

**DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
FY 2019-20 JOINT BUDGET COMMITTEE HEARING AGENDA**

Monday, December 17, 2018

9:20 a.m. – 12:00 p.m.

9:20-9:35 INTRODUCTION & OPENING COMMENTS

Main Presenters:

- Kim Bimestefer, Executive Director

9:35-9:45 HEALTH CARE TRENDS & COST CONTAINMENT

Main Presenters:

- Kim Bimestefer, Executive Director

Topics:

- Questions 1-10, Pages 4-23, Slides 1-22
- Cost Containment (R-7 Primary Care Alternative Payment Methods)
- Health Care Coverage and the Uninsured
- All-Payer Claims Database (R-11 All-Payer Claims Database Financing)
- Administrative Costs

9:45-10:15 HOSPITALS

Main Presenters:

- Kim Bimestefer, Executive Director
- John Bartholomew, Chief Financial Officer

Topics:

- Questions 11-15, Pages 23-33, Slides 23-31
- Hospital spending and variations between hospitals
- Relationship between hospital costs and insurance premiums
- Data needed to evaluate hospital costs

10:15-10:30 BREAK

10:30-10:45 BUDGET AGENDA

Main Presenters:

- Josh Block, Budget Director

Topics:

- Questions 16-24, Pages 33-37, Slides 32-33
- General overview of Department Decision Items
- R-8 Benefits and Technology Advisory Committee
- R-9 Long Term Home Health and Private Duty Nursing Acuity Tool
- R-14 Office of Community Living Governance
- Savings associated with prior year budget requests

10:45-11:00 CUSTOMER SERVICE & ELIGIBILITY

Main Presenters:

- Tom Massey, Deputy Executive Director/Policy, Communication & Administration Office Director

Topics:

- Questions 25-28, Pages 38-40, Slide 34
- R-6 Local Administration Transformation
- Returned Mail Processing
- R-10 Improve Customer Experience
- Member Contact Center

11:00-11:30 RATES

Main Presenters:

- Kim Bimestefer, Executive Director
- John Bartholomew, Chief Financial Officer

Topics:

- Questions 29-37, Pages 41-47, Slide 35
- R-13 Provider Rate Increases
- Targeted rate increases
- Effects of the rising minimum wage
- Performance-based payments
- Program of All-inclusive Care for the Elderly (PACE) rates
- University of Colorado School of Medicine supplemental payments

11:30-11:45 MISCELLANEOUS

Main Presenters:

- Tom Massey, Deputy Executive Director/Policy, Communication & Administration Office Director

Topics:

- Questions 38-47, Pages 48-53, Slide 36
- Reauthorization of the Breast and Cervical Cancer Prevention and Treatment program
- Expenditure growth in the Medicaid program
- Changes in Medicaid demographics
- Colorado Choice Transitions program savings
- Coordination with the Veterans' Administration

11:45-12:00 CLOSING REMARKS & ADDITIONAL QUESTIONS

**DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
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HEALTH CARE TRENDS & COST CONTAINMENT

- 1. How does the Department's R7 primary care alternative payment fit with the Department's other initiatives to contain costs? Please address specifically how it fits with the additional funding provided in FY 2018-19 for administration of the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE), S.B. 18-266 concerning controlling Medicaid costs, and H.B. 17-1353 concerning Medicaid delivery and payment initiatives.**

RESPONSE

The Department is driving a host of initiatives that (a) efficiently manage Medicaid funds to the betterment of Medicaid members, the state, and taxpayers; (b) improve the affordability of health care to consumers, employers, and the state; and, (c) improve quality care and member satisfaction across the spectrum. The Department's November 1, 2018 Budget Request R-7 "Primary Care Alternative Payment Models" focuses the Department on having the right data and tools to inform appropriate reimbursement and methodologies impacting Medicaid, including the ability to access and employ clinical outcomes in measuring and determining value-based provider rewards. This approach further aligns Medicaid's payment methodologies with the shared goals of improving health through cost-effective, quality care and prevention.

The Department's strategy to improve health care affordability for consumers, employers, Medicaid, and all stakeholders across the state includes the following interrelated initiatives: constrain prices on hospital and prescription drugs; champion alternative payment methodologies; align and strengthen data infrastructure and shared systems; improve population and behavioral health; and maximize innovation.

The FY 2019-20 budget request R-7 has three elements and is focused on primary care. If approved, the request would allow the Department to pursue more sophisticated alternative payment methodologies with interested providers that share risk on not just quality performance, but also utilization risk. This would create a strong financial incentive for providers to manage clients to a lower total cost of care without sacrificing quality of care. The request would also allow the Department to support practices in connecting to the state's Health Information Exchanges which would allow practices to receive and share real-time information with others involved in the care of their patients, allowing for more immediate interventions that will drive down costs and improve patient experience. Lastly, the request would allow the Department to partner with other payers to give practices tools at the point of the care that will help improve clinical decision-making processes that will again, drive down costs and improve client experience. This request is a key component for all five cost containment initiatives as it is about the data, tools, innovation, and payment methodologies needed to contain costs for both Health First Colorado, and the Colorado health care market in general. To put this in perspective, the limited dollars associated with this request drive the primary care incentives to manage more than \$4 billion in basic medical care provided to Medicaid members. The Department anticipates that the implementation of alternative payment models will ultimately improve patient health outcomes through greater use of immediately accessible and actionable electronic clinical

quality measures and that there would be less utilization of higher cost medical care like hospitals. The Department's request included estimated savings of approximately \$1.4 million total funds, beginning in FY 2021-22, as a result of avoided utilization of unnecessary services.

HB 17-1353 "Concerning Medicaid Delivery and Payment Initiatives" explicitly authorized the Department to pursue payment reform initiatives. It also includes accountability mechanisms to ensure appropriate evaluation and monitoring of the initiatives the Department implements. The bill directly supports the "championing of alternative payment methodologies" component of the Department's cost containment strategy and provides the statutory backing for the activities in the FY 2019-20 R-7 budget request.

The CHASE administrative funding (FY 2018-19 R-15 "CHASE Administrative Costs" and SB 17-267) allows the Department to engage in ongoing valuable analysis of hospital costs and quality and hospital market dynamics such as cost shifts from public sector to private sector. Hospital expenditures are 30 percent of annual Health First Colorado expenditures and are approximately 40 percent of private health insurance expenditures, making hospitals the leading recipient of health care funds from public and private payers. The proportion of uninsured Coloradans reduced from 15.8 percent to 6.5 percent following the health coverage expansion due to the Colorado Healthcare Affordability Act (CHCAA) and CHASE hospital provider fee programs, and the implementation of the federal Affordable Care Act (ACA). Moreover, hospitals have received more than \$400 million in net new federal funds from CHASE in the most recent year to their financial advantage.

The emphasis on this research was conveyed from the General Assembly via a modification to the Department's request wherein seven FTE were appropriated to the Department with the explicit intent of having the Department target the drivers of hospital expenditures, particularly to explore why the cost shift to commercial employers and consumers does not appear to be decreasing as expected. The shift in focus directed by the General Assembly remains aligned with the Department's cost containment strategy; this ties in to the Department's cost containment strategy by providing the transparency and information needed to constrain prices to appropriate levels. It is also important to note that SB 17-267 also mandated pursuit of federal authority to change how hospitals are paid, essentially allowing for opportunity to engage in broader alternative payment methodologies with hospitals.

SB 18-266 "Concerning Controlling Medicaid Costs" resourced and prioritized cost containment activities for the Department. The bill provided funding to: modernize claim edits to reduce overpayments; expand the Department's hospital admission reviews to ensure inpatient admissions are proper and improve supports upon discharge to reduce complications and readmissions; create a single tool that gives doctors access to pharmacy costs so that they can prescribe more cost effectively and provide access to health improvement programs available to their patient so that they can prescribe programs that address the root of disease; provide prescribers, Regional Accountable Entities, and hospitals with a tool that identifies potentially avoidable complications and costs so that they can improve quality and reduce inefficiencies; and, create an Office in the Department to focus on cost containment strategy and programming. The bill was the foundation for the development of the Department's cost containment strategy and provided resources which will ultimately allow the Department to maintain a focus on cost containment and to effectuate the strategy.

While there are multiple different initiatives, requests, and bills, they all represent or support components of a cohesive cost containment strategy geared at making sure providers are paid appropriately and have the right resources and incentives to provide high quality, cost-effective care.

- 2. The Colorado Health Institute estimates 6.5 percent of the population, or 350,000 people, were uninsured in Colorado in 2017. Please describe the process used for arriving at this estimate and potential strengths and weaknesses of the process that might affect the accuracy of the estimate. Does the Department agree with the estimate? Is there any evidence to suggest the number of uninsured is increasing since 2017? How does the number of uninsured vary by region across the state?**

RESPONSE

The Colorado Health Institute (CHI) estimated the percent of the uninsured population in Colorado by surveying 10,029 randomly selected households via cell phones and landlines in 2017. Survey data was weighted based on the demographics of the state's population. The uninsured population was identified as people who responded that they had no insurance at the time of the survey or indicated that Indian Health Services was their only form of coverage. For more detail, refer to the 2017 Colorado Health Access Survey report.¹

The benefit of this process is being able to ask multiple questions over multiple years to capture changes in the health care landscape. The main shortfall is that there is a margin of error inherent in the results due to the possibility that the random sample size does not perfectly reflect the population at large. For that reason, any differences in the year-to-year comparisons that have at least a 5 percent chance of resulting from coincidence in who was surveyed are marked as "essentially unchanged." Additionally, through this method, the estimates are only updated every other year when the survey is administered. The Department does not estimate rates of insurance and therefore cannot verify the accuracy of the estimates.

From 2015 to 2017, the change in the uninsured rate was statistically insignificant, which means that it is possible that the uninsured rate changed but it was too small for a statistical sample to confidently detect. The Department does not have any evidence that the uninsured rate has increased since the 2017 survey. That said, the average income for a household in Colorado in 2016 was \$65,718, and the average cost of private insurance is \$20,940. Given the magnitude of insurance costs, it is challenging for the typical Colorado household to afford health care coverage if it is not covered by an employer and their income is too high to qualify for subsidies. With medical inflation increasing at rates significantly higher than income growth, the uninsured rate may be climbing for households that fall into that group.

The 2017 Colorado Health Access Survey report provides a breakdown of the uninsured rates by region. From that analysis, the report concludes, "The ACA's success in expanding coverage in Colorado has been uneven, with rural areas seeing less progress than the state's more populated urban counties. The uninsured

¹https://www.coloradohealthinstitute.org/sites/default/files/file_attachments/2017%20CHAS%20DESIGN%20FINAL%20for%20Web.pdf

rate in northwest Colorado (Region 11), is the highest in Colorado. Still, it has dropped by nearly half since 2013.” The report provides a map of the uninsured rate by county.²

3. What percent of children in Colorado are covered by the Children's Basic Health Plan (CHP+) and Medicaid respectively?

RESPONSE

In FY 2017-18, 39.86 percent of children under the age of 19 in Colorado were enrolled in Medicaid and 5.93 percent were enrolled in CHP+. Combined, 45.79 percent of children were enrolled in Medicaid or CHP+.

| Percent of Children Enrolled in Medicaid and CHP+ in Colorado | | | | | | | |
|---|---------------------------|-------------------------|-----------------------|---------------------|-----------------------|-------------------------------------|-----------------------|
| Fiscal Year | State Population Under 19 | Total Medicaid Under 19 | | Total CHP+ Under 19 | | Total Children in Medicaid and CHP+ | |
| | | Caseload | Percent of Population | Caseload | Percent of Population | Caseload | Percent of Population |
| FY 2015-16 | 1,331,063 | 558,450 | 41.96% | 51,041 | 3.83% | 609,491 | 45.79% |
| FY 2016-17 | 1,337,175 | 564,140 | 42.19% | 65,260 | 4.88% | 629,400 | 47.07% |
| FY 2017-18 | 1,340,572 | 534,388 | 39.86% | 79,458 | 5.93% | 613,846 | 45.79% |

4. Please describe the economic impact of the decrease in the uninsured. What cost savings have been achieved? Please specifically address the impact on charity care costs for hospitals and any other providers for which the Department has data.

RESPONSE

Economic Impact

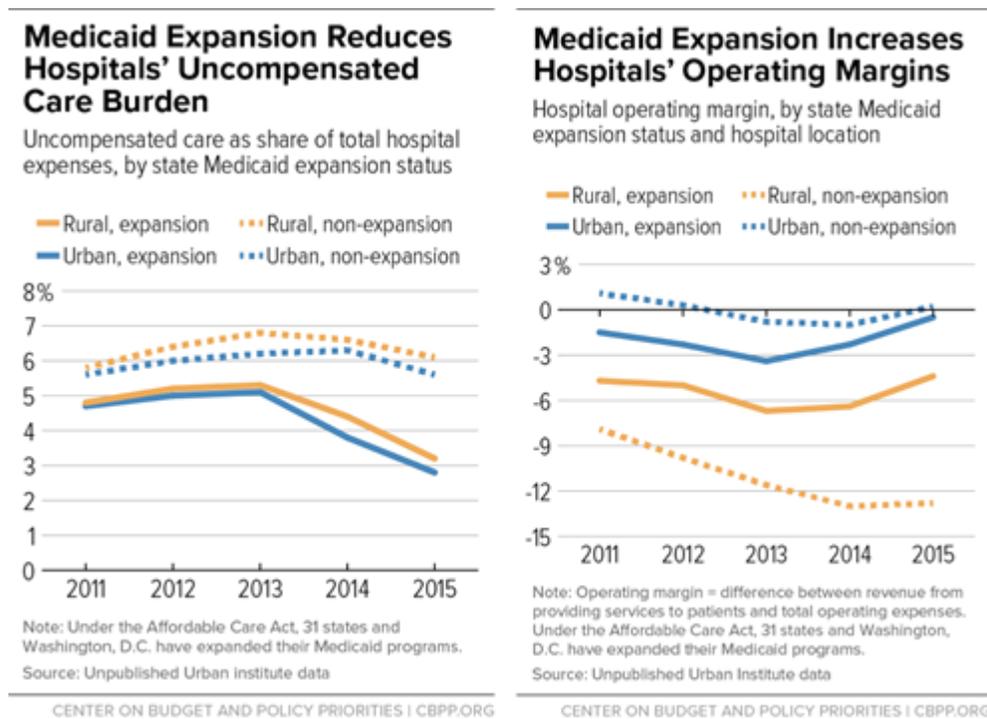
The decrease in the uninsured rate has a positive economic impact as it reduces health-related debt, enables consumers to spend more in local economies, and improves the health and well-being of Coloradans which increases workplace productivity and economic output. Key findings in the Colorado Health Foundation’s 2016 publication, *Assessing the Economic and Budgetary Impact of Medicaid Expansion in Colorado*, indicated that Colorado’s economy in 2016 was 1.14 percent larger in terms of state gross domestic product as a result of Medicaid expansion and will be 1.38 percent larger by FY 2034-35. In addition, in 2016 Colorado’s economy supported 31,074 additional jobs due to Medicaid expansion. By FY 2034-35, that number will grow to 43,018, resulting in total employment that is 1.35 percent larger than it would be without Medicaid expansion.³

² Ibid., page 12.

³ The payment less cost per patient for the CICP/Self Pay-Other payer group may show a positive result in calendar years 2015 through 2017 due to hospitals reporting revenue incorrectly as CICP revenue, rather than Medicaid revenue, or because of a decline

Hospital Charity Care Impact and Cost Savings

The Center on Budget and Policy Priorities found nationally that hospitals' uncompensated care costs have decreased while operating margins have increased following Medicaid expansion.⁴ Similar effects are seen in Colorado.



In Colorado, following the health coverage expansion due to the Colorado Healthcare Affordability Act (CHCAA) and Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) hospital provider fee programs, and the implementation of the federal Affordable Care Act (ACA), the proportion of uninsured Coloradans reduced from 15.8 percent to 6.5 percent. Moreover, hospitals have received more than \$400 million in net new federal funds from CHASE in the most recent year to their financial advantage.

The increased hospital reimbursement and reduction in the number of uninsured Coloradans were expected to reduce the need for hospitals to shift uncompensated care costs to private payers. However, a reduction to the cost shift has not occurred. Rather than using the additional reimbursement to reduce hospital payments from commercial payers, hospitals have seen margins increase by 153 percent on a per patient basis. See below.

The following table displays cost shifting through the ratio of total payments to total costs for Medicare, Medicaid, private sector insurance, and Colorado Indigent Care Program (CICP)/Self Pay/Other payer groups. Ratios below 1 mean that costs exceed payments, which is generally the case for Medicare and

in the allocation of bad debt and charity care to this payer group. More analysis is needed to understand the change in payment less cost per patient for the CICP/Self Pay/Other payer group.

⁴ Center on Budget and Policy Priorities. (2017). Affordable Care Act's Medicaid Expansion Benefits Hospitals, Particularly in Rural America. Retrieved from <https://www.cbpp.org/research/health/affordable-care-acts-medicaid-expansion-benefits-hospitals-particularly-in-rural/>.

Medicaid. Values greater than 1 mean that payments exceed costs, as is the case for the private sector insurance group.

As shown below, in 2009, prior to the implementation of the CHCAA, Medicaid reimbursement to Colorado hospitals was approximately 54 percent of costs, while in 2017, the payment to cost ratio for Medicaid is 69 percent of costs. The payment to cost ratio for the CICP/Self Pay/Other payer group has also increased from 52 percent in 2009 to 114 percent in 2017³. However, the payment to cost ratio for private sector insurance and the overall payment to cost ratio have also increased, driving increased costs for commercial employers and consumers and increased profits or margins for hospitals (153 percent increase in margins).

| Year | Medicare | Medicaid | Insurance | CICP/Self Pay/Other | Overall |
|----------------|----------|----------|-----------|---------------------|---------|
| CY 2009 | 0.78 | 0.54 | 1.55 | 0.52 | 1.05 |
| CY 2010 | 0.76 | 0.74 | 1.49 | 0.72 | 1.06 |
| CY 2011 | 0.77 | 0.76 | 1.54 | 0.65 | 1.07 |
| CY 2012 | 0.74 | 0.79 | 1.54 | 0.67 | 1.07 |
| CY 2013 | 0.66 | 0.8 | 1.52 | 0.84 | 1.05 |
| CY 2014 | 0.71 | 0.72 | 1.59 | 0.93 | 1.07 |
| CY 2015 | 0.72 | 0.75 | 1.58 | 1.11 | 1.08 |
| CY 2016 | 0.71 | 0.71 | 1.64 | 1.08 | 1.09 |
| CY 2017 | 0.69 | 0.69 | 1.66 | 1.14 | 1.08 |

Colorado hospitals have realized costs savings from the reduction in the number of uninsured Coloradans through a substantial reduction in uncompensated care costs from bad debt and charity care. Hospital bad debt and charity care are provided to the Department from the Colorado Hospital Association (CHA) DATABANK and reported in the CHASE Annual Report at a statewide level. As shown below, hospital bad debt and charity care decreased beginning in calendar year 2014 when the health coverage expansion under the Affordable Care Act (ACA) was fully implemented. Total bad debt and charity care are approximately \$413 million lower in 2017 compared to 2013, decreasing by 59 percent. Charity care specifically is nearly \$311 million lower in 2017 compared to 2013 – a decrease of 70 percent.

| Year | Bad Debt | Charity Care | Total |
|----------------|---------------|---------------|---------------|
| CY 2009 | \$255,161,427 | \$438,432,609 | \$693,594,036 |
| CY 2010 | \$234,216,738 | \$430,871,543 | \$665,088,281 |
| CY 2011 | \$194,825,791 | \$473,157,782 | \$667,983,573 |
| CY 2012 | \$206,347,067 | \$465,558,867 | \$671,905,934 |
| CY 2013 | \$255,306,707 | \$444,436,807 | \$699,743,514 |
| CY 2014 | \$145,964,802 | \$174,150,188 | \$320,114,990 |
| CY 2015 | \$145,358,187 | \$118,526,410 | \$263,884,597 |
| CY 2016 | \$145,381,741 | \$147,180,251 | \$292,561,992 |
| CY 2017 | \$152,801,781 | \$133,474,605 | \$286,276,386 |

At the same time that hospital reimbursement for Medicaid patients increased and bad debt and charity care costs decreased, hospital payments, costs, and margins have increased. As seen below, from 2009 to 2017 on

a per patient basis, Colorado hospital costs have increased by 5.1 percent on average per year compared to 3.2 percent nationally – a 59 percent higher cost growth than the national average. As payments per patient have grown at an even higher rate than costs, hospital margins have increased 153 percent from \$542 to \$1,373 for an annual average increase of 19.2 percent over the eight-year time period.

| Year | Payment Per Patient | Cost Per Patient | Margin Per Patient |
|------------------------------|----------------------------|-------------------------|---------------------------|
| CY 2009 | \$12,313 | \$11,771 | \$542 |
| CY 2010 | \$13,285 | \$12,584 | \$701 |
| CY 2011 | \$13,786 | \$12,868 | \$918 |
| CY 2012 | \$14,663 | \$13,760 | \$903 |
| CY 2013 | \$15,224 | \$14,477 | \$747 |
| CY 2014 | \$15,766 | \$14,727 | \$1,039 |
| CY 2015 | \$16,045 | \$14,802 | \$1,243 |
| CY 2016 | \$17,126 | \$15,779 | \$1,347 |
| CY 2017 | \$17,930 | \$16,557 | \$1,373 |
| Average Annual Change | 5.7% | 5.1% | 19.2% |

Other Providers Charity Care Impact

The reduction in the number of uninsured Coloradans has also lowered uncompensated costs for Community Health Centers and other safety net clinics that participate in the Colorado Indigent Care Program (CICP), which provides discounted health care services at participating providers for low-income Coloradans who are not eligible for Medicaid or CHP+.

