

**DEPARTMENT OF HEALTH CARE POLICY AND FINANCING  
FY 2011-12 JOINT BUDGET COMMITTEE HEARING AGENDA**

**Tuesday, December 21, 2010  
9:00 am – 5:00 pm**

*HEALTH CARE POLICY AND FINANCING*

**9:00-9:20: INTRODUCTIONS AND OPENING COMMENTS**

**9:20-10:00: QUESTIONS COMMON TO ALL DEPARTMENTS**

- 1. Please identify your department's three most effective programs and your department's three least effective programs, and explain why you identified them as such. How do your most effective programs further the department's goals? What recommendations would you make to increase the effectiveness of the three least effective programs?**

RESPONSE:

Answered in 2.

- 2. For the three most effective and the three least effective programs identified above, please provide the following information:**
  - a. A statement listing any other state, federal, or local agencies that administer similar or cooperating programs, and outline the interaction among such agencies for each program;**
  - b. A statement of the statutory authority for these programs and a description of the need for these programs;**
  - c. A description of the activities which are intended to accomplish each objective of the programs, as well as, quantified measures of effectiveness and efficiency of performance of such activities;**
  - d. A ranking of the activities necessary to achieve the objectives of each program by priority of the activities; and**
  - e. The level of effort required to accomplish each activity associated with these programs in terms of funds and personnel.**

RESPONSE:

MOST EFFECTIVE:

1. *Colorado Health Care Affordability Act (HB 09-1293)*

In SFY 2009-10 and the first quarter of SFY 10-11, the implementation of the Colorado Healthcare Affordability Act (CHCAA, or HB 09-1293) generated more than \$146 million in new federal funds in supplemental Medicaid and Disproportionate Share Hospital (DSH) payments paid to hospitals. These net new funds represent the reduction in uncompensated costs incurred by hospitals for care provided to Medicaid, Colorado Indigent Care Program (CICP) and uninsured clients. In FFY 2010-11, it is expected that hospitals will receive an additional \$159 million in new federal funds to further reduce cost-shifting and the high cost of uncompensated care.

To date, the Colorado Health Care Affordability Act health care expansions have allowed 27,000 Medicaid parents, 3,300 CHP+ children, and 230 CHP+ pregnant women to enroll in health care coverage. The Department is now focused on expanding coverage to the uninsured with the Adults without Dependent Children health care program in early 2012 and implementing a Medicaid Buy-In Program for People with Disabilities in the summer 2011. The additional payments to hospitals and health care expansions were all achieved with no General Fund expenditure.

The expansion of Medicaid and the expanding coverage to the uninsured with the Adults without Dependent Children health care program through the Colorado Health Care Affordability Act align with federal health care reform legislation. Since the Department implemented the health care expansion for Medicaid after the federal law became effective, the Department will receive 100% federal funding on this population and the Adults without Dependent Children in 2014 through 2016. Then as the federal match rate falls from 95% to 90%, the state share will be covered through the hospital provider fee. Therefore, the Colorado Health Care Affordability Act significantly reduced the impact on the General Fund related to the federal health care reform legislation.

In addition, the hospital provider fee has allowed the State additional revenue to assist with the recent budget shortfalls. Because these hospital provider payments were made during the enhanced federal Medicaid matching rate made available under American Recovery and Reinvestment Act (ARRA), the payments generated additional federal funds in the amounts of \$46 million in federal funds in FY 2009-10 and \$53 million in FY 2010-11 to provide General Fund relief through SB 10-169. In addition, at the direction of the Office of State Planning and Budgeting, the Department is requesting to draw additional Hospital Provider fee for budget balancing purposes in the Medical Services Premiums base budget. In FY 2011-12, the Department would collect an additional \$50,000,000 in provider fee, which would leave the aggregate net benefit to all hospitals at approximately the same level as FY 2010-11. In FY 2012-13 and going forward, the Department would collect an additional \$25,000,000 increased by an inflationary factor to be determined based on growth in hospital revenue, which will allow the net benefit to all hospitals to increase from the FY 2011-12 level.

The Department is responsible for administering the provider payments and health care expansions through the Colorado Health Care Affordability Act. No other state, federal, or local agencies administer similar or cooperating programs.

The Colorado Health Care Affordability Act is authorized through 25.5-4-402.3. This section was enacted as part of a comprehensive health care reform and is intended to provide the following state services and benefits:

- Providing a payer source for some low-income and uninsured populations who may otherwise be cared for in emergency departments and other settings in which uncompensated care is provided by expanding access to high-quality, affordable health care.
- Reducing the underpayment to Colorado hospitals participating in publicly funded health insurance programs and reducing the cost shift of uncompensated care to other payers.

The following is a description of the activities which are intended to accomplish each objective of the programs, as well as, quantified measures of effectiveness and efficiency of performance of such activities.

*Providing a payer source for some low-income and uninsured populations who may otherwise be cared for in emergency departments and other settings in which uncompensated care is provided by expanding access to high-quality, affordable health care:*

Activities:

- Medicaid expansion for parents to 100% FPL and CHP+ expansions for children and CHP+ pregnant women to 250% FPL – implemented. Expansions have allowed 27,000 Medicaid parents, 3,300 CHP+ children, and 230 CHP+ pregnant women to enroll in health care coverage.
- Medicaid Buy-In Program for People with Disabilities - in development for summer 2011.
- Adults without Dependent Children health care program - in development for early 2012.

*Reducing the underpayment to Colorado hospitals participating in publicly funded health insurance programs and reducing the cost shift of uncompensated care to other payers:*

Activities:

- Increase hospital payments through supplemental Medicaid and CICIP payments – implemented. Generated more than \$146 million in new federal funds in supplemental Medicaid and Disproportionate Share Hospital (DSH) payments paid to hospitals in SFY 2009-10 and it is expected that hospitals will receive an additional \$159 million in new federal funds to further reduce cost-shifting and the high cost of uncompensated care in FFY 2010-11.
- Medicaid expansion for parents to 100% FPL and CHP+ expansions for children and CHP+ pregnant women to 250% FPL – implemented. Expansions have allowed 27,000 Medicaid parents, 3,300 CHP+ children, and 230 CHP+ pregnant women to enroll in health care coverage.
- Medicaid Buy-In Program for People with Disabilities - under development for summer 2011.
- Adults without Dependent Children health care program - under development for early 2012.

Ranking of the activities necessary to achieve the objectives of each program by priority of the activities:

- 1) Increase hospital payments through supplemental Medicaid and CICIP payments – implemented. Generated more than \$124 million in new federal funds in supplemental Medicaid and Disproportionate Share Hospital (DSH) payments paid to hospitals in FY 2009-10 and it is expected that hospitals will receive an additional \$141 million in new federal funds to further reduce cost-shifting and the high cost of uncompensated care in FY 2010-11.
- 2) Medicaid expansion for parents to 100% FPL and CHP+ expansions for children and CHP+ pregnant women to 250% FPL – implemented. Expansions have allowed 27,000 Medicaid parents, 3,300 CHP+ children, and 230 CHP+ pregnant women to enroll in health care coverage.
- 3) Medicaid Buy-In Program for People with Disabilities - under development for summer 2011.
- 4) Adults without Dependent Children health care program - under development for early 2012.
- 5) Implementing hospital quality incentive payments - under development for FY 2012-13.
- 6) Implementing continuous eligibility for Medicaid eligible children – under development for CY 2012.

Through the Colorado Health Care Affordability Act (CHCAA) the Department has been appropriated funding for administrative expenses to implement the CHCAA and not by specific activities. The detailed fiscal note for HB 09-1293 is available upon request.

