was placed on the CBMS work plan once funding became available in July 2014, which was the earliest that it could be scheduled. Due to the amount of changes currently being made to the system, the earliest the Department could schedule the system change was for the first half of 2015 with a scheduled implementation date of June 2015. Since the system change is currently prioritized, the Department is now working to secure federal approval through a State Plan Amendment and has begun drafting rules to present to Medical Services Board so that it can implement the policy as soon as the system change is complete.

The Department estimated a similar system change timeline when the original legislation (HB 09-1353) was passed in 2009 as noted in the fiscal note under "Caseload Estimates". The Department has been required to prioritize system changes over the past several years due to the limited amount of hours for system changes and the many projects requested by HCPF and DHS.

3:15-3:30 BREAK

3:30-4:00 RATES AND ACCESS

35. Please identify some underutilized preventive care measures that save money on medical expenses in the long run. What does the Department need from the General Assembly to increase utilization of these preventive care measures?

The Department offers a wide range of preventive services to Medicaid clients, including screenings to prevent and treat chronic conditions such as depression, heart disease and diabetes and counseling to promote healthy eating, regular exercise and tobacco cessation. Preventive services allow providers to detect and treat chronic diseases early, improving client outcomes and reducing health care costs. Nationally, Americans use preventive services at about half the recommended rate, according to the Centers for Disease Control. This trend appears to be the same among Colorado Medicaid clients.

A few examples of underutilized preventive care services that save money in the long run include:

- U.S. Preventive Services Task Force (USPSTF) Recommended Benefits. The Medicaid benefit package covers more than 50 USPSTF recommended preventive care services. Examples of covered benefits include screenings for cancer, diabetes, and sexually transmitted diseases (STDs); counseling for alcohol misuse, obesity, STDs, and tobacco use; and vaccinations for a host of infectious diseases. The USPSTF services help to prevent, detect and treat chronic conditions before they become complex and costly. Although the Department removed copays for all these services in January 2014, utilization remains low.

- Depression Screening. In August 2011, the Department added depression screening as a covered benefit for adolescents ages 11-20. In January 2014, the Department expanded the benefit to adults. Clients suffering from depression often have a comorbid chronic condition that is exacerbated when the underlying mental health condition is not diagnosed and treated.

- Preventive Oral Health Care Services for Children. All children with Medicaid coverage have access to dental care, however utilization of important preventive oral health care services among children could be improved. Dental risk assessments, anticipatory guidance and/or appropriate use of fluoride varnish, are an essential part of early oral health care and primary prevention of oral diseases in children.

Percentage of Medicaid Children Receiving Dental Services

	2011	2012	2013
Number of Children Receiving Services	264,201	215,317	220,419
Number of Children Eligible for Services	481,579	441,069	412,626
Percentage of Eligible Children Receiving Dental Services	55%	49%	53%

Notes:

1. Total number of children receiving dental services --- CMS EPSDT report, line 12G.

2. Total number of children eligible for services --- CMS EPSDT report, line 1b.

3. Years are Federal fiscal years, Oct 1 - Sept 30.

- Advanced Care Planning. In August 2013, the Department began providing coverage for end of life counseling in accordance with HB13-1202. Under this new benefit, primary care providers can counsel clients with serious, chronic, or terminal illnesses regarding treatment options available to them and get paid for the service. Providers can counsel and help the client document their wishes in an Advanced Directive that may be shared with family and other providers. Completion of an Advanced Directive can reduce the costs associated with medical treatment for the terminally ill. Currently, there is no central repository for Advanced Directives in Colorado making it difficult for providers to know if a client has filed an Advanced Directive and for clients to share their Advanced Directives with their health care team. The lack of a statewide registry for Advanced Directive serves as a disincentive for providers and clients to engage in end of life counseling.

An unmanaged fee-for-service (FFS) Medicaid environment is part of the reason that clients are not utilizing preventive care services. Simply opening new FFS codes for preventive services will not result in more value or better health. As a result, the Department implemented the Accountable Care Collaborative (ACC) to transform the Medicaid delivery system. Under the ACC, the Regional Care Collaborative Organizations and their care coordinators can promote wellness and prevention with clients.

As the program evolves, the ACC is transitioning from a strict medical model toward a broader model that integrates community, social services, and non-medical resources and makes Coloradans healthier. RCCOs and Primary Care Medical Providers (PCMPs) are working with ACC members to address barriers to accessing preventive and wellness services.

Currently, RCCOs and PCMPs are rewarded for performing well on several key performance indicators, including preventive measures such as well-child visits and post-partum follow-up care. Going forward, the Department is examining various payment strategies for the ACC to reward positive outcomes rather than incentivizing a high volume of services. The Department is also looking for new ways to tie payment to value in the ACC by targeting provider rate increases to services that result in high-value, cost-effective care.

The General Assembly can support expanded access to preventive services by supporting the evolution of the ACC. The Department needs support for efforts to tie payment to value and support for rate innovations. Additionally, the General Assembly can support efforts to bolster primary care, increase data sharing and transparency in the ACC. The following decision items in this year's budget proposal support this continued evolution of the ACC:

- R-11 Public Health and Medicaid Alignment
- R-12 Community and Targeted Provider Rate Increase
- R-13 ACC Reprocurement Preparation

Other opportunities for the General Assembly to expand access to preventive services include:

- Establishing a Statewide Registry for Advanced Directives. Many states have established a statewide registry for Advanced Directives. The registries serve as a single repository for all Advanced Directives in the state. States with these registries have seen an increase in the number of Advanced Directives filed. Providers can access the registry to determine if their client has already received end of life counseling and registered their treatment directions.

- Education and Outreach Campaign on Preventive Services. The Department would like to partner with the Colorado Department of Public Health and Environment to help promote preventive services to clients and providers. One idea is to develop a Medicaid Preventive Services Handbook that the Department and CDPHE can share with providers across the state.

36. Please provide a status update on the implementation of the rate increases approved by the General Assembly last year. Have all the rate increases been implemented? Are any of the rate increases being paid retroactively?

The Department required 20 State Plan Amendments (SPAs) to implement the FY 2014-15 rate increases approved by the General Assembly, and has successfully implemented rate increases for 14 of the 20 SPAs.

The following table list the service categories and status of the 6 outstanding SPAs:

SPA Service Category	Status
Home Health	CMS issued a Request for Additional Information (RAI), which has been returned to CMS and is under review.
Hospice	Rates are prescribed by CMS and issued in October. The SPA, when approved, will have an October 1st effective date.
Mental Health Fee-For-Service	CMS issued a RAI. The Department is currently developing its response and will submit the response by December 12.
EPSDT	CMS issued a RAI. The Department is currently developing its response and will submit the response by December 12.
Non-Emergent Medical Transportation (NEMT)	CMS issued a RAI. Responses will be submitted to CMS upon finalization of cost allocation reporting.
Adult Dental Services	Approved by CMS. Rate increase scheduled to be implemented on December 6, 2014.

Given that CMS approval of the 14 SPAs occurred after July 1, 2014 the rate increases were applied retroactively, the Department began making retroactive payments in September 2014. The Department paid providers a lump sum equaling the difference between the former rate and the newly implemented rate for services provided between July 1, 2014, and the rate increase implementation date.

37. Did the targeted rate increases approved by the General Assembly achieve their intended purposes?

The Department's historical approach to rate increases was either across the board increases or increases focused on a narrow service category. During the 2014 legislative session, the General Assembly approved a new, collaborative approach focused on improving value, health outcomes and access to needed services. The purpose of these targeted rate increases was to infuse funding into the system in targeted areas to promote utilization of low-cost, high-value procedures with the goal of improving client outcomes and reducing expenditures. The increases were also aimed at addressing large inequities in rates to improve client access to cost-effective care.

Although the targeted rate increase was implemented less than six months ago, these increases have already started to show signs of success in reaching these goals. Medicaid clients are already experiencing the benefits of wider utilization of low-cost, high-value procedures. Additionally, access to care has increased for clients with critical health care needs.

The Department worked with stakeholders to assess the delivery system and determine specific providers, codes, and services where reimbursement could be increased to drive value into the system and reduce costs. Ultimately, the General Assembly approved a host of targeted rate increases that included both Department and stakeholder recommendations.

The approved rate increases include:

- Pediatric Hospice Waiver Services
- Extended/After Hours Primary Care
- Transitional Living Program for Brain Injury Clients
- Pediatric Developmental Assessments
- Single Entry Point (SEP) Funding
- Ambulatory Surgical Center (ASC) – Surgeons
- High-Value Specialist Services
- Mammography Codes
- Complex Rehabilitation Codes
- Federally Qualified Health Center's (FQHCs)
- Family Planning Codes

Although data is limited because the rate increases have only been recently implemented, the observed effects of the targeted rate increases are favorable:

- In the last six months, more providers have enrolled in Medicaid and have begun providing more services to more clients in terms of evaluative, developmental and preventive services.

- Providers and clients are responding favorably to extended hours for primary care. Over the next year, utilization of the emergency department should decrease as a result of doctor's offices remaining open to clients after the work day.

- The Department is seeing increases in Medicaid clients receiving needed services such as vision exams and diagnostic services.

- Prior to the targeted rate increase in July, there was not a single provider in the state providing transitional living services for clients that have suffered a brain injury. These clients were subject to long hospital stays and were eventually discharged to an inappropriate and costly setting. As a result of the targeted rate increase, there is now one provider helping brain injury clients transition to an independent setting with significantly lower costs. Several more providers have indicated they plan to begin offering these services to brain injury clients in the next six months.

- Over the last few months, the Department has engaged stakeholders to identify targeted rate increases in Ambulatory Surgery Centers to encourage high-value procedures and create meaningful changes in facility utilization. Selections were finalized with the providers in October, and implemented by the Department. While provider involvement extends the implementation timeframe, it enables a focused collaboration that maximizes results of the rate increase.

Even with these initial indicators or success, it often takes at least a year or more of experience to see measureable change in the delivery system from rate increases. Additionally, it can be difficult to measure improved client outcomes and reduced expenditures through claims data alone. That said, the Department is encouraged by the early findings of the targeted rate increase of increased providers and increased services and are expecting this will translate into improved health of our clients. The Department will continue to monitor multiple measures, including increased utilization of low-cost, high-value services and increased access to cost-effective care.

38. The Department's request discusses rates in terms of their influence on access to care, but what does access to care mean, and how does the Department determine when an appropriate level of access to care has been achieved?

The Department considers access to care a critical element to achieving the Triple Aim: improving health outcomes, improving client experience of health care, and lowering costs. That said, defining access to care and determining when an appropriate level of access to care has been achieved is complex and involves multiple factors, many of which are hard to monitor and track. In fact, there is no consistent definition of access and many of our partners, like the Colorado Health Institute, agree there is no single standard measure of access to care and that reliable methods are being developed and tested to ensure a comprehensive understanding of patient's experiences with access to care. Access covers a broad range of activities from Medicaid

eligibility, to access to providers, to developing a relationship with providers that includes care coordination and activities to maximize health. In addition, the Department thinks that while access is important, we also need to consider impacts on value and health outcomes.

