DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
FY 2014-15 JOINT BUDGET COMMITTEE HEARING AGENDA
Wednesday, January 8, 2014
1:30 pm – 5:00 pm

1:30-1:45 COMMISSION ON FAMILY MEDICINE

1:45-1:50 BREAK

1:50-2:10 DEPARTMENT INTRODUCTION AND OPENING COMMENTS

2:10-2:15 QUESTIONS COMMON TO ALL DEPARTMENTS

1. **Please describe how the Department responds to inquiries that are made to the Department. How does the Department ensure that all inquiries receive a timely and accurate response?**

There are several ways inquiries are addressed and responded to at the Department.

- The Governor's Advocate Corps, established in 1993, has a Governor's Advocate assigned in each Department to assist with constituent issues.
- Most of the Department's programs have fact sheets on Department website which lists contact information for the program managers. Many program-specific inquiries are directly responded to through that avenue.
- Clients with questions about their services can contact the Department's toll-free customer contact center.
- Media inquiries are directly responded to by the Department's Communications Director.
- Providers with billing inquires contact the Department's claims system vendor directly.

In addition, any question that is posed directly to staff is routed to the appropriate subject matter expert for a response and responded to in a timely manner with contact information for the inquirer to follow up directly with additional questions/concerns via phone or email.

2:15-2:45 HEALTH INFORMATION EXCHANGE (R-5)

2. **Please provide an overview of the Department's R-5 Medicaid health information exchange.**

This request was generated through a joint effort of the Department, Department of Public Health and Environment (DPHE), Department of Human Services (DHS), Governor's Office of Information Technology (OIT), and public/private stakeholder groups who came together to strategize on how to leverage health information technology to lower the cost of providing health care. The information in the health information exchange (HIE) will provide meaningful clinical patient data to the Department's Accountable Care Collaborative, which will allow Regional

Care Collaborative Organizations (RCCOs) and Primary Care Medical Providers (PCMPs) to provide better coordinated care for Medicaid clients.

This request takes advantage of federal financing opportunities to invest in and leverage statewide HIE in Colorado that already exist. Transferring clinical information from the point-of-care to another provider, care coordinator or payer through an electronic health record that connects via HIE is not new. The entire health care industry, not just public health care, is moving toward the exchange of meaningful clinical patient data at the point of care. Clinical data can be used in near real-time to address emergency department use and hospital follow-up care, as opposed to claims payment data which relies on providers billing for services to be paid.

Rather than build a state-operated connection to every Medicaid provider, which is not feasible, this funding leverages the scalability of pre-existing HIE resources in Colorado (i.e., Colorado Regional Health Information Organization (CORHIO) and Quality Health Network (QHN)). CORHIO was designated Colorado's statewide entity for HIE by executive order in 2009 and is the strategic partner for the Department in expanding the use the HIE for Medicaid providers.

This request funds not just technology through the existing HIE network, but outreach and technical assistance to providers serving Medicaid clients to expand the use of HIE where the majority of care is provided.

Without this resource, the Department will not have the ability to proactively understand and improve client health and measure the effectiveness of Medicaid services by utilizing HIE and clinical information. If health information is not shared, Medicaid providers will continue to have a limited ability to coordinate care and avoid duplicative or unnecessary treatments. The goal of this request is to make use of data sharing to improve decision-making at the provider level for Medicaid clients.

Further, a robust HIE resource has the potential to ensure better connectivity and alignment of health information across state agencies providing health services (e.g., DPHE, DHS, and DOC).

3. What access will patients have to information about themselves through the Health Information Exchange (HIE)? Would the patient need to pay a fee to access the data?

The current focus of the Health Information Exchange (HIE) is on information sharing among health care providers, hospitals and care coordinators serving Medicaid clients. Patients have access to information about themselves directly through their providers. Patients do not have to pay a fee to access any of their own data. In the future, a statewide HIE platform (like Colorado Regional Health Information Organization (CORHIO) and/or Quality Health Network (QHN)) may allow easier access for Medicaid clients to see all of their information in one place. In addition, the Department and its stakeholder group are examining how to initiate a client or patient portal, which will easily provide the client's health record directly at no cost to the client.

4. Who "owns" the data connected through the HIE and accepts liability for potential abuse of it?

Data is owned by the health care provider who generated the data, and ultimately by the patients themselves. Medicaid, as a payer, may collect data on Medicaid patients for the purposes of treatment, payment or operations. The Health Information Exchange (HIE) acts as a steward of the data, but may not view or otherwise use the data except as needed for technical troubleshooting. Abuses of patient data are subject to penalty under federal law as outlined in the Health Information Portability and Accountability Act (HIPAA). CORHIO and QHN regularly conduct audits of internal policies, processes and their workforce for HIPAA compliance.

5. **How much information connected through the HIE will be accessible by the federal government? Is this a precursor to greater federal control and regulation of health care?**

No patient-specific information from the Health Information Exchange (HIE) network is shared with federal systems or infrastructure. In some cases, providers must report population-level statistics (number of Medicare and/or Medicaid patients, clinical quality metrics) to the federal government in order to qualify for federal technology incentive payments.

6. **Explain the financing model for the HIE and the subscription fees. Are providers supplying information and then paying a subscription fee to get the information back?**

Providers do pay a subscription fee to access value-added information and services provided by the Health Information Exchange (HIE) which enhance their in-house data capabilities. This includes access to information not directly generated by them (e.g., lab results from an independent lab entity), and services such as automated public health reporting to the Department of Public Health and Environment.

2:45-3:10 FY 2013-14 RATE INCREASES

7. **Please discuss the implementation of the provider rate increases approved by the General Assembly last year, including the timing of approval from the Centers for Medicare and Medicaid Services (CMS) and the process for retroactive payments. In particular, what is the Department doing about hospice rates? Will any of the other rate increases not be approved by CMS?**

Provider rate increases for most Medicaid services require that the Centers for Medicare and Medicaid Services (CMS) approve a State Plan Amendment (SPA). Once the Department submits a SPA, CMS has 90 days to make a decision and CMS has the authority to stop the 90 day clock at any time with requests for additional information. Prior to submitting the SPA to CMS, the Department is required to give tribal governments at least 30 days' notice of proposed changes. These requirements can increase the duration between the submission of a SPA and federal approval to 120 days. In years past, CMS had allowed states to pay provider rate increases while the SPA was pending. CMS has since changed its policy and the Department cannot increase rates without an approved SPA, or the federal portion of increased reimbursements would be at risk.

As soon as the Department receives federal approval of the SPA, the Department works with its fiscal agent (Xerox) to load the new payment rate into the Medicaid Management Information System (MMIS). The timeline below details how the Department has worked to quickly implement the rate increases:

DATE	**ACTION TAKEN**
May 2013	Long Bill signed
June 2013	Documents drafted and cleared by HCPF to conduct tribal noticing, and public noticing 23 State Plan Amendments submitted to the Centers for Medicare and Medicaid Services (CMS)
August 30, 2013	Inpatient and Federally Qualified Health Center (FQHC) State Plan Amendments submitted to CMS
Sept. 5, 2013	Approval from CMS received on increases for: EPSDT, Transportation, Dental Surgery, Lab and Radiology, Private Duty Nursing, Physician Services, Physical Therapy, Occupational Therapy, Speech Therapy, Audiology, Prosthetics, Prenatal Plus Program
Sept. 12, 2013	CMS requested additional information for clinic services rate increases
Sept. 19, 2013	Approval from CMS received on increases for: Immunizations, Non-Physician Practitioners, Tobacco Cessation Services for Pregnant Women, Screening, Brief Intervention and Referral to Treatment, Rehabilitation services, Behavioral Health, Home Health, Outpatient Substance Abuse, Targeted Case Management, Outpatient Substance Abuse Treatment, Durable Medical Equipment
Sept. 20, 2013	Outpatient hospital SPA submitted to CMS
Sept. 23, 2013	Transmittals sent to Xerox (HCPF Fiscal Agent) requesting new rates to be loaded into MMIS.
Oct. 24, 2013- Dec. 18, 2013*	New rates paid to providers
Feb. 7, 2014*	Adjustment made for claims paid to providers for claims made July 1

** New rates paid to providers include only those SPAs currently approved by CMS*

Since CMS approval of the rates was retroactive, new provider rate payments will also be paid retroactively. In order to do this, the Department must "mass adjust" affected claims to pay the increase. The fiscal agent does this by querying all claims for services July 1, 2013 and forward that were paid at the prior rate. A lump sum payment is then provided to the affected providers. Implementing mass adjustments involves the following:

a) The July 1, 2013 rate change applied to over 12,000 procedure codes, revenue codes, hospital rates, and provider specific rates. Millions of claims are being mass adjusted to implement the increases.

b) The system must check each procedure code and due to the massive volume of claims, it is taking over 4 minutes to check each code. The fiscal agent can make payments on 150 procedure codes per night. This adds approximately 10 hours to the nightly adjudication cycle, which is the maximum time available without impacting claim processing the following day. The fiscal agent also must calculate and provide for the total number of claims the payment updates will affect, so a single transmittal could take a week or more to complete. This requires significant data entry time and oversight to ensure all requests are entered correctly.

Hospice rates differ from many other provider rates because hospice rates are set by the federal government. Hospice rates are set according to the Medicare rates published in 42 CFR § 418.306, and are increased annually by CMS by a wage index multiplier to compensate for regional differences in wage costs plus a fixed non-wage component. It is important to note that because the rates are set by CMS, these providers have not been subject to the same state rate decreases other providers have experienced during the recent economic downturn.

CMS indicated to the Department that approval of a SPA for hospice services would likely be denied. While approval was unlikely, the Department submitted a SPA to CMS for the hospice provider increase on December 19, 2013. CMS has up to 90 days to approve or deny the SPA, and has not yet issued its decision.

The Department understands that the intent of the Joint Budget Committee was to apply the rate increase to hospice providers. Under current law, the Department is not authorized to use General Fund moneys on a program that does not receive a federal match. Additionally, further stipulations in the Long Bill prevent the use of General Fund moneys without matching federal funds.

Given these statutory restrictions, the Department has submitted a supplemental request, S-8, to request authority to make one-time state-only payments to these providers. The Department would issue the one-time supplemental payments to hospice providers and expects payments to be issued by April 1, 2014.

Aside from the hospice rate increase described above, the Department is confident that all other pending rate increases will be approved with a July 1, 2013 effective date.

In addition to the rate process described above, the Department must utilize a different process for Home and Community Based Services (HCBS). CMS permitted the Department to increase the rates for HCBS services without amending the federal waiver granting us authority to provide these services. These rate increases were loaded into the claims payment system (MMIS) by transmittal and claims were paid with the new rates beginning on July 1, 2013. Although the new rates were loaded, a small number of providers were not paid properly. In working to implement the rate increases for these codes, the Department encountered specific systems limitations. Recognizing the urgency of addressing the systems limitations, additional staff time

was allocated accordingly and the limitations have since been addressed. At this time, all HCBS waiver rates are paying correctly. The mass adjustments are expected to be completed for all HCBS providers by January 31, 2014.

8. Did the department do everything possible to expedite CMS approval of the rate increases? Does the Department anticipate similar delays with the targeted rate increases requested for FY 2014-15, and if so, how will the Department manage those delays?

Given the complexity of the State Plan Amendment (SPA) process and the scrutiny with which the Centers for Medicare and Medicaid Services (CMS) reviews the submissions to meet the federal approval and noticing requirements, the implementation of FY 2013-14 provider rate increases has occurred as quickly as possible. Twenty-seven SPAs were required to implement the across the board rate increases. Twenty-two of the 27 SPAs were submitted *prior* to the July 1, 2013 effective date and each of those SPAs was approved before the expiration of the 90 day period that CMS has before giving the Department a response. Of the five SPAs submitted after July 1, 2013, two have already been approved and the remaining three will be approved in the first quarter of 2014.

Given that rates cannot be paid while a SPA is pending, the Department has taken steps to standardize and streamline the process for submitting SPAs. The processes being implemented will help to minimize the amount of time that lapses between when the Long Bill is signed giving authority for the rate increases, CMS' approval is received and the new rates are loaded into the claims payment system.

The fact that the Department is no longer able to pay providers the increased rate without approval from CMS extends the length of the process and the time before providers are able to get paid the new rate. This will continue to be the reality for the upcoming fiscal year and ongoing fiscal years. The Department worked to expedite the process and will continue to work toward reducing the amount of time before rates can be loaded into the claims payment system for next fiscal year.

9. Have there been any delays in implementing and distributing the enhanced primary care reimbursement, and if so, how is this impacting providers?

The primary care rate increases provided for in Section 1202 of the Affordable Care Act were effective on January 1, 2013. The Department was one of the first seven states to receive Centers for Medicare and Medicaid Services (CMS) approval to make payments to providers. Providers that qualify for the rate increase are paid on a quarterly basis through supplemental payments made by the Department. The Department received CMS approval of the State Plan Amendment on June 4, 2013 and the first quarterly payments were made on June 28, 2013. To date, payments have totaled approximately $28,242,119 over three quarters. Those payments were made to 3,812 Medicaid providers.

The only delay in distributing the enhanced primary care payments has been for providers under the Department's managed care contract with Rocky Mountain Health Plans (RMHP). RMHP providers have not yet received their enhanced reimbursement, because RMHP uses its own

payment system which required development of a new process for identifying qualified providers within RMHP data submissions. The Department worked with RMHP throughout 2013 to develop and test the process, resolving issues of inaccurate and incomplete data. The Department anticipates that RMHP providers will receive payments for all four quarters of calendar year 2013 with the next quarterly payment in January 2014.

10. What are the Department's plans regarding reimbursement for primary care providers when the enhanced federal funding expires in 2015? Is primary care reimbursement an area the Department will address with the 0.5 percent provider rate funds set aside for targeted increases?

On January 2, 2014, the Department submitted BA-10: "Enhanced Federal Medical Assistance Percentage." This budget amendment includes a request to both continue the primary care rate increase from Section 1202 of the Affordable Care Act and to make payments available to more providers including advanced practice nurses. As part of the budget amendment, the Department has requested funding to evaluate the effectiveness of the rate increase in attracting and retaining providers.

While certain primary care procedures may be subject to targeted rate increases, the intent of the 0.5% targeted rate increases is not to address the sunset of the Section 1202 rate increases, primarily because the 0.5% rate increase is insufficient to fully fund a continuation of Section 1202.

11. If the General Assembly is interested in continuing a portion of the enhanced rate for primary care services, what would be the best way to do this and scale the total cost to available funding. Please provide a couple of scenarios at different funding levels. Would it make sense to limit the funding to primary care specialties and exclude sub-specialties?

The Department has requested funding to continue the primary care rate increase in its FY 2014-15 budget request BA-10: "Enhanced Federal Medical Assistance Percentage." As requested, the rate increase would be continued in FY 2014-15 and FY 2015-16 without the requirement of self-attestation by providers. This would allow advanced practice nurses who independently practice to get the increase and may allow non-primary care providers that are providing a medical home for clients to obtain the increase (for example, nephrologists or HIV doctors may be the primary provider for certain clients). The Department believes this is the optimal solution as this creates an incentive for a broader spectrum of providers to increase their Medicaid panels and allows for the greatest amount of Medicaid provider network growth. Table B.1, from the Department's FY 2014-15 BA-10 request, shows the estimated costs for continuation of the rate increases through FY 2015-16.

Table B.1: Continuation of Section 1202 Primary Care Rate Increases				
Row	Item	Fiscal Year		Notes
		FY 2014-15	FY 2015-16	
A	Average Increase in Total Reimbursement per Provider per Quarter	$1,914	$2,009	Based on FY 2012-13 MMIS data and CY 2013 Medicare rates.
B	Number of providers	11,569	11,569	Assumes self-attestation is no longer required.
C	Applicable Quarters	2	4	Assumes January 1, 2014 implementation and a direct rate increase rather than supplemental payments.
D	**Total Funds Impact**	**$44,277,696**	**$92,983,162**	**Row A * Row B * Row C**
E	Estimated Federal Match Rate	58.24%	59.10%	Based on forecast of percentage of clients qualifying for 100% FMAP, 50.75% base FMAP in FY 2013-14, and 51.01% base FMAP in FY 2014-15.
F	General Fund Portion	$18,490,366	$38,030,113	Row D * Row E
G	Federal Funds Portion	$25,787,330	$54,953,049	Row D - Row F

Maintaining an attestation process would reduce the fiscal impact by approximately 50%. Further adjustment could easily be accomplished by reducing the relative percentage of Medicare the rates are increased by. This adjustment allows the flexibility to adjust the fiscal impact from $0 to the maximums listed in the table above, or any amount in between.

12. JBC members have heard national discussions about a 10-year freeze on provider rates. What does the Department know about this possibility? Does this apply to Medicaid or Medicare or both? How would this impact Medicaid providers?

The possible 10-year freeze on physician rates applies to rates paid by Medicare and would not directly affect Medicaid reimbursement. Congress is considering addressing the Sustainable Growth Rate (SGR) for Medicare payments to physicians. The SGR was developed in 1997 and starting in 2002 the SGR formula began calling for rate cuts. Congress has consistently enacted temporary legislative fixes to avoid any Medicare cuts to physician rates; the most recent such fix was passed in the Congressional Bipartisan Budget Act of 2013 on December 18, 2013. The possible 10-year freeze discussions would be a potential solution to the rate cuts calculated by the SGR formula.

13. Please provide an update on the implementation of footnote 10 allowing primary care providers to receive reimbursement for providing oral health risk assessments and applying fluoride varnishes up to three times per year for children five years and older.

The Department has been unable to implement the Fluoride Varnish program as the FY 2013-14 Long Bill footnote did not include funding. The Department's FY 2014-15 S-1 Medical Services Premiums Request included a request for fluoride varnishes funding to enable implementation. With appropriate funding, the Department will reimburse primary care providers to provide oral health risk assessments and apply fluoride varnish up to three times a year for children five years and older. The Department will work with the new dental Administrative Services Organization contractor to implement appropriate controls for tracking utilization of the fluoride varnish benefit.

3:10-3:30 PROPOSED RATE INCREASES (R-11)

14. What makes the Department believe that 0.5% for targeted rate increases is a sufficient incentive for providers to change behavior? Should increases aimed at changing provider behavior be a priority when base reimbursement rates are inadequate?

The Department believes a targeted rate increase aimed at specific procedures, programs or behaviors that can improve health outcomes, will increase provider participation in key Medicaid services and have a measurable impact on the value of health care services available to Medicaid clients in Colorado. The Department recognizes that the 0.5% is not an allocation that will solve provider rate deficiencies but this is step in the right direction by allowing our limited resources to be targeted in the most effective way to ensure our clients are receiving value based care. In addition, for those targeted services the amount will be much greater than if spread out in an equal amount across all providers; this will make the targeted increases more impactful for those affected providers. Across the board increases continue to incentivize volume over value and with competing priorities for our state budget the Department wants to ensure it is the best stewards of taxpayer dollars, using our limited resources to promote high quality, cost effective procedures that improve client outcomes and reduce expenditures for the State.

The Department established an internal multi-disciplinary rate-increase workgroup that considered several factors when prioritizing potential targets for the 0.5% targeted rate increase. Among the questions discussed by the workgroup:

- Are there low-cost, high-value, underutilized services that providers can be incentivized to deliver on a more consistent basis to Medicaid clients?
- Are there procedures or visits that are markedly underpaid that raising reimbursement would encourage providers to take Medicaid clients?
- Are there provider behaviors, such as offering extended hours, that if more widely practiced could have a positive impact on problematic issues, like emergency room overutilization?
- Are certain programs falling significantly short of their objectives due to a lack of Medicaid funding, and can the limited funding available through the 0.5% targeted rate increase benefit the programs to the point of consistently servicing the needs of Medicaid clients?

The workgroup used evidence-based research and subject matter expert recommendations to define a preliminary tiered list of potential targets for the rate increase. The proposed list is attached, titled Targeted Rate Increase Recommendations. This list includes the rationale, goal statement and an estimate of the budgetary impact of each proposal.

Targets under consideration are:

1. Increasing the rate for pediatric hospice services that could encourage more providers to serve clients on the Children with Life Limiting Illness (CLLI) waiver, affording clients better access to outpatient services and allowing them to stay in their homes and out of hospitals;

2. Increasing the rate for the Transitional Living Program (TLP) would fund TLP for brain injury patients and serve to reduce costs by shortening hospitals stays and avoiding nursing facility admissions;
3. Increasing reimbursement for in-home respite services, which could increase provider participation and alleviate the need for many clients to utilize residential nursing home services;
4. Increasing the fee for certain complex pediatric developmental assessments, which may increase provider participation and reduce wait list times;
5. Increasing the rate for primary care services rendered after hours in a doctor's office. Evidence shows that after-hours access to primary care providers decreases emergency room utilization;
6. Increasing reimbursement rates for certain specialist codes, such as eye exams and colonoscopies that are currently reimbursed far below Medicare rates. This is aimed at expanding the pool of specialists and timely specialty services available to Medicaid clients.

The Department will seek input from a wide range of stakeholders on these targets and others, and use that input to develop a final list of recommendations for submission to the legislature.

15. Please describe the Department's process for soliciting stakeholder input on the targeted rate increases and the responses from stakeholders to date.

The Department is committed to facilitating transparent and robust stakeholder engagement on how to best utilize the 0.5% targeted rate increase for FY 2014-15. The Department recognizes the importance of engaging with all interested parties in a constructive process. The Department created a Request for Input document (attached), further outlining the process for stakeholder input on the Targeted Rate Increase Recommendations.

The stakeholder input process will consist of:

i. Develop an initial prioritized list of potential rate-increase targets.
The Department convened an internal rate-increase workgroup to identify potential ideas for the increase and develop a process for soliciting stakeholder feedback on the subject. The workgroup used subject-matter expert recommendations and evidence-based research to define a preliminary list of potential targets for the rate increase (attached). In addition to the recommendations drafted, this internal process allowed the Department to identify specific areas that can be addressed through more work with stakeholders and help inform our future budget requests.

ii. Request stakeholder feedback/information
Stakeholders will be asked to consider each option and respond to questions such as:

- How will a proposed rate increase ensure or improve client access to care?
- How might a proposed increase improve quality health outcomes for Medicaid clients?
- How will a proposed increase enhance efficiency, value, and cost-effectiveness of service utilization?

- What proposals will best address gaps in services to better meet the needs of Colorado Medicaid clients?