At the end of FY 2009-10, the Department hired 26 positions for the administration of CHCAA. The Department's administration cost was \$2,938,743 in FY 2009-10, less than 0.5% of total expenditures under CHCAA. In FY 2010-11, the Department's administrative expenses are expected to increase to \$20,395,575 with approximately 35 FTE. In FY 2011-12, the Department's administrative expenses are expected to increase to \$20,231,547 with approximately 53 FTE. Most of the increase in administration expenditures is related to implementing system changes in MMIS and CBMS, county administration and increases to contractual costs, while the Department's personal services increases by approximately \$1,200,000 between FY 2009-10 and FY 2011-12. The appropriations for administrative costs contain no General Fund, and are funded through hospital provider fee and federal matching funds.

In addition, the Colorado Health Care Affordability Act reduced the impact on the General Fund related to the federal health care reform legislation. Without the Colorado Health Care Affordability Act, the Department will need to request an increase in General Fund appropriations associated with the administration of the Adults without Dependent Children expansions provided through the federal health care reform legislation.

2. *HRSA State Health Access Program Grant: CO-CHAMP*

The Department requested funding from Health Resources and Services Administration (HRSA), State Health Access Program (SHAP) for eight comprehensive and interrelated projects totaling \$42,773,029 over five years that is referred to as Colorado's Comprehensive Health Access Modernization Program (CO-CHAMP). CO-CHAMP reflects the Department's responsibility as leaders to "champion" policies that will lead to greater access to health care, increase positive health outcomes and reduce cost-shifting. Modernization includes not only making investments in infrastructure and technology, but also includes implementing new strategies around benefit design and cost-sharing. Coverage expansions to over 100,000 Coloradans under the Colorado Health Care Affordability Act (CHCAA) make it essential to ensure that current systems work as well as possible to support the increased caseload, making the health care delivery system and access to programs more outcomes-focused and client-centered. Despite the State's current fiscal challenges, project teams are moving forward on the implementation of the CHCAA. Staff and stakeholders are discussing the program design as well as benefits and new outreach strategies that will be needed to identify and educate these newly eligible populations. Because of the SHAP grant funding, the Department is able to implement health care reform without General Fund revenue.

There are eight CO-CHAMP projects:

- Maximizing Outreach, Retention and Enrollment (MORE) - design, develop, and implement an outreach plan for the expansion populations;
- Eligibility Modernization: Streamlining the Application Process - streamline the application process by replacing paper documentation with electronic data where possible, develop web-based services for clients, and create interfaces to other State

and Federal systems to ease data exchange for the expansions populations while making it easier for clients to apply for public health insurance programs;

- Childless Adults and Buy-in for Individuals with Disabilities Implementation - develop potential program designs, including models for premium structures, and cost-sharing provisions for the childless adults and buy-in for individuals with disabilities expansion populations;
- Premium Assistance Program - expand the CHP+ at Work program statewide to expand coverage to newly CHP+ eligible children who have access to employer-sponsored insurance;
- Health Access Pueblo Community Share Expansion - design, develop and implement an outreach and marketing plan to new businesses in Pueblo County's community-share program known as Health Access Program (HAP) to expand coverage to the working uninsured;
- San Luis Valley Three-Share Community Start-Up - create health care coverage for the working uninsured through the San Luis Valley Health Access Program by using SHAP funding to initially support the "community share;"
- Evidence-Based Benefit Design Pilot - create an innovative benefit design tool that can be implemented easily and administered efficiently for carriers for the purpose of developing new insurance products targeted at previously uninsured populations, and;
- Adult Patient Centered Medical Home Pilot - realign payment to include standard fee for service, a monthly care management fee and an incentive for exceeding quality outcomes.

Additionally, with the passage of the Patient Protection and Affordable Care Act (ACA) – the federal health care reform bill and signed into law by President Barack Obama on March 23, 2010 – the HRSA SHAP grant serves as a bridge to help position Colorado to successfully implement national health care reform. For example, under ACA, states have critical responsibilities for the implementation of new federal policies. One critical area for planning is the development of exchanges, or virtual marketplaces, where thousands of currently uninsured Coloradans will seek information to select and purchase health insurance. Many of these individuals and families will be eligible for federal subsidies to help them pay their insurance premiums. The Department used \$25,000 in SHAP grant funds to initiate a series of community forums to discuss the options for the State, as well as to seek and collect input from stakeholders and consumers until the Department received funding from the US Department of Health and Human Services for the Consumer Assistance Program grant. Many of the CO-CHAMP projects are critical in terms of informing the State's approach on how best to implement the provisions of ACA.

### 3. *Improving Value and Quality of Care*

The third area in which the Department has been most effective is in its continuing concentration on improving the value and quality of care in the Medicaid program. Crossing multiple projects and program areas, this undertaking was motivated by the findings of the Blue Ribbon Commission for Health Care Reform and a series of initiatives referred to as the “Building Blocks to Health Care Reform,” requested on February 15, 2008 in request S-1A, BA-A1A, “Building Blocks to Health Care Reform.” The Building Blocks provided a statewide plan for containing costs, improving quality and expanding the availability of care, with much of the focus on children's health and system-wide transparency, accountability, and efficiencies. The Department's efforts to ensure better value and quality for every taxpayer dollar spent range from broad initiatives that address inefficiencies and deficits in the service delivery system to targeted policy improvements. Starting with development and implementation of the children's medical home program and continuing with implementation of multiple other value-driven initiatives, the Department has been successful at emphasizing positive health outcomes, aligning incentives with desired behavior, and maximizing the value of each dollar spent. These initiatives were either requested by the Department and approved by the General Assembly or established in legislation.

There are eight specific areas where the Department has been most effective at improving value: 1) Promoting the medical home model of care and designing the Accountable Care Collaborative (ACC) Program; 2) cost-effective pharmacy reimbursement policy and financing; 3) encouraging appropriate hospital use and payments; 4) improving access to preventive dental services for children; 5) implementing a transparent process for benefit policy development; 6) transitioning to evidence-guided utilization review processes; 7) reforming reimbursement policies and instituting financing efficiencies; and 8) recovery and auditing improvements.

#### Medical Home Models and the ACC Program

The Department is fundamentally redesigning the Medicaid service delivery system to move away from the current structure of fragmented, volume-driven sick care and towards an outcomes-based, efficient health improvement model of care that emphasizes accountability for value and quality of care. The Department has had success with implementation of the children's medical home program, has implemented a targeted medical home project in select counties for some of the highest-need/highest-cost adult clients, and is currently in the process of implementing the ACC Program for the broader Medicaid population.

Through SB 07-130, “Medical Homes for Children,” the Department was granted authority to implement a medical home model of care for children enrolled in Medicaid and the Children's Basic Health Plan. Over 270,000 children enrolled in Medicaid and the Children's Basic Health Plan are now linked to a medical home. A medical home is a team approach to providing quality and cost-effective health care that is client/family-centered, comprehensive, continuous, coordinated, and culturally-competent. This integrated, coordinated approach helps to not only contain costs but also improves health

and reduces the need for emergency or complex care services. This model focuses on ensuring that children are receiving all recommended preventive care and screenings, that they are able to easily access specialty care and other services when necessary, and that their care is coordinated and comprehensive. Success of this program is evidenced by significant improvement in many national quality measures. According to Colorado Medicaid fee-for-service scores from the Healthcare Effectiveness Data and Information Set (HEDIS), between 2009 and 2010, the percent of children with no visits to the doctor in the first fifteen months of life was reduced from 32% to 6%. The percent of children with six or more visits in the first fifteen months of life increased from 30% to 55%. There were also significant improvements in the percent of records reviewed that contained documentation that the child/family was counseled on the importance of nutrition and physical activity.