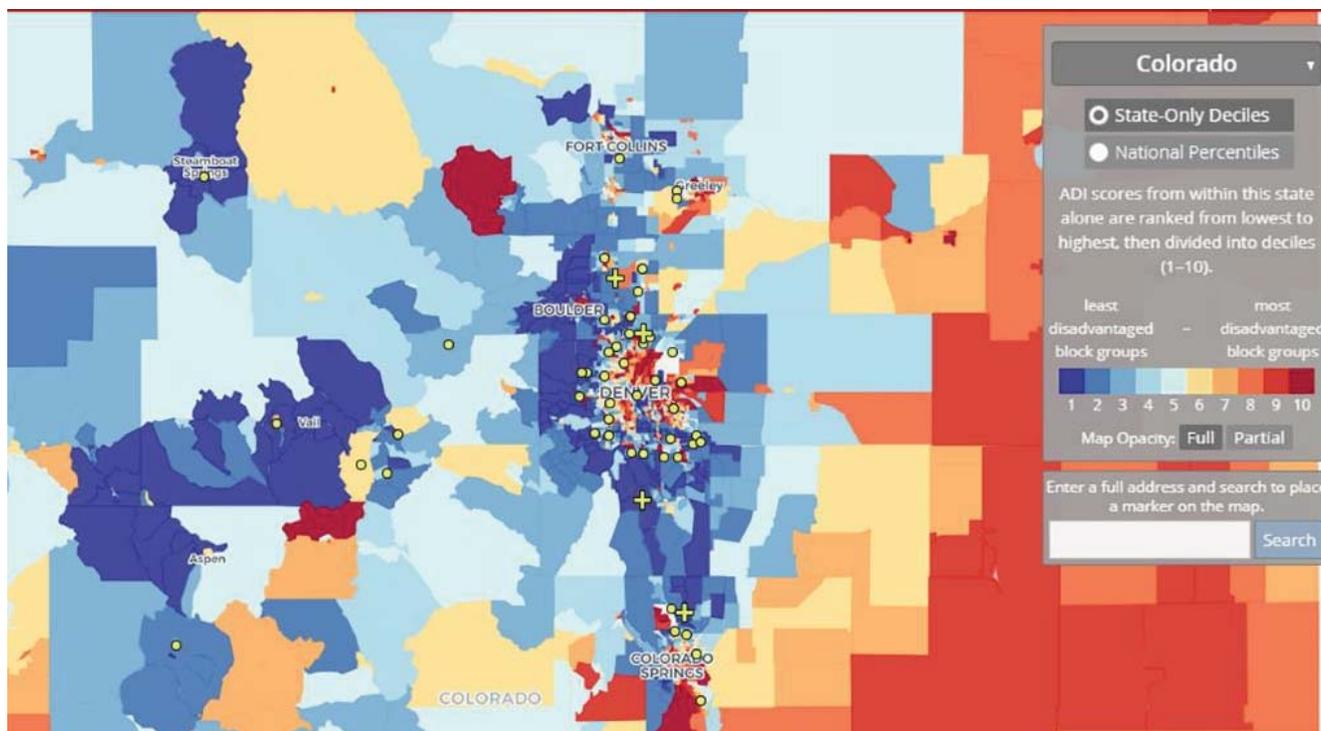
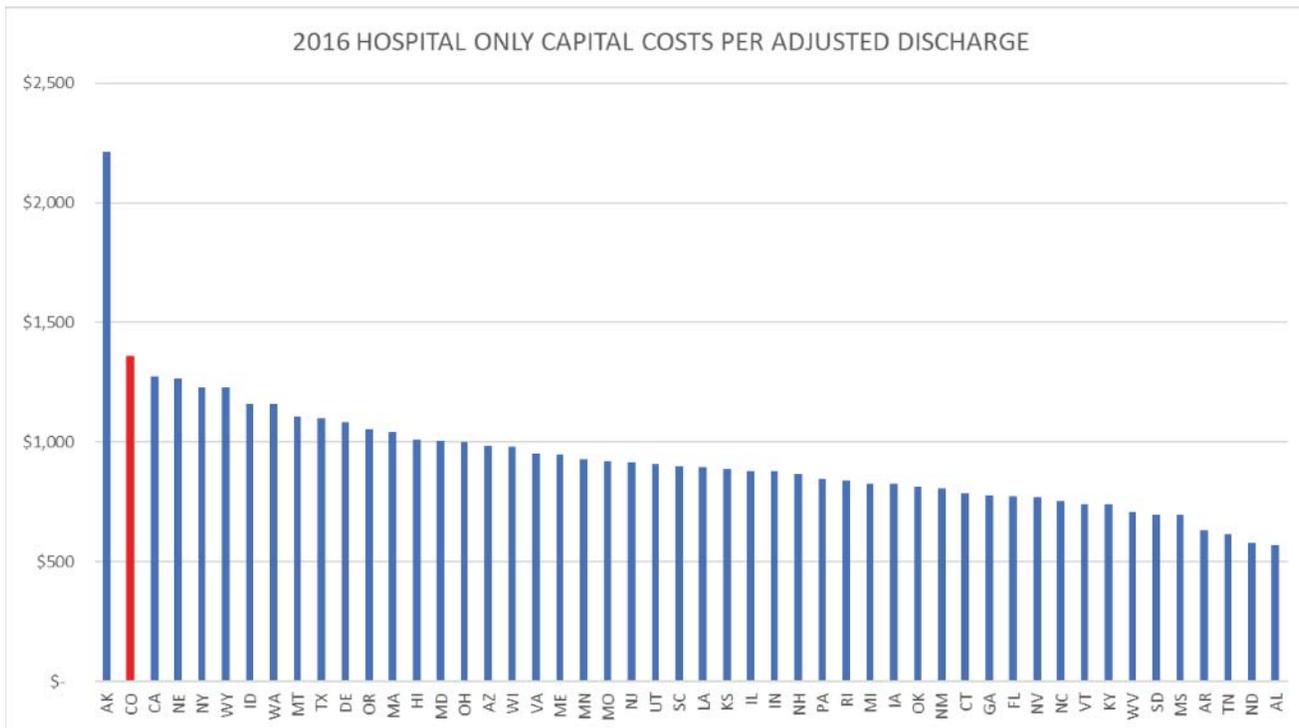
From FY 2012-13, prior to the implementation the health coverage expansion under the ACA, to FY 2017-18, uncompensated care for CICP clients at participating clinics was reduced from \$43.5 million to approximately \$13 million – a decrease of 70 percent.

Impact to Commercially Covered Employers and Consumers

As the number of uninsured Coloradans reduced by half and Medicaid reimbursement increased through the CHCAA and CHASE provider fees, hospital margins increased by 153 percent per patient, bad debt/charity declined by 59 percent, and yet the cost shift to commercial employers and consumers continues unabated. There has been - and continues to be - an opportunity for hospitals to make different business decisions – perhaps reducing rate increases to commercial payers for products and services that serve employers and consumers.

Concurrent hospital business decisions have resulted in an increase in hospital costs rising at a rate 59 percent greater than the national average. This corresponds with the increase in hospital construction across the state (free standing emergency departments, new hospitals, hospital expansion projects and the like). The first chart below illustrates that Colorado hospital construction is leading the country, creating excess capacity which has been proven to increase health care market prices (overhead spread over fewer patients; lower quality and increased complications follows lower patient volume; lower procedure volume necessitates

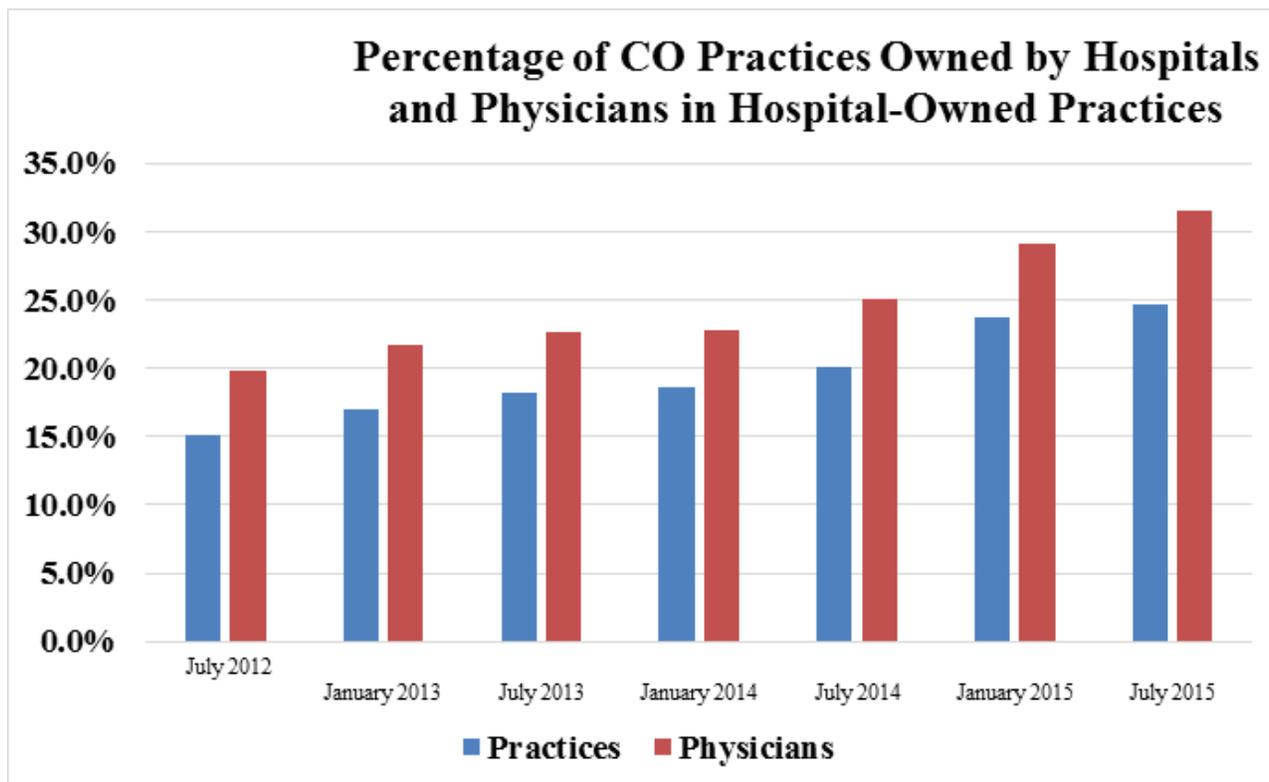
higher market prices). The second chart shows that new construction of hospital owned free standing emergency rooms and new hospitals are largely occurring in the higher income areas, which would have higher rates of commercial versus Medicaid coverage.



Source: CHI, Nov 2018.

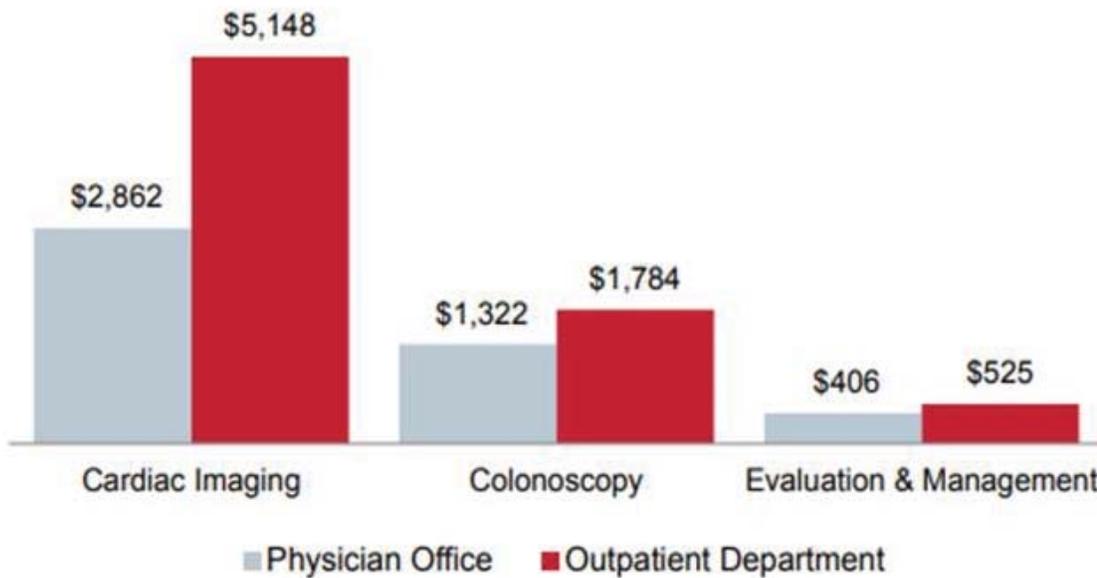
In the above illustration, the yellow circles represent newly constructed free-standing emergency rooms while the crosses reflect newly constructed hospitals.

This increase in Colorado hospital overhead costs also corresponds with the increase in their acquisition of physician groups. The below two charts illustrate the increase in physician and physician group acquisition as well as the impact to the prices paid by consumers, employers and public programs post acquisition. The reader should also note that the increase in physician group acquisition is not equal across all of Colorado. There are some areas where the acquisition of physician groups is much higher as hospitals try to gain control of the admissions provided by such groups, creating a more adverse impact to health care prices.



Source: Physicians Advocacy Institute

Risk-Adjusted Payment Differences Between Physician Office and Outpatient Department by Episode of Care



Source: Avalere study for Physicians Advocacy Institute <http://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/2016-PAI-Physician-Employment-Study-Final.pdf>

5. Why has the proportion of the population receiving insurance through employer-sponsored plans decreased?

RESPONSE

The 2017 Colorado Health Access Survey (CHAS),⁵ published by the Colorado Health Institute (CHI), indicates that the percentage of individuals covered through employer-sponsored insurance has decreased from 57.7 percent in 2009 to 49.4 percent in 2017; in total, CHI estimated that the number of people covered by employer-sponsored insurance declined from approximately 2.89 million in 2009 to 2.67 million in 2017.

Although the Department does not maintain data about the number of employers offering coverage to employees or changes in the types of employment that may help to explain the changes in the type of insurance coverage, it conferred with Division of Insurance within the Department of Regulatory Agencies on this question. Reasons that the proportion of the population receiving insurance through employer-sponsored plans has decreased may include:

- An increase in Medicare coverage, particularly because of Colorado's aging population. CHI estimates that 487,000 people were covered by Medicare in 2009, and that this figure grew to 776,000 by 2017. Those individuals previously uninsured and gaining insurance through Medicare reflect an improvement in income to providers through a decrease in the uninsured rate. Those moving from commercial insurance to Medicare reflect a reduction in income to providers.
- An increase in Medicaid coverage. CHI estimated that Medicaid coverage increased from 518,000 in 2009 to 1.13 million in 2017. The 2017 number may also be understated; the Department's

⁵ <https://www.coloradohealthinstitute.org/research/colorado-health-access-survey>

caseload reporting showed over 1.3 million people eligible in 2017. This reduction in the uninsured rate provided a net increase in revenue to providers overall – a favorable, financial net gain. Consider the below results provided by the Department specific to Colorado hospitals during the period 2009 through 2017:

- The number of uninsured Coloradans decreased by half
- Medicaid reimbursement increased through the Colorado Health Care Affordability Act (CHCAA) and Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) hospital provider fees
- Hospital margins increased by 153 percent (reflecting increased income from hospital fees and the reductions in the uninsured rate)
- Hospital bad debt/charity declined by 59 percent (reflecting a reduction in the uninsured rate)
- Changes in the insurance market since 2009, largely due to the Affordable Care Act. Small employers have experienced an increase in costs, which may be passed along to employees in the form of increased premiums and may make coverage unaffordable.

The Division of Insurance indicated that they would be available for further analysis on this topic.

6. Please describe how a reinsurance program, such as the one proposed in H.B. 18-1392, could reduce private insurance premium costs. How did the financing for H.B. 18-1392 work and was there any General Fund cost?

RESPONSE

SB 17-300 “High-risk Health Care Coverage Program” directed the Division of Insurance (DOI) to study solutions to rising individual health insurance costs, especially the reimbursement for services for high cost medical conditions. The DOI held a stakeholder process and published a report October 2, 2017⁶. The report indicates that:

- Reinsurance is insurance for insurance companies against risks for unusually expensive claims. It is a mechanism to spread the risk of high cost conditions, so they do not threaten market stability and it may provide an incentive for carriers to provide coverage in areas with few options. Increasing claim predictability can lower the risk charge in the premium calculation, thereby lowering the premium rate to purchasers.
- Health care costs are a significant driver of premium increases in Colorado. In recent years, the average medical loss ratio (MLR) for carriers in the individual market has exceeded 100 percent, meaning that carriers are spending more on medical services than they are taking in through premiums, leaving no funds to cover administration costs. High loss ratios necessitate carrier decisions to increase premiums or withdraw from market areas.
- The purpose of establishing a high-risk reinsurance program is to foster competition among health insurance companies and provide more choice for consumers to develop market stability. A high-risk coverage program reduces premiums by providing funds to counterbalance the highest cost claims.

⁶ <http://www.leg.state.co.us/library/reports.nsf/ReportsDoc.xsp?documentId=4415ACC434A346198725813700787FE4>

This would benefit consumers through reduced premiums with the most benefit received by consumers eligible for the advance premium tax credits (APTC) or employer provided coverage.

Alaska, Minnesota and Oregon have or are in the process of establishing reinsurance programs and are experiencing or have estimated premium reductions.

HB 18-1392 “State Innovation Waiver Reinsurance Program” would have authorized DOI to apply for a state innovation waiver, federal funding, or both to allow the state to implement and operate a reinsurance program to assist health insurers in paying high cost insurance claims. To fund the reinsurance program, DOI would be authorized to assess a fee on state-regulated health insurance carriers of up to two percent of premiums. In addition, the reinsurance program would have been supported by federal funds that would have otherwise been provided to consumers as federal APTC. The fiscal note⁷ indicates the bill would have resulted in one-time costs to seek a federal waiver and, conditional upon federal approval, would have increased state revenue and expenditures for at least five years. The fiscal note indicates a one-time General Fund savings of \$15,000 and that the program would be fully financed by cash and federal funds.

7. What regions and service areas have the lowest number of providers accepting Medicaid patients relative to the need? What is the Department doing to address provider shortfalls?

RESPONSE

While the Department can quantify the number of enrolled and active Medicaid providers in each county, it cannot quantify those providers accepting new Medicaid patients, and to what extent. The Department is in the process of trying to gather such information through qualitative analysis, including survey data.

The Department evaluates member access to care, such as measuring the availability and accessibility of services, to assess how well member needs are being met. There are a number ways access to care is measured in Colorado, both by the Department and by other agencies. For example:

- The Colorado Health Institute (CHI) conducts the [Colorado Health Access Survey \(CHAS\)](#) every two years, which provides information on health insurance coverage, access to health care, and use of health care services in Colorado, and allows for comparisons across counties, populations, and payer types. In 2017, CHI used CHAS data to create an [Access to Care Index](#) that scored each county on a number of access metrics, including provider workforce. CHI concluded that, in general, across payers, urban Front Range counties have better access to health care than rural areas. CHI is presently working on a Medicaid-specific Access to Care Index in collaboration with the Department. The 2017 CHAS reported that nine of 10 Medicaid members statewide are happy with the range of services covered, trailing only Medicare. Eight of 10 are happy with their choice of doctors, a better rate than those with individual coverage, but trailing employer-sponsored insurance and Medicare. Finally, 81.0 percent of Medicaid members said their family’s needs are being met by the health care system, which is higher than any insurance type, including employer-sponsored insurance.