Stakeholders will be asked to also provide any data based evidence to support their responses to these questions.

iii. **Request further recommendations for proposals beyond those on the list.** Stakeholders will be asked to provide their own recommendations and include the following information:
    - An explanation of the rationale for each proposal and how it aligns with Colorado Medicaid's goal of delivering high-value, cost-effective services;
    - An estimate of the dollar amount that each proposal will add to the total reimbursement for these services during FY 2014-15;
    - Comments on whether or not the proposed increase requires additional legislation to implement;
    - An explanation of how the proposed increase will:
        - Ensure or improve client access to care,
        - Improve quality health outcomes for Medicaid clients, and
        - Address a gap in services to better meet client needs.

When soliciting stakeholder input, the Department will clarify that, in addition to the requested information, other considerations will factor into the final decision of how to allocate the targeted rate increase. These include operational and regulatory considerations, such as the need for a State Plan Amendment or other federal approval process prior to implementation; whether or not system changes will be necessary and if so, what such changes will cost; and what rule changes may be necessary to implement the proposal. Through this process we expect to receive feedback and input that will help illustrate areas to be targeted in our larger payment reform process and help inform our future budget requests.

The Department will be releasing the Request for Information in early January 2014.

16. The proposed process for targeting rate increases creates uncertainty for stakeholders about what their reimbursement rates will be in FY 2014-15. How is this better than a more transparent rate proposal?

The 1.0% rate increase is an across the board increase for all eligible providers. The Department will conduct outreach through professional associations and communications to stakeholders in order to gather input on the 0.5% increase. The proposed process for targeted rate increases includes in-depth internal research on potential targeted increases through an internal multi-disciplinary workgroup dedicated to identifying viable payment rate increases as well as a stakeholder engagement process. The workgroup has conducted analysis on procedures and visits that are reimbursed lower than Medicare rates, including codes that range from 3% of Medicare rates to 99% of Medicare rates. The Department has identified in the attached document, Targeted Rate Increase Recommendations, targeted areas that increasing payments may lead to better access and health outcomes for Medicaid clients. The Department will clearly

communicate that the targeted rate increase is an allocation, in addition to the proposed 1.0% and work to address any provider uncertainty. The Department will actively seek stakeholder input on how to best target the increases, soliciting and responding to feedback in an open and transparent manner.

The Department's list of potential rate increase targets includes the rationale, goal statement and budgetary impact estimate for each increase. The Department will explore advantages and potential drawbacks of each proposed increase, ensuring that the rate increase more-effectively impacts health care value and service availability for Colorado Medicaid clients.

17. Please discuss the adequacy of the provider network and whether the Department's clients have access to timely services. What is the Department doing to improve the adequacy of the provider network?

With 34,767 enrolled Medicaid providers, the Department has built an adequate provider network to meet the majority of the needs of the current caseload of 744,085 Medicaid clients. However, there are still areas where the network can and should be improved. For example, rural clients continue to experience problems accessing both primary care and specialty care. Additionally, providers have reported difficulty accessing a number of key specialty care services, such as neurology and pain management.

Over the last two years, the General Assembly and the Department have implemented a number of reimbursement and outreach initiatives that have significantly strengthened the Medicaid provider network. The Department saw an 8% increase in new providers enrolled in FY 2012-13. Acute care and long-term services and supports providers have also been responding favorably to the recent state approved rate increases. As a result of these rate increases, the Department expects to experience continued strong growth in provider enrollment this year.

Through targeted outreach programs, the Department is actively working to engage new providers and strengthen relationships with current providers. It is important to note that access to care is not just about the number of providers but also about practices improving efficiencies through re-design and process improvement that will allow them to see more patients, more efficiently. The following are the range of activities the Department is engaged in to increase access:

- The Department’s Chief Medical Officer meets with provider groups every four to six weeks. Participants include the Colorado Medical Society, the American Academy of Family Physicians, the American Academy of Pediatrics, and Medical Directors from the seven Regional Care Collaborative Organizations. The Department also recently has a new Chief Nursing Officer who will be conducting outreach to nursing professionals.
- The Accountable Care Collaborative (ACC), Colorado’s flag ship service delivery model, was designed to build regional networks of care. The ACC’s seven Regional Care Collaborative Organizations (RCCOs) started with creating a base of Primary Care Medical Providers (PCMPs) and are now working to link these providers with a comprehensive system of specialty care.

- Through the ACC our RCCO partners are working with practices to help re-design work flow and processes to increase efficiency and to be medical homes that provide comprehensive care.
- The Provider Outreach position funded by a grant from the Health Resources and Services Administration has proven extremely valuable in improving relationships with providers; the Department is seeking ways to continue this position beyond the grant period.
- The Department's benefit managers work closely with provider association groups and individual providers to design and implement programs that are attractive and support provider efforts to deliver the highest quality care.
- As specialist participation is a problem for Medicaid programs nationwide, the Department has recently begun meeting with a specialist stakeholder group to explore reimbursement and other strategies that can likely increase specialist enrollment (for more information see questions #29 and #30).

Other initiatives underway to expand the provider network include:

- Contracted reporting on network adequacy and utilization by managed care providers, including the Behavioral Health Organizations (BHOs) and RCCOs to identify and address significant gaps;
- Sustain the enhanced primary care reimbursement rate (BA-10);
- R-11 budget request for reimbursement rate increases;
- Telehealth opportunities to more effectively and efficiently leverage specialty care; and
- Specialty care reimbursement strategies to compensate specialists for different treatment levels.

A key indicator of provider network adequacy is whether or not clients have timely access to health care services. The Department relies on both informal and formal methods to gather this information directly from clients and providers. Results from the FY 2012-13 Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey of Medicaid clients revealed that 78-84% of adults and 82-90% of children were able to access necessary medical treatments in a reasonable time frame. The Department is exploring a variety of methods to improve the timely delivery of health care services with a goal that greater than 90% of both adults and children are able to access services when needed.

Beyond expanding the provider network, the Department is currently involved in the following efforts to monitor and improve the ability of clients to access necessary treatment.

- All of the Department's managed care contracts, including the ACC, BHOs, Denver Health, Rocky Mountain Health Plans include regular reporting on standard access times for urgent care, routine care, and non-symptomatic care. Contractors are responsible for creating detailed plans to remedy any significant deviations from the agreed upon standard access times.

- A particular focus for the Department is on supporting primary care providers in delivering a broader array of services within the scope of their license; this is often referred to as comprehensive primary care. Telehealth programs, such as Project ECHO and Doc2Doc, are potential vehicles to assist providers in delivering higher levels of care and using specialists more efficiently. The Department requested funding in its November 1, 2013 R-9 Budget Request to investigate and implement a robust telehealth program.
- The ACC features a number of initiatives to bolster the capacity of the regional networks, including streamlining referrals for specialists and providing care coordination that addresses non-medical barriers to accessing care (e.g., transportation).

Through these various methods, the Department expects to make significant progress over the next two years in expanding the provider networks and reducing the time it takes for clients to access necessary medical treatments, both within primary and specialty care.

18. If the JBC approves a similar dollar amount as requested in the Department's R-11 1.5% Provider Rate Increase, but votes that the funding should be distributed as an across-the-board increase, rather than a targeted increase, will the Department be bound by that decision?

If the Joint Budget Committee votes that the funding should be distributed as an across-the-board increase, the Department would comply with the Committee's direction.

3:30-3:40 BREAK

3:40-4:00 HOME AND COMMUNITY BASED SERVICES & CONSUMER DIRECTION

19. Please discuss expenditure trends for the Consumer Directed Attendant Support Services (CDASS).

Consumer Directed Attendant Support Services (CDASS) is a service delivery option that allows clients to maintain their own budget for attendant services (personal care, homemaker, and health maintenance activities) and pay their attendant the rate they choose (within the established wage cap). CDASS is available in the following Home and Community Based Services (HCBS) waivers – Elderly Blind and Disabled (EBD), Community Mental Health Services (CMHS), and Spinal Cord Injury (SCI).

There continues to be significant growth in total CDASS expenditures and the number of clients accessing CDASS. Although the CDASS expenditures have increased, the average cost per participant has decreased each fiscal year.[1]

[1] The Department's analysis is based on the date that services were provided. This differs from how the Department projects the budget for this program, which is based on the date that claims were paid. The Department believes the date-of-service analysis provides a more accurate look at the underlying trends in the program.

In an effort to balance clients' health care needs while containing costs and increasing health outcomes, the Department is working with stakeholders through the Participant Directed Programs Policy Collaborative (PDPPC) to implement policy and program changes to ensure CDASS is programmatically stable and financially sustainable.

The following table show the total expenditures for CDASS and cost per client across the three HCBS waivers over the last five fiscal years.

Consumer Directed Services and Supports (CDASS) Expenditure Data					
Fiscal Year	**Unique Clients**	**Expenditure**	**Percent Change**	**Expenditure Per Client**	**Percent Change**
FY 2008-09	860	$30,082,555		$34,979.72	
FY 2009-10	1,158	$40,280,682	33.90%	$34,784.70	-0.56%
FY 2010-11	1,764	$53,168,218	31.99%	$30,140.71	-13.35%
FY 2011-12	2,259	$63,933,318	20.25%	$28,301.60	-6.10%
FY 2012-13	2,799	$76,708,563	19.98%	$27,405.70	-3.17%

- Total expenditure and clients include three waiver programs; the Elderly, Blind, and Disabled waiver, the Community Mental Health Supports waiver, and the Spinal Cord Injury waiver.
- Expenditure is considered part of the fiscal year in which it was incurred, not when claims were paid. Therefore, this table may vary from other reports produced by the Department.

20. Please discuss opportunities for performance incentives in Consumer Directed Attendant Support Services.

Currently the Department does not offer any performance incentives for any of its Long-Term Services and Supports programs except a limited pay for performance opportunity for nursing facilities. The Department is working with stakeholders through the Participant Directed Programs Policy Collaborative to implement an extensive work plan to improve Consumer Directed Attendant Support Services (CDASS). One of the items on the work plan is to evaluate the feasibility of re-implementing an appropriate performance metric. The Department would like to explore options in the future for performance incentives for all of our Long-Term Services and Supports, not just for CDASS.

21. What new Medicaid options is the Department considering for home and community based services?

The Affordable Care Act provided two new options for home and community based services, the Balancing Incentive Program (BIP) and Community First Choice (CFC). The BIP was only available to states that spend more than 50% of their long-term supports budget on institutional services. The BIP authorized grants to states to increase access to non-institutional long-term services and supports. Colorado was not eligible for the BIP because the state spends 56% of the

long-term services budget on home and community based services and 44% on institutional services. However, the state is working to increase access to home and community based services by implementing many of the requirements of the BIP. Specifically, through the subcommittees of the Community Living Advisory Group, the state is working on the following:

- "No Wrong Door" approach for access to services- Entry Point/Eligibility Subcommittee
- Conflict Free Case Management- Care Coordination Subcommittee
- Core Standardized Assessment- Waiver Simplification Subcommittee

Community First Choice (CFC), authorized in section 1915(k) of the Social Security Act, allows states to put some services that are traditionally only available in Home and Community Based waivers into the Medicaid state plan at an enhanced federal match. Through CFC, participants would have the option to direct their attendant care services or to receive services through an agency. Attendant care services are those that assist in accomplishing:

- Activities of daily living such as eating, dressing and bathing;
- Instrumental activities of daily living such as shopping and keeping doctor appointments;
- Health-related tasks such as medication monitoring.

The Department is determining the feasibility of implementing CFC. Please refer to question #22 for a more detailed status update.

22. Please provide a status update on the Community First Choice initiative. What are the enhanced federal match opportunities? When will the feasibility report be released to the public? Does the Department support legislation for implementation in 2015?

The Department supports many of the goals of Community First Choice (CFC) including person centered planning, eliminating conflicts of interest, expanding participant directed service delivery options and providing services in the community based on functional need rather than based on age or diagnosis. Due to significant policy, financial and operational complexities within the current system, a 2015 implementation of CFC is not feasible. The Department is working towards addressing these barriers in collaboration with stakeholders and within existing stakeholder processes.

The Department believes more analysis and modeling needs to be done to fully understand the implications of CFC in Colorado, including the following:

- Analyzing final federal rules on home and community based setting (not yet published in Federal Register)
- Determining service delivery options
- Analyzing the fiscal impact of providing personal care and health maintenance services in the community as well as in the home
- Exploring the fiscal and operational impact of changes to Long-Term Home Health (LTHH)
- Eliminating conflicts of interest

Once the policy and financial decisions have been made the Department will need to operationalize CFC, which in summary may require:

- Amendments to home and community based services waivers
- Amendments to the State Plan
- Legislative changes
- Regulatory promulgation and revision
- IT system changes
- Rate development
- Provider and case management training
- Outreach and communication to families and individuals

The Department established a CFC Council that has been meeting monthly since September 2012. The Department contracted with Mission Analytics Group to prepare the feasibility study. The CFC Council has been deeply involved with the study and provided continuous feedback to Mission Analytics.

The feasibility study created modeling to determine the cost of CFC implementation. The study, posted online on December 30, 2013, identified a number of issues to be addressed, some of which may help to reduce the ultimate cost.[2] Congress has incentivized states to adopt CFC by authorizing a higher federal match on CFC related Medicaid expenditures. Under CFC, Colorado would pay approximately 44% of program costs instead of the 50% it currently pays on most services. Even with the higher reimbursement, the cost is estimated to be between $46 and $79 million General Fund ($133 to $212 million total funds) on an annual, on-going, basis.

The CFC Council discussed the feasibility study in more detail at the January 6th Council meeting. The changes necessary for CFC implementation represent a significant re-design of Colorado's Medicaid Long-Term Services and Supports system and time is needed to work through the changes needed for successful implementation.

23. What is the Department doing to comply with the 1999 Olmstead decision? How many people have been transitioned from skilled nursing facilities to the community?

<u>Olmstead Decision</u>

Since the Olmstead decision in 1999, the Department has made significant efforts in transforming its long-term services and supports programs to serve clients in the least restrictive environment possible. Presently, Colorado serves a large majority of individuals who require long-term services and supports in a home and community based setting (HCBS), rather than in institutional care. In a United States Senate committee report, Colorado was cited as a model for diverting people from institutional care. [3]

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[2] http://tinyurl.com/nxb4cnb

[3] United States Senate Health, Education, Labor, and Pensions Committee, *Separate and Unequal: States Fail to Fulfill the Community Living Promise of the Americans with Disabilities Act*

Serving clients in the community requires multi-agency collaboration to address issues of access to other publicly funded programs such as housing and transportation. The Department is working with the Colorado Department of Human Services (DHS) and the Division of Housing at the Department of Local Affairs (DOLA) to develop an Olmstead Plan to identify what the state is currently doing right and goals for furthering Olmstead in Colorado. The plan is anticipated to be released in late January or early February 2014. Presently, CDHS and the Department are in the process of establishing transitional services for individuals residing in long-term care facilities. Specifically, the Department has launched Colorado Choice Transitions (CCT).

Colorado Choice Transitions

Colorado Choice Transitions (CCT), which launched in April 2013, provides additional support for assisting people to transition from nursing facilities and will help transition more difficult to place clients as the program matures. Just in the last seven months the Department transitioned 21 clients through CCT and 13 clients using transition services available through the Elderly, Blind and People with Disabilities waiver. The program currently has 156 people working with transition coordinators who have started the process of transitioning out of nursing facilities.

4:00-4:10 PRIMARY CARE SPECIALTY COLLABORATION (R-10)

24. Please describe the involvement of specialists in developing this proposal. Who has the Department consulted? What makes the Department believe that specialists will support the proposal and will participate in the program?

Stakeholders have expressed support for a multi-pronged solution to enhance specialist participation in Medicaid, including an electronic consultation program. The Department has held two specialty care reform stakeholder meetings and another is scheduled for January 15, 2014.

The Department's FY 2014-15 R-10 "Primary-Specialty Care Collaboration" requests authority for specialty payment reform and to explore the feasibility of creating an electronic consultation program similar to the Doc2Doc program. Medicaid primary care providers and specialists have been involved in conversations with the Department to develop ideas on how to improve specialty participation in Medicaid. The Doc2Doc program was originally introduced during a Regional Care Collaborative Organization (RCCO) Medical Neighborhood Round Table in February 2013. Follow-up discussions with regional providers and industry leaders revealed the program may be part of a comprehensive solution to bolster primary care and enhance access to specialty care in the Accountable Care Collaborative.

Specialty care providers in other states are reported to prefer electronic consultation systems as it allows them to quickly review and decide on a case (the average time spent per referral/consult is 2-4 minutes) on their own time rather than having to use a full office visit to realize that they did not need to see the client. In northeastern Oklahoma, the Doc2Doc program has received more than 110,000 referrals connecting 2,100 regional providers and services (imaging, labs, etc.).

The Department has consulted with the following stakeholders:

- RCCO leadership
- Colorado Medical Society
- Colorado Chapter of the American Academy of Pediatrics
- Children's Hospital Colorado
- Colorado Radiological Society
- Colorado Society of Anesthesiologists
- Colorado Chapter of American College of Emergency Physicians
- Colorado Psychiatric Society
- Colorado Chapter of the American Academy of Family Physicians
- University of Colorado, School of Medicine
- Kaiser Permanente
- Denver Health and Hospital Authority
- Clinica Family Health Services
- Colorado Community Health Network

With continued stakeholder input, the Department is confident it can design a solution that will increase specialty care participation in Medicaid and support Colorado providers in delivering higher quality care more efficiently.

25. What is the potential liability for specialists who provide consultation services through the Department's proposed R-10 Primary Care Specialty Collaboration? Will provider aversion to accepting the liability without an in-person visit be a barrier to successful implementation of the program?

Liability concerns have not been a barrier to specialist participation in other states. In fact, research on electronic programs nationwide indicates that specialty care providers often prefer electronic consultations, as these systems:

- deliver more complete clinical information;
- allow providers to review the consult/referral on their own time;
- support providers in quickly triaging patients; and
- reduce avoidable office visits.

The Department does not expect the electronic consultation program described in its FY 2014-15 R-10 "Primary-Specialty Care Collaboration" request to create any added medical liability for participating providers. Doc2Doc and other similar electronic consultation programs are an advanced, technological sort of informal consultation doctors frequently provide each other, often known as a "curbside consultation." These types of consultations have been used for many years and occur every day in hospital hallways, by phone and through email. Telehealth systems provide an opportunity to structure consultations to ensure specialists receive the comprehensive clinical information needed to provide useful guidance to the primary care practitioner. The system documents the interaction between physicians and tracks follow-up care, often providing greater liability protection for specialists. While the Department does not expect any added liability concerns, the Department will conduct a thorough legal analysis of the proposed electronic consultation system prior to implementation.

The Department realizes that an electronic consultation program will not be effective unless the program is designed to encourage specialist participation in Medicaid. The Department has already begun stakeholder meetings on specialty care reform and specialists have expressed interest in pursuing Doc2Doc as part of a comprehensive solution to address specialty care access in Medicaid. Given the experience of other states and feedback stakeholders have already provided, the Department is optimistic that electronic consultation will successfully expand access to specialty care.

4:10-4:25 APPLICATION PROCESSING

26. The Department's statistics on the timely processing of Medicaid applications show that the state is falling just short of the court-ordered goal of 95% timely determinations. Why is closing the final performance gap proving challenging? What is the Department doing to improve performance? How does Colorado's performance compare to other states? Was the court-ordered goal a reasonable and realistic objective?

Why is closing the final performance gap proving challenging?

Over the last six months, Colorado's timely processing has maintained at around 93-94% of new applications. Closing the final performance gap is challenging. At this level of performance, the 1 or 2 percentage points can be as simple as losing key staff at an eligibility site. The counties, eligibility sites and the state are committed to improving business processes to make eligibility determinations more streamlined.

What is the Department doing to improve performance?

The Department has embraced the LEAN Six Sigma methodologies to improve processes coupled with information technology system enhancements to automate processes. The Department's business process improvement initiatives include all county departments, Medical Assistance sites and the Department of Human Services (DHS) through the Colorado Eligibility Process Improvement Collaborative (CEPIC). CEPIC is funded through the Colorado Health Foundation with matching federal funding and takes private industry quality and process improvement methodologies and applies it to Medicaid and CHP+ application processing. The Department is also creating efficiencies through offering online self-service options for customers. For instance, the Department allows consumers to apply and update their information online and has reduced the need for applicants to provide paper verifications by implementing electronic interfaces to obtain necessary verifications.

How does Colorado's performance compare to other states?

The Department was not able to locate publicly available data on the processing time for most states. Of the few states where application time was publicly available, North Carolina is processing at 88% timely and Connecticut processes at 78% timely.

Was the court-ordered goal a reasonable and realistic objective?

The Department is committed to achieving the highest possible performance and is continually working with all our partners to improve that performance. More time is needed to evaluate the impact of system and business process enhancements to determine what the highest possible processing percentage will ultimately be.

27. What are the wait times for people seeking phone service from the Department and from Connect for Health Colorado? How do the agencies try to minimize the impact of hold times on the users' experience?

The Department cannot speak to the wait times for people calling Connect for Health Colorado.

The current call wait time for clients calling the Department's call center is approximately 50 minutes. It is important to note that the Department's customer contact center has seen a 45% increase in call volume since October 1, 2013.

The Department's customer contact center is currently staffed by 12 FTE and provides support for more than 800,000 Medicaid and Child Health Plan *Plus* (CHP+) clients. In an effort to reduce wait times and improve client experience, the Joint Budget Committee granted the Department funding in FY 2013-14 to implement a modern, cloud-based call center technology. Through this system, the Department has been able to provide guidance to many callers by relaying information on Frequently Asked Questions while the client is waiting for a representative. The new system also informs clients that they can apply for Medicaid online and educates callers on self-service options through PEAK. For example, prior to its launch, the call center received an average of 3,500 calls per month from customers requesting a replacement Medicaid ID. The new system allows for clients to request the replacement card without having to speak to a representative. Since October 1, 2013 the Department has seen a dramatic reduction in Medicaid ID replacement-related calls.

The Department is utilizing its existing contract for the Eligibility and Enrollment Medical Assistance Program (EEMAP) vendor to handle the increased volume of calls related to Connect for Health Colorado and the implementation of the Affordable Care Act. The EEMAP call center is staffed with 25 FTE and receives over 6,000 calls with over 1,000 calls answered daily. Calls take longer as the callers are assisted with their application over the phone. The Department anticipates that volumes and wait times will stabilize after the Marketplace's open enrollment closes March 31, 2014.

28. When eligibility is determined, what personal information is collected about the applicant and how is the security of this personal information maintained?