Given that there is no standard of definition of access, there is no precise way to measure when an appropriate level of access has been achieved. The Department does measure a variety of factors that help us identify where there may be problems that include nationally recognized measures (e.g., Health Effectiveness Data and Information Set [HEDIS], Consumer Assessment of Healthcare Providers and Systems [CAHPS]). These factors center on the key areas of network adequacy, utilization of services, and client perceptions. There are also some Department-specific metrics including the geographic distribution of providers across Colorado, number/type of providers who serve Medicaid clients and eligibility "churn" off/on Medicaid.

For larger, more long-standing issues with access, the Department can pursue policy changes such as the targeted rate increases. For the current fiscal year, the legislature approved the Department's request to increase reimbursement rates for primary care services delivered outside of normal business hours. The Department pursued this request based on the findings that many regions of the state reported very limited access to primary care outside of normal business hours and reports of increased utilization of the Emergency Department. Anecdotally, it has been relayed to the Department that more providers are offering extended office hours as a result of the increased reimbursement.

Addressing access to care will require coordination and collaboration with others outside the Department. Access impacts both Medicaid and private insurance. The Department will continue to work with our partners in other state agencies, our Regional Care Collaborative Organizations and stakeholders on addressing access to care.

39. What is the Department doing to ensure access to care in rural areas?

The Department is committed to exploring a variety of new and innovative programs and policies aimed at increasing access to care for rural Coloradans. As referenced in the Department's response to Legislative Request for Information #2, submitted to the Joint Budget Committee on November 3, 2014, the Department is taking a multi-pronged approach to ensuring access to care in rural areas.

- **The Accountable Care Collaborative (ACC) Program** –The ACC was designed to offer practice improvement support, care coordination, data, and other critical resources to busy providers, especially those in rural areas.

- **Primary Care Rate increases** – The Affordable Care Act provided federal funding to increase Medicaid primary care rates to the equivalent Medicare rate; however, this funding expires at the end of 2014. For FY 2014-15, the Department submitted and received approval for a budget request to continue the primary care rate increase and to expand the number of providers who will receive the increase. The funding to continue this increase is a critical factor in encouraging rural primary care providers to participate in Medicaid. In addition to this targeted

increase, Medicaid has requested both across-the-board provider rate increase, as well as targeted rate increases for high value services. Anecdotally the Department has heard from providers that they are more willing to care for Medicaid clients as a result of some of the recent rate increases.

- **Extended hours/after-hours care** – The Department has recently opened codes that financially incentivize providers to offer office hours outside of normal business hours as a way to improve primary care access.

- **Telehealth programs** - The Department is in the process of expanding the use of telehealth technologies as a means to expand access to care in rural and underserved areas.
    - Chronic Disease Pain Management Program – Starting this fiscal year the Department will utilize videoconferencing to connect Colorado primary care providers with a multi-disciplinary team of pain management specialists.
    - eConsult Program – The Department is working with the Colorado Regional Health Information Organization (CORHIO) to pilot an eConsult program in early 2015. The eConsult program will enable primary care and specialty care providers to easily exchange clinical questions, messages, and share patient medical records through a secure web-based platform.

- **Provider outreach** – In April 2014, the Department established a new division focused on provider relations signifying the Department's commitment to provider recruitment and retention.

The Department is also engaged in a number of state initiatives designed to support providers in rural areas:

- **The Colorado Health Services Corps (CHCS) program** - a state educational loan repayment program that supports providers to live in and serve rural and under-served communities across Colorado.

- **NGA Healthcare Workforce Technical Assistance Grant** –this statewide initiative is developing and implementing a plan for expanding Colorado's health care workforce capacity, with a focus on rural and underserved areas of the state.

- **Colorado Area Health Education Center (AHEC) programs** – These regional initiatives promote health care professions to youth.

- **Rural Track at the University of Colorado School of Medicine** – since 2005, the Rural Track has provided students with training and practical experience in an effort to increase the number of physicians who enter and remain in practice in rural Colorado.

- **Community Para-Medicine Initiatives** – these models use emergency medical technicians (EMTs) and paramedic teams for the delivery of basic primary care health services in rural areas with extremely limited capacity.

40. In some areas of the state, particularly rural areas, Medicaid is a dominant payer. In these areas are Medicaid reimbursement rates repressing the number of providers and the overall access to care, essentially dictating access to care for people who are not enrolled in Medicaid?

Recruiting providers to underserved areas is an issue for both Medicaid and private insurance. Addressing access to care will require collaboration across state agencies, and with private insurance, educational institutions, and local communities.

The Department agrees that Medicaid's overall reimbursement rates may play a part in the decision by some providers not to practice in rural areas with high Medicaid enrollment. While provider capacity is a challenge in many areas, the Department has no data by which to determine how many providers might choose to practice in these areas if Medicaid reimbursement rates were higher. The social, economic, and educational infrastructures of rural and frontier areas are also important factors in a provider's choice of practice location.

Approximately 21% of Coloradans have Medicaid. Of Colorado's 64 counties, 23 are designated as rural (non-metro) and 24 are designated as frontier.[2] Not all rural and frontier counties have a high population of Medicaid enrollees. Currently, 10 rural counties and 8 frontier counties have a percentage of Medicaid enrollees at or below the state average of 21%. Rural counties with the highest percentage of Medicaid enrollees are: Alamosa, Conejos, Montezuma, Otero, Prowers and Rio Grande, ranging from 31-42%. Frontier counties with the highest percentage of Medicaid enrollees are: Baca, Bent, Costilla, Huerfano, Las Animas, and Saguache, ranging from 30-50%.

The remaining non-Medicaid population is comprised of people with commercial health plan coverage, Veterans benefits, Medicare, and people with no coverage. While a high volume of Medicaid patients can impact a practice's income, it's also true that in many rural areas, there isn't a critical mass of patients under any one payer. All payers are vital to keeping the doors open. The Department has also received positive feedback for Medicaid expansion from some rural providers, as their percent of uncompensated care has dropped significantly.

The Department understands that many providers whose practices focus on Medicaid and underserved populations choose to stay in larger metro areas, where patient volume compensates somewhat for lower reimbursement rates. One of Colorado's most successful efforts to encourage providers with an interest in serving these populations to practice in rural areas is the Colorado Health Services Corp (CHCS) Loan Repayment Program administered by the Colorado Department of Public Health and Environment (CDPHE). Interest in this loan repayment program

[2] Defined as fewer than 6 persons per square mile.

for health care professionals is growing exponentially each year. With one of the largest state loan repayment programs in the nation, CDPHE received 149 applications in the most recent award cycle (November 2014). Unfortunately, funding was only available for 26 awards. This demonstrates that there is significant interest in serving in areas with a high concentration of Medicaid and underserved populations when providers are partially relieved of the burden of student loan debt.

The Rural and Under-served track at the University of Colorado Medical School has also demonstrated success in educating providers about the needs of Medicaid and under-served populations. Funding from both of these programs supports providers to practice in rural and under-served areas.

The Department continues to request funding for across-the-board provider rate increases as well as targeted rate increases for specific high-value services with relatively low reimbursement rates. These increases help providers regardless of location. The Department is also actively promoting participation in the Accountable Care Collaborative (ACC) program as a way for providers in rural and frontier areas to obtain additional funding and support for their practices. The Department will continue to explore ways to reach out to partners, providers and communities across Colorado to address barriers to the health and wellbeing for Coloradans.

41. Why is the Department unable to quickly implement an annual rate review process that is transparent and open to the public while the Workers' Compensation program doesn't appear to struggle to do so?

It is very important that the Department is thoughtful about a permanent rate review process because it will likely have significant impact on future state budgets. We want this process to be thorough and have enough flexibility to allow for times when there isn't enough funding. We agree there should be a standardized, transparent process. Most Medicaid rates have historically only been adjusted in accordance with appropriations, resources for an extensive process such as that used by Workers' Compensation do not currently exist. The Division of Workers' Compensation (DOWC) at the Colorado Department of Labor and Employment is required by section 8-42-101(3), C.R.S. to review the Medical Fee Schedule annually. To comply with this requirement, the Division engages in a 4 to 6 month process of extensive data analytics with an additional 4-to-6 months of review, clearance, public notice, and stakeholder training. Further, the fee schedule that the DOWC publishes does not change state expenditure; the rates reflect a maximum level that a health care provider may charge an insurer or employer for services rendered to injured workers.

The Department is still engaged in the design and development activities of such a process. The activities include:

- Phase 1 work with Public Consulting Group: This is LRFI #1 which is a report from PCG that reviews existing rate processes and recommends a framework to measure access and value.
- Phase 2 work with PCG: There are three remaining deliverables from PCG. These will provide additional recommendations on methodology and how to operationalize a rate review process. PCG will also pilot the rate review process on a subset of our fee

schedule to identify potential problems that can be addressed before the process is implemented.

- Federal guidance: The Center for Medicare and Medicaid Services proposed new regulations in 2011 that recommend periodic rate review. These final regulations were expected November 2014 but it is difficult to determine when they will be released. We are continuing our work but if this guidance is released soon, we will incorporate that into our process.
- Engaging stakeholders: The proposed process must include opportunity for legislative input and modification. On a parallel track, we also need to provide opportunity for input from other stakeholders including providers, clients and advocates.
- Legislative, budget and Federal authority: The Department must obtain statutory and spending authority from the legislature and consent from our federal partners.

As a result, we have come back with an interim solution of targeted rate increases. The targeted rate increases are a good way for the Department to incentivize value and improved health outcomes and ensure access, while continuing to work on thoughtfully developing this process.

42. Please provide an overview of the recommendations from the Public Consulting Group. Why hasn't the Department implemented the recommendations?

The Public Consulting Group (PCG) provided the Department a report in November 2014 to respond to the JBC's LRFI #1. This reports included a proposed methodology for determining sufficiency of rates for access and a proposed methodology for prioritizing rates to promote proper utilization and cost-effective care. PCG recommended:

- An access review that investigates access to care, followed by a rate review that focuses on services that appear to be affected by inadequate provider networks or increased enrollee need.
- Developing policy options to address access or utilization issues through rate adjustments or other administrative strategies. The Department thinks that not only is access important, as outlined in the recommendations, but that we must also have a process to review rates for their impact on value and the ability to improve health outcomes for our clients. The Department would use access, value and health outcomes to guide rate adjustment and the development of other policies and programs.
- A rate review cycle that is conducted over the course of the year and aligns with key legislative timelines.
    - Phase 1: Access, value and health outcome review over three months
    - Phase 2: Rate review over three months
    - Phase 3: Budget review over four months
    - Phase 4: Implementation over eight months

The Department has not implemented the annual rate review process because we are still engaged in the design and development activities of such a process as described in Question #41.