⁷ http://leg.colorado.gov/sites/default/files/documents/2018A/bills/fn/2018a_hb1392_fl.pdf

- Federal regulations require the Department to evaluate Medicaid member access to services, address access deficiencies, and monitor the impacts of any actions taken to mitigate those deficiencies, on a continual basis. It also requires the Department to draft and submit to Centers for Medicare and Medicaid Services an Access Monitoring Review Plan (AMRP) every three years. The AMRP must include an analysis of data and the state's conclusion of the sufficiency of access to care, for five broad categories of service, including: primary care, specialty care, home health, obstetrical care, and fee-for-service behavioral health. If the Department determines that access to a service is not sufficient, the AMRP must also include a plan for how the Department will address that issue. The Department published the first AMRP in 2016, which included a comparison of access across Health Statistics Regions⁸; the next AMRP will be published October 1, 2019 and will include comparisons across counties.
- State statute requires the Department to review provider reimbursement rates on a five-year schedule to assess whether payments are sufficient to allow for provider retention and client access and to support appropriate reimbursement of high-value services and provide its analysis and recommendations to the Joint Budget Committee in reports published each May and November⁹. Each report includes an analysis of how access to the service grouping under review compares across Health Statistics Regions, including, for example, how far members must travel for services. The Department plans to include comparisons across counties in future reports. Where the Department identifies a potential access deficiency it takes action to further investigate and address the issue; for example, if the Department believes that low provider counts may be the result of insufficient reimbursement, the Department may recommend an increase to provider rate reimbursement within the Rate Recommendation Report and the Governor's Budget Request.

As part of the activities above, the Department is leveraging partnerships to further develop and measure access metrics, including work with: CHI; the Center for Improving Value in Health Care (CIVHC); the Colorado Department of Public Health and Environment; and others. The goal of this work is to build a complete picture of member access to Medicaid services and how that access compares across specialties, regions, and payer types. The Department will use these partnerships to investigate, for example, the types and proportion of services provided in each county and across payers.

The Department is also presently engaged in several efforts to strengthen and monitor its provider network, including, but not limited to:

- Establishing a partnership with the University of Colorado School of Medicine to conduct a community needs assessment (completed in May 2018) and to improve Medicaid member access to primary and specialty care based on the needs identified. Particular focus has been placed upon: mental & behavioral health access, including substance use disorder treatment; adult access to specialty care; and developmental pediatrics and services for children and youth with special health care needs.

⁸ The access to care evaluation and conclusions can be found in the [2016 Access Monitoring Review Plan](#).

⁹ Rate review evaluation and conclusions can be found on the [Department's website](#), including the [2016, 2017 \(Physician Services, Surgery, and Anesthesia\) \(Home- and Community-Based Services Waivers\)](#), and [2018 Medicaid Provider Rate Review Analysis Reports](#) and the [2016, 2017, and 2018 Medicaid Provider Rate Review Recommendation Reports](#).

- Holding Regional Accountable Entities (RAEs) accountable for creating and maintaining a primary care and behavioral health network of providers that is capable of serving all members. The RAEs' networks must include providers with specialized training and expertise across all ages, levels of ability, gender identities, and cultural identities. The RAEs are required to submit an annual Network Adequacy Plan and quarterly Network Adequacy Reports describing how they are meeting contractual network adequacy requirements and any strategies to address any network deficiencies. The RAEs are encouraged to utilize telemedicine to address geographic barriers to accessing clinical providers.
- Awarding two recent county grants focused on recruitment and enrollment of new providers in non-metro areas (Mesa and El Paso counties).
- Working with its fiscal agent, DXC, to establish Regional Field Representatives across Colorado, that assist providers with provider enrollment via phone calls, emails, and in person site visits.
- Working with Kaiser to understand their financial concerns, their plans to cure, and the subsequent impact to Medicaid member access. Effective July 2018, Kaiser discontinued providing access to Medicaid members in all areas except greater Denver.
- The Department converted to a new claims system in March 2017. Since operations returned to normal in 2018, enrolled providers have continued to increase. In November 2018, the number of providers increased by 23 percent since the prior year.

The Department continues to develop best practices and metrics to evaluate service utilization, access to and quality of care, and provider retention to best meet member needs.

8. Please describe the Department's communications with the federal government regarding Medicaid's share of the All-Payer Claims Database (APCD) prior to the passage of H.B. 18-1327. How was it a surprise that the federal government subsequently did not agree with the Department's methodology for allocating costs?

RESPONSE

The Department has worked with the Centers for Medicare and Medicaid Services (CMS), the Center for Improving Value in Health Care (CIVHC), and its cost allocation vendor, Public Consulting Group (PCG), since September 2017 on developing a cost allocation plan to obtain CMS approval for Title XIX (Medicaid) funding to support the All Payer Claims Database (APCD). CMS agrees with the Department that expenditures related to the APCD are federally allowable under Medicaid although the exact amount of APCD expenditures allocable to Medicaid has been difficult to quantify. Other state Medicaid agencies have not had this difficulty because other state Medicaid agencies directly administer their APCDs. Federal guidance regarding vendor-administered APCD cost allocation methodologies does not exist. This guidance would have assisted the Department with developing an initial cost allocation methodology that could have been approved by CMS in a more timely manner. This lack of clear federal guidance resulted in several months of meetings, communications and collaboration between CMS, the Department, and its partners.

The Department began this process in September 2017 by working with CIVHC to develop an initial cost allocation methodology for the APCD. This cost allocation methodology was originally submitted to CMS and Cost Allocation Services (CAS) in the Department's November 2017 Public Assistance Cost Allocation

Plan (PACAP) amendment. The Department received initial questions from CMS regarding this cost methodology in December 2017 and responded promptly.

Between December 2017 and November 2018, the Department had numerous discussions with CMS and its Central Office regarding the APCD cost allocation methodology and responded to several rounds of questions. This resulted in changes to the original APCD cost allocation methodology including a change in the overall format. In June 2018, CMS decided the APCD cost allocation methodology should be submitted as a Medicaid Administrative Claiming (MAC) plan and not as an amendment to the Department's PACAP. This decision resulted in additional and unexpected work for the Department and PCG and created additional delays.

As of December 12, 2018, CMS has not officially approved the amount of federal funding in the APCD MAC plan. The Department did receive some additional feedback from CMS on November 30, 2018 where CMS stated that the APCD MAC plan was largely acceptable with some exceptions to the treatment of applicable credits and program income. The Department and PCG had a follow-up phone call with CMS on December 6, 2018 to discuss this feedback and will be working with CIVHC to address these final exceptions to the APCD MAC plan. The Department expects to have a response to CMS in January 2019 for final review.

9. Who uses and benefits from the All-Payer Claims Database (APCD)? Who pays for the operations? How many other states have a facsimile of the APCD and how are those entities financed? Should there be a charge on private insurance for the operations of the APCD?

RESPONSE

Who uses and benefits from the All-Payer Claims Database (APCD)?

Colorado's All-Payer Claims Database (APCD) is a comprehensive claims database that includes claims from Medicaid, Medicare, and over 21 commercial health insurance companies. The APCD is administered by the Center for Improving Value in Health Care (CIVHC), a not-for-profit organization. The APCD is a resource enacted by legislation to benefit all Coloradans. APCD data releases provide consumers, organizations, communities, legislators, and more with access to information to help lower costs and improve quality of care. Information is also available publicly on hospital, pharmacy, outpatient, and professional costs, as well as utilization of emergency rooms, readmissions, condition prevalence and quality of care.

Claims data in the APCD includes information about location of service, cost of service, diagnosis, and type of service across all insurance providers. The claims database provides the most complete picture of health care in Colorado, and crucial information on the costs associated with it. In October, the APCD was approved to start collecting information which more accurately completes the claim information, including information related to alternative payments models, prescription drug rebates, and other compensation paid by pharmaceutical manufacturers to payers. This latter change further helps employers and the state understand how much of these rebates and other compensation are being retained by the carriers and how much is being passed along to employers to offset the cost of their prescription drug benefits. Ultimately, this information increases price transparency throughout the state's health care market.

State agencies have been using APCD data to improve health care in Colorado since 2013. For example, the Department uses APCD data internally to study access to care and services between Medicaid and other coverage groups, such as commercial insurance and Medicare. This analysis shows provider participation in Medicaid and other coverage groups by county, region, and health statistic region, and will soon also include provider participation by provider specialty. The analysis highlights where there is an access to care issue within Medicaid, which can lead to policy changes, enhanced provider outreach for Medicaid participation, and ultimately better access to care for Medicaid members.

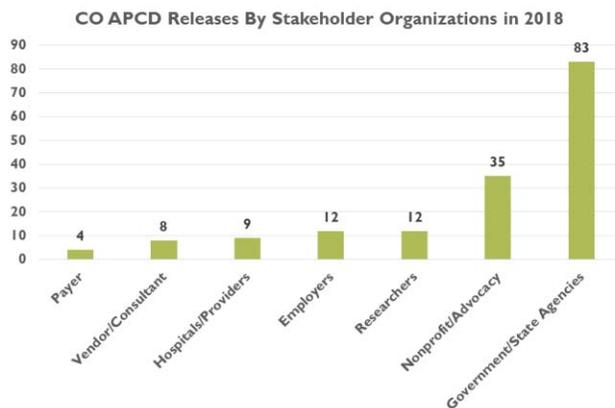
The Division of Insurance has used the APCD for many of its recent studies, including the following:

- Colorado Health Cost Trend Study – Reviewed trends and health care costs in the commercial non-Medicare and non-Medicaid population. Analysis is valuable in the trend review of health coverage rate filings. APCD data has also been used to determine acceptable population risk morbidity, cost trend, and utilization factors that are applied to allowed claims used in rate filings.
- Colorado Pharmacy Cost Study – Reviewed the cost associated with specialty and traditional drugs for the commercial insured non-Medicare and non-Medicaid population, with an emphasis on unit cost, utilization, total cost, and pharmacy trends.
- Colorado Total Health Cost and Geographic Areas 2016 Study – Evaluated the appropriateness of the nine (9) geographic rating areas that are currently in effect for the Affordable Care Act plans and the impact of moving to one rating area for the state. Analyzed regional costs, determined cost drivers, and examined the appropriateness of area rating factors used by insurance carriers.

Some of the non-state data requestors have used the data to:

- Improve outcomes for vulnerable patients
- Lower costs for procedures
- Improve reimbursements and increase access to care
- Evaluate the effectiveness of policy changes, such as providing a return on investment of tailored nutrition for chronically ill patients

In 2018, government and state agencies received a little over half (51 percent) of all custom data releases with 83 data requests. Below is a chart that summarizes the releases of data from the APCD.



This budget submission is part of a broader Health Care Affordability Roadmap intended to better control health care costs across the state. The above chart illustrates one of the critical challenges this budget request is trying to address: that employers and communities are not using the APCD to identify drivers of increasing health care costs. As a result, employers and communities are not able to perform critical evaluations of their network such as provider outlier comparisons to identify providers who have excessive charges or lower quality performance. Nor are they set up to review the Prescription Drug Rebates and other compensation paid by pharmaceutical manufacturers to payers that will become available after March 2019 that will help them identify and redirect pharmaceutical carrier payments that should be flowing through to employers to offset rising health care costs. Activities such as these are critical to address major population health challenges as the state and the nation grapple with controlling rising health care costs.

This budget request specifically enables the following:

- a. Led by the Department, the governing body over the APCD, the state has created a Health Care Affordability Roadmap (Roadmap) to improve health care affordability for consumers, employers, Medicaid, and all stakeholders across the state. It includes cost control initiatives across five major areas: constraining prices on hospital and prescription drugs; championing alternative payment methodologies; aligning and strengthening data infrastructure and shared systems; improving population and behavioral health; and maximizing innovation. This Roadmap was piloted in Grand Junction to guide the initiatives they will implement to significantly improve affordability in their area.

That said, the key to choosing the initiatives and to measuring their impact is data. This budget request would encourage self-funded employers to add their data to the APCD to create a single source of reporting and truth that would support strategic insights, cost driver identification, and increase the effectiveness of the Roadmap in communities across the state. It also specifically supports employers in better managing their costs by enabling comparisons with other employers and improved analytics in their own communities. When the Denver Metro Chamber of Commerce was asked, the consensus was that having the right insights and data was the most important initial step to ensure effective cost control strategy by region and create the ability to measure the impact of implemented cost control strategy. Having employers actively engaged in the fight to control health care costs is of paramount importance. This budget request fuels that engagement, respects their top priority request for help, provides reliable insights into cost drivers by community, and enables analysis going forward necessary to execute the proper control costs strategy.

- b. The state agencies – such as the Division of Insurance – need information from the APCD but cannot get it due to the charges required for the reporting. This funding will allow the agencies to secure the information they need to manage their project work.

While the Health Care Affordability Roadmap provides leadership in identifying possible solutions that can be implemented by communities and employers, the data must drive both the choices on which options to implement and the measures as to how effective those solutions are in driving down costs and prices for the betterment of consumers, employers, taxpayers, Medicaid and the state.

Who pays for the current operations?

The APCD is currently supported in three ways:

1. Medicaid funding appropriated in the prior session to support the Medicaid-only portion of database;
2. Revenue generated from licensing and providing analytics and custom datasets from the APCD; and
3. Grant funding, which came to an end this year (June and November 2018).

Historically, CIVHC has used general operating funds awarded by The Colorado Health Foundation (TCHF). However, TCHF and other foundations never intended to support long-term funding for Colorado's APCD.

How many other states have a facsimile of the APCD and how are those entities financed?

Eighteen states have legislatively mandated APCDs. Of these, five are funded exclusively by their state, seven receive Medicaid matching funds (state funding plus matched funds from CMS), four receive state appropriations and assess fees on submitters, and two rely on grant funding. Several APCDs across the nation earn revenue from data sales/licensing but none are sustainable solely on this income.

Mandated APCDs and State Funding Sources

(Provided by CIVHC and Summarized by Freedman Healthcare Consulting)

| Type of Funding | # of States | % of Total |
|--|-------------|------------|
| All state funded (including contributions from state Agencies) | 5 | 27.8% |
| State Medicaid match and/or contribution | 7 | 38.9% |
| Grants | 2 | 11.1% |
| State appropriations and assessments | 4 | 22.2% |
| Total | 18 | 100% |

Details by State

| | |
|----|--|
| AR | All state funded |
| CT | State appropriations and assessments through the state Health Marketplace |
| DE | Initial funding through Health Information Exchange and SIM grants; ongoing funding TBD |
| FL | Medicaid match |
| KS | All state funded |
| MA | Agency as a whole funded by assessments on hospitals and insurers |
| MD | All state funded, with contributions from state agencies for specific projects |
| ME | No state funds, only assessments on providers and payers and data use fees |
| MN | All state funded |
| NH | Medicaid match |
| NY | Funding from Medicaid, Dept of Financial Services, Dept of Health/Child Health Plus and state appropriations |
| OR | Medicaid match |
| RI | Medicaid match |
| TN | Medicaid match |
| UT | Medicaid match |
| VA | Medicaid contribution |
| VT | SIM funds, state appropriations, assessment on insurers |
| WA | Center for Consumer Information and Insurance Oversight grants funding through 2018 |

Should there be a charge on private insurance for the operations of the APCD?

The majority of APCDs have funding from their state to support ongoing operations. Four states assess fees from private insurance payers who submit data to their APCD. Although some states do charge payers to submit data to their APCD, Colorado’s payer community was not engaged to pay such a fee during the initial development of the APCD. When approached in the past, payers in Colorado have been reluctant to contribute a fee to support the operations of the APCD because they already incur a cost (e.g., internal resources, programing changes) to submit data into the APCD. Note that payers have their own systems to evaluate costs and to manage their own strategy to control costs. Those systems are proprietary and cannot be accessed by employers, consumers, communities, or the state. The state must have a comprehensive source of truth to manage what is arguably the most pressing budget concern we have which is managing health care costs that are now consuming one-third of the state’s budget and household budgets.

10. What is the true indirect administrative overhead of running Medicaid including federal, state, local government, and provider costs? How much of the money actually gets to recipients in the form of services?

RESPONSE

The table below shows the Department’s total appropriation, total administrative costs, and total Personal Services appropriations from the Long Bill for FY 2018-19.

Total Administration

| | Total Funds | General Fund |
|--------------------------|------------------|-----------------|
| Total HCPF Appropriation | \$10,130,526,763 | \$2,891,689,537 |
| Administrative Costs | \$335,389,423 | \$84,686,455 |
| Percent of Total | 3.31% | 2.93% |
| HCPF Personal Services | \$46,768,516 | \$16,268,121 |
| Percent of Total | 0.46% | 0.56% |

The Department also administers the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE). The table below shows the Department’s total appropriations and administration related to CHASE. State funding is appropriated through the Healthcare Affordability and Sustainability (HAS) Fee cash fund.

CHASE Administration

| | Total Funds | HAS Fee Cash Fund |
|---------------------------------|-----------------|-------------------|
| Total CHASE Related Expenditure | \$3,469,420,386 | \$914,896,944 |
| CHASE Total Administration | \$73,405,884 | \$26,977,609 |
| Percent of Total | 2.12% | 2.95% |
| CHASE Personal Services | \$6,226,010 | \$3,113,005 |
| Percent of Total | 0.18% | 0.34% |

The Department’s administrative costs include items such as: payroll and other staff costs; administration of information technology systems such as the Medicaid Management Information System and the Department’s share of the Colorado Benefits Management System; payments to counties; payments for

utilization management and cost control programs; payments for eligibility determinations; and payments for other Medicaid operations such as medical identification cards and payments to more than 350 vendors who perform many of the related functions necessary to operate a health plan.

According to the national association America's Health Insurance Plans (AHIP), the comparable administrative allowance for commercial insurance carriers is 13.4 percent.¹⁰ Importantly, these commercial carriers maintain this level of administrative allowance over a significantly larger population and revenue base, such as United Healthcare covering approximately 50,000,000 people, Anthem covering over 40,000,000 people, and Aetna covering over 22,000,000 people.¹¹ To control costs, these commercial carriers spend significantly greater proportions than the Department of their revenue to cover care management, technology and analytics, customer engagement, provider management, and general administration. It is critical that the state continue to make prudent administrative investments into improving its cost control, efficiency, prevention, and quality improvement initiatives to better manage its \$10.1 billion annual health care spend, which represents 33 percent of the state's total operating budget and 25 percent of the state's General Fund.

The Department does not have information to estimate provider administrative costs. Third party estimates of provider administrative cost vary depending on provider types. For example, in a recent article, the New York Times reported that American hospital administrative costs total over 25 percent of total spending on hospital care.¹² Authors in the Journal of the American Medical Association¹³ estimated that for a large academic health care system "...costs of billing and insurance-related activities ranged from \$20 for a primary care visit to \$215 for an inpatient surgical procedure, representing 3 percent to 25 percent of professional revenue."

HOSPITALS

11. In the Department's analysis of hospital expenditures, please describe what is included in the capital costs?

RESPONSE

The Department reports capital costs from analysis of a worksheet in the Medicare hospital cost report that reports annual capital costs and includes depreciation of previously acquired assets, leases, and rentals for the use of facilities and/or equipment, and interest incurred in acquiring land or depreciable assets used for patient care. The Department chose this method to analyze capital costs because the data from this worksheet is reviewed more closely by Medicare auditors than capital-related data in other areas of the cost report. This method also aligns with the methods the Department uses to analyze total hospital-only operating, administrative, and medical costs.

¹⁰ https://www.ahip.org/wp-content/uploads/2017/03/HealthCareDollar_FINAL.pdf

¹¹ "The Biggest Health Insurers in the U.S.," Forbes, Retrieved December 13, 2018.