A considerable amount of personal information is required for the application including full legal name, address, Social Security number, date of birth, employer and income information, information about people in the household and citizenship information. This information is needed in order to meet the requirements of federal law and to accurately determine eligibility for Medicaid. Where appropriate, counties keep a written record of this information. The Department also keeps an electronic record of this information.

The Department and counties along with vendors (Business Associates) involved in processing applications fall under the requirements of the Health Insurance Portability and Accountability Act (HIPAA). In general, HIPAA requires custodians of protected health information to develop policies for employees to follow, and electronic system requirement standards that protect the information from outside disclosure. For example, standard HIPAA policies require all employees to be trained in HIPAA requirements within 60 days of beginning their employment. It is also standard for that training to continue annually for all employees. Systems are required to log the identity of persons accessing information. Upon termination, ex-employees are removed from authorization for electronic access. All application data collected is protected by the federal HIPAA regulations.

29. For people handling personal information as they assist applicants for publicly-funded health programs, including both the programs operated by the Department and the tax credits available through Connect for Health Colorado, are there background check requirements? What screening of employees occurs to ensure the privacy of the information? What are the sanctions for inappropriate use of the information and who is liable?

The Department cannot speak to the screening processes conducted by Connect for Health Colorado.

All Department employees are subject to criminal background checks before hire. Counties may conduct background checks on their employees and many county agencies perform criminal background checks as part of their hiring process. Application vendors of the Department are required to perform background checks when their work involves protected health information (PHI).

State and county employees are subject to discipline including termination for failing to follow Health Insurance Portability and Accountability Act (HIPAA). The Department retains the right to require that a vendor remove an employee from Department work when the employee has violated HIPAA. The Department, county eligibility workers and Medical Assistance sites (MA sites) are bound by the federal HIPAA regulation regarding PHI. Breaches of PHI for any individual must be reported to federal agencies including the Office for Civil Rights. The Department is fully liable for breaches by county departments and jointly liable for breaches by vendors (who have a Business Associate Agreement with the Department). The Office for Civil Rights has the power to impose fines as a sanction for failing to follow HIPAA. Department

vendors are required to reimburse the Department when a fine is levied due to the conduct of the vendor.

Where circumstances surrounding the breach indicate a possible criminal violation (theft or fraud), the conduct is reported to the Medicaid Fraud Control Unit of the Office of the Attorney General for review for possible involvement of other federal agencies. The incident is also reported to local police for investigation and possible criminal prosecution.

30. How will Medical Assistance sites be reimbursed?

Currently Medical Assistance (MA) sites do not receive reimbursement for application processing. In its R-6 budget request, the Department requested funding for a study to assist in the alignment of payment methodologies for all eligibility sites. Under this request, the Department plans to evaluate, recommend and implement the most effective reimbursement structure that will support and sustain the statewide application site network. The Department anticipates this study would guide the Department in creating the MA site reimbursement methodology. Additionally, the Department would create a stakeholder workgroup to evaluate and implement a payment plan.

31. Is the Department making any changes to the Random Moment Sampling system as part of R-6 Eligibility determination enhanced match, and if so, please describe those changes?

The Department worked closely with the Department of Human Services (DHS) to change Random Moment Sampling (RMS) activity coding. The RMS is a system that tracks county workers' activities to determine how costs are split between programs. The code changes were required to be able to receive the enhanced funding for County Administrative activities. Previous codes included some activities that were eligible and some that were not within the same code. As a result, the Departments split the codes to allow eligible activities to receive the 75% enhanced funding. These changes have already been made and have been submitted by DHS for approval in the annual cost allocation (Public Assistance Cost Allocation Plan) approval process. In addition to changes to the RMS, the Departments created a code to allow counties to directly report costs associated with the 75% match activities.

4:25-4:35 UTILIZATION REVIEW

32. Please provide an overview of R-13 Utilization review. To some members of the JBC it feels like there is a component of the request every year related to utilization review, especially for pharmaceuticals. How does this request fit with funding provided in prior years and the utilization review performed by the Department in general? Is it time for a comprehensive look at the Department's utilization review activities?

The Department conducts utilization review of Medicaid services, including review of clients who receive long-term services and supports (LTSS) and review of prescription drug therapy. These services are delivered in whole or in part by contracted vendors. The current funding level for LTSS utilization reviews has remained unchanged since 2002, despite increases in caseload

and scope of work, and the Department does not believe it would be able to procure another vendor after the current contract expires on June 30, 2014 at the current funding level. The Department's current budget for drug utilization review (DUR) does not allow for analysis of complex prescription drug cases. Due to funding limitations, drug utilization reviews are performed by Department staff, while the DUR vendor analyzes the data and offers a clinical interpretation. This arrangement provides severe limitations to the types of cases that can be reviewed.

LTSS Utilization Review

Utilization review of LTSS is done by two types of vendors: 1) a Quality Improvement Organization (QIO) that performs a number of clinical reviews on LTSS clients, and 2) single entry points (SEPs), which are comprised of 20 counties and three private entities that perform non-clinical assessments and identify local resources to match services to a client's needs. In 2009, the Department learned that SEPs do not qualify as a QIO, thus reviews conducted by SEPs are not eligible for an enhanced 75% federal match, as had been previously assumed. This reduced the total funds appropriation for SEPs by 50%.

The Department has recently learned it is out of compliance with federal requirements relating to preadmission screening and resident review level I (PASRR I) reviews performed by the QIO. Approximately 50% of Preadmission Screening and Resident Review (PASRR) I reviews are automatically approved. When a client is automatically approved, an actual review is not performed. Federal requirements now require that PASRR I clients be reviewed annually, prohibiting any further automatic approvals. The Department expects that this federal requirement will double the current PASRR I review annual caseload, as some clients require more than one review per year.

Drug Utilization Review (DUR)

At present, the Department has one pharmacy staff who conducts retrospective reviews of prescription drug utilization. The DUR vendor maintains two pharmacists and one analyst who receive the reviews from the Department, analyze the reviews, provide a clinical interpretation, and create a presentation consisting of narrative, evidence and recommendations that is presented quarterly to the DUR Board. The DUR vendor does four, in-depth drug-class reports per year and frequently identifies areas for clinical efficiencies and cost savings.

Currently, case review is inconsistent in some areas and non-existent in others. Cases involving drugs prescribed to treat multiple sclerosis, chronic pain or psychiatric disorders are reviewed by Department pharmacy staff. Many of these cases are complex and would benefit from additional review by experts in the respective fields. Cases involving drugs prescribed to treat cancer are not currently reviewed. The DUR vendor has access to specialists and could provide additional review of these drugs. The level of expertise required to perform these reviews cannot be afforded by the current appropriation for drug utilization review and is beyond the scope of knowledge of a general pharmacist. In addition, the Department would like to have experts

available for Medicaid providers to use to consult about complex clients. The Department does not have that expertise in-house and the DUR vendor can provide experts for the peer-to-peer consultations. Without these services, clients with these diagnoses may receive unnecessary or duplicative drug treatment, due to a lack of analysis of their prescription regimens by clinical experts. Reviewing these cases could reduce cost and improve the health of the client.

For further details, please see the R-13 decision item in the Department's November 1, 2013 Budget Request.[4]

Prior Year Utilization Review Funding Requests

The Department's most recent stand-alone requests for utilization review funding were submitted in November 2009 and January 2010, and related to reprocuring and expanding the Department's acute care utilization review contractor. However, the Department frequently includes requests for utilization review funding as part of other budget requests and fiscal notes. For example, in FY 2013-14, the Department received utilization review funding for new caseload as part of SB 13-200, and utilization review funding related to administering the adult dental benefit as part of SB 13-242 (originally requested via the Department's FY 2013-14 R-8 budget request).

Utilization review is a critical and federally required component of managing the Medicaid program and covers all Medicaid services including prescription drugs, long-term services and supports, durable medical equipment, home health and many other services. Most reviews are prospective, which means that clients cannot receive services until the reviews are complete. Although the Department has taken steps to automate many prior authorization reviews, particularly related to prescription drugs, many processes, including the PASRR reviews and drug utilization reviews requested in R-13, require manual review. As Medicaid caseload increases, the workload for the Department's utilization review contractors also increases, as those vendors have more cases to review. Without proper funding, Medicaid clients may experience unnecessary delays in receiving services while they wait for these contractors to review their cases.

Although the Department forecasts Medicaid caseload and services expenditure through multiple budget requests each year, the Department does not frequently request funding for utilization review contracts related to caseload. Because available revenue is limited, the Department understands that it must encourage its contractors to live within fixed budgets. The Department requests funding only for major changes that require significant modifications to staffing levels. In general, the Department has been successful in maintaining a robust utilization review program, by constantly reviewing those items and services under review, making changes to prior authorization requirements where necessary, and automating processes when possible. However, the Department's contractors cannot indefinitely absorb additional workload. As a result, the Department must periodically request additional funding through the budget process.

[4] Colorado Department of Health Care Policy and Financing. *FY 2014-15 Budget Requests*. November 1, 2013. http://tinyurl.com/mx758se

The Department does not believe that this process should change; requesting funding through the budget process provides for an open and transparent accounting for the Department's proposals.

4:35-4:45 MEDICAID PROJECTIONS AND EXPENDITURES

33. What is the average length of stay on Medicaid and on the Children's Basic Health Plan (CHP+)?

The table below shows average length of stay for Medicaid and Child Health Plan *Plus* (CHP+) clients with dates of enrollment in FY 2008-09 through FY 2012-13.

Medicaid and CHP+ Average Length of Stay in Months							
Fiscal Year(1)	**Categorically-Eligible Low-Income Adults**	**Expansion Adults to 60% FPL**	**Expansion Adults to 100% FPL**	**Eligible Children**	**Baby Care Adults**	**CHP+ Children**	**CHP+ Prenatal**
FY 2008-09	14.91	13.05	-	17.72	10.12	14.57	8.02
FY 2009-10	16.05	14.11	11.42	19.01	10.03	12.97	7.58
FY 2010-11	14.03	14.02	12.27	15.49	10.33	12.09	7.29
FY 2011-12(2)	*14.02*	*15.89*	*13.84*	*16.1*	*10.53*	*9.75*	*6.54*
FY 2012-13(2)	*12.59*	*13.30*	*11.08*	*13.95*	*8.96*	*8.86*	*5.48*

(1) Figures reported for each fiscal year represent the average length of stay for clients that had at least one date of eligibility within the fiscal year.
(2) Because many clients that had dates of eligibility in a given year are still eligible and therefore have unknown actual lengths of stay on Medicaid/CHP+, figures for all fiscal years are understated (potentially significantly). This is particularly true for FY 2012-13, and to a lesser extent FY 2011-12. For example, there are clients that enrolled in June of FY 2012-13 that will be on Medicaid for a year or more, but show a total length of stay of only six months due to the lack of future period data. Since these clients are contributing a lower length of stay to the average than their true length of stay, it artificially skews the aggregate statistic downward.

34. How does the Department measure the churn of clients gaining and losing access for Medicaid and CHP+? What is the Department doing to minimize churn and any potential negative impacts for health outcomes associated with it?

Churn is defined as the monthly movement of individuals on and off of the Medicaid and Child Health Plan *Plus* (CHP+) programs, largely for income fluctuations, and is measured by identifying the coverage gaps of individuals. Approximately 3% (or 30,000) of the population with earned income experiences churn within a year.

Children enrolled in CHP+ currently receive 12 months of continuous eligibility, regardless if there are changes to their family's income or household size.

Although the passage of HB 09-1293 gave the Department the authority to begin providing 12 months of continuous eligibility to children covered by Medicaid, the Department was not given spending authority to implement continuous eligibility for Medicaid children until SB 13-200. This policy change and is scheduled for implementation in spring 2014.

With the implementation of the Affordable Care Act, changes were made to reduce the churn for all Medicaid and CHP+ populations. If a discrepancy in earned income is identified through an electronic source that impacts eligibility, the adults, parents and children are first given an opportunity

to provide a reasonable explanation for the reported difference and then to provide current income information. Prior to this change, families were moved immediately based on the income reported from the interface.

35. What is the Department's projection of the portion of the state population enrolled in Medicaid? Please estimate the portion of baby deliveries and expenditures attributable to Medicaid and the portion of long-term care services attributable to Medicaid.

State Population Enrolled in Medicaid

In FY 2012-13, an estimated 13.06% of Colorado's population was on Medicaid. The Department estimates this will grow to 18.69% by FY 2015-16. The following table provides a two-year history and three-year forecast of Medicaid enrollment relative to total Colorado Population.

Percentage of Colorado Population on Medicaid			
Fiscal Year	Total Colorado Population(1)(2)	Medicaid Caseload(3)	Average Percent of Colorado Population on Medicaid
FY 2011-12	5,153,605	619,963	12.03%
FY 2012-13	5,231,201	682,994	13.06%
FY 2013-14	5,318,704	813,250	15.29%
FY 2014-15	5,409,878	967,681	17.89%
FY 2015-16	5,504,297	1,028,871	18.69%

(1) State Demography Office: http://www.colorado.gov/cs/Satellite?c=Page&childpagename=DOLA-

(2) Averages between calender years were utilized to estimate fiscal year population.

(3) R-1 "Medical Services Premiums", FY 2014-15 Budget Request, November 1, 2013, Exhibit B, page EB-1.

Births Covered by Medicaid

In FY 2012-13, 4 out of 10 births in Colorado were covered by Medicaid. FY 2012-13 expenditures are summarized in the table below. The Department reports detailed statistics on Medicaid births in the annual Performance Plan, submitted in November.[5]

[5]Colorado Department of Health Care Policy and Financing FY 2014-15 Performance Plan, http://tinyurl.com/lcwx5lp

FY 2012-13 Medicaid Deliveries and Associated Gestational/Post-Partum Expenditures by Delivery Type			
Delivery Type	**Unique Deliveries**	**Total Payments**	**Average Payment**
Caesarian	5,772	$55,680,231	$9,647
Vaginal	18,423	$124,227,329	$6,743
Unknown/No Delivery Information	1,977	$12,370,040	$6,257
Total	**26,172**	**$192,277,600**	**$7,347**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to 45 days after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only. Deliveries not classified (unknown) were identified via antepartum/stand-alone claims. Delivery method could not be ascertained with this data.

Long-Term Care Expenditures

Several national studies have been conducted that provide insight regarding the relative percentage Medicaid comprises of total Long-Term Care expenditure. Based on 2011 national data, The Kaiser Family Foundation reports that Medicaid is the payer for approximately 40% of total national expenditure on long-term care services[6]. *Statista* reports a declining trend in the proportion of national Medicaid spend on institutional care from 1990 to 2011 (from 87% to 55%), but an increasing trend in home and community-based care during the same period (13% to 45%).[7]

36. Please provide an extended forecast of state obligations for Medicaid through 2020. What portion of the cost is attributable to the SB 13-200 expansion?

The following table summarizes estimated expenditure through FY 2019-20, and itemizes the portion of total expenditure attributed to clients newly eligible under SB 13-200. Please note that populations authorized under HB 09-1293 or already eligible for Medicaid are not included in the newly eligible category in the table even though these populations may have been included in the fiscal note for SB 13-200. The tables below include expenditure for both physical and behavioral health. Lastly, the Department cautions that these figures represent very rough estimates of future Medicaid costs. Medicaid expenditure is highly variable based on economic conditions; for example, Medicaid caseload tends to increase rapidly during economic recessions. Long-term forecasts of economic conditions are not generally reliable. Since the necessary economic data for the time periods included is not currently available, the Department's projection relies on a simple trend to provide out year costs. This forecast should only be used as a rough guide to future costs.

[6] http://kff.org/medicaid/fact-sheet/five-key-facts-about-the-delivery-and-financing-of-long-term-services-and-supports/
[7] http://www.statista.com/statistics/245439/distribution-of-medicaid-long-term-care-services-expenditures-by-type/

Total Medicaid Service Expenditure and Extended Forecast (Figures in Millions)
SB 13-200 State Obligations

Fiscal Year	Total Funds	General Fund	Cash Funds	Federal Funds
FY 2016-17	$207	$0	$5	$202
FY 2017-18	$214	$0	$12	$202
FY 2018-19	$220	$0	$14	$206
FY 2019-20	$227	$0	$19	$208

Note: While the SB 13-200 expansion is effective January 1, 2014, there is no state funds impact for newly eligible clients until FY 2016-17. Consequently, FY 2013-14 and FY 2014-15 newly eligible expenditures are not shown.

Total Medicaid Service Expenditure and Extended Forecast (Figures in Millions)

Fiscal Year	Total Funds	General Fund	Cash Funds	Federal Funds
FY 2011-12	$3,919	$1,341	$642	$1,936
FY 2012-13	$4,242	$1,494	$657	$2,091
FY 2013-14	$5,166	$1,675	$669	$2,822
FY 2014-15	$5,987	$1,732	$629	$3,626
FY 2015-16	$6,361	$1,839	$628	$3,894
FY 2016-17	$6,718	$1,865	$715	$4,138
FY 2017-18	$6,982	$1,931	$766	$4,285
FY 2018-19	$7,217	$1,998	$806	$4,414
FY 2019-20	$7,433	$2,068	$859	$4,507

37. Discuss the impact on hospitals when the enhanced federal match rate for expansion populations is reduced from 100% to 90%. How will this impact their bottom line and financial viability?

Pursuant to SB 13-200, the Hospital Provider Fee is the source of funding for 100% of the state share of expansion populations as the federal financial participation rate is reduced. The rate steps down from 100% to 90% between CY 2017 and CY 2020, and there is a corresponding increase in the fee obligation to hospitals. Below is a chart depicting the step down rate with corresponding federal and state match rates. The state share will be covered using Hospital Provider Fee and will not use General Fund dollars.

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

The Hospital Provider Fee provides an overall net benefit to hospitals. Expansion populations funded by the Hospital Provider Fee and SB 13-200 greatly decreases the number of uninsured Coloradans, reducing the amount of uncompensated care provided by hospitals. In addition, the Hospital Provider Fee funds supplemental payments to increase reimbursement for care provided to Medicaid and Colorado Indigent Care Program clients.

38. Discuss the constitutionality of the Hospital Provider Fee and whether it is truly a fee or whether it is a tax that requires a vote of the people for approval.

Please see the attached Office of Legislative Legal Services Legal Memorandum dated December 22, 2008 regarding whether a "Hospital Provider Fee" is a tax for purposes of section 20 (4) (a) of article X of the Colorado Constitution. The memorandum concludes:

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

39. Using the Department's most recent forecast, compare the estimated Medicaid costs and CHP+ savings associated with S.B. 11-008 Aligning Medicaid eligibility for children and S.B. 11-250 Eligibility for pregnant women in Medicaid.

The following tables summarize the revised fiscal impact estimates of SB 11-008 and SB 11-250, both of which migrated clients from the Child Health Plan *Plus* (CHP+) program to Medicaid under the assumption that the overall costs for the Medicaid program would be lower than in CHP+. The Department has accounted for these savings as part of its November 1, 2013 Budget Requests R-1 and R-2.

Table 1: SB 11-008: "Aligning Medicaid Eligibility for Children" Revised Fiscal Impact Estimates

Row	Item	Fiscal Year			Source/Calculation
		FY 2012-13	FY 2013-14	FY 2014-15	
A	Migrated Caseload	8,237	25,600	26,987	FY 2014-15 R-1: "Medical Services Premiums" Exhibit B
B	Average Per Capita in CHP+	$2,063.49	$2,201.30	$2,348.32	FY 2014-15 R-3: "Children's Basic Health Program" Exhibit C3
C	Average Per Capita in Medicaid (Physical Health)	$1,210.54	$1,271.06	$1,334.62	FY 2014-15 R-1: "Medical Services Premiums" Exhibits F and C
D	Average Per Capita in Medicaid (Behavioral Health)	$209.18	$212.22	$217.01	FY 2014-15 R-3: "Medicaid Mental Health Community Programs" Exhibit BB
E	Net Savings Per Client	($643.77)	($718.02)	($796.69)	(Row C + Row D) - Row B
F	**Total Savings**	**($5,302,733)**	**($18,381,202)**	**($21,500,249)**	**Row A * Row E**

Table 2: SB 11-250: "Eligibility for Pregnant Women in Medicaid" Revised Fiscal Impact Estimates

Row	Item	Fiscal Year			Source/Calculation
		FY 2012-13	FY 2013-14	FY 2014-15	
A	Migrated Caseload	738	1,873	1,931	FY 2014-15 R-1: "Medical Services Premiums" Exhibit B
B	Average Per Capita in CHP+	$14,307.81	$12,482.90	$13,074.42	FY 2014-15 R-3: "Children's Basic Health Program" Exhibit C3
C	Average Per Capita in Medicaid (Physical Health)	$9,038.10	$9,497.51	$9,399.88	FY 2014-15 R-1: "Medical Services Premiums" Exhibit C
D	Average Per Capita in Medicaid (Behavioral Health)	$281.43	$282.62	$291.00	FY 2014-15 R-3: "Medicaid Mental Health Community Programs" Exhibit BB
E	Net Savings Per Client	($4,988.28)	($2,702.77)	($3,383.54)	(Row C + Row D) - Row B
F	**Total Savings**	**($3,681,349)**	**($5,062,297)**	**($6,533,611)**	**Row A * Row E**

40. Please describe trends in nursing bed days and what impact, if any, the SB 13-200 expansion is expected to have on utilization.

Since FY 2004-05, utilization of nursing facilities has declined slightly. In FY 2004-05, total patient bed days were 3,519,234. Patient bed days totaled 3,471,451 in FY 2012-13, or a decline of just over 1% in eight years. While the aged population continues to grow, factors such as promotion of community based long term care and the program of all inclusive care for the elderly (both of which have experienced significant growth in recent years) have provided a viable substitute for nursing facility care for many people. As a result, the Department has not experienced any sustained growth in nursing facility bed days.

Fiscal Year	Patient Days	Percentage Change
FY 2004-05	3,519,234	0.47%
FY 2005-06	3,529,589	0.29%
FY 2006-07	3,546,807	0.49%
FY 2007-08	3,435,003	-3.15%
FY 2008-09	3,427,547	-0.22%
FY 2009-10	3,452,700	0.73%
FY 2010-11	3,528,080	2.18%
FY 2011-12	3,502,759	-0.72%
FY 2012-13	3,471,451	-0.89%

The Department does not expect an impact on nursing bed days due to the implementation of SB 13-200. SB 13-200 expanded eligibility for adults to 133% of the federal poverty level; however, any person with requisite needs who has income below 300% of the federal poverty level and who meets resource limits was previously eligible for Medicaid prior to SB 13-200. Due to the high acuity nature of nursing facility clients, individuals currently not receiving nursing facility care would not be expected to utilize nursing facilities due to the SB 13-200 expansion alone.