In order to improve the value and quality of care provided to Medicaid's high-need/high-cost adult clients, the Department is participating in a national collaborative sponsored by the Center for Health Care Strategies, as requested in the Department's October 31, 2008 October 31, 2008 FY 2009-10 DI-6, "Medicaid Value-Based Care Coordination Initiative." The Colorado Regional Integrated Care Collaborative (CRICC) is a partnership among the Department, the Center for Health Care Strategies, local health plans and providers, consumer organizations and other stakeholders. The ultimate goal is to better coordinate the physical health, mental health and substance abuse services received by these clients. Through this initiative, the Department is targeting clients age 21 and older who are in the Aid to the Needy Disabled/Aid to the Blind (AND/AB) eligibility category or clients who are pensioners under age 65 (OAP-B eligibility category) who are not eligible for Medicare, who are enrolled in any of the Home- and Community-Based Services waiver programs (except the Mental Illness waiver), and who live in one of the targeted counties. Through this program, contracted health plans provide robust care coordination and manage service utilization. Savings are found through avoiding unnecessary hospitalizations and better coordinated care that reduces duplication of services (please see the Department's response to question 9d).

Ultimately, the Department expects to see improved health outcomes, increased efficiency, and cost savings for the majority of the Medicaid population through implementation of the ACC Program, which was originally requested in the Department's October 31, 2008 FY 2009-10 DI-6, "Medicaid Value-Based Care Coordination Initiative" and amended in the January 4, 2010 FY 2010-11 S-6 BA-5, "Accountable Care Collaborative." The ACC Program is a client-centered approach to managed care that is focused on delivering efficient and coordinated care that improves the overall health of clients. This model of care differs from capitated managed care by investing directly in community infrastructure to support care teams and care coordination and creates aligned incentives to measurably improve client health and reduce avoidable health care costs. The ACC Program was designed to address the two central goals of improving health outcomes and controlling costs by integrating the principles of a patient-centered medical home model, increasing emphasis on primary and preventive care, applying best practices in care coordination and medical management, and supporting unprecedented access to and analysis of data. The ACC Program will ensure

that every Medicaid client has a medical home, that clients and providers have dedicated partners to help guide them through the system and help coordinate care, and that outcomes are being measured and positive outcomes are being rewarded. Implementation of the ACC Program will allow the Department to more effectively manage the way care is delivered, ensure that it is delivered effectively, and ensure that internal processes are as efficient as possible. The Department has made significant advances in implementation of the ACC Program. Please see the Department's response to Question 9a for further details the status of implementation and the activities and efforts involved in implementation of the ACC Program.

#### Pharmacy Reimbursement Policy and Financing

In addition to developing benchmarks to measure progress and efficiency in key areas of the pharmacy benefit related both to cost and appropriate utilization, the Department has instituted a number of changes in administration of the pharmacy benefit that have both positively impacted the quality of services received by clients and achieved savings. In January 2007, Governor Ritter signed an executive order to implement a Preferred Drug List (PDL) for Colorado Medicaid, and the program was further expanded in the Department's August 24, 2009 FY 2009-10 ES-2, "Medicaid Program Reductions." The PDL promotes clinically appropriate utilization of pharmaceuticals in a cost-effective manner. There are currently over 30 drug classes on the PDL. The medications on the PDL are chosen from classes of medications where there are multiple drug alternatives available. Committees of experts including the Pharmacy and Therapeutics Committee and the Drug Utilization Review Board choose the medications for the PDL based on safety, clinical efficacy and cost-effectiveness. By incentivizing utilization of more cost-effective therapies like generics while aggressively negotiating Supplemental Rebate offers with drug manufacturers for increased savings on brand name products, use of the PDL saved the state over \$7 million in FY 2009-10.

Additionally, the Department implemented a State Maximum Allowable Cost (SMAC) for some pharmaceuticals. This initiative was requested in the Department's October 31, 2008 FY 2009-10 BRI-1, "Pharmacy Technical and Pricing Efficiencies." SMAC is a mechanism for managing drug reimbursement that uses acquisition costs submitted by Colorado pharmacies to determine a standardized reimbursement rate for multi-source (generically available) prescription drugs. At least 35 other states have implemented SMAC programs that maximize the savings realized from increasing generic utilization, because the reimbursement rate is derived from actual state-specific pharmacy costs and not pricing indicators that may be inflated. In fiscal year 2010-11, the Department projects a cost savings of over \$2.7 million from SMAC pricing (please see the Department's response to question 23).

The Department has also increased access to several medications that lead to better health outcomes and decreased costs. In 2009, the Department expanded coverage for tobacco cessation medications from one quit attempt per lifetime to two quit attempts per year (as evidence shows that the first attempt is often unsuccessful) in an effort to improve health and decrease expenditures for chronic conditions related to tobacco use. Also in 2009, to

encourage use, the Department removed the prior authorization requirement for prenatal vitamins and folic acid, two items that are both shown to improve birth outcomes. Through implementation of Senate Bill 10-117, the Department further intends to increase access to these and other items that improve outcomes and avert higher-cost care. SB 10-117 gives the Department the authority to reimburse pharmacies for providing certain over-the-counter medications to clients if prescribed by a licensed pharmacist, rather than first requiring office visits to health practitioners to obtain prescriptions. This will be limited to medications that, if reimbursed, will result in overall cost savings to the state. This policy will allow clients access to medications that could treat health conditions earlier and prevent the need for costly office visits or trips to the emergency room. The medications included in this policy will be selected by the Drug Utilization Review Board.

To streamline the process for those medications that require prior authorization and to reduce the administrative burden on providers and the Department, the Department is in the process of converting to an automated prior authorization system that will allow for better management of the fixed price contract currently in place for management of pharmacy claims. This change was requested in the Department's January 23, 2009 FY 2009-10 BA-33, "Provider Volume and Rate Reductions." Automating the system will significantly decrease the number of manual prior authorization determinations made through the cumbersome manual process and allow the Department to include new prior authorization criteria without hitting the cap on the fixed price pharmacy claims management contract. Automating prior authorizations would provide cost savings in the Medical Services Premiums line and adding additional prior authorization criteria within and outside the PDL allows the Department to better monitor and control drug utilization.

#### Appropriate Hospital Use and Payments

The Department has also undertaken several activities and implemented several efficiencies related to appropriate hospital use. In addition to administering a federal grant for reduction of emergency room utilization in two Colorado communities, the Department convened an emergency room utilization reduction workgroup to address this issue.

Among the activities to reduce emergency room utilization that were identified by the workgroup, the Department developed a campaign to increase the use of its under-utilized Nurse Advice Line. Nurse Advice Lines are able to offer clients appropriate medical advice and help clients determine if their condition requires immediate attention or if care should be sought in an outpatient office setting, helping to divert unnecessary emergency room use. While the Department has had the Nurse Advice Line available to all Medicaid clients for many years, a survey of Medicaid clients revealed that 86% would talk with an advice line prior to visiting an emergency room if an advice line was available. Therefore, the Department developed a client awareness campaign to increase utilization of this resource by printing the toll-free Nurse Advice Line number on each new Medicaid card, by sending wallet cards and magnets to high-volume offices to distribute to clients, and by providing this information in Women, Infants, and Children

(WIC) offices. The Department also sent letters to clients who visited the emergency room more than six times in one year, giving them the toll-free number and scheduling many of them for visits with primary care providers. As a result of these efforts, calls to the Nurse Advice Line have doubled over the past fifteen months.