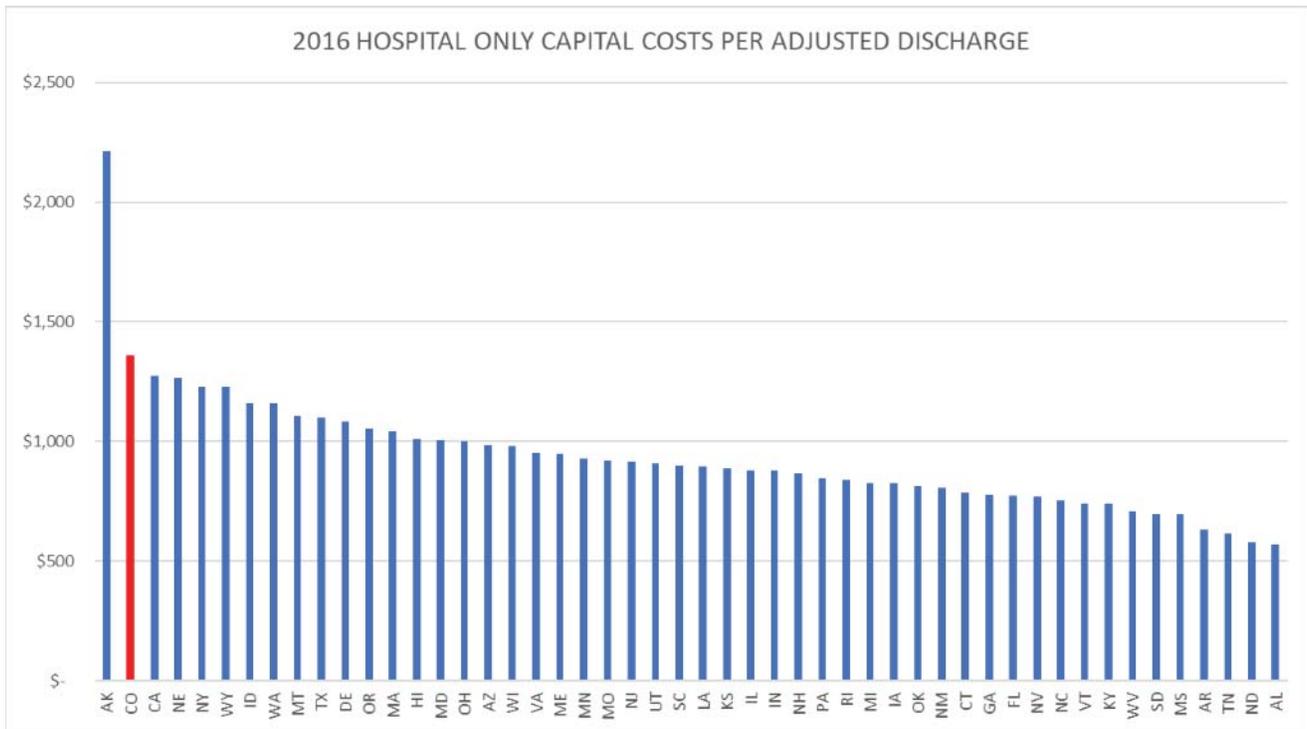
<https://www.forbes.com/pictures/5a8c601ca7ea43169013eb91/clone-of-americas-biggest/#175586881e72>

¹² <https://www.nytimes.com/2018/07/16/upshot/costs-health-care-us.html>

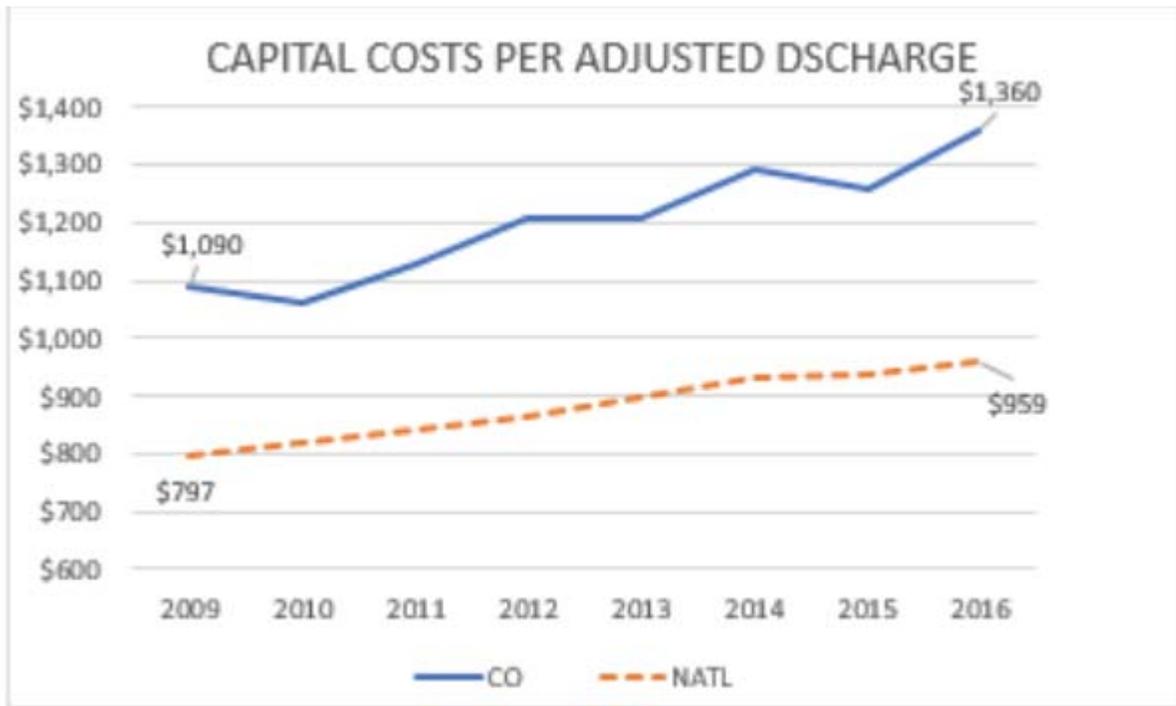
¹³ <https://jamanetwork.com/journals/jama/fullarticle/2673148>

The Department reports capital costs on a per adjusted discharge basis. Using adjusted discharges is an established way to report and compare total hospital volume, accounting for both inpatient and outpatient hospital utilization. In this way, the Department reports capital costs per patient volume.

The 2016 hospital-only capital costs per adjusted discharge for all states is displayed below. Colorado is second to Alaska in capital costs per adjusted discharge.



The following graph shows that Colorado hospitals' capital costs have been above the national figure each year 2009 through 2016, growing at 3.5 percent per year as compared to 2.9 percent nationally. While that is not a large variance, the difference compounds each year. By 2016, Colorado's capital costs per adjusted discharge were 42 percent above the national average.



The Medicare hospital cost report has the potential to provide a wealth of information about the amount of capital hospitals employ, changes in capital balances including purchases and disposals, and the ongoing annual cost of capital. The Department considered two other ways to analyze capital costs using the Medicare hospital cost report: net capital assets employed and capital purchases. However, hospitals often do not complete the Medicare cost report worksheets used for these other methods correctly. Nonetheless, in any method chosen, Colorado ranks in the top three for hospital capital costs compared to other states.

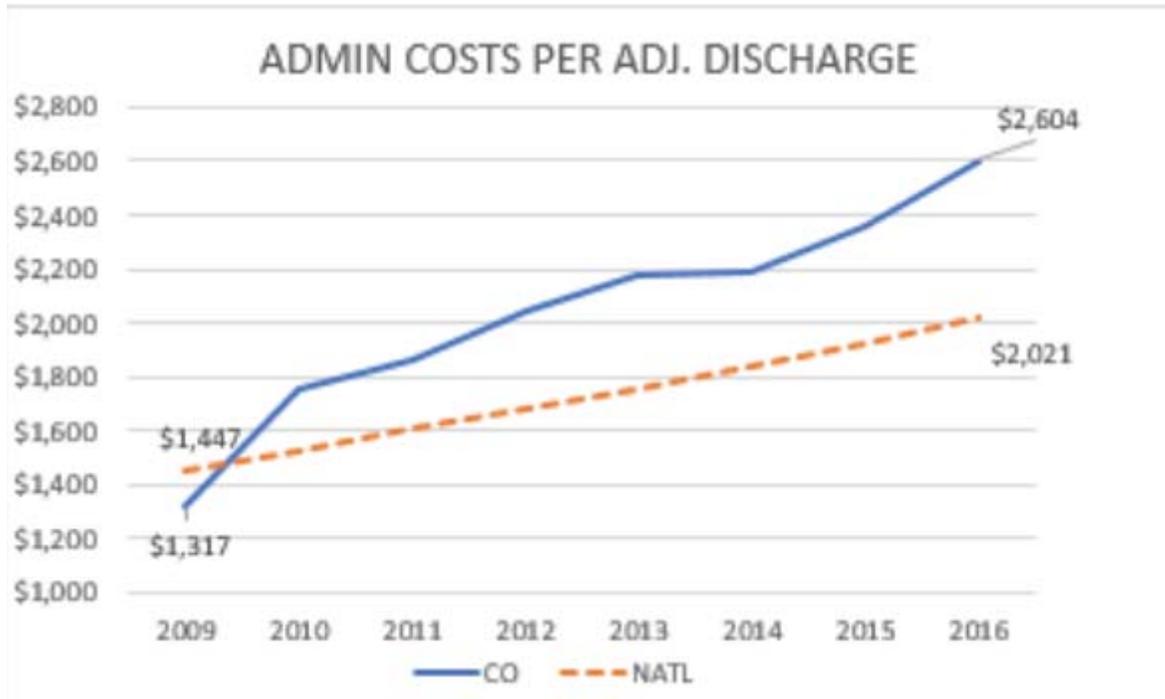
12. Please explain how to interpret the Department's analysis of hospital expenditures. Are medical costs staying stable, but administrative and capital expenses driving an increase in overall expenditures?

RESPONSE

In aggregate, Colorado's hospital costs are growing more than the nation's hospital costs in all cost categories: medical, administrative, and capital. Administrative costs have grown substantially more than the national rate.

| 7-year average growth per adjusted discharge | Colorado | National | Difference |
|--|----------|----------|------------|
| Medical cost | 3.6% | 2.7% | 0.9% |
| Administrative cost | 14.0% | 5.7% | 8.3% |
| Capital cost | 3.5% | 2.9% | 0.6% |
| Operating cost | 5.0% | 3.2% | 1.8% |

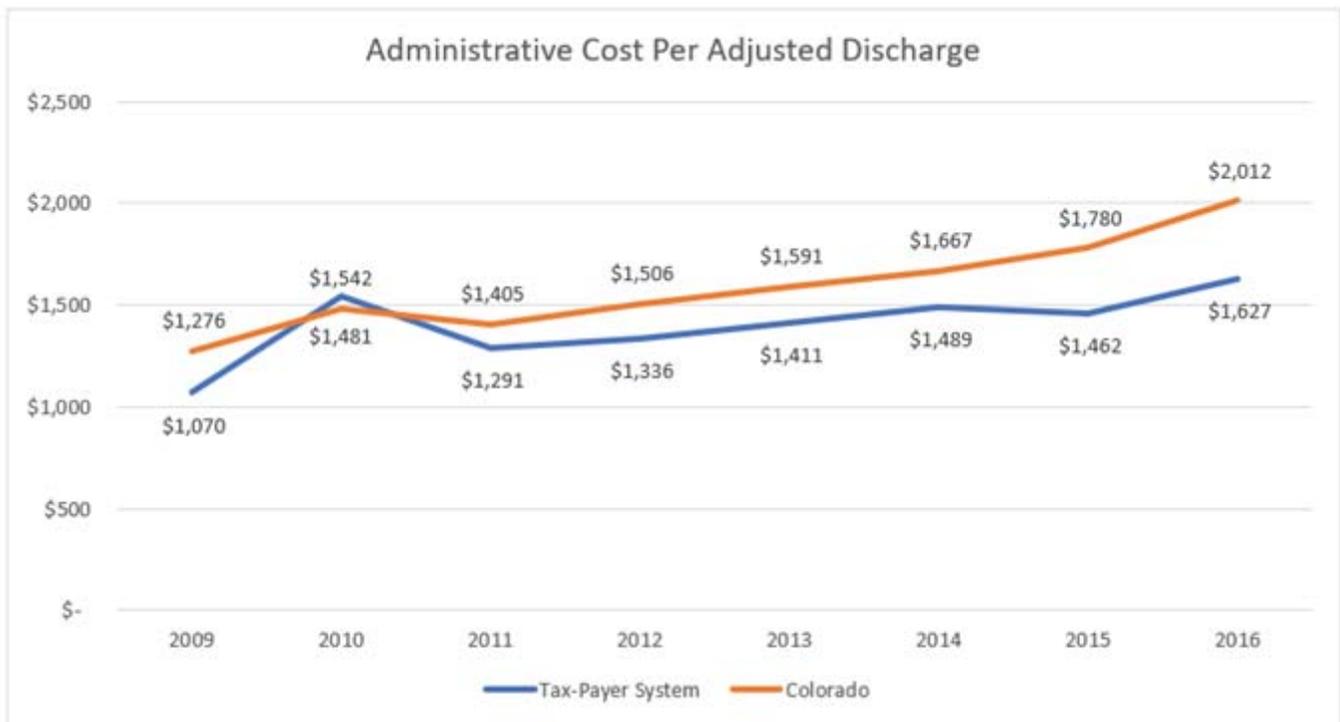
The rapid growth in Colorado’s administrative costs compared to the national figures is shown graphically below. By 2016 Colorado hospitals administrative costs per discharge is 29 percent higher than national figure, whereas in 2009, Colorado was below the national figure. ¹⁴



Moreover, there is great variation in hospital costs by hospital type. In 2016, the tax-paying/for-profit hospital system exhibited administrative costs per adjusted discharge 19 percent below the statewide costs. ¹⁵

¹⁴ These figures include hospital provider fee expenditures. Most states have a hospital provider fee; therefore, it is appropriate to include in the analysis when comparing to national figures.

¹⁵ In this analysis, hospital provider fee has been removed from the administrative cost per discharge so that variation in individual hospital fee rates do not unduly influence the analysis.



In addition, for Colorado hospitals the proportion of costs associated with medical care is shrinking. In 2009, medical costs for the majority of hospitals made up more than 75 percent of costs per adjusted discharge. In 2016, only around a third of hospitals saw medical costs make up more than 75 percent of costs per adjusted discharge. This indicates that overhead (administrative costs and capital costs) are making up a greater proportion of Colorado’s hospital operating costs over time.

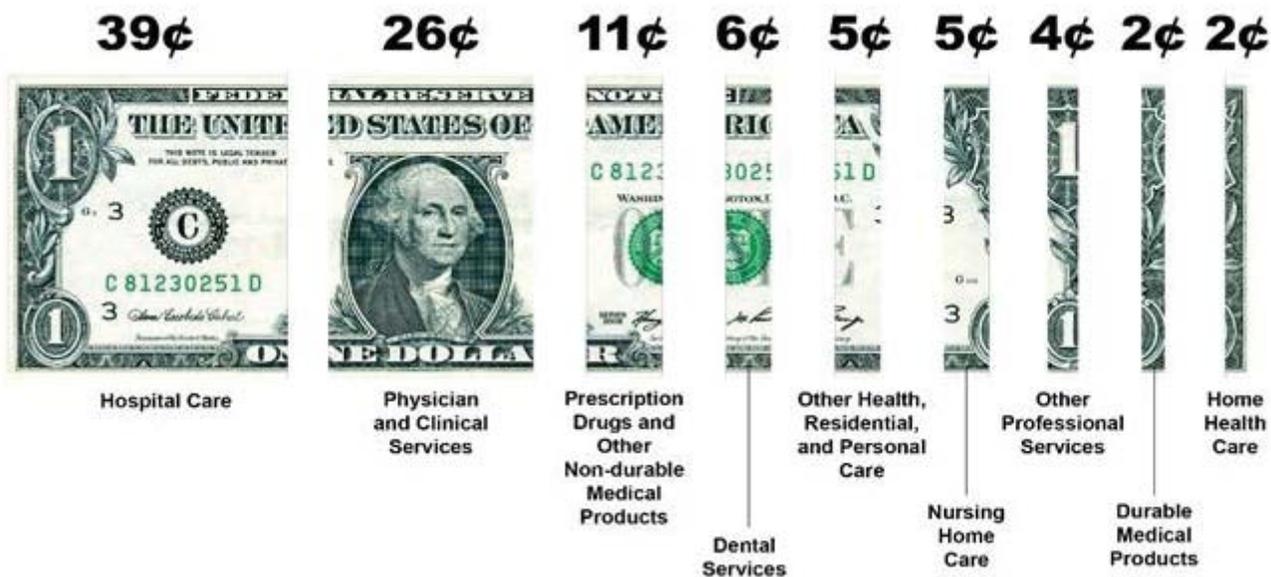
13. Are the places with high hospital costs also the places with high insurance premiums? Specifically, are western slope hospital costs the cause of high western slope insurance premiums?

RESPONSE

Hospital costs vary by region and by hospital in Colorado. Premiums similarly vary by region and by payer. While the Department cannot draw causality from previous analyses, we can highlight financial factors that influence insurance premiums, such as hospital operating and administrative costs and hospital margins/profits. Given that hospital costs represent 39 percent of the average premium dollars, their impact on insurance premiums – which directly reflect the cost of health care - is significant. Note the chart below reflects national figures and was provided by the Colorado Health Institute (CHI) to the Department in 2018. The report released by CHI for the Colorado Hospital Association (CHA) in December 2018 indicates 34 percent of care goes to hospitals in Colorado, which parallels recent information from the Centers for Medicare and Medicaid Services about National Health Expenditures.¹⁶ Both sources indicate that hospitals

¹⁶<https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf>

consume the greatest share of the health care dollar; their impact on insurance premiums is therefore the most significant.



National Health Expenditure Accounts, CMS, Office of the Actuary, 2011 and 2014; Colorado Commission on Affordable Health Care

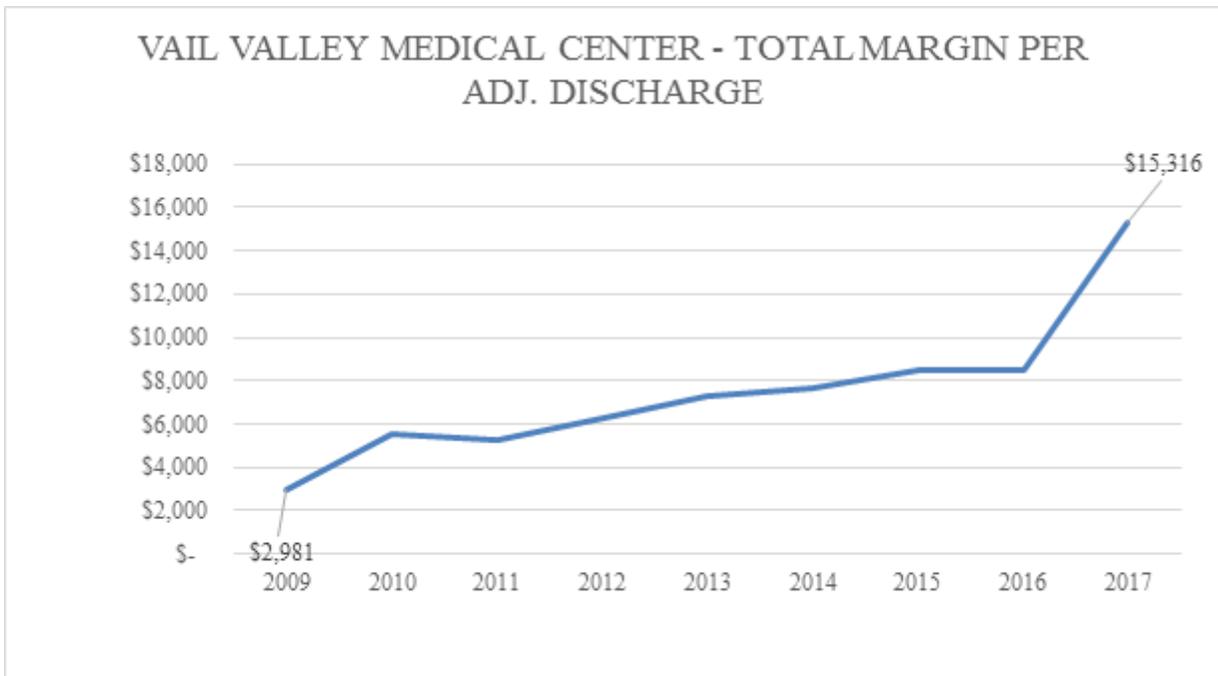
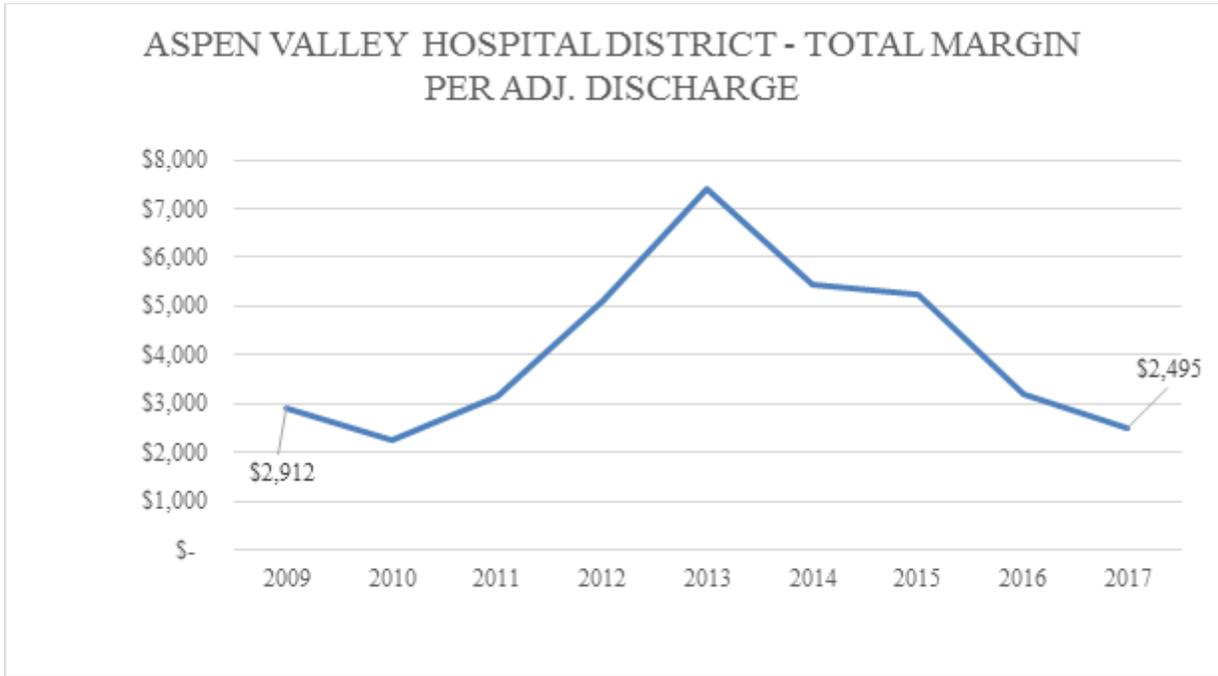
From initial analysis, many hospitals on the western slope have costs above the statewide costs. The Department has provided some examples below which merit additional analysis and conversation. That is, the Department has observed that certain nonprofit hospitals, such as Aspen Valley Hospital, St. Mary’s Hospital, Vail Valley Medical Center, and Valley View Medical Center, exhibit overhead and operating costs greater than the statewide costs. As a further example, based on 2016 available information the majority of hospitals in the Grand Junction and the West Division of Insurance (DOI) regions had operating and overhead costs above the statewide figures.