4:45-5:00 MISCELLANEOUS

41. Should the Breast and Cervical Cancer Program be reauthorized, and if so, how should the program be financed moving forward?

The Department believes the Breast and Cervical Cancer Prevention Program (BCCPP) should be reauthorized. Even with Medicaid expansion and the option to purchase private health insurance on the Connect for Health Colorado Marketplace, some women will remain uninsured and be in need of these services. This population could include uninsured women with incomes are between 134% federal poverty level and 250% federal poverty level who may be exempt from the individual mandate, or who choose not to purchase private health insurance.

The Department estimates that there is sufficient funding in the Breast and Cervical Cancer Prevention and Treatment Fund to fully finance the program through FY 2018-19. The current transfer from the Department of Public Health and Environment's Prevention Early Detection and Treatment fund can be discontinued.

42. The JBC staff recommended excluding administrative expenses from the Medicaid overexpenditure authority when the statutes are renewed. What is the executive branch's position on this recommendation? Would it present any problems for the implementation of the Medicaid program? Please coordinate with the Office of State Planning and Budgeting in providing a response.

The Department and the Office of State Planning and Budgeting (OSPB) do not support a change to the existing language in the overexpenditure statute. The current statute, section 24-75-109(1)(a), C.R.S., restricts overexpenditure to "Medicaid programs." This language is sufficient to prevent overexpenditure on appropriations that are considered to be administrative in nature.

Adding language to the statute that disallows "administrative expenses" could have unintended consequences because the term "administrative" is ambiguous. For example, some services in the Department's main appropriation for Medicaid services (Medical Services Premiums) are considered "administrative" under the Social Security Act, but cannot reasonably be denied if the Department is in an overexpenditure situation. Single Entry Points, who provide level of care assessments for clients who require long term services and supports, are one such example. If the Department were to cease paying Single Entry Points because overexpenditure was not permitted, clients would have to wait until the next fiscal year to gain eligibility, which could result in adverse health outcomes and higher costs in the long term.

There are, however, existing safeguards to prevent the Department from any type of abuse of the overexpenditure statute. Pursuant to section 24-75-109(3), C.R.S., the State Controller is required to restrict the corresponding appropriations in the next fiscal year. This is true regardless of whether or not the overexpenditure is for a Medicaid program, administration or any other area of the State budget. Each year the Joint Budget Committee authorizes a supplemental appropriation to release the restrictions on the appropriations, pursuant to section 24-75-109(4), C.R.S. However, if the Joint Budget Committee believes that the Department has used its overexpenditure authority inappropriately, the committee is not required to authorize

supplemental funding. This would restrict the Department's spending authority and require the Department to reduce its spending in subsequent years to offset the overexpenditure.

As noted by Committee staff in the briefing packet, "[a] review of Medicaid overexpenditures since the last reauthorization of the statute reveals no requests or approvals for overexpenditures for administrative expenses." The Department and OSPB believe that the existing process works well and should not be changed.

43. Please explain the Department's policies regarding estate recoveries. When and how does the Department attempt to recover money from estates? How much is collected annually?

The Colorado Estate Recovery Program is a federally-mandated program pursuant to 42 U.S.C. § 1396p that requires the Department to recover medical assistance expenditures paid on behalf of certain Medicaid clients. The program applies to clients in nursing facilities or clients age 55 and older who receive medical assistance in any living situation. Estate recoveries are effectuated by filing a claim against the estate of a deceased client. The estate includes all property (personal and real) of the client's estate. Customarily, the personal representative handling the estate uses the proceeds from the sale of real property in the estate to pay the Department for the costs of medical assistance provided to the client. The Department may place a lien on the property while the client is alive. A lien secures property to ensure that costs are recovered when the property is sold.

The Colorado General Assembly's direction to the Department regarding estate recovery is codified at section 25.5-4-302, C.R.S. This section provides exceptions to estate recovery and the ability to compromise claims. The Department has collected an average of $4,143,902 in estate recoveries per state fiscal year over the past ten years.

44. Please discuss the adequacy and appropriateness of the dental benefits offered through the programs administered by the Department, including the Old Age Pension Health and Medical Program. Discuss the status of the dental provider network. How have recent changes in rates and benefits improved client access to providers?

Presently, the State has a comprehensive dental benefit for children. Over the past few years, the Department has been exploring ways to improve the children's dental benefit to ensure that children receive services that are clinically appropriate, evidence based and effectively managed.

In order to evaluate the appropriateness of the children's dental benefit, the Department partnered with the Caring for Colorado Foundation and contracted with a consultant to conduct a thorough review of the benefit. The reviewers recommended creating policies that clearly defined the covered benefits, particularly for orthodontia, so providers had clarity on benefit limitations and exclusions. The review also recommended that the state procure a third party administrator, or Administrative Services Organization (ASO), specializing in dental administration and claims processing. Last year, the General Assembly approved the Department's budget request to procure an ASO for the children's dental benefit.

Until recently, dental benefits for adults in Medicaid were largely limited to emergency dental treatment. Last year, the General Assembly passed SB 13-242 which created a dental benefit for adults. The adult dental benefit has a $1,000 annual limit which the Department believes is adequate to meet the needs of most Medicaid clients. The Department retained the same consultant referenced above to help design a benefit that reflects the best practices of evidence based dentistry. In developing the benefit package the Department utilized a Dental Benefits Collaborative. The Collaborative conducted structured meetings over the last six months with stakeholders to discuss the benefit design and encouraged feedback from all constituencies, dental professionals (including orthodontists), dental practice managers, and other interested stakeholders.

The Department worked with stakeholders and decided to also use the ASO for the new adult dental benefit. The ASO will provide administration of the benefit and claims processing, comprehensive utilization management and review and benefit utilization analytics. Administration by the ASO is expected to provide the optimal benefit delivery and management to (1) improve the health of the clients served, (2) improve the client's health care experience and (3) ensure appropriate utilization.

The adult Medicaid dental benefit program is scheduled to begin April 1, 2014. Since Colorado has not previously had an adult dental benefit, there is likely pent-up need as those individuals who have not received dental care begin to seek treatment. Utilization is expected to be high in the first three years, but the demand is likely to normalize over time. The Department plans to begin delivering dental services for both children and adults through the ASO in July 1, 2014.

The Department is working to expand the number of dental providers that accept Medicaid. Dental providers received an increase in rates beginning July 1, 2013. Increasing provider payment rates is an important component of network adequacy, but needs to be combined with other efforts to increase provider enrollment.

When the ASO is in place it will support and expand the provider network by actively recruiting providers, helping providers sign-up to accept Medicaid patients and train providers on covered benefits and billing. In addition, the Department plans to offer incentives to the new ASO to significantly expand the dental provider network through outreach and education. It is important to note that SB 13-242 passed with the strong support of the Colorado Dental Association (CDA). As part of that support, CDA is embarking on a campaign called "Take Five" to encourage dentists who are not currently providers to accept new Medicaid adults and families. The Department appreciates the support of dental providers and is optimistic that all of these changes will increase provider participation. Additionally, the Department has requested funding as part of its January 2, 2014 Budget Request BA-10 to increase provider participation.

Presently, the Old Age Pension Health and Medical Care Program (also known as the Old Age Pension State-Only Program) dental benefit is limited to emergency dental services. Most of the clients in this Program (approximately 2,300) became eligible for Medicaid on January 1, 2014, and thus will receive the new adult Medicaid dental benefit scheduled to begin April 1, 2014. After the January 2014 Medicaid expansion, approximately 795 clients are estimated to

remain eligible for the Old Age Pension (State-Only) Health and Medical Care Program. Beginning in April 2014, the Old Age Pension Health and Medical Care Program client's dental benefits will mirror the new Medicaid adult dental benefit and be included in the ASO. Utilization and expenditure projections indicate that the current appropriation is adequate to cover this population's new benefit.

45. Please coordinate with the Department of Local Affairs to explain how the Department's request for housing assistance payments in R-9 Medicaid community living initiative fits with other FY 2014-15 proposals for increased housing vouchers and the overall level of funding for housing assistance.

The R-9 Request "Community Living Initiatives Housing Assistance Payments" is specifically for Colorado Choice Transitions (CCT) clients who receive assistance when leaving nursing facilities and entering the community. The funding requested by the Department of Local Affairs, Division of Housing, however, could be for anyone that has a disability or has qualifying income and may include CCT clients. Due to the high demand for housing assistance, the Department was concerned the Division of Housing request would be oversubscribed and that CCT clients would not have access to housing resources to enable them to enter the community. Having funding specifically allocated for CCT clients ensures available housing for these clients.

The Department has been in close collaboration with the Division of Housing, both in crafting R-9 and also on broader issues of housing policy. To avoid duplication, if the General Assembly funds both requests the departments would ensure that the R-9 funding is used for CCT clients, and that the Division of Housing funding request is used only for non-CCT populations

Department	Request	FY 2014-15
DOLA	Priorities:2-6 Housing Development Grant (HDG)	$4,000,000
HCPF	R-9 "Community Housing Initiatives"	$450,375

46. Where will the increase in General Fund come from for the Medicare Modernization Act state obligation to backfill the loss of federal bonus payments that have been used to offset costs for this program? What efficiencies is the Governor proposing to pay for this cost?

On November 1, 2013, the Governor submitted a balanced budget which included sufficient funding to account for the loss of the temporary bonus payments authorized under the Children's Health Insurance Program Reauthorization Act of 2009. No program cuts or service reductions were needed.

47. The Department sent a letter after November 1 requesting that the JBC sponsor legislation regarding nursing home rates. Please describe the specific proposal and why the JBC should carry this legislation.

Medicaid funding for nursing facilities is limited by the 3% General Fund growth cap and the limit on provider fees. A change is needed to clarify that an adjustment to prior year's per diem rates, whether through appeals or through finalization of the cost report audit process, will be

handled through the Nursing Facility Provider Fee in the following year. The Department requests that the Joint Budget Committee sponsor legislation to allow the Department to account for successful appeals through an adjustment to supplemental payments from the Nursing Facility Provider Fee in the subsequent fiscal year.

The Department believes that it is appropriate for the Joint Budget Committee to sponsor this legislation because it is a technical budget and financing issue, not a matter of policy. The statute for nursing facilities rates and supplemental payments is very prescriptive and does not account for this type of circumstance. Further, this legislative change was proposed by Joint Budget Committee staff last fiscal year during the Department's supplemental briefing; the Committee did not choose to move forward with this proposal until more stakeholder agreement was achieved. With that in mind, the Department has worked diligently with stakeholders in the off session to reach consensus. Both the Colorado Health Care Association Board as well as the Nursing Facility Provider Fee Advisory Board have agreed to support the proposed change.

48. Please coordinate with the Office of State Planning and Budgeting to describe all the sources of funding used for flood relief and why Medical Service Premiums was selected as one of the fund sources. How will funding for Medical Service Premiums be restored?

Please see the attached Executive Orders regarding the funding for flood relief. On January 2, 2014, the Governor's Office submitted a General Fund supplemental request that will allow for the repayment of $50.0 million to the Department of Health Care Policy and Financing's Medical Services Premiums line item. With approval of this request, the Disaster Emergency Fund will receive a direct appropriation of $70.0 million, of which $50.0 million would be used to reverse the transfer funds out of Department of Health Care Policy and Financing.

ADDENDUM: Other questions for which solely written responses are required

A1. Provide a list of any legislation that the Department has: (a) not implemented or (b) partially implemented. Explain why the Department has not implement or has partially implemented the legislation on this list.

See Attachments A and B

A2. Does Department have any outstanding high priority recommendations as identified in the "Annual Report of Audit Recommendations Not Fully Implemented" that was published by the State Auditor's Office on June 30, 2013? What is the department doing to resolve the outstanding high priority recommendations?

http://www.leg.state.co.us/OSA/coauditor1.nsf/All/D36AE0269626A00B87257BF30051FF84/$FILE/1337S%20Annual%20Rec%20Database%20as%20of%2006302013.pdf

See Attachment C

A3. Does the department pay annual licensing fees for its state professional employees? If so, what professional employees does the department have and from what funding

source(s) does the department pay the licensing fees? If the department has professions that are required to pay licensing fees and the department does not pay the fees, are the individual professional employees responsible for paying the associated licensing fees?

With the exception of the Legal Division Director, the Department of Health Care Policy and Financing does not pay annual licensing fees for its state professional employees. The license fees associated with the Legal Division Director are paid from the Department's annual operating budget. All other employees are responsible for maintaining their professional license fees.

A4. Does the department provide continuing education, or funds for continuing education, for professionals within the department? If so, which professions does the department provide continuing education for and how much does the department spend on that? If the department has professions that require continuing education and the department does not pay for continuing education, does the employee have to pay the associated costs?

The Department allows managers to approve the use training dollars in the Department's Operating Budget to pay for employee requests for continuing education expenses.

A5. During the hiring process, how often does the number one choice pick candidate turn down a job offer from the department because the starting salary that is offered is not high enough?

The Department does not currently track whether a managers first hiring choice declined based on the starting salary offered.

A6. What is the turnover rate for staff in the department?

According to statistics provided by the Department of Personnel and Administration, the Department had a turnover rate of 12.2% in FY 2012-13.

ATTACHMENT A: LEGISLATION NOT FULLY IMPLEMENTED 2008-2013

Total HCPF Related Bills 2008-2013: 148
Not Fully Implemented 2008-2013: 15

The Department has records of the status of implementation for legislation dating back to 2008. Over the last six years, the Department has successfully implemented over 133 bills. Since Medicaid is governed as a partnership between the states and the federal government, any new Medicaid programs or changes to the current program that requires federal funding must be approved by the Centers for Medicare and Medicaid Services (CMS). Several bills passed during this period were contingent upon federal approval which was denied. Without federal financial participation, the Department was unable to implement these bills.

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

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

Legislation	Legislation Summary	Barriers to Implementation	FTE
	to conduct site visits of providers who are designated, under federal regulations, as moderate or high risks to the Medicaid program.		
SB 13-002 Civil Unions (Steadman/Ferrandino)	The bill authorizes civil unions in Colorado and sets forth the rights, responsibilities, and requirements of persons entering a civil union. Two persons, regardless of gender, may enter into a civil union if they are not related by blood, not married to or in a civil union with another person, and are over the age of 18. The bill sets the fees and procedures to obtain a civil union license from a county clerk and to petition the court for the dissolution, invalidation, and legal separation of a civil union.	This bill requires changes in the CBMS system that create a new relationship category for civil unions that are not able to be completed until April 2014. The changes would affect state-only funded programs since Title XIX has specific provisions that apply only to married couples. Medicaid determinations must still be conducted under the requirements provided by federal law. Colorado does not recognize the parties to a civil union as being married. In compliance with federal and state law, the Medicaid eligibility determination for individuals in a civil union must be completed in separate households. Medical Assistance programs that are funded by State dollars only are not bound by the federal law. Therefore, the Old Age Pension Health Care Plan (OAP-HCP) can allow for parties in a civil union to have their determination considered as one household. The OAP Health Care Plan (OAP-HCP) provides benefits to OAP recipients who do not qualify for Medicaid.	0
SB 13-264 Develop Rural Family Medicine Residency Program (Aguilar & Kefalas/McLachlan)	This bill requires that, in addition to existing duties, the Advisory Commission on Family Medicine (COFM) in the Colorado Department of Public Health and Environment (CDPHE) support the development of rural family medicine residency programs. The bill takes effect August 7, 2013, if the General Assembly adjourns on May 8, 2013, as scheduled, and no referendum petition is filed.	The Department submitted a proposal to use federal financial participation for this program to CMS and received approval on December 5, 2013. The Department's accounting and procurement sections are working to ensure that the funds are transferred to the Commission on Family Medicine by January 31, 2014.	0
HB 12-1068 Health Facility Safety Standards (Acree/Hudak)	The proposed legislation moves the responsibility of inspecting building and fire safety compliance of health facility buildings from the Department of Public Health and	This bill has been partially implemented. Implementation of federally required new billing/diagnosis codes (ICD-10) into the MMIS was moved to fall 2014, therefore life safety code	0

Legislation	Legislation Summary	Barriers to Implementation	FTE
	Environment (DPHE) to the Division of Fire Safety within the Department of Public Safety (DPS). Currently an interagency agreement exists between DPHE and the Department for inspections of facilities that affect Department clients or programs.	changes will also be moved to coincide with the ICD-10 implementation timeline.	
SB 12-023 Improve Access to PACE Program (Boyd/Summers-Kerr A)	The Department would not be responsible for creating or distributing the marketing material. However, should PACE providers contract with an enrollment broker to target Medicaid clients, the Department could see an increase in PACE enrollment as a result of the marketing effort. In this event, the Department may request additional funding through the normal budget process to cover the short term costs associated with increased Medicaid PACE enrollment if the additional marketing results in additional enrollments in PACE programs.	The Department needs two rules in place to fully implement the program. Both rules are currently going through the process within the Department. The first rule will allow for clients to disenroll from a managed care entity or RCCO and enroll in PACE at any time assuming they qualify for the program. The second rule will allow PACE providers to contract with an enrollment broker. The Department anticipates that these rules will be submitted to the Medical Services Board for approval before the end of the fiscal year.	0
SB 12-128 Alternative Care Facility Reimbursement Pilot (Roberts/Summers)	This bill allows HCPF to create an enhanced reimbursement program in which an alternative care facility (ACF) will receive a temporary increase in the Medicaid per diem reimbursement rate for a client discharged from a nursing facility. Legislation required that any such program be budget-neutral or result in cost savings.	The Department intended to implement SB 12-128 through the Community Choice Transitions (CCT) program. However, CMS requirements for ACF's to be eligible for enhanced payments under CCT preclude many if not most ACF's in the state from participating. As required by the legislation, any enhanced payment has to be cost neutral. The Department understands the intent of this legislation and is working with stakeholders to identify long term solution to ACF utilization and reimbursement.	0
SB 11-177 Pregnancy and Dropout Prevention	The bill extends the repeal date for the teen pregnancy and dropout prevention program (program) by 5 years to September 1, 2016, and requires the department of regulatory	The Department has yet to receive approval by CMS on whether non-licensed providers trained in the curriculum and supervised by a licensed physician or dentist can provide services.	1

Legislation	Legislation Summary	Barriers to Implementation	FTE
	agencies to review the program prior to its repeal.		
SB 10-061Medicaid Hospice Room and Board Charges (Tochtrop, Williams/Soper, Reisberg)	Nursing facilities are to be paid directly for inpatient services provided to a Medicaid recipient who elects to receive hospice care; reimburse inpatient hospice facilities for room and board.	The Department has not received approval for this change by CMS. The Department has recently restarted this conversation with stakeholders around plans to reach out again to CMS to continue this discussion. If CMS approves this funding change, the Department will fully implement this legislation otherwise there would be no federal match for these services.	0
SB 10-117 Over the Counter Medications (Foster/Primavera)	This bill adds over-the-counter medications identified through the drug utilization review process to services provided under Medicaid when the medications are prescribed by a licensed practitioner or a qualified licensed pharmacist	In order to implement the bill, system changes are needed in the Pharmacy Benefit Management System (PBMS) which will be completed in 2015 or 2016. The Department did not anticipate the amount of hours it would require to make the necessary system changes in 2010. The Department was also restricted by the current system that would require pharmacists to enroll individually as providers. Given the extra burden of enrolling twice, the Department assumed low participation among pharmacists and decided to wait until the PBMS was reprocured to eliminate these barriers to participation.	0
HB 09-1103 Presumptive Eligibility Long-Term Care (Riesberg/Newell)	Persons in need of long-term care who declare all of the information necessary to determine eligibility under the Medicaid program shall be presumptively eligible for benefits.	The bill authorized the Department to seek federal approval to allow people who are in need of long-term care to be presumptively eligible for Medicaid. The bill directed the Department to seek federal approval from CMS, which was denied. Without federal approval, the Department was not able to implement the legislation.	0
HB 09-1252 Local Access to Health Care (Roberts/Isgar)	This bill expands the "Local Access to Health Care Pilot Program Act" to allow the creation of a pilot program in the San Luis valley.	The bill was permissive and dependent upon gifts, grants, and donations. Not enough funds were collected to expand the program.	0
HB 08-1072 Medicaid Buy-In for Persons with Disabilities (Soper/Williams)	This bill establishes a Medicaid Buy-in Program for people with disabilities who earn too much to qualify for Medicaid and for those whose medical	The Medicaid Buy-in Program for people with disabilities has been implemented. The Department has not implemented a buy-in for the “medically improved” group. The goal of the buy-in for the medically improved was to allow clients with improved but preexisting conditions to access health care.	2

Legislation	Legislation Summary	Barriers to Implementation	FTE
	condition improves while participating in the program.	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 08-006 Suspend Medicaid for Confined Persons (Boyd/Solano)	Confined persons will continue to be eligible for Medicaid benefits, if Medicaid benefits were being received immediately prior to designation as a confined person, provided availability of Federal funds	CMS requires that clients who became incarcerated have their eligibility re-determined. Once incarcerated, the client would become a household of one - making them ineligible for Medicaid as Medicaid does not traditionally cover single adults. Until the recent Adults without Dependent Children (AwDC) expansion created by HB 09-1293, there was no category for single adults. Prior to January 1, 2014, there was a cap on the amount of clients covered under the AwDC program at 10,000 clients. The Department will be implementing this legislation now that the full ACA expansion occurs and the waitlist has been eliminated.	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	0

Legislation	Legislation Summary	Barriers to Implementation	FTE
		Department's SPAs, concluding that the Department's reimbursement methodology did not meet the requirements of federal regulations [42 CFR §433.68 (f)] addressing hold harmless arrangements.	
HB 05-1243 Consumer Directed Care Under Medicaid*	This bill extends the option of receiving Home and Community Based Services (HCBS) through the Consumer Directed Attendant Support Services (CDASS) delivery model to all Medicaid recipients who are enrolled in an HCBS waiver for which the Department of Health Care Policy and Financing has federal waiver authority. The bill specifies that an eligible person shall not be required to disenroll from the person's current HCBS waiver in order to receive services through the consumer-directed care service model.	CDASS is available in the following Home and Community Based Services (HCBS) waivers: Elderly Blind and Disabled (EBD), Community Mental Health Services (CMHS), Brain Injury and Spinal Cord Injury (SCI). The legislation authorized the Department to seek federal approval to expand Consumer Directed Attendant Support Services (CDASS) to all the HCBS waivers but the fiscal note assumed significant savings in out years in order to expand. While a valuable and important delivery model, research and data show that clients in CDASS do not produce net savings. The current structure of CDASS allows clients to direct their own personal care, homemaker, and health maintenance activities. There are four waivers that do not offer these distinct services: Children with Autism, Children with Life Limiting Illness, Persons with Developmental Disabilities, and Children's Residential Habilitation Program. There is additional work that must happen prior to expanding CDASS, as it is currently structured, into waivers where these services are not in the federally approved waivers. Additionally, the participant directed care advisory group (PDPPC) has not examined the policy and operational implications of offering consumer direction to children when the parent or other legally responsible adult might be the person providing services as well as the one responsible for directing the care. Finally, operational barriers have been identified in expanding CDASS into the Supported Living Services (SLS) waivers. The Department is working with stakeholders and the Department of Human Services to eliminate these barriers. The Department has been extensively engaged with stakeholders to develop and implement a plan to expand CDASS to more waivers.	0.5

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

ATTACHMENT B: BUDGET REQUESTS NOT FULLY IMPLEMENTED

During the Department's briefing on December 19, 2013, Sen. Steadman asked for a list of budget requests that had not been implemented in addition to legislation. This did not come through as a formal question on the hearing agenda; however, the Department has provided the requested information below.