In 2009, the Department instituted a policy, and programmed the claims system, to deny reimbursement for readmission to a hospital that occurs within twenty-four hours of discharge if the admitting diagnoses are related to the same condition. This emphasizes good discharge planning and appropriate medical management. Preliminary data from a recent sample of readmission claims from about 150 cases resulted in a savings of over \$1 million. This policy was the result of the Department's January 23, 2009 FY 2009-10 BA-33, "Provider Volume and Rate Reductions." The Department is proposing to amend this policy to deny readmissions that occur within forty-eight hours of discharge if the admitting diagnoses are related to the same condition (please see the Department's response to question 48a).

As a result of Executive Order D 006 09, and as requested in the Department's October 31, 2008 FY 2009-10 BRI-2, "Medicaid Program Efficiencies," the Department implemented a Serious Reportable Events reimbursement policy that denies payment for a number of serious medical errors including surgery on the wrong client, surgery on the wrong body part, and the wrong surgery performed on a client. This policy results in improved patient safety and decreased Medicaid costs.

#### Access to Preventive Dental Services for Children

The Department began covering fluoride varnish sealants on children's teeth to reduce early childhood caries and tooth decay in 2009. This initiative was requested in the Department's October 31, 2008 FY 2009-10 BRI-2, "Medicaid Program Efficiencies." By allowing this preventive service to be provided in the primary care setting as well as the dental office, physical health and oral health services can be integrated. Over time, the Department anticipates a 40% reduction in treatment related to tooth decay for children with four or more screenings and fluoride varnishes before age four, based on North Carolina's experience. The Department is currently taking the necessary steps to allow reimbursement for a number of dental services when provided by unsupervised dental hygienists. The Department has also made it possible for some dental procedures requiring heavier anesthesia to be reimbursed when performed in an ambulatory surgery center rather than in the outpatient hospital setting. Each of these dental services improvements provides greater access to care while reducing overall costs in the long run.

## Benefit Policy Development

Appropriate utilization, evidence-guided care, and cost efficiencies have been the focus of the Department's Benefits Collaborative initiative, which was part of the Department's October 31, 2008 FY 2009-10 BRI-2, "Medicaid Program Efficiencies." This Department-led initiative that clearly defines the amount, scope and duration of each Medicaid benefit, will save the state money by ensuring that all benefits offered are medically necessary and consistent with current evidence-guided standards of practice. This initiative brings stakeholders together, including provider associations, practitioners, clients, client advocates and community organizations to help the Department develop effective and efficient benefit policies for Medicaid services (please see the Department's response to question 9b). Recently, through this process, the Department's oxygen benefit was reformed to add limitations and institute official policy that had been previously lacking. The Department worked with clinicians, client representatives, oxygen suppliers, nursing homes, and other state agencies to design and implement a policy that emphasizes appropriate use, correct billing practices, and controlling liquid oxygen costs without affecting clients. Through these three avenues the Department anticipates an annual savings of over \$880,000 in oxygen benefit expenditures (please see the Department's response to question 31).

The Department also focused on ensuring that benefits provided under the Home- and Community-Based Services waiver programs are reasonable and appropriate. To this end, the Department capped the amount of non-medical transportation that would be reimbursed by Medicaid for clients enrolled in a Home and Community Based Services waiver. This was requested in the Department's August 24, 2009 FY 2009-10 ES-2, "Medicaid Program Reductions." Previously unlimited, the Department set the cap at two round trips per week. Trips to adult day programs are not subject to the cap.

## Evidence-Guided Utilization Review

Value in health care can be greatly improved by ensuring that services are medically necessary and appropriate. The Department has determined that its current utilization management structure is inadequate and inefficient, and requested to improve that structure through the Department's January 25, 2010 FY 2010-11 BA-12, "Evidence Guided Utilization Review." The Department is in the process of transitioning to an evidence-guided utilization review program that will achieve measurable cost efficiencies and gains in client safety and health outcomes by using evidence-guided clinical practices, translating rigorous research, and drawing on change management practices. By contracting with a single Quality Improvement Organization (QIO) to manage all utilization review activities (for which the Department can draw down enhanced federal match), utilization management processes will be automated for greater transparency, speed, clinical accuracy, and client and provider satisfaction. Enhanced analytics will be used to strategically identify and address appropriate and inappropriate utilization patterns and to address those variations. The Department is finalizing the Request for Proposals for this single QIO contractor and intends to have the contract awarded by spring 2011.

Management of utilization of high-cost, high-volume procedures is paramount. The Department is therefore in the process of fully implementing utilization policy for high-tech radiology services. In 2009, in response to national data showing overutilization of some radiology services, the Department instituted a prior-authorization policy for all non-emergent computed tomography (CT) scans, magnetic resonance imaging (MRI) procedures, and positron emission tomography (PET) scans performed in the non-hospital setting in order to ensure medical necessity. The Department is currently taking the necessary steps to implement this prior authorization policy in the outpatient hospital setting as well. Based on changes in utilization trends in the non-hospital setting, the Department anticipates significant savings resulting from appropriate use of radiology services by Medicaid clients and providers in both the hospital and non-hospital settings (please see the Department's response to question 9c).

### Reimbursement Policy and Financing Efficiencies

The Department has taken multiple steps to modify reimbursement policies, implement financing efficiencies, and reform payment methodologies to maximize the value of every taxpayer dollar spent. Many of these have already been implemented and some are in progress. These initiatives range from broad, system-wide reforms to targeted efficiencies for certain benefits.

Through the broad-based Coordinated Payment and Payment Reform (CPPR) initiative, requested in the Department's November 2, 2009 FY 2010-11 BRI-2, "Coordinated Payment and Payment Reform," the Department will improve value and achieve cost savings through streamlined and coordinated payment processes, enhanced recovery efforts, and proactive integration of care while expanding the application of performance-based payment structures that incentivize desired outcomes. Practitioner payment reform and waiver rate reform will create payment plans based upon health outcomes, allowing the Department to purchase better health for its clients rather than to simply purchase medical services. Still in the process of being implemented, this initiative, in addition to investigating system-wide payment reforms, will address four specific payment coordination reforms: consolidation of payment and billing processes for Federally Qualified Health Centers and Behavioral Health Organizations; expansion of audits conducted by the Department's Nursing Facilities Section; initiation of a pilot audit of a Community Mental Health Center; and increased enrollment of Medicare-eligible clients into Medicare

In addition to making progress on the COPPR initiative, the Department has improved value and quality of care through additional projects as well. Through HB 08-1114, "Medicaid Nursing Facility Reimbursements," the Department adopted a Pay-for-Performance program which offers financial incentives to nursing homes to provide higher quality services. The Department has also instituted a policy to ensure that every contract with every vendor includes liquidated damages and/or withholding clauses to emphasize accountability and value in purchased services and quality performance.

Further, as a result of the Deficit Reduction Act of 2005, the Department is now able to collect drug rebates on drugs administered directly by physicians and hospitals.