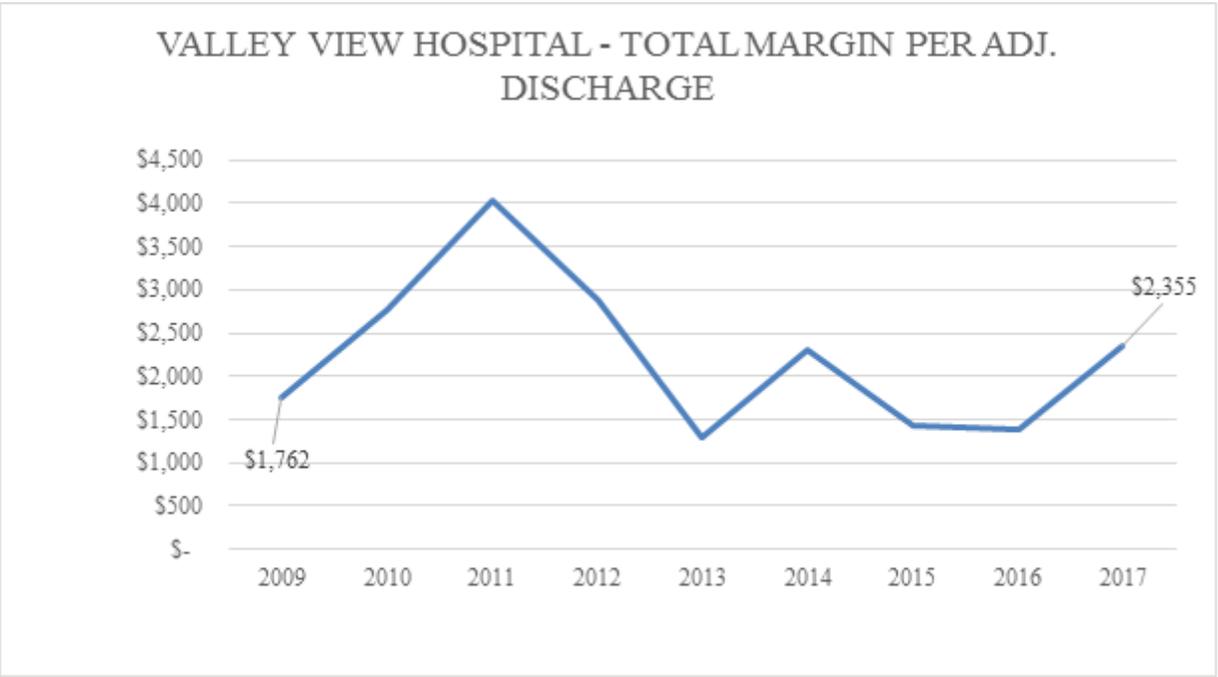
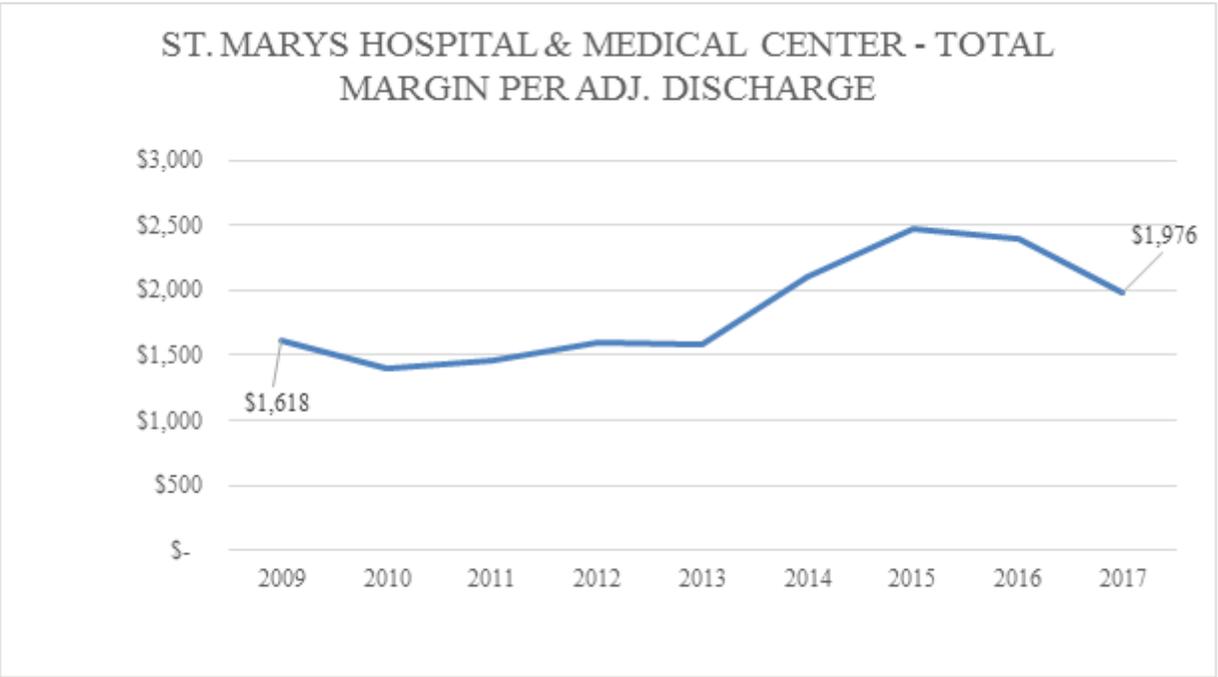
The Department will collaborate with DOI to analyze the relationship between hospital costs and insurance premiums with respect to regional variation in Colorado. Increased transparency into hospital expenditures, costs, and prices is necessary to maximize the analysis.

| 2016 Cost Per Adjusted Discharge | Operating | Administration | Capital |
|----------------------------------|-----------------|----------------|----------------|
| Aspen Valley Hospital | \$20,477 | \$3,735 | \$3,570 |
| Vail Valley Medical Center | \$20,305 | \$3,964 | \$2,633 |
| St. Mary’s Hospital | \$13,623 | \$2,624 | \$2,307 |
| Valley View Medical Center | \$13,443 | \$3,194 | \$1,754 |
| Statewide | \$12,745 | \$2,012 | \$1,360 |

The total margin per adjusted discharge trend from 2009 to 2017 for each of these hospitals is shown in the graphs below. Total margin (i.e., net income for the period) is taken from the Medicare cost report Worksheet G-3, Line 29. In 2017 total margin for these nonprofit hospitals was as follows: Aspen Valley Hospital, \$8.8 million; Vail Valley Medical Center, \$84.4 million; St. Mary’s Hospital, \$48.4 million; Valley View Medical

Center, \$22.4 million. Note that total margins during this same period for all Colorado hospitals increased by 153 percent. Those margins are reflected in insurance premiums, as they reflect rates paid by commercial carriers above financial requirement. It should also be noted that the majority of these hospitals are not for profit.





14. What drives the variation in cost by hospital? Does the size of the hospital matter?

RESPONSE

Currently, the Department does not have a definitive answer on the drivers of hospital cost variation. The Department’s analysis uses costs per adjusted discharge to address variation in size, but the Department has found that variation exists within peer groups and regions. The makeup of operating costs varies significantly within peer groups, and each hospital has a different operating structure and resources. The Department has

found that on average there are economies of scale for hospitals with more than 25 beds. This topic bears further research, and the Department will continue to identify and analyze cost drivers with available information.

15. What additional information does the Department need to analyze hospital costs? What would the Department do with the additional information? Where is all the analysis of hospital costs going and what are the ultimate policy implications?

RESPONSE

To fully analyze hospital costs and trends, in addition to the hospitals’ Medicare cost reports, the Department needs audited financial statements, financial and utilization data that hospitals report to the Colorado Hospital Association (CHA) DATABANK, and cost data on hospital construction including build-out construction costs, physician group acquisition, mergers and acquisitions costs, reserves and reserves over bond requirements, charitable care contributions with comparisons to community revenue needs (i.e.: schools, low income housing, etc.). Hospital reporting of such data occurs in a number of other states, including Oregon, Washington, and Arizona.

Across the nation, hospitals consume about 39 percent of the health care dollar. Hospitals play an important role in the health care system, both as institutions that provide medical, surgical, and nursing care, and as employers, research institutions, and centers to train the health care workforce. Hospital care accounts for about 30 percent of the Department’s health care spending. As Colorado continues health care transformation efforts, tracking costs and utilization of hospitals is an important part of monitoring the impact of these efforts.



Source: National Health Expenditure Accounts, CMS, Office of the Actuary, 2011 and 2014; Colorado Commission on Affordable Health Care

Hospitals also have a direct and meaningful effect on the economy in the communities they serve. This is increasingly true as health care reflects a growing portion of the state’s and nation’s gross domestic product (GDP). Colorado’s health care GDP parallels the nation at 18 percent, growing at a rate that is higher than other industries due to the higher rate of medical inflation versus wages or normal inflation. This can be seen in the chart below, where the “healthcare and wellness” sector is growing at an average of approximately 4.5 percent per year. Given that about 39 percent of health care GDP is driven by hospitals nationally and that most hospitals in Colorado are not for profit, hospitals’ impact on available community tax revenues merits

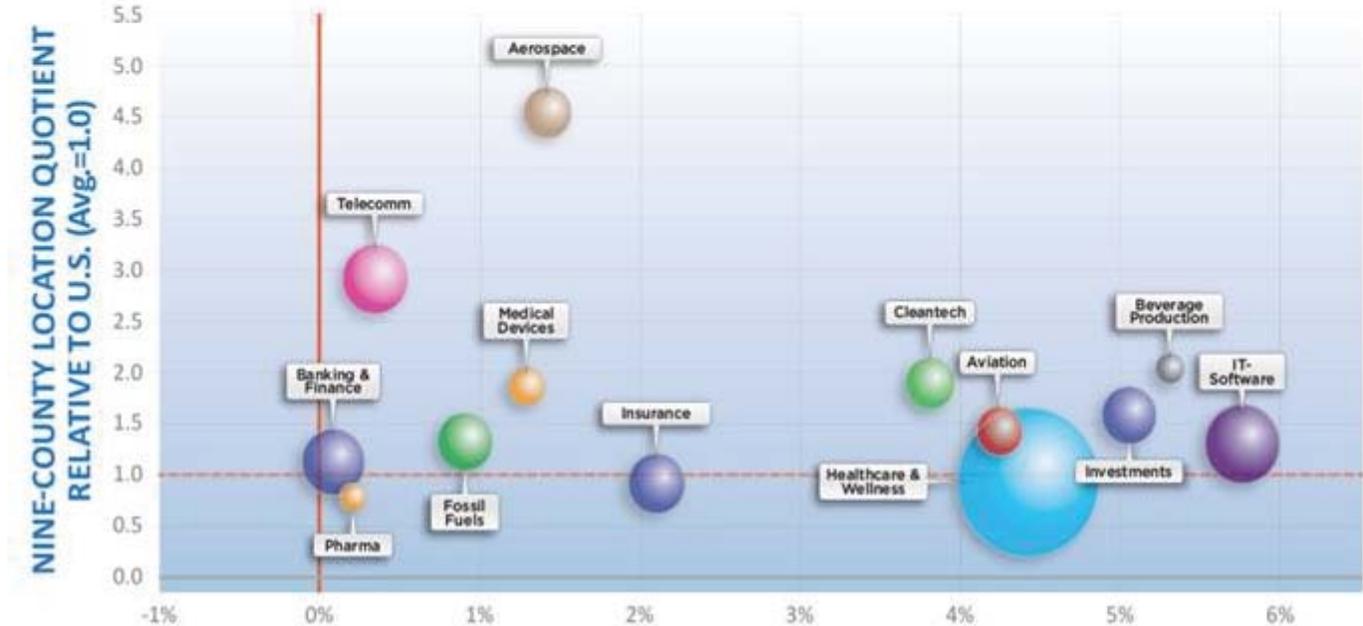
further study. That is, transparency is needed into the actual charitable contributions including the charitable choices hospitals make versus the community needs, i.e.: schools, low income housing, etc. For example, a hospital may choose to make a charitable contribution into a residency program when the community is desperate for financial resources in other community support areas. Further transparency is needed into the specifics of charitable care choices versus community needs to inform policy going forward.

Metro Denver and Northern Colorado Industries Economic Performance Snapshot

Bubble charts are popular tools used to illustrate industry clusters. These charts allow multiple variables to be plotted within the same graph, making it easy to assess relative economic performance. Bubble charts are often used for pinpointing priority industries since they allow visual comparisons of economic measures.

This chart illustrates industry cluster relationships for the 13 industry clusters and subclusters. The following three variables are plotted:

- Average annual employment growth, 2012 to 2017; on the x-axis (*horizontal*);
- The industry's location quotient, 2017; on the y-axis (*vertical*); and
- Employment size of the industry, 2017; indicated by the size of the bubble.



Source: Denver Chamber of Commerce, Economic Development Corporation

Moreover, this information will allow the Department to develop specific, comparable measures across hospitals, systems, and peer groups. This information will benefit communities by providing information about hospital capacity and how that meets the community's need. Specifically, it will call into question construction of hospitals in communities where there is an abundance of capacity and relatively low inpatient utilization. It will also benefit communities by supporting engagement with hospital partners and increasing the alignment of hospital contributions with the voiced needs of the community. Furthermore, this information will improve monitoring of billing practices, bring transparency to nonprofit cost growth, and allow hospitals to see how they compare to others and where they may improve efficiency and performance.

Further, the analysis of hospital costs will inform policy decisions and provide valuable information to evaluate the effects of policy. Analyzing hospital costs assists policymakers and the public in monitoring the impact of state and federal health reforms on hospital care, decisions that impact health insurance rates, hospital financial stability, efficient access standards that influence the price and quality of care, and the like. The Department would be able to publicly report and track key measures of hospital finances and utilization including hospital-specific cost shifts, charity care, bad debt, inpatient, outpatient, and emergency department visits, and profitability. This will increase transparency for the community, patients, stakeholders, and the public and will allow the Department to derive meaningful hospital-to-hospital comparisons and comparison to community needs. It will also shine a light into the drivers of increasing costs and inform public policy that can directly impact health care affordability by community.

BUDGET AGENDA

16. What technology issues will be addressed by the new committee proposed in R8 Benefits and technology committee?

RESPONSE

The committee would evaluate specific medical technologies, services, surgeries, or procedures to determine safety, efficacy, and cost-effectiveness to make coverage recommendations to the Department. Examples of medical technology that could be evaluated include: devices (e.g., communication devices), equipment (e.g., diagnostic imaging machines), or supplies (e.g., durable medical supplies).

17. Please discuss why the Department proposes to adopt a new process for assessing the need for home health services in January 2019 BEFORE a new assessment tool has been developed or tested?

RESPONSE

The Department requested and received funding through its FY 2018-19 budget request R-8 “Medicaid Savings Initiatives” to move the Adult Long-Term Home Health prior authorization review process from the Single-Entry Point (SEP) and Community Centered Board (CCB) entities to the Utilization Management (UM) vendor, eQHealth Solutions, beginning in January 2019. The purpose of the shift is to allow physician and nurse reviewers to complete medical necessity reviews for skilled Adult Long-Term Home Health Services, rather than SEP and CCB case managers who lack the appropriate clinical training.

To accommodate the Department’s planning, provider outreach and stakeholder communication and ensure a smooth implementation, the Adult Long-Term Home Health portion of the FY 2018-19 R-8 will be implemented after January 1, 2019. The Department is currently working with Case Management Agencies, Single Entry Point Agencies, the UM vendor, and other appropriate stakeholders to finalize the implementation plan for Adult Long-Term Home Health reviews in 2019.

While the FY 2018-19 R-8 request shifts the medical necessity reviews to clinically trained individuals under the UM vendor, the Department’s FY 2019-20 budget request R-9 “Long-Term Home Health and Private Duty Nursing Acuity Tool” would, if funded, supplement that clinical review process by adding a clinically

and statistically valid acuity tool to determine the amount of medically necessary services. This would further align the process for Adult Long-Term Home Health authorization with reviews done for other prior authorized services requiring review by medically trained individuals.

Per the funding allocated by the FY 2018-19 R-8 request, eQHealth Solutions will review prior authorization requests for Adult Long-Term Home Health Services in 2019 using the benefit coverage criteria outlined in the Home Health portion of the Colorado Code of Regulations (10 C.C.R. 2505 -10 § 8.520). The Department would work with eQHealth Solutions to incorporate the acuity review tool into the prior authorization process when it is completed, tested, and validated.

18. In R1 Medical Services Premiums, the Department lowered the forecasted expenditures for FY 2018-19 for Private Duty Nursing from the assumptions used for the appropriation, but in R9 Long-term home health and private duty nursing acuity tool the Department requests funding for a new acuity tool to contain costs. Please explain why the new acuity tool is needed, given the lower projection in FY 2018-19

RESPONSE

Although the Department did reduce its forecast for Private Duty Nursing (PDN) for FY 2018-19, the new acuity tool is still needed. Final expenditure for PDN in FY 2017-18 was lower than forecast due to lower than projected utilization per person. The Department revised its forecast for FY 2018-19 to reflect the lower starting point. However, even if utilization per person remains constant, the Department still expects that PDN expenditure will continue to grow rapidly year-over-year as the number of people utilizing the service continues to increase, which will drive future growth. From FY 2017-18 to FY 2018-19, the Department projects that PDN expenditure will grow by 11.7 percent, an increase of approximately \$10.6 million. Long-term expenditure and utilization trends support strong projections of growth: over the last 10 years, PDN expenditure has increased from \$23.7 million in FY 2009-10 to an estimated \$101.2 million in FY 2018-19, over a 327 percent increase. During that time, the number of utilizers increased from 164 in FY 2009-10 to an estimated 711 in FY 2018-19. The Department projects that by FY 2020-21, total expenditure will be \$118.3 million with 898 utilizers. Similarly, the Department has seen high growth in Long-Term Home Health expenditure and utilizers.

This rapid growth in both utilizers and expenditures underlies the Department's request to establish tools to properly assess members' needs for these services. The Department does not currently use a statistically valid or clinically based assessment tool to authorize adult members 21 years old or older for Long-Term Home Health or Private Duty Nursing services for any age. Private Duty Nursing services for all ages are currently assessed with a 2003 pilot tool. Without proper assessment, members are likely not receiving the appropriate level of services. Members are being over-authorized units of care or are authorized to receive medical level care for a condition that could be addressed through a more appropriate level of service. This, in turn, drives up costs for the Department and the State of Colorado.

19. Who will administer the new acuity tool proposed in R9 Long-term home health and private duty nursing acuity tool?

RESPONSE

When a physician orders Long-Term Home Health (LTHH) or Private Duty Nursing (PDN) services, a medical professional from the licensed Home Health agency will accept the referral, perform an initial assessment of the member's needs and complete the acuity tool. The completed tool, with the supporting documentation and plan of care, will then be submitted to the Department's third-party Utilization Management (UM) vendor, currently eQHealth Solutions, for a complete medical necessity review and prior authorization.

Registered nurses and physician reviewers employed by the UM vendor will then perform the medical necessity reviews and forward the authorization results to the requesting home health agency, Single Entry Point (SEP), and Community Centered Board (CCB) case managers, a process that is currently being developed.

20. How does the new acuity tool proposed in R9 Long-term home health and private duty nursing acuity tool differ from current procedures for determining acuity?

RESPONSE

The Department's third-party Utilization Management (UM) vendor, eQHealth Solutions, currently prior authorizes all Private Duty Nursing (PDN) services, using a 2003 PDN pilot acuity tool, completed and submitted by the agency requesting to provide nursing services to the member. Adult Long-Term Home Health (ALTHH) services are currently prior authorized by the Single-Entry Point (SEP) and Community Centered Board (CCB) case managers, without any acuity tool.

The R-9 request would replace the 2003 PDN pilot acuity tool with a statistically valid acuity tool to be completed by agencies and used by eQHealth Solutions in conducting medical necessity reviews for PDN services. For FY 2018-19, the Department requested and received funding for eQHealth Solutions to begin reviewing prior authorization requests for Adult Long-Term Home Health Services using the benefit coverage criteria outlined in the Home Health portion of the Colorado Code of Regulations (10 C.C.R. 2505 -10 § 8.520), with the process beginning in 2019. The Department's current budget request would supplement that new clinical review process by adding a statistically valid acuity tool to accurately determine the amount of medically necessary Adult Long-Term Home Health Services.