The Department notes that where implementations have not occurred, or if implementations have been delayed from initial projected start dates, the Department has already accounted for any needed changes to funding through the Budget Request process. For reference, the Department provides the initial projected savings or costs related to the project in each section.

1. FY 2012-13 Cost Containment Measures R-6: Augmentative Communication Devices: ($492,000 TF), ($240,391 GF)

The FY 2012-13 R-6 change request's augmentative communication devices subsection was undertaken to provide access to less costly durable medical equipment for disabled clients that require the aid of augmentative communication devices. While the policy on Augmentative and Alternative Communication Devices (AACDs) was implemented and incorporated by reference to the Durable Medical Equipment and Disposable Medical Supplies rule, 10 CCR 2505-10 § 8.590, effective September 30, 2013, the cost savings that was anticipated is not yet being realized because of the delay in implementation that was the result of staffing issues. Also, there is currently a lack of providers willing to supply tablet computers for various reasons, so the Department is working with stakeholders to resolve the related process issues. A primary issue with convincing providers to supply tablet computers is the problem of dedicated versus integrated devices.

Traditionally, augmentative communicative devices have been dedicated devices. Manufacturers of dedicated augmentative communicative devices are now releasing their own version of tablet computers that are dedicated as communication devices, meaning that the tablets come with the software on them and are locked so that clients cannot access other functions of the tablet until they pay to have it unlocked. These are significantly more expensive than normal tablets (integrated devices), ranging from approximately $5,000 to $10,000 per tablet.

Normal tablets are not dedicated and the software must be purchased through an account such as iTunes. The logistics of purchasing tablets, software, creating accounts, and uploading software on the tablets has become an issue. Tablets with software and accessories can be purchased for less than $1,000. This means that there is no incentive for suppliers to spend time and money to provide tablets that are not dedicated, when they can continue to provide dedicated devices at a much higher reimbursement with less involvement in the process.

2. FY 2012-13 Cost Containment Measures R-6: Durable Medical Equipment Preferred Provider: ($1,150,732 TF), ($562,246 GF)

Through this subsection of its FY 2012-13 R-6 change request, the Department hoped to initiate a competitive procurement process to acquire a sole source diabetic testing supply provider, whereby the Department could leverage purchasing power to obtain significant rebates. Initially, systems issues prevented rebate collection on the equipment. Upon initial research, it was thought that such a program could result in significant cost savings.

However, upon further review and research with other payers who implemented preferred provider programs for monitoring equipment, the anticipated savings were not as significant as estimated and did not align with actual savings because of multiple factors that were dependent upon how the preferred program was established. As evidenced by other payers' analysis on estimated and realized savings, implementation of a preferred provider program was put on hold indefinitely.

3. **FY 2012-13 Cost Containment Measures R-6: Dental Efficiency: ($1,641,594 TF) ($802,081 GF)**

Through this subsection of its FY 2012-13 R-6 change request, the Department sought to clarify rules regarding eligibility for orthodontics to reduce utilization of orthodontics for all cases except those where the client has a severely handicapping malocclusion. Implementation began July 1, 2013; however, until the Dental Benefits Collaborative process is complete, there are no specifics on how this benefit will be applied and administered. Additionally, the coverage standard will not be implemented earlier than July 1, 2014.

4. **FY 2012-13 Cost Containment Measures R-6: Ambulatory Surgical Centers: ($1,000,000 TF), ($488,599 GF)**

The Department initiated a pilot project to shift outpatient surgery utilization from the outpatient hospital setting to the less costly ambulatory surgical setting. However, the trial was not successful and expansion of the program is not recommended.

5. **FY 2011-12 BRI-1: Client Over Utilization Program: $71,300 TF, ($16,325 GF)**

The Department requested authorization to pay providers an enhanced per member per month payment to participate in the Client Over Utilization Program. The Client Over Utilization Program restricts Medicaid clients to one designated pharmacy and one primary care provider when there is documented evidence of abuse or over-utilization of benefits. The per member per month payment has not yet been implemented for the following reasons:

- There are limitations within the Department's Medicaid Management Information System, including the inability to "lock-in" eligible Accountable Care Collaborative clients into the Client Over Utilization Program;
- The implementation of the Accountable Care Collaborative program has presented new opportunities for supporting these clients through the Regional Care Collaborative Organizations; and
- The administration of the program was transferred from Department internal staff to the Department's Utilization Management vendor, and the implementation timeline was extended to allow sufficient time for the Utilization Management vendor to fully operationalize the program.

The Department is in the process of addressing the systems issues and monitoring the progress of the Utilization Management vendor. The Department is eager to implement the per member per month payment and anticipates the payment will incentivize provider participation in the program, which would lead to greater reductions in the inappropriate use of medications and services.

ATTACHMENT C: AUDIT RECOMMENDATIONS NOT YET IMPLEMENTED AS OF DECEMBER 2013

The Department is providing a response and update to all the recommendations in the State Auditor's Office (OSA) Annual Report of Audit Recommendations Not Fully Implemented (As of June 30, 2013). Out of the thirteen performance and information technology recommendations listed in the report only eight remain not implemented. Some of the long-term care recommendations are challenging because it requires linking across multiple computer systems to link Medicaid clients to other public programs such as food assistance, TANF and LEAP to obtain expenditure data for those programs. The Department has implemented all of the recommendations to the Medicaid Hospital Provider Fee Audit released in 2012.

As summarized in Table A1, the Department is pleased to report that two Material Weakness recommendations have been implemented since the last update provided to the State Auditor's Office that was used to generate the OSA report.

As provided in Table A1, of the 28 outstanding audit recommendations reported in the OSA report, the Department has since implemented eleven of those recommendations.

Table A1: Number of Outstanding Audit Recommendations

Number of Outstanding Audit Recommendations Summary	Number of Outstanding Audit Recommendations from OSA October 2013 Report	Number of Outstanding Audit Recommendations from Department January 2014 JBC Hearing	Change in the Number of Outstanding Audit Recommendations
Financial Audit Recommendations			
Material Weakness	3	1	2
Significant Deficiency	5	4	1
Deficiency in Internal Control	7	4	3
Total Financial Audit Recommendations	**15**	**9**	**6**
Performance Audit Recommendations			
Access to Medicaid Home and Community-Based Long-Term Care Services (2009)	1	1	0
Implementation of the Pediatric Hospice Waiver	7	7	0
Medicaid Hospital Provider Fee Program, (2012)	5	0	5
Total Performance Audit Recommendations	**13**	**8**	**5**

Audit Classification, Report, Audit Year, Audit Release Date, and Rec Number	Audit Recommendation	Department's Implementation Status Update	Implementation Date
Classification: none **Report:** OSA - Access to Medicaid Home and Community-Based Long-Term Care Services Performance (Feb 2009) **Audit Year:** 2009 **Audit Release Date:** May 11 **Rec Number:** 5d	The Department of Health Care Policy and Financing should help ensure the future financial sustainability of the State's community-based long-term care programs by taking a more comprehensive and forward-looking approach to managing and analyzing program costs and evaluating available policy options, such as those under the federal Deficit Reduction Act of 2005. To provide a basis for such policy decisions, at a minimum, the Department should (d) Identify the extent to which HCBS waiver clients access other public outlays of non-Medicaid benefits and the cost to these other services to determine the true cost of serving long-term care clients in the community versus in a nursing facility.	The Department continues to work with our sister agency, Department of Human Services (DHS) to obtain the cost of other public outlays of non-Medicaid benefits for Medicaid Home and Community Based Services (HCBS) waiver clients. This has proved to be a much more difficult task than first anticipated due to multiple computer systems housing the non-Medicaid benefit information as well as different client identifiers across systems. Once the non-Medicaid benefit information is obtained from DHS, HCPF can do the cost comparison analysis between total State expenditures for waiver clients and Medicaid nursing facility costs.	Not Implemented – Implementation Date: March 31, 2014.

Audit Classification, Report, Audit Year, Audit Release Date, and Rec Number	Audit Recommendation	Department's Implementation Status Update	Implementation Date
Classification: none **Report:** Implementation of the Medicaid Pediatric Hospice Waiver Program Performance Audit **Audit Year:** 2011 **Audit Release Date:** May 11 **Rec Number:** 1A	Provide clear, written direction to SEP agencies on care planning, including comprehensive definitions of how Palliative/Supportive Care waiver services are different from similar services under the standard Medicaid program and a requirement that SEP case managers obtain and use the input of both palliative and curative service providers to assess a child's service needs, plan services to address the needs, and determine the proper source for each service.	This recommendation remains partially implemented. The Department has worked with stakeholders to provide a clear comprehensive definition for Palliative/Supportive Care. A waiver amendment was completed and submitted to CMS on September 30, 2013. CMS is currently reviewing the amendment. Once the amendment is approved, the Department will begin changing the regulations to match the changes in the waiver and provide training to all case managers around all services and how they are different from state plan, how they should be used to address the client's needs, and how to care plan with the providers and families. The Department expects to have this recommendation fully implemented by July 1, 2014.	Partially Implemented –Fully Implemented by July 1, 2014.

Audit Classification, Report, Audit Year, Audit Release Date, and Rec Number	Audit Recommendation	Department's Implementation Status Update	Implementation Date
Classification: none **Report:** Implementation of the Medicaid Pediatric Hospice Waiver Program Performance Audit **Audit Year:** 2011 **Audit Release Date:** May 11 **Rec Number:** 1B	Providing training on what specific services may be offered under the palliative/Supportive Care waiver service category. The training should cover the comprehensive definitions of how these waiver services are different from similar services offered through the standard Medicaid program recommended in Part "a," above.	This recommendation remains partially implemented. The Department has worked with stakeholders to provide a clear comprehensive definition for Palliative/Supportive Care. A waiver amendment was completed and submitted to CMS on September 30, 2013. CMS is currently reviewing the amendment. Once the amendment is approved, the Department will begin changing the regulations to match the changes in the waiver and provide training to all case managers around all services and how they are different from state plan, how they should be used to address the client's needs, and how to care plan with the providers and families. The Department expects to have this recommendation fully implemented by July 1, 2014.	Partially Implemented –Fully Implemented by July 1, 2014.

Audit Classification, Report, Audit Year, Audit Release Date, and Rec Number	Audit Recommendation	Department's Implementation Status Update	Implementation Date
Classification: none **Report:** Implementation of the Medicaid Pediatric Hospice Waiver Performance Audit **Audit Year:** 2011 **Audit Release Date:** May 11 **Rec Number:** 1C	Enforcing federal and state care planning requirements that are in place to ensure that the services a child receives are based on need and are coordinated among resource options to avoid gaps or overlaps in service provisions. This should include using the newly implemented review and monitoring process. The Department's review and monitoring process should ensure that SEP case managers are determining the waiver service needs of enrolled children rather than fully delegating this responsibility to waiver providers; documenting service needs when a provider is not available; and basing the care plan on the child's needs rather than on provider availability.	This recommendation remains partially implemented. The Department has worked with stakeholders to provide a clear comprehensive definitions for all services. A waiver amendment was completed and submitted to CMS on September 30, 2013. CMS is currently reviewing the amendment. Once the amendment is approved by CMS the Department will begin changing the regulations to match the changes in the waiver. At the same time, the Department will begin designing and providing training to all case managers. This training will include information on how to care plan with the input of providers and the family and based on the child's needs. Additionally, case managers will be services are documented based on the assessed need of the client and not provider capacity. The Department in partnership with the Single Entry Point agencies will increase the provider recruitment efforts to ensure the waiver has enough providers for all of the services and the children can receive the services they need.	Partially Implemented –Fully Implemented by July 1, 2014

Audit Classification, Report, Audit Year, Audit Release Date, and Rec Number	Audit Recommendation	Department's Implementation Status Update	Implementation Date
Classification: none **Report:** Implementation of the Medicaid Pediatric Hospice Waiver Performance Audit **Audit Year:** 2011 **Audit Release Date:** May 11 **Rec Number:** 2B	Reevaluating and changing, if warranted, the current limitations placed on who can become a waiver service provider. This should include an evaluation of whether qualified providers who are not employed by a hospice or home health agency can be enlisted to provide services within the broad Palliative/Supportive Care service category. This should also include assessing whether the requirement that all waiver providers must apply separately for both a Medicaid Provider ID number and a Pediatric Hospice Waiver Provider ID number can be streamlined to require potential providers to go through only one, rather than two, approval process.	This recommendation remains partially implemented. The Department has worked with stakeholders in redefining all services and reviewing and changing provider qualifications. Many of the services will receive a change in the provider qualifications. A waiver amendment was completed and submitted to CMS on September 30, 2013. CMS is currently reviewing the amendment. Once the amendment is approved by CMS the Department will begin changing the regulations to match the changes in the waiver. All Medicaid Home and Community Based Service (HCBS) waiver providers must complete an application to become an HCBS provider and receive a provider ID for the waiver in which they plan to provide services. State plan Medicaid services must be approved through a different process and require different provider types and IDs. The Department updated qualified providers for the Palliative/Supportive Care service category to include both hospice and home agencies.	Partially Implemented –Fully Implemented by July 1, 2014

Audit Classification, Report, Audit Year, Audit Release Date, and Rec Number	Audit Recommendation	Department's Implementation Status Update	Implementation Date
Classification: none **Report:** Implementation of the Medicaid Pediatric Hospice Waiver Performance Audit **Audit Year:** 2011 **Audit Release Date:** May 11 **Rec Number:** 3A	Establishing a tracking mechanism to ensure that the Department can differentiate bereavement counseling services from other waiver services, including other counseling services. To accomplish this, the Department should consider making bereavement counseling a separate waiver service category with separate service limitations from the general Counseling waiver service category.	This recommendation remains partially implemented. The Department has worked with stakeholders in redefining all services. The Department has proposed separating bereavement services from counseling and allowing providers a way to bill for this service separate and apart from counseling services. This will allow the Department to track when providers plan to provide bereavement services to a family. A waiver amendment was completed and submitted to CMS on September 30, 2013. CMS is currently reviewing the amendment. Once the amendment is approved by CMS the Department will begin changing the regulations to match the changes in the waiver.	Partially Implemented –Fully Implemented by July 1, 2014

Audit Classification, Report, Audit Year, Audit Release Date, and Rec Number	Audit Recommendation	Department's Implementation Status Update	Implementation Date
Classification: none **Report:** Implementation of the Medicaid Pediatric Hospice Waiver Performance Audit **Audit Year:** 2011 **Audit Release Date:** May 11 **Rec Number:** 3B	Providing guidance to Single Entry Point (SEP) agencies on how to identify the need for bereavement services in care plans. This guidance should include the requirement that a bereavement plan of care be initiated prior to an enrolled child's death.	This recommendation remains partially implemented. The Department has worked with stakeholders in redefining all services. The Department has proposed separating bereavement services from counseling and allowing providers a way to bill for this service separate and apart from counseling services. This will allow the Department to track when providers plan to provide bereavement services to a family. A waiver amendment was completed and submitted to CMS on September 30, 2013. CMS is currently reviewing the amendment. Once the amendment is approved by CMS the Department will begin changing the regulations to match the changes in the waiver. The Department will train case managers in the Spring of 2014 on how to identify and care plan for bereavement.	Partially Implemented –Fully Implemented by July 1, 2014

Audit Classification, Report, Audit Year, Audit Release Date, and Rec Number	Audit Recommendation	Department's Implementation Status Update	Implementation Date
Classification: none **Report:** Implementation of the Medicaid Pediatric Hospice Waiver Performance Audit **Audit Year:** 2011 **Audit Release Date:** May 11 **Rec Number:** 4	The Department of Health Care Policy and Financing (the Department) should evaluate whether revising the design of the Pediatric Hospice Waiver program (the Waiver program) is warranted to improve the program and ensure enrolled children are able to access needed services. Specifically, the Department should address the problems identified in this report with respect to care planning and access to providers, and use utilization data to determine whether changes should be made to the current frequency requirement or waiver service categories. If the Department chooses to change the frequency requirement or include case management and another service as a waiver service, the Department should submit a waiver application amendment reflecting these changes to the federal Centers for Medicare and Medicaid Services (CMS) for approval. Regardless of changes to the frequency requirement or waiver services, the Department should enforce the requirements it establishes regarding the frequency of service provision and disenrollment of children who are no longer eligible for the program.	This recommendation remains partially implemented. The Department has worked with stakeholders to provide clear comprehensive definitions for all services. Additionally, provider qualifications were updated to better reflect industry standards thereby increasing provider capacity. A waiver amendment was completed and submitted to CMS on September 30, 2013. CMS is currently reviewing the amendment. Once the amendment is approved, the Department will begin changing the regulations to match the changes in the waiver and provide training to all case managers around all services and how they are different from state plan, how they should be used to address the client's needs, and how to care plan with the providers and families. The Department in partner with the Single Entry Point agencies will increase the provider recruitment efforts to ensure the waiver has enough providers for all of the services and the children can receive the services they need. The Department expects to have this recommendation fully implemented by July 1, 2014.	Partially Implemented –Fully Implemented by July 1, 2014

Audit Classification, Report, Audit Year, Audit Release Date, and Rec Number	Audit Recommendation	Department's Implementation Status Update	Implementation Date
Classification: none **Report:** Medicaid Hospital Provider Fee Program - October 2012 **Audit Year:** 2012 **Audit Release Date:** October 12 **Rec Number:** 1A	Establishing data collection methods to obtain hospital data for the Hospital Provider Fee Model that are based on existing, reliable data sources where possible. The Department should consider gathering data directly, whenever possible, from the most recently available Medicare cost reports rather than requiring hospitals to self-report data in the Hospital Provider Survey.	The Department recently contracted with a vendor to develop an online Uniform Inpatient and Outpatient Medicaid and Uninsured Care Cost and Charge Report (Uniform Cost Report) to allow hospitals to report data necessary for calculation of the hospital provider fee model and supporting documentation. The vendor began work on the Uniform Cost Report on July 1, 2012 and the first Uniform Cost Reports are scheduled to be received from hospitals in spring 2013 for use in the 2013-14 hospital provider fee model.	Implemented
Classification: none **Report:** Medicaid Hospital Provider Fee Program - October 2012 **Audit Year:** 2012 **Audit Release Date:** October 12 **Rec Number:** 1B	Developing clear, consistent requirements for the data sources and methodologies hospitals must use to complete the Hospital Provider Survey.	The online Uniform Cost Report was launched in April 2013 and the Hospital Provider Survey was eliminated. A comprehensive manual and instructions was developed and deployed with the Uniform Cost Report. Data sources that are utilized and allowable include the CMS 2552-10 Medicare cost report, the Department's MMIS, audited hospital financial statements, and hospital accounting and payment records.	Implemented

Audit Classification, Report, Audit Year, Audit Release Date, and Rec Number	Audit Recommendation	Department's Implementation Status Update	Implementation Date
Classification: none **Report:** Medicaid Hospital Provider Fee Program - October 2012 **Audit Year:** 2012 **Audit Release Date:** October 12 **Rec Number:** 1C	Requiring hospitals to maintain supporting documentation for the data points reported in the Hospital Provider Survey.	Uniform Cost Report trainings were held for hospitals in March 2013 before the online system was launched, and annual trainings will be held each year hereafter. As part of the Uniform Cost Report certification process, hospitals attest that they will retain all supporting and backup documentation used to complete the Uniform Cost Report for seven years.	Implemented

Audit Classification, Report, Audit Year, Audit Release Date, and Rec Number	Audit Recommendation	Department's Implementation Status Update	Implementation Date
Classification: none **Report:** Medicaid Hospital Provider Fee Program - October 2012 **Audit Year:** 2012 **Audit Release Date:** October 12 **Rec Number:** 1D	Developing and implementing policies and procedures for an annual, risk based review, to determine the accuracy and reliability of the self-reported data in the Hospital Provider Survey. The Department should also establish and implement procedures to take follow-up action with hospitals on data points in question, including, but not limited to, adjustments to future fees and payments for errors.	The Department has developed a process to review information submitted by hospitals for reasonableness. Providers are asked to review questionable data and revise any erroneous data found during this ongoing review. The Department will be conducting an additional review of all provider reported data elements through a multiyear data comparison process. Data errors found after the finalization of the hospital provider fee model will warrant an adjustment to the provider's fees and/or supplemental payments, which will be reconciled within a reasonable adjustment period. The Uniform Cost Report was launched in April 2013, and this is the first year of that new process. The Department's vendor has conducted desk reviews of selected hospitals. A summary of findings from those desk reviews is due mid-December 2013. The Department is evaluating the implementation of Uniform Cost Report system, and will continue to review and revise its policies and procedures as warranted after the implementation evaluation and on an ongoing basis.	Implemented

Audit Classification, Report, Audit Year, Audit Release Date, and Rec Number	Audit Recommendation	Department's Implementation Status Update	Implementation Date
Classification: none **Report:** Medicaid Hospital Provider Fee Program - October 2012 **Audit Year:** 2012 **Audit Release Date:** October 12 **Rec Number:** 3B	Developing a method to track changes in the Provider Fee Model spreadsheet that allows the Department to document the history of changes made in the spreadsheet over time.	The Department has implemented processes to track versions of models and to document changes. The versioning is being achieved with the use of naming conventions and independent model versions. The Department is also keeping a log that documents the key changes that are made in a particular model. The Department will transition the hospital provider fee model to SharePoint and utilize that software's versioning capability after the Department's conversion to Office 365 is complete.	Implemented and Ongoing