43. Every state has to set Medicaid rates. What do other states do? Are there any states that the Department believes do a particularly good job of setting ratings?

State Medicaid delivery systems vary widely and therefore, corresponding rate setting does as well. While a majority of states tie rates to a percentage of Medicare or use the Resource Based Relative Value Scale (RBRVS) system to inform their rate setting methodology (as Colorado does), the variation in delivery systems (managed care, fee-for-service, etc.) makes cross-state comparisons very difficult. A summary of Medicaid rate setting by the Medicaid and Children's Health Insurance Program Payment and Access Commission (MACPAC) stated,

> "In the Medicaid program, state flexibility to develop payment policies has led to significant variation in payment methods, reflecting individual state policy decisions, geographic differences in costs, and practice patterns. Moreover, there is no easily accessible source of state payment methods, no comprehensive analysis of which are more or less effective, and no uniform data that permit meaningful comparisons of payment levels."

There is also variation in how states update rates and no one methodology that the Department wants to adopt.

These noted complexities and Colorado's unique managed fee-for-service delivery model through the ACC program imply that a specific solution for Colorado must be developed. Across the board rate increases are a blunt tool that do not allow us to focus on improved outcomes such value and health, and focus on problem areas such as poor access. Using an existing framework, like adjusting our rates as some percentage of Medicare, is easy but has problems. These problems include that Medicare does not typically cover pregnant women and children which would require the Department to find an alternative framework in order to set those rates and others not covered by Medicare. In addition, using a set framework from Medicare also does not allow for consideration of value, improved health outcomes and access. We want flexibility to use rates to improve the health of our population. The Department wants to adopt a process that incorporates PCGs recommendations for a regular cycle and integrates our focus on value and health outcomes that is supported by the ACC. The Department believes this process could be operationalized with proper funding and staff. Adoption of such a review process would achieve the goal of creating a consistent and data-driven process that would help address disparities in Medicaid rates, value, health outcomes and access.

44. Discuss the pros and cons of assuming rate increases take effect in January, rather than July, and the Department's position on this potential policy.

Yes, the Department supports transitioning to a January 1 implementation date for targeted rate increases.

First and foremost, this implementation date would allow adequate time for approval of provider rate increases by the Department's federal partner, the Centers for Medicare and Medicaid Services (CMS). The Department cannot implement rate changes without approval from CMS. Implementation prior to federal approval is now likely to result in disallowance of federal matching

funds. This year, the has Department submitted numerous State Plan Amendments to CMS representing all of the rate increases approved by the JBC; however, the Department has not been able to implement all of those rate increases as of November 1, 2014 due to lengthy approval process with CMS.

There are several subsequent negative consequences. In addition to provider confusion and frustration caused by inconsistent timing for applying rate increases, in some cases providers may have to resubmit claims to receive the higher reimbursement rates. This is not just frustrating for providers, but costly and administratively burdensome. The retroactive implementation of provider rate changes following CMS approval is resource intensive for the Department. Hundreds of thousands of claims have to be reprocessed in the case of retroactive implementation of a rate increase.

The Department is confident it can get approval of the majority, if not all, of the rate increases from CMS by January 1st and would have sufficient time to input the changes into the MMIS. This change would improve administrative efficiencies to the Department and provide certainty to providers about the effective dates of rates.

While there are multiple advantages to a January 1st implementation date for provider rate increases, the Department recognizes that there will need to be an increased emphasis on communicating the full impact a rate increase will have on future years' expenditures. Because the first-year impact of a provider rate increase will only reflect approximately half of the full annual impact, approving rate increases without fully understanding the annualization of the increase could create large budgetary problems in future years.

4:00-4:15 MMIS AND TECHNOLOGY

45. What is the implementation status of the new Medicaid Management Information System (MMIS)? Is the project on schedule and on budget?

The Department's initiative to procure the new Medicaid Management Information System (MMIS), and related contracted services, is titled the Colorado Medicaid Management Innovative & Transformation (COMMIT) Project. This project is divided into three request for proposals (RFPs) and contracts that include new claims processing and Fiscal Agent Service, pharmacy claims processing system and drug-rebate service, and business and data analytics service. The Department has identified contractors for two of the three RFPs. The final cost of the vendor proposals for the two contracts that are not yet finalized are not known and the Department will use the usual budget process if necessary.

The project is on schedule with the implementation of all three contracts scheduled for November 2016.

- *Claims processing and Fiscal Agent Service:* Effective March 1, 2014, the Department contracted with HP Enterprise Services (HP) to develop and operate a state of the art replacement system to the current MMIS. The HP system is called the Colorado interChange. Colorado interChange is scheduled to assume claims processing and Fiscal

Agent services in November 2016. The transition to the Colorado interChange is currently on schedule and within the fixed budget specified in the contract with HP.

- *Pharmacy Claims Processing System and Drug-Rebate Service:* The Pharmacy Benefits Management System (PBMS) processes pharmacy claims through a point-of-sale system and provides drug-rebate services. Proposals for the Pharmacy Benefit Management Services project are due December 11, 2014. The Department expects to have a vendor selected in May 2015 with a contract start date of November 2015. The specified implementation date of the new PBMS is slated for November 2016.

- *Business and Data Analytics Service*: The Business Intelligence and Data Management (BIDM) Services provide data-driven analytical tools. BIDM will also support the Department's Accountable Care Collaborative (ACC) program as a replacement to the current Statewide Data Analytics Contractor. The Department issued an Intent to Award to Truven Health Analytics, Inc. on November 20, 2014. The Department will shortly begin contract negotiations with Truven Health Analytics, Inc., working towards a start date of May 1, 2015. The specified implementation date of the BIDM under the RFP is November 2016.

46. What is the relationship between the proposed stabilization of the DDDWeb and the Medicaid Management Information System (MMIS)? Who is in charge of stability and security for MMIS? Why isn't stability and security for the DDDWeb part of the MMIS contract? What is the role of the Office of Information Technology (OIT)?

The DDDWeb is a system that was developed outside of the Medicaid Management Information System (MMIS); however, DDDWeb is used to submit authorized service data to the MMIS for creating prior authorizations for three of the Department's waiver programs. There is no relationship between the DDDweb stabilization and the MMIS stability and security.

Office of Information Technology (OIT) hosts and maintains the DDDWeb. OIT is entirely responsible for the security and stability of the DDDweb. The Department has worked closely with OIT to develop a comprehensive cost and transition strategy to migrate the DDDweb functionality to a more stable, robust and secure platform imbedded in the new MMIS.

In November 2016, the current MMIS will be replaced with a more modern system, Colorado interChange. At that time, the DDDWeb will no longer be used for purposes of communicating authorized service data to MMIS as the functionality will be integrated into the Colorado interChange.

Currently, through contracted services, Xerox is in charge of stability and security for the current MMIS. OIT is engaged in some functions related to the current MMIS as it relates to network connections with data centers that require OIT staff and oversight, and security assessments.

Following the launch of the Colorado interChange, HP Enterprise Services (HP) will be responsible for the ongoing stability and security of the system. OIT will remain a key partner in the operation of the Colorado interChange in regards to network connections with data centers which will continue to require OIT staff and oversight, and security assessments.

The Department has worked with OIT to ensure all appropriate safeguards have been included in the HP contracts for the development and operation of the Colorado interChange. OIT assisted the Department with the review and approval of all contract language related to cybersecurity including, but not limited to, the inclusion of all state cybersecurity policies. Additionally, the HP contract specifies that HP shall maintain at all times network, system, and application security, which includes network firewalls, intrusion detection, and annual security testing as required by the Office of Information Security within OIT.

Functioning as the Department's information security officer, OIT assessed the Colorado interChange and determined the Colorado interChange security to be adequate. The Colorado interChange's security was found to have sufficient protections in place to ensure the overall security of the state's information assets, with the stipulation that the Department will initiate a renegotiation of the terms and requirements if any significant changes to OIT's security policies would impact the ability of either party to perform the agreed upon services.

47. How is Colorado availing itself of the enhanced federal match opportunities available under the Affordable Care Act for technology enhancement and enrollment activities leading up to and during the second open enrollment period?

Colorado continues to leverage the enhanced federal match opportunities under the Affordable Care Act (ACA) to improve and modernize the eligibility and enrollment process through technology solutions. The Department continues to improve client service and increase administrative efficiencies by leveraging a 90% federal match available for system development costs. Recent enhancements include the integration of the Colorado Benefits Management System (CBMS) with Connect for Health eligibility into a shared eligibility system, as well as upgrades to the online PEAK system that further simplify the user experience for automated and accurate eligibility determinations for the state's medical programs. Additionally, a mobile application for medical assistance programs has been designed so that PEAK users can easily access information, maintain eligibility, and find nearby health care providers in Colorado for the Medicaid network. These technological advancements ensure seamless and minimal interoperability as perceived by the applicant.

Further, the 75% federal financial participation rate for maintenance and operations has enabled the Department to increase the existing eligibility administration funding to assist the Department in compliance with ACA and prepare for the Medicaid population expansions. This funding for the administration of the eligibility determination process includes funding for staffing at the county, state and vendor levels, including line staff, supervisory and support staff. After receiving approval through the budget process in FY 2014-15 (R-6, November 1, 2013), additional temporary staff have been hired by the Department to support a back office that assists with enrollment into and administration of medical assistance programs through the shared eligibility system. This funding also provides opportunities to fund county and eligibility sites who wish to

provide contact center support for Medicaid eligibility and applications through the existing funding streams identified. The Department is currently revising contracts that would allow for funding the medical assistance sites (previously unfunded) for their enrollment efforts. Doing so will provide them the opportunity to expand their enrollment services to more of the expanded populations.

4:15-4:30 FINANCING AND FORECASTING OF HCPF PROGRAMS

48. Please discuss potential upcoming federal legislation and regulations that the Department anticipates could have a significant effect on the operations of Medicaid and the Children's Basic Health Plan (CHP+), including federal reauthorization of the funding necessary for CHP+. As part of the response, highlight the flexibility, or lack thereof, for the state in deciding how to respond to the potential new federal guidance.

The Department actively monitors and tracks proposed federal legislation and regulations; however, it is often hard to determine what the final legislation and regulations will look like. That said, the Department uses its best judgment to identify new policies that are most likely to be implemented and starts making plans based on all available information. There are currently two proposed regulations the Department is actively preparing for:

- a requirement for periodic rate reviews for all covered services and
- changes to the conditions of participation for home health agencies.

While the Department has been tracking these proposed regulations, it is unclear when the regulations will be finalized.

The most significant upcoming legislation that could have a major impact on Medicaid and CHP+ operations is the reauthorization of the Children's Health Insurance Program (CHIP).[3] The Affordable Care Act (ACA) authorized CHIP through federal fiscal year (FFY) 2019, but only extended federal funding for CHIP allotments through FFY 2015 (September 30, 2015).

