HCPF JBC HEARING RESPONSES

January 4, 2012

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QUESTIONS COMMON TO ALL DEPARTMENTS

1) Please describe the process the Department used to develop its strategic plan.

RESPONSE:

Each spring, the Department reviews its five-year strategic plan and annual performance measures. The purpose of the review is to ensure the quality, measurability, and continued relevance of future performance measures. The annual strategic plan review is coordinated by the Department's strategic performance manager who solicits input from executive committee and leadership team members as well as from policy staff and program managers. The focus is on improving measurability of benchmarks for the next fiscal year. When the Department inserts new measures three to five years out, such measures are stated in conceptual terms pending future baseline data needed to establish specific benchmarks.

In May 2007, executive branch agencies received instructions from Office of State Planning and Budgeting (OSPB) to revise and reformat their strategic plans (May 24, 2007 OSPB Budget Instructions, Chapter 3, Strategic Plan). These instructions included a requirement that strategic objectives and performance measures be consistent for a period of at least three years. As a result, the Department established some new measures in FY 2008-09 which could not be revised again until FY 2011-12.

Two years after revising its strategic plan in FY 2008-09, Department staff involved with coordinating the strategic plan review process noted the strategic plan could be clarified and the measurability of benchmarks improved. In addition, some of its FY 2008-09 objectives and performance measures were outdated due to changes driven by health care reform initiatives. The Department postponed making any changes to its strategic plan until FY 2011-12 when the three-year consistency period was fulfilled. This timing coincided with the new Hickenlooper administration and new budget instructions from OSPB.

With respect to measuring progress on an ongoing basis, the Department does this semi-annually. It collects and analyzes data from various internal and external data sources to gauge progress of key performance indicators. For example, the Department reviews data on emergency room utilization, hospital readmissions, care coordination between mental health and physical health providers, annual dental visit rate, mental health consumer satisfaction surveys, and pharmacy utilization measures.

In addition, the Department requires organizational units to complete operational plans each year, and each unit is required to conduct semi-annual progress reports. Operational Plans for each fiscal year are finalized in the months preceding the next fiscal year; FY 2012-13 Operational Plans will be finalized in May or June 2012. The Department included its Operational Plans for FY 2011-12 in its FY 2012-13 Budget Request for reference to illustrate how each organizational unit contributes to the Department's

strategic goals (November 1, 2011 FY 2012-13 Budget Request, Strategic Plan, pages C-22-58).

a) Please identify recent major successes and failures with regard to the Department's strategic goals and objectives. Do resources need to be reallocated to address any problem areas where the Department is failing to perform?

RESPONSE:

Since Building Blocks to Health Care Reform in FY 2008-09, the Department has been successful with improving health outcomes, improving long-term supports and services, increasing access to health care, increasing the number of insured Coloradans, and containing health care costs. Specific initiatives such as the Accountable Care Collaborative, Benefits Collaborative, Utilization Management, and Long-Term Care Redesign are instrumental in making notable progress toward multiple strategic goals.

Recent Department Successes:

Accountable Care Collaborative
Implementation of the Accountable Care Collaborative (ACC) is well underway. As of December 2011, 74,481 clients have enrolled in the ACC, and the Department has contracted with 1,588 rendering providers and 79 primary care medical providers to serve ACC clients. The ACC's Statewide Data and Analytics Contractor has created a data repository and reports that will provide information on how ACC members are using services and how well the program is meeting its goals.

The ACC controls costs by reducing avoidable, duplicative, variable, and inappropriate use of health care resources. The ACC program and its providers are evaluated on the appropriate use of services and positive health outcomes for members. The program gives providers the tools and the incentives to reduce unnecessary care.

Benefits Collaborative
The Benefits Collaborative created a transparent process that allows stakeholders – including providers, clients, and client advocates – to collaborate with the Department to review coverage policies which outline the appropriate amount, scope, and duration of Medicaid benefits. Reviewing utilization and expenditure data will help determine whether the goals of the Benefits Collaborative – defining clinical criteria, reducing inappropriate utilization, and promoting proper billing practices – have been met. The Department anticipates these initiatives will not only result in cost savings but will also result in better health outcomes for clients as the Department begins to move the perception of Medicaid toward a commercial insurance product rather than a public benefit. As a result, the Department hopes to see fewer appeals for denial of non-medically necessary services and non-covered services and utilization data that aligns with the generally accepted best practices outlined in the benefit coverage policies.

Evidence Guided Utilization Review
Evidence Guided Utilization Review (EGUR), Colorado Medicaid's new utilization management program focuses on appropriate utilization of high-growth, high-cost medical spending categories, including radiology, hospital outpatient services, selected outpatient therapies, ancillary services, emerging technologies, and selected client groups such as high-risk deliveries and pre-term newborns. The expansion of utilization review is not only anticipated to yield savings but also lead to enhanced quality and improved health outcomes.

Healthy Living Initiatives
The goal of the Healthy Living Initiatives program is to improve health from infancy, through childhood, to aging while supporting Colorado's 10 Winnable Battles. The Healthy Living Initiatives program focuses on improving oral health among children, preventing depression among adolescents, improving childhood nutrition and fitness, and encouraging tobacco cessation. While these are new initiatives, the Department received an early indicator of success with its oral health efforts in that Colorado now ranks in the top quartile of states for the percentage of Medicaid children who have received a dental visit. (Source: 2011 Annual Report on the Quality of Care for Children in Medicaid and CHIP, U.S. Department of Health and Human Services, Figure 11, page 61.)

Redesigning Long-Term Supports & Services
The Department is redesigning its long-term care data systems and delivery systems to transform long-term care from institution-based to efficient, person-centered, community-based care. The Colorado Choice Transitions grant program (formerly the Money Follows the Person grant program) will provide enhanced transition services to clients currently living in nursing facilities to transition them to the community. The Department anticipates 100 clients per year will receive services and transition to the community setting starting in July 2012. This will improve clients' quality of life and realize cost savings as clients move from nursing facilities into community-based settings. As a result of this program, Colorado's Long-Term Care system will become more person-centered, navigable, and integrated. This will make it easier to coordinate between agencies, providers, consumers, and families so the elderly and adults with disabilities have greater access to home- and community-services instead of facing institutionalization.

Data Strategies
The development of a data strategy for future integration of clinical and claims data to improve health outcomes has been initiated. The Department's kickoff of the procurement process for the new Medicaid Management Information System (MMIS) and Decision Support System (DSS) began in December. It is currently focusing efforts on the Medicaid Information Technology Architecture (MITA) assessment and Request-for-Proposals. This will include a MITA modular approach, allowing integration of clinical data with claims data when clinical data becomes available to the state information systems. Clinical Decision Support Systems are in their infancy

across the entire health industry so the Department is focusing on incremental inclusion of data as it becomes available.

Benefits Coordination
The Benefits Coordination Section pursues responsible payment sources to recover costs for medical care paid for by Medicaid. The amount recovered in FY 2010-11 was $40.4 million, the highest total on record for activities including estate recovery, income trusts and repayment, tort and casualty, and post-pay (i.e., pay-and-chase) recoveries. The Department is on track in FY 2011-12 to exceed the amount of monies recovered through benefits coordination in FY 2010-11.

Eligibility and Enrollment
The Department's benchmark for timely processing of new eligibility determinations was 75% for June 2011. The Department exceeded the benchmark at 78%. The Department has been offering assistance to eligibility sites to increase processing times by providing an overflow unit and temporary staff to process applications, training sites on business process improvements, and implementing system changes within the Colorado Benefits Management System (CBMS). To aid in continuing to meet these benchmarks, the Department is requesting funding to enhance CBMS through the FY 2010-11 supplemental process.

Audit Compliance
The Audit and Compliance Division is implementing several new processes to address inappropriate payments. The Medicaid Recovery Audit Contract (RAC) Program has been implemented to audit claims in Medicaid Fee-For-Service, Medicaid Waiver Service, Medicaid Managed Care, and CHP+ for overpayments and underpayments. In addition, the Department is currently re-procuring the Hospital Diagnosis Related Groups (DRG) Retrospective Claims Review contract to identify and recover overpayments to providers due to fraud, abuse, waste, billing, or processing errors. The Department is also continuing to work with the Colorado Healthcare Fraud Taskforce in a collaborative effort with health care entities across the state to identify fraud. The Department has also implemented fraud and abuse technologies such as the Enterprise Surveillance Utilization Reporting System (ESURS), which marks a significant departure from the previous system to identify statistical outliers in billing patterns. Transition to this new system marked a paradigm shift for the Department, as the Department can now proactively identify potential fraud, errors, and abuse rather than responding only to external fraud and abuse referrals.

<u>Recent Department Challenges:</u>

The Department administers the Colorado Medicaid and CHP+ programs today with relatively fewer resources and the highest caseload on record. With over three continuous years of budget cuts in a row, the current economic environment has caused clients, providers, and staff to bear the impact of increasing financial constraints.

Doing More with Less
All states are facing similar challenges to manage more clients with fewer resources. Colorado, however, has the fastest-growing child poverty rate in the nation. The child poverty rate has climbed by 72% since 2000, according to KIDS COUNT in Colorado, an annual report by the Colorado Children's Campaign. As of November 2011, there were 614,146 Medicaid clients enrolled in Medicaid (historical high), and 71,988 children and pregnant women enrolled in CHP+. This data reflects increases in caseload of 57.7% and 42.7%, respectively, for Medicaid and CHP+ since January 2007.

The Department has an efficient administrative budget at less than 3% of total expenditures. With a total budget of $5.1 billion, this translates to each of the Department's 313 FTE being responsible for approximately $16 million in expenditures.

Eligibility and Enrollment
Although the Department met its benchmark for timely processing of new eligibility determinations last June, it has not achieved its benchmark for timely processing of redeterminations. The most recent redeterminations benchmark was 65% on September 30, 2011, and the Department achieved a timely processing average of 63%. The next redetermination benchmark for the Department is to maintain a 95% timely processing for 12 months. To assist sites with meeting processing challenges, the Department implemented an auto re-enrollment process within CBMS to streamline the redetermination process.

Data Analytics Systems
Developing sound data-analytics systems is integral to the Department's ability to meet its strategic goals. The current challenge is in not yet having all of the necessary baseline data and other reference points to ensure appropriate benchmarks are being established and achieved. The ACC's Statewide Data and Analytics Contractor is compiling baseline data to measure improvement related to numerous health outcome and cost containment measures. For example, the ability to measure potentially preventable events such as avoidable hospital admissions and readmissions, preventable complications, unnecessary emergency room visits, and unnecessary ancillary services are key performance indicators for improving health outcomes and containing costs.

<u>Do resources need to be reallocated to address any problem areas?</u>

The Department is currently reorganizing several of its major business divisions to maximize efficient use of current staffing levels.

b) For the objective "Increase Access to Health Care" the Department provided historical data that showed a dip in the number of providers participating in Medicaid. What will happen to the need for Medicaid providers with the expansions required by the federal Affordable Care Act, and what is the Department doing to ensure that the supply of providers will be adequate?

RESPONSE:

Provider enrollment since FY 2007-08 are shown in the table below:

Fiscal Year	Distinct Rendering Providers
FY 2007-08	23,481
FY 2008-09	17,526
FY 2009-10	18,887
FY 2010-11 (through 6/22/2011)	20,422

There was a drop in providers for FY 2008-09 due to federally required adoption of the National Provider Identifier (NPI) for Medicaid providers by May 2008. Between September 2007 and April 2008, the Department experienced a large increase in the number of providers submitting Medicaid claims in advance of this federal requirement. In May 2008, the number of providers that could submit Medicaid claims dropped dramatically, which was due to providers not having an NPI under which they could submit claims. However, there has been a steady increase in the number of rendering providers of approximately 80 providers per month since this level shift occurred.

The Department continually works to enroll as many providers as possible, and has had success in getting good representation from family medicine, internal medicine, and pediatrics providers. The percent of primary-care specialists in these three categories who accept Medicaid in Colorado is 81% of the total available. To ensure an adequate network of providers to serve the future expansions required by the federal Affordable Care Act, the Department's Office of Client and Community Relations (OCCR) is conducting additional provider outreach activities with funding from the Health Resources Services Administration (HRSA) grant and is developing a strategic plan for provider recruitment. Since HRSA funding expires in August 2012, provider recruitment activities will be significantly reduced after that date.

c) As part of the objective "Contain Health Care Costs" the Department proposes to reduce or stabilize utilization of the top ten cost drivers, which include vaginal deliveries without complicating diagnosis. Is the Department proposing to reduce pregnancies? Please explain how the Department will measure success relative to this objective?

RESPONSE:

The Department's performance measure to reduce or stabilize utilization of the top 10 cost drivers is a measure anticipated for FY 2014-15, not FY 2012-13 as JBC staff may have mistakenly believed. The Department is in the process of gathering baseline data as a guide in setting appropriate measurement criteria for this benchmark and designing cost-containment strategies that will address it. The Department has no intention of reducing the number of healthy deliveries in Medicaid.

2) Please explain why the Department has audit recommendations that have not been fully implemented after extended periods of time. What are the obstacles the Department has faced in implementing recommendations? How does it plan to address outstanding audit findings? If applicable, please focus on those financial audit findings classified as "material weakness" or "significant deficiency."

RESPONSE:

Audit Findings and Implementation
The Department takes every audit recommendation seriously. Recommendations listed in OSA's spreadsheet to the JBC and the Department's responses are outlined in Attachment A.

Through an internal tracking system, the Department has calculated that 39 out of 52 (75%) of the OSA recommendation subparts have been implemented from the Single Statewide Audits going back to FY 2007-08. Of the 39 implemented recommendation subparts, 19 (49%) are eligibility related and occur through human error when processing client applications.

Since 2006, the Department has been maintaining its own audit recommendation database to record, track, and monitor progress of all audits affecting the Department. This database, which includes recommendations from 2001 to present, includes audits performed by the OSA, and two federal agencies, Centers for Medicare and Medicaid Services (CMS) and the Office of the Inspector General (OIG). The database captures all recommendations and Department responses, from the original response to the most recent update. In addition, the Department has 1.0 FTE dedicated to tracking audit recommendations, soliciting progress reports on those recommendations from staff quarterly, ensuring that auditors receive timely responses, and meeting the auditor's needs and requests.

The Departments estimates that more than 20.0 additional FTE throughout the Department are dedicated to responding to external audits, which diverts resources from daily operations. Each audit requires considerable effort by Department staff to fulfill data/information requests, respond to the auditors' questions on how programs are administered, and implement recommendations. These assignments are in direct response to the increase in the volume of requests from auditing agencies.

The Department's audit recommendation database and FTE resources are necessary so the Department can maintain accountability for implementing the audit recommendations. In 2010, the Department was audited 18 different times. These audits were conducted by the OSA, CMS and OIG.

Obstacles

The Department does not have the financial and personnel resources to fully implement some of the recommendations. Audit recommendations and the Department's agreement to implement recommendations do not automatically include financial and personnel resources. The budget process to request those financial and personnel resources may create delays in implementing audit recommendations. In addition, competing priorities as set by the Executive Branch or General Assembly impact the Department's ability to request financial and personnel resources. To assist with these resource constraints, the General Assembly could appropriate flexible funding that could be used to hire temporary FTE, hire contractors, and implement system changes related to audit findings.

Audit recommendations that require system changes to Department's claims processing system and provider enrollment (Medicaid Management Information System, or MMIS) or Colorado Benefits Management System (CBMS) often require significant programming time and increased payments to vendors who maintain those systems. Additionally, the Department does not have the authority to unilaterally approve and initiate system changes within CBMS. Implementation may be delayed due to competing priorities between the Department, Department of Human Services, and Governor's Office of Information Technology. Recommendations have to be prioritized based on the impact to clients and the potential of federal sanctions relative to programmatic and legislative changes.

Obstacles Specific to Eligibility Recommendations

Often, the OSA's eligibility audit findings are more stringent than federal audit findings. Many of the OSA's eligibility audit finding are related to human error in data entry and processing client applications that would take significant funding and effort to minimize or eliminate.

The Department has implemented an extensive long-term corrective action plan to address eligibility audit findings. However, there are 73 different eligibility sites and over 4,275 individual users of the eligibility system. Even with additional financial and personnel resources, achieving OSA's eligibility accuracy requirements may not be achievable without significant financial and personnel resources.

To demonstrate where audits are duplicative and more stringent than the OSA's recommendations compared to federal audit findings, the Department provides the following example. States are required by federal regulations to participate in the Payment Error Rate Measurement (PERM) Program. The purpose of the program is to examine the accuracy of eligibility determinations and claims payments to ensure that the Department only pays for appropriate expenditures. The federal government then develops an individual State and National error rate. The Department's eligibility error rate is below the national error rate, thus reducing or eliminating the risk of losing federal funding. The table below demonstrates that Colorado is substantially below the national error rate for eligibility.

FFY 2010 PERM Error Rate		
	National	**Colorado**
Eligibility Error Rate	6.10%	**1.00%**
Overall Payment Error Rate	8.10%	**6.90%**

Duplicative of this federal audit, the OSA audits the Department's eligibility determinations and claims payments. Any data entry error, including those errors which have no impact on eligibility determinations, are then included in the OSA's recommendations and payment calculations even though there is little or no risk of federal sanctions related to these findings.

3) How does the Department define FTE? Is the Department using more FTE than are appropriated to the Department in the Long Bill and other legislation? How many vacant FTE did the Department have in FY 2009-10 and FY 2010-11?

RESPONSE:

The Department calculates FTE consistent with direction from the Governor's Office of State Planning and Budgeting. FTE are calculated by taking the total number of hours reported in the Colorado Personnel Payroll System, as provided by the Department of Personnel and Administration (DPA) and dividing by 2080 hours (for non-leap year).

Historically, the Department has not paid for more FTE than what have been contained in the Long Bill (note that, per Governor's direction and previous JBC direction, FTE are not "appropriated" in the Long Bill). The Department also utilizes and pays for additional FTE through non-appropriated funding sources such as federal and private grants. These FTE are reported to the General Assembly through the Department's response to LRFI-5 affecting all departments.

Differences between actual FTE paid by the Department through funding appropriated in the Personal Services line in the Long Bill are reflected in Schedule 3 for the Personal Services line. In FY 2009-10 the Long Bill plus special bills reflected 287.6 FTE in the Department's Personal Services line; the Department paid 276.5 FTE in its Personal Services line, for a difference of 11.1 FTE. In FY 2010-11 the Long Bill plus special bills reflected 294.8 FTE in the Department's Personal Services line; the Department paid 270.6 FTE in its Personal Services line, for a difference of 24.2 FTE. (See page K.1-6 of the Department's November 1, 2011 FY 2012-13 Budget Request.)

In order to ensure that Department business continued to be completed, the Department paid for 3.4 FTE worth of temporary employees in FY 2009-10 and 12.4 FTE worth of temporary employees in FY 2010-11. Although this allowed the Department to continue operating, filling positions that require permanent staff with temporary employees is not a long-term solution. Since temporary employees are limited to six months employment with the state, individuals are forced to leave before they are fully trained and, as a result, the Department is unable to fully recoup its training costs. Due to the complexity of the

programs administered by the Department, many positions cannot effectively be filled by temporary employees.

Despite having used temporary staff and having vacant FTE relative to the Long Bill and special bills, the Department's General Fund expenditures in its Personal Services line have been very close to the appropriation. In FY 2009-10, the Department under spent its General Fund appropriation in its Personal Services line by $10,955. In FY 2010-11, the Department overspent its General Fund appropriation in its Personal Services line by $10,849.

The Department has struggled to attract and retain talent as a result of several factors, including:

- the challenges and stresses associated with the administration of a $5 billion program by approximately 313 FTE (administration costs comprise approximately 3% of the Department's budget);
- constraints imposed by the state personnel system pertaining to hiring and retention; and,
- the adverse impact of the state employee wage freeze.

The Department is currently undertaking a study of its staff turnover in order to develop plans to help the Department retain staff, thereby reducing costs associated with high turnover.

WAIVERS AND MEDICAID PROGRAM CHANGES

4) Is the Department willing to discuss waivers and how they might help Colorado? In what ways might waivers be used to contain costs without eliminating eligibility categories?