Audit Classification, Report, Audit Year, Audit Release Date, and Rec Number	Audit Recommendation	Department's Implementation Status Update	Implementation Date
Classification: Material Weakness **Report:** State of Colorado Statewide Single Audit June 2011 **Audit Year:** 2011/2012 **Audit Release Date:** June 2011/2012 **Rec Number:** 26/36	The Department of Health Care Policy and Financing (the Department) should improve its controls over eligibility of Medicaid providers to ensure that it complies with federal regulations. In addition, it should develop, implement, and document a process for removing providers from the Medicaid Management Information System providers who are no longer in compliance with provider eligibility requirements.	Full compliance will be achieved with the implementation of the replacement Medicaid Management Information System (MMIS) in 2016. While the replacement MMIS and Fiscal Agent Operations Services is expected to be operational by July 2016, the Department's implementation of the Affordable Care Act (ACA) Provider Screening Rules needs to be completed by March 2016 under federal regulations. The MMIS and Fiscal Agent Operations Services contractor is expected to work with the Department to implement ACA Provider Screening Rules as a top priority under the Request for Proposals (RFP). However, several initiatives are underway to improve compliance in advance of the replacement MMIS. In June 2013, the Department implemented changes to the provider enrollment application and process, which improved our compliance with federal regulations.	Partially Implemented –Fully Implemented by March 2016

Audit Classification, Report, Audit Year, Audit Release Date, and Rec Number	Audit Recommendation	Department's Implementation Status Update	Implementation Date
Classification: Material Weakness **Report:** State of Colorado Statewide Single Audit June 2011 **Audit Year:** 2011/2012 **Audit Release Date:** June 2011/2012 **Rec Number:** 29/37	The Department of Health Care Policy and Financing (the Department) should ensure that requirements are met for the Children's Basic Health Plan (CBHP) program related to determining whether an individual has creditable coverage. In addition, the Department should ensure that the Colorado Benefits Management System (CBMS) is properly programmed to deny CBHP eligibility for individuals who are receiving Medicaid or Children's Health Insurance Program benefits in other states.	The Department has reviewed all three cases and determined that these were a result of data entry errors performed by eligibility site workers. As of February 2012, the errors been addressed with the eligibility site. Other health insurance information has correctly been entered in CBMS and the disenrollment of one individual from CHP+ has been completed. The Department has a process in place to utilize the PARIS tool to determine if a recipient is receiving public assistance benefits in another state. If it is verified that the recipient is residing out-of-state, the case will be end dated in CBMS to reflect the effective date that the individual began receiving public assistance in the other state. The Department is currently and will continue to work with its CHP+ vendor to ensure that this process and tool is being utilized. This process will replace the previous plans to implement PARIS in CBMS as an automated process to meet this recommendation.	Implemented

Audit Classification, Report, Audit Year, Audit Release Date, and Rec Number	Audit Recommendation	Department's Implementation Status Update	Implementation Date
Classification: Significant Deficiency **Report:** State of Colorado Statewide Single Audit June 2011 **Audit Year:** 2011 **Audit Release Date:** June 11 **Rec Number:** 35b	The Department of Health Care Policy and Financing should improve controls over the processing of medical claims for the Medicaid program by: (b) modifying the Medicaid State Plan and Department rules, as necessary, to include the exemptions from Lower of Pricing and submitting the State Plan modifications to the federal government for approval.	The Department does agree to work with the federal Centers for Medicare and Medicaid Services (CMS) to determine whether changes are needed to the State Plan based on the results of the federal Office of Inspector General's (OIG) report as it applies to the lower-of-pricing logic for Medicare cross-over claims. However, the Department disagrees with the OIG's finding related to this audit, and therefore will not make any changes to the State Plan unless required by CMS. The Department does agree that the pricing logic in the MMIS for Medicare cross-over claims identified in the OIG audit report should be reviewed to verify that coinsurance and deductible amounts are being paid when these types of claims cannot not be directly priced using the Medicaid pricing logic since the Medicare pricing logic is substantially different.	Not Implemented – Implementation Date: December 31, 2014.

Audit Classification, Report, Audit Year, Audit Release Date, and Rec Number	Audit Recommendation	Department's Implementation Status Update	Implementation Date
Classification: Significant Deficiency **Report:** State of Colorado Statewide Single Audit June 2012 **Audit Year:** 2012 **Audit Release Date:** June 12 **Rec Number:** 25	The Department of Health Care Policy and Financing (Department) should continue to work with the counties, Medical Assistance (MA) sites, and the Governor's Office of Information Technology and third-party administrator to ensure the accuracy of eligibility determinations and redeterminations for the Children's Basic Health Plan.	The Department continues to make tremendous improvements with eligibility determinations for the Medicaid and CHP+. Through its ongoing incentives with Medical Eligibility Quality Improvement Plan (MEQIP) and Colorado Eligibility Process Improvement Collaborative (CEPIC), the Department will continue to monitor its eligibility sites accuracy of eligibility determinations and redeterminations. Sites found to be struggling with the accurate processing of medical applications and/or redeterminations will be provided with individualized technical assistance and trainings to ensure accuracy. However, in a process that requires manual and human intervention, errors will always exist. One hundred percent accuracy is difficult to achieve when there are over 400 eligibility sites statewide that receive and/or process medical applications. The Department recognizes that this finding continues to occur yearly which is why various processes have been put in place to improve accuracy.	Implemented and Ongoing

Audit Classification, Report, Audit Year, Audit Release Date, and Rec Number	Audit Recommendation	Department's Implementation Status Update	Implementation Date
Classification: Significant Deficiency **Report:** State of Colorado Statewide Single Audit June 2012 **Audit Year:** 2012 **Audit Release Date:** June 12 **Rec Number:** 26	The Department of Health Care Policy and Financing (Department) should seek guidance from the federal oversight agency, the Centers for Medicare and Medicaid Services regarding the appropriate manner for reclassifying payments between the Children's Basic Health Plan and Medicaid programs. Additionally, the Department should develop and implement policies and procedures based on the guidance provided by the federal oversight agency.	The Department continues to work with the federal Centers for Medicare and Medicaid Services (CMS) on determining an appropriate process for reclassifying payments between Medicaid and CHP+. The Department has responded to the original questions from CMS and is waiting for further guidance. Once guidance is provided by CMS, the Department will develop and implement policies and procedures that are applicable when payments are required to be reclassified between Medicaid and CHP+.	Deferred – Implementation Date: Within 6 months of receiving CMS guidance
Classification: Significant Deficiency **Report:** State of Colorado Statewide Single Audit June 2012 **Audit Year:** 2012 **Audit Release Date:** June 12 **Rec Number:** 28	The Department of Health Care Policy and Financing (Department) should develop and implement procedures to ensure that personnel costs charged to federal grant programs are supported with adequate documentation. These procedures should include requirements to maintain required certifications, personnel activity reports, quarterly comparisons between estimated and actual budgets, or other equivalent documentation.	The Department will coordinate with its federal partner, the Centers for Medicare and Medicaid Services (CMS), to create a certification form that complies with the requirements set forth in OMB Circular A-87. In addition, the Department will create and implement procedures, which require Department staff to complete semi-annual certifications for all federal programs that it administers.	Deferred – Implementation Date: June 30, 2014

Audit Classification, Report, Audit Year, Audit Release Date, and Rec Number	Audit Recommendation	Department's Implementation Status Update	Implementation Date
Classification: Deficiency in Internal Controls (IC) **Report:** State of Colorado Statewide Single Audit June 2012 **Audit Year:** 2012 **Audit Release Date:** June 12 **Rec Number:** 31	The Department of Health Care Policy and Financing should improve its interagency agreement process to ensure that interagency agreements are initiated and approved timely, the related funds are transferred timely and appropriately, and that interagency agreement activity is timely and accurately recorded on the Colorado Financial Reporting System, the State's accounting system, throughout the year.	The Department has Implemented (a) option letters to ensure that interagency agreements are initiated and approved timely and appropriately and, (b) implemented the recording of Accounts Payable to ensure that activity is timely and accurately addressed on the Colorado Financial Reporting System (COFRS) throughout the year.	Implemented

Audit Classification, Report, Audit Year, Audit Release Date, and Rec Number	Audit Recommendation	Department's Implementation Status Update	Implementation Date
Classification: Deficiency in IC **Report:** State of Colorado Statewide Single Audit June 2012 **Audit Year:** 2012 **Audit Release Date:** June 12 **Rec Number:** 49	Strengthen controls by requiring that the CBMS service provider remediate the 18 exceptions listed in the Fiscal Year 2012 Statement on Standards for Attestation Engagements 16 report in a timely manner. Ensure the CBMS Service provider is held accountable for information system controls over the CBMS system.	Response from the Governor's Office of Information Technology: The Colorado Benefits Management System (CBMS) service provider has worked towards and implemented resolutions to remediate the 18 exceptions listed in the Fiscal Year 2012 Statement on Standards for Attestation Engagements 16 reports. For more information, please contact the Governor's Office of Information Technology who administers the CBMS service provider contract.	Implemented

Audit Classification, Report, Audit Year, Audit Release Date, and Rec Number	Audit Recommendation	Department's Implementation Status Update	Implementation Date
Classification: Material Weakness **Report:** State of Colorado Statewide Single Audit June 2009 **Audit Year:** 2009 **Audit Release Date:** June 09 **Rec Number:** 59c	Reduce eligibility determination errors for the Children's Basic Health Plan (CBHP) by improving oversight and training of eligibility sites by (c) investigating the causes of the CBMS errors identified in the audit and modify CBMS as needed to correct them.	The Department continues to make tremendous improvements with eligibility determinations for Medicaid and CHP+. Through its ongoing incentives with Medical Eligibility Quality Improvement Plan (MEQIP) and Colorado Eligibility Process Improvement Collaborative (CEPIC), the Department will continue to monitor its eligibility sites accuracy of eligibility determinations and redeterminations. Sites found to be struggling with the accurate processing of medical applications and/or redeterminations will be provided with individualized technical assistance and trainings to ensure accuracy. However, in a process that requires manual and human intervention, errors will always exist. One hundred percent accuracy is difficult to achieve when there are over 400 eligibility sites statewide that receive and/or process medical applications. The Department recognizes that this finding continues to occur yearly which is why various processes have been put in place to improve accuracy.	Implemented and Ongoing
Classification: Significant Deficiency **Report:** State of Colorado Statewide Single Audit June 2009	Improve the Medicaid Management Information System (MMIS) user access controls by immediately implementing our prior year recommendation and strengthening MMIS's operating system, including (a) evaluating MMIS user access profiles and identifying those profiles, or combinations of profiles, that are	(a) The Department agrees that client and provider information in the MMIS must be protected and appropriate access by Department staff must follow proper controls. It should be noted that Department staff access to the MMIS does not provide the ability for staff to update client information, submit claims, or authorize payment to a provider. The Department staff utilize the MMIS for the retrieval of	Not Implemented – Implementation date: December 31, 2014

Audit Classification, Report, Audit Year, Audit Release Date, and Rec Number	Audit Recommendation	Department's Implementation Status Update	Implementation Date
Audit Year: 2009 **Audit Release Date:** June 09 **Rec Number:** 73a, c, d	appropriate for different system users. This information should be shared with the supervisors of MMIS users; (c) ensuring that profiles or profile combinations that provide escalated system privileges are identified and tightly controlled, including the establishment of compensating controls; (d) Periodically reviewing MMIS user access level for appropriateness and promptly removing access for terminated users, including comparing active MMIS users to termination information contained in the Colorado Personnel and Payroll System and requiring Business Managers to annually verify the accuracy and relevance of access level belonging to the MMIS users they supervise.	information on clients, providers, and claims and general access to the system is read-only. The ability to update information in the MMIS is very limited, such as manually enrolling clients into a Managed Care Organization, and is limited to particular staff based on their job function. All access to the MMIS is authorized through proper security controls and Department's Information Security Unit verifies user role and provides access to the MMIS through a formal request process. At this time, user specific profiles to provide role-based access are not clearly defined and documented. The Department has initiated a LEAN initiative that will define user profiles and will assign the appropriate use profile through the user's the Department's official Position Description Questionnaire (PDQ) that is required for all positions. (c) The Department has initiated a LEAN initiative that will define user profiles and will assign the appropriate use profile through the user's the Department's official Position Description Questionnaire (PDQ) that is required for all positions. Through the LEAN initiative, if a user's access needs to be terminated or modified, the appropriate supervisor will need to approve that change through a modification to the PDQ. The Department will request that the appropriate supervisor review periodically that user access to the MMIS is specified correctly in the PDQ. Further, Department staff access to the MMIS is only available through an authorized Department LAN access, as access is not web-based. Therefore, when staff are no longer employees of the Department,	

Audit Classification, Report, Audit Year, Audit Release Date, and Rec Number	Audit Recommendation	Department's Implementation Status Update	Implementation Date
		their MMIS user access is disabled but so is their LAN access, which would prevent access to the MMIS. (d)) periodically reviewing MMIS user access levels for appropriateness and promptly removing access for terminated users, including comparing active MMIS users to termination information contained in the Colorado Personnel Payroll System and requiring business managers to annually verify the accuracy and relevance of access levels belonging to the MMIS users they supervise.	
Classification: Deficiency in IC **Report:** State of Colorado Statewide Single Audit June 2009 **Audit Year:** 2009 **Audit Release Date:** June 09 **Rec Number:** 75	Health Care Policy and Financing should review its policy that excludes certain procedures from the Medicare lower of pricing logic to assess the appropriateness of these exclusions, particularly related to cost-control strategies for the Medicaid Program.	The Department does agree to work with the federal Centers for Medicare and Medicaid Services (CMS) to determine whether changes are needed to the State Plan based on the results of the federal Office of Inspector General's (OIG) report as it applies to the lower-of-pricing logic for Medicare cross-over claims. However, the Department disagrees with the OIG's finding related to this audit, and therefore will not make any changes to the State Plan unless required by CMS. The Department does agree that the pricing logic in the MMIS for Medicare cross-over claims identified in the OIG audit report should be reviewed to verify that coinsurance and deductible amounts are being paid when these types of claims cannot not be directly priced using the Medicaid pricing logic since the Medicare pricing logic is substantially different.	Not Implemented – Implementation Date: December 31, 2014.

Audit Classification, Report, Audit Year, Audit Release Date, and Rec Number	Audit Recommendation	Department's Implementation Status Update	Implementation Date
Classification: Deficiency in IC **Report:** State of Colorado Statewide Single Audit June 2009 **Audit Year:** 2009 **Audit Release Date:** June 09 **Rec Number:** 76a	Improve controls to prevent Medicaid payments for services to deceased individuals by (a) periodically evaluating the effectiveness of methods used to identify payments made for services provided after a client's death and implementing changes to these methods, as necessary.	The Department recovers managed care capitation payments and subsequently added certain fee-for-service payments for recovery as well. The Department has also reviewed other fee for service payments to determine whether such payments should be included in the Department's recovery process.	Implemented

Audit Classification, Report, Audit Year, Audit Release Date, and Rec Number	Audit Recommendation	Department's Implementation Status Update	Implementation Date
Classification: Control Deficiency **Report:** State of Colorado Statewide Single Audit June 2009 **Audit Year:** 2009 **Audit Release Date:** June 09 **Rec Number:** 79c	Strengthen contract provisions and its monitoring of contractors responsible for performing prior authorization reviews of durable medical equipment and supplies requested for Medicaid clients by: (c) implementing a formal oversight program for each of its prior authorization contractors, including on-site visits.	A formal oversight of the State's Utilization Management (UM) program has been an integral part of the Department's management since APS became its contractor. APS submits reports to the Department regularly to provide information on UM activities and progress as well as current utilization measures. APS also provide a monthly Utilization Review Report to summarize all Utilization Review activities. These reports include: 1) The number of prior authorizations (PAR) requested for each service requiring a PAR during the month, the number of Technical/Administrative plus Denials issued, and the number of medical denials issue. 2) The PAR Response Center report, including call volume during the quarter, the number and percentage of these that were answered within 15 seconds, the number and percentage answered within 2 minutes, and the number and percentage of busy signal/abandoned calls. 3) Trends in review overcomes during the month, including services with few or no denials of PAR requests and services with a high percentage of denials. The Department's UM Contract Manager is currently developing meaningful audit criteria for the site visit and will schedule the visit within FY 2013-14.	Implemented

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LEGAL MEMORANDUM

TO: Senator Maryanne ("Moe") Keller

FROM: Office of Legislative Legal Services

DATE: December 22, 2008

SUBJECT: Whether a "hospital provider fee" is a tax for purposes of section 20 (4) (a) of article X of the Colorado constitution[1]

I. Background

You have proposed a bill that would establish a "hospital provider fee" to be paid by hospitals in Colorado to the department of health care policy and financing. Moneys generated by the provider fee would be used to obtain federal matching funds. Both the hospital provider fee and the matching federal funds would then be used to increase reimbursement rates for hospitals under Medicaid, the Children's Basic Health Plan ("CHP+"), and the Colorado Indigent Care Program ("CICP"), and to expand eligibility thresholds under Medicaid and CHP+.

II. Issue Presented

Would the imposition of a hospital provider fee to be used for increasing Medicaid hospital reimbursement rates and expanding Medicaid eligibility constitute a tax requiring voter approval for purposes of section 20 (4) (a) of article X of the Colorado Constitution?

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[1] This legal memorandum results from a request made to the Office of Legislative Legal Services (OLLS), a staff agency of the General Assembly, in the course of its performance of bill drafting functions for the General Assembly. OLLS legal memorandums do not represent an official legal position of the General Assembly or the state of Colorado and do not bind the members of the General Assembly. They are intended for use in the legislative process and as information to assist the members in the performance of their legislative duties. Consistent with the OLLS' position as a staff agency of the General Assembly, OLLS legal memoranda generally resolve doubts about whether the General Assembly has authority to enact a particular piece of legislation in favor of the General Assembly's plenary power.

III. Conclusion

No. The intent of the hospital provider fee would be to increase reimbursements to the hospitals paying the fee, not to increase revenue for general governmental purposes. Therefore, the hospital provider fee would not be a tax requiring prior voter approval under 20 (4) (a) of article X of the state constitution.

IV. Analysis

A. Proposed Legislation

You have requested this office to draft a bill to impose a hospital provider fee. The proposed bill would contain the following general provisions:

- Creation of a fee that:
  - -- Would be assessed on hospitals based upon the number of patient days;
  - -- Would represent approximately 3% of the hospital's total patient revenue;
  - -- May be lower for rural or critical access hospitals;
  - -- May not be imposed on psychiatric and Medicare certification long term hospitals; and
  - -- Would be deposited into a hospital provider cash fund in the state treasury (the "cash fund").
- Provide that moneys in the cash fund would be used to:
  - -- Increase Medicaid, CHP+, and CICP hospital reimbursement rates; and
  - -- Increase the eligibility thresholds for Medicaid and CHP+, thereby increasing reimbursements to hospitals and other public health care providers.
- Ensure that the moneys in the cash fund would not
  - -- Supplant existing moneys appropriated for Medicaid, CHP+, or CICI; and
  - -- Would not revert to the general fund at the end of a fiscal year.
- Require that the department of health care policy and financing ("department") receive a match from the federal government at least equal to the hospital provider fee payments made by hospitals.
- Direction to the department to use moneys from the federal match to further expand eligibility for recipients under Medicaid and CHP+ resulting in increased payments to all providers, including but not limited to hospitals.

- Require that, due to the federal match, hospitals as a whole would receive more than the fees collected, although not every hospital would necessarily receive back the full amount of the fee it paid.

B. Is the proposed hospital provider fee a "tax" within the meaning of TABOR?

The issue has been raised whether the imposition of a hospital provider fee by the department is a tax requiring voter approval pursuant to section 20 of article X of the Colorado Constitution ("article X, section 20"). Article X, section 20 (4) (a), requires "voter approval in advance" for "any new tax, tax rate increase, mill levy above that for the prior year, valuation for assessment ratio increase for a property class, or extension of an expiring tax, or a tax policy change directly causing a net tax revenue gain." If the hospital provider fee is determined to be a "tax", it would require prior voter approval.

Since "tax" is not defined by article X, section 20, this office has developed guidelines, based upon Colorado judicial decisions, for the purpose of determining whether a pecuniary charge is a "tax" under this constitutional provision. The first step is determining whether a charge is a pecuniary charge imposed by legislative authority to raise money for a public purpose. In applying the first step of the analysis, the hospital provider fee may be a tax since it meets all three provisions of the first step. Based upon this conclusion, it is necessary to proceed to the second step of the analysis.

The second step requires a determination of whether the hospital provider fee qualifies as one of several types of charges that are not taxes. One type of charge that is not a tax is a "fee", which, based upon Colorado court decisions, we believe is "a charge which is made to defray the cost of a product, service, or regulation that is reasonably related to the overall cost, even though mathematical exactitude is not required, and which is not made primarily for the purpose of raising revenue for general public purposes." Since the purpose of the hospital provider fee is to increase reimbursements to hospitals, it is not intended to raise money for general public purposes. Thus, under the guidelines of this office, we believe that the proposed hospital provider fee would be a fee, not a tax requiring voter approval.

The determination that the hospital provider fee is a fee under article X, section 20, is consistent with Colorado Supreme Court decisions. In *Barber v. Ritter*, __ P.3d __ (Colo. 2008) (2008 WL 4767999), the Colorado Supreme Court specifically examined the distinction between a "fee" and a "tax" for purposes of article X, section 20. In *Barber*, the Colorado Supreme Court

held:

> A fee is distinct from a tax in that, "[u]nlike a tax, a special fee is not designed to raise revenues to defray the general expenses of government, but rather is a charge imposed upon persons or property for the purpose of defraying the cost of a particular governmental service." *Bloom v. City of Fort Collins*, 784 P.2d 304, 308 (Colo. 1989). To determine whether a government mandated financial imposition is a "fee" or a "tax," the dispositive criteria is the primary or dominant purpose of such imposition at the time the enactment calling for its collection is passed. *Zelinger v. City and County of Denver*, 724 P.2d 1356, 1358 (Colo. 1986).

(2008 WL 476799 at *30). The Court went on to hold:

> If the language discloses that the primary purpose for the charge is to finance a particular service utilized by those who must pay the charge, then the charge is a "fee." On the other hand, if the language states that a primary purpose for the charge is to raise revenues for general governmental spending, then it is a tax. Moreover, the fact that a fee incidentally or indirectly raises revenue does not alter its essential character as a fee, transforming it into a tax. *Western Heights Land Corp. v. City of Fort Collins*, 146 Colo. 464, 469, 362 P.2d 155, 158 (1961).