If federal funding for CHIP is approved, it may be for a time-limited period. If so, this would give the Department more time and flexibility to address key questions raised by the Medicaid and CHIP Payment and Access Commission (MACPAC) regarding the affordability and sustainability of children's coverage following the expiration of CHIP. The Department would use this period to establish a plan and procedures to transition children and pregnant women to viable coverage options once federal funding for CHIP expires, and work with CMS and state officials to gain approval for the plan.

If federal funding for CHIP is not appropriated, the Department would hasten the transition of Colorado's CHIP clients to other health insurance plans – Medicaid, Connect for Health Colorado (exchange) health plans or employer-sponsored insurance plans, if available. MACPAC warns that this would most likely increase the number of uninsured children and increase cost-sharing

[3] The Child Health Plan *Plus* (CHP+) is Colorado's implementation of the federal CHIP program.

significantly for low-income families. An analysis cited by MACPAC estimated that the end of CHIP could lead to as many as 2 million more children becoming uninsured nationally.[4]

This change would impact operations and result in increased call and enrollment volumes at Colorado PEAK, the call centers and the Medicaid enrollment broker. For those clients who are not eligible for Medicaid, or cannot afford insurance in the exchange, the Department would start looking at mechanisms to cover those clients with a viable coverage option, such as Medicaid, an affordable qualified health plan in the exchange, or an employer-sponsored insurance plan.

Under the ACA, states are required to maintain the same eligibility levels for children in Medicaid and CHIP until 2019. This requirement is known as "maintenance of effort". If CHIP funding is not reauthorized, the Department would need additional guidance from CMS to determine whether the maintenance of effort requirements were still being enforced; it is possible that if the Department does not maintain those eligibility levels, the State could lose all federal matching funds for Medicaid until it corrects the violation.

Not reauthorizing CHIP at the federal level would reduce the amount of flexibility the Department has to work with stakeholders and CMS to design an effective transition plan, address key concerns, such as maintenance of effort requirements, and get CMS and state approval for these changes. There would be budgetary impacts due to the switch from the enhanced CHIP federal match rate to the Medicaid federal match rate for clients who transitioned from Colorado's CHIP program (CHP+) to Medicaid as part of the Affordable Care Act implementation. Furthermore, beginning October 2015, per the ACA, the CHIP match is scheduled be raised 23 percentage points until September 2019. For Colorado, this means the CHIP match would increase from approximately a 65% federal match rate to over 88%.

49. Why does the Department have such high confidence that federal funding for CHP+ will be reauthorized? What is the contingency plan if federal funding is not reauthorized?

The CHP+ program is authorized in federal statute through 2019. Because the program is authorized in statute, the Department believes that it is reasonable to assume that Congress will provide funding to meet its obligations. Since initially authorized, Congress has never failed to provide adequate funding for this program. The Department has not developed a formal contingency plan for Congress failing to meet its funding obligation for this program, but as described in the response question 48, the Department would work to hasten the transition of CHP+ clients to other health insurance plans – Connect for Health Colorado (exchange) health plans or employer-sponsored insurance plans, if available.

50. Discuss how tobacco settlement and tobacco tax revenues are used to support the activities of the Department. Are these declining sources of revenue for the Department, and if so, how does that effect operations?

Although both the Tobacco Master Settlement Agreement (MSA) and tobacco tax revenues are declining, the impact to the Department's programs vary. The MSA funds are used by the

[4] http://www.macpac.gov/reports/2014-06-13_MACPAC_Report.pdf?attredirects=0

Department to support the Children with Autism (CWA) waiver services, the Children's Basic Health Plan (CHP+), and the Breast and Cervical Care Prevention and Treatment program. The Department also has an appropriation from the Colorado Immunization Fund in the CHP+ program, which is funded by MSA and is reported on by the Colorado Department of Public Health and Environment. Tobacco tax revenue is used to support the Primary Care Fund program, provides an offset to General Fund expenditures for other Medicaid expenditures in the Medical Services Premiums line item, and supports Medicaid's participation in the Colorado QuitLine.

Tobacco Master Settlement Agreement

Children with Autism: Section 24-22-115 (1) (a), C.R.S. requires that $1,000,000 per year from the MSA revenue be deposited into to the Autism Treatment Cash Fund. These funds are then used to fund waiver and administrative costs for the program. With the CWA funding allocation capped at $1,000,000 State funds, enrollment for the program is currently capped at 75 clients, with a waiting list of approximately 320. The Department submitted a budget request (R-8) on November 3, 2014 requesting General Fund to eliminate the waitlist and make other needed changes to the program.

Children's Basic Health Plan: Section 24-75-1104.5, C.R.S. provides for the transfer of MSA revenue to the Children's Basic Health Plan Trust Fund. The amount cannot exceed $33,000,000 nor fall below $17,500,000. The amount of MSA allocated to CHP+ in FY 2013-14 is expected to be approximately $28,000,000. Beginning in October 2015, the federal medical assistance percentage for CHP+ services is scheduled to be increased by approximately 23 percentage points. Because of the increase in the federal match, the Department does not believe that the declining amount of MSA revenue will affect operations during the forecast period.

Breast and Cervical Cancer Prevention and Treatment: Section 24-22-115(1)(a), C.R.S. requires that all interest derived from the deposit and investment of moneys in the Tobacco Litigation Settlement cash fund are be credited to the Breast and Cervical Cancer Prevention and Treatment (BCCPT) fund. Indirectly, because of changes made during the recession (SB 09-269), the amount of funding that the BCCPT fund receives was substantially reduced. As a result, the fund does not receive sufficient revenue to support expenditure and is currently in deficit. As part of the reauthorization of the program (HB 14-1045), the Department projected that the existing fund balance and incoming revenue from other sources is sufficient to last through the new statutory expiration of the program in FY 2018-19; after that point, General Fund (or another revenue source) would be needed if the program was reauthorized again.

Colorado Immunization Fund: Section 25-4-2301, C.R.S. provides for the transfer of MSA revenue to the Colorado Immunization Fund, which is primarily used by the Department of Public Health and Environment. Some of this cash fund is appropriated to the CHP+ to cover a portion of the costs for children under 205% of FPL. The Department was appropriated $234,000 from the fund in FY 2014-15. The Department does not believe that the declining amount of MSA revenue will affect operations during the forecast period.

Tobacco Tax Revenues

Primary Care Fund: Pursuant to section 24-22-117(2)(b), tobacco tax revenues are used by the Department to administer the Primary Care Fund (PCF). The PCF program is a State-only program that provides allocations to community clinics and primary care providers that meet specific criteria including the provision of comprehensive primary care services to uninsured or medically indigent patients in Colorado. Declining tobacco tax revenues have caused an annual reduction in the amount of funding that is available for the PCF program; however, the Department does not believe that the declining revenues will materially affect the program and its qualified providers in the near future.

Health Care Expansion Fund: Pursuant to 24-22-117(2)(a), the Health Care Expansion Fund was used to fund certain eligibility expansions for the Medicaid and CHP+ programs. However, beginning in FY 2011-12, tobacco tax revenues were insufficient to fully cover the cost of the covered populations. During that year, the General Assembly virtually eliminated appropriations from the Health Care Expansion Fund to all line items except Medical Services Premiums (which pays for Medicaid physical health services). Each year, the Department receives an appropriation of the total projected balance of Health Care Expansion Fund to cover as much of the cost as possible, with the remainder of the cost coming from the General Fund. Because there is sufficient funding from all sources, there is no impact to the Department's operations.

Tobacco Education Programs Fund: Pursuant to 24-22-117 (2) (c) (I), sixteen percent of the moneys deposited in the tobacco tax cash funds and sixteen percent of the interest and income earned on the deposit and investment of those moneys are appropriated to the Tobacco Education Programs Fund, administered by the Department of Public Health and Environment. A portion of this cash fund is appropriated to Medical Services Premiums to provide Medicaid funding for the Colorado QuitLine. The Department was appropriated $630,706 from this fund in FY 2014-15. The Department does not believe that the declining amount of tobacco tax revenue will affect operations in during the forecast period.

51. Has the implementation of S.B. 11-008 saved money? Please estimate the difference in cost of serving the S.B. 11-008 population on Medicaid versus CHP+.

The Department estimates that SB 11-008 reduced total expenditure by approximately $11.7 million in FY 2013-14. SB 11-008 expanded eligibility for children in Medicaid to 133% of the Federal Poverty Level (FPL) (142% FPL post MAGI).

To calculate the estimated savings, the Department compared actual Medicaid expenditures to an estimate of what would have been paid in CHP+ based on the capitation rates in effect during FY 2013-14. As shown in the table below, the Department experienced a reduction in costs for clients who would have been served in the CHP+ program; this is because the average cost per client was lower than what the Department would otherwise have paid in the CHP+ program. There is an offset to the savings in the form of newly enrolled clients. As a result of SB 11-008, clients who were not previously eligible for CHP+ because they have other insurance became eligible for Medicaid, which generated new costs. In total, the actual savings exceeded the projected savings in the fiscal note by over $1.3 million.

SB 11-008 Savings - FY 2013-14			
	Estimated CHP+ Expenditures	**Actual Medicaid Expenditures**	**Net Savings**
Movement from CHP+ to Medicaid	$52,164,447	$38,509,995	**$13,654,452**
New Enrollment	$0	$1,937,379	**($1,937,379)**
Totals	$52,164,447	$40,447,374	**$11,717,073**

52. Why didn't the Department increase the projection of funding from the hospital provider fee required to finance continuous eligibility for children in FY 2014-15, and why is the Department requesting that the General Fund finance continuous eligibility for children in FY 2015-16?

The Department did not revise the estimated funding need for this purpose due to data constraints. The policy was implemented in March 2014, and the Department's November forecast incorporates data through June 2014; the limited amount of new information regarding children with incomes that exceed Medicaid eligibility thresholds was insufficient to justify a revision of estimates. Additionally, the CBMS does not currently flag clients' eligibility spans in a way that would allow the Department to tell the difference between a client being eligible due to qualifying for Transitional Medicaid, qualifying due to Continuous Eligibility, or qualifying due to a court-ordered exception. Because the system doesn't give an exact measure, the Department's budget separates the cost between Transitional Medicaid and Continuous Eligibility based an estimate. This second factor will continue to prohibit the Department from directly tying expenditures to clients eligible specifically due to Continuous Eligibility.

a. Should the JBC sponsor legislation to allow financing of continuous eligibility for children from the General Fund?

The Department does not believe that legislation is necessary. As described above, there is no immediate need for the General Assembly to substitute General Fund for Hospital Provider Fee to fund Continuous Eligibility. Further, even if the General Assembly prefers to use General Fund for Continuous Eligibility (or any other program that is currently funded by the Hospital Provider Fee), the Department believes that such an appropriation would be allowable under current law and would not require a change in statute.