21. Will the new acuity tool proposed in R9 Long-term home health and private duty nursing acuity tool affect needs assessments and care authorization for the Home- and Community-Based Services waivers, in addition to long-term home health and private duty nursing? How does the

Department currently assess needs and authorize care for the Home- and Community-Based Services waivers and is the process in need of reform?

RESPONSE

The Adult Long-Term Home Health and Private Duty Nursing acuity tool proposed under R-9 would not affect need assessments or care authorization for Home- and Community-Based Services (HCBS) waivers. The R-9 acuity tool would be used solely to assess the medical necessity of requested State Plan Adult Long-Term Home Health and Private Duty Nursing Services. The Department's Utilization Management (UM) vendor, eQHealth Solutions, would complete the prior authorization reviews using the acuity tool, and the results would be forwarded to Single Entry Point and Community Centered Board case managers.

Currently, the Department uses the Uniform Long-Term Care (ULTC) 100.2 to determine level of care eligibility for HCBS waivers. The Department began work in 2014 with a contractor to develop a new assessment process for all individuals seeking or receiving Long-Term Services and Supports (LTSS), which includes HCBS. To further support and reform this effort, the General Assembly passed SB 16-192 "Concerning a Needs Assessment Tool for Persons Eligible for Long-Term Services and Supports, including Persons with Intellectual and Developmental Disabilities," which requires the Department to develop a needs assessment tool for all individuals in need of LTSS. This legislation also approved funding for the Department to engage stakeholders, hire contractors to assist in the development of the new LTSS needs assessment tool, automate the process for using the tool, and train case managers. Beginning early 2019, the Department with a contractor will pilot the new assessment process to ensure reliability and validity. The Department anticipates statewide implementation by June 30, 2021.

22. Community mental health centers currently perform the Preadmission Screening and Resident Review (PASRR) that identifies mental health or intellectual and developmental disability needs before people enter a nursing home. Why is the Department proposing to contract with a preferred vendor that does not have the clinical expertise of the community mental health centers?

RESPONSE

Currently, Community Mental Health Centers do not perform the Preadmission Screening and Resident Review (PASRR) that identifies mental health or intellectual and developmental disability needs before individuals enter a nursing home. When an individual is admitting into a skilled nursing facility (SNF) that accepts Medicaid, the SNF, hospital, or Single Entry Point (SEP) agency completes the Level I PASRR Screen. The Community Mental Health Centers receive referrals for Level I review and evaluation.

Community Mental Health Centers review the Level I screen and determine whether additional evaluations are necessary in the form of a Level II evaluation. There is a conflict of interest that exists in that the Community Mental Health Centers are recommending specialized services and are also the agencies providing and submitting claims to the Department for those same specialized services. Additionally, Community Mental Health Centers are making determinations on what additional evaluations are needed for an individual and submitting invoices to the Department for these evaluations.

The Department is seeking a contractor to assume responsibility for this work to eliminate the conflict. The contractor will be required to have clinical expertise and provide for greater consistency across the state.

23. For FY 2019-20, the Department's annualizations include reductions of \$35.8 million General Fund for H.B. 17-1353 concerning Medicaid delivery and payment initiatives and \$10.6 million General Fund for S.B. 18-266 concerning controlling Medicaid costs. Are these actual savings that are already occurring, or just the assumptions from the fiscal notes? How is the Department tracking whether H.B. 17-1353 and S.B. 18-266 actually achieve the projected savings?

RESPONSE

The annualizations included in the Department's FY 2019-20 budget requests for HB 17-1353 and SB 18-266 are based on the assumptions from the fiscal notes; in both cases, savings are not projected to begin until 2019. To estimate actual savings, the Department will use its claims data to compare costs for individuals before and after the implementation of each bill. In both cases, statute requires the Department to provide reports to the Joint Budget Committee concerning "fiscal performance" (HB 17-1353) or "estimates of the cost savings achieved" (SB 18-266). SB 18-266 contains further requirements for an independent evaluation of the cost-control measures that were authorized by the bill.

The next report evaluating the implementation of HB 17-1353, which will be the first to evaluate data from the implementation of the Accountable Care Collaborative Phase II, is due to the Joint Budget Committee on December 1, 2019. The next report evaluating the implementation of the cost control measures authorized by SB 18-266, which will be first report to evaluate data from the implementation, is due to the Joint Budget Committee on November 1, 2019.

24. For each FY 2019-20 request with projected savings, please explain how the Department will determine whether the savings actually occur.

RESPONSE

Six of the Department's budget requests contain estimates of savings. The methodologies used to determine actual savings (or costs avoided) would vary for each request.

- R-6 "Local Administration Transformation." The Department included savings in this request based on an estimated reduction to Medicaid caseload when individuals cannot be located. The Department would evaluate savings based on the number of people whose eligibility is closed.
- R-7 "Primary Care Alternative Payment Methods." The Department included savings in this request to account for expected savings to medical spend as providers are given more flexibility through alternative payment methodologies. The Department would be able to track members' costs over time (before and after implementation) and compare those costs to members being paid for using other payment methodologies to evaluate savings.
- R-8 "Benefits and Technology Advisory Committee." The Department included savings in this request to account for shifts in utilization to evidence-based technology or treatments. To estimate savings, the Department would estimate costs avoided by comparing actual costs to estimated costs

of alternative non-evidence based treatments. The Department's request included funding for a third-party analysis of cost savings achieved as a result of this request.

- R-9, "Long-Term Home Health and Private Duty Nursing Acuity Tool." The Department included savings in this request based on the assumption that individuals would move from higher cost skilled care to lower cost Home and Community-Based Services (HCBS). The Department would be able to evaluate whether people have switched from skilled services to HCBS and would also be able to evaluate whether there have been changes in trend in utilization of skilled services.
- R-12, "Medicaid Enterprise Operations." The Department included savings in this request based on a contractual guarantee from the vendor that at a minimum \$1,000,000 in savings will occur. The Department would be able to identify savings through tracking by the vendor from specific edits identified from the service. If the Department is unable to recover up to the guarantee, the vendor will reimburse the Department for the difference.
- R-15, "Operational Compliance and Oversight." The Department included savings in this request based on an estimated reduction in caseload as the Department identifies people who have incorrectly been granted eligibility. The Department would be able to identify savings based on the specific individuals that are identified as incorrectly eligible, and by evaluating caseload trends before and after the implementation of any system change that has been identified through the audit process.

In all cases, the Department would use the regular budget process to account for any difference between the projected savings and the actual savings achieved.

CUSTOMER SERVICE & ELIGIBILITY

- 25. Please provide information about the current protocol for returned mail. For example, how many pieces of returned mail from a household trigger a termination of benefits? What steps does the Department require counties to take before termination? How does the Department assure itself that counties have entered all updates and new case information before termination? Further, how does the Department intend to ensure due process before termination, if the recommendations in R6 Local administration transformation are adopted?**

RESPONSE

In early 2017 the Department engaged with county partners as well as the Department of Human Services (CDHS) to revisit the returned mail policy. Based on feedback from the counties, review of federal regulations, guidance from the Centers for Medicare and Medicaid Services (CMS), and guidance from the Attorney General's Office, the Department modified the returned mail policy in April 2018 to act on cases based on one piece of returned mail instead of the prior policy of three pieces of returned mail. CDHS also revised the returned mail policy in July 2018 to act on the first piece of returned mail instead of three months of returned mail.

Through [Agency Letter HCPF 18-007](#),¹ the Department has provided guidance to counties to contact members via the member's preferred contact method (e.g., email, phone, text) to verify the new address prior to updating the case. If they are not able to reach the member, the county should update the case with the new information. Returned mail marked as "undeliverable" or those with out-of-state addresses may cause the

member's coverage to be terminated as their whereabouts are unknown. Similarly, CDHS has provided the same type of guidance to counties through the [Operational Memo OM-EBD-2018-0007](#).²

Currently, the Department and CDHS do not have a mechanism to track all the returned mail received by the counties. The return mail process is completely reliant on counties and there is no centralized database to track the volume to be processed. However, the Department has created reports to track timely disenrollments and has implemented performance-based benchmarks to ensure counties are disenrolling ineligible members within Department-specified timeframes. The Department and counties, through the Medical Eligibility Quality Improvement Plan (MEQIP), conduct quality checks to ensure the disenrollments are made accurately and timely.

Both the Department and the CDHS will coordinate thorough, thoughtful planning for the implementation of the consolidated returned mail center in order to ensure due process for members. This planning will include collaboration from the counties to understand the nuances of returned mail which may lead to identifying policy and systematic solutions to streamline the process. The planning will also include identifying systematic approaches for proactively updating contact information prior to the correspondence being mailed to reduce the volume of returned mail. This may include leveraging services from the United States Post Office to match addresses or leveraging sophisticated services to validate addresses in multi-unit residential buildings. In addition, the ability to leverage automated services through the United States Post Office could be used to receive electronic files that provide information on undeliverable mail or forwarding addresses. If a member's eligibility is discontinued after due diligence of obtaining correct address information, the member's due process will involve providing them with appeals rights and reopening the case if the member provides updated information within established timelines.

Understanding that members who apply may not have a permanent address, the Department, CDHS and the counties will leverage the current process for identifying individuals as homeless in the eligibility system or establishing a general delivery address with the county to ensure they are not discontinued inappropriately. The planning efforts for the implementation of the centralized return mail center will include identifying additional policy and systemic processes to manage these cases appropriately.

26. The Department has submitted multiple requests over the years related to improving the customer experience and the performance of the call center. Will R10 Customer experience finally solve the problems? Is this the last request? Did the Department ask for enough?

RESPONSE

The Department is committed to continually improving the customer experience and the Department appreciates the Joint Budget Committee's support of its customer service requests over the last few years. The Department's November 1, 2018 budget request R-10 "Transform Customer Experience" addresses three issues: improving caller wait times at the Member Contact Center, improving member communications, and sustaining the Member Experience Advisory Councils (MEAC). The Department believes that it has asked for enough to address these issues as outlined in R-10. Recently, members have experienced wait times in the 45-minute range. This request will improve customer service but will likely not drive service levels to, ideally, an average speed to answer of less than one minute. To achieve a service level of this kind would

likely involve a significant increase in staff, possibly a doubling of current staff. Being conscious of a finite budget, the Department is making a number of changes to drive incremental improvement. In the future, as Medicaid caseload increases from population growth and economic changes, additional staffing may be needed to maintain appropriate service levels.

27. If the performance of the call center is low, why is the Department proposing temporary employees? Is this request a bridge to a more permanent solution? Please describe the current staffing and funding level for the call center and how this request augments it.

RESPONSE

The Department's Member Contact Center experiences turnover that is higher than other Department positions. The vacancy rate for the 32 FTE assigned to the contact center was 29.3 percent in FY 2017-18 and is 29.5 percent so far for FY 2018-19 (through November), slightly more than double the Department's overall vacancy rate of 14 percent in FY 2017-18.

A key barrier to maintaining full staffing is the amount of time it takes to recruit, hire, and train new FTE. Because of the high complexity of the call issues, there is an extensive training and ramp-up period for agents to function independently. These issues contribute to higher hold times as fewer agents are available to take calls.

The request is not a bridge to a permanent solution but is the Department's proposed long-term strategy and aligns with industry practices. The Department proposes to recruit and hire temporary employees on a rolling basis to supplement the current full-time staff and better ensure appropriate staffing levels to address the calls daily. This staffing model would increase day-to-day staffing in the Department's member contact center which would improve average speed to answer and reduce abandonment rates. The temporary contract would create a strong recruiting pool for when full-time positions become available allowing the Department to more quickly fill vacancies.

28. How does R10 Customer experience relate to the Department's current and future strategies for the use of outward facing technology to communicate with clients (common hearing question #9)?

RESPONSE

The Department's November 1, 2018 budget request R-10 "Transform Customer Experience" creates the framework and infrastructure for continued customer experience improvements. Partners and counties that opt into the Department's contact center technology will have a robust knowledge and resource library at their fingertips and the potential to save them time and money. Sustaining the Member Experience Advisory Council offers the Department invaluable and direct member input into high-impact customer-focused initiatives. Standardizing all member communications ensures proper use of branding, style, tone, plain language, translation, and increases overall comprehension thus reducing customer calls to partners.

RATES

29. Please describe how increases in the minimum wage are affecting nursing home expenditures. Is the minimum wage a driving factor for increasing nursing home costs?

RESPONSE

The minimum wage increase will impact nursing facility costs by increasing the hourly pay for Certified Nursing Assistants (CNAs) and other support staff (such as those who help residents with activities, housekeeping, and laundry). However, the increase in expenditures will have a negligible impact on the state's expenditure for nursing facilities because the growth of nursing facility rates is limited to a 3 percent per year, pursuant to section 25.5-6-202 (9)(b)(I), C.R.S.

Nursing facilities' cost-based rate is driven largely by health care costs, which make up approximately 63 percent of costs, followed by administrative and general costs at approximately 28 percent and fair rental value at approximately 8 percent. While total direct nursing costs comprise more than half of health care costs, Director of Nursing, Registered Nurses (RNs), and Licenses Practical Nurses (LPNs) are the greatest share of direct nursing costs and their salaries are already above the proposed minimum wage.

30. How often do increases in actual nursing home costs exceed the three percent statutory cap on General Fund increases for nursing homes? How does the nursing home provider fee fill in the difference? Does the fee make the providers whole relative to their actual costs?

RESPONSE

In prior years, average nursing facility cost growth was above the 3 percent statutory cap, even as high as 4.5 percent. More recently, the average cost growth has been less than 3 percent, including in FY 2017-18, when the average cost growth was 2.6 percent. While the average was below 3 percent, there is variation among facilities, and 90 out of 190 nursing facilities had growth greater than 3 percent in FY 2017-18.

The nursing facility provider fee funds Medicaid supplemental payments according to a hierarchy established in statute. That hierarchy means that payments for higher quality performance and payments for increased resource utilization for residents with higher needs are funded before payments for the difference between the nursing facility's cost-based per diem rate and the General Fund share, referred to as the rate true-up supplemental.

In most years, there is not enough provider fee to fully fund the rate true-up supplemental payment to make nursing facilities whole. In FY 2018-19, approximately 87 percent of the rate true-up supplemental payment is funded. Even though the rate true-up payment is not fully funded, between the claims-based reimbursement funded with General Fund and the rate true-up supplemental payment, nursing facilities were reimbursed on average 99 percent of their cost-based rates in FY 2018-19.

31. How did the Department decide on a 0.75 percent across-the-board rate increase for providers? The Department proposes that after FY 2019-20 personal care and homemaker services would receive an annual increase equal to inflation. Why does the Department propose singling out

these providers for annual adjustments, rather than more broad-based inflationary increases for all providers?

RESPONSE

The Governor, as part of the November 1, 2018 Budget Request, included funding for a 1 percent provider rate increase for “community providers.” As in prior years, the Department chose to allocate some of the available funding to correct known rate disparities in concert with the recommendations from the statutorily-required Medicaid Provider Rate Review Recommendation Report.¹ After accounting for targeted rate adjustments, the remaining funding available for general provider rate increases permitted a request for a 0.75 percent across-the-board rate adjustment.

The Department is proposing a different, targeted increase for personal care and homemaker services beginning in FY 2019-20 because this group of Medicaid providers is uniquely affected by the rising minimum wage and play a vital role in allowing seniors and people with disabilities to remain in their homes and communities, and out of nursing facilities. Attendants for these services are often paid at or near minimum wage. If the rates for these services do not keep pace with rising wages around the state, potential and existing attendants would likely choose other near-minimum wage jobs over direct support professional positions because these alternatives are not as challenging emotionally and physically. This creates an access-to-care problem for members who need to receive these services.

Personal care and homemaker attendants play a vital role in keeping Colorado’s elders, aging parents and grandparents, and people with disabilities in their homes and communities. If there are not enough people in Colorado who are willing to perform these tasks, individuals cannot stay in their homes; the alternative care settings are more expensive, such as placement in nursing facilities or assisted living facilities. The state’s demographer indicated that the senior population in Colorado (ages 65 and over) increased by 43 percent from 2010-2017, compared to 14 percent for the rest of the state population, and is projected to increase by more than 60 percent by 2030. Supporting a workforce that can most efficiently care for this population, which will increase by approximately 500,000 people over this period, is critical to managing the state budget in future years.

32. Please provide an updated analysis of how transportation rates compare to the benchmark after the rate increases provided in recent years by the General Assembly.

RESPONSE

The Department estimates that the rates for Emergency Medical Transportation (EMT) and Non-Emergency Medical Transportation (NEMT) state plan services rose from 30.74 percent of the benchmark in FY 2014-15 to 33.88 percent after the recent increases. The Department’s estimate is based on: the analysis used for the May 2016 Medicaid Provider Rate Review Analysis Report, updated using FY 2017-18 utilization; applicable Colorado Medicaid rates as of July 1, 2018; and 2018 Medicare comparison rates. For codes that were originally compared to an average of other state Medicaid rates, the Department applied the benchmark rates used in the 2016 analysis. Additionally, had the proposed rate changes requested in FY 2019-20 R-13,

“Provider Rate Adjustments,” been in effect on July 1, 2017, the Department estimates that the rates as a percent of the benchmark would have further risen to 38.96 percent in FY 2017-18.

33. Please provide an overview of the Department's efforts to implement performance-based payments.

RESPONSE

Movement towards more value-based purchasing has been a focus of the Department since the inception of the Accountable Care Collaborative (ACC) program in 2011 and is now one of the pillars of the Department’s cost containment strategy. The initial rollout of the ACC program included performance-based payments for the regional entities and primary care providers participating in the program. Other pay-for-performance initiatives in the ACC program included the Enhanced Primary Care Medical Provider (ePCMP) program where providers that met a higher standard were certified as ePCMPs and received additional per member per month payments through the ACC. As the program has evolved, the measures have been updated and the level of accountability for outcomes has increased.

In addition to the pay-for-performance under the Accountable Care Collaborative, the Department has also implemented pay-for-performance tied to service reimbursement, capitation payments, and provider fee financed payments. An overview of the initiatives is provided below.

Provider Fee Financed Pay-for-Performance

Pay-for-performance programs tied to provider fee financed payments include the Hospital Quality Incentive Payment Program (HQIP) which is now part of the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE), and the Nursing Facility Provider Fee pay-for-performance program.

The HQIP provides incentive payments to hospitals for improving health care and patient outcomes. For 2019 it will have performance-based measure groups for: Perinatal and Maternal Care, Patient Safety, Patient Experience, Behavioral Health, Substance Use, and Addressing Cost of Care. Under the requirements of SB 17-267, the Department will significantly strengthen the linkage between hospital supplemental payments and performance.

Similar to hospitals, there is a pay-for-performance program for skilled nursing facilities linked to provider fee funded payments they receive. The Nursing Facility Provider Fee finances a pay-for-performance program in which facilities can earn an add-on to their per diem rates. The program rewards high performers that demonstrate improvements in federal Centers for Medicare & Medicaid Services (CMS) quality metrics, quality of life programs, quality surveys, stable staffing, medication reduction, reduced hospitalizations, and other measures established through a stakeholder-driven process.

Managed Care Pay-for-Performance

The Department has two pay-for-performance mechanisms in the current managed care contracts: quality adjusted medical loss ratio and a behavioral health incentive program.

The quality adjusted medical loss ratio allows managed care entities to keep a higher percentage of margin and administrative expense when they hit certain quality measure performance standards. The behavioral

health incentive program allows the entities managing the behavioral health capitation to earn additional funds above and beyond the capitation payments they receive when they demonstrate improved performance in key areas. Greater detail on this program was provided in the JBC staff briefing.

Pay-for-Performance Tied to Service Reimbursement

In 2017 and 2018, the Department worked with primary care providers to develop an alternative payment methodology. As of January 1, 2019, most providers in the ACC will be participating in an alternative payment methodology. Providers that perform well on a suite of self-selected measures will see an increase in fee-for-service reimbursement. Providers that do not perform well will see a decrease in fee-for-service reimbursement.

Federally Qualified Health Centers participated in the development of a parallel alternative payment methodology and it also begins January 1, 2019.

Future Pay-for-Performance Initiatives

The Department proposed, as part of its budget request R-16 “Employment First Initiatives and State Programs for People with IDD,” a pilot program to provide additional payments to providers based on supported employment outcomes. Supported employment is a service offered to individuals with intellectual and developmental disabilities, who need intensive ongoing support to perform in a work setting. The pilot program would provide incentives and value-based payments to supported employment providers based on employment outcomes such as whether a person is able to maintain employment over time.

The Department also plans to explore hospital services (separate from provider fee funded payments) pay-for-performance, maternity services pay-for-performance, additional long-term services and supports pay-for-performance, and more.

34. What are the policy implications of including maternity services in performance-based payments?

RESPONSE

As the largest insurer of pregnant women in the state, the Department can drive statewide improvements in the quality and safety of prenatal and postnatal care, and labor and delivery services, by implementing quality incentive and value-based payments (e.g. performance-based payment). The Department’s goal in implementing performance-based payments for maternity care is to promote services that improve quality outcomes for both mothers and newborn children.