(2008 WL 4767999 at *31). The issue in *Ritter* was whether the transfer of moneys in various cash funds to the general fund constituted a "tax policy change directly causing a net tax revenue gain" requiring voter approval under article X, section 20. In concluding that the transfers were not such a tax policy change, the court specifically found that fees intended to defray the cost of special services provided to those who paid the charge were not taxes.

The proposed hospital provider fee, similar to the fees in *Ritter*, would not be intended to raise revenues for general governmental spending. Rather, the fees would be used to increase reimbursement rates to the hospitals that paid the fees. The hospitals would benefit from paying the fees because the higher reimbursement rates would result in increased matching money from the federal government that would be used to both increase the hospital reimbursement rates and increase the number of persons eligible for benefits under Medicaid and the CHP+. As providers under those programs, the hospitals would see increased revenue generated by the increased number of

recipients. Thus, the hospital provider fee would not be intended to generate, and would not result in, increased revenues for general governmental purposes.

In an earlier decision, *Bloom v. City of Fort Collins*, 784 P.2d 304 (Colo. 1990), the Colorado Supreme Court discussed the differences between various types of assessments, including property taxes, excise taxes, special assessments, and special fees. Although the case arose before article X, section 20, was adopted, the Court's discussion contains some language that is helpful in distinguishing a fee from a tax:

> Unlike a tax, a special fee is not designed to raise revenues to defray the general expenses of government, but rather is a charge imposed upon persons or property for the purpose of defraying the cost of a particular governmental service. *See* 1 Cooley, *The Law of Taxation* § 33 (4th ed. 1924); O. Reynolds, Jr. *Local Government Law* §105. The amount of a special fee must be reasonably related to the overall cost of the service. . . Mathematical exactitude, however, is not required, and the particular mode adopted by a city in assessing the fee is generally a matter of legislative discretion.

Bloom, 784 P.2d at 308. The question in that case was whether a "transportation utility fee", assessed on property owners whose lots fronted on city streets and calculated on the basis of the number of linear feet of frontage, was actually a tax. The revenue was devoted to the maintenance of city streets. The Court held that the charge was not a tax so long as an accompanying transfer provision was not used. The Court stated:

> The ordinance creating the fee, however, is not devoid of all defect. Section 108A-13 authorizes the city council to transfer any excess revenues not required to satisfy the purpose of the ordinance to any other fund of the city. The transfer of a substantial amount of money generated by the transportation utility fee to some other city fund would be tantamount to requiring the class of persons responsible for the fee--the owners or occupants of developed lots fronting city streets--to bear a disproportionate share of the burden of providing revenues to defray *general governmental expenses* unrelated to the purpose for which the fee is imposed. The effect of such a transfer would be to render the transportation utility fee the functional equivalent of a tax.

Id., 784 P.2d at 311 (emphasis in original). Applying this reasoning to the hospital provider fee, the provider fee is not a tax because no portion of it is used to defray "general governmental expenses". The moneys collected pursuant to the provider fee are placed in the hospital provider cash fund, a special cash fund created for, and specifically limited to the use of, increasing hospital reimbursement rates under Medicaid, CHP+, and CICP. The hospital provider cash fund is separate from the general fund of the state from which general governmental expenses are paid. Moneys collected and credited to the cash fund are to be used only for the specified purposes. If any moneys remain in the cash fund at the end of a year, it does not revert to the general fund.

Additionally, the proposed hospital provider fee is very similar to the nursing home provider fee established in section 25.5-6-203, C.R.S. Under that section, similar to the proposed hospital provider fee, the department can charge a provider fee to nursing facility providers, the fee is deposited in a cash fund in the state treasury, moneys in the cash fund are used to obtain federal matching funds, and moneys in the fund and from the federal match can only be used for specified purposes relating to reimbursements of nursing facility providers. The nursing facility provider fee was not submitted for voter approval under section 20 (4) (a) of article X. The Colorado Supreme Court has held that there is a heavy presumption of constitutionality of enacted statutes and that the presumption of a statute's constitutionality can be overcome only if it is shown that the enactment is unconstitutional beyond a reasonable doubt. *Colorado Ass'n of Pub. Employees v. Board of Regents of the Univ. of Colo.*, 804 P.2d 138, 142 (Colo. 1990). As the nursing facility provider fee is presumed to be constitutional, given the similarities between it and the hospital provider fee, the hospital provider fee should also be presumed to be constitutional.

For these reasons, the hospital provider fee would be considered a fee and not a tax under *Ritter* and *Bloom* and would not be subject to voter approval under article X, section 20.

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OFFICE OF THE GOVERNOR

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John W. Hickenlooper
Governor

D 2013-033

EXECUTIVE ORDER

Extending and Amending the Declaration of Disaster Emergency Due to Historic Flooding of September 2013

Pursuant to the authority vested in the Governor of the State of Colorado and, in particular, pursuant relevant portions of C.R.S. § 28-3-104 and relevant portions of the Colorado Disaster Emergency Act, C.R.S. § 24-33.5-701, *et seq.*, I, Joseph A. Garcia, Lieutenant Governor of the State of Colorado, hereby issue this Executive Order extending the Declaration of Disaster Emergency and incorporating by reference all sections therein unless specifically altered below due to the historic flooding of September 2013.

I. Background and Purpose

The Governor is responsible for meeting the dangers to the state and people presented by disasters. C.R.S. § 24-33.5-704. The Colorado Disaster Emergency Act defines a disaster as "the occurrence or imminent threat of widespread or severe damage, injury, or loss of life or property resulting from any natural cause or cause of human origin, including but not limited to . . . flood." C.R.S. §24-33.5-703(3).

As a result of the historic flooding this September, nine people were killed, 218 people were injured and over 18,000 people were forced to leave their homes. Additionally one individual was killed assisting in the recovery effort. The flooding was widespread and impacted twenty-four counties. Property damage has been extensive: 1,852 homes have been destroyed, and as of December 6, 2013, 28,432 households have registered with the Federal Emergency Management Agency ("FEMA"). Over 200 households remain displaced, and FEMA continues to deploy its direct housing mission to those most severely impacted. Five households remain in the Transitional Sheltering Program.

The State of Colorado, in strong collaboration with local municipalities, the National Guard, the federal government, and non-govermental organizations, continue to make considerable

progress in rebuilding Colorado's infrastructure. Although all state highways are now open, flooding of this magnitude caused damage to infrastructure on multiple levels. Over 200 households remain displaced due to damage to private roads and bridges. Federal and state authorities continue to develop plans to address this critical issue. Work remains to be done in repairing water treatment facilities, wastewater treatment facilities, and miles of water lines. It is critical the recovery efforts continue at full speed, even with the arrival of winter. This Executive Order extends the declaration of Disaster Emergency and supports the critical and ongoing flood recovery efforts.

II. Declaration and Directives

A. The Front Range flooding and recovery continues to constitute a Disaster Emergency under C.R.S. §§ 24-33.5-701, 705. The declarations and directives found in Executive Orders D 2013-026, D 2013-027, 2013-028, D 2013-030, and D 2013-031 are hereby extended an additional 30 days from December 7, 2013.

B. Paragraph II (B) of Executive Orders D 2013-028 and D 2013-031 is hereby replaced to read as follows.

> Pursuant to C.R.S. § 24-33.5-706(4) the funds in the Disaster Emergency Fund are found to be insufficient to pay for the flood response and recovery. Therefore, it is ordered that $12,950,000 be transferred into the Disaster Emergency Fund from the Controlled Maintenance Trust Fund established in C.R.S. 24-75-302.5; and $50,000,000 be transferred into the Disaster Emergency Fund from the General Fund appropriation in Fiscal Year 2013-14 to the Department of Health Care Policy and Financing Medical Services Premiuims line item. It is further ordered that this $91,500,000 from the Disaster Emergency Fund is encumbered to pay for the flood response and recovery. This amount shall include $26,000,000 encumbered pursuant to Executive Order D 2013-027(II)(C) and $65,000,000 encumbered pursuant to Executive Orders D 2013-028 and D 2013-031(II)(B), as amended herein. The Director of the Office of Emergency Management is hereby authorized and directed to allocate the funding to the appropriate government agencies and non-profit organizations and execute awards, purchase orders, or other mechanisms to effect the allocation of the funds. The Director of the Office of Emergency Management is also authorized to allocate up to $20,000,000 to be used as short-term, no-interest loans in order to provide any political subdivision of the state with short-term capital needed for flood response and recovery. These funds shall remain available for this purpose for thirty-six months from the date

of this Executive Order, and any unexpended funds shall remain in the Disaster Emergency Fund.

III. Duration

This Executive Order shall expire thirty days from December 7, 2013, unless extended further by Executive Order, except that the funds described in paragraph II(B) of this Executive Order and paragraph II(C) of Executive Order D 2013-027 above shall remain available for the described purposes for thirty-six months from today's date.

GIVEN under my hand and the Executive Seal of the State of Colorado this ninth day of December, 2013.

Joseph A. Garcia
Lieutenant Governor

STATE OF COLORADO

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John W. Hickenlooper
Governor

D 2013-031

EXECUTIVE ORDER

Extending the Declaration of Disaster Emergency Due to Historic Flooding of September, 2013

Pursuant to the authority vested in the Governor of the State of Colorado and, in particular, pursuant to relevant portions of C.R.S. § 28-3-104 and relevant portions of the Colorado Disaster Emergency Act, C.R.S. § 24-33.5-701, *et seq.*, I, John W. Hickenlooper, Governor of the State of Colorado, hereby issue this Executive Order extending the Declaration of Disaster Emergency and incorporating by reference all sections therein unless specifically altered below due to the historic flooding of September, 2013.

I. Background and Purpose

The Governor is responsible for meeting the dangers to the state and people presented by disasters. C.R.S. § 24-33.5-704. The Colorado Disaster Emergency Act defines a disaster as "the occurrence or imminent threat of widespread or severe damages, injury or loss of life or property resulting from any natural cause or cause of human origin, including but not limited to . . . flood." C.R.S. § 24-33.5-703(3).

As a result of the historic flooding this September nine people were killed, 218 people were injured and over 18,000 people were forced to leave their homes. Additionally, one individual was killed assisting in the recovery effort. This flooding was widespread and impacted twenty-four counties. Damage to property has been extensive: 1,882 homes have been destroyed and as of November 5, 2013, 26,893 households have registered with FEMA.

The State of Colorado, in strong collaboration with local municipalities, the National Guard, the federal government, and non-governmental organizations, continues to make considerable progress in rebuilding Colorado's infrastructure. Eighty-one percent of state highways are now open, but flooding of this magnitude caused damage to infrastructure on multiple levels. Work remains to be done in repairing water treatment facilities, wastewater treatment facilities, and miles of water lines. It is critical the recovery efforts continue at full speed before winter fully

arrives. This Executive Order extends the declaration of Disaster Emergency and supports the critical and ongoing flood recovery efforts.

II. Declaration and Directives

A. The Front Range flooding and recovery continues to constitute a Disaster Emergency under C.R.S. § 24-33.5-701, 705. The declarations and directives found in Executive Order D 2013-026, Executive Order D 2013-027, Executive Order D 2013-028 and Executive Order D 2013-030 are hereby extended an additional 30 days from the signing of this Executive Order.

B. Paragraph II (B) of Executive Order D 2013-028 is hereby replaced to read as follows:

> Pursuant to C.R.S. 24-33.5-706(4), I find the funds in the Disaster Emergency Fund to be insufficient to pay for the flood response and recovery. Therefore, it is ordered that $12,950,000 be transferred into the Disaster Emergency Fund from the Controlled Maintenance Trust Fund established in C.R.S. 24-75-302.5; and $50,000,000 be transferred into the Disaster Emergency Fund from the General Fund appropriation in Fiscal year 2013-14 to the Department of Health Care Policy and Financing Medical Services Premiums line item. It is further ordered that $65,500,000 from the Disaster Emergency Fund is encumbered to pay for the flood response and recovery. The Director of the Office of Emergency Management is hereby authorized and directed to allocate the funding to the appropriate government agencies and non-profit organizations and execute awards, purchase orders, or other mechanisms to effect the allocation of the funds. The Director of the Office of Emergency Management is also authorized to allocate up to $20,000,000 to be used as short-term, no-interest loans in order to provide any political subdivision of the state with short-term capital needed for flood response and recovery. These funds shall remain available for this purpose for eighteen months from the data of this Executive Order, and any unexpended funds shall remain in the Disaster Emergency Fund.

III. Duration

This Executive Order shall expire thirty days from November 6, 2013, unless extended further by Executive Order, except that the funds described in paragraph II(B) above shall remain available for the described purposes for eighteen months from the date of this Executive Order.

GIVEN under my hand and the Executive Seal of the State of Colorado this sixth day of November, 2013.

John W. Hickenlooper
Governor

STATE OF COLORADO

OFFICE OF THE GOVERNOR

136 State Capitol Building
Denver, Colorado 80203
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John W. Hickenlooper
Governor

D 2013-030

EXECUTIVE ORDER

Amending the Authorization of Disaster Emergency to Include Additional Counties Affected by the Historic Flooding of September, 2013.

Pursuant to the authority vested in the Governor of the State of Colorado and, in particular, pursuant to relevant portions of C.R.S. § 28-3-104 and relevant portions of the Colorado Disaster Emergency Act, C.R.S. § 24-33.5-701, *et seq.*, I, John W. Hickenlooper, Governor of the State of Colorado, hereby issue this Executive Order amending the authorization of Disaster Emergency to include additional counties affected by the historic flooding of September, 2013.

I. Background and Purpose

The Governor is responsible for meeting the dangers to the state and people presented by disasters. C.R.S. § 24-33.5-704. The Colorado Disaster Emergency Act defines a disaster as "the occurrence or imminent threat of widespread or severe damages, injury or loss of life or property resulting from any natural cause or cause of human origin, including but not limited to . . . flood." C.R.S. § 24-33.5-703(3).

As a result of the historic flooding this September, eight people were killed, one person is still missing, 218 people were injured and over 18,000 people were forced to leave their homes. Damage to property has been widespread and extensive: 1,882 homes have been destroyed and FEMA estimates that over 26,000 households are directly affected by the flooding. As of October 6, 2013, 23,078 households have registered with FEMA.

The Colorado Department of Transportation, with assistance of the National Guard of Colorado, the National Guard of other states and local jurisdictions, has made record setting progress in repairing highways, roads, and bridges. Nevertheless, communities continue to be isolated, residents remain displaced, and many local businesses are shuttered or struggling. Three water treatment facilities and four wastewater treatment facilities are still not operating, with over twenty of each needing some type of repair and/or restoration. This does not include the miles of water and wastewater lines that need repair or replacement. As the state continues to

realize the magnitude of this disaster, additional counties, beyond those identified in previous Executive Orders, require state assistance to recover and rebuild.

The list of counties affected by the flooding, as declared and memorialized by Executive Order D 2013-026, Executive Order D 2013-027 and this Executive Order now include: Adams, Arapahoe, Broomfield, Boulder, Chaffee, Clear Creek, Crowley, Denver, El Paso, Fremont, Gilpin, Jefferson, Lake, Larimer, Lincoln, Logan, Morgan, Otero, Park, Pueblo, Prowers, Sedgwick, Washington, and Weld.

II. Declaration and Directives

A. The flooding along the Front Range continues to constitute a Disaster Emergency under C.R.S. § 24-33.5-701, 705. The declarations and directives found in Executive Order D 2013-026, Executive Order D 2013-027 and Executive Order D 2013-028 are hereby amended to be extended an additional 30 days from the signing of this Executive Order.

B. I hereby declare a Disaster Emergency due to the flooding for Chaffee, Crowley, Gilpin, Lake, Lincoln, Otero, Park and Prowers counties. This declaration shall have the full force and effect as if contained in Executive Order D 2013-026.

III. Duration

This Executive Order shall expire thirty days from October 8, 2013, unless extended further by Executive Order.

GIVEN under my hand and the Executive Seal of the State of Colorado this eighth day of October, 2013.

John W. Hickenlooper
Governor

STATE OF COLORADO

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Denver, Colorado 80203
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John W. Hickenlooper
Governor

D 2013-026

EXECUTIVE ORDER

Declaring a Disaster Emergency Due to the Flooding in Adams, Arapahoe, Broomfield, Boulder, Denver, El Paso, Fremont, Jefferson, Larimer, Logan, Morgan, Pueblo, Washington, and Weld Counties (Front Range Flooding)

Pursuant to the authority vested in the Governor of the State of Colorado and, in particular, pursuant relevant portions of C.R.S. § 28-3-104 and relevant portions of the Colorado Disaster Emergency Act, C.R.S. § 24-33.5-701, *et seq.*, I, John W. Hickenlooper, Governor of the State of Colorado, hereby issue this Executive Order declaring a state of disaster emergency due to the flooding in Adams, Arapahoe, Broomfield, Boulder, Denver, El Paso, Fremont, Jefferson, Larimer, Logan, Morgan, Pueblo, Washington, and Weld Counties, Colorado, and making resources available to search for flood victims, assist flood survivors, remove the flood debris, provide flood emergency protective measures, address the disaster emergency, and assist with flood recovery.

I. Background and Purpose

The Governor is responsible for meeting the dangers to the state and people presented by disasters. The Colorado Disaster Emergency Act defines a disaster as "the occurrence or imminent threat of widespread or severe damages, injury or loss of life or property resulting from any natural cause or cause of human origin, including but not limited to . . . flood." C.R.S. § 24-33.5-703(3).

Beginning on September 11, 2013, heavy rainfall fell west of Interstate 25 from south of Colorado Springs to the Wyoming border. The greatest impact was in Boulder County, where up to eight inches of rain fell by 0700 hours on September 12, 2013. Rainfall continues with the National Weather Service predicting another 2 – 4 inches by 0700 hours on September 13, 2013. While authorities cannot conduct damage assessments until the rainfall subsides and the flooding recedes; known consequences are three fatalities, three injuries, damage to a natural gas distribution pipeline, power outages, at least two structures destroyed, water damage to

approximately 40 building on the University of Colorado – Boulder campus, isolation of the towns of Estes Park, Jamestown, Lyons, and Nederland, damage to U.S. Highway 34 near Drake, Dillon Road in Boulder County, closure of numerous roads in local jurisdictions, and damage to the Town of Lyons wastewater treatment system.

On September 12, 2013, Boulder County requested state assistance of the Colorado National Guard for helicopter search and rescue missions at daylight. At approximately 0045 hours, I verbally approved this request. At approximately 0235 hours, Boulder County upgraded the request to utlilize National Guard assets immediately. I approved this request and authorized use of the Colorado National Guard for this or any other flood related mission in any affected counties. Further, this Executive Order authorizes the Colorado National Guard to enforce the laws of the State of Colorado upon request from any local jurisdiction affected by the flooding.

At approximately 0700 hours, I verbally declared a disaster emergency for the flooding in Boulder and Larimer Counties and activated the State Emergency Operations Plan. This declaration adds additional counties affected by the continuing flooding.

II. Declaration and Directives

A. The flooding along the Front Range constitutes a disaster emergency under C.R.S. § 24-33.5-701, 705. My verbal order of September 12, 2013, declaring a disaster emergency is hereby memorialized by this Executive Order and shall have the full force and effect of law as if it were contained within this Executive Order.

B. The State Emergency Operations Plan is hereby activated. All State departments and agencies shall take whatever actions may be required and requested by the Director or Acting Director of the Office of Emergency Management, including provision of appropriate staff and equipment as necessary.

C. Pursuant to C.R.S. § 24-33.5-706(4) the funds in the Disaster Emergency Fund are found to be insufficient to pay for the flood response and recovery. Therefore, it is ordered that $6,000,000 be transferred into the Disaster Emergency Fund from the General Fund appropriation in Fiscal Year 2013-14 to the Controlled Maintenance Trust Fund. It is further ordered that this $6,000,000 from the Disaster Emergency Fund is encumbered to pay for the flood response and recovery. Included in the specified amount is $1,000,000 for recovery related to this disaster. The Director of the Office of Emergency Management is hereby authorized and directed to allocate the funding to the appropriate government

agencies and non-profit organizations and execute awards, purchase orders or other mechanisms to effect the allocation of the funds. These funds shall remain available for this purpose for eighteen months from the date of this Executive Order, and any unexpended funds shall remain in the Disaster Emergency Fund.

D. The Division of Homeland Security and Emergency Management is authorized and directed to coordinate application to the federal government for funds available for reimbursement and to coordinate application for any other funds available related to this disaster emergency.

E. My verbal orders of September 12, 2013, activating the National Guard, authorizing the utilization of National Guard assets for any flood related missions, and enforcing the laws of the State of Colorado as provided in C.R.S. § 16-2.5-144 are hereby memorialized by this Executive Order and shall have the full force and effect of law as if they were contained within this Executive Order.

F. Under the provisions of C.R.S. § 24-33.5-704 (7) (a), (e), & (g) and in the interest of public safety, I hereby authorize and local sheriff and police departments to suspend recreational boating in the affected counties as appropriate and the Division of Parks and Wildlife to do the same for state public recreation areas in the affected counties for the duration of this Executive Order.

G. For the purposes of sections 125 and 120(e) of Title 23 of the United States Code, I hereby find that the damage to the affected counties as a result of the flooding constitutes an emergency. The immediate repair to highways in these counties is vital to ensuring that necessary improvements are made to mitigate future similar incidents and provide for safe and reliable transportation for area residents. The Federal Highway Administration Colorado Division Administrator is requested to concur in the declaration of this emergency. This declaration shall permit the Colorado Department of Transportation to pursue federal transportation emergency relief funds, as is provided under the United States Code. The Executive Director of the Colorado Department of Transportation is authorized and directed to coordinate application to the federal government for funds available for reimbursement and to coordinate application for any other funds available related to this disaster emergency.

III. Duration

This Executive Order shall expire thirty days from September 12, 2013 unless extended further by Executive Order, except that the funds described in paragraph II (C) above shall remain available for the described purposes for eighteen months from the date of this Executive Order.

GIVEN under my hand and the Executive Seal of the State of Colorado this thirteenth day of September, 2013.