RESPONSE:

States have a lot of flexibility when it comes to designing and running their Medicaid and Children's Health Insurance Programs (CHIPs). However, there are important federal laws that set minimum standards for operating those programs. Sections 1115 and 1915 of the Social Security Act define specific circumstances in which the federal government may, at a state's request, "waive" certain provisions of the federal Medicaid and CHIP laws. The "waiver" is the agreement between the federal government and the state that exempts the state from the provisions of the federal law that were waived. The waiver includes special terms and conditions that define the strict circumstances under which and for whom the state is exempt from the provisions of federal Medicaid and CHIP laws. Waivers include a budget-neutrality requirement, which means that the waiver program cannot cost the federal government more than the state would have spent on Medicaid for people covered by the waiver if the waiver did not exist.

The Department is always willing to discuss waivers. The Department is continually looking at ways to improve the delivery system and services for its clients, whether through a waiver, a state plan amendment, or the State's rule making process. According to 2008 data from the Kaiser Family Foundation, Medicaid was the primary payer for 58% of all nursing facility residents in Colorado, compared to 64% nationally. In addition, Colorado is in the top quartile nationally of the percentage of Medicaid enrollees who are receiving services through a Home- and Community-Based waiver. This indicates Colorado is ahead of the curve in keeping Medicaid clients in the community and out of institutions.

5) Could a waiver be used to delay an eligibility expansion, for example if changes to information technology systems necessary to handle the expansion were not yet in place?

RESPONSE:

As discussed in the response to Question 4, the federal government grants waivers to certain provisions of the federal Medicaid and CHIP laws under specific circumstances only. It is highly unlikely that a waiver would be approved to delay an eligibility expansion required under federal law if changes to information technology systems necessary to handle the expansion were not yet in place.

6) Where can the Joint Budget Committee find a comprehensive list of all active waivers?

RESPONSE:

http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html

7) Are there any active waivers in other states that Colorado should emulate?

RESPONSE:

No. As discussed in the response to Question 4, the Department is continually looking at ways to improve the delivery system and services for clients, whether through a waiver, a state-plan amendment, or the State's rule making process. The Department regularly reviews what other states are doing through meetings with the regional office of the Centers for Medicare and Medicaid Services, work funded by grants received by the Department, numerous statewide workgroups, the National Association of Medicaid Directors (NAMD), the National Academy for State Health Policy (NASHP), the Center for Medicare and Medicaid Innovation Center, and many other initiatives. The Department is proactive in bringing forth any ideas gained from other states' Medicaid work to the General Assembly through the normal budgetary process.

8) Please respond to the staff recommendation to extend Medicaid eligibility to some or all of the population eligible for the Old Age Pension State Medical Program.

a) What does the Department see as the pros and cons of this approach?

b) Are there constitutional, statutory, or federal limits that would prohibit the expansion to some or all of the population, for example for people with a mental health diagnosis?

RESPONSE:

Although extending Medicaid eligibility to some or all of the population eligible for the Old Age Pension Health and Medical Program (OAP-SO) would provide benefits such as receipt federal matching funds, the Department has received federal guidance indicating this would not be approved. The OAP-SO Program provides medical benefits to individuals receiving OAP financial assistance who do not meet the Supplemental Security Income (SSI) disability or resource limits and currently do not qualify for Medicaid eligibility. Section 7(c) of Article XXIV of the Constitution only explicitly excludes OAP recipients who are patients in "an institution for tuberculosis or mental disease" from receiving medical benefits through the OAP-SO Program. The out-dated term "Institution for Tuberculosis" is no longer applicable to any facility in Colorado and therefore not a concern for eligibility. While OAP-SO does exclude individuals who are inpatients in an Institution for Mental Disease, it should be noted that Medicaid generally excludes these individuals as well. Expanding Medicaid to include any of the clients in OAP-SO would thus require approval from the Centers for Medicare and Medicaid Services (CMS) to waive the resource limit for just the OAP-SO clients. Beginning in 2014, law limiting eligibility for Medicaid as it pertains to OAP recipients will be at the federal level.

It should be noted that even after Medicaid expansion under the federal Accountable Care Act in January 2014, OAP-SO recipients who are over age 65 and who do not meet the SSI disability or resource limit will continue to be ineligible for Medicaid and will remain in the state-funded OAP-SO Program. However, the Department estimates enrollment in OAP-SO will decrease substantially and drastically reduce program costs.

The Department is currently researching ways to restructure OAP-SO to align it with Medicaid. After the Medicaid expansions in 2014, it is believed reimbursement rates in the remaining OAP-SO program can be increased to more closely align with Medicaid and still have funding remaining from the constitutional allotment. The Department is also considering whether it would be beneficial to provide full Medicaid benefits to OAP-SO clients under the Accountable Care Collaborative (ACC) to ensure proper care coordination using state-only funding.

Section 7(c) of Article XXIV of the Constitution states:

> "Any moneys remaining in the old age pension fund, after full payment of basic minimum awards and after establishment and maintenance of the stabilization fund in the amount of five million dollars, shall be transferred to a health and medical care fund. The state board of public welfare, or such other agency as may

be authorized by law to administer old age pensions, shall establish and promulgate rules and regulations for administration of a program to provide health and medical care to persons who qualify to receive old age pensions and who are not patients in an institution for tuberculosis or mental disease; the costs of such program, not to exceed ten million dollars in any fiscal year, shall be defrayed from such health and medical care fund."

The Department believes the constitutional language is flexible enough that the allocation remaining after paying for medical services for clients who remain in OAP-SO can be used to offset medical costs for OAP recipients who are enrolled in Medicaid. This, however, is based on the Department's reading of the Constitution. The Department recommends Legislative Legal Services staff perform their own analysis of this section to ensure that they agree with the Department's interpretation.

c) Compare the benefits and reimbursement rates for Medicaid and the Old Age Pension State Medical Program. Are there services that the Old Age Pension State Medical Program covers that Medicaid does not cover that should be preserved?

RESPONSE:

Most services available to Medicaid clients are available to OAP-SO clients, including physician and practitioner services, inpatient hospital services, outpatient services, laboratory and x-ray, emergency transportation, emergency dental, pharmacy, home health services, and medical supplies. Some services available to Medicaid clients, however, are not offered by the OAP-SO Program. These include managed-care options like the Behavioral Health Organizations, Home- and Community-Based Services (HCBS) waiver services, inpatient psychiatric care, and nursing facility care. The majority of services and expenditures for this population are for primary care services including pharmacy, physician, and outpatient/clinic services.

There are no benefits funded through OAP-SO that are not available to Medicaid recipients except for the Oral Health Program administered by the Department of Public Health and Environment (DPHE). The Oral Health Program, however, is not funded at this time. Note that none of the $10 million constitutional allotment for the OAP Health and Medical Care Program is used for the Oral Health Program for OAP-SO recipients.

To remain within available constitutional funding, reimbursement rates for services provided to OAP–SO clients are set at a percentage of Medicaid rates. OAP-SO reimbursement rates are indicated in the following table.

OAP Health and Medical Care Program Provider Reimbursement Rates Effective Since 4/15/2009	
Service Type	**OAP-SO Rates as a Percentage of Medicaid Rates**
Pharmacy	75%
Inpatient Hospital	10%
Outpatient Services	65%
Practitioner/Physician	65%
Emergency Dental	65%
Laboratory and X-Ray	65%
Medical Supply	65%
Hospice and Home Health	65%
Emergency Transportation	65%

MEDICAID FEE-FOR-SERVICE REFORM (R-5) AND ACCOUNTABLE CARE COLLABORATIVE

9) Please discuss the preliminary work of the Department in coming up with the gainsharing proposals contained in R-5.

RESPONSE:

Medicaid services are largely reimbursed on a fee-for-service basis in Colorado, a system that encourages a high volume of services and does not necessarily promote cost-effective care. Providers have little financial incentive to manage and coordinate care for their clients, resulting in an increased likelihood of preventable episodes that need to be treated in the emergency room or inpatient hospital setting. This reimbursement system leads to greater costs for the state.

Most of the payment reforms included in R-5 involve an element of shared savings (or gainsharing), whereby providers who manage care effectively for their clients receive a percentage of savings from other service categories, such as hospitalizations. Shared savings put an emphasis on providing appropriate treatments to clients and preventing more costly care. Incentive payments are only paid to providers when they are able to demonstrate savings against benchmarks in predetermined service areas, so the shared savings reforms are guaranteed to be budget neutral or negative.

The Department is exploring shared savings opportunities with the Behavioral Health Organizations (BHOs), Federally Qualified Health Centers (FQHCs), and Rural Health Centers (RHCs) as a launching point for other shared savings and payment reform initiatives because these providers have an existing history of rate-reform work with the Department. Through the use of incentives, the Department encourages competent providers to increase capacity and expand their abilities. Based on the success of the shared-savings methodology, the Department would like to extend payment-reform options to other provider groups as well, including the Accountable Care Collaborative (ACC) and primary care providers receiving increased funding, financed by the Affordable Care Act (ACA), Section 1202. Payment reform within the ACC and the distribution of funds

through ACA Section 1202 is a natural extension of these initial shared-savings efforts with FQHCs, RHCs, and BHOs. The Department is committed to expanding payment reform mindfully and recognizes the next steps of reform will be an iterative process.

a) How many providers did the department contact?

RESPONSE:

For the shared-savings initiatives that will happen in the near future, the Department has contacted dozens of providers as well as provider associations representing both urban and rural providers. Specifically, the Department has worked extensively with the FQHC and RHC providers, the BHOs, and the Colorado Behavioral Health Council (CBHC) for feedback, support, and direction related to upcoming shared-savings activities. FQHCs are represented by the Colorado Community Health Network (CCHN), which meets monthly and quarterly with Department staff. FQHCs and RHCs have been actively involved with the Department in a data-collection pilot that identifies obstacles and opportunities related to collecting data necessary for shared savings.

For the BHO shared-savings initiative, the Department held a kick-off meeting with the BHOs and the CBHC to discuss the shared-savings proposal and next steps. A follow-up meeting will be held in late January with this same group. Additionally, the Department presented the shared-savings proposal at the annual CBHC conference in October 2011 to the Community Mental Health Centers (CMHCs) and the behavioral health providers.

The Department plans to engage other providers as necessary for subsequent shared-savings efforts. Payment reform is being explored through the ACC Payment Reform Subcommittee, though stakeholder input is in its beginning stages. Outreach from the current shared-savings initiatives related to FQHCs, RHCs, and BHOs will inform these future outreach activities.

b) What was the outcome of those discussions with providers?

RESPONSE:

FQHCs and RHCs have been receptive to the proposal and assisting the Department in moving forward with a shared-savings methodology. Encouraged by their involvement in the process, clinic staff and representatives have collaborated with Department staff to identify particular measures, determine data system capabilities, and develop plans for implementation. FQHCs and RHCs are participating in a trial run of data collection, funded with grant money from the reauthorization of the Children's Health Insurance Program Reauthorization Act (CHIPRA).

The BHOs also have been receptive to the proposal and are working with the Department to determine a shared-savings methodology that will decrease costs and

improve client health outcomes. After discussions with the Department, the BHOs began researching how to implement a shared-savings methodology, if approved. The BHOs have already researched clients' psychotropic drug utilization and identified potential ways to manage those costs.

Certain quality outcome measures must be maintained or improved as a condition of receiving the shared savings. The BHOs conceptually understand and agree with the need to ensure quality under this proposal. The Department and the BHOs have started to discuss which measures are most appropriate. This discussion will be expanded to other mental health stakeholders prior to implementation.

c) How do providers feel about the proposal?

RESPONSE:

The Department has received generally positive feedback from providers participating in the most imminent shared-savings initiatives, as expressed by public support for these budget proposals from CCHN, the BHOs, and the CBHC. Though providers conceptually support shared savings, some providers have raised questions and concerns about the details of the initiatives and wish to be involved in the process of formulating the detailed structure of these initiatives. This feedback will help inform the specifics of a shared savings methodology as it is developed. In particular, FQHC and RHC providers understand the need to transition from a fee-for-service system that rewards volume to a system that encourages health outcomes and lowers costs, and the BHOs understand the need for management of psychotropic drugs. These provider groups have repeatedly said their management of clients provides improved outcomes and cost management. These particular providers believe that a system that holds them accountable for value will be beneficial to them in the long run.

10) Please describe the measures the Department has in place to prevent fraud, particularly in the Accountable Care Collaborative and in the gainsharing initiatives proposed by the Department.

RESPONSE:

General Provider Fraud Prevention and Detection
The Department's Program Integrity section does a number of things to prevent provider fraud, waste, and abuse. The Department checks state and national databases to ensure providers are allowed to practice in the State of Colorado and have not been excluded from participation for any reason.

The Department also does both "data reviews" and "records reviews," in which it checks records to ensure there is adequate documentation to substantiate claims submitted for reimbursement. The Enterprise Surveillance Utilization Reporting System (ESURS) is used to analyze peer group claims to identify providers who are billing claims differently than their peers. Identifying these outliers is an efficient use of limited resources to review

the most probable aberrant provider billing patterns. In addition, the Department has a Recovery Audit Contractor to enhance the monitoring of all provider types for fraud, waste, abuse, and identifying overpayments and underpayments.

The Department investigates any referrals it receives, or calls from clients, that indicate there may be fraud. A preliminary investigation is done on all referrals to determine whether there is a need for a full investigation or referral to the Medicaid Fraud Control Unit (MFCU).

Finally, the Department receives feedback and recommendations from investigative partners (such as the Federal Bureau of Investigation, the Office of the Inspector General, and the Medicaid Fraud Control Unit) when vulnerabilities in the Medicaid program are discovered. This prevents future fraud, waste, and abuse.

Fraud Prevention in the Accountable Care Collaborative Program
Providers who serve clients in the Accountable Care Collaborative (ACC) program are reimbursed on a fee-for-service basis for health care services. Therefore, the mechanisms used to detect fraud among all Medicaid providers are also used to detect fraud for ACC program providers.

In addition to the fraud-detection methods used for all Medicaid providers, the ACC program has access to additional data that makes it easier to detect unusual variations in provider utilization. The ACC Statewide Data and Analytics Contractor (SDAC) will produce a series of dashboards showing Regional Care Collaborative Organization (RCCO) and PCMP risk-adjusted measures that will allow the State and RCCOs to compare provider practices. In addition, RCCOs have not only a contractual responsibility to identify fraud but also a financial incentive to ensure there are no unnecessary costs incurred by the providers in their region.

Providers who serve as Primary Care Medical Providers (PCMPs) in the ACC program receive a per-member-per-month fee for the care-coordination work they do as "medical homes" for ACC program clients. The Department ensures these providers are fulfilling medical home responsibilities by tracking both health outcomes and cost containment at the practice level and regional level.

Likewise, RCCOs receive a per-member-per-month fee for the work they do to support PCMPs and to ensure ACC program clients have access to appropriate care when they need it. Like PCMPs, RCCOs are subject to evaluation based on both health outcomes and cost containment.

In the expansion phase of the ACC, the Department will implement an incentive-based payment structure by which RCCOs and PCMPs would need to earn part of their per-member-per-month fee by meeting program outcomes. Payments for meeting program outcomes are retrospective (that is, they are paid after the RCCOs and PCMPs have demonstrated they met the goal), not prospective.

Fraud Prevention in Gainsharing Initiatives
Hospital, emergency room, and pharmacy claims make up the majority of the claims that will be used to measure whether a primary care provider generated savings. The fraud-prevention measures the Department exercises for all claims (described above) will prevent and detect fraud on these claims. Shared-savings payments will be paid to primary care providers only after the Department has seen demonstrated savings for clients who receive care from that primary care provider.

11) Please provide an update on implementation of the Accountable Care Collaborative (ACC).

RESPONSE:

The Accountable Care Collaborative (ACC) is the Department's Medicaid program that unites providers, clinics, hospitals, and social-service organizations with the goal of improving the health of Coloradans while containing costs. Medicaid clients enrolled in the ACC receive services using the fee-for-service model and also belong to a Regional Care Collaborative Organization (RCCO) that coordinates care and services among providers and other community and government services. There are seven RCCOs, each of which covers a different geographic area of Colorado. The RCCOs were selected in December 2010 through a competitive procurement process, and client enrollments were effective in May 2011.

Client Enrollment
The Department has been strategically enrolling clients into the program, focusing first on clients who have a claims history with providers in the ACC program. This strategy has positioned the RCCOs and primary care providers for success by offering clients who are known to them and with whom they can refine their medical home practices, then slowly adding clients who are new and may require more care and assistance. This enrollment process ensures patient-client relationships are maintained, which is important both for the client's quality of care and for the providers' positive experience of the program.

The Department has enrolled over 74,000 Medicaid clients in the ACC program while maintaining these policy goals. This number takes into consideration clients who have chosen not to participate or who have lost eligibility. The average number of clients who have chosen to opt out of the program is less than 5%. There are over 23,000 additional enrollments scheduled for January 1, 2012.

Client Experience
The Department is already beginning to hear from RCCOs about positive feedback their member clients have shared. Here is some of what they have told us:

> "Our nurse practitioner met with the client and was able to review her medications in detail and clarify possible side-effects. She also helped the client form a list of questions for her next PCP visit. We discussed the possibility of a Med Minder to

enhance her compliance with medications. The client is very happy to have this assistance with her health management."

"I have been meeting with the client for about three weeks. The client is currently homeless and has been recently diagnosed with MS. She is aware that securing stable housing will help her to manage her medical issues – asthma, COPD, Diabetes Type II, and the new MS diagnosis. She was delighted to be chosen for this program and says she would love to have help coordinating her care as she finds it fairly difficult to do with all of the stressors in her life. Since we have been working together, the client has scheduled an appointment with a neurologist, found an apartment, has applied for rental assistance, and has been approved for a housing program through HUD. She is very resourceful and just needs a little help to get things going in the right direction."

"Since being contacted by the Care Coordinator, having PCP involvement, and being regularly engaged in her care, the patient has not been to the ER in the past two months."

"The patient is now connected and linked to community resources and is compliant with her Care Plan and medical treatment. She has not been to the ER for almost a month, a significant improvement from her previous use, which had escalated to multiple times per week."

"The client reported that he feels better equipped to manage the healthcare system independently and with confidence based on the support and education from his PCP. He was very articulate in saying that his relationship with his PCP 'is everything,' and has been the key to increased independence and self-sufficiency."

Provider Enrollment and Participation

The RCCOS have been rapidly expanding their networks of contracted Primary Care Medical Providers (PCMPs). There are 79 PCMPs in the ACC program. These PCMPs include safety-net providers such as federally qualified health centers (FQHCs), Denver Health, Kaiser, and large clinics, as well as individual practitioners. Therefore, a single PCMP often represents multiple providers in multiple locations. The following table shows the total clients and providers participating in each region.

Provider and Stakeholder Experience

One of the core tenets of the ACC program is collaboration between the Department and the RCCOS, collaboration among the RCCOS, and collaboration among the different delivery systems that serve medical clients such as behavioral health and long-term care. The Department has put significant effort toward creating appropriate forums for communication and coordination to facilitate this collaboration.

One important forum is the ACC program Improvement Advisory Committee, which is composed of RCCO representatives, Department staff, providers, and stakeholders. It began meeting monthly in August, 2011. The stakeholders on the committee include

representatives from the Department of Human Services, the Department of Public Health and Environment, Primary Care Medical Providers, and Behavioral Health Organizations. This committee provides technical assistance and guidance and makes recommendations on all aspects of the ACC program.

Two additional forums for collaboration are the two, monthly operations meetings. These meetings ensure adequate communication and coordination among RCCOs, the Statewide Data and Analytics Contractor, and the Department. In addition to the forums sponsored by the Department, the RCCOs have decided to meet independently and work together on certain issues.

Systems and Data Infrastructure
Several significant systems changes had to be made to the Medicaid Management Information System (MMIS) to allow the ACC program to operate. These changes include linking a client in the system to a Primary Care Medical Provider practice, generating client reports for PCMPs and RCCOs, and setting a panel size limit.

Treo Solutions, Inc., the Statewide Data and Analytics Contractor, has created a claims data repository and is using the data to provide meaningful information about client health outcomes and outcomes for the PCMP and RCCOs. The Department, RCCOs, and PCMPs will use this information to meet the needs of clients and evaluate the ACC program.

Summary of Client and Provider Participation
The following table shows the number of enrolled clients, the number of participating PCMPs, and the number of participating providers for each RCCO as of December 1, 2011.