In the briefing document, JBC staff wrote that "[if] the JBC wants to finance continuous eligibility from the General Fund in FY 2015-16 legislation would be needed" (page 24). This recommendation may be because, pursuant to section 25.5-4-402.3(5)(b), C.R.S., there is a specific procedure for reducing benefits or eligibility if there is insufficient Hospital Provider Fee available. However, nothing in this section prohibits the General Assembly from using its discretion to appropriate General Fund in lieu of Hospital Provider Fee. While the programs authorized in HB 09-1293 were clearly envisioned to be funded using the Hospital Provider Fee, in the absence of a

specific prohibition on the use of General Fund, there is no reason that a statute change would be necessary if General Fund was needed.

b. Can the Department implement system changes to track the number of children who gain eligibility due to continuous eligibility?

Yes, however, in order to get a precise measure, and due to the interaction between Transitional Medicaid and Continuous Eligibility, needed systems changes would be complex. Preliminary estimates from the CBMS contractor indicate a project requiring between 2,000 and 2,500 hours of programming and testing to implement a tracking mechanism ($250,000 - $320,000 total funds). Given the size of the project and competing priorities, it is unlikely the change could be implemented in the near future.

Further, because the necessary changes to transmit the new data element from the CBMS to the MMIS cannot be implemented prior to rollout of the new MMIS, manual processes to tie CBMS data to MMIS data and subsequently reclassify expenditures in CORE would be needed, which wuld drive additional use of Department staff resources.

53. What is the actual cost of implementing the Medicaid expansion, including the welcome mat effect, and how does this differ from previous assumptions?

In FY 2013-14, actual cost for implementing the Medicaid expansion authorized in SB 13-200 was $383.9 million total funds.

Because there are a large number of components in the Medicaid expansion, the Department has summarized only the major differences between actual FY 2013-14 and the fiscal note for SB 13-200 in the text below. Appendix B 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.

<u>Expansion Populations</u>

The fiscal note for SB 13-200 underestimated expansion population caseload by 14,854 in FY 2013-14. Primarily, this difference was in the "MAGI Adults" population (previously known as "Adults without Dependent Children"), which is 100% federally funded. 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 per capita costs were generally lower than estimated. However, the Department experienced a significant overexpenditure for behavioral health expenditure. Primarily, this was also due to the federally funded MAGI Adults population, as capitation rates came in higher than originally anticipated. This was due to the high percentage of homeless or indigent individuals who are in need of mental health, and that it was necessary to ensure that the behavioral health organizations had enough funding to serve all those who needed services at the

time. The Department implemented a risk-sharing mechanism (known as a risk-corridor) to recoup funding if actual costs differ from the rates; Department staff are currently in the process of evaluating the actual expenditure to determine if a recoupment is necessary.

Welcome Mat Effect

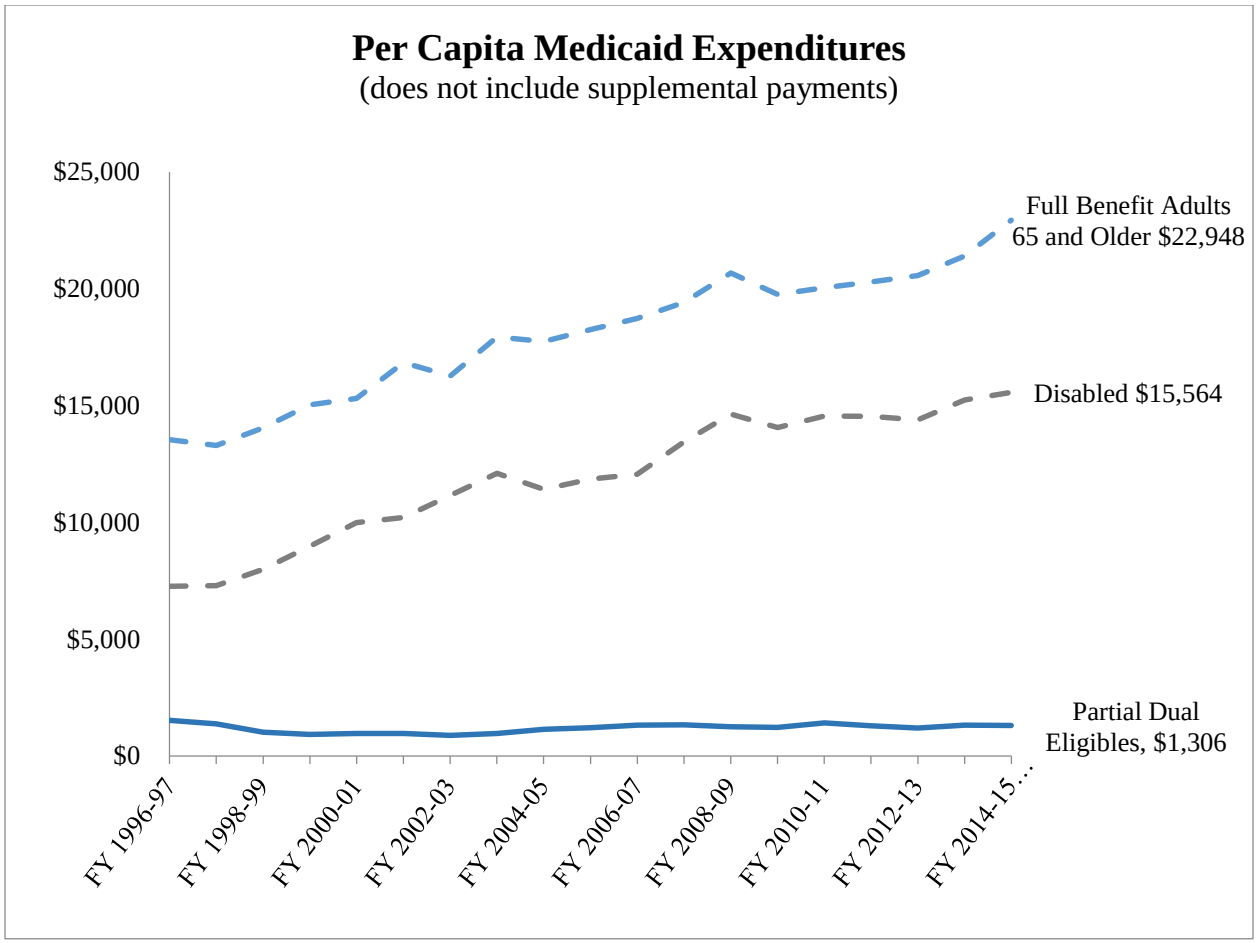
The fiscal note for SB 13-200 underestimated the "welcome-mat" caseload (also known as "enrolled but not eligible") by 16,362 in FY 2013-14. The welcome-mat effect was significantly stronger than estimated in the fiscal note, and is likely attributable to the individual mandate, particularly for parents 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.

Both physical health and mental health per capita costs were higher than anticipated, although the size and reasons for the effects vary. The fiscal note for SB 13-200 assumed that individuals who were previously eligible but not enrolled would have lower costs than the existing Medicaid population. This was because these individuals are less likely to have chronic conditions or need immediate medical assistance. Actual costs, however, proved to be much more similar to existing Medicaid clients. The Department has adjusted per capita costs for these groups in its most recent budget submission to reflect actual utilization, and continues to investigate the cost of these clients, and the results will inform future budget requests for the Medicaid program.

54. The JBC staff presented a graph showing that per capita costs for people with disabilities are increasing faster than per capita expenditures for the elderly. Why is this happening?

The Department believes that the cost trends for the elderly and individuals with disabilities are more similar than shown in the graph on page 7 of the briefing packet. The graph below contains the same information, but in the revised version, the Department has segmented the elderly population into two groups: "Full Benefit" Adults 65 and Older, and "Partial Dual Eligibles". Although Partial Dual Eligibles are the same age as the full benefit adults, these individuals receive a much smaller benefit package (limited to Medicaid premiums and, in some cases, coinsurance).

As seen below, the underlying trends for Full Benefit Adults 65 and Older and Individuals with Disabilities are quite similar.



55. Please provide an update on the status of the Old Age Pension Health and Medical program. Is there a reversion from the $10 million constitutional allocation to the fund, and if so, what is the plan for that money?

Beginning with FY 2013-14, the $10,000,000 appropriation for the Old Age Pension Health and Medical Care Program (OAP HMCP) has been reduced to cover the needs of Medicaid beneficiaries aged 60 and over. Corresponding transfers have been made to the Medical Services Premium Line where the General Fund receives a federal match. The OAP HMCP appropriation for FY 2014-15 and requested budget for FY 2015-16 is $4,504,973.

Caseload in the OAP HMCP was reduced substantially in January 2014 due to the simultaneous expansion of Medicaid for adults under the age of 65, and the implementation of deeming of sponsor income to legal immigrants for OAP eligibility by the Department of Human Services in accordance with HB 10-1384 (Noncitizen Eligibility Old Age Pension), which affected eligibility for the state-only Old Age Pension program administered by the Department of Human Services. In late 2013, the OAP HMCP caseload stood at 2,878. As of October 2014, that figure had dropped to 142. The recorded caseload for August 2014 was 372 and for September 2014 was 364. The Department saw another significant reduction for the month of October 2014, with the caseload

being 142. Due to these significant fluctuations in the OAP HMCP caseload, the Department is using these figures cautiously and is unable to provide a reliable projection until caseload stabilizes.

Moreover, in April 2014 the Department began offering a dental benefit to OAP HMCP beneficiaries that mirrors the new Medicaid dental benefit for adults. The new dental benefit is being managed in a new way under a contracted administrative services organization, utilization and expenditures are likely to be much lower now but may increase as the availability of the benefit matures. Additionally, the expenditures for the dental benefit will continue to evolve due to the addition of a denture benefit in July 2014. Consequently, the Department is conservative in its forecasts until expenditures in the dental category reach consistent levels.

The Department has not requested any adjustments to the OAP HMCP's current appropriation of $4,504,973, nor does the Department have plans for any potential unexpended funds that might be reverted to the Old Age Pension Health and Medical Care Fund, pursuant to section 25.5-2-101(2). Due to the uncertainties expressed above related to caseload following the Medicaid expansion for adults, the ongoing implementation of the deeming of sponsor income under HB 10-1384, and future utilization of the dental benefit, the Department does not recommend a change to this appropriation for future years. The Department continues to monitor this program closely and will use the regular budget process for any budgetary or programmatic changes.

4:30-4:45 MISCELLANEOUS QUESTIONS

56. What is the Comprehensive Primary Care initiative (CPCi) and why should the state support it through the funding requested in R16? If the Health Information Exchange supports the sharing of data between providers, why is the additional technology of the CPCi needed?

Comprehensive Primary Care initiative (CPCi) is a federal initiative started in 2012 to foster collaboration between public and private health care payers to strengthen primary care through coordinated payments for practice transformation and care coordination. CPCi aligns with the goals of primary care medical homes in the Medicaid Accountable Care Collaborative (ACC) program and the majority of CPCi providers are participants in both.