For example:

- As of July 2018, Regional Accountable Entities’ (RAEs’) Key Performance Indicators will measure regional increases in the number of women who have a prenatal visit (a 1-5 percent or over 5 percent improvement) for tiered incentive payments to the RAEs.
- Beginning with the FY 2018-19 Hospital Quality Incentive Program (HQIP), the Department allots points (and supplemental funding) to hospitals participating in the HQIP based on measures that include promoting breastfeeding and reducing the number of elective caesarian deliveries. The

Department will include additional maternal measures, such as maternal anxiety and depression screening, preparedness for maternal emergencies, and reproductive life/family planning into the FY 2019-20 HQIP measure set.

- Maternal measures are also being developed for the Hospital Transformation Program.

35. Is the benchmark for anesthesia services flawed, as asserted by some anesthesia providers, and why?

RESPONSE

No, the benchmark is not flawed. Per SB 15-228, the Department is tasked with evaluating rate sufficiency, which includes determining appropriate rate comparison benchmarks. The Department's decision to compare anesthesia rates to Medicare is informed by Department subject matter expert research, guidance from the Centers for Medicare and Medicaid Services (CMS), and by the Medicaid Provider Rate Review Advisory Committee (MPRRAC) established in SB 15-228. One of the guiding principles established by the MPRRAC is to use an existing rate benchmark where appropriate. The Department relies primarily upon Medicare rates when available and appropriate and, when unavailable, upon other state Medicaid agency rates. The Department utilizes Medicare rates for comparison for reasons including:

- Medicare is the single largest health insurer in the country and is often recognized by the health insurance industry as a reference for payment policies and rates.
- Medicare's rates, methodologies, and service definitions are generally available to the public.
- Medicare rates are typically updated on a periodic basis.
- Most services covered by Colorado Medicaid are also covered by the Medicare program.

The Department and the MPRRAC reviewed points made by the anesthesia community regarding the appropriateness of Medicare as a comparator and determined that Medicare is an appropriate comparator. The MPRRAC also voted not to have the Department conduct additional rate comparison analyses using different benchmarks.

36. Is the Grade of Membership analysis of the Program for All-Inclusive Care for the Elderly (PACE) flawed, as asserted by some PACE providers, and why?

RESPONSE

For context, PACE is a managed care program for qualifying elderly Medicare and Medicaid enrollees. Currently, there are approximately 4,300 Medicaid clients enrolled in the program. PACE organizations receive a monthly capitation from Medicaid that is intended to cover all costs that would otherwise be covered by the Medicaid program; this reimbursement is around \$4,000 on average, but varies depending on provider, region, and whether the enrollee has other forms of insurance. For enrollees that are also in Medicare, which is the vast majority of enrollees, Medicare pays approximately an additional \$3,400 per month above and beyond what Medicaid pays. This is a total of \$7,400 per month, or just shy of \$90,000 per year per enrollee.

PACE operates under a unique federal regulatory framework and is exempt from some of the typical managed care requirements. One key difference is that unlike typical managed care programs where rates are set using historical utilization for the clients actually enrolled in the program, rates are instead negotiated and simply need to be below an estimate of what the clients would have cost had they remained under a fee-for-service delivery system instead of in PACE. This conceptual reimbursement limit is referred to as the Upper Payment Limit, or UPL.

In 2016, some of the PACE organizations were successful in having a specific methodology put in statute (SB 16-199) that the Department is now required to use to calculate the UPL. The methodology has never been used as part of rate setting for PACE organizations anywhere in the country. In fact, the national PACE professional association that represents most PACE organizations in Colorado says it does not believe the methodology should be used for rate setting. Additionally, the data required to successfully implement the model was not tested for completeness, accuracy, or availability prior to codification of the methodology. The Department testified that implementing an untested, unvalidated model using Colorado data was highly risky and could result in reductions to the UPL. The Department also testified that the methodology would likely result in greater reductions to newer, smaller providers if implemented. The General Assembly indicated it was their intent to implement the model even if it resulted in decreases to reimbursement, and acknowledged the risks of codifying a specific, untested reimbursement methodology.

The Department continues to work with PACE organizations to refine the analysis and explore issues such as potential selection bias. Until that work is complete, the Department cannot take a position on whether the analysis is “flawed.” That said, the results of the model align with expectations in some regard and diverge from expectations in others. The disproportionately negative impact of the model on newer, smaller PACE organizations is one that was expected due to the population being younger. Conversely, the summary statistics related to functional status that describe the “PACE-like” population in the model do not align with the expectations of the provider community. This calls into question the reliability of the underlying data needed to run the Grade of Membership model. Unfortunately, the Department cannot validate the underlying data as there is not an alternative source of information that can be used to accurately characterize the needs of the clients at the point in time when they entered the program.

Consequently, given the data constraints and statutory mandate to implement the model, the Department believes that the analysis will ultimately result in a significant reduction to PACE organization rates. The Department and contractors have conducted some robustness tests on the model to come to this conclusion. For example, the Department tested what would happen if instead of using the actual results of the model, some of the assumptions were modified to be as favorable as possible to the PACE organizations (i.e., if the most expensive enrollees were only attributed to the PACE cohort in the model rather than the ‘unassigned’ group); even under these extreme assumptions, the model produced results that drive PACE reimbursement down.

Because PACE is a program that has an incredibly high per enrollee cost and the population has high needs, transparency and appropriate reimbursement models are essential as this program continues to grow to meet the needs of the aging population. There are alternative methodologies that can be explored, but moving away from the Grade of Membership model would require statutory changes. It is important to note that these

models require the availability of encounter data that the Department does not currently receive from the organizations, but is working with the organizations to obtain. That data is due to the Department by May 1, 2019. Financial information on the PACE organizations is also due at this time. This data is critical to the proper oversight and management of the PACE relationships. The senior population is growing at a rate that is three times that of the rest of the population, faster than any other segment. This data is also necessary to understand why the PACE option costs so much more than its fee-for-service alternative.

37. How many additional Medicaid clients were seen by physicians of the University of Colorado School of Medicine as a result of using appropriations for the Anschutz Medical Campus as the state match for supplemental payments to the physicians? Why is a two-year ramp-up required before the physicians will see the additional 15,000 patients anticipated when the financing was approved by the General Assembly?

RESPONSE

The baseline number for FY 2016-17 is 126,456 unique members seen by CU Medicine primary and specialty care faculty. Based on claims data, the Department estimates the University of Colorado School of Medicine (CUSOM) saw 141,323 unique members in FY 2017-18. This is a 14,867 increase in unique members served by CUSOM providers. Data for FY 2018-19 will be reported in the fourth quarter Performance Measures Report due to the Department on August 24, 2019. Unique members seen is one of five performance measures in the Department's interagency agreement with CUSOM. Other identified priority areas for fiscal year 2018-19 include, but are not limited to, the following:

1. Expansion of telemedicine and e-Consultation services to providers serving members residing in rural, frontier, and underserved areas.
2. Mental & Behavioral Health Access for adults and children, including Substance Use Disorder (SUD) treatment
 - a. Expand access for behavioral health integration for pregnant and postpartum mothers
 - b. Improve access to quality, evidence-based substance use disorder treatment services within CU clinics
3. Adult Specialty Access
 - a. Expand e-Consults in areas such as renal disease and pain management
4. Pediatric Specialty Access
 - a. Ensure access to coordinated specialty outreach clinics for children and youth with special health care needs
 - b. Increase capacity for pediatric developmental services
5. Comprehensive integrated primary care teams for adults and children
 - a. Designate all CUSOM primary care practices as Primary Care Medical Homes
6. Transitions of Care programs for high risk and/or high utilizing Medicaid patients
 - a. Improving the continuity and transitions of care for patients aging out of Children's Hospital Colorado's Special Care Clinic with complex medical needs
 - b. Evolve the Bridges to Care (B2C) model, an evidence-based multidisciplinary care coordination process to reduce hospital and emergency department utilization among high-utilizers

The two-year implementation period was jointly agreed on as a time to build infrastructure, increase staffing to meet the Interagency Agreement requirements, and complete initial assessments while simultaneously increasing service delivery. It was necessary to complete a Community Needs Assessment in May 2018 that identified specific focus areas where access to care is an issue for members. This provided a strategic plan for future expansion in FY 2018-19 and beyond for CUSOM providers to see more members in areas of highest need.

MISCELLANEOUS

38. How much does the Breast and Cervical Cancer Prevention and Treatment Program receive from specialty license plate fees? How does this revenue relate to the total cost of services? Should the program be reauthorized?

RESPONSE

Colorado's Breast and Cervical Cancer Prevention and Treatment Program (BCCP) provides breast and cervical cancer screening and diagnostic services to low-income, uninsured and underinsured people in Colorado who do not qualify for Medicaid. The program is set to expire July 1, 2019. The Department supports extending this vital safety net program. Extending the BCCP is one of the Department's legislative priorities.

The Department is projecting that it will receive \$972,835 annually in revenue from the license plate fees for the Breast and Cervical Cancer Prevention and Treatment Fund, which funds the state share of the Breast and Cervical Cancer Program (BCCP). The Department projects that it will collect interest on the fund balance of \$158,368, for a total of \$1,131,203 in revenue each year.

The Department has concluded that there is sufficient revenue in the fund to maintain expenditure for an additional five years without General Fund, as most participants in the program have transitioned to Medicaid (funded differently, and at a higher federal match rate). The remaining caseload for the program is estimated to be 130 individuals in FY 2019-20, covering people with income between approximately 142-250 percent FPL. The Department projects that it will spend \$1,085,483 in FY 2019-20 and \$960,451 in FY 2020-21 on the program. For more details, see the cash flow summary in the Department's FY 2019-20 Schedule 9.¹⁷

39. In FY 2019-20, how much of the projected increase in enrollment is attributable to the elderly and people with disabilities? How much of the projected increase in General Fund is attributable to these populations?

RESPONSE

The Department is projecting total Medicaid enrollment to increase by 1.41 percent, or 18,404 members, in FY 2019-20, compared to an increase of 4.03 percent, or 7,076 clients, for the older adults and people with disabilities. This means that 38.45 percent of the projected increase in total enrollment is attributable to the older adult and people with disabilities populations. The Department is projecting that it will need an increase

¹⁷<https://www.colorado.gov/pacific/sites/default/files/HCPF%2C%20FY20%2C%20Schedule%2009%20-%20Cash%20Fund%20Summary.pdf>

of \$142.6 million General Fund in FY 2019-20 compared to FY 2018-19 to fund all Medicaid and CHP+ services. Of that amount, approximately \$120.4 million is attributable to services for older adults and people with disabilities. This means that 84.43 percent of the projected increase in General Fund is attributable to expected growth in services for older adults and people with disabilities.

The older adult and people with disabilities populations can be eligible through the long-term services and supports category. This means they must have a significant disability, and the data shows that older adults and people with disabilities often have multiple chronic conditions.

40. How does the actual General Fund rate of growth in prior years compare to the projected General Fund rate of growth and to inflation? Is the General Fund rate of growth slowing, and why?

RESPONSE

General Fund expenditure tends to grow at a higher rate than inflation each year, because it is driven primarily by Medicaid caseload growth. The table below shows the growth in General Fund as it compares to caseload growth for populations funded with the General Fund and the Colorado inflation rate. In recent years, caseload growth has been higher for categories of older adults and people with disabilities, which have a higher per capita cost than eligibility categories that are growing more slowly or declining. For FY 2018-19 and FY 2019-20, the Department is projecting General Fund expenditure to grow more quickly than overall caseload due to projected increases in utilization of long-term services and supports for the elderly and people with disabilities and increases in utilization and cost of specialty drugs, while overall caseload growth is projected to remain relatively flat.

| General Fund Growth Compared to Caseload and Inflation | | | | | |
|---|---|--|--------------------------------|-----------------------------------|--|
| Fiscal Year | General Fund Expenditure⁽¹⁾ | Percentage Change in General Fund | General Funded Caseload | Percent Change in Caseload | Colorado Inflation Rate⁽²⁾ |
| FY 2012-13 | \$1,829,127,060 | 8.21% | 629,304 | 7.99% | 2.44% |
| FY 2013-14 | \$2,084,486,240 | 13.96% | 723,513 | 14.97% | 2.82% |
| FY 2014-15 | \$2,313,291,303 | 10.98% | 844,814 | 16.77% | 1.83% |
| FY 2015-16 | \$2,477,432,099 | 7.10% | 883,109 | 4.53% | 2.17% |
| FY 2016-17 | \$2,530,514,767 | 2.14% | 890,721 | 0.86% | 2.83% |
| FY 2017-18 | \$2,796,452,030 | 10.51% | 879,670 | -1.24% | 3.43% |
| FY 2018-19 | \$2,904,579,002 | 3.87% | 879,122 | -0.06% | 3.40% |
| FY 2019-20 | \$3,106,304,745 | 6.95% | 889,140 | 1.14% | 3.20% |

(1) The General Fund amount is the appropriation for FY 2018-19 and the Governor's Request for FY 2019-20.

(2) The inflation rate for FY 2018-19 and FY 2019-20 is based on the Legislative Council Staff's September 2018 Economic & Revenue forecast.

41. The State Demographer's projections of Colorado's population by age show a decreasing number of children aged 10 and under, but the department projects enrollment in the Children's Basic Health Plan. Please explain. Are we having fewer children, but the children are poorer?

RESPONSE

Enrollment growth in the CHP+ program does not necessarily indicate that children are poorer. The CHP+ program has an upper and lower bound on the eligibility criteria. Children from families who are below the lower bound of the federal poverty level criteria are eligible for Medicaid, and improvements in the economy can move children from the Medicaid program to the CHP+ program. Caseload for children in CHP+ has seen steady growth, even as caseload growth for children in Medicaid has fallen. The caseload for both programs combined declined in FY 2017-18 and is expected to decline again in FY 2018-19. The Department is projecting small, positive growth for combined caseload in FY 2019-20 and FY 2020-21 due to projections of a slow increase in unemployment in those years and both populations' sensitivity to economic conditions.

| Projected Growth in Medicaid and CHP+ Enrollment | | | | | | |
|--|-------------------|----------------|---------------|----------------|----------------|----------------|
| Fiscal Year | Medicaid Children | Percent Change | CHP+ Children | Percent Change | Total Children | Percent Change |
| FY 2014-15 | 524,314 | | 53,704 | | 578,018 | |
| FY 2015-16 | 558,450 | 6.51% | 51,041 | -4.96% | 609,491 | 5.45% |
| FY 2016-17 | 564,140 | 1.02% | 65,260 | 27.86% | 629,400 | 3.27% |
| FY 2017-18 | 534,388 | -5.27% | 79,458 | 21.76% | 613,846 | -2.47% |
| FY 2018-19 Projection | 521,879 | -2.34% | 83,358 | 4.91% | 605,237 | -1.40% |
| FY 2019-20 Projection | 524,659 | 0.53% | 87,916 | 5.47% | 612,575 | 1.21% |
| FY 2020-21 Projection | 534,034 | 1.79% | 92,412 | 5.11% | 626,446 | 2.26% |

42. The Department of Local Affairs (DOLA) is requesting an increase of \$1,693,126 General Fund for FY 2019-20 (for a total of \$4,297,891) to provide housing vouchers for 363 individuals participating in the Colorado Choice Transitions program. This equates to an average cost of \$11,840 General Fund per year per participant who receives housing assistance. We understand that these state costs are offset by reductions in costs incurred by the Department of Health Care Policy and Financing (HCPF). Please quantify the total HCPF savings related to the Colorado Choice Transitions program. Please include information concerning the total number of Program participants (not just those who require housing assistance from DOLA) and differentiate savings in state and federal funds.

RESPONSE

The Department roughly estimates savings of \$27.8 million total funds, including \$13.9 million General Fund and \$13.9 million federal funds, over the lifetime of the Colorado Choice Transitions program. Since 2013,

391 people have transitioned from an institution into the community. Of those transitions, 93 percent have remained in the community after a year. A transition has an average savings of roughly \$33,000 per person, as estimated in HB 18-1326. Savings occur due to the lower cost of community care versus care in an institution. Further, savings accumulate year-over-year as people remain in the community.

43. The federal Family First Prevention Services Act of 2018 makes significant changes to the child welfare system aimed at keeping children and youth safely with families and avoiding placement in foster care by strengthening the protective capacity of families long before child welfare services are needed. The Act also expands the eligible use of funds from Title IV-E of the Social Security Act to include approved prevention and intervention services meeting the evidence-based threshold of promising-, supported-, or well-supported practices as defined by the federally selected clearing house. Several programs currently exist in the State of Colorado through which services are provided and that are intended to strengthen the protective capacity of families. The coordination or delivery of many of these services are or could be integrated with other programs and services with the intent of providing wrap-around services to children and families. The FFPSA provides an opportunity for the State of Colorado to evaluate existing programs and funding in order to leverage resources across systems, departments, and divisions and to improve service delivery. In what way will the federal Family First Prevention Services Act impact the Department’s programs and budget? What statutory, policy, and rule changes does the Department anticipate will be required to ensure that the State of Colorado complies with all provisions of the federal Act?

RESPONSE

The Department is actively engaged in broad-based collaborative efforts to leverage and build the state’s programs and funding to improve the delivery of preventive services to children and families in an effort to avoid foster care placements. To achieve the vision outlined by the federal Family First Prevention Services Act (FFPSA), the Department is working to improve collaboration with the Department of Human Services, counties, and other agencies and providers, working closely with Child Welfare-involved children and families. While the state has a strong foundation of state and Medicaid services to build upon, the requirements for utilization of Medicaid funding for eligible individuals and services prior to accessing Title IV-E funds requires stronger cooperation.

While the Department is still in the process of reviewing the federal guidance published on November 30, 2018, and working with other agencies and the Governor’s Office, based on preliminary analysis, the Department anticipates that the provisions in the FFPSA will impact policy and utilization in the following areas:

1. **Data:** To appropriately identify affected children and youth and monitor services, the Department will assess whether improved processes for shared eligibility systems and increased TRAILS/CBMS interoperability may be required.
2. **Vendor Collaboration:** To support appropriate utilization of state resources and programs, there is a need to improve partnerships between Department vendors (specifically the Regional Accountable Entities and Community Centered Boards) and other agencies. Depending on the statewide design and requirements, this could result in changes to vendor contracts.

3. **Residential Child Care Facilities (RCCF):** FFPSA requires these facilities to add services (such as 24-hour access to nursing services and a third-party assessment process to determine medical necessity) that may impact reimbursement rates. The Department is evaluating whether the new services will require changes to the current benefit structure, which could also require a rule change.
4. **Behavioral Health Capitation:** Most, if not all, of the FFPSA identified intensive community-based services aimed at preventing the removal of children from their homes are currently covered under the Department’s capitated behavioral health benefit. The Department is analyzing the potential impacts on the covered benefits, utilization, and rates.
5. **Children’s Habilitation Residential Program (CHRP):** The Home-and-Community Based Services in the CHRP waiver are available for children meeting eligibility criteria in the child welfare system as well as those who may be “candidates” for placement within the child welfare system, as seen in the FFPSA. As the state determines the criteria for placement “candidacy” for FFPSA, the Department will evaluate any budget impact to the CHRP waiver.

The Department will use the regular budget process to request any necessary changes to the budget, both to affected services and for administrative resources, and will initiate rule changes with the Medical Services Board as needed.

44. Do you believe a pilot program to match Medicaid and federal VA data could yield beneficial results for veterans and their families? On what scale? Do you believe a pilot program is likely to yield General Fund savings without a change to Medicaid policy on A&A? Please provide additional data explaining the basis for the estimates in the consultant's report on Medicaid matching and/or provide updated estimates from HCPF.

RESPONSE

The Department believes that acting on the PARIS/VA data would yield beneficial results for veterans and their families by providing Colorado Department of Military and Veterans Affairs (CDMVA) with concrete leads of individuals whose benefits could reasonably be enhanced.

It is not clear whether General Fund savings could be achieved or on what scale. Any potential savings hinge upon the ability to perform outreach to individual veterans and help them through the VA application process. There is no guarantee that the affected veterans would complete the application process, and there is no comprehensive information that would inform a reliable estimate about how much savings are possible. The Department does believe that there are areas where savings may be achieved, such as:

- Non-Nursing Home Payments. Ensure that veterans who are discharged from a nursing facility have their pension benefits restored from the \$90 institutionalized amount.
- PARIS matches that reveal \$0 in monthly benefits are researched to identify opportunities to increase compensation.
- Ensure Vietnam-era veterans are receiving benefits due to the effect of the herbicide “agent orange” in cases of exposure.
- Research opportunities to increase veterans’ service-connected disability ratings.
- Enroll individuals into VA prescription drug benefits.

In terms of scale, any successful implementation would require a joint effort between HCPF and CDMVA akin to the interagency arrangement utilized in Washington state. A successful implementation would require sufficient resources to achieve the necessary level of outreach, i.e., filing and tracking applications for the dually eligible Medicaid/VA recipients. This would likely necessitate the appropriation of funding to CDMVA for staff who would work with identified veterans to complete the application process.