Previously, the Department was unable to invoice for these rebates due to the lack of information provided in the billing of these claims. The new regulations in place require physicians and hospitals to provide national drug code information for all single-source drugs and the top twenty multiple source drugs on claims. The Department has made the systems changes necessary to take advantage of this additional rebate invoicing and is now recouping higher rebate amounts each quarter. In addition to this financing efficiency, additional efforts have been made in order to reduce the administrative burden on providers and the Department while ensuring appropriate payment rates. For example, many services and supplies that were once manually-priced (requiring invoices and other specific information) have now been assigned set fee schedule rates based on rates paid by other Medicaid agencies, Medicare, or commercial payers, or based on the average historical amounts reimbursed by the Department. This has reduced costs and increased efficiency.

Finally, the Department has recently gathered preliminary data on the success of a newly-implemented efficiency related to payment for outpatient sterilization procedures. By incentivizing practitioners to perform hysteroscopic sterilizations in the office setting (where they were designed to be performed) rather than the outpatient hospital setting, the Department has managed to save money while increasing in-office reimbursement for practitioners and encouraging providers to perform the procedure in the most safe and convenient setting. Since implementation, the Department has seen the proportion of procedures performed in the outpatient hospital setting decrease by 60%, reducing the average per-client cost with no effect on the average total number of procedures performed. By simply modifying reimbursement methodology, based on preliminary data for seven months, the Department has seen a savings of over \$125,000 (total funds). By fully compensating practitioners for performing the right service, in the right setting, at the right time, the Department was able to generate savings with no impact on access.

#### Recovery and Auditing Improvements

The Department has taken many steps to enhance its recovery processes and activities to ensure that every dollar is being spent appropriately. Program integrity activities identify potentially excessive or improper utilization or improper billing by Medicaid providers. These efforts recover approximately \$8 million per year. Recoveries have increased in part due to the purchase of “smarter” technology to detect provider fraud as recommended by Governor Ritter’s GEMS project. Total recoveries from July 2006 through June 2009 equaled \$373,535,593. These efforts were outlined in the Department’s January 23, 2008 FY 2008-09 BA-9, “Efficiencies in Medicaid Cost Avoidances and Provider Recoveries” and furthered in SB 10-167, “False Claims Act” (please see the Department’s response to question 10). Because of the Department’s demonstrated success in collecting recoveries, Colorado has been selected by the federal government to participate in a pilot project to identify provider fraud and improve the efficiency of recoveries by matching provider data between Medicare and Medicaid.

The Department has also been very successful at ensuring that Medicaid is always the payer of last resort. Benefits coordination and estate recovery activities are designed to

recover costs for medical care paid for by Medicaid from other insurance plans, trusts, estate recoveries, and recovering any payments to clients who were discovered to be ineligible for Medicaid. In FY 2009-10, \$36 million was recovered from estates, income trusts, tort and casualty, and coordination of benefits. These efforts were aided by the Department's January 15, 2009 FY 2009-10 BA-36, "Enhanced Estate and Income Trust Recoveries."

The Department has also made advances in outpatient hospital auditing and maximizing collection of overpayments. Outpatient hospital claims are paid at a percentage of costs; however, because actual cost is not known until after hospitals cost reports are audited, hospitals are immediately paid following the delivery of services based on the hospital's cost-to-charge ratio. Later, a financial audit process reclaims any expenditure that resulted in payments made above the actual cost of services rendered. Historically, the Department has had a series of technical difficulties that have prevented it from settling with all providers; this has created a backlog of financial audits which is currently being resolved. The Department became increasingly concerned over the growing backlog of financial audits and instituted a project plan to address both the technical issues and the workload necessary to become caught up. In FY 2008-09, the Department's contracted auditor was able to complete only 77 audits due to issues with expenditure reports from the Department's fiscal agent. With these issues resolved, 136 audits were completed in FY 2009-10. The Department's original appropriation assumed \$21,918,565 in recoveries from cost settlements. However, actual cost settlements for FY 2009-10 totaled \$34,146,385. Please see question 9e for more information on payment recoveries.

*CONTINUING TO IMPROVE THE VALUE AND QUALITY OF CARE: FY 2011-12 BUDGET REQUEST*

The initiatives described above represent many of the multiple efficiencies the Department has implemented over the past several years or is in the process of implementing. The Department is proposing the following additional initiatives as part of the November 2, 2010, Budget Request:

- *Pharmacy Reimbursement Policy and Financing*  
The Department has proposed expanding utilization of the SMAC pricing methodology for additional pharmaceuticals to fully take advantage of this proven efficiency. This is requested in the Department's November 2, 2009 FY 2010-11 BRI-3, "Expansion of State Maximum Allowable Cost Pharmacy Pricing Methodology." The Department has also proposed reducing certain Federally Qualified Health Centers' rates to remove unsupported pharmacy costs. For Federally Qualified Health Centers that do not allow Medicaid clients to use their pharmacies, the pharmacy cost center would be removed from their rate calculation (please see the Department's response to question 23).
- *Appropriate Hospital Use and Payments*  
The Department has proposed reducing the amount paid to hospitals for uncomplicated cesarean section deliveries to the same amount paid for complicated vaginal deliveries. This reduction would not apply to the individual practitioner payment. Further, the Department suggests reducing the amount paid for inpatient

renal dialysis from 185% of cost to 100% of cost. To further emphasize quality clinical care, the Department has proposed denying hospital claims for readmissions that occur within forty-eight hours of discharge if the admitting diagnoses are related to the same condition. The Department currently enforces this policy for readmissions within twenty-four hours of discharge (please see the Department's response to question 48a). This is requested in the Department's November 1, 2010 FY 2011-12 BRI-5 "Medicaid Reductions."

- *Benefit Policy Development*

The Department has proposed amending the adult oral nutrition benefit for clients five years of age or older to only those clients who have malnourishment conditions, have inborn errors of metabolism, or who require nutritional supplements through a feeding tube. The Department also proposes more strict enforcement of existing limitations on acute home health services. Acute home health services are those provided for 60 days or less. After the 60 day period, prior authorizations are required to receive additional services. Enforcing this requirement is not anticipated to deny home health services for any client who has a medical need. This is requested in the Department's November 1, 2010 FY 2011-12 BRI-5, "Medicaid Reductions."

- *Evidence-Guided Utilization Review*

As discussed above, effective April 1, 2012, the Department has proposed requiring prior authorization for non-emergent high-tech radiology procedures performed in the outpatient hospital setting. Additionally, to improve client health and ensure that services are being utilized appropriately, the Department has proposed expanding the Client Overutilization Program (COUP). COUP improves client health by ensuring that clients are accessing services appropriately and it generates savings by decreasing inappropriate use of medical services, thereby reducing the expenditure for medically unnecessary services. The program criteria primarily targets the abuse of prescription medication, but also includes inappropriate use of emergency room and/or practitioner services. This is requested in the Department's November 1, 2010 FY 2011-12 BRI-1, "Client Overutilization Program Expansion."

- *Reimbursement Policy and Financing Efficiencies*

In order to improve value by aligning current payment rates with other payers and market values, the Department has proposed reducing the payment for blood glucose/reagent strips from \$31.80 per box of 50 strips to the current median market price of \$18.00, as well as setting a maximum rate of 95% of the equivalent Medicare rate for most procedure codes that are currently paid at rates above 95% of the Medicare rate. Codes that are currently paid below the 95% level would not be affected. This reduction would primarily affect physician services, injectable drugs, and durable medical equipment, although other service categories may also be affected.

The Department has also proposed setting a cap on the wage rate that a client enrolled in the Consumer Directed Attendant Support Services (CDASS) waiver program is allowed to pay attendants. This cap would be based on current rates for similar services in the Home- and Community-Based Services' Elderly, Blind and Disabled waiver, including homemaker, personal care, and health maintenance. The actual

wage caps will be set after the Department solicits stakeholder input. Both of these items are requested in the Department's November 1, 2010 FY 2011-12 BRI-5, "Medicaid Reductions."