Sharing information directly between payers and providers requires additional infrastructure and tools separate from Health Information Exchange (HIE) data sharing. Care providers currently receive multiple reports from each health plan and must input data in to several websites to access patient data, making it cumbersome and inefficient for care providers to coordinate a patient's care. Seven health plans in Colorado are currently collaborating on a multi-payer data-sharing online tool that aims to enhance and improve the delivery of care for Colorado residents. In order to ease the burden on practices, these payers have committed to a single online tool for measures such as: emergency department visits, hospitalizations, screenings, etc. to increase the clarity, consistency, and security of payer reporting.

CPCi provides an opportunity to standardize payer reporting while creating a common platform for future reporting to practices of data shared via the state's HIE networks, Colorado Regional

Health Information Organization (CORHIO) and Quality Health Network (QHN). The CPCi community of practices are a proving ground to measure the benefit of this kind of coordinated data sharing effort. The federal Statewide Innovation Model (SIM) grant (for which Colorado has applied) aims to build on CPCi to further the integration of payer and HIE data sharing statewide.

The Department is not alone in committing resources to the CPCi effort. So far, six additional local and national payers have also committed financing and resources: Anthem, Cigna, Colorado Access, Colorado Choice, Rocky Mountain Health Plans and United Healthcare. A cost-sharing model has been adopted by the group of payers according to the relative number of covered lives for each payer. The Centers for Medicare and Medicaid Services is also evaluating options to support the effort on behalf of Medicare beneficiaries and it is likely they will also contribute funding in the near future.

57. Please describe the Public School Health Services and why the increase requested in R19 is necessary.

The School Health Services Program (SHS) is a financing mechanism that allows public school districts, Boards of Cooperative Educational Services (BOCES) and K-12 educational institutions to receive federal Medicaid matching funds for amounts spent providing health services to students who are Medicaid eligible and have an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP). Since SHS Program providers are public entities, the Department is able to draw federal matching Medicaid funds through the certification of public expenditures mechanism. There are no General Fund appropriations associated with this program.

While the federal funds are drawn for services provided for Medicaid students who have an IEP or IFSP, the state statute requires SHS Program providers to use the revenue received from this program to fund health services for all students. Each participating SHS Program provider develops a local services plan with community input to identify the types of health services needed by its students and submits an annual report detailing how the revenue was spent.

The SHS Program is administered jointly by the Department and the Department of Education. The Department draws and disburses the federal Medicaid funds and administers other processes to ensure compliance with federal requirements. The Department of Education provides technical assistance related to the development of local services plans and annual reports as well as reviews and approves local services plans.

The services provided to Medicaid eligible students with an IEP or IFSP under the SHS Program include:

- Physician Services
- Nursing Services
- Personal Care Services
- Psychology, Counseling and Social Work Services
- Orientation, Mobility and Vision Services
- Speech, Language and Hearing Services
- Occupational Therapy

- Physical Therapy
- Specialized Transportation
- Targeted Case Management Services

The Department requested an increase in the appropriation for the SHS Program due to growth in program expenditures caused by the overall growth in the number of Medicaid eligible children statewide. The State share for this program is a certified public expenditures and the appropriation is comprised of certified public expenditures and federal funds only; thus there is no impact to General Fund expenditures. The increased appropriation requested in R-19 will allow the Department to draw and disburse additional federal funds to SHS providers to fund health services to all students.

A SHS Program was provided in the Department's response to the Legislative Request for Information #7 delivered to the Joint Budget Committee on November 3, 2014.

58. How has the Medicaid expansion affected the amount of uncompensated care? Please address overall uncompensated care and uncompensated care for the subset of hospital providers.

The information available to the Department at this date indicates that the Medicaid expansion is transitioning patients from high uncompensated cost settings and programs, such as the Colorado Indigent Care Program (CICP), into the Medicaid program where provider reimbursement compared to costs is higher.[5]

Colorado expanded Medicaid eligibility pursuant to SB 13-200 and the Affordable Care Act (ACA) on January 1, 2014. As of September 30, 2014, the Department has enrolled more than 217,000 adults, parents, and caretakers into Medicaid as a part of this expansion and has reimbursed providers more than $718 million for care provided to these newly eligible clients.

As expected, preliminary data following the January 2014 Medicaid expansion is showing a sharp decline in the number of individuals needing care through the CICP. Preliminary CICP data for FY 2013-14, which includes the first six months following the Medicaid expansion, suggests that the unduplicated count of CICP clients who received services in FY 2013-14 may have dropped by more than 40,000 individuals compared to the prior year. This would represent a decrease of more than 20%. Similarly, preliminary CICP data for FY 2013-14 indicates that CICP uncompensated costs were approximately 35% lower in FY 2013-14 than in FY 2012-13.

Reporting by the Colorado Hospital Association (CHA), which collects financial and volume-related data from hospitals, likewise indicates a decrease in self-pay and charity care patients and

[5] Reimbursement under the Medicaid program is greater than CICP reimbursement for similar services. The Department reports on the undercompensation for hospital services in the Medicaid program in its annual Hospital Provider Fee Oversight and Advisory Report delivered to the Joint Budget Committee on January 15th each year. From the latest report published January 15, 2014, the data shows Medicaid reimburses hospitals at approximately 79% of cost. From the latest available CICP Annual Report, published February 1, 2014, the CICP reimbursed hospitals in FY 2012-13 at 56% of costs.

an increase in Medicaid patient volumes since the January 2014 Medicaid expansion. In a report examining the first quarter of calendar year 2014,[6] CHA states: *"The Medicaid proportion of patient volume at hospitals in states that expanded Medicaid increased substantially in the first quarter of 2014. At the same time, the proportion of selfpay and overall charity care declined in expansion-state hospitals."* A subsequent report published in September 2014, showed that the Medicaid portion of hospital volumes continued to increase in the second quarter, but at a slower rate than the first quarter of 2014.

In a Colorado-specific analysis, CHA has observed that the mix of Medicaid patients being seen since January 1, 2014 have more complex conditions than the average Medicaid patient seen prior to the expansion and that emergency department utilization for Medicaid patients may be higher than before. Therefore, examining utilization trends as more definitive data becomes available will be important in order to quantify the impact of patients moving from uninsured status to Medicaid and the impact on uncompensated care.

Due to lags in the availability of data and the time gaps between service and reporting, it will be some time before the Department can report on the payment to cost comparisons, utilization trends, and expenditures for the time period January 1, 2014 forward. The Department will publish the CICP Annual Report incorporating FY 2013-14 data on February 2, 2015. Because the Medicaid expansion took effect January 1, 2014, which was halfway through FY 2014-15, its full financial impact to the CICP program will not be realized until FY 2015-16.

59. What are the Department's views on converting the Hospital Provider Fee to an enterprise?

The Department is aware that there is discussion around converting the Hospital Provider Fee to an enterprise. No decision has been made around any changes to policy. The Department can provide analysis and further information when a specific proposal is available.

ADDENDUM: OTHER QUESTIONS FOR WHICH SOLELY WRITTEN RESPONSES ARE REQUESTED

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

Please see Attachment A.

61. What is the turnover rate for staff in the department? Please provide a breakdown by office and/or division, and program.

The table below shows the turnover rate of staff by office for FY 2013-14.

[6] Colorado Hospital Association, Center for Health Information and Data Analytics. *Impact of Medicaid Expansion on Hospital Volumes.* June 2014. http://www.cha.com/Documents/Press-Releases/CHA-Medicaid-Expansion-Study-June-2014-(1).aspx.

Turnover Rate by Office for FY 2013-14			
Office	**Number of Separations**	**Total Employees**	**Turnover Rate**
Client and Clinical Care Offices	12	90	13.33%
Clinical Services Office	3	25	12.00%
Community Living Office	2	26	7.69%
Executive Director's Office	0	2	0.00%
Finance Office	27	196	13.78%
Health Programs Office	11	95	11.58%
Policy, Communications and Operations Office	9	58	15.52%
Total	**64**	**492**	**13.01%**

The Department is not organized based on the programs it administers, therefore information on the turnover rate by program is not available.

62. Please identify the following:

a. The department's most effective program;

The Department considers the Accountable Care Collaborative (ACC) its most effective program. As discussed in Question #20 and LRFI #3, the ACC is achieving its goal of improving the overall health of clients while lowering costs. The ACC achieved gross savings in medical costs between $98 million and $102 million with net savings totaling $29 million to $33 million after administrative expenses. The ACC has delivered reductions in emergency room visits, reductions in 30 day, all-cause hospital readmissions, reductions in high-cost imaging and made progress on health care delivery system transformation. Regional Care Collaborative Organizations across the state have improved communication, referrals and relationships among both medical and non-medical providers, thereby improving care coordination for clients.

b. The department's least effective program (in the context of management and budget);

Please see below.

c. Please provide recommendations on what will make this program (2.b.) more effective based on the department's performance measures.

The Department has identified components of two programs that require action by the General Assembly:

<u>Children with Autism Home and Community-Based Services Waiver Program</u>

The Department's Home and Community-Based Services program for Children with Autism (HCBS-CWA) is one of the Department's least effective programs because the Department is

unable to serve children when it is most effective to do so, which without appropriate and timely service can have a negative impact on these children for the rest of their lives.

The HCBS-CWA program is the only Medicaid children's program that still has a waitlist. Currently, approximately 320 children who are eligible for the HCBS-CWA program cannot access services because of funding constraints. Of those children who do access services, most only receive services for less than a year. Research suggests treatment is most effective if received before eight, for 20 to 40 hours per week, for three years; thus, the current program does not provide enough time or coverage for clients and is an inefficient use of limited State resources as the treatments and interventions are ineffective if not received for a longer duration.

The Department, though the budget process and its legislative agenda, has proposed to fully fund the waiting list, allow for a three year stay on the program, and make other desperately needed modifications to the enabling statute. If approved, this request would ensure children with autism spectrum disorder (ASD) have proper access to behavioral interventions and treatments for the correct duration of time improving health outcomes, the client experience, and possibly lowering future per capita costs for clients with ASD.

This supports two strategic policy initiatives within the Department's performance plan: (1) improving health outcomes and client experience while delivering services in a cost-effective manner and (2) demonstrating sound stewardship of financial resources.

Customer Service Center

The Department's Customer Service Center (CSC) is one of its least effective programs because the Department is only able to devote 10 FTE despite serving almost 1.2 million Coloradoans. Since the implementation of the Affordable Care Act (ACA) and SB 13-200 "Expand Medicaid Eligibility" in October 2013, the Department's Customer Service Center (CSC) has experienced historic call volumes. Call volumes increased from 10,471 calls in May 2013 to 68,169 calls in May 2014 as clients sought information about their health coverage; at the peak in January 2014, the Department received 97,775 calls. CSC staff were only able to answer about 50% of calls received in FY 2013-14. The Department expects call volumes to continue to increase as a result of new Medicaid enrollees, the annual redetermination process and the open enrollment period for Connect for Health Colorado.