RCCO*	Number of Clients Enrolled	Expected new Enrollments as of January 1, 2012	Number of PCMPs	Number of Providers
Region 1: Rocky Mountain Health Plan	8,149	2,605	15	133
Region 2: Colorado Access	7,166	1,871	14	706
Region 3: Colorado Access	17,666	4,923	31	896
Region 4: Integrated Community Health Partners	14,043	5,519	25	173
Region 5: Colorado Access	3,860	1,741	32	999
Region 6: Colorado Community Health Alliance	10,252	2,799	21	150
Region 7: Community Health Partnership	13,345	4,424	2	67
Total	**74,481**	**23,882*** **	**79****	**1,588*** **

** A map of the regions is included as Attachment B*
*** Some providers serve more than one region.*
**** This number is the number of clients the Department enrolled into the program. The number of clients actually participating in the program is lower due to loss of eligibility and clients opting out of the program.*

12) Please provide preliminary estimates of the savings associated with the ACC. When will the Joint Budget Committee receive more information about the savings associated with the ACC?

RESPONSE:

The estimates the Department has for the ACC program savings are very preliminary, showing some improvements in quality measures and decreases in utilization. The data is preliminary because of the lag between when a service is provided and when it is paid, as well as the time required to process and analyze the data. As Legislative Request For Information 9 (Accountable Care Collaborative) describes, the Statewide Data and Analytics Contractor (SDAC) will create comparative analytical reports that will compare those clients in the ACC program against the initial baseline period, as well as against a similar "control group" of Medicaid clients not enrolled in the ACC program. This will give the Department a better sense of the program's cost savings. The SDAC has already established these baselines for the three utilization measures that will serve as indicators of cost savings: emergency room visits, hospital re-admissions, and outpatient radiology utilization. The SDAC contract requires the SDAC to submit a preliminary savings report for FY 2011-12 by June 2012, with the final report complete by November 2012.

The Department currently has complete data only for the first month of operation of the ACC. The data from this very first month of operation shows small amounts of decreased utilization, but the Department does not believe this limited amount of data is a reliable measure of ACC effectiveness. The data, however, is consistent with the positive stories and reports the Department is hearing from clients and providers.

13) Describe the involvement of providers in developing the ACC. What feedback has the Department received from providers about the ACC? Are they supportive? Have they identified any problems with the program?

RESPONSE:

Provider Involvement
The Department has worked with stakeholders, including providers, starting in 2008 when the planning for the ACC program began. This extensive, multi-year planning process allowed providers to have input in shaping the program at every step of development.

In 2008, consultants facilitated two workgroups to help the Department identify the challenges, opportunities, and concerns about care delivery and managed care. One of the workgroups was made up of clients and advocates, the other was made up of providers and health plans. This essential first step afforded the Department recommendations that became the foundation of the ACC program plan.

The Department continued to bring its program plan to stakeholders in March through June 2009, with well-attended public forums that were broadcast by webinar and conference

call. The Department also set up mechanisms for ongoing communication and updates, such as a listserv. Over 500 individuals and organizations, ranging from providers to community stakeholders, participated in this ongoing communication.

In July 2009 when the Department began to create the scope of work for what would become the Regional Care Collaborative Organizations, the Department issued a Request for Information (RFI). Stakeholders helped to create the RFI, assisting the Department in asking the right questions. For example, one question inquired to the feasibility of adapting the medical-home criteria that was already in use for the Children's Medical Home program. The RFI asked providers to give specific feedback on over 200 questions to better understand what providers and other stakeholders thought about the program details. The RFI received 81 responses that affected many program decisions, such the referral requirement. Provider feedback also guided the Department to create a program structure that is not prescriptive or rigid but allows providers and health plans to the flexibility to focus on improving health outcomes in their regions.

The Department continues to engage providers and other stakeholders through the ACC advisory committees. The flexibility of the program structure has allowed the Department and its providers to keep learning from one another and refining the program.

Feedback Received

Providers have been engaged throughout the process, providing both constructive criticism and positive feedback. Providers expressed appreciation that the Department was seeking their input in the early stages and collaborating with them in a new way. This sentiment came from many types of providers, ranging from individual practices to health plans to the Colorado Medical Society.

Providers are in support of many elements of the program design. Specifically, they have expressed support of the medical home approach, the supporting role of the RCCOs, and the introduction of client- and practice-specific data to help them manage the care of clients. Providers have also commented on the Department's regional approach to the program, including the focus on community-based care delivery systems and the use of medical and non-medical community resources.

Providers continue to tell the Department they want to help the program succeed. The Colorado Medical Society has hosted meetings of its membership to share information and solicit input and has published positive articles about the program in its newsletter. Similarly, the Colorado Children's Healthcare Access Program has hosted forums and includes an ACC update in their monthly newsletter.

Finally, the most significant indication of support is the number of providers who have been willing to participate in the program and serve Medicaid clients, despite regulatory and practical challenges. For example, primary care providers are required to sign two contracts: one with their Regional Care Coordination Organization to become part of the network, and one with the Department to meet federal regulations.

Identification of Problems
The Department has worked with providers to identify problems and solve them. Most of the problems are operational, and many were identified early in the program because of the frequent involvement of stakeholders. For example, providers expressed concerns over the length and complexity of their contracts with the Department, the per-member-per-month reimbursement for children who were not a part of the Children's Medical Home program, and challenges with enrollment. Providers continue to work through challenges with the Department, such as identifying which Medicaid clients on their panels are eligible for the ACC program. This partnership and constant problem-solving is what makes the program strong.

14) How will the ACC, gainsharing payments, prospective payments, and fee-for-service payments interact with each other?

RESPONSE:

The Department is still discussing some of these payment structures at a conceptual level, as it is not finalizing methodology until further discussions with stakeholders. However, the Department does believe various payment systems are likely to co-exist and can interact. It is helpful to first define these terms:

- *Fee-for-service payments*: A set reimbursement for a particular and distinct service. For instance, a single payment is made to a provider who performs a spine surgery.
- *Shared savings (gainsharing):* Providers are rewarded for managing client care under a set budget or utilization target. An example of this would be a provider whose preventative care results in a lower hospitalization rate than expected. The savings accrued from avoiding those hospitalizations are shared between the provider and the Department.
- *Prospective payments:* A risk-adjusted lump-sum payment for a defined basket of services. An example is this would be a primary care provider who receives a monthly payment for primary care for each patient. Those lump-sum payments comprise that provider's budget for those services, and the provider is responsible for operating to that budget. Prospective payment for any particular service is in lieu of fee-for-service.
- *ACC payment mechanisms:* The ACC has many components; two are directly related to payment. First, the ACC provided for monthly payments to primary care practices for care management. Providers are also reimbursed fee-for-service for the care they provide. The Request for Proposals for Regional Care Collaborative Organizations stated that the ACC would provide a forum for future payment reform initiatives.

The payment reform initiatives proposed suggest the Department will only pay for each service rendered once, though the payment methodology may vary. Additionally, the Department has ensured savings will only count once in budget projections.

The payment methodologies proposed in the Department's FY 2012-13 Budget Request to implementing shared savings (R-5 "Medicaid Fee-for-Service Reform") are consistent with

the direction provided in the Request for Proposals for the Regional Care Collaborative Organizations. The Department has convened an ACC Payment Reform Subcommittee, which is currently providing feedback and guidance to the Department.

a) Can a single provider serve populations through all four programs?

RESPONSE:

It is hypothetically possible that providers could serve populations through all four programs; however, the Department is continuing to work with providers to determine the design of these programs.

The proposed gainsharing, or shared-savings payment methodology, will provide for additional payments to providers to share savings through their efficiency efforts. These efficiencies will be measured by the experience of a clinic's assigned clients across the Medicaid system or, in the case of BHOs, with psychotropic drug utilization. By their nature, shared-savings payments can be made concurrently with fee-for-service payments.

Each service rendered by a particular provider is reimbursed only once, and savings projections will not overlay one another. A provider can, however, receive multiple payments that are not duplicative. For example, a provider might receive a prospective payment for primary care for a client enrolled in the ACC but might also receive a fee-for-service payment for another client who is not enrolled in the ACC.

b) Can a single client receive services that are reimbursed through all four programs?

RESPONSE:

Clients often receive multiple services. These multiple services could certainly each have different payment methodologies. Therefore, it is possible that a client could receive services reimbursed through these four payment mechanisms. For example, a client with physical and behavioral health needs could see a primary care physician who receives a prospective payment for those primary care services, while the BHO receives a share of savings accrued by appropriately managing the client's psychotropic medications.

c) How will the department ensure that all clients get equal care at a facility?

RESPONSE:

Access and quality of care for Medicaid members is ensured by a variety of federal, state and contractual mechanisms. Federal regulations detail member rights and stringent requirements for federally funded health care programs. State statutes and rules govern provider and facility qualifications and client health, safety, and welfare

provisions. In addition, managed care contracts and provider agreements may specify quality and access standards that are monitored by Department contract managers, quality staff, and advocacy groups. The Department cannot ensure that each Medicaid member gets "equal" care but strives to ensure access to the appropriate services – delivered in the appropriate setting, amount, and duration – is provided to each member.

15) Will the gainsharing program only apply to primary care physicians, or will other types of providers be involved? Would it apply to medical boutiques?

RESPONSE:

As described in R-5, the Department hopes to expand shared-savings opportunities to all provider types as appropriate, in the future. The Department has chosen to start its shared-savings initiatives with the FQHCs, RHCs, and BHOs because the groundwork has already been laid for these providers. The Department has done extensive rate-reform work with the BHOs and has worked with the FQHCs and RHCs to evaluate data collection from the lens of value-based purchasing methodologies. Therefore, these provider groups presented a unique opportunity to explore shared-savings initiatives.

Once shared savings are expanded to other providers, any provider who accepts Medicaid may participate. Many medical boutiques do not accept health insurance and require patients to pay out of pocket. Some medical boutiques do accept health insurance but also require patients to pay an additional annual fee. This would disqualify medical boutiques from treating Medicaid clients, who may not be charged anything but nominal co-payments for their care per federal regulation. Therefore, it is unlikely medical boutiques would participate as Medicaid providers.

16) What is the CO-OP program authorized through the Affordable Care Act? What is happening with CO-OP programs in Colorado? What is the Department's interaction with CO-OP programs?

RESPONSE:

The Patient Protection and Affordable Care Act (ACA), authorizes the formation of nonprofit, member-run, consumer operated and oriented health insurance plans, in section 1322. This is a separate initiative than the Colorado Health Care Cooperative Bill (SB 11-168). In the CO-OP program, federal funds are available to establish and provide substantial initial capital to launch one or more private CO-OPs, which are nonprofit health insurance plans run by and operated in the interest of their member owners. These plans can only be run by organizations that are not already health insurance providers, and are not sponsored by state or local government.

LONG-TERM CARE

17) What is the Department going to do in the next two years to slow the growing cost of long-term care?

RESPONSE:

The Department is undertaking multiple efforts to address the growing cost of long-term care as outlined in the Department's strategic plan. The Department has devoted considerable time and effort over the last several years on efficiently managing acute care benefits and improving the acute care service delivery system. Going forward, the Department is placing a renewed focus on addressing appropriate and effective management of long-term services and supports and ensuring that benefits are well managed across the continuum of care. These efforts will be focused on both administrative and operational improvements.

In order to better manage the provision of long-term services and supports to the eligible population, the Department is taking steps to improve the internal administrative structure and functioning of the Long-Term Benefits Division. These administrative improvements include a strategic reorganization of the division, fully staffing all vacant positions in the division, focusing on staff training and development, and improving communication and collaboration with the Department of Human Services (DHS) in anticipation of the proposed consolidation of certain long-term services and supports to the Department.

In the near term, the Department and DHS will request that the Division for Developmental Disabilities (DDD), the State Unit on Aging (SUA), and Children's Habilitative Residential Program (CHRP) waiver be moved from DHS to the Department. The immediate move of DDD to the Department will allow the Department to appropriately manage all waivers consistently for program quality and fiscal integrity. The relocation of these programs is the first step and will happen concurrently with the work around long-term services and supports redesign, which is crucial to both containing the upward trending cost of these programs and improving clients' health and experience of care.

Additional administrative efforts that are anticipated to result in improved management of benefits and costs include:

- use of established benefit definition and design processes such as the Benefits Collaborative;
- ensuring case management agencies are regularly trained on Department expectations for application of consistent functional assessment criteria to ensure that only clients who meet the appropriate level of care are approved for long-term services and supports;
- renewed emphasis on monitoring vendors and contractors and holding these entities accountable; and
- strategically modernizing the Home- and Community-Based Services (HCBS) waivers to improve client experience, improve health outcomes, and control costs.

Operationally, the Department is also addressing the growing costs of long-term services and supports by taking steps to specifically address expenditures and utilization. First, new Medicaid rules governing Consumer Directed Attendant Support Services, offered through a few HCBS waivers, took effect earlier this fiscal year. The new rules authorize a wage cap on attendant pay and restrict clients from exceeding their allocated budget during the course of a year. Staff continues to meet internally in a cross-functional team and to meet with stakeholders to identify areas for improving the cost-effective delivery of consumer-directed services.

Further, the Colorado Choice Transitions Program (CCT), formerly known as the Money Follows the Person grant, will support the transitions of residents in long-term care facilities who have an interest and the potential to return to the community. On average, the cost of serving clients in the community versus serving them in a long-term care facility is substantially less. It is estimated that clients in CCT will utilize roughly $34,000 for their year on the program compared to the average annual cost of a nursing home placement of approximately $60,000.

In coordination with the Department, the Department of Human Services, Division for Developmental Disabilities (DHS/DDD) recently implemented several measures for cost containment in the HCBS waivers for individuals with developmental disabilities and is in the process of implementing others. These measures include amendments to the HCBS waivers to more clearly define the limitations for services such as behavioral services, dental services, and targeted case management and implementation of new rules that define the use of the Supports Intensity Scale and Support Levels in Developmental Disability and Supported Living Services waivers to provide a consistent statewide process for determining an individual's service needs.

Additional operational efficiencies that are likely to result in better management of costs and quality of long-term services and supports include: the Department's Dual Eligibles initiative (see Question 14); better integration of long-term care clients into the Accountable Care Collaborative program (see Question 11); and exploring alternative payment methodologies for long-term care supports and services that emphasize quality and sustainability (see the Department's November 1, 2011 Budget Request R-5 "Medicaid Fee-for-Service Reform," and Questions 9 and 14).

These operational and administrative efforts are anticipated to result in better monitoring and management of the costs and quality of long-term services and supports over the next several years and beyond.

18) How does the Program for All-inclusive Care for the Elderly (PACE) fit within the Department's plans for addressing the increasing costs of long-term care?

RESPONSE:

The Colorado Program of All-Inclusive Care for the Elderly (PACE) program is a vital part of the continuum of care that Medicaid provides to clients who need long-term care. PACE

is an option these individuals may choose among the other Medicaid long-term care options and Home- and Community-Based Services Waivers. Currently, there are three PACE provider organizations in Colorado: Total Longterm Care, Inc., Rocky Mountain PACE, and VOANS PACE, Inc.

a) How is the PACE program performing?

RESPONSE:

Currently, PACE serves approximately 1,900 clients aged 55 years and over who meet the state Medicaid nursing facility level of care. The Department projects FY 2011-12 PACE expenditure will be approximately $84.8 million and projects caseload and costs will continue to grow in future years. The intent of PACE is to prevent serious health events such as hospitalizations and nursing facility admissions. Therefore, to evaluate PACE outcomes and performance requires measuring a "non-event" (i.e., What would have happened without PACE? Would the client have gone into a nursing facility? Would the client have used many services or none at all?). The Department is still researching how to best answer these questions.

To learn more about the client and provider experience with PACE, the Department has set up regular meetings with each PACE organization to better understand how each organization is performing and to identify areas for improvement. In the coming months, the Department will also participate in a workgroup with other states in the region to share knowledge about best practices on evaluating the effectiveness of PACE programs.

b) How much is it saving?

RESPONSE:

Currently, PACE serves approximately 1,900 clients and its projected expenditure for FY 2011-12 is $84.8 million. This is approximately $45,000 per member, per year; a total that includes both acute care and long-term care services. To evaluate whether this is more than the Department would have spent on the client if the client were not in PACE is difficult to measure, as described in the above question. Therefore, cost savings from the PACE program are not yet known. The Department is committed to working with PACE providers to understand what is driving the cost of the program and evaluating the effectiveness and cost-efficiency of the program. An independent study would be necessary to properly evaluate savings.

c) Is the Department doing anything to encourage greater utilization of the program?

RESPONSE:

As described above, an independent study would help the Department better understand and evaluate the existing program and its costs before actively expanding the program. However, the Department has been responsive to PACE provider requests for expansion and approved an application from Total Longterm Care, Inc. to expand their services to northern Colorado on October 6, 2011. This expansion will include certain ZIP codes in Larimer and Weld counties. Over the next five years, this expansion is expected to increase the PACE population by roughly 250 individuals.

19) How is the Department planning to redesign long-term care services? What steps is the Department taking to involve stakeholders in the design of the restructure?

RESPONSE:

As discussed in the Department's response to Question 17, several administrative and operational improvements will be implemented over the coming months and years. Specifically, with regard to redesigning long-term services and supports, there are a number of primary strategies the Department plans to employ:

- Waiver modernization/integration
- Relocation of Division of Developmental Disabilities (DDD), the State Unit on Aging (SUA), and the Children's Habilitative Residential Program (CHRP) waiver from DHS to the Department
- Improving the entry point and case management system
- Evaluate cost-efficient long-term care options available through the Affordable Care Act

The overall goal of the relocation is to begin a larger process to redesign Colorado's system of long-term services and supports. This effort will ultimately improve Colorado's ability to get the right services to the right people and to take the first steps toward reducing the system fragmentation that causes delays and confusion for clients and their families. The immediate move of DDD to the Department will allow the Department to appropriately manage all waivers consistently for program quality and fiscal integrity. The two departments plan to engage a wide range of system stakeholders in a broad effort to redesign the long-term services and supports system. The relocation of these programs is the first step and will happen concurrently with the work around long-term services and supports redesign. It is the redesign work that is crucial to both containing the upward trending cost of these programs and improving clients' health and their experience of care.

The Department plans to modernize Colorado's Home- and Community-Based Services (HCBS) waiver programs. The goals of this effort align with the Department's strategic plan, which focuses on improved patient experience, improved health outcomes, and containing costs:

- Through consolidation of waivers, improve access to a broader array of services and offer more choices to clients who are eligible to receive services
- Refine the assessment and service planning tools and processes to appropriately identify and monitor the status of eligible clients and to ensure clients receive the appropriate services at the right time
- Identify new payment methodologies to ensure sustainable financing for HCBS services

Over the past few years, the departments have engaged in a variety of discussions with Community Centered Boards and other stakeholders on a variety of topics related to reducing fragmentation and conflicting rules and regulations. Some recent examples of these discussions include Colorado's Olmstead Plan (2010), the Conflict of Interest Task Force (2010), and Study of Funding Associated with Single Entry Point and Targeted Case Management Activities Performed by Community Centered Boards (November 2009) by Myers and Stauffer LC.

The Department will also examine how the state currently structures its entry point system (how clients become eligible for and connected to long-term services and supports) and case management system. The Department will consider restructuring these to align with the Department's initiatives through the Accountable Care Collaborative program and the coordination of care for dual eligibles.

The Department will also evaluate cost-efficient, long-term services and supports options available through the Affordable Care Act. Currently, the Department offers consumer-directed services through Consumer Directed Attendant Support Services in certain HCBS waivers. The Department is considering whether to pursue the Community First Choice (CFC) option within the Affordable Care Act. CFC is a new state-plan option that allows states to receive a six percentage-point increase in its federal medical assistance percentage (FMAP) for providing community-based attendant services and support to Medicaid beneficiaries with disabilities, if the state meets certain criteria. Final federal rules for CFC have not yet been published by CMS. Once the final federal rules are published, the Department will form an internal evaluation team and solicit input from stakeholders on CFC to determine what programmatic changes will be necessary to qualify for the enhanced FMAP. The Department will also consider other incentives available through the Affordable Care Act, such as funding for Aging and Disability Resource Centers.

The Department will ensure a robust stakeholder involvement process in long-term services and supports redesign through:

- a dedicated position for managing stakeholder relations;
- statewide DHS/DDD consolidation forums conducted by department executive directors;
- reconvening the Long-Term Care Advisory Committee; and
- use of the Benefits Collaborative process for long-term services and supports.

First, to ensure stakeholder involvement in redesign efforts, a dedicated position has been developed within the Department to be specifically responsible for managing stakeholder

engagement around long-term services and supports. This position will ensure the Department has a plan for stakeholder engagement and outreach as redesign efforts are developed and implemented.

The executive directors of the Department, DHS, and the Department of Public Health and Environment held one stakeholder forum in November and will be holding multiple additional forums across the state throughout the next several months. These forums are designed to collect stakeholder input, address questions and concerns, and update interested parties on the proposal to consolidate administration of long-term services and supports at the Department.