The consultant's report derived its high-level estimates by comparing Washington's program with Colorado's demographics. This comparison was used in connection with Washington's savings numbers to estimate what could potentially be achieved in Colorado.

45. Should the state consider a more limited pilot with outreach to a sample of veterans to help clarify the benefits of any collaboration?

RESPONSE

Yes, the state should consider a limited pilot with outreach to a sample of veterans to help clarify the benefits of any collaboration. As previously noted, the Department believes that the PARIS/VA data could provide beneficial results for this dually eligible population. Moreover, HCPF currently receives the PARIS/VA data and could analyze it to identify potential individuals who would benefit from outreach.

46. How will the state be able to tell if a pilot provides benefits to veterans or the state? Will it be possible to determine this from the data from the PARIS system?

RESPONSE

CDMVA would need to track the success of a veteran obtaining new or enhanced benefits based on the outreach conducted. CDMVA would track the results of new or enhanced benefits successfully obtained by veterans and their families based upon approvals received through the application process. The results of this process would be sent back to HCPF. HCPF could then analyze the CDMVA data in conjunction with its claims data to determine the pilot's successes or failures.

47. Have the departments clarified their position on whether they support any change to Medicaid rules associated with this report, i.e., do they recommend changing how VA aid and attendance is treated in Medicaid calculations?

RESPONSE

The Department does not recommend changing how VA Aid and Attendance is treated in Medicaid income calculations at this time without further analysis of impact to Medicaid clients and whether there would be significant cost savings.

ADDENDUM: OTHER QUESTIONS FOR WHICH SOLELY WRITTEN RESPONSES ARE REQUESTED

- 1. Provide a list of any legislation that the Department has: (a) not implemented, or (b) partially implemented. Explain why the Department has not implemented or has only partially implemented the legislation on this list. Please explain any problems the Department is having implementing any legislation and any suggestions you have to modify legislation.**

RESPONSE

Total HCPF Related Bills 2008-2018: 232

Not Fully Implemented 2008-2018: 9

The Department has records of the status of implementation for legislation dating back to 2008. Over the last 10 years, the Department has successfully implemented over 220 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.

| Legislation | Legislation Summary | Barriers to Implementation | FTE |
|--|---|---|-----|
| SB 16-120 Review by Medicaid Client for Billing Fraud (Roberts/Coram) | The bill requires HCPF to provide explanation of benefits (EOB) statements to Medicaid clients beginning July 1, 2017. The EOB statements must be distributed at least once every two months and HCPF may determine the most cost-effective means of sending out the statements, including email or web-based distribution, with mailed copies sent by request only. The bill specifies the information to be included in the EOB statements, including the name of the client receiving services, the name of the service providers, a description of the service provided, the billing code for the service, and the date of the service. | SB 16-120 has not been fully implemented. Though the Department has been unable to launch the Medicaid Explanation of Benefits on July 1, 2017 due to system, policy and operational issues, the Department has completed the development of the Explanation of Benefits Letter and Member Educational Messaging, which includes legislatively required stakeholder feedback and member testing. The SB 16-120 EOBs will be available through the interchange Member Portal once the interchange Member Portal itself is fully operational and launched. The Department does continue to send Medicaid members the federally required Explanation of Benefits as defined by 42 CFR 433.116. | 0.5 |
| HB 15-1186 | This bill expands eligibility for the Autism Waiver Program by increasing the age limit from 6 years | The Department cannot implement this bill as written because it was contingent on approval from the | 0.8 |

| Legislation | Legislation Summary | Barriers to Implementation | FTE |
|---|---|---|---------------|
| <p>Services for Children with Autism (Young/Steadman)</p> | <p>of age to 8 years of age. If a child enrolls prior to his or her eighth birthday, he or she is eligible to receive services for a total of three full years. The bill removes the existing per child spending cap of \$25,000 per year and instead directs the Medical Services Board to set the per child spending cap each year based on available appropriations. The bill eliminates the program waiting list.</p> | <p>federal Centers Medicare and Medicaid Services (CMS). CMS denied the waiver amendment on September 14, 2015. The Department sent communication to parents and a broad scope of stakeholders. The communications informed parents and stakeholders how to access the services available in the Children w/ Autism Waiver through the Early Periodic Screening, Diagnostic, and Treatment Waiver (EPSDT).</p> | <p>(Temp)</p> |
| <p>HB 15-1318 Consolidate Intellectual and Dev. Disability Waivers (Young/Grantham)</p> | <p>This bill requires HCPF to consolidate the two Medicaid HCBS waiver programs for adults with intellectual and developmental disabilities.</p> | <p>The Department has reached significant milestones across all components of waiver redesign. Specifically, progress has been made analyzing the breadth of fiscal, operational and programmatic impacts of a redesigned waiver. The Department has nearly finished developing models for quality measures, provider qualifications, service utilization forecasts, individualized budgets with norm referenced service limits, and continues to benefit from our stakeholders ongoing consultation and advice throughout the waiver design and implementation process. Combining the Supported Living Services (SLS) and Developmental Disabilities (DD) waivers is an extremely complex undertaking, thus the analysis has taken longer than anticipated. Current actuarial work is underway to make decisions and inform next steps for the service delivery option for the Residential Habilitation Service. To accomplish this work, the General Assembly appropriated additional resources to the Department for FY 2018-19.</p> | <p>3</p> |

| Legislation | Legislation Summary | Barriers to Implementation | FTE |
|---|--|--|----------|
| <p>SB 10-061</p> <p>Medicaid Hospice Room and Board Charges</p> <p>(Tochtrop, Williams/Soper, Riesberg)</p> | <p>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.</p> | <p>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 facility to be reimbursed by the state for room-and-board with federal financial participation.</p> | <p>0</p> |
| <p>HB 09-1103</p> <p>Presumptive Eligibility Long-Term Care</p> <p>(Riesberg/Newell)</p> | <p>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.</p> | <p>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.</p> | <p>0</p> |
| <p>HB 08-1072</p> <p>Medicaid Buy-In for Persons with Disabilities</p> <p>(Soper/Williams)</p> | <p>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.</p> | <p>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</p> | <p>2</p> |

| Legislation | Legislation Summary | Barriers to Implementation | FTE |
|---|---|--|-----|
| | | improved but preexisting conditions to access health care. Under federal rule, the earliest any of these potential clients could have been covered was March 2013. With SB 13-200 and SB 11-200 these clients will either qualify for Medicaid as part of the expansion population or be able to seek subsidies on private health insurance through Connect for Health regardless of a preexisting condition. | |
| 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 08-214 Local Government Medicaid Provider Fees (Shaffer/Frangas) | This bill made changes to legislation enacted in 2006 via SB 06-145, which authorized local governments to implement a provider fee on hospital and home health care agencies to draw federal matching funds to increase reimbursement for services provided to Medicaid clients. | As noted in both bills, imposition and collection of a provider fee by a local government is prohibited without federal approval of a Medicaid State Plan Amendment (SPA) authorizing federal financial participation. The Department filed two SPAs with the federal Centers for Medicare and Medicaid Services (CMS) in 2006 and worked with CMS for more than two years for approval. Ultimately, CMS denied the Department's SPAs, concluding that the Department's | 0 |

| Legislation | Legislation Summary | Barriers to Implementation | FTE |
|--|---|---|-----|
| | | 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 to receive services through the consumer-directed care service model. | 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. While a valuable and important delivery model, research and data show that participants in CDASS do not produce significant savings. The Department has received federal approval and implemented CDASS into five HCBS waiver programs, including the recent addition of CDASS into the Support Living Services HCBS waiver program in 2018. The Department continues to review opportunities to expand consumer direction into additional waivers and services. | 0.5 |

*While the Department does not have record of the implementation status of bills prior to 2008, HB 05-1243 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.

2. **Does the Department have any high priority outstanding recommendations as identified in the "Annual Report: Status of Outstanding Audit Recommendations" that was published by the State Auditor's Office and dated June 30, 2018 (link below)? What is the Department doing to resolve the high priority outstanding recommendations? Please indicate where in the Department's budget request actions taken towards resolving HIGH PRIORITY OUTSTANDING recommendations can be found.**

RESPONSE

Regarding the outstanding audit recommendations identified in the Office of the State Auditor's "2018 Annual Report of Audit Recommendations Not Fully Implemented", the Department of Health Care Policy and Financing (the Department) has one recommendation that is considered "high priority" in the report.

Recommendation 2017-058 relates to the Department ensuring personnel costs charged to federal grant programs are compliant with federal cost regulations.

The Department will require staff to semi-annually certify their time spent working on federal or state programs, to comply with federal cost regulations, until the state can implement its new Human Resource Information System (HRIS) and Department staff can track their time. This will be implemented by March 2019.

3. If the Department receives federal funds of any type, please respond to the following:

Are you expecting any changes in federal funding with the passage of the FFY 2018-19 or 2019-20 federal budget? If yes, in which programs, and what is the match requirement for each program?

Does the Department have a contingency plan if federal funds are eliminated?

Please provide a detailed description of any federal sanctions or potential sanctions for state activities of which the Department is already aware. In addition, please provide a detailed description of any sanctions that MAY be issued against the Department by the federal government during FFY 2018-19 or 2019-20.

RESPONSE

Changes in Federal Funding

The Department does not expect any changes in federal funding that are connected to the FFY 2018-19 or 2019-20 federal budget.

However, current federal law does provide for a change in the federal match rate for the Children's Health Insurance Program (CHIP), referred to at the Child Health Plan *Plus* (CHP+) in Colorado. Through September 30, 2019, the federal match rate for CHP+ is 88 percent. On October 1, 2019, the federal match rate for CHP+ will drop to 76.5 percent, and on October 1, 2020, the federal match rate will drop to 65 percent and remain there for future years. Because CHP+ requires a state match, the Department has accounted for the required increase in state funding as part of the November 1, 2018 budget request.

In addition, current federal law provides for a change in the federal match rate for parents and adults newly eligible under the Affordable Care Act (ACA). The federal match rate will drop from 94 percent to 93 percent effective January 1, 2019 and to 90 percent effective January 1, 2020. It will remain at 90 percent for future years. The Department has accounted for the required increase in state funding from the Healthcare Affordability and Sustainability Fee cash fund as part of the November 1, 2018 budget request.

Contingency Plan

The Department does not have a contingency plan if federal funds for Medicaid or CHP+ were eliminated, as the elimination of federal funding for these programs would require a comprehensive reevaluation of the state's health care programs. Almost 57 percent of the Department's FY 2019-20 budget request is federal funds. In addition, most of the Department's appropriations have an (M) headnote, which restricts the Department from spending state funds if there is no longer a federal match. The Department would be unable

to continue to pay for any services without a federal match, and the Department, Governor's Office, and General Assembly would need to decide which coverage options to extend with state funding, if any, and make the corresponding statutory and budgetary changes.

Sanctions

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

Federal disallowances can be issued by CMS when they determine that a claim or a portion of a claim is not allowable under the SSA or a program violates CMS rules or regulations. In these situations, the Department may be required to pay back the federal share of the claim(s). The federal disallowances the Department typically encounters are due to disagreements over the administration of various activities. The Department actively challenges and engages with CMS regarding any disallowances by appealing disallowances to the Health and Human Services Departmental Appeals Board (DAB). However, it is unusual for the DAB to rule against CMS' disallowances, even when CMS applies current guidance retroactively or disallows funding for legitimate services provided to eligible clients.

There are no disallowances during FY 2018-19. Deferral is a delay in payment by CMS while CMS requests documentation from the Department in order to determine allowability of the claim. Below are two active deferrals:

- On July 11, 2018, the Centers for Medicare and Medicaid Services (CMS) deferred \$495,388 federal financial participation funds related to the Department's contingency fees resulting from recovering funds from third parties. CMS stated that the Department did not provide documentation regarding the amount reported on Form CMS-64.10P – Line 49 related to Private Attorney fees. CMS State Medicaid Manual addresses contingency fee reimbursement for third-party liability collections. The Manual instructs each state to report any proper administrative expenses (attorney/contractor collection fees) incurred in making the recovery, which are eligible for reimbursement. Colorado State law provides the state Department will pay its reasonable share of attorney fees. The Department continues to work with CMS to resolve questions.
- On July 25, 2018, CMS deferred \$1,018,632 federal financial participation (FFP) related to the Department reporting on FORM CMS-64.10P, Line 49-Other Financial Participation for the quarter ending March 31, 2018. On November 22, 2018, the Department responded with answers to CMS's questions and provided additional support documents. The Department requested that CMS release the deferred amount of \$1,018,632. The Department is waiting for CMS to respond.

- 4. Is the Department spending money on public awareness campaigns? If so, please describe these campaigns, the goal of the messaging, the cost of the campaign, and distinguish between paid media and earned media. Further, please describe any metrics regarding effectiveness and**

whether the Department is working with other state or federal departments to coordinate the campaign?

RESPONSE

No. The Department is not spending any money on public awareness campaigns.

5. Based on the Department’s most recent available record, what is the FTE vacancy and turnover rate by department and by division? To what does the Department attribute this turnover/vacancy? Do the statewide compensation policies administered by the Department of Personnel help or hinder in addressing vacancy or turnover issues?

RESPONSE

Below is the Department’s FTE turnover and vacancy rate by office. The Department tracks this data by office rather than division, so information on the turnover and vacancy rate by division is not available.

| Turnover and Vacancy Rate by Office for FY 2017-18 | | | |
|--|-----------------------------------|----------------------------------|---------------------------------|
| Office | Number of Unique Employees | Turnover Rate¹ | Vacancy Rate² |
| Client and Clinical Care | 44 | 11% | 8% |
| Community Living | 90 | 13% | 16% |
| Executive Director's | 28 | 21% | 20% |
| Finance | 137 | 12% | 8% |
| Health Information | 122 | 17% | 12% |
| Health Programs | 73 | 11% | 13% |
| Policy, Communications, and Administration | 126 | 21% | 15% |
| Total | 620 | 15% | 14% |
| ¹ Turnover rate is calculated as the number of times an employee separated from the Department, either voluntarily or involuntarily, divided by the total number of unique employees. ² Vacancy rate is the percentage of time in FY 2017-18 that positions have been vacant. | | | |

Based on existing historical survey data, the most frequently cited reasons for leaving employment are: 1) to pursue a promotional opportunity; 2) personal reasons, such as a spouse relocation, educational pursuits, or a grant position ending; and 3) dissatisfaction with a supervisor.

To attract and retain employees, the Department is continuing to enhance employee engagement through developing a leadership development program; expanding employee coaching; revising and streamlining the new employee orientation and first-year onboarding process; and providing training to managers to more effectively use competency-based, in-range salary adjustments. Future planned projects include an expansion of career development opportunities for all leaders and staff to increase the value of the employee experience.

The statewide compensation policies, compensation ranges, and implementation rules continue to make competing with the private sector to attract and retain top talent a challenge. As the Department of Personnel and Administration noted in its FY 2019-20 Annual Compensation Report, “[when] the State’s total compensation package is valued, there is a variance of 9.2 percent below the prevailing market.” This disparity, particularly in wages, is a constant source of concern when hiring staff. This is exacerbated by the State’s general policies to fund new positions and hire new staff at the minimum of the salary range. Most Department job postings include disclaimers that new hires are generally paid at the bottom of the range, which can have the effect of discouraging qualified candidates, and particularly those candidates with industry experience.

6. Please identify how many rules you have promulgated in the past two years (FYs 2016-17 and 2017-18). With respect to these rules, have you done any cost-benefit analyses pursuant to Section 24-4-103 (2.5), C.R.S., regulatory analyses pursuant to Section 24-4-103 (4.5), C.R.S., or any other similar analysis? Have you conducted a cost-benefit analysis of the Department’s rules as a whole? If so, please provide an overview of each analysis.

RESPONSE

From October 2016 to October 2018, the Department promulgated 84 rules. The Department does cost-benefit and regulatory analyses for each proposed rule prior to its introduction to the Medical Services Board (MSB). The analyses are included in the rule-making document packet that accompanies each rule proposed by the Department. The cost-benefit analysis includes the following components:

- Description of persons who will bear costs of the proposed rule and persons who will benefit from the proposed rule;
- Discussion of the probable costs, to the Department or any other agency, of implementation and enforcement, and any anticipated effect on state revenue;
- Comparison of the probable costs/benefits of the proposed rule to the probable costs/benefits of inaction; and
- Determination of whether there are less costly or less intrusive methods for achieving the purpose of the proposed rule.

The Department makes the rule-making document packet available to the public when the public notice of proposed rule-making is published, and it is also included in the public record after the MSB adopts the rule.

With respect to these rules, no person requested a separate cost-benefit analysis for any of the rules. Section 24-4-103 (2.5), C.R.S., states that anyone may request a cost-benefit analysis within five days of the publication of notice of proposed rulemaking in the Colorado Register. The Department performed a regulatory analysis of all 84 rules pursuant to section 24-4-103 (4.5), C.R.S. The regulatory analysis performed on each rule is compliant with statute and is available to the public for review five days prior to the rule-making hearing on the Department’s public website. The Department has not conducted a cost-benefit analysis of the rules as a whole.

Each year the Department is required to submit a Regulatory Report to the General Assembly and the Secretary of State. This report documents all rules promulgated by the Department and is on the Department's website.¹

7. What are the major cost drivers impacting the Department? Is there a difference between the price inflation the Department is experiencing compared to the general CPI? Please describe any specific cost escalations.

RESPONSE

The primary cost driver impacting the Department's FY 2019-20 General Fund budget is growth in utilization of Medicaid long term services and supports, including home and community-based services (HCBS), long-term home health, private duty nursing, and nursing facilities. Over the long term, the Department expects that its General Fund growth will be driven in large part by the aging of Colorado's population. Seniors and people with disabilities who qualify for Medicaid are paid for using General Fund and receive a 50 percent federal match rate.

For most services, the Department does not experience "price inflation," as the Department does not automatically adjust rates for inflation. Instead, the Department adjusts most rates only when additional funding is appropriated by the General Assembly. As providers experience rising costs due to factors such as wage growth, the increasing cost of benefits, or increasing rents, they generally must absorb those cost increases until the General Assembly appropriates funding to increase Medicaid rates. Among these issues, the Department is particularly concerned about the effect of the rising minimum wage on providers who deliver personal care and homemaker services to people with disabilities; without annual rate growth to keep pace with the Constitutionally-required minimum wage increases, the Department fears that the people who deliver these services will seek other occupations that pay similarly. Please see the Department's response to question 31 for further discussion about personal care and homemaker wages.

Although most services do not see inflationary rate changes without additional appropriations, some service categories do receive automatic rate increases when required by statutory formulas. Key examples include nursing facilities (required by state statute), federally qualified health centers (required by federal law), pharmacy (required by federal regulation), and Medicare premiums.

8. How is the Department's caseload changing and how does it impact the Department's budget? Are there specific population changes or service needs (e.g. aging population) that are different from general population growth?

RESPONSE

Medicaid caseload grew significantly from FY 2008-09 through FY 2015-16, primarily for children and adult populations. Since then, overall caseload growth has been low due to improving economic conditions. The Department is projecting a decline in FY 2018-19 caseload, and small growth of 1.41 percent in FY 2019-20. For populations in which eligibility is not driven by economic conditions, such as older adults and people with disabilities, the Department is projecting growth of 4.03 percent in FY 2019-20. The projected growth is informed by projections of the aging population and historical growth of people with disabilities.

As caseload grows more rapidly for older adults and people with disabilities, the Department is projecting that it will spend more on long term services and supports. The Department is projecting that it will need an increase of \$142.6 million General Fund in FY 2019-20 compared to FY 2018-19 to fund all Medicaid and CHP+ services. Of that amount, approximately \$120.4 million is attributable to services for older adults and people with disabilities, primarily for long term services such as community-based waiver services, nursing facilities, long term home health, and private duty nursing.

9. Please provide an overview of the Department’s current and future strategies for the use of outward facing technology (e.g. websites, apps) and the role of these technologies in the Department’s interactions with the public.

RESPONSE

The Department’s current strategy is focused on providing the right tools and resources to enable its member contact center to handle calls more effectively and efficiently. As part of this strategy, the Department has requested resources in its November 1, 2018 Budget Request R-10 “Transform Customer Experience” to improve its member contact center by developing a robust knowledge library and adding automated response and chat functionality. The Department also collaborates with its partners to improve the customer experience that expands beyond the contact center and includes: a detailed online member handbook, a provider directory, online application and benefit management through the Colorado Program Eligibility and Application Kit (PEAK)¹⁸, a mobile app (PEAKHealth)¹⁹, partner and county contact centers, the Department’s websites, and in-person experiences.

Moving forward, the Department envisions a coordinated customer support system that aligns and consolidates websites where it makes the most sense for the members and creates interconnected and self-service support models to enable an improved customer experience.

¹⁸ <https://coloradopeak.secure.force.com/>

¹⁹ <https://www.colorado.gov/pacific/hcpf/peakhealth>