While the Department has attempted to supplement staffing through the use of temporary employees, the Department will be unable to maintain the enhanced level of staffing after the end of FY 2014-15. This will cause the wait times and abandonment rates to further increase. Concerns about long wait times and frustrated clients have been raised by advocates, plaintiffs working with the Attorney General's office on eligibility lawsuits, and the Department's federal partners, the Centers for Medicare and Medicaid Services (CMS).

This supports three strategic policy initiatives within the Department's performance plan: (1) improving health outcomes and client experience while delivering services in a cost-effective manner, (2) enhancing communications through effective internal and external relationships, and

(3) providing exceptional service through technological innovation. Staffing the CSC is a step towards the long-term goal of a coordinated and efficient customer service experience for Medicaid clients, which would bring together state agencies, counties, providers and stakeholders through an integrated system allowing representatives at any agency to view caller information and offer complete and accurate information to meet their needs.

63. How much capital outlay was expended using either operating funds or capital funds in FY 2013-14? Please break it down between the amount expended from operating and the amount expended from capital.

In FY 2013-14, the Department spent $854,398 from its Operating Expenses line item to build-out leased space at 303 East 17th Avenue and 225 East 16th Avenue. The Department was approved $728,014 total funds to build-out the seventh floor at 303 East 17th via a 1331 Funding Request, dated June 20, 2013. The Department absorbed the remaining $126,384 by foregoing other purchases in its Operating Expenses line item, such as limiting office supply purchases and minimizing travel and official function expenses.

These build-out costs include the purchase of furniture, office equipment, and networking equipment, as well as contractor services, through the Governor's Office of Information Technology, to wire the network and security systems. Costs relating to electrical, plumbing, drywall, painting, flooring, and other construction-related services are covered within the lease agreement.

The Department spent an additional $181,009 total funds on computers and software for staff in FY 2013-14. Of the aforementioned build-out costs, $57,054 was for computers and software, bringing the expenditure total on computers and software to $238,063. Historically, the Department had received one-time funding to provide computers for newly approved FTE, but had to absorb computer replacement costs going forward. Last year, the Department submitted and the JBC approved request R-17 "Computer Replacement and Office Software," which, beginning FY 2014-15, adds an ongoing $295,711 total funds to the Department's Operating Expenses line to provide a dedicated budget for software and computer replacement.

For FY 2014-15, the Department has been appropriated $1,420,402 total funds to its Operating Expenses line item to build-out two more floors at 303 East 17th Avenue, as other leased space contracts are expiring and it is in the Department's best interest to consolidate staff into one building.

The Department did not expend any capital funds in FY 2013-14.

64. 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 on June 30, 2014? What is the department doing to resolve the outstanding high priority recommendations?

The Department has four recommendations, totaling 7 subparts that have been identified by the Office of the State Auditor as high priority. The Department takes State Auditor recommendations

seriously and seeks to implement effective and systemic changes identified in their report. The Department has an External Audit Coordinator (EAC) who monitors all audit recommendations and requests. The EAC tracks the implementation of recommendations and reports this information to Executive Management. The four outstanding recommendations are

- Medicaid Management Information System (MMIS) IT Controls;
- Medicaid Claims Processing;
- Medicaid Provider Eligibility;
- Medicaid Nursing Facility Oversight.

MMIS Controls

This recommendation has three subparts. The recommendation states that the Department should improve MMIS user access controls.

New user access, changes to user access, and escalated system privileges to the MMIS are documented and verified through the Department's Information Security Unit. Through a Lean initiative, if a user's access needs to be modified, the appropriate supervisor will need to approve that change through a modification to the Position Description Questionnaire. The Department has now taken this approach to all major system access and this recommendation will be implemented by the end of this calendar year.

Medicaid Claims Processing

This recommendation has two subparts. The recommendation states that the Department should improve controls over the processing of medical claims for the Medicaid program by (1) leveraging the results of the federal Office of Inspector General's (OIG) 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, and (2) Ensuring that claims delayed by third-party insurers are denied if the claim is submitted beyond 365 days from the date of the service and ensuring guidance to providers accurately reflects requirements for Department rules. In addition, ensuring the new MMIS is programmed to deny payments delayed by third-party insurers if a claim is submitted beyond 365 days from the date of service.

In terms of leveraging the OIG report in the first subpart of the recommendation, the Department does not agree with the OIG's assessment and recommendation. However, a State Plan Amendment is in development and will be issued by December 2014, which aligns with the agreed-to audit implementation date.

As for denying claims submitted by a third party insurer after 365 days, the Department has reviewed the federal and state regulations, and the Department's provider publications related to this finding and updated the General Provider Information manual to clarify the Department's policy.

Per the audit recommendation, the requirements are included in the new MMIS requirements related to this recommendation to enforce the federal and state regulations. The new MMIS is set to be functional in 2016.

Medicaid Provider Eligibility

This recommendation asks that the Department to improve its controls over eligibility of Medicaid providers to ensure that it complies with federal regulations and the Department should implement, and document a process for removing providers from MMIS who are no longer in compliance with provider eligibility requirements.

The Department wants to be good stewards of taxpayers' money. The Department is delaying full implementation for some of the requirements until the upgraded 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.

Full compliance will be achieved with the implementation of the Department's new MMIS in 2016. While the replacement MMIS and Fiscal Agent contract is expected to be operational by November 2016, the Department's implementation of the Affordable Care Act (ACA) Provider Screening Rules needs to be completed by March 2016 under federal regulations. HP Enterprise Services, the Department's new MMIS and Fiscal Agent contractor, will work with the Department to implement ACA Provider Screening Rules as a top priority under their contract. The Department implemented changes to the provider enrollment application and process which improved its compliance with current federal regulations. These changes, which included updating provider disclosure requirements in the Department participation agreements, occurred in June 2013.

Medicaid Nursing Facility Oversight

This recommendation asks that the Department 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 recommendation is partially implemented. After full investigation of this audit recommendation, the Department wanted to implement a long-term, comprehensive and automated approach. The Department will put requirements into the new MMIS to systematically use information from DPHE to ensure that the MMIS only adjudicates payments for providers that have current licensure and/or certification (depending on provider type) as determined by that DPHE's process. In the interim, the Department has reviewed data submitted by DPHE to ensure that DPHE is following standards and procedures as set forth in our interagency agreement, Department and DPHE regulations, and federal law. In addition, DPHE is creating a spreadsheet that will track certification/survey dates, which they will submit to the Department monthly to a new, shared email address. It will include all planned survey dates as well notes for facilities which are unable to be surveyed on that schedule for various reasons.

APPENDIX A: LEGISLATION NOT FULLY IMPLEMENTED 2008-2014

Total HCPF Related Bills 2008-2014: 172
Not Fully Implemented 2008-2014: 11

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 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 1970's, any changes to the system require 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
HB 13-1068 On-site Inspections of Medicaid Providers (Young/Roberts)	This bill aligns state law concerning the inspection of Medicaid providers with federal law. Federal law requires that Medicaid providers allow the state to conduct on-site inspections, unannounced and without advance notice, for audit or review reasons or to otherwise ensure compliance with state and federal law. The bill also aligns state law with federal law concerning pre- and post-enrollment site visits of providers. It specifies that HCPF or its designated agent is required to conduct site visits of providers who are designated, under federal regulations, as	The Department is prepared to conduct unannounced onsite inspections if necessary; therefore the first part of the bill is implemented. The Department currently is unable to conduct the pre- and post-enrollment of providers designated as moderate or high risk. The Department is including this requirement in the new contract for its Medicaid Management Information System vendor. That contract and the resulting enrollment screenings will begin in 2015.	0

Legislation	Legislation Summary	Barriers to Implementation	FTE
	moderate or high risks to the Medicaid program.		
SB 13-011 Colorado Civil Union Act (Steadman/Ferrandino)	The bill authorizes civil unions in Colorado and sets forth the rights, responsibilities, and requirements of persons entering a civil union. Two persons, regardless of gender, may enter into a civil union if they are not related by blood, not married to or in a civil union with another person, and are over the age of 18. The bill sets the fees and procedures to obtain a civil union license from a county clerk and to petition the court for the dissolution, invalidation, and legal separation of a civil union.	This bill requires changes in the CBMS implement a consideration of income of resources for civil unions that are applying for long term care. Those change that cannot be made to the system until the end of 2015.	0
SB 12-128 Alternative Care Facility Reimbursement Pilot (Roberts/Summers)	This bill allows HCPF to create an enhanced reimbursement program in which an alternative care facility (ACF) will receive a temporary increase in the Medicaid per diem reimbursement rate for a client discharged from a nursing facility. Legislation required that any such program be budget-neutral or result in cost savings.	The Department intended to implement SB 12-128 through the Community Choice Transitions (CCT) program. However, CMS requirements for ACF's to be eligible for enhanced payments under CCT preclude many if not most ACF's in the state from participating. As required by the legislation, any enhanced payment has to be cost neutral. The Department understands the intent of this legislation and is working with stakeholders to identify long-term solution to ACF utilization and reimbursement.	0
SB 10-061 Medicaid Hospice Room and Board Charges (Tochtrop, Williams/Soper, Reisberg)	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 Environment for the provision of residential and inpatient hospice care, they must be licensed as a class I nursing	0

Legislation	Legislation Summary	Barriers to Implementation	FTE
		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	2

Legislation	Legislation Summary	Barriers to Implementation	FTE
		private health insurance through Connect for Health regardless of a preexisting condition.	
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 continues to examine now this can be implemented without costly system changes.	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	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	0

Legislation	Legislation Summary	Barriers to Implementation	FTE
	reimbursement for services provided to Medicaid clients.	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.	
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 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.	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 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. The Department has requested resources to expand CDASS into the Supported Living Services Waiver as part of its FY2015-16 request. If approved, SLS clients would be able to access CDASS beginning July 2015.	0.5

*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.