The Department is the single state agency responsible for administration of the Medicaid program. However, successful operation of the Medicaid program is only possible with the cooperation of sister state agencies like the Department of Human Services and the Department of Public Health and Environment, as well as community-based organizations, county departments of human services, provider associations like the Colorado Medical Society, individual clinicians, clients and client advocates and other partners.

All of the activities associated with the development and implementation of the efficiencies and projects described above have taken considerable time and effort. The Department remains committed to developing, implementing, and managing these and similar value-driven initiatives. With agency-wide efforts, across sections and divisions, the Department has been able to successfully achieve these efficiencies and manage these projects with little or no additional full time equivalent employees and with little or no implementation funding. Two FTE were appropriated to implement HB 08-1114, "Medicaid Nursing Facility Reimbursement," both of which are funded through the nursing facility cash fund and have specific responsibilities for the nursing facilities program. One FTE was appropriated to oversee the Accountable Care Collaborative, a position that was originally intended for two employees. Not counting program integrity activities, only two FTE were appropriated to implement all of the other programs combined; one of these was appropriated as part of the Department's October 31, 2008 FY 2009-10 BRI-2, "Medicaid Program Efficiencies," and the other was appropriated as part of the Department's November 2, 2009 FY 2010-11 BRI-2, "Coordinated Payment and Payment Reform." Therefore, the Department has been able to improve the value and quality of care to Medicaid clients in most of its programs by only increasing its General Fund appropriation by three FTE. Due to the high potential for savings associated with recoveries, the Department was appropriated six FTE as part of the Department's January 23, 2008 FY 2008-09 BA-9 "Efficiencies in Medicaid Cost Avoidances and Provider Recoveries," and seven FTE for implementation of SB 10-167 "Colorado False Claims Act."

#### LEAST EFFECTIVE:

##### 1. *Hospital Backup Unit (HBU)*

One of the Department's least effective programs is the Hospital Backup Unit program. The purpose of this program is to provide alternative placement for clients in hospitals who do not need the expensive, acute level of care provided in hospitals, but do require an inpatient setting. The Hospital Backup Unit (HBU) program was intended to provide inpatient care in the least restrictive setting, thereby decreasing costs and increasing the satisfaction of the clients and their families. The Department's adult HBU program has

been operational since 1987 and costs approximately \$5-6 million per year. HBU services are currently delivered exclusively in the nursing home setting.

There are no similar programs administered by other state, federal, or local agencies. The Department had anticipated the program would generate savings as a result of placing clients who do not need inpatient hospital care in a less restrictive, lower-cost setting. At the same time, it was believed that the program would keep clients who were in need of sub-acute care from being prematurely discharged from the hospital, resulting in reduced costs associated with hospital readmissions, which can result when clients are discharged prematurely from hospitals. Over time, the Department expected to see a reduction in number of hospital “outlier days” (days beyond the maximum allotted for a given diagnosis) for adult clients. After analysis of FY 2009-10 claims data, no reduction was identified. This suggests either that outlier days are not a reliable measure of the effectiveness of the program, or that the program did not meet its goals of reducing unnecessary hospital care. As the Department sought to find additional efficiencies to address budget deficits it was suggested that the HBU program be expanded. Department staff investigated the feasibility of this proposal and found that expansion would not result in savings, but would rather cost the Department more money. It is the Department’s belief that the HBU program is an example of how good intentions do not always net the desired financial results. The Department believes that, although the HBU program helps with the care of vulnerable populations, it will continue to generate additional costs rather than save money. Therefore, the Department plans to phase out the adult HBU program and will not implement a pediatric HBU program. All current HBU clients will continue to receive this care, but no new adult or pediatric clients will be added to the program.

## 2. *Management of Home- and Community-Based Services Waiver Programs*

The Department’s Home- and Community-Based Services have been effective in their goal of reducing the need for institutional care and keeping clients in their homes and communities, even when they have ongoing long term-care needs. However, the Department is not appropriately staffed to administer and manage the existing number of waivers. The Department recommends consolidating the 11 waiver programs into fewer programs offering the same services with more efficient management.

Currently there are 11 Home- and Community-Based Services waiver programs for Medicaid clients with long term care needs, based on population (adult or children) and diagnosis. These “waiver” programs are authorized under Section 1915(c) of the Social Security Act, allowing states to waive certain Medicaid statutory requirements. State authorization for these programs is in 25.5-6-301 through 25.5-6-902, C.R.S. (2010). There are no similar programs administered by any other state, federal, or local agencies.

Waiver programs provide additional Medicaid benefits to specific populations who meet special financial, medical, and program criteria. Clients applying for these services must be at risk of placement in a nursing facility, hospital, or intermediate care facility for the mentally retarded and be willing to receive services in their homes or communities. Clients may only receive services from one waiver program at any given time. A client

may not use all of the services available within that one particular waiver, which means service utilization is not maximized even though the waiver may have met its enrollment cap.

The state of Colorado has more waiver programs than any other state. Managing the 11 waivers requires increased staffing resources to manage the duplicative functions, such as monitoring enrollment, cost effectiveness and quality outcomes for each waiver. Currently the seven adult and children's waivers are administered through the Department and the four waivers for persons with developmental disabilities are administered through the Colorado Department of Human Services. The Department is responsible for oversight of all the waivers, which requires intense coordination and additional resources to ensure program quality.

The Department recommends the following activities to improve the effectiveness and efficiency of the waivers. First, the Department will collect waiver utilization data to have the most accurate and up-to-date information on which services are utilized at what rates. Next, the Department will work with the Centers for Medicare and Medicaid Services (CMS) to establish a strategy for the consolidation, looking at which waivers can be consolidated and how many waivers Colorado requires to meet the needs of its clients. The Department will then create an operational plan for consolidation, and meet with stakeholders to create a strategy for implementation. The Department of Human Services will be a key part of these discussions. Once these steps are completed, the Department will initiate the necessary legislative and rule-making actions to reflect the new organization of the programs and write new waivers to submit to the CMS. The Department believes that it would be appropriate for the planning and stakeholder engagement activities to take place during FY 2011-12 and legislation could be initiated in FY 2012-13.

The total resources needed for this plan is not yet known. However, some steps will be accomplished using resources from the Money Follows the Person grant (see question 46 for more information).

### *3. Cash-Funded Program Administration*

One of the largest inefficiencies in the Department is generated because the Department's appropriations for major programs are fragmented between multiple state funding sources. Not only does this fragmentation create a substantial administrative burden for the Department, but it also presents problems for both the Department and the General Assembly to maintain proper program oversight or to adapt to changing financial or regulatory conditions.

Perhaps the most significant challenge the Department is currently facing with cash funded programs relates to the programs funded through tobacco taxes. Article X, Section 21 of the Colorado Constitution (also known as Amendment 35) specifies specific distributions for revenue received from tobacco taxes; however, as tobacco-related revenue decline, the Department will be increasingly unable to meet its Constitutional and statutory directives in administering the required programs. Among

the problems the Department is currently facing include the shortfall in the Health Care Expansion Fund, projected to be over \$90 million in FY 2012-13. Further, the Constitutional distribution on spending for clinics from the Primary Care Fund has limited the Department's ability to maximize federal funds; as a result, the state was ineligible to draw between \$24 million and \$30 million in federal funds per year. This is funding that would have been directly passed along to clinics that serve low-income and uninsured populations.