The Department has also recently reconvened the Long-Term Care Advisory Committee, which represents constituents across the spectrum of long-term services and supports. This committee will have a statewide presence through meetings conducted in various regions. The committee members will provide direct input in the development and implementation of the Department's redesign of the delivery system. The members will also solicit feedback regarding redesign efforts from the constituencies they represent, convey that feedback to the Department, and relay information back to these constituencies on the status of redesign efforts.

The Benefits Collaborative process for defining covered services has been successfully used for acute care benefits. This process will also be used to define long-term services and supports over time. This is a collaborative stakeholder process where providers, clients, and advocates come together to provide the Department with input and advice on service definitions, limitations, and client needs. Responses from a recent Benefits Collaborative survey show that participants value this process and look forward its use in the long-term services and supports arena.

20) How is the Department planning on streamlining waivers for Home- and Community-Based Services (HCBS) without sacrificing service quality and availability?

RESPONSE:

As the Department moves forward with integrating waivers, the anticipated administrative efficiencies resulting from streamlining the waivers will allow for better oversight of service quality and availability. Integration will create the opportunity for waiver services currently available in individual waivers to potentially be combined into a limited number of new, integrated waivers that can serve multiple populations (i.e., the elderly, children with exceptional health care needs, and people with mental illness, physical disability, or developmental disability). As a result, these new consolidated waivers may have an expanded array of services that can meet a greater variety of needs for clients through services that the clients may not have previously been able to access. The Department will also be able to give clients a more individualized service package that addresses their specific needs as a result of a more robust assessment and service planning process.

Waiver modernization will facilitate the Department's ability to update and improve quality assurances and performance measures utilized in the waivers. Further, waiver modernization will allow the Department to streamline provider enrollment processes, thus reducing the administrative burden on prospective waiver providers and encouraging broad-based provider participation. This is expected to result in greater provider willingness and availability to serve waiver clients.

The Department is currently developing a strategy and "road map" for integrating the waivers, which the Department estimates will be completed by November 1, 2012. As part of this process, the Department will work with stakeholders and learn from other states about how they have improved their waiver services and administration.

21) What information does the Department have about the cost effectiveness of tiered rates for assisted living residences in Medicaid? If the information is not currently available, when will it be available, since the Department was required to study tiered rates pursuant to statute?

RESPONSE:

As was required by HB 10-1053, the Department contracted with Milliman, Inc. in September of 2011 to make recommendations about the cost-effectiveness of tiered rates for assisted living residences in Medicaid. On December 19, 2011, Milliman delivered: a summary report on cross-state policy analysis of alternative-care facility tiered reimbursement structures; a summary report on the Uniform Long Term Care 100.2 Assessment, minimum data set, and claims data analysis; and a draft comprehensive ACF tiered rate study report. The final report is on track for Milliman to submit to the Department in the beginning of January 2012, at which time Department staff will review the recommendations. Pursuant to section 25.5-6-108.5(b), C.R.S., if the recommendations conclude the changes would result in cost savings, the Department will seek federal authorization to implement the changes and request, through the state budget process, the program be implemented.

22) Is the intention of the Department to enroll all people dually eligible for Medicaid and Medicare into the Accountable Care Collaborative? The strategic plan includes a goal of 70 percent by FY 2015-16.

RESPONSE:

It is not the Department's intention that all people who are dually eligible for Medicaid and Medicare are enrolled into the Accountable Care Collaborative. Rather, the Department intends to strengthen and expand the capacity and expertise of the ACC to provide enhanced, coordinated care to this population, and then offer ACC as an option for dually eligible clients. It is the Department's vision that all Medicaid clients, including clients also eligible for Medicare, be enrolled in a single service-delivery system that includes a medical home for each individual and which: 1) controls costs through coordinated and clinically-managed care, and 2) increases healthy outcomes with preventive services and

integration of care. The ACC program is one way to provide these individuals with the advantage of a medical home that proactively coordinates the health needs of each member and is designed to meet the needs of dually eligible clients.

Some dually eligible clients receive care coordination through PACE or the Medicare Special Needs Plans (SNPs). However, there are other dually eligible clients who would benefit from care coordination. It is not the Department's intention to discourage dually eligible clients who are eligible for PACE, Special Needs Plans, or other similar programs from enrolling in these programs. Rather, the Department envisions these programs to be part of the continuum of care options for dually eligible clients. Dually eligible clients who are not enrolled in SNP or PACE also need assistance with making the most of their Medicare and Medicaid benefits to reach better health outcomes. The ACC is designed to do this.

In May 2011, the Department was awarded a contract with the Centers for Medicare and Medicaid Services (CMS) in the amount of $1 million to design a plan to integrate care for people dually eligible for Medicaid and Medicare. This proposal will outline how the Department plans to maximize the effectiveness of all of its programs that are able to serve this vulnerable population. A final proposal is due to CMS in May 2012, and CMS will subsequently determine whether to fund the implementation of the plan.

23) The Department received federal funding to study services for people dually eligible for Medicaid and Medicare, and plans appear to link the Accountable Care Collaborative with this project. How will the Department modify the dual eligible proposal based on stakeholder input and how is the Department coordinating between the duals project and the larger ACC project? What expertise do the ACC vendors have to serve this more vulnerable population, and what assurances can you provide that the model is cost effective and of the highest quality?

RESPONSE:

The Department has received federal funding to develop a proposed plan to integrate care for people who are dually eligible for Medicaid and Medicare. The Department's original proposal for this funding focused on the ACC so the Department could explore how to overcome the challenges of enrolling dually eligible clients into the ACC and make it feasible to offer the ACC as an option to these clients. As discussed in the response to Question 22, the Department has designed the ACC program to be one of several options for serving the needs of dually eligible clients. Although the federal funding focuses on using the ACC program, it does not exclude or limit the Department's other options for delivering services to dually eligible clients.

The work that was funded by the grant is currently underway and includes gathering stakeholder input which will guide the development of the proposal to CMS for a plan to provide integrated care to dually eligible clients. This plan is due to CMS in May 2012. In order to develop this proposal, the Department is actively engaging stakeholders with

expertise and interest in dually eligible populations, as well as stakeholders who are involved with the ACC.

Meaningful stakeholder participation is essential to the Dual-Eligible Demonstration Proposal's success. For example, the Department is utilizing established committees and advisory groups such as the Long-Term Care Advisory Committee, the Medicaid Infrastructure Grant Steering Committee, the Single Entry Point Administrators' Advisory Council, the Nursing Facilities Advisory Council, and the Consumer-Directed Attendant Support Services Advisory Council to help provide input and to ensure the Department is reaching as many stakeholders as possible. Meeting with and listening to members of these groups is one avenue for input.

In addition, the Department is requesting statewide feedback through its collaborative alliances with community organizations, task forces, and coalitions to ensure that all voices are heard and all opinions are expressed. More than 550 individuals representing over 230 organizations and departments comprise the primary stakeholder list. Stakeholder meetings are occurring in Denver (with a statewide call-in option) on a monthly basis. Small group presentations are also taking place weekly. Focus groups and individual, focused interviews are being scheduled to obtain the opinions of service recipients and care givers. Large and small regional stakeholder meetings will occur in January and February 2012 throughout the state.

Moreover, stakeholders have volunteered to participate in five small work groups to address specific input areas: Behavioral Health, Communication (Outreach and Information), Coordination of Care, Developmental Disabilities, and Financing Strategies and Quality Medical Outcomes. The Department has dedicated a page on its website to provide direct contact information, background information and reports, and progress updates. The Department is utilizing stakeholder input to help guide the development of the proposal to the Centers for Medicare and Medicaid Services to be submitted in May 2012.

The Department awarded contracts to the RCCOs based partially on their ability to address the needs of special populations such as dually eligible clients. Many of the RCCOs and the Primary Care Medical Providers (PCMPs) in their networks are already experienced in working with dually eligible clients and already have these clients as part of their Medicaid panels. The Department is working with the RCCOs and ACC providers, along with stakeholders and providers in the long term-care and behavioral health systems to determine the best ways to leverage the expertise, strengths, and capacity of these existing systems to ensure that the ACC is robust in its ability to provide care coordination for people who are dually eligible. This includes expanding the RCCO networks to include more long-term care providers, specialists, and other resources that may be needed by the clients. The project implementation timeline provides sufficient time to address any remaining capacity issues in the ACC.

Another part of the ACC structure is the Statewide Data and Analytics Contractor, which will provide the RCCOs with the data necessary to identify gaps or weaknesses in the care

of this population. The ACC program uses data to look at both the cost and quality metrics to evaluate its ability to meet the needs of this population.

24) What is the Department's opinion about removing the prohibition against managed long-term care services, particularly in light of the current budget situation?

RESPONSE:

The Department interprets the language concerning managed long-term care services at 25.5-5-402(2)(b) C.R.S. (2011) as prohibiting the inclusion of long-term care services as part of the defined set of services under a risk capitation contract or, in managed fee-for-service, prohibiting the use of a restrictive or "closed" network.

The Department does not interpret the language at 25.5-5-402(2)(b) as prohibiting collaboration among providers, care management, or care coordination.

The current prohibition does limit the flexibility of the Department. As a general rule, the Department prefers flexibility in statute. Removing the prohibition against managed long-term care services would give the Department the maximum flexibility to manage the costs and quality of long-term care services.

However, the Department has not formulated any specific program design nor crafted policy that would utilize that flexibility. The Department notes that the absence of the prohibition does not necessarily provide clarity in terms of program design. The Department understands, among its stakeholders, there are some who have strong views on the current prohibition, and the Department believes it would be necessary to have a robust stakeholder process prior to utilizing that flexibility.

25) How will the Department work with the Program for All-inclusive Care for the Elderly (PACE), the Community Centered Boards, and Single Entry Points in designing the dual eligible project?

RESPONSE:

The Department has included these important partners in its discussions about the proposal. All three PACE organizations, which serve approximately 1,900 seniors, are currently represented in the main stakeholder group for the dual-eligibles project. Additionally, the PACE organizations are also contributing to the financing strategies and quality medical outcomes workgroup and the care coordination workgroup. Furthermore, the Department has had several meetings with the PACE organizations in an effort to explore the most effective ways to leverage the expertise and strengths of the PACE organizations and model in providing the best care to dual-eligible individuals.

In addition, 20 Community Centered Boards throughout Colorado currently serve approximately 11,000 individuals and families with developmental delays and disabilities. Several of the boards participate in the Department's main stakeholder group for dual

eligibles and are active in the Developmental Disabilities work group. Moreover, the Department is actively soliciting input from the boards as it conducts statewide community meetings in January and February of 2012. Additionally, 23 Single Entry Point agencies across the state serve as the access point for the elderly, the blind, those with other disabilities, individuals with brain injuries, people with mental illnesses, and persons living with AIDS. Their experience in level-of-care assessments for community-based long-term services, care planning, and case management adds valuable perspective to the dual-eligibles proposal. The Single Entry Points are also represented in the Department's main stakeholder group for dual eligibles and participate in the project's dedicated work groups. The Department will be obtaining more focused input from the Single Entry Points during its statewide community meetings early in 2012. The response to Question 22 includes more information on the Department's stakeholder process.

26) How is the Department planning on utilizing current Medicaid long-term care providers who coordinate care for this population in the development of the dual-eligible proposal?

RESPONSE:

The dual-eligible integrated-care proposal will lay out a plan for how the Department will coordinate existing and new programs that serve dually eligible clients. It is still in the development phase and is due to the Centers for Medicare and Medicaid Services (CMS) in May 2012. Over the past six months, the Department has held several stakeholder meetings, has met with individual stakeholders and stakeholder groups, and has formed five work groups that meet regularly. Long-term care providers have been included in these meetings and outreach. Staff continues to perform outreach and expand the list of stakeholders to be contacted for input on the proposal and will continue to do so over the next five months as the proposal is being finalized. In addition, the Department is planning to conduct regional meetings across the state in late January and early February 2012 to host forums for stakeholder input and to provide information on the proposal requirements. Staff working on the proposal will be incorporating stakeholder feedback as well as collaborating with the Long-Term Care Benefits Division of the Department when crafting the proposal.

EXPENDITURE AND CASELOAD FORECAST

27) Briefly describe the Department's method for forecasting the Medicaid caseload, highlighting the population and economic indicators that are most predictive of the caseload.

a) Include a discussion of whether the Department uses U3 or U6 unemployment statistics in the forecast, and why.

RESPONSE:

The Department's November 1, 2011 Budget Request contains a detailed narrative of the methodology used to forecast Medicaid caseload on pages H-63 through H-145. Medicaid caseload trends are influenced by a number of factors including: population trends (at the subgroup level), in-State migration, age of the population, length of stay, economic conditions, and State and federal policy changes. The Office of State Planning and Budgeting and the Colorado Department of Local Affairs' Demography Division supply actual and forecasted monthly values of the following independent variables, which are used in regression models to forecast Medicaid caseload:

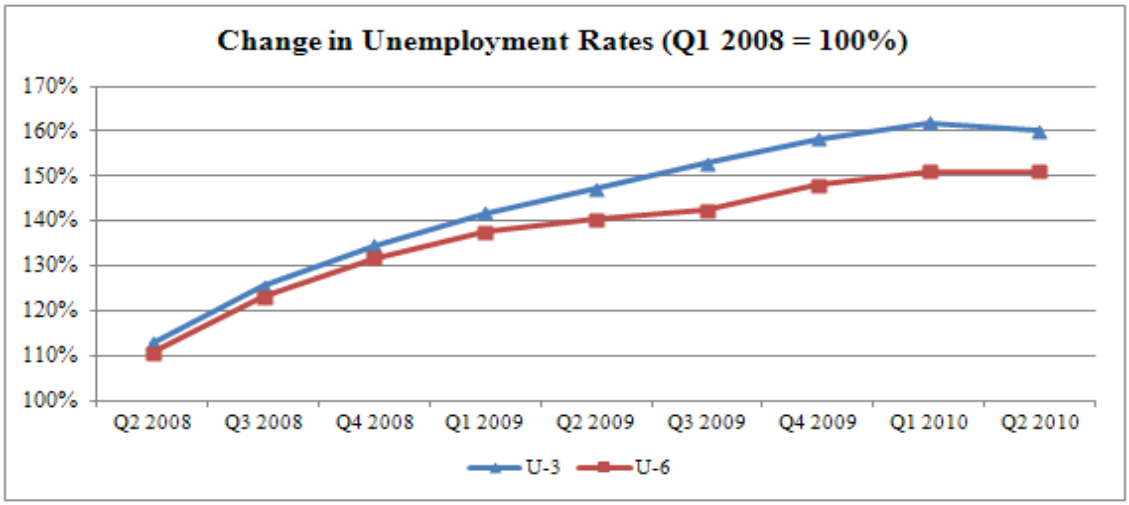
- Employment – level of employment, measured in thousands
- Unemployment Rate – the number of unemployed divided by the number in the labor force, measured as a percent (U-3 unemployment rate)
- Total Wages – level of total wages, measured in billions
- Population by Age Group – level of population broken into specific age groupings
- Births – number of births per thousand women
- Migration – net increases or decreases in the State population adjusted for births and deaths

Subgroup population projections, migration patterns, and age of the population tend to be most statistically predictive of caseload in the aged and disabled categories in Medicaid. Economic indicators help partially explain why some Medicaid caseload trends occur. Since Medicaid is a needs-based program where clients must meet income and resource limits, it follows that caseload for families and children should be countercyclical to economic conditions. For example, as the state experiences recessionary conditions, the Medicaid caseload will increase.

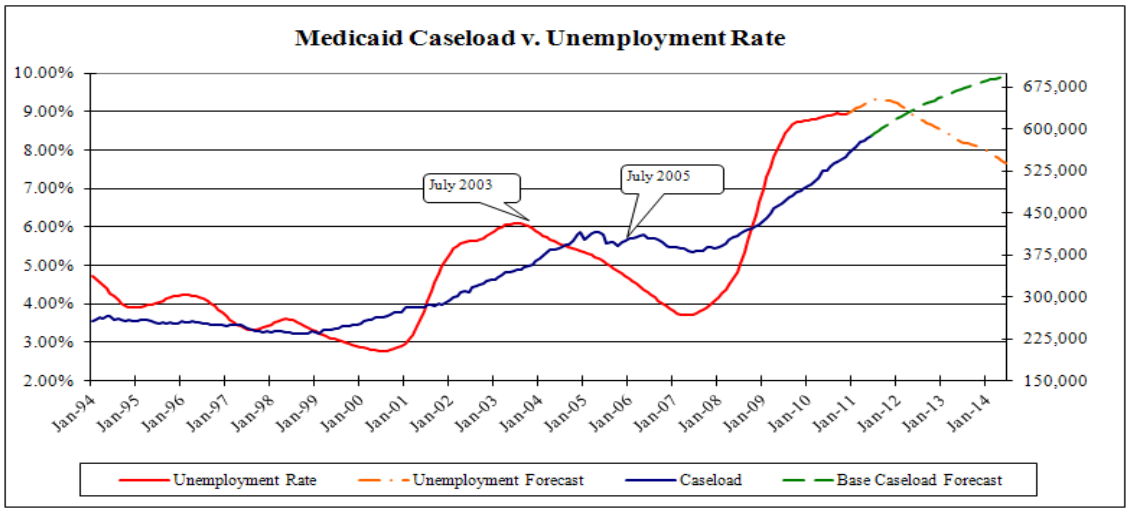
Despite the fact that U-6 unemployment is widely considered to be a more broad measure of unemployment, as it includes total unemployed plus all persons marginally attached to the labor force and total employed part-time for economic reasons, the Department believes U-3 unemployment rate is a better option for forecasting purposes for two main reasons. First, the Bureau of Labor Statistics publishes the U-6 unemployment data on a four-quarter, moving-average basis, whereas U-3 data is available on a monthly basis. This increases the sample size that the Department can use in its forecasts, which increases the reliability of the model. Second, the

Department does not currently have access to projections of Colorado-specific U-6 unemployment rates, which is essential if it is to be used in regression modeling.

Even if the Department had access to monthly historical and independently forecasted data on Colorado-specific U-6 unemployment rates, the Department does not believe use of this measure would materially improve its Medicaid caseload forecast. The absolute level of unemployment used in the regression model is irrelevant; rather, it is the relative change between data points that matters. In a regression model, if two variables have a very similar pattern over time, both will yield very similar forecasts regardless of differences in absolute value. As can be seen in the graph below, the four-quarter moving average of U-3 and U-6 unemployment have displayed very similar trends since the first quarter of 2008.

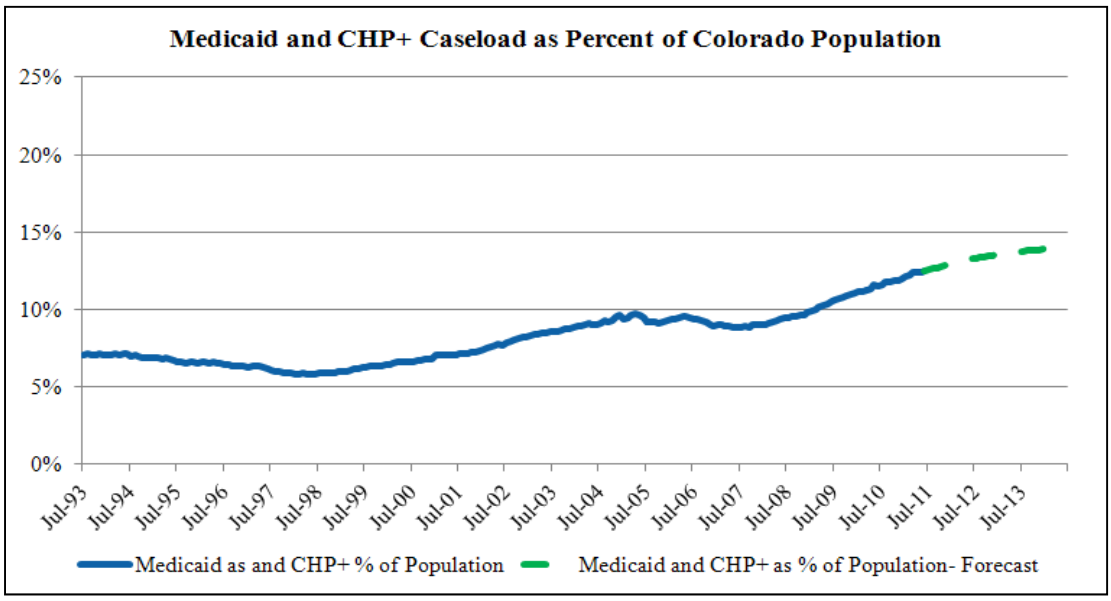


The lagged effect of economic conditions on Medicaid caseload is reflected in its relationship with U-3 unemployment. Based on analysis of caseload trends following prior recessions, the Department anticipates Medicaid caseload will continue to grow for 18 to 24 months after economic conditions begin to improve.



b) Please show the Medicaid caseload as a percentage of Colorado's population over time, and indexed to Colorado's population.