APPENDIX B: QUESTION 53 – SB13-200 COMPARISION

Question 53 Appendix Table 1.1 - 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	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 2014 Budget Request	Caseload	4,802	8,957	68,564	10,190	693	432	184	93,822
		Expenditure	$11,606,403	$21,448,473	$324,238,163	$14,029,142	$745,688	$2,422,012	$2,856,160	$377,346,041
	Difference	*Caseload*	*(4,433)*	*(2,423)*	*(13,730)*	*(9,423)*	*(693)*	*(356)*	*(158)*	*(31,215)*
	(SB 13-200 - Nov. 2014 Budget)	***Expenditure***	***($10,883,624)***	***($5,073,028)***	***($37,974,421)***	***($13,435,588)***	***($745,688)***	***($1,996,171)***	***($2,397,202)***	***($72,505,722)***
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 2014 Budget Request	Caseload	7,785	24,576	204,525	15,066	1,774	2,035	430	256,191
		Expenditure	$18,670,837	$61,994,306	$1,001,286,907	$20,090,944	$2,073,716	$11,725,324	$7,187,110	$1,123,029,144
	Difference	*Caseload*	*(5,485)*	*(7,387)*	*(60,281)*	*(10,284)*	*(1,774)*	*(1,482)*	*(338)*	*(87,031)*
	(SB 13-200 - Nov. 2014 Budget)	***Expenditure***	***($13,864,550)***	***($14,098,189)***	***($158,660,937)***	***($16,100,809)***	***($2,073,716)***	***($8,617,027)***	***($5,535,405)***	***($218,950,633)***
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 2014 Budget Request	Caseload	8,549	26,881	236,674	16,112	2,059	2,101	449	292,825
		Expenditure	$20,127,922	$66,535,787	$1,214,102,119	$21,547,811	$2,419,125	$12,268,075	$7,780,317	$1,344,781,156
	Difference	*Caseload*	*(3,336)*	*(7,011)*	*(69,926)*	*(5,272)*	*(2,059)*	*(985)*	*(290)*	*(88,879)*
	(SB 13-200 - Nov. 2014 Budget)	***Expenditure***	***($9,040,601)***	***($10,187,249)***	***($222,766,056)***	***($12,343,133)***	***($2,419,125)***	***($5,963,702)***	***($4,853,405)***	***($267,573,271)***

APPENDIX B: QUESTION 53 – SB13-200 COMPARISION

Question 53 Appendix
Table 1.1 - 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 2014 Budget Request	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 (SB 13-200 - Nov. 2014 Budget)	*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 2014 Budget Request	Caseload		21,849	204,525			2,035	430	228,839
		Per Capita		$2,262.86	$4,205.11			$3,209.59	$16,714.21	$4,034.32
		Expenditure		**$49,441,228**	**$860,050,123**			**$6,531,516**	**$7,187,110**	**$923,209,977**
	Difference (SB 13-200 - Nov. 2014 Budget)	*Caseload*		*(4,660)*	*(60,281)*			*(1,482)*	*(338)*	*(66,761)*
		Per Capita		*$217.53*	*$974.39*			*$189.73*	*$1,239.11*	*$860.11*
		Expenditure		***($6,805,855)***	***($112,937,943)***			***($4,651,692)***	***($5,535,405)***	***($129,930,895)***
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 2014 Budget Request	Caseload		23,898	236,674			2,101	449	263,122
		Per Capita		$2,194.01	$4,394.73			$3,223.99	$17,328.10	$4,207.57
		Expenditure		**$52,432,451**	**$1,040,118,328**			**$6,773,603**	**$7,780,317**	**$1,107,104,699**
	Difference (SB 13-200 - Nov. 2014 Budget)	*Caseload*		*(4,028)*	*(69,926)*			*(985)*	*(290)*	*(75,229)*
		Per Capita		*$330.37*	*$876.49*			*$169.09*	*$1,080.15*	*$773.13*
		Expenditure		***($2,273,042)***	***($161,152,738)***			***($2,986,926)***	***($4,853,405)***	***($171,266,111)***

APPENDIX B: QUESTION 53 – SB13-200 COMPARISION

Question 53 Appendix
Table 1.2 - 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 2014 Budget Request	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 2014 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				7,083
		Per Capita	$1,860.17	$0.00		$718.02				$1,088.92
		Expenditure	**$4,278,381**	**$0**		**$3,433,925**				**$7,712,306**
	November 2014 Budget Request	Caseload	7,785	2,727		15,066	1,774			27,352
		Per Capita	$2,148.21	$1,715.26		$1,161.75	$997.19			$1,487.03
		Expenditure	**$16,723,793**	**$4,677,513**		**$17,502,967**	**$1,769,016**			**$40,673,289**
	Difference (SB 13-200 - Nov 2014 Estimate)	*Caseload*	*(5,485)*	*(2,727)*		*(10,284)*	*(1,774)*			*(20,270)*
		Per Capita	*($288.04)*	*($1,715.26)*		*($443.73)*	*($997.19)*			*($398.11)*
		Expenditure	***($12,445,412)***	***($4,677,513)***		***($14,069,042)***	***($1,769,016)***			***($32,960,983)***
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 2014 Budget Request	Caseload	8,549	2,983		16,112	2,059			29,703
		Per Capita	$2,088.98	$1,663.08		$1,157.96	$995.40			$1,465.38
		Expenditure	**$17,858,707**	**$4,960,977**		**$18,657,015**	**$2,049,521**			**$43,526,220**
	Difference (SB 13-200 - Nov 2014 Estimate)	*Caseload*	*(3,336)*	*(2,983)*		*(5,272)*	*(2,059)*			*(13,650)*
		Per Capita	*($195.73)*	*($1,663.08)*		*($427.18)*	*($995.40)*			*($357.11)*
		Expenditure	***($7,989,179)***	***($4,960,977)***		***($10,735,436)***	***($2,049,521)***			***($25,735,113)***

APPENDIX B: QUESTION 53 – SB13-200 COMPARISION

Question 53 Appendix
Table 2.1 - 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 2014 Budget Request	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. 2014 Budget)	*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 2014 Budget Request	Caseload		21,849	204,525			2,035	430	228,839
		Per Capita		$329.30	$690.56			$2,552.24	$0.00	$671.33
		Expenditure		**$7,194,876**	**$141,236,784**			**$5,193,808**	**$0**	**$153,625,468**
	Difference (SB 13-200 - Nov. 2014 Budget)	*Caseload*		*(4,660)*	*(60,281)*			*(1,482)*	*(338)*	*(66,761)*
		Per Capita		*($23.25)*	*($28.39)*			*($330.77)*	*$0.00*	*($41.98)*
		Expenditure		***($1,934,132)***	***($45,722,994)***			***($3,965,335)***	***$0***	***($51,622,461)***
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 2014 Budget Request	Caseload		23,898	236,674			2,101	449	263,122
		Per Capita		$349.49	$735.12			$2,615.17	$0.00	$713.85
		Expenditure		**$8,352,112**	**$173,983,791**			**$5,494,472**	**$0**	**$187,830,375**
	Difference (SB 13-200 - Nov. 2014 Budget)	*Caseload*		*(4,028)*	*(69,926)*			*(985)*	*(290)*	*(75,229)*
		Per Capita		*($38.01)*	*($61.23)*			*($359.17)*	*$0.00*	*($69.46)*
		Expenditure		***($2,162,983)***	***($61,613,318)***			***($2,976,776)***	***$0***	***($66,753,077)***

APPENDIX B: QUESTION 53 – SB13-200 COMPARISION

Question 53 Appendix
Table 2.2 - 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			768				1,137
		Per Capita	$205.90			$101.41				$135.34
		Expenditure	**$75,978**			**$77,835**				**$153,813**
	November 2014 Budget Request	Caseload	4,802	1,813		10,190	693			17,498
		Per Capita	$242.76	$167.87		$168.81	$31.66			$183.58
		Expenditure	**$1,165,695**	**$304,372**		**$1,720,223**	**$21,939**			**$3,212,229**
	Difference (SB 13-200 - Nov 2014 Estimate)	*Caseload*	*(4,433)*	*(1,813)*		*(9,423)*	*(693)*			*(16,362)*
		Per Capita	*($36.85)*	*($167.87)*		*($67.40)*	*($31.66)*			*($48.24)*
		Expenditure	***($1,089,717)***	***($304,372)***		***($1,642,388)***	***($21,939)***			***($3,058,416)***
FY 2014-15	SB 13-200	Caseload	2,300			4,783				7,083
		Per Capita	$229.52			$116.30				$153.07
		Expenditure	**$527,906**			**$556,210**				**$1,084,116**
	November 2014 Budget Request	Caseload	7,785	2,727		15,066	1,774			27,352
		Per Capita	$250.10	$249.61		$171.78	$171.76			$201.83
		Expenditure	**$1,947,044**	**$680,689**		**$2,587,977**	**$304,700**			**$5,520,410**
	Difference (SB 13-200 - Nov 2014 Estimate)	*Caseload*	*(5,485)*	*(2,727)*		*(10,284)*	*(1,774)*			*(20,270)*
		Per Capita	*($20.58)*	*($249.61)*		*($55.47)*	*($171.76)*			*($48.76)*
		Expenditure	***($1,419,138)***	***($680,689)***		***($2,031,767)***	***($304,700)***			***($4,436,294)***
FY 2015-16	SB 13-200	Caseload	5,213			10,840				16,053
		Per Capita	$233.607			$118.37				$155.79
		Expenditure	**$1,217,793**			**$1,283,099**				**$2,500,892**
	November 2014 Budget Request	Caseload	8,549	2,983		16,112	2,059			29,703
		Per Capita	$265.44	$264.92		$179.42	$179.51			$212.77
		Expenditure	**$2,269,215**	**$790,247**		**$2,890,796**	**$369,604**			**$6,319,862**
	Difference (SB 13-200 - Nov 2014 Estimate)	*Caseload*	*(3,336)*	*(2,983)*		*(5,272)*	*(2,059)*			*(13,650)*
		Per Capita	*($31.83)*	*($264.92)*		*($61.05)*	*($179.51)*			*($56.98)*
		Expenditure	***($1,051,422)***	***($790,247)***		***($1,607,697)***	***($369,604)***			***($3,818,970)***

FY 2014-15 Targeted Rate Increase Implementation

State Plan Amendments	Change Required	Implementation Date
Increase Reimbursement for Pediatric Hospice Services	Waiver Amendment	Implemented prior to effective date of 7/1/2014
Increase Reimbursement Rates for Extended Hours/After Hours Care	No Amendment required	Implemented in system on 6/16/2014 with effective date of 7/1/2014
Fund the Transitional Living Program for Brain Injury Clients	No Amendment required	Implemented prior to effective date of 7/1/2014
Increase Reimbursement for Pediatric Developmental Assessments	No Amendment required	Implemented in system on 6/16/2014 with effective date of 7/1/2014
Increase Funding for Single Entry Point Case Management	No Amendment required	For public SEPs, the Department worked to develop a new methodology which will be implemented by 2/1/15. These SEPs will bill at a higher rate going forward to maximize their contract allowable for the full fiscal year. Private SEPs have an implementation date of 2/1/15 and will bill for activities previously not billable going forward to maximize their contract allowable for the full fiscal year.
Incentive Payments to Surgeons to Provide Care at Ambulatory Surgery Centers	No Amendment required	Implemented in system 11/24/2014 with effective date 11/1/2014
Increase Reimbursement Rates for High-Value Specialist Services	No Amendment required	Implemented in system 6/16/2014 with effective date of 7/1/2014
Increase Reimbursement for Digital Breast Cancer Screening Exams	No Amendment required	Implemented in system 6/16/2014 with effective date of 7/1/2014