The Children's Basic Health Plan is also funded primarily through non-General Fund revenue sources that are declining, such as the Tobacco Master Settlement funds and tobacco taxes. In addition, various legislative actions over the last 5 years have resulted in an increasingly complicated financing structure. For example, enrollees with family incomes up to 185% of federal poverty line are funded through two different sources- Tobacco Master Settlement funds for those below the FY 2003-04 level, and the remainder funded from tobacco tax. This adds complexity not only to the financing of the program, but also to the forecasting of expenditures. Children's Basic Health Plan caseload is currently split into four different populations that largely exist only because they have different funding streams. This is unlike Medicaid, where caseload is split into groups with similar demographic and utilization trends. If the Children's Basic Health Plan financing were streamlined, the Department believes that the difficulties around forecasting this program would be alleviated.

A number of other programs are also funded through program-specific cash funds: the Breast and Cervical Cancer Treatment Program; home and community based services for clients with autism; the coordinated care for people with disabilities pilot program; home health telemedicine services; the Children's Basic Health Plan; and, the Old Age Pension State Medical program. Each program has its own requirements and each requires separate administration.

The strict statutory and constitutional requirements have become problematic when programs need to change to adapt to new conditions. For example, the Constitutional distribution of tobacco revenues was determined in 2005; however, with the passage of the Colorado Health Care Affordability Act (HB 09-1293) and the Patient Protection and Affordable Care Act, the programmatic need for that revenue is changing. Whereas current population expansions are tied to specific revenue sources, federal maintenance of effort and Medicaid expansion requirements make the delineation of revenue for specific populations unnecessary. The State will no longer have the ability to restrict Medicaid eligibility to these populations if revenue from these specific sources is insufficient. As a result, tying services and populations in the Medicaid and the Children's Basic Health Plan to specific sources of funds only increases the administrative burden on the Department without creating any tangible benefit.

Taken together, these programs generate a significant administrative burden for state personnel in administering these programs. Managing cash funds require a significant level of effort from accounting, budget, and auditing personnel to ensure that funds are properly spent, recorded, and forecast. None of these activities, however, are integral to

accomplish the mission of any given program; they are simply technical requirements that have become necessary because of the requirements surrounding the Department's appropriations.

The Department does not typically receive administrative resources when new cash funds are created, and the burden of properly managing the cash fund falls on existing staff. As a result, staff must be diverted from other projects, which further increases risk in other areas as oversight is diminished.

Although a detailed ranking of specific activities is not possible because this inefficiency touches a large number of Department programs, in general, the activities involved with the programs can be delineated into two groups: program administration, which includes interacting with clients and providers, determining grant allocations, etc.; and, technical administration, which includes accounting, budget, and audit functions. Clearly, program administration is the more important of these activities. However, because of the onerous requirements and sources of funding, the technical administration of the programs consumes more resources and staff time. It is very likely that a substantial reduction in requirements around cash-funded programs would allow the Department to reallocate its resources in a way that would both enhance program oversight and allows some technical positions (such as budget or accounting staff) to be redirected in order to better achieve the Department's mission, vision, and goals.

Meeting the statutory and fiscal requirements consumes a large number of current staff hours. The Department's Budget and Controller divisions have several staff members who spend a substantial portion of their time during certain months (such as quarterly or year-end close) ensuring that cash fund transfers are made correctly. This involves other members of the Department as well, including members of the Department's Data Analysis section and program administrators to determine the correct amount of the transfer. Further, these transfers that are made must be audited by internal staff, and are typically audited by external staff as well, including the Office of the State Controller.

The Constitutional and statutory restrictions are located in the following places:

- The Department's authority for programs funded through the tobacco revenues resides in the Colorado Constitution, Article X, Section 21. Statutory funding requirements are contained in 24-22-117, C.R.S. (2010).
- The Department's authority for Medicaid programs funded through cash funds is located in title 25.5, articles 4, 5, and 6.
- The Department's authority for the Children's Basic Health Plan is located in title 25.5, article 8. Specific requirements related to the Children's Basic Health Plan Trust Fund are located in 25.5-8-105, C.R.S, (2010).
- The Department's authority to administer the Old Age Pension Health and Medical Program is located in title 25.5, article 2.

The Department will work within the Executive Branch to identify any possible solutions, and will request changes through the normal budgetary process.

#### *4. Administration Funding and Transfer Constraints*

Two other inefficiencies the Department contends with relates to the manner in how it is appropriated administrative funding and the inflexibility of the state procurement code. These inefficiencies lead directly to delays in the implementation of programs as the Department is forced to wait for technical corrections through the supplemental budget process and follow the lengthy and highly technical request-for-proposal and contracting processes that does not necessarily achieve a lower price for needed services.

By FY 2011-12, the Department estimates that its total funding need will exceed \$5.18 billion. The majority of technical corrections required by the Department are for issues that are less than \$250,000 total funds, or 0.005% of its total budget. It is inefficient for the Department to be overly constrained by the state budget process of administrative funding and procurement process when the successful operation of its program depends on its ability to procure services timely to comply with statutory deadlines.

#### *Long Bill Organization*

As a result of footnote 22 in the FY 2007-08 Long Bill (SB 07-239), the Department submitted a report to the Joint Budget Committee with recommended changes on how to restructure the Executive Director's Office Long Bill group into a more programmatic format by combining some line items and creating subgroups within the division. The Department's recommendations were incorporated into the budget process beginning with the FY 2008-09 Long Bill.

While the reorganization simplified the Department's budget and accounting practices, it quickly became apparent that the reorganization has not led to greater efficiencies within the Medicaid budget. Typically, supplemental bills are not signed by the Governor until March of the fiscal year. As a result, the Department must typically wait between 6 and 12 months between the time the need is identified and the time that action can be taken. This is particularly problematic when the change involves procurement issues or system changes: while the Department waits for technical changes in its appropriations, little or no progress is made in implementation. The emergency supplemental process does not allow for technical corrections.

These problems occur frequently; the Department writes fiscal notes and change requests that are based on specific implementation timelines. However, in many cases, these implementation timelines can change based on a variety of factors that the Department has no control over. If the Department requests one-time funding in a fiscal year to implement a project and the implementation is delayed into the next fiscal year, the implementation funding expires and the Department is required to follow the supplemental appropriation process for the next fiscal year. For example, the Department is not able to start system changes for programs until the Centers for Medicare and Medicaid Services (CMS) approves a state plan amendment or a waiver amendment; while the Department makes an assumption in budget requests about how long this process will take, it is never certain. In some cases, waiver amendments have taken multiple years to be approved, such as the waiver amendments required as a result of SB 04-177, "Concerning Home- and Community-Based Services Under the State's Medicaid Program for Children with Autism". In this case, the waiver was approved by CMS in January 2006, but constraints in funding delayed implementation until May 2007.

The Department plans to work with the Office of State Planning and Budgeting to consider the issue and develop solutions and proposals for the FY 2012-13 budget cycle.

### *Procurement*

Due to changes in health care administration, the number of procurements issued by the Department has increased steadily over the years. Through various state and federal initiatives, the Department is required to: expand fraud, abuse, and recovery efforts; modify and advance payment and quality incentive payments; modernize data reporting and information technology systems; and, outsource administrative functions. Currently, the Department has approximately 30 procurements that still need to be issued and completed this fiscal year. This backlog creates significant delays in implementing projects timely. For example, the Department is currently working on several RFPs that will implement background checks of providers, increase post payment review for non-institutional providers, increase post payment review of hospital inpatient payments, and increase 3rd party recoveries. Though the Department believes that these duties are necessary to help with the efficient administration of the Medicaid program, the state procurement process has hindered the Department's ability to implement these programs. As a result, there are significant delays in implementing programs designed to reduce General Fund cost.