RESPONSE:



28) Please show changes in expenditures by service type over time. Which service types are increasing most rapidly and what is the Department doing to contain costs for these services?

RESPONSE:

Cost containment has been a central focus of most of the Department's recent initiatives. The Department has experienced high percentage growth in a number of Medicaid service areas over the last several years. For reference, the Department has included total expenditure by service category and by year in the General Data section of its responses, in Section 6. The Department is constantly monitoring its program expenditure and making interventions to help control costs.

While specific cost-containment activities are described below, it must be noted that much of the recent growth is directly attributable to increasing Medicaid caseload. Between FY 2007-08 and FY 2010-11, Medicaid caseload has increased from 391,962 clients to 560,722 clients, an increase of 43%. For example, the effect of caseload is evident in the Department's spending on prescription drugs; in FY 2010-11, total expenditure for prescription drugs increased by 16.0%, but per-capita spending (cost per client) increased by only 3.2%. Thus, it would not be effective for the Department to pursue a global strategy to reduce prescription drug expenditure because of the total growth rate, because the growth is due to the number of clients, not something specific to prescription drugs.

Many service categories contain a number of distinct services. As a result, the Department cannot simply "manage" a service category. Rather, the Department must make interventions that focus on specific high-growth areas within a service type (i.e., emergency department use within the Outpatient Hospital service area) or on high-cost clients, whose costs generally span several service types.

The Department's recent cost-containment efforts can be grouped generally into the following areas:

- To help control costs over time for acute care services, the Department has focused on providing better tools and support to providers through the Accountable Care Collaborative. The Accountable Care Collaborative (ACC) is the Department's new Medicaid program that unites providers, clinics, hospitals, and social service organizations with the goal of improving the health of Coloradans while containing costs. Medicaid clients enrolled in the ACC receive services using the fee-for-service model and also belong to a Regional Care Collaborative Organization (RCCO) that coordinates care and services among providers and other community and government services. For further information on the ACC, see Questions 10 through 14.

- To further help control costs for long-term care services, the Department is engaged in deinstitutionalization efforts through the Colorado Choice Transitions program (formerly known as the Money Follows the Person grant). The Department can achieve significant savings when clients who meet the nursing facility level of care are able to remain in the community by receiving services through a Home- and Community-Based Services (HCBS) program.

- Initiatives that are more narrowly focused on certain services within a service type include the Benefits Collaborative and the Department workgroups for reducing inpatient readmission and emergency department overuse. In addition, the Department's new utilization management review contractor is able to respond flexibly to utilization management needs in specific program areas as they arise.

- The Department makes specific and timely adjustments to services as circumstances require. The Department receives periodic reports on expenditure and utilization for all Medicaid services. Based on these reports, where expenditure or utilization is increasing unexpectedly, the Department can make simple and timely policy changes, such as implementing prior authorization requirements that can eliminate inappropriate utilization. For example, in the Department's November 1, 2011 Budget Request R-6 "Medicaid Budget Reductions," the Department is accounting for numerous program changes that have occurred as a result of monitoring program expenditure and utilization. For detailed information on R-6 see Question 33.

- A more fundamental reason why service costs continue to increase relates to the fee-for-service reimbursement system used for the majority of Medicaid payments

(both in Colorado and nationally). The Department is engaged in a long-term program of reforming the way that it pays for these services. The Department's November 1, 2011 Budget Request R-5 "Medicaid Fee-for-Service Reform" contained a number of initiatives to begin to realign financial incentives to encourage better outcomes, not simply more services. For detailed information on these initiatives see Question 9.

However, not all areas of high growth require specific interventions. Other factors influence where the Department takes action to help reduce costs, including (but not limited to):

- Impacts upon other areas of the budget. For example, expenditure for health maintenance organziations is a managed care substitute for fee-for-service acute care. Cost growth in this service area is in lieu of cost growth in other services areas, such as physician services, hospitals, and prescription drugs.

- Feasibility of intervention. Medicare co-insurance costs incurred by the Department on behalf of Medicare/Medicaid dual eligibles is largely a function of Medicare cost growth, which has previously been outside of the administrative control of the Department. The Department is hoping that its federal contract to provide better integration of care and funding for dual eligibles gives the Department an administrative lever in the near future to control costs for the dual eligibles in this service type and others as well.

- Effect of policy changes. New programs or budgetary actions can cause spikes (or drops) in expenditure patterns. When this occurs, a global intervention for affected services categories is not warranted.

In short, the Department is continuously engaged in monitoring expenditure to prevent unnecessary expenditure and actively working on long-term strategies to control cost growth.

29) In March 2011, the Department provided a table with both monthly and annual income levels associated with different percentages of the federal poverty guidelines. Please provide an update of that table in the same format.

RESPONSE:

See Attachment C.

a) Does the Department have a projection of what the federal poverty guidelines will be in FY 2013-14 when the Affordable Care Act is fully implemented?

RESPONSE:

The poverty guidelines used to determining financial eligibility for certain federal programs, including Medicaid and CHP+, are issued each year in the Federal Register by the federal Department of Health and Human Services (HHS). The Department does not have projections of what the federal poverty guidelines will be in FY 2013-14.

30) How will federal sequestration and related federal budget balancing measures impact Colorado's Medicaid program?

RESPONSE:

A large number of mandatory programs are exempt from sequestration, including Medicaid.

31) Please define the foster children ages 21-26 who will be newly eligible for Medicaid under the Affordable Care Act? Does this include children who are adopted?

RESPONSE:

Section 2004 of the Affordable Care Act extends Medicaid eligibility to individuals who are under 26 years of age and who were enrolled in Medicaid and in foster care under the responsibility of the State on the date of attaining 18 years of age or a higher age elected by the State. Per 25.5-5-201(1)(n), C.R.S. (2011), as enacted by SB 07-002, Colorado currently extends Medicaid eligibility to such individuals through the 21st birthday. Beginning in January 2014, eligibility for this group will be expanded through the 26th birthday.

Pursuant to 25.5-5-201(l), C.R.S. (2011), Colorado has also elected to provide Medicaid to children for whom state subsidized adoption assistance or foster care maintenance payments are made through the child's 21st birthday (the expansion from the 18th birthday was enacted by SB 08-099). The Affordable Care Act does not extend eligibility for these individuals through the 26th birthday.

32) The majority of Colorado's Medicaid reimbursement rates appear below the rates paid by Medicare. Is that appropriate? Please explain why Colorado's Medicaid rates for radiology pay more than Medicare.

RESPONSE:

The vast majority of state Medicaid programs use Medicare reimbursement rates as a starting point and set their rates as a percentage of Medicare rates. On average, state

Medicaid programs reimburse for services at 72% of the Medicare rates (Kaiser State Health Facts, Medicare-to-Medicaid Fee Index, 2008).[1] Although reimbursement varies by service, Colorado Medicaid reimburses an average of 63.2% of Medicare.

The Department supplied information to Joint Budget Committee staff in advance of the December 15, 2011, briefing on Medicaid rates as a percentage of Medicare rates. However, after the briefing, Congress passed legislation changing Medicare rates (commonly referred to as the "Doc Fix"). The following table shows a revised comparison of Medicaid rates as a percentage of Medicare rates.

Procedure Code Category	Medicaid Reimbursement as a Percent of Projected Medicare Reimbursement
Total	**63.2%**
Durable medical equipment (DME)	57.3%
Enteral and Parenteral Therapy	85.0%
Evaluation & Management	78.9%
Medical and Surgical Supplies	62.4%
Medicine	54.4%
Orthotic Procedures and services	71.2%
Pathology	61.4%
Pathology and Laboratory Services	23.7%
Procedures / Professional Services	59.6%
Prosthetic Procedures	76.1%
Radiology	67.2%
Surgery	49.1%
Temporary Codes	95.4%
Transportation Services Including Ambulance	48.8%
Vision Services	35.1%

As can be seen in the table, the Department is not anticipated to pay more for radiology services than Medicare. The comparison provided in the briefing assumed a large decrease in the Medicare rate which will not occur.

The recession and budget challenges of the last few years have necessitated some provider rate reductions. The Department has worked with providers to minimize across-the-board rate reductions whenever possible. Because the Department was able to raise rates in the years prior to the recession, the net decrease over the last seven years is small.

[1] Sources: Stephen Zuckerman, Aimee Williams, and Karen Stockley, "Medicaid Physician Fees Grew By More Than 15 Percent From 2003 to 2008, Narrowing Gap With Medicare Physician Payment Rates," Health Affairs, April 2009; available at http://www.kff.org/medicaid/kcmu042809oth.cfm.

The Department agrees it is important to pay enough to recruit and retain providers and appropriately compensate them for the services they deliver to clients. However, the Department's goal is to change not only the amount that providers are paid but also how providers are paid so providers are incentivized to provide good health outcomes rather than a high volume of services.

MEDICAID BUDGET REDUCTIONS

33) Please take the Joint Budget Committee on a tour through the cost containment strategies contained in R-6.

a) How many people will be impacted by each proposal and what will be the impact on their benefits?

b) What will be the impact on providers of each proposal?

RESPONSE:

For convenience, the Department is including a brief overview of each initiative. All proposals are explained in detail in the Department's November 1, 2011 FY 2012-13 R-6 request, "Medicaid Budget Reductions."

FY 2012-13 R-6: "Medicaid Budget Reductions" Summary

As part of the Department's strategic objective to contain health care costs, the Department proposes to reduce Medicaid expenditure through a series of initiatives. The proposed initiatives will also assist in meeting budget balancing goals for FY 2012-13. These initiatives provide a combination of rate adjustments to realign incentives, service restrictions, and financial efficiencies to reduce Medicaid program expenditures by $29,699,322 total funds and $30,471,105 General Fund in FY 2012-13.

The components of this request represent significant reductions in expenditure and consequently impact stakeholders in a variety of ways. To the extent possible for each initiative, the Department has engaged stakeholders to collaboratively develop proposals. Stakeholders have provided invaluable feedback that allowed the Department to identify reductions and find efficiencies that will have the least negative consequences to Medicaid clients and providers while still achieving significant savings.

Department initiatives include the following:

- *Preterm Labor Prevention*: The Department is offering coverage of injections which reduce the occurrence of preterm labor. Preventing preterm labor will reduce expenditure and improve client outcomes as preterm babies are more fragile and require more intensive levels of care. The Department does not anticipate any significant impact on providers. Approximately 1,122 clients will be treated, and an

estimated 204 preterm births will be avoided in FY 2012-13. See R-6, Appendix C, Tables A.1 – A.3. *FY 2012-13 General Fund savings: $451,368*

- *Synagis PAR Review*: The Department will be increasing review of prior authorizations for Synagis, a drug used to reduce the risk of respiratory illness for certain high-risk children, to ensure only appropriate dosages are utilized of this drug. This drug helps the Department contain health care costs by avoiding costly treatment of respiratory illness but is itself expensive. Prior authorization review ensures the drug is used in appropriate dosages by only those clients that will benefit from the use of the drug. Because the drug will continue to be authorized for clients who will benefit from it and approved dosages will be sufficient to achieve clinical efficacy, there will be no negative impact on clients. No significant impact on providers is anticipated. See R-6, Appendix C, Table B.1. *FY 2012-13 General Fund savings: $205,100*

- *Expansion of the Physician Administered Drug Rebate Program*: The Department has expanded the list of physician-administered drugs for which it collects rebates. This initiative is not expected to impact providers or clients. See R-6, Appendix C, Table C.1. *FY 2012-13 General Fund savings: $1,209,138*

- *Reimbursement Rate Alignment for Developmental Screenings*: Effective August 1, 2011, the Department reduced the rates paid and implemented appropriate age limits for developmental and adolescent depression screenings to better align the rates with both Medicare and private insurers. Previously, the rate paid for developmental and depression screenings was well above the rates paid by Medicare and commercial insurance plans for these screenings. Services will continue to be provided as federally required, appropriate based on industry standards, and when clinically appropriate. Exceptions to limitations will be granted on a case-by-case basis. Consequently, the Department feels there will be no significant impact on clients. Aggregate reimbursement to providers is reduced as estimated in the request. See R-6, Appendix C, Tables D.1 – D.3. *FY 2012-13 General Fund savings: $1,022,490*

- *Physician Administered Drug Pricing and Unit Limits*: The Department has realigned the pricing and unit limits on three physician-administered drugs (all antipsychotics) to achieve both consistency for billing and cost savings. There is no anticipated impact on clients from this initiative. Provider reimbursement for these drugs will, on aggregate, be lower. See R-6, Appendix C, Tables E.1 – E.4. *FY 2012-13 General Fund savings: $203,488*

- *Public Transportation Utilization*: The Department has built incentives and expectations into the non-emergent medical transportation program to increase client utilization of public transportation in the Denver-metro area. Public transportation is a significantly cheaper alternative to private transportation such as taxis. Clients will continue to have access to transportation for non-emergent services, but the mode of transportation will be different for some clients as they

will be using public transportation when it is a viable option. Medical service providers will not be impacted by shifts in utilization to public transportation. See R-6, Appendix C, Table F.1. *FY 2012-13 General Fund savings: $102,398*

- *Home Health Therapies Cap*: The Department is limiting the number of home health visits for therapy to 48 visits per calendar year. Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services are excluded from these limitations. Colorado Medicaid offers restorative and rehabilitative therapies as a covered benefit; maintenance therapies are not a covered benefit. The Department believes therapy visits in excess of 48 are not likely to be restorative or rehabilitative. Exceptions to the cap will be considered on a case-by-case basis when documentation can be provided that hours beyond the 48 visit limit are restorative or rehabilitative and medically necessary. Approximately 10% of home health therapy services in FY 2010-11 were in excess of the 48 visit limit. Of the clients utilizing services in excess of the limit, a portion will qualify for an exemption under EPSDT. Stakeholder outreach continues through the benefits collaborative process as the policy is refined to ensure client outcomes are not negatively impacted and the impact to the provider community is minimal. See R-6, Appendix C, Table G.1. *FY 2012-13 General Fund savings: $186,866*

- *Home Health Care Cap*: The Department has limited the number of hours of skilled care a patient can receive in the home health setting to eight hours per day. The eight-hour-per-day limitation is consistent with Medicare policy; however, the Medicaid limit offers additional flexibility in that a client can receive services seven days per week, whereas Medicare will only cover services for five days each week. EPSDT services are excluded from the limitations. In FY 2010-11, only 459 clients had dates of services with hours in excess of the eight-hour limit. Of these clients, some would qualify for exemptions under EPSDT. For the remainder, the impact is varied based on their unique utilization behavior. As with the therapies cap, stakeholder outreach continues through the benefits collaboration process to refine the policy initiative and minimize negative client and provider impacts. See R-6, Appendix C, Table H.1. *FY 2012-13 General Fund savings: $2,011,640*

- *Seroquel Restrictions*: The Department has implemented policies to prevent the utilization of Seroquel for off-label use. Seroquel is a drug used to treat schizophrenia; however, it is sometimes prescribed for treatment of insomnia and anxiety. Other, more appropriate, treatments for insomnia and anxiety are available and are more cost-effective than Seroquel. The Department does not anticipate any significant impact to the provider community or clients as there are more appropriate substitutes for this drug. See R-6, Appendix C, Table I.1. *FY 2012-13 General Fund savings: $943,568*

- *Dental Efficiencies*: The Department will clarify rules regarding eligibility and reimbursement for orthodontics. These clarifications are expected to reduce utilization of orthodontics for all cases except those where the client has a condition where speech or the ability to eat is significantly impaired. Further, changes in

policy will ensure that payment is only made when services are rendered. The Department will no longer pay in full, up front, for services that have not yet been rendered. In some cases, this results in the Department paying for services that are never rendered or for clients who are no longer eligible. This part of the initiative should not impact clients. While this does represent a significant change from previous reimbursement policy, providers will be reimbursed the same amount for the same services rendered. The Department has also identified language pertaining to the criteria under which a client qualifies for orthodontia is overly ambiguous. This results in a high level of subjectivity in determining whether services are medically necessary. The Department looked at other states' expenditure on orthodontia relative to the restrictiveness of their orthodontia criteria and estimated an approximate 10% reduction in expenditure on orthodontia. Because this estimate includes eliminating payment for services that were not rendered, the actual impact to clients is significantly less than a 10% reduction in the number of clients receiving services. The Department is working with stakeholders to establish reimbursement methodologies and clear definitions of qualifying criteria for this benefit to ensure clients have access to services when appropriate. See R-6, Appendix C, Table J.1. *FY 2012-13 General Fund savings: $802,081*

- *Augmentative Communication Devices*: The Department has implemented an initiative to provide access to less-costly equipment for disabled clients who face challenges with speaking. New computing technology can be used as a substitute for the more-expensive options that were previously available. As this involves product substitution, the Department believes there will be no negative impact on clients. There is no anticipated impact to providers. See R-6, Appendix C, Table K.1. *FY 2012-13 General Fund savings: $240,391*

- *Durable Medical Equipment Preferred Provider:* The Department initiated a competitive procurement process to acquire a sole source diabetic testing supply provider whereby the Department can leverage purchasing power to obtain significant rebates. No provider or client impact is anticipated. See R-6, Appendix C, Table L.1. *FY 2012-13 General Fund savings: $562,246*

- *Continuation of Nursing Facility Reduction:* The Department proposes a continuation of the 1.5% rate reduction to class I nursing facility reimbursement currently scheduled to end July 1, 2012. This initiative is not expected to impact clients but will impact all class I nursing facilities. See R-6, Appendix A, Table M.1. *FY 2012-13 General Fund savings: $4,512,338*

- *Ambulatory Surgical Centers:* The Department has initiated a pilot project to shift some outpatient surgery utilization from the outpatient hospital setting to the less-costly ambulatory surgical setting. There will be no direct impact for clients; however, clients should have broader access to ambulatory surgical centers for certain treatments. Aggregate reimbursement to hospitals may be reduced and reimbursement to ASC providers increased as costs shift between settings. See R-6, page 13. *FY 2012-13 General Fund savings: $488,599*

- *Pharmacy Rate Methodology Transition*: To accommodate a change in available drug-pricing information, the Department is changing the pricing methodology for drugs. As part of the change in pricing, reimbursement for drugs will be decreased to more accurately reflect actual acquisition cost of drugs and the dispensing fee will be increased to reflect the actual costs to pharmacists for dispensing a drug. There will be no impact to clients. Aggregate reimbursement to providers is estimated to be reduced by approximately $4,000,000. The new methodology will impact all Medicaid pharmaceutical providers. See R-6, page 14. Additionally, see the Department's responses to questions 35-43. *FY 2012-13 General Fund savings: $1,954,394*

- *Hospital Provider Fee Financing*: The Department is utilizing hospital provider fee to offset lost federal funds associated with certification of public expenditure for outpatient hospital services in accordance with HB 09-1293. Certification of public expenditure is the process by which costs incurred by state-run facilities, but not directly compensated for through the Medicaid program, are identified for the purpose of obtaining matching federal funds. An annual amount of $15,700,000 cash fund will be used to offset General Fund in the Medical Services Premiums line effective FY 2011-12. There will be no impact to clients or hospitals; this amount has been incorporated into the hospital provider fee modeling and does not reduce supplemental payments or other reimbursement. See R-6, page 15. *2012-13 General Fund savings: $15,700,000*

c) Will pediatric services be subject to the caps on home health care and home health therapies?

RESPONSE:

Unless the request for home health therapies is made under EPSDT, a standard pediatric home health therapy request will be subject to the 48-unit therapy cap per calendar year. Due to EPSDT, this cap will not apply to clients aged 20 years and under. This is also true for the home health clinical services eight-hour cap. According to Medicare guidelines, a standard home health plan of care should not exceed more than eight hours of clinical services in a day. However, this cap will, again, not apply to clients aged 20 and under due to EPSDT.

d) How will the Department fulfill minimum standards for Early and Periodic Screening, Diagnostic, and Treatment services with the proposed caps on Home Health?