John W. Hickenlooper
Governor

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John W. Hickenlooper
Governor

D 2013-027

EXECUTIVE ORDER

Amending the Declaration of Disaster Emergency Due to the Flooding in Adams, Arapahoe, Broomfield, Boulder, Denver, El Paso, Fremont, Jefferson, Larimer, Logan, Morgan, Pueblo, Washington, and Weld Counties (Front Range Flooding)

Pursuant to the authority vested in the Governor of the State of Colorado and, in particular, pursuant to relevant portions of C.R.S. § 28-3-104 and relevant portions of the Colorado Disaster Emergency Act, C.R.S. § 24-33.5-701, *et seq.*, I, John W. Hickenlooper, Governor of the State of Colorado, hereby issue this Executive Order amending Executive Order D 2013-026 declaring a disaster emergency due to the flooding in Adams, Arapahoe, Broomfield, Boulder, Denver, El Paso, Fremont, Jefferson, Larimer, Logan, Morgan, Pueblo, Washington, and Weld Counties, Colorado.

I. Background and Purpose

The Governor is responsible for meeting the dangers to the state and people presented by disasters. The Colorado Disaster Emergency Act defines a disaster as "the occurrence or imminent threat of widespread or severe damages, injury or loss of life or property resulting from any natural cause or cause of human origin, including but not limited to . . . flood." C.R.S. § 24-33.5-703(3).

On September 13, 2013, I issued Executive Order D 2013-26 declaring a Disaster Emergency in 14 counties on account of flooding. Since that time, the affected areas received extensive additional rainfall. As of September 18, 2013, the National Weather Service reported that 7-day rain totals have reached as high as 18.1 inches in Boulder County, 12.4 inches in Larimer County, 15.6 inches in Adams County, and 11.6 inches in El Paso County. Initial estimates of the casualties and property damage are as follows: six persons are deceased, 17,648 structures have been damaged, which includes 4,047 structures that have been destroyed, 30 bridges have been destroyed, and 20 others have been seriously damaged. As of 1100 on September

18, 2013, a total of 754 troops, 19 helicopters, 20 ground search-and-rescue teams, and 67 traffic-control points were operational.

After the Executive Order was issued on September 13, 2013, I verbally declared a disaster emergency and activated the State Emergency Operations Plan in two additional counties, Clear Creek and Sedgwick, because of significant rainfall to that area.

In Executive Order D 2013-26, I ordered that $6,000,000 be transferred into the Disaster Emergency Fund. The estimated cost of disaster relief so far has been approximately $ 3.5 million per day, and the Acting Director of the Office of Emergency Management estimates that 75% of the funds originally ordered had been expended as of September 16, 2013. As extensive relief efforts continue, I find that the $6,000,000 that was originally ordered is insufficient to pay for the flood response and recovery.

As a result of the recent flooding, Colorado's transportation infrastructure has been significantly compromised, limiting the ability of the citizens of Colorado to access their homes, businesses and farms and negatively impacting our ability to provide necessary goods and services to the hardest hit counties. The severity of the damage to the transportation infrastructure, taken together with the brevity of time before winter weather conditions set in, requires extraordinary measures to assist in the reconstruction and repair of Colorado's transportation infrastructure.

The flooding has also damaged businesses and hindered their ability to provide their communities with essential goods and services including food and other daily necessities. Extraordinary measures are necessary to reopen food service businesses promptly in a manner that does not compromise food safety but also recognizes that the rules and regulations in normal times might be unduly burdensome under the circumstances.

II. Declaration and Directives

In addition to the declarations and directives contained in Executive Order D 2013-26, I declare and direct that paragraph II(C) of Executive Order D 2013-026 is hereby amended as follows and paragraphs II(H), II(I), and II(J) are hereby added as follows:

C. Pursuant to C.R.S. § 24-33.5-706(4) the funds in the Disaster Emergency Fund are found to be insufficient to pay for the flood response and recovery. Therefore, it is ordered that $26,000,000 be transferred into the Disaster Emergency Fund from the General Fund appropriation in Fiscal Year 2013-14 to the Controlled Maintenance Trust Fund. This

amount shall include the funds transferred by written executive order dated September 13, 2013. It is further ordered that this $26,000,000 from the Disaster Emergency Fund is encumbered to pay for the flood response and recovery. The Director of the Office of Emergency Management is hereby authorized and directed to allocate the funding to the appropriate government agencies and non-profit organizations and execute awards, purchase orders or other mechanisms to effect the allocation of the funds. These funds shall remain available for this purpose for eighteen months from the date of this Executive Order, and any unexpended funds shall remain in the Disaster Emergency Fund.

H. My verbal order declaring a disaster emergency for Clear Creek County and Sedgwick County as additional counties affected by the continued flooding is hereby memorialized and shall have full force and effect as if these counties were contained in the original Executive Order.

I. As provided in C.R.S. § 24-33.5-704(7)(a), I hereby authorize the following department Executive Directors, upon approval of the Governor's Chief Recovery Officer, or his/her designee as described below, to suspend the provisions of any regulatory statute prescribing the procedures for conduct of state business, or the orders, rules, or regulations of any state agency: Department of Higher Education, Department of Revenue, Department of Public Health and Environment, Department of Labor and Employment, Department of Regulatory Agencies, Department of Agriculture, Department of Natural Resources, Department of Local Affairs, Department of Military and Veterans Affairs, Department of Personnel, Department of Corrections, Department of Public Safety, Department of Transportation, Department of Human Services, and Department of Health Care Policy and Financing. Prior to the suspension of any statute, order, rule or regulation, the Governor's Chief Recovery Officer must find that strict compliance with the provisions of any statute, order, rule, or regulation would in any way prevent, hinder, or delay necessary action in coping with the emergency.

J. I hereby authorize the Director of the Office of Emergency Management or his designee to enter into all necessary cost-sharing agreements with the federal government for the purpose of making available financial assistance pursuant to 42 U.S.C. § 5174. The Director of the Office of Emergency Management or his designee is directed to work with local government partners in the affected counties to reach an equitable method for paying the non-federal share of the costs.

III. Duration

This Executive Order shall expire thirty days from September 13, 2013, unless extended further by Executive Order, except that the funds described in paragraph II(C) above shall remain available for the described purposes for eighteen months from the date of this Executive Order.

GIVEN under my hand and the Executive Seal of the State of Colorado this nineteenth day of September, 2013.

John W. Hickenlooper
Governor

STATE OF COLORADO

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John W. Hickenlooper
Governor

D 2013-028

EXECUTIVE ORDER

Making Available Additional Resources and Extending the Declaration of Disaster Emergency Due to the Flooding in Adams, Arapahoe, Broomfield, Boulder, Clear Creek, Denver, El Paso, Fremont, Jefferson, Larimer, Logan, Morgan, Pueblo, Sedgwick, Washington, and Weld Counties.

Pursuant to the authority vested in the Governor of the State of Colorado and, in particular, pursuant to relevant portions of C.R.S. § 28-3-104 and relevant portions of the Colorado Disaster Emergency Act, C.R.S. § 24-33.5-701, *et seq.*, I, John W. Hickenlooper, Governor of the State of Colorado, hereby issue this Executive Order making available additional resources and extending the declaration of disaster emergency due to the flooding in Adams, Arapahoe, Broomfield, Boulder, Clear Creek, Denver, El Paso, Fremont, Jefferson, Larimer, Logan, Morgan, Pueblo, Sedgwick, Washington, and Weld Counties.

I. Background and Purpose

The Governor is responsible for meeting the dangers to the state and people presented by disasters. C.R.S. § 24-33.5-704. The Colorado Disaster Emergency Act defines a disaster as "the occurrence or imminent threat of widespread or severe damages, injury or loss of life or property resulting from any natural cause or cause of human origin, including but not limited to . . . flood." C.R.S. § 24-33.5-703(3).

As a result of the historic flooding this September, eight people were killed, 218 people were injured, and nearly 6,000 people were forced to leave their homes. Damage to property has been extensive: 1,882 homes have been destroyed and over 16,101 homes have been damaged.

Colorado's transportation infrastructure has been significantly compromised, limiting the ability of the citizens of Colorado to access their homes, businesses and farms and negatively impacting our ability to provide necessary goods and services to the hardest hit counties. The severity of the damage to the transportation infrastructure, taken together with the brevity of

time before winter weather conditions set in, requires extraordinary measures to assist in the reconstruction and repair of Colorado's transportation infrastructure.

On September 13, 2013, I issued Executive Order D 2013-26 declaring a Disaster Emergency due to the flooding and ordered that $6,000,000 be transferred into the Disaster Emergency Fund. On September 19, 2013, in Executive Order D 2013-027, I ordered that an additional $ 20,000,000 be transferred into the Disaster Emergency Fund. Based on initial damage estimates, these funds are insufficient for the extensive recovery efforts that must be undertaken. Pursuant to C.R.S. § 24-33.5-706(4)(b), the Governor may transfer and expend monies appropriated for other purposes if the monies in the Disaster Emergency Fund are deemed insufficient.

II. Declaration and Directives

A. The flooding along the Front Range continues to constitute a disaster emergency under C.R.S. § 24-33.5-701, 705. The declarations and directives found in Executive Order D 2013-026, and Executive Order D 2013-027 are hereby extended an additional 30 days from the date of this Executive Order.

B. Pursuant to C.R.S. § 24-33.5-706(4), I find the funds in the Disaster Emergency Fund to be insufficient to pay for the flood response and recovery. Therefore, it is ordered that $15,500,000 be transferred into the Disaster Emergency Fund from the General Fund appropriation in Fiscal Year 2013-14 to the Controlled Maintenance Trust Fund established in C.R.S. § 24-75-302.5; and $50,000,000 be transferred into the Disaster Emergency Fund from General Fund appropriation in Fiscal Year 2013-14 to the Department of Health Care Policy and Financing Medical Services Premiums line item. It is further ordered that this $65,500,000 from the Disaster Emergency Fund is encumbered to pay for the flood response and recovery. The Director of the Office of Emergency Management is hereby authorized and directed to allocate the funding to the appropriate government agencies and non-profit organizations and execute awards, purchase orders, or other mechanisms to effect the allocation of the funds. The Director of the Office of Emergency Management is also authorized to allocate up to $20,000,000 to be used as short-term, no-interest loans in order to provide any political subdivision of the state with short-term capital needed for flood response and recovery. These funds shall remain available for this purpose for eighteen months from the date of this Executive Order, and any unexpended funds shall remain in the Disaster Emergency Fund.

III. Duration

This Executive Order shall expire thirty days from September 26, 2013, unless extended further by Executive Order, except that the funds described in paragraph II(B) above shall remain available for the described purposes for eighteen months from the date of this Executive Order.

GIVEN under my hand and the Executive Seal of the State of Colorado this twenty-sixth day of September, 2013.

John W. Hickenlooper
Governor

Department of Health Care Policy and Financing
Targeted Rate Increase Recommendations

Option: Increase Reimbursement for Pediatric Hospice Services

Rationale: The Children with Life Limiting Illness (CLLI) program provides services to critically ill children in the home, allowing clients to receive care in a more comfortable, less expensive setting. Increasingly providers are either capping the amount of CLLI services they provide or are unable to provide the services altogether due to low reimbursement rates. This option would increase provider reimbursement for CCLI services to ensure these children can continue to receive medical care in their home. The option also reduces costs by providing care in less expensive settings.

Projected Total Cost per Year: $246,878, a 20% increase in the reimbursement rate.

Federal Authority: The Department will need to amend the current federally approved waiver.

Timeline: The minor systems changes that are required can be implemented quickly. Minor amendments to the existing waiver can be completed within a few months and should not cause a delay in implementation. The waiver may be amended retroactively if necessary.

Option: Increase Reimbursement Rates for Extended Hours/After Hours Care

Rationale: Often times Medicaid clients seek care after physician offices are closed for the day or on the weekends. Although the client may only require basic primary care, they must go to the emergency room (ER) to receive that care. This option provides a financial incentive for physicians to keep their offices open later and on the weekend by increasing reimbursement for care that is provide after normal business hours and on weekends. Clients will be able to receive the care they need in a less expensive setting, saving money for the state and improving health care outcomes for clients. The Department estimates there will be savings associated with this increased reimbursement based on a reduction in ER visits.

Projected Total Impact: $58,927 in savings. The estimate is based avoiding 5% of ER visit costs because those services would be delivered in a physician's office. Evaluation and management codes associated with after-hours care are increased by 10% at a cost of $641,597. The savings of reducing ER visits by 5% is $700,491.

Federal Authority: (SPA or Waiver required?) No

Timeline: The minor systems changes that are required can be implemented quickly.

Option: Fund the Transitional Living Program for Brain Injury Clients

Rationale: The Transitional Living Program (TLP) assists clients with critical injuries in returning home and integrating back into their community. The program provides both rehabilitative and habilitative care. Due to rates, there are currently no providers for this integral service within the care spectrum for individuals who have suffered a brain injury. The lack of services requires these patients to remain in the hospital for longer periods of time with eventual

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discharge to a more costly service option. This option would fund TLP for brain injury patients. Extending TLP to brain injury clients should serve to reduce costs by shortening hospitals stays and avoiding nursing facility admissions.

Percent Rate Increase: $876,000. A 191.28% increase in the reimbursement rate.

Projected Total Cost per Year: $876,000.00

Federal Authority: (SPA or Waiver required?) No

Timeline: The minor systems changes that are required can be implemented quickly. Minor amendments to the existing waiver can be completed within a few months and should not cause a delay in implementation. The waiver may be amended retroactively if necessary.

Option: Increase Reimbursement for Pediatric Developmental Assessments

Rationale: If a physician determines that a child may have a developmental delay, that child must undergo a comprehensive developmental assessment prior to receiving additional health care interventions. Currently only three entities are providing these assessments to Medicaid clients. Each of these entities currently has a 6-9 month waitlist to provide the full developmental assessment. As a result, many children are not receiving the services they need in a timely fashion, resulting in missed windows of opportunity for development. This option increases the reimbursement rate for providing developmental assessments to children with the goal of incentivizing more entities to provide these assessments.

Projected Total Impact: $64,000, a 50% increase in the reimbursement rate.

Federal Authority: (SPA or Waiver required?) No

Timeline: The minor systems changes that are required can be implemented quickly.

Option: Increase Funding for Single Entry Point Case Management

Rationale: Single Entry Point (SEP) providers administer case management services for long term care clients throughout the state. SEP caseloads have grown significantly, reducing the ability of case managers to provide comprehensive and effective case management services for all clients. This option increases funding for SEPs to hire additional qualified case management staff. As the number of these staff increase, caseloads will fall enabling case managers to provide more person-centered service including: better assessment of need; better alignment of services; and better and more thoughtful care coordination. These service enhancements will improve the client experience, increase their quality of life, and reduce Medicaid costs.

Project Total Impact: $1,229,790, a 10% increase

Federal Authority: (SPA or Waiver required?) No.

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Timeline: The minor systems changes that are required can be implemented quickly.

Option: Incentive Payments to Surgeons to Provide Care at Ambulatory Surgery Centers

Rationale: Ambulatory Surgery Centers (ASC) can provide certain services at a lower cost and similar quality to hospitals. In an attempt to shift some volume from hospitals to ASCs, the Department previously conducted a pilot program with ASCs. The pilot increased the ASC payment rate, but the pilot did not result in a significant shift in care to ASCs. Rather than increasing payments to the ASC, this option instead creates a financial incentive to surgeons—who decide the setting of surgery—to provide the same level of care but in an ASC rather than a hospital. The Department would establish target ratios of ASC vs. outpatient hospital utilization for services that can be provided at a lower cost without compromising quality, and surgeons would be eligible to receive an incentive payment for reaching ASC targets.

Project Total Impact: $250,000 - $500,000

Federal Authority: (SPA or Waiver required?) No.

Timeline: The minor systems changes that are required can be implemented quickly.

Option: Increase Reimbursement Rates for High-Value Specialist Services

Rationale: Department analysis reveals that reimbursement rates for some specialty care are significantly lower than Medicare reimbursement rates. The analysis reveals Medicaid reimbursement rates for individual codes range from 3 to 99 percent of Medicare rates and 21 to 94 percent of Medicare rates for aggregated codes by specialties. Targeted increases for certain, high-value specialty care may serve to increase specialty care access for clients and result in better health outcomes. The Department recommends the following list of codes—which were chosen from specialties who had aggregate reimbursement of 50% of Medicare rates or below—be increased to 80% of Medicare rates and requests stakeholder input on how best to target the increases.

Projected Total Impact: $11,312,434.52

Federal Authority: (SPA or Waiver required?) No

Timeline: The minor systems changes that are required can be implemented quickly.

List of Potential Codes to Increase

Procedure Code	Description	CO Medicaid Fee as % of Medicare Fee
92002	EYE EXAM, NEW PATIENT	23%
92004	EYE EXAM, NEW PATIENT	18%

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92012	EYE EXAM ESTABLISHED PAT	21%
92014	EYE EXAM & TREATMENT	21%
92018	NEW EYE EXAM & TREATMENT	18%
92019	EYE EXAM & TREATMENT	32%
92020	SPECIAL EYE EVALUATION	52%
92060	SPECIAL EYE EVALUATION	39%
92502	EAR AND THROAT EXAMINATION	22%
92506	SPEECH/HEARING EVALUATION	14%
92511	NASOPHARYNGOSCOPY	28%
92520	Laryngeal function studies	77%
92545	OSCILLATING TRACKING TEST	17%
92553	AUDIOMETRY, AIR & BONE	33%
92555	SPEECH THRESHOLD AUDIOMETRY	27%
92556	SPEECH AUDIOMETRY, COMPLETE	34%
92563	TONE DECAY HEARING TEST	16%
92565	Stenger test, pure tone	30%
92567	TYMPANOMETRY	57%
92579	VISUAL AUDIOMETRY (VRA)	42%
92585	AUDITOR EVOKE POTENT, COMPRE	65%
92601	COCHLEAR IMPLT F/UP EXAM < 7	65%
92607	EX FOR SPEECH DEVICE RX, 1HR	60%
92609	USE OF SPEECH DEVICE SERVICE	39%
92625	Tinnitus assessment	43%
93922	EXTREMITY STUDY	43%
93923	EXTREMITY STUDY	53%
93924	EXTREMITY STUDY	46%
93925	LOWER EXTREMITY STUDY	41%
93926	LOWER EXTREMITY STUDY	63%
93930	Upper extremity study	42%
93931	UPPER EXTREMITY STUDY	48%
93965	Extremity study	37%
93970	EXTREMITY STUDY	31%
93975	VASCULAR STUDY	38%
93976	VASCULAR STUDY	51%
93978	VASCULAR STUDY	46%
93979	VASCULAR STUDY	47%
93990	DOPPLER FLOW TESTING	33%
95812	EEG, 41-60 MINUTES	16%
95813	EEG, OVER 1 HOUR	17%
95873	GUIDE NERV DESTR, ELEC STIM	24%
95874	GUIDE NERV DESTR, NEEDLE EMG	25%

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95928	C MOTOR EVOKED, UPPR LIMBS	39%
95929	C MOTOR EVOKED, LWR LIMBS	41%
95953	EEG MONITORING/COMPUTER	57%
95954	EEG monitoring/giving drugs	24%
95956	Eeg monitoring, cable/radio	16%
95958	EEG monitoring/function test	25%
96111	DEVELOPMENTAL TEST, EXTEND	76%
96440	CHEMOTHERAPY, INTRACAVITARY	3%
96450	CHEMOTHERAPY, INTO CNS	16%
97001	PT EVALUATION	46%
97002	PT RE-EVALUATION	55%
97003	OT EVALUATION	41%
97004	OT RE-EVALUATION	43%
97597	ACTIVE WOUND CARE/20 CM OR <	41%
G0365	VESSEL MAPPING HEMODIALYSIS ACSS	60%
G0389	Ultrasound exam AAA screen	65%

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Department of Health Care Policy and Financing
Targeted Rate Increase Recommendations

Guidelines For Submitting Input

Notice: The Colorado Department for Health Care Policy and Financing (Department) is seeking stakeholder input regarding potential targeted rate increases using funds that may be appropriated. Approximately $19 million may be available for targeted rate increases in FY 2014-2015.

Any rate increase(s) MUST be implemented no later than July 1, 2014**. Stakeholders are asked to submit their input on or before 5pm, Tuesday, January 21, 2014 to allow the Department sufficient time to implement the increase(s).**

Below please find the intended purpose of the rate increase and guidelines for submitting input.

Purpose: Targeted rate increases should:

- promote utilization of low-cost, high-value procedures that ultimately improve client outcomes and reduce expenditures; and/or
- address inappropriate provider reimbursement rates to improve client access to cost-effective care.

The Department has identified an initial list of rate increase options intended to promote high-value, cost effective care and/or serve to alleviate some access to care issues related to inappropriate reimbursement rates. This initial list is based on client and provider feedback as well as Department analysis.

The Department requests your input on the list of options attached to this notice. Additionally, the Department welcomes your suggestions for rate increases that will result in high-value, cost effective care and/or will address access to care issues that stem from low reimbursement rates.

Guidelines for Submitting Input:

The attached list of rate increase options contains information regarding the rationale, cost, projected timeline for implementation, and related information.

A. Please consider each option on the list and respond to the following questions <u>for each option</u>:

   1. Do you support or oppose the option?
      a. If you support the option, please explain how the proposed increase will accomplish the following goals:
         i. Ensure or improve client access to care
         ii. Incentivize more providers to deliver the service(s)

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iii. Improve quality health outcomes for Medicaid clients

iv. Increase efficiency, effectiveness and cost-effectiveness of service utilization

2. If you do not support the option, please explain why.

B. Please provide your recommendations for a rate increase(s) that:

a. promote utilization of low-cost, high-value procedures that ultimately improve client outcomes and reduce expenditures; and/or

b. address inappropriate provider reimbursement rates to improve client access to cost-effective quality care.

Each rate increase recommendation should be limited to 2 pages and should include the following information.

a. Specific service or units of service recommended for an increase

b. Percentage and dollar amount of the recommended rate increase

c. Known challenges and barriers to implementation, including the need for state legislative or regulatory changes and/or federal approval.

d. Explain how the proposed increase will likely:

i. Ensure or improve client access to care

ii. Incentivize more providers to deliver the service(s)

iii. Improve quality health outcomes for Medicaid clients

iv. Increase efficiency, effectiveness and cost-effectiveness of service utilization

e. Would the Department be able to implement the increase by July 1, 2014?

f. Is the proposed increase operationally and programmatically feasible and sustainable?

Please note the Department must select rate increase option(s) that comply with legal requirements and are operationally feasible. When selecting options, the Department must consider whether major system changes would be required and the associated cost and timeline for those changes. Only rate increases that are able to be implemented on or before July 1, 2014 can be selected.

Please submit feedback to: Medicaid2015@state.co.us

Input must be received by the Department by 5pm, Tuesday, January 21st.

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