RESPONSE:

The cap allows for eight hours of clinical service a daily. While the Department feels this is more than sufficient to satisfy all EPSDT requirements, it recognizes there may

be circumstances where additional hours will be necessary to comply with federal standards. Those cases will be approved on a case-by-case basis.

e) How does the Durable Medical Equipment Preferred Provider proposal to use a sole-source contract for diabetic testing supplies relate to cost containment measures requested last year?

RESPONSE:

Reimbursement for diabetic testing strips was reduced from $31.48 per box to $18.00 per box in accordance with FY 2011-12 BRI-5 "Medicaid Reductions" as approved by the JBC. The proposal included in R-6, wherein the Department leverages purchasing power to obtain discounted pricing, is above and beyond the savings achieved last year.

34) Please explain recent cuts in Medicaid services and programs by service and program area, noting the impetus for each change, the savings, net system impacts, and performance.

RESPONSE:

The Department has implemented and the General Assembly has approved over 75 cost-savings initiatives in recent years to reduce General Fund expenditures. The Department has also proposed over 20 cost-saving initiatives that would be implemented in FY 2011-12 or FY 2012-13. Below is an explanation of the impetus, system impacts, and performance of these initiatives as categorized by program area, as well as a table showing the savings by each program area.

Across-the-Board Rate Cuts
Since FY 2009-10, the Department has cut rates for most acute care providers by a cumulative 6.10% and has cut rates for community-based long-term care providers by a cumulative 5.86%.[2] These rate cuts were taken in order to reduce the Medicaid budget in response to the recession and corresponding fiscal crisis. All rate cuts were implemented to achieve the estimated savings in the following tables.

Targeted Rate Cuts
The Department identified several services for which the Medicaid rates were not in line with Medicare or commercial insurance, even after the across-the-board rate cuts were effective. The Department adjusted these rates in order to align them with other payers' rates and to incentivize providers to deliver services only when appropriate. Examples of these include rate cuts for uncomplicated caesarean section delivery and certain diabetes supplies. In addition, certain provider groups were not affected by the across-the-board rate cuts, such as FQHCs and nursing facilities. The Department reduced the rates for those providers through separate initiatives or legislation. These rate cuts were taken in order to reduce the Medicaid budget in response to the recession and corresponding fiscal

[2] Rate cuts are multiplicative; incremental rate cuts will not add to the cumulative total.

crisis. All targeted rate cuts were implemented or, for proposed initiatives, would be implemented to achieve the estimated savings in the following tables.

Efficiencies

The Department has added limits or expanded existing limits on many of its services to create efficiencies. For example: the Department no longer reimburses hospitals for a client who was readmitted within 48 hours of admission; prior authorizations are now required for some services, such as radiology; utilization limits were added to certain services, including HCBS transportation and acute home health; and certain services were eliminated from the benefit package, including oral hygiene instruction. These efficiencies were identified by the Department's Benefits Collaborative, stakeholder input, or national best practices as appropriate ways to manage utilization. The goal of all of the efficiencies is to align the Department's policies with clinical evidence and best practices. The Department only phased out a program or service when there was no clinical evidence that it provided any value to clients. To ensure that clients still have access to medically necessary services, the Department has a prior authorization process through which providers can request an exception for a service that would not normally be reimbursed due to imposed limits. All efficiencies were implemented or, for proposed initiatives, would be implemented to achieve the estimated savings in the following tables.

Accountable Care Collaborative

The Accountable Care Collaborative (ACC) program was designed to improve client health and reduce costs by changing the financial incentives for providers from a system that encourages increased utilization and billing to one that rewards improvements in client health outcomes. The Department provides both incentives and tools, such as client health data, that help providers better manage care, resulting in fewer duplicative, unnecessary, and avoidable care and the costs associated with it. The ACC changed the Medicaid delivery system by shifting to a focus on care coordination while also bending the cost curve for short- and long-term savings. The program is still in the initial stages; the Department anticipates that it will achieve the estimated savings in the following tables.

Pharmacy

The Department has implemented various pharmacy initiatives to reduce costs, increase its ability to collect rebates, and better manage utilization of prescription drugs. One of the primary mechanisms used to control pharmacy costs and encourage appropriate utilization is through the Preferred Drug List (PDL), which requires providers to obtain a prior authorization for non-preferred drugs; a non-preferred drug may have the same clinical efficacy as a preferred drug but is more expensive net of rebate. The Department also uses recommendations from the Drug Utilization Review (DUR) Board to determine appropriate utilization limits and prior authorization criteria for certain drugs, which create efficiencies and reduce costs without creating barriers to access when drugs are medically necessary. In addition, the Department has decreased the rates for all pharmaceuticals through overall rate cuts and for targeted pharmaceuticals through the State Maximum Allowable Cost (SMAC) pricing methodology. All pharmacy initiatives were implemented or, for proposed initiatives, would be implemented to achieve the estimated savings in the following tables.

Financing
The Department has made transfers from cash funds to General Fund to provide General Fund relief, particularly for its Medical Services Premiums line. If transfers from the Hospital Provider Fee Cash Fund to the General Fund had not been made, hospitals would have been required to pay less in fees to receive the same amount of supplemental payments. Instead of reducing those fees, the Department used the funding to pay for Medicaid services. For other cash fund transfers, such as from the Primary Care Fund, the Department maximized federal funding as much as possible through other mechanisms in order to minimize the impact to providers. Without these transfers, the Department would have had to reduce the budget in other ways, such as by further cutting rates or eliminating more services. All transfers were made or, for proposed initiatives, would be made to achieve the savings in the following tables.

CHP+
Within the CHP+ program, the Department is implementing several initiatives to align its policies more closely with Medicaid and commercial insurance, which will create efficiencies for the State. Examples of these include requiring a prior authorization on any services provided out of network and eliminating inpatient coverage for prenatal presumptive eligibility. The Department also reduced CHP+ managed-care rates by 3.0%. This rate cut was taken in order to reduce the CHP+ budget in response to the recession and corresponding fiscal crisis. All CHP+ initiatives are being implemented to achieve the estimated savings in the following tables.

Mental Health
The Department cut the capitation rates for Behavioral Health Organizations by 2.5% in FY 2009-10 and an additional 2.0% in FY 2010-11. The 2.0% rate reduction was implemented by reforming the rates to include a case-rate component, which is the BHO statewide average cost by diagnosis category. It allows for any savings achieved to be spread across the entire system, rather than directly reducing the rate of the BHO responsible for generating savings. Incorporating the case rate serves to better align the rate-setting process with the Department's goals by incentivizing the BHOs to be more efficient without sacrificing the quality of the care provided to their clients. These rate cuts were taken in order to reduce the Medicaid budget in response to the recession and corresponding fiscal crisis. All rate cuts were implemented to achieve the estimated savings in the following tables.

Executive Director's Office
In FY 2009-10, the Department identified savings that would result from reducing its operating expenses and the MMIS contract. There was also a small amount of savings achieved through a statewide personal services reduction. These administrative reductions were taken in order to reduce the Department's budget in response to the recession and corresponding fiscal crisis. All administrative reductions were implemented to achieve the estimated savings in the following tables.

MMIS Payment Delay

In FY 2009-10, the Department was directed by the Governor's Office of State Planning and Budgeting to shut down payments from the Medicaid Management Information System (MMIS) for the last two weeks of the fiscal year as a result of a fiscal emergency. These payments were then made at the beginning of FY 2010-11. This payment delay achieved the savings in the following tables.

Fee-for-Service Reform

For FY 2012-13, the Department is proposing to reform the fee-for-service payment system to better align provider incentives with delivering quality, efficient care. Most of the payment reforms involve an element of gainsharing (shared savings), which is a payment methodology whereby providers receive a percentage of savings that result from greater care management of their clients. Shared savings puts an emphasis on providing appropriate treatments to clients and preventing more costly care. Incentive payments are only paid to providers when they are able to demonstrate savings against benchmarks in predetermined service areas, so the shared savings reforms are guaranteed to be budget neutral or negative. The Department anticipates that the initiatives would achieve the estimated savings in the following tables in FY 2012-13 and would continue to significantly bend the cost curve in the long run.

Cost Sharing

The Department is proposing to increase current copayment amounts on Medicaid services to the maximum allowable under federal regulation and to add copayments on additional Medicaid services in FY 2012-13. The Department is also proposing to increase enrollment fees and copayment amounts for CHP+ clients. The Department anticipates increasing co-payment amounts would reduce unnecessary emergency or specialty care and would not only generate short-term savings but also slow long-term Medicaid and CHP+ cost growth. Shifting some of the cost of health care to clients could encourage a more involved decision-making process when clients decide whether or not they need to visit a physician or hospital. The Department anticipates that the initiatives would achieve the estimated savings in the following tables.

Implemented Budget Reductions: General Fund				
	FY 2009-10	**FY 2010-11**	**FY 2011-12**	**FY 2012-13**
Across-the-Board Rate Cuts	($18,564,778)	($33,229,641)	($48,824,740)	($50,267,797)
Targeted Rate Cuts	($4,678,355)	($10,012,192)	($14,550,666)	($10,141,504)
Efficiency	($1,534,728)	($2,009,714)	($10,199,983)	($14,033,383)
Accountable Care Collaborative	$0	($341,383)	($4,519,319)	($8,004,972)
Pharmacy	($8,386,425)	($12,582,293)	($17,233,835)	($17,315,095)
Financing	($66,492,848)	($74,106,110)	($99,428,359)	($36,492,584)
CHP+	($96,013)	($96,013)	($2,596,817)	($3,876,645)
Mental Health	($3,137,493)	($3,369,889)	($5,247,614)	($5,428,819)
Executive Director's Office	($381,917)	($198,748)	($198,748)	($198,748)
MMIS Payment Delay	($25,201,899)	$25,201,899	$0	$0
Total	**($128,474,456)**	**($110,744,084)**	**($202,800,081)**	**($145,759,547)**

Note: Where appropriate, implemented budget reductions have been updated to include the Department's most current estimates. Totals may not match with prior Department material for that reason.

Proposed Budget Reductions: General Fund				
	FY 2009-10	**FY 2010-11**	**FY 2011-12**	**FY 2012-13**
Targeted Rate Cuts	$0	$0	($791,810)	($5,534,828)
Efficiency	$0	$0	($1,213,075)	($4,845,589)
Pharmacy	$0	$0	($1,975,871)	($4,515,688)
Financing	$0	$0	($26,289,958)	($31,343,291)
Fee-for-Service Reform	$0	$0	$0	($910,826)
Cost Sharing	$0	$0	($138,601)	($1,438,020)
Total	**$0**	**$0**	**($30,409,315)**	**($48,588,242)**

PHARMACY

Background and Recent History

Historically, the Department has reimbursed Medicaid fee-for-service pharmacy claims using a lesser-of methodology. This reimbursement methodology compares the lesser of several pricing benchmarks and reimburses a pharmacy provider the lowest of the available prices. With this methodology, the majority of claims reimbursed using the Average Wholesale Price (AWP) as the majority of drugs had an available AWP price while the other pricing benchmarks did not.

One of the available pricing benchmarks under the lesser-of methodology was State Maximum Allowable Cost (SMAC). The Department defined the SMAC pricing benchmark as the Average Acquisition Cost (AAC) based on Colorado surveyed pharmacies plus 18%. The number of drugs included in the SMAC pricing benchmark was limited to a few generic products with the intent of containing costs in areas where great differences existed between AWP reimbursement and acquisition cost.

AWP was found to be an artificially inflated price by a federal lawsuit. It was determined that Fist Data Bank (FDB) raised the AWP to the wholesale acquisition cost (WAC) +25% on over 400 drugs. Previously, the AWP for these same drugs was WAC +20%. This action artificially increased the reimbursement paid to pharmacies by insurers. When FDB stopped publishing AWP as of September 30, 2011, following the lawsuit, the Department evaluated multiple pricing benchmarks and determined an AAC-based reimbursement methodology was the most appropriate replacement for the previous lesser-of methodology based primarily on AWP.

The Department believes a methodology based entirely on AAC pricing best aligns Medicaid reimbursement with the acquisition costs incurred for a drug by Colorado pharmacies. Through a complete AAC reimbursement methodology, the Department can effectively set prices at the lowest possible level without risking barriers to access for clients. Further, Colorado pharmacies are protected from under-reimbursement, as the rates are set at cost based on Colorado-specific data. The Department also believes, with an AAC reimbursement methodology, there is an increased importance on having a dispensing fee that reflects the cost of dispensing for a pharmacy. The Department's current dispensing fees ($4.00 for most providers) are well below the average dispensing cost. Under the previous methodology, AWP significantly inflated the ingredient costs, and providers were able to supplement the lower paid dispensing fee with the portion of ingredient cost that exceeded acquisition cost. While federal legislation does not require a dispensing fee, guidance issued to states from the Center for Medicare and Medicaid Services indicates an increase to a dispensing fee will not be approved without completion of a dispensing fee survey. The Department has hired a vendor Mercer Government Human Services Consulting to survey all pharmacies in the state to determine the true cost of dispensing, which may include expanding the number of dispensing fees beyond the current three dispensing fees.

Both the AAC pricing benchmark and updated dispensing fees will be obtained by the Department's vendor through a statewide survey of pharmacy costs funded using existing Department resources. The data will be representative of acquisition cost and dispensing cost data from different pharmacies and pharmacy types. The Department is currently working with the vendor and pharmacy stakeholders to develop a survey process that minimally impacts Colorado pharmacy providers while still providing the Department with accurate and reliable cost data. The Department expects the survey to be sent to the pharmacy community in January 2012 with the survey completed by spring 2012.

During the interim period between AWP discontinuation by FDB (September 30, 2011) and the implementation of the AAC reimbursement methodology (tentative May 1, 2012), the Department is utilizing a hybrid SMAC and WAC reimbursement methodology. Through the hybrid model, the number of drugs covered under SMAC expanded to include all generic name drugs while the remaining brand name drugs are covered using the WAC pricing benchmark. The Department switched pricing mechanisms in a budget-neutral manner so that the Department's pharmacy expenditures would remain constant. Unlike the previous SMAC pricing benchmark used in the lesser-of reimbursement methodology, the Department is now defining the SMAC pricing benchmark in the interim period as the AAC based on national wholesaler cost data plus 233% for rural pharmacies and AAC plus 51% for non-rural pharmacies. The Department adjusted the nationally based AAC pricing benchmark so that the projected reimbursement using the hybrid reimbursement methodology will match the budgeted pharmacy reimbursement for FY 2011-12.

The Department expects a complete AAC-based reimbursement methodology with a dynamic reimbursement system for the costs of dispensing will be implemented by May 2012. Through this new methodology, every possible drug covered by the Department will be reimbursed based on Colorado-specific acquisition costs, no longer depending on inflated national pricing benchmarks. Medicaid providers billing for fee-for-service pharmacy claims will now be reimbursed at an amount close to their actual acquisition and dispensing costs will be representative of the cost of providing professional services.

35) What is the Department doing to contain the cost of pharmaceuticals?

RESPONSE:

Please see the response to question 42.

36) What was the original projected savings in FY 2011-12 when the Department planned to add more drugs to the State Maximum Allowable Cost (SMAC) list? What savings has the Department actually realized by adding more drugs to the SMAC?

RESPONSE:

FY 2011-12 BRI-5 "Medicaid Reductions" included $1,833,333 in savings for FY 2011-12 associated with the expansion of the SMAC list.

Under the prior reimbursement methodology, SMAC list pricing was a tool that assisted in cost containment where a great disparity existed between AWP reimbursement price and acquisition cost. SMAC list pricing allowed the Department to expand the preferred drug list to include select generic products which were not cost-effective under the AWP reimbursement methodology. This resulted in greater generic utilization for the benefit, savings attributed to lower reimbursement levels for three generic drugs, and additional PDL savings from migration to more cost-effective generics. The landscape of pharmacy reimbursement changed greatly with the discontinuation of First Data Bank published AWP. The Department's current reimbursement methodology utilizes SMAC pricing as a primary pricing benchmark (as opposed to being limited to a small number of drugs), which allows the Department to adjust acquisition prices of numerous products to appropriate levels. Consequently, reimbursement for all drugs has been set at a level which is expected to achieve the $1,833,333 in savings target approved by the Joint Budget Committee. SMAC is currently defined as AAC plus 233% for rural pharmacies and AAC plus 51.1% for non-rural pharmacies because this was a budget-neutral way to transition from AWP. The high percentages added reflect the degree of price inflation in AWP. Going forward, the Department plans to use surveys to determine actual acquisition costs and the costs of dispensing relative to Colorado pharmacies. This will allow for unadjusted reimbursement of pharmaceuticals at responsible reimbursement levels that cover pharmacy costs and allow ample payment for professional services.

It is not possible to calculate the exact total saved year-to-date, as this would require comparing current reimbursement to what reimbursement would have been under the previous reimbursement methodology. Because AWP, the primary pricing statistic for that methodology, is no longer available to the Department, the impact can only be estimated. Using the last available AWP pricing information from September, the Department believes the current methodology is achieving budget neutrality while accounting for savings obligations as approved by the JBC.

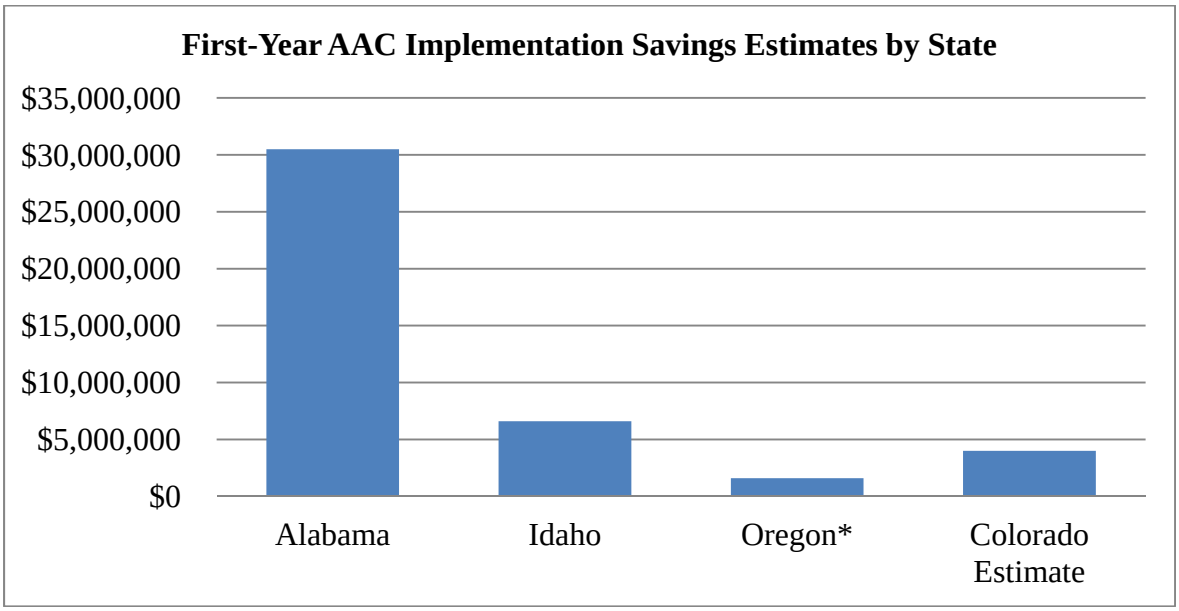
37) How can the Department guarantee $4.0 million in savings from the Pharmacy Rate Methodology Transition before completing the studies of dispensing and acquisition costs?

RESPONSE:

The Department has estimated it will achieve at least $4.0 million in savings as a result of the conversion to average acquisition cost (AAC) pricing; this is a rough estimate based on the Department's current pricing levels and the experience of other states.

Currently, state maximum allowable cost (SMAC) prices are currently set at AAC plus 233% for rural pharmacies and AAC plus 51.1% for non-rural pharmacies; therefore, there is strong reason to believe, even with a significantly higher dispensing fee, when material component reimbursement is set equal to the Colorado specific AAC, pharmaceutical reimbursement will be reduced at the aggregate level. The Department's estimate of $4.0 million would reduce aggregate expenditure by less than 1.5%. This is evidenced by the fact Alabama estimated a 6% reduction to pharmaceutical expenditure utilizing an AAC-

based methodology and paying a dispensing fee of $10.64.[3] Both Idaho and Oregon anticipate savings from utilizing this reimbursement methodology. See the table below.



** Oregon has a higher percentage of Medicaid clients enrolled in managed care. This reduces likely savings under an AAC reimbursement methodology.*

38) What portion of the projected $4.0 million savings from Pharmacy Rate Methodology Transition will be from the additional drugs added to the SMAC list and what portion will be from the reimbursement charges?

RESPONSE:

The changes to the reimbursement methodology reduce reimbursement for the material cost of a drug from the inflated AWP levels to a level that is commensurate with actual provider acquisition costs based on a Colorado-specific AAC. This is achieved by pricing all drugs possible with the SMAC pricing benchmark (defined as AAC +0%). It also increases the dispensing fee to a level that fairly reimburses pharmacies for professional services rendered. After adjusting the two components, ingredient reimbursement and professional services reimbursement (dispensing fee), the Department estimates aggregate reimbursement will be $4.0 million lower than it would have been under the current reimbursement methodology. Therefore, all of the savings is achieved through the methodology transition.

[3] http://www.stateline.org/live/details/story?contentId=587423

39) Why are there pre-determined dollar amounts for the dispensing fee when the Department has not completed a study on the cost of dispensing? Does the Department already believe the cost of dispensing should be $9.00?

RESPONSE:

The Department provided the $9.00 figure in the budget request as a reference and, in its November 1, 2011 FY 2012-13 R-6 "Medicaid Budget Reductions," noted, "[T]he Department cannot explicitly state how much reimbursement for the raw material cost of pharmaceuticals will be reduced, or the exact level of the dispensing fee." The Department has not, and will not, provide any information to its contractor with the purpose of unduly influencing the process.

While the Department estimated the result will be between $8.00 and $10.00, based on a survey results in other states ranging from $9.51 (Louisiana) to $11.74 (Idaho), the dispensing fee study will determine what the final fee is, even if it is outside of the range estimated by the Department. CMS will not approve a dispensing fee arbitrarily set by the Department. The Department's only options are either to conduct a study specific to Colorado or to use another state's study and use their dispensing fee. With input from pharmacy stakeholders, the Department opted to conduct its own study. This means Colorado pharmacies will be surveyed to determine a reasonable cost for the professional services component of dispensing a prescription.

The Department is committed to continue working closely with stakeholders through the process to determine the cost of dispensing in Colorado.

40) What is the aggregate reduction in pharmacy reimbursement since 2007? How does the 5.0 percent market reduction from the First Databank Lawsuit impact the aggregate reduction in pharmacy reimbursement? How does the aggregate reduction in pharmacy reimbursement since 2007 compare to reductions for other providers?

RESPONSE:

Please see the response to question 42.

41) Why are 340B pharmacies included in the cost of dispensing study when they purchase well below what retail pharmacy can?

RESPONSE:

Pharmacy providers eligible to purchase drugs under the 340B purchasing program are able to purchase many products at greatly reduced prices. The manufacturers offer this pricing advantage to government-approved entities that serve low income populations through various safety net programs. Currently, the Prime Vendor Program works closely with HRSA to negotiate 340B ceiling prices for these entities. Many State Medicaid programs, like Colorado, have low dispensing fees paid to pharmacies utilizing 340B drugs.

Currently, the total reimbursement for a prescription claim filled with 340B drug is the acquisition cost of the medication plus the dispensing fee of $1.89.

The Department is including 340B pharmacies in the dispensing fee study. The intent of the study is to examine the variations in costs between differing pharmacy types and set appropriate dispensing fee reimbursement levels in accordance with the considerations of CMS. The resulting dispensing fees proposed will be greatly dependent upon the data received from the study. As reimbursement will vary depending on provider type, higher or lower costs in one setting will not impact reimbursement in another setting.

The Department does not anticipate material reimbursement for 340B pharmacies will be affected by the transition to AAC.

42) Please provide a five-year history of pharmacy expenditures and rebates.

RESPONSE:

The following table shows a five-year history of reimbursement to pharmaceutical providers and rebates collected from manufacturers. Over the five-year period, aggregate annual reimbursement to providers for pharmaceuticals has grown by 44%. Factors driving this growth include caseload, changes in utilization patterns, and a reimbursement methodology that automatically increases reimbursement rates when the acquisition cost of drugs increases.

Historical Pharmaceutical Expenditure from FY 2006-07 to FY 2010-11

Fiscal Year	Reimbursement to Providers	Percentage Change	Rebates Collected from Manufacturers	Percentage Change	Net Pharmaceutical Expenditure	Percentage Change
FY 2006-07	$189,833,449	-	$58,644,804	-	$131,188,645	-
FY 2007-08	$216,864,136	14.24%	$55,465,088	-5.42%	$161,399,048	23.03%
FY 2008-09	$233,666,309	7.75%	$91,818,104	65.54%	$141,848,205	-12.11%
FY 2009-10[(1)]	$234,923,161	0.54%	$99,855,328	8.75%	$135,067,833	-4.78%
FY 2010-11[(1)(2)]	$272,469,874	15.98%	$126,909,710	27.09%	$145,560,164	7.77%

(1) FY 2009-10 and FY 2010-11 figures are adjusted for the June 2010 payment delay.

(2) The federal minimum rebate amount increased significantly in FY 2010-11 with the passage of the Affordable Care Act.

Source: FY 2012-13 R-1: "Medical Services Premiums Request", Exhibit M

As can be seen in the table above expenditures table, rebates from manufactures play an important role in controlling pharmaceutical expenditure. While rebate revenues have increased significantly in the last year, the catalyst for this change is the increase in minimum federal rebate included in the Affordable Care Act (ACA). The incremental amount of rebates resulting from implementation of ACA is 100% federal funds. As a result, growth in net pharmaceutical expenditure is understated when looking at state funds only.

Despite the aggressive growth in aggregate provider reimbursement, the Department has utilized a variety of mechanics to contain costs and ensure appropriate utilization of pharmaceuticals (Question 35). Many of these cost containment mechanisms are discussed in detail in the Department's annual report the Joint Budget Committee regarding the Department's Pharmacy Utilization Plan for FY 2011-12, as well as in the Department's response to FY 2011-12 Legislative Request for Information 5. The following provides a basic overview of the primary cost containment mechanisms utilized by the Department:

Preferred Drug List
Governor Ritter signed Executive Order D 004 07 in January 2007 establishing a preferred drug list (PDL) program for Colorado Medicaid. The purpose of this program is to provide clinically appropriate medications to Medicaid clients while decreasing expenditures on pharmaceuticals. This involves selecting drugs based on safety, cost-effectiveness, and clinical outcomes from classes of medications where there are multiple drug alternatives available. Since implementation of the PDL, the majority of the Department's Pharmacy Utilization Plan has switched from individual drug prior authorization mechanisms to implementing drug classes on the PDL.

The PDL achieves savings by designating preferred drugs for which migration to a more cost-effective drug and/or collection of supplemental rebates from pharmaceutical manufacturers is possible. Supplemental rebates are rebates above the federally required minimum rebate level, which manufacturers offer to the Department in exchange for preferred status on the PDL. It is difficult to determine the exact amount of savings from the PDL that comes from supplemental rebates versus migration to preferred drugs for each drug class; however, the Department is able to provide aggregate level information. In FY 2010-11, the Department collected $3,322,507 in total supplemental rebates.

Drug Utilization Review
The Drug Utilization Review (DUR) Board, established by the Department, reviews drug utilization issues and makes recommendations to the Department to ensure utilization of prescription drugs is appropriate and cost effective. The Department evaluates the issues identified by the DUR Board and implements utilization policies that are appropriate and will achieve cost savings. In addition, the Department has recently contracted with the University of Colorado, School of Pharmacy to provide additional DUR analysis and make recommendations to the Department and the DUR Board.

Prior Authorization Review
Prior authorization review (PAR) is another tool used to contain costs and ensure appropriate utilization of pharmaceuticals. The prior authorization review process ensures that a client meets all eligibility criteria for utilization of certain pharmaceuticals prior to authorization of reimbursement. Most recently, the Department included two savings initiatives in its November 1, 2011 FY 2012-13 R-6 "Medicaid Budget Reductions," which will reduce expenditure on Synagis (a drug used to reduce the severity of infection from respiratory virus in at risk children) and low-dose Seroquel (an antipsychotic) through the PAR process. These initiatives are described in greater detail in the request.

Maximize Rebate Collection
The Department continually pursues supplemental rebate agreements through the PDL program to increase rebate revenue. Additionally, the Department is performing outreach with the provider community to ensure sufficient information is submitted on physician administered drug claims in order for the Department to pursue rebates. This particular initiative is described in the Department's November 1, 2011 FY 2012-13 R-6 "Medicaid Budget Reductions."

Provider Rates
Pharmaceutical reimbursement has been subject to many changes over recent years. The following table shows the various reductions that have impacted pharmaceutical reimbursement rates.

Fiscal Year	Budget Action	Estimated Impact as a Percentage of Reimbursement[(1)]	Notes
FY 2008-09	AWP Adjustment	-2.30%	Methodology Change
FY 2009-10	BRI-1	-0.02%	SMAC
FY 2009-10	ES-2	-1.50%	Rate Reduction
FY 2010-11	BRI-3	-0.77%	SMAC
FY 2010-11	BRI-6	-1.00%	1% Rate Reduction
FY 2011-12	BRI-5	-0.73%	SMAC
FY 2012-13	R-6	-1.47%	Methodology Change

(1) Percentage calculated as the amount requested in the budget action divided by actual expenditure for the appropriate year. FY 2010-11 expenditures are used to estimate impacts for FY 2011-12 and FY 2012-13.

Other acute care provider types have experienced a cumulative 6.1% reduction in rates since FY 2008-09 (Question 40). When comparing reductions between provider types, there are several important considerations. First, the reimbursement methodology for pharmaceuticals is unique. Reimbursement for pharmaceuticals is based on a pricing statistic (such as WAC, AWP, or SMAC) plus or minus a fixed percent. These pricing statistics fluctuate continuously but, over time, have a positive trend, as the inputs to production are increasing in price over time due to inflation and scarcity. The result is pharmacies receive rate increases that other provider types reimbursed on a fixed-fee schedule do not. This is despite the fact other provider types see increases in costs over time as well. Consequently, rate reductions impact this provider type differently, though still significantly, than others; a comparison of cumulative rate cuts between provider types can be very misleading.

Further, when comparing cumulative rate reductions over time, it is important to recognize not all provider types start at the same benchmark. For example, the Department pays, on average, 63.2% of the Medicare rate for services delivered by physicians and practitioners. Because not all providers start at the same relative level of reimbursement, the impact of a rate reduction will vary accordingly for the various provider types.

The following table shows pharmacy provider enrollment. Based on this data, the indication is providers have not been "priced out of the market" as a result of rate reductions.

Historical Provider Enrollment FY 2006-07 through FY 2010-11				
Fiscal Year	**Pharmacies Enrolled to Provide Services**	**Percentage Change**	**Pharmacies with Paid Claims**	**Percentage Change**
FY 2006-07	903	-	878	-
FY 2007-08	899	-0.44%	850	-3.19%
FY 2008-09	934	3.89%	852	0.24%
FY 2009-10	960	2.78%	852	0.00%
FY 2010-11	981	2.19%	851	-0.12%

Despite multiple reductions to pharmacy rates and utilization of multiple cost containment mechanisms, over the past few years, aggregate reimbursement to pharmaceutical providers has continued to show significant growth. Aggregate reimbursement to providers has grown from $189.8 million in FY 2006-07 to $272.5 million in FY 2010-11 (Question 40).

Average Wholesale Pricing

Historically, the Department has utilized Average Wholesale Price (AWP), a pricing statistic provided by First Data Bank, as the primary component of the reimbursement methodology for drug ingredient costs. However, following a lawsuit, First Data Bank ceased to publish AWP data. It was discovered the AWP statistic overstated actual drug acquisition costs for providers and resulted in artificially inflated reimbursement rates for many medical payers across the nation.

When the issue was resolved, First Data Bank applied a new methodology to their calculation of the AWP statistic. This resulted in a downward level shift, on a national level, in reimbursement of approximately 5% for those drugs that priced at the AWP rate (an estimated 2.3% reduction to aggregate reimbursement in Colorado based on drug mix and ratio of drugs that priced at AWP); the AWP statistic was not used to price all drugs. While this shift did reduce reimbursement to providers, it was necessary to correct for the overcompensation occurring under the inflated AWP statistic (Question 40).

The transition away from AWP pricing, while presenting many challenges, also presents a major opportunity. Under AWP pricing, the Department's reimbursement to pharmacies did not appropriately reflect the true cost of either pharmaceutical ingredients or the cost of a pharmacy to dispense the drugs. Fair reimbursement in a scenario where costs are not readily available presents obvious challenges. The Department is transitioning to a methodology where a Colorado-specific AAC will be the primary pricing statistic. The Department will reimburse pharmacies at a level that is commensurate with both the actual acquisition cost of the drugs and the cost of providing professional services.

43) How does the Department's pricing for pharmaceuticals compare to the pricing for the Department of Corrections? Would there be efficiencies from combining the reimbursement schedules?

RESPONSE:

The Department does not believe there are efficiencies from combining its reimbursement schedule with that of the Department of Corrections (DOC). There is an important distinction to be made between the two Departments and their associated expenditure on pharmaceutical products: the Department is a payer, while DOC is a provider/purchaser. As a result, DOC is not reimbursing providers for drugs in the same manner as the Department, and DOC's acquisition cost schedule and the Department's provider reimbursement schedules are not comparable. This is important because DOC purchases pharmaceuticals much like a pharmacy and may receive manufacturer discounts or rebates based on volume and wholesaler. The Department, however, reimburses pharmacy providers for professional services as well as the cost of the drug. Following this payment, the Department then submits utilization information to manufacturers in order to collect the federally mandated rebate offered by the manufacturer. Current rebate agreements do not allow DOC utilization to be included in the reported utilization; this is likely because manufacturers are not required under federal law to provide these rebates for non-Medicaid clients. Pharmacy staff from the Department and DOC have recently started meeting every other month. Both departments are committed to identifying opportunities for additional efficiencies.

While the issues surrounding pharmaceutical pricing are fundamentally different between the Department and DOC, other efficiencies are being shared. Both departments are examining opportunities to work together for clinical information dissemination and medication consistency between the Department pharmacy coverage policies.

COST-SHARING FOR MEDICAID AND CHP+ (R-7)

44) A number of proposals in the Department's request have already been implemented. What is the Department's process for keeping the legislature informed of rule-making decisions that impact the budget?

RESPONSE:

The Department uses the standard budget process to account for all rule-making decisions that have a budget impact. As part of the Department's strategic plan, the Department is continuously assessing its programs and implementing policies and procedures to contain or reduce health care costs to provide the most cost-effective care possible. To be as transparent as possible and to minimize over- or underexpenditure resulting from specific policy changes, the Department reports expected changes in expenditure so that the Joint Budget Committee and the General Assembly can make changes to the appropriation.

In most circumstances, the Department prospectively accounts for any potential rule-making through a Funding Request (previously, Decision Item or Base Reduction Item) in its November 1 budget. This is particularly true for any discretionary policy which has a positive fiscal impact, such as a proposed rate increase. In some cases, the Department must expedite rule-making; in these cases, the Department accounts for rule-making decisions with a Supplemental request or a Budget Amendment request. This typically occurs when rule-making is in response to a change in state law, federal law, or federal regulations.

Additionally, pursuant to 25.5-1-120(1)(c), C.R.S. (2011), when the Executive Director of the Department determines adequate appropriations for the payment of the requirements in Title 25.5 have not been made and an overexpenditure of an appropriation will occur based upon the Department's estimates, the Medical Services Board may take actions consistent with state and federal law to bring the rate of expenditure into line with available funds. In these circumstances, the Department will account for any changes through a Supplemental request.

For FY 2011-12, the Department has estimated that its expenditure for Medicaid and Children's Basic Health Plan programs will exceed appropriations by $61,410,139 General Fund.[4] In accordance with 25.5-1-120(1)(c), C.R.S. (2011), the Department has begun implementing a series of actions to reduce expenditure. The Department has officially requested the funding changes for FY 2011-12 as part of its January 2012 Supplemental requests, in accordance with the statutory dates for Supplemental requests. However, in an effort to be as transparent about the process as possible, these actions are described in detail in the Department's Budget Requests R-6 "Medicaid Budget Reductions" and R-7 "Cost Sharing for Medicaid and CHP+." These requests include the relevant calculations and assumptions for FY 2011-12, as well as the projected impacts to FY 2012-13 and FY 2013-14.

Further, it is worth nothing the Department has not determined these reductions in complete isolation. Rather, the Department uses a combination of best practices and evidence guideline research, outreach to other state Medicaid agencies, and stakeholder engagement. For instance, the Department's research and discussions with other states, as well as feedback from stakeholders through the Benefits Collaborative, helped identify two of the initiatives in R-6 (Alternative Augmentative Communication Devices and Developmental, Depression, and Autism Screening), where reductions could be absorbed without jeopardizing client health. While the proposals were not necessarily submitted to stakeholders prior to being implemented or submitted in the budget process, the feedback the Department has received through regularly scheduled stakeholder meetings, such as the Benefits Collaborative, have been invaluable in helping the Department craft reductions that should have a minimal impact, and allow the Department to avoid implementing broad rate cuts.

[4] The Department included estimates of this shortfall for informational purposes as part of its November 1, 2011 FY 2012-13 Budget Request in requests R-1, R-2, and R-4, and has officially requested this amount when Supplemental requests were submitted in January.

45) Please update the Committee on the status of implementing the cost-sharing proposals in R-7. Will there be a supplemental associated with this request?

RESPONSE:

The Department has presented the rules required to implement the cost-sharing proposals in R-7 to the Medical Services Board (MSB), which voted for their final permanent adoption on November 18, 2011. As stated in the Department's November 1, 2011 FY 2012-13 R-7 "Cost-Sharing for Medicaid and CHP+," page R-7.4, the Department will implement the tripling of annual enrollment fees for certain families on January 1, 2012. In the request, the Department also provides an estimate of the FY 2011-12 fiscal impact of this initiative which is included among the Department's supplemental budget requests for FY 2011-12 submitted to the Joint Budget Committee on January 3, 2012.

46) What is the experience of other states in allowing state employees to enroll in those states' version of the Children's Basic Health Plan?

RESPONSE:

The following states have received approval from the Centers for Medicare and Medicaid Services (CMS) to allow the children of their state employees to enroll in their Children's Health Insurance Program (CHIP, the federal program authorizing Colorado's CHP+) and have begun implementing this initiative or are in the process of doing so:

- Alabama – Began enrolling children of state employees in April 2011 in its CHIP program. Has waived its three-month waiting period temporarily until December 31, 2011.[5]
- Texas – Had a state-funded program to insure low-income children of state employees (SKIP). Children enrolled in SKIP (State Kids Insurance Program) were allowed to participate in CHIP as of September 1, 2011. Children enrolled in the state employee group insurance plan had to drop that coverage within 31 days of becoming approved for CHIP.[6]
    - Expects to save $16 million over two years, according to a spokeswoman.[7]
- Kentucky – Provided insurance for low-income children of state employees through CHIP but with 100% state funding. Began using federal funds to pay for this population (around 750 children) on October 1, 2011. State employees who voluntarily drop their health insurance are subject to a six-month waiting period.[8]
    - Due to the state's 80% FMAP, it is expected to save $1.6 million annually.[9]

[5] http://www.adph.org/allkids/assets/Dep.Coverage.Notice.pdf
[6] http://www.uh.edu/hr-communications/Benfits%20Updates/index.php
[7] http://www.kaiserhealthnews.org/Stories/2011/November/07/Childrens-Health-Insurance-Program-Low-Income-State-Employees.aspx?p=1
[8] http://www.cms.gov/NationalCHIPPolicy/downloads/KYSPA12FINAL.pdf
[9] http://www.kaiserhealthnews.org/Stories/2011/November/07/Childrens-Health-Insurance-Program-Low-Income-State-Employees.aspx

- Pennsylvania – Allows children of state employees to enroll if they demonstrate that at least 5% of their income goes towards their health care expenses. Estimates less than 1% of employees would be eligible.[10]
- Montana – Began enrolling children of state employees in October 2011.[11] Montana has a shorter waiting period of one month without insurance prior to enrollment (it is unclear whether this was waived).
- Georgia – Began taking applications from state employees for its CHIP program on October 1, 2011. Will waive its six-month waiting period from January to June 2012.[12]
    - Officials expect 42,000 children to switch to its CHIP program for state savings of $32 million in fiscal year 2012.[13]

47) Why did the Department let SB 10-213 get vetoed, rather than offering the compromise approach contained in R-7 during debate on the bill?

RESPONSE:

The Governor vetoed SB 11-213, stating, "We respect the General Assembly's intention to reduce the budget impact of increasing Child Health Plan Plus (CHP+) costs and the goal of encouraging personal responsibility by CHP+ recipients for a reasonable share of these costs. Expecting low-income families in Colorado to contribute when it comes to providing for, and placing a priority upon, their health care, makes sense." However, the Department's analysis indicated the bill, as written, would have had a positive fiscal impact that was not reflected in the Legislative Council fiscal note. At the time, the Department was not in a position to offer informed compromises as there was not sufficient time to engage stakeholders and research best practices thoroughly.

In order to allow for the design of a more effective cost-sharing plan for CHP+ clients, Governor Hickenlooper vetoed SB 11-213 on May 31, 2011, and committed his staff and the Department to developing an approach to increase cost sharing that would minimize any negative impact on CHP+ families. The Department has since conducted extensive research and collaborated with the Governor's office and CHP+ stakeholders to devise an appropriate cost-sharing structure for CHP+. Development of this cost-sharing structure involved numerous meetings over three months to ensure the Department's plan balances stakeholder concerns with reasonable cost-sharing levels.

[10] http://www.georgiahealthnews.com/2011/09/state-ala-kids-health-plan-switch/
[11] https://www.cms.gov/NationalCHIPPolicy/downloads/MTSPA7.pdf
[12] http://www.peachcare.org/FaqView.aspx?displayFaqId=107
[13] http://www.kaiserhealthnews.org/Stories/2011/November/07/Childrens-Health-Insurance-Program-Low-Income-State-Employees.aspx?p=1

CHP+ ELIGIBILITY FOR CHILDREN OF STATE EMPLOYEES (R-9)

48) Please coordinate with the Department of Personnel and provide an estimate of the net fiscal impact of allowing state employees to enroll in the Children's Basic Health Plan and waiving the three-month waiting period for state employees (R-9).

RESPONSE:

The Department and DPA worked on this request together. The Department began consulting with program, budget, analytics, and data staff at the Department of Personnel Administration (DPA) nine months before submitting its November 1, 2011 FY 2012-13 R-9 "CHP+ Eligibility for Children of State Employees." The Department collaborated with DPA staff continuously as this request progressed. DPA was also able to provide state-wide employee and benefits data, but insufficient data at the agency level.

However, determining the actual number of eligible children who would switch to CHP+ from the state health insurance is much more difficult to estimate as this decision may be based on factors other than income. Factors such as geographical location, CHP+ plan availability, or the desire to stay with a particular provider are nearly impossible to estimate. The Department's state-wide estimate is only based on income and cannot account for the varying geographical distribution of employees between state agencies. Due to the heterogeneity and constraints on the data available to DPA, the Department cannot provide an appropriate estimate of the impact of the request on each agency. The Department believes it would also be unfair and unsound to merely divide the total estimated savings for the entire state by the number of departments and alter appropriations based on that calculation.

49) How much of R-9 can be implemented through rule and what statutory changes are required?

RESPONSE:

Colorado's rules for the Children's Basic Health Plan (CHP+) exclude children of state employees from participating in the program. Since this exclusion is not in state statute, children of state employees can become eligible through rule change alone. However, the Department believes actual implementation of R-9 is impeded by state statute 25.5-8-109 (1) C.R.S. (2011), which requires that a child not have been insured by a comparable health plan through an employer, with the employer contributing at least 50% of the premium cost, in the three months prior to application for CHP+. Children who have lost coverage due to a change in, or loss of, employment are exempt from this three-month rule. The current statute would force eligible children of state employees to go uninsured for three months (or purchase costly small-group insurance) before applying for CHP+, effectively discouraging movement into the program. The Department is thus proposing a statutory change that would create a temporary moratorium on this three-month waiting period for children of state employees to allow this newly eligible population to enroll in CHP+. To do otherwise would create a competitive disadvantage for current state employees who did

not receive an opportunity to enroll their children in CHP+ prior to their employment with the State. This is similar to actions used in other states that have implemented this policy change, as discussed in the response to Question 46.

50) If R-9 is implemented, how will health options for state employees compare to health options for private-sector employees? Will the State have a competitive advantage as an employer?

RESPONSE:

The Department's proposal for the implementation of R-9, including the temporary moratorium on the three-month waiting period described in Question 49 above, would create a level playing field for lower-income State employees. Families with a member currently employed by the State would be allowed to enroll their children in CHP+ for the first time, while families already enrolled in CHP+ would be able to work for the State without losing CHP+ coverage. Once the temporary moratorium on the three-month waiting period ends, state and private-sector employees – and those moving between the two sectors – would have the same availability of public health care options. This policy change will also create consistency between the Department's programs, as children of state employees with income eligibility within Medicaid guidelines may enroll in that program.

UTILIZE SUPPLEMENTAL PAYMENTS FOR GENERAL FUND (R-10)

51) Please describe the impact on providers of withholding federal funds from the Physician Supplemental Payment and the Inpatient High Volume Supplemental Payment (R-10), including the impact on Rural Health Centers and School-Based Health Centers.

RESPONSE:

The Department uses the certification of public expenditure (CPE) funding methodology to allow public providers of Medicaid services to receive matching federal funds to partially offset the uncompensated costs they incur for providing services to Medicaid clients. Drawing federal funds through this process allows the Department to provide these supplemental payments to public providers in addition to their regular Medicaid claims payments.

Upon approval of State Plan Amendments currently under review by the Centers for Medicare and Medicaid Services (CMS) and the Department's November 1, 2011 FY 2012-13 R-10 "Utilize Supplemental Payments for General Fund Relief," the Department would retain 10% of the federal matching funds earned via this CPE process for specified provider services; the qualified providers would be paid 90%. The 10% retained by the Department would be appropriated to the Medical Services Premium line item to provide General Fund relief to Medicaid costs. The payments from which the 10% is being

withheld are supplemental payments made to providers and are not directly related to claims costs incurred by providers for Medicaid services.

This request does not impact rural, community-based, or school-based providers, and the Department has communicated with each affected provider. The facilities understand that under this proposal they will be receiving partial reimbursement for Medicaid costs that otherwise would have remained uncompensated and that general Medicaid costs will be supported through the 10% that will be retained in the Medical Services Premium line item.

COLORADO INDIGENT CARE PROGRAM

52) Please explain the financing for the Colorado Indigent Care Program.

RESPONSE:

The Colorado Indigent Care Program (CICP) is not an insurance program but rather a financial vehicle for participating providers to recoup some of their costs for providing medical services to the medically indigent who are not eligible for Medicaid or Child Health Plan Plus (CHP+).

Payments to participating CICP providers are financed through several mechanisms and vary for hospitals and clinics. Payments to CICP providers appear in the Long Bill under the Department's Indigent Care Program Long Bill Group in the following line items:

- Safety Net Provider Payments
- The Children's Hospital, Clinic Based Indigent Care
- Health Care Services Fund Programs

The available funding for CICP providers is distributed to each provider based on its estimated costs compared to the total costs of all participating providers. For example, in FY 2011-12, reimbursement for clinics is based on CICP clinic charges submitted for FY 2009-10 reduced by the client copayment and any reimbursement from private insurance, converted to costs, and inflated for two years. Payments are allocated to each clinic based on its proportion of estimated costs compared to all participating clinics. Payments are allocated to hospitals in a similar manner.

For more information on the Colorado Indigent Care Program and the line items above, including the appropriation history, please refer to pages H-244 through H-252 of the Line Item Description included in the Department's November 1, 2011 FY 2012-13 Budget Request.

53) Has the Department recently implemented any caps on the Colorado Indigent Care Program?

RESPONSE:

The Colorado Indigent Care Program (CICP) is not an insurance program but rather a financial vehicle for participating providers to recoup some of their costs for providing medical services to the medically indigent who are not eligible for Medicaid or Child Health Plan Plus (CHP+). The Department has not implemented any caps on CICP, and there is no limit on the number of persons who can apply. Available funding for Colorado Indigent Care Program (CICP) providers is a fixed amount and does not change based on the number of individuals served or the cost of their care.

54) Please compare actual provider uncompensated and undercompensated care with payments through the Colorado Indigent Care Program. What percentage of uncompensated and undercompensated care does the Colorado Indigent Care Program cover?

RESPONSE:

Available funding for Colorado Indigent Care Program (CICP) providers is a fixed amount with no overexpenditure authority. The Department estimates the percentage of costs that CICP providers will be reimbursed during the fiscal year, but the actual percentage of costs reimbursed is not known until several months after the fiscal year ends when all write-off cost data has been reported by the providers.

In FY 2009-10, CICP clinics were reimbursed at 66.4% of costs and all CICP hospitals were reimbursed at 61.4% of costs. Denver Health Medical Center was reimbursed 65.5% of costs, while University Hospital was reimbursed 44.9% of costs.

Data for FY 2010-11 is currently being finalized. Percent of costs reimbursed will be reported in the FY 2010-11 CICP Annual Report, which will be delivered to the General Assembly and the Joint Budget Committee on February 1, 2012.

55) How does the Department anticipate the Colorado Indigent Care Program changing with the implementation of the Affordable Care Act?

RESPONSE:

The federal Affordable Care Act (ACA) will reduce the number of uninsured Coloradans but will not eliminate the need for the Colorado Indigent Care Program (CICP).

CICP allows low-income Coloradans with incomes up to 250% of the federal poverty level (FPL) who are not eligible for Medicaid or the Child Health Plan Plus (CHP+) to obtain discounted health care services at participating providers. CICP provides some reimbursement for the uncompensated costs incurred by CICP providers in serving low-

income Coloradans, including those who are uninsured and those who have private health coverage or Medicare but cannot meet their out-of-pocket expenses.

The ACA will expand Medicaid eligibility to 133% of the FPL for adults. While this expansion to Medicaid will provide health care coverage to many clients who would otherwise be eligible for CICP, not all will be covered. Those who are between 133% and 250% of the FPL will still be eligible for CICP. Also, legal permanent residents who have been in the United States less than 5 years cannot be eligible for Medicaid or CHP+ but can be eligible for CICP. Finally, while many low-income Coloradans may be eligible for a federal subsidy to purchase health care, there will continue to be clients under 250% of the FPL who cannot meet their out-of-pocket expenses.

The Department is exploring how CICP should evolve with the implementation of ACA, and continues to actively engage stakeholders to explore possibilities for CICP.

OTHER QUESTIONS

56) Please provide an update on grants applied for and received related to implementing federal health care reform. Is this information available through a state website?

RESPONSE:

The Department has applied for and received the following two grants related to federal health care reform.

- Colorado Choice Transitions grant: The Centers for Medicare and Medicaid Services (CMS) awarded a $22 million five-year Money Follows the Person grant. The goal of the program is to build and improve the infrastructure that supports Home- and Community-Based Services (HCBS) for people of all ages with long-term care needs.
- Integrated Care for Dual Eligible Individuals contract: The Centers for Medicare and Medicaid Services (CMS), Innovation Center, awarded Colorado and 14 other states with contracts to develop new ways to better coordinate care for clients who are eligible for both Medicare and Medicaid programs, known as "dual eligibles." The goals of the contract are to improve care coordination, client experience, and health outcomes for dual eligibles, as well as decrease costs associated with unnecessary and duplicative services.

The Department is not aware of any non-Medicaid related grants related to implementing federal health care reform.

57) Is the Department in compliance with the Secure and Verifiable Identity Document Act and related provisions contained in Sections 24-72.1-101 through 106 and Section 18-5-102, C.R.S.?

RESPONSE:

The Department is in compliance with the requirements of the Secure and Verifiable Identity Document Act and related provisions contained in Sections 24-72.1-101 through 106 C.R.S. (2011), and with Offenses Involving Fraud, Forgery Section 18-5-102, C.R.S. (2011) as follows:

> The Children's Health Insurance Program Reauthorization Act of 2009 (Public Law 111-3), mandates that the Social Security Administration (SSA) provide a citizenship confirmation to State Medicaid agencies for individuals who apply for Medicaid or the Children's Health Insurance Program (CHIP) on or after January 1, 2010. SSA has chosen to provide this data via the State Verification Exchange System (SVES) Social Security Number Verification batch process. The Centers for Medicare and Medicaid Services (CMS) has determined that if the response from SSA confirms the United States citizenship, no additional documentation of either citizenship or identity is required.

The Department is also in compliance with the Citizenship and Identity requirements of the Federal Deficit Reduction Act of 2005. Specific compliance information can be found on the Department's website at: Citizenship and Identity - DRA.

ADDENDUM: OTHER QUESTIONS FOR WHICH SOLELY WRITTEN RESPONSES ARE REQUIRED

1) **What is the Department's entire Information Technology (IT) budget for FY 2011-12 and FY 2012-13? Does the Office of Information Technology (OIT) manage the Department's entire IT budget? If not, what IT activities is the Department managing separate from OIT and what percentage is that of the entire IT budget for the Department for FY 2011-12 and FY 2012-13? Of the IT activities the Department still manages outside of OIT, what could be moved to OIT?**

   RESPONSE:

   For FY 2011-12, the Department's entire Information Technology (IT) budget is approximately $48,545,417 total funds, comprised of $12,760,063 General Fund, $1,766,092 cash funds, $123,221 reappropriated funds, and $33,941,042 federal funds. See Table A.1.1 for a line item breakdown of FY 2011-12 IT costs. For FY 2012-13, the Department's entire IT budget is approximately $42,752,107 total funds, comprised of $11,856,688 General Fund, $1,713,122 cash funds, $123,711 reappropriated funds, and $29,058,586 federal funds. See Table A.1.2 for a line item breakdown of FY 2012-13 IT costs.

   The Office of Information Technology (OIT) does not manage the Department's entire IT budget. Separate from OIT, the Department manages the Medicaid Management Information System (MMIS) and related Medicaid IT systems (namely, the Provider Web Portal and Fraud Detection Software). For FY 2011-12, the MMIS and related systems make up approximately 77% of the Department's entire IT budget, or $37,221,915 total funds. For FY 2012-13, the MMIS and related systems make up approximately 75% of the Department's entire IT budget, or $32,017,217 total funds.

   In a letter dated January 15, 2009, and in response to potential impacts on the MMIS by Colorado SB 08-155, which centralized state IT resources to OIT, CMS upheld its position that the Department is "ultimately responsible for the administration of the MMIS." CMS also cautioned that enhanced federal funding of 90% and 75% will not apply "should the MMIS, and staff dedicated to the supervision of MMIS not be under the direct control of the State Medicaid Director and DHCPF." Although it may be possible to move the MMIS and related systems to OIT, previous consideration and input from the Centers for Medicare and Medicaid Services (CMS) have suggested that such a move may be inefficient and impractical. In consideration of CMS' guidance, the Department felt that moving the MMIS to OIT would be administratively impractical due to the complexity and difficulty of maintaining direct control over OIT staff and resources and potentially cost-inefficient for the State due to the possibility of jeopardizing enhanced federal funding rates.

Table A.1.1: FY 2011-12 Department Total IT Budget					
Line Item	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
Purchases of Services from Computer Center	$835,843	$414,566	$0	$3,375	$417,902
Multiuse Network Payments	$227,900	$113,950	$0	$0	$113,950
Management and Administration of OIT	$631,234	$315,617	$0	$0	$315,617
Information Technology Contracts	$36,971,915	$7,069,663	$1,751,575	$100,328	$28,050,350
Fraud Detection Software Contract	$250,000	$62,500	$0	$0	$187,500
Colorado Benefits Management System	$8,983,839	$4,461,609	$14,428	$19,399	$4,488,403
CBMS SAS-70 Audit	$55,204	$27,416	$89	$119	$27,580
Other Office of Information Technology Services	$556,271	$278,136	$0	$0	$278,135
Systematic Alien Verification for Eligibility	$33,211	$16,606	$0	$0	$61,605
Total FY 2011-12 IT Budget	**$48,545,417**	**$12,760,063**	**$1,766,092**	**$123,221**	**$33,941,042**

Table A.1.2: FY 2012-13 Department Total IT Budget					
Line Item	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
Purchases of Services from Computer Center	$1,021,717	$509,171	$0	$3,375	$509,171
Multiuse Network Payments	$231,333	$115,667	$0	$0	$115,666
Management and Administration of OIT	$0	$0	$0	$0	$0
Information Technology Contracts	$31,767,217	$6,459,471	$1,698,513	$100,328	$23,508,905
Fraud Detection Software Contract	$250,000	$62,500	$0	$0	$187,500
Colorado Benefits Management System	$8,895,282	$4,416,786	$14,520	$19,889	$4,444,087
CBMS SAS-70 Audit	$55,204	$27,416	$89	$119	$27,580
Other Office of Information Technology Services	$497,403	$248,701	$0	$0	$248,702
Systematic Alien Verification for Eligibility	$33,951	$16,976	$0	$0	$16,975
Total FY 2012-13 IT Budget	**$42,752,107**	**$11,856,688**	**$1,713,122**	**$123,711**	**$29,058,586**

2) What hardware/software systems, if any, is the Department purchasing independently of the Office of Information Technology (OIT)? If the Department is making such purchases, explain why these purchases are being made outside of OIT?

RESPONSE:

Independently of OIT, the Department makes purchases for the Medicaid Management Information System (MMIS) and related Medicaid IT systems (namely, the Provider Web Portal and Fraud Detection Software). MMIS and related systems purchases are made outside of OIT due to the considerations discussed in question A-1.

3) Please list and briefly describe any programs that the Department administers or services that the Department provides that directly benefit public schools (e.g., school based health clinics, educator preparation programs, interest-free cash flow loan program, etc.).

RESPONSE:

School Health Services Program
The School Health Services Program allows public schools, Boards of Cooperative Educational Services (BOCES), and state K-12 educational institutions to receive Medicaid funds for amounts spent providing health services through public schools to students who are Medicaid eligible. As the original expenditure of the medical service was incurred by a public entity using local tax dollars or General Fund appropriated to educational institutions, the Medicaid reimbursement is entirely federal funds. Since its inception in 1997 through FY 2010-11, the School Health Services Program has allowed the state to reimburse participating school districts and BOCES more than $116 million in federal funds. Currently, 54 school districts and one BOCES participate in the program. The Department administers the program and, together with the Department of Education, provides technical assistance and oversight monitoring to ensure that school districts and BOCES comply with federal and state statutes, regulations, and policies.

Using the disbursed federal funds within a health service delivery process established through the Local Services Plan, school districts have been able to address some of the health care needs unique to their communities. Additionally, the School Health Services Program has helped improve learning environments by providing students increased access to health care services and improving the quality of school health services. The School Health Services Program has allowed public schools to increase their nursing services, improve and enhance the quality of health services they provide, increase access to health care services for the uninsured and underinsured, and provide health services where none were previously available.

School-Based Health Center Program
The Colorado Department of Public Health and Environment's School-Based Health Center Program was created in 1987 to assist in the establishment, expansion and ongoing operations of school-based health centers (SBHCs) in Colorado. SBHCs are clinics

operated within a public school, charter school or State-sanctioned GED building that provide primary and mental health services that compliment services provided by school nurses. Establishing a school-based health center is a community-driven process that requires multiple partnerships - between school districts, the medical and mental health communities and local and state funders - to be effective. The Colorado Department of Public Health and Environment does not run these clinics, but rather sets standards and provides some funding. SBHCs that are Medicaid or CHP+ providers receive reimbursement from the Department for their Medicaid claims and through CHP+ managed care organizations for their CHP+ services.

School-Based Health Center Improvement Project

As part of the 2009 Children's Health Insurance Program Reauthorization Act (CHIPRA), the Department, in partnership with the New Mexico Medicaid Program, received a federal grant of just under $7.8 million to demonstrate that SBHCs can effectively participate in Medicaid and CHP+, and can effectively improve the health of children. Federal funding for the School-Based Health Center Improvement Project began in February 2010 and is effective for five years. SBHCs enrolled as Medicaid providers may apply through the Colorado Department of Public Health and Environment (CDPHE) to participate in the SBHC Improvement Project. A total of ten clinics in each of the two States will be enrolled over a three-year period.

Participating SBHCs are granted up to $10,000 per year to increase their participation in a patient-centered medical home approach to health care, improve data collection and management of chronic conditions for kids with special needs. Special attention is given to Early and Periodic Screening, Diagnosis and Treatment (EPSDT) examinations, chlamydia screenings, depression screening, immunizations, overweight and obesity-related services. In Colorado, CDPHE staff provide quality improvement coaching to participating SBHCs, which the Department helps fund through the grant.