Often times the budget for the contract awarded through the RFP process has already been established through appropriations; the RFP process is not used to determine the lowest cost for the State. Rather, the RFP process is used to determine the most qualified vendor to perform the services. However, consulting services in the public health care market are limited to several large vendors. For example, when issuing the RFP to help the Department procure consulting services for hospital provider fee modeling and

modernizing hospital payment principles, only one vendor responded to the Department's RFP. By following the traditional RFP process, the contracting and program development were delayed by at least eight months. This example demonstrates how the state's procurement processes and limitations is one factor in restricting the Department's flexibility in the changing and advancing health care environment.

The Department's procurement backlog is also exacerbated by simple, ongoing contracts. A significant amount of the Department's contracts are with health care providers that voluntarily participate in Medicaid, the Children's Basic Health Plan (or CHP+), and the Colorado Indigent Care Program (CICP). To participate in the Department's programs, providers are often required to sign a standard Department-issued provider agreement to verify they have the credentials and licenses to provide services and sign a standard State contract, which contains many provisions not applicable to health care providers. Further, the Department has regulations to which all providers must adhere. Providing services to the Medicaid, CHP+ and CICP populations should not require providers to complete the additional standard State contract or commitment voucher, which is often considered burdensome by the providers, when the Department has clear regulatory authority over the programs and participating providers. However, because of the requirements in the state procurement system, the Department must expend time and resources to develop and maintain contracts with these providers. This prevents the Department from dedicating its limited resources to more significant issues.

The Department believes that simple modifications to the current purchasing limits set forth in statute and fiscal rules would ease the procurement backlog and give the Department more flexibility to contract with providers and consultants. For example, the Department is currently required to have CICP Provider Contracts with more than 60 providers and School Health Services Provider Contracts with more than 70 providers, because these providers are paid through COFRS rather than the Medicaid Management Information System (MMIS). Each of these contracts must be cleared and reviewed per state fiscal rules, generating a significant and unnecessary administrative burden.

The Department believes that the most effective way to combat these inefficiencies is through statutory changes. The Department's Contracts and Procurement Section has 7 FTE total, including the section manager. This level of staffing has proven to be insufficient to accomplish all of the Department's procurement needs.

Specifically, the Department believes that any statutory changes should include at least the following:

- Specifically apply limits on purchase orders to only the state share of expenditure. Current purchase orders are limited to \$25,000 total funds. However, a majority of the Department's administration costs are 50% state funds and 50% federal funds, and many federal mandates to implement changes to the Medicaid Management Information System or other systems receive a higher federal share of either 75% or 90%. Therefore the Purchase Order limits would be up to \$50,000 with 50% state funds and 50% federal funds, up to \$100,000 with 25% state funds and 75% federal funds, and up to \$250,000 with 10% state funds and 90% federal funds.

- Increase the maximum allowable request for documented quote to \$200,000 total funds per year for up to 5 years. Amounts greater than \$200,000 per year should remain subject to the request for proposals process.
- Exempt spending on 100% federally funded projects from procurement rules, subject to Department regulation and compliance with federal regulation and applicable grant rules.
- Statutory clarification that contracts are not necessary if the providers signs the Department's standard provider agreement and the administration of the program is established in Department regulations.

These modifications would greatly enhance the Department's ability to implement required changes timely. Without changes, the Department will continue to experience significant delays in the contracting process, which quickly becomes delays for clients from gaining eligibility or receiving services. It is very likely that allowing the Department more flexibility around procurement would allow the Department to reallocate its resources in a way that would both enhance program oversight and allows Procurement resources to be redirected in order to better achieve the Department's mission, vision, and goals.

The Medicaid program is a jointly funded by the state and federal governments; as a condition of receiving federal financial participation, the Department must adhere to federal laws and regulations promulgated by the Centers for Medicare and Medicaid Service (CMS).

The Department's authority to administer the Medicaid program is located in Title 25.5. Statutory transfer authority is located in Title 24, Article 75. The state procurement code is located in Title 24, Articles 101 through 112.

The Department will work within the Executive Branch to identify any possible solutions, and will request changes through the normal budgetary process.

**3. Detail what could be accomplished by your Department if funding for the department is maintained at the fiscal year 2009-10 level.**

RESPONSE:

In general, Medicaid expenditures are counter-cyclical. With an economic downturn, more people become eligible for Medicaid, and the Department's caseload increases. As Medicaid is a federal entitlement program, the state has limited options to control the growth of expenditures during economic downturns.

Total Medicaid caseload for all eligibility categories is anticipated to increase from 498,797 in FY 2009-10 to a projected 551,570 in FY 2010-11. Additionally, HB 09-1293 (the Colorado Health Care Affordability Act) has allowed the Department to extend eligibility to additional populations that would not otherwise qualify for Medicaid without any General Fund impact to the state.

Cuts to the Medicaid program in FY 2009-10 and FY 2010-11 reduced General Fund appropriations by approximately \$174 million from the Department's Medical Services Premiums and Medicaid Mental Health Community Program lines. If this funding were restored, the Department would be able to:

- eliminate transfers from cash funds such as the Prevention, Early Detection, and Treatment Fund, which provide funding for programs in other Departments;
- withdraw its request for payment delays in FY 2010-11, and;
- provide rate increases to providers.

However, it is unlikely that the Department would restore every cut taken.

The Department has identified and implemented a wide variety of efficiency measures. Such measures allow the Department to reduce the cost of providing services to clients without negatively impacting client access to these services. Some of these measures include establishing appropriate limits and implementing certain utilization review controls. Another example is the Department's January 4, 2010 FY 2010-11 S-6 BA-5 "Accountable Care Collaborative," which represents a Department initiative to improve health outcomes for clients by coordinating care and proactively addressing client needs. This system generates significant efficiencies by reducing redundancies in care and information acquisition. Consequently, expenditure is lower as the Department will avoid paying for redundancies in care and exacerbated patient conditions due to patients' health care needs being addressed proactively. These policies, while reducing costs, are positive long-term steps that help ensure the future financial stability of the Medicaid program and would remain in place even if funding were fully restored.

A return to FY 2009-10 Personal Services funding levels would eliminate the FY 2010-11 annualization of HB 09-1293 "Colorado Health Care Affordability Act," which increased the Department's FTE and appropriation by 23.3 and \$880,890, respectively. This would put at risk approximately \$618 million of federal financial participation that is drawn from a non-General Fund state share. The Department's FY 2009-10 appropriation contained \$1,737,029 for 25 FTE that have since been transferred to the Governor's Office of Information Technology at the end of FY 2009-10. The Department's FY 2009-10 appropriation does not contain \$447,118 and 7.0 FTE for implementation of SB 10-167 "Colorado False Claims Act." Loss of this funding and FTE would hinder or potentially prevent the implementation of this bill and its associated savings.

Additionally, the Department's FY 2009-10 Personal Services appropriation did not contain annualizations related to other bills and Departmental initiatives. These include:

- FY 2009-10 BRI-2, "Medicaid Program Efficiencies" (October 31, 2008);
- FY 2009-10 DI-6, BA-38, "Medicaid Value-Based Care Coordination Initiative" (October 31, 2008, January 23, 2009);
- FY 2009-10 DI-12, "Enhance Medicaid Management Information System Effectiveness" (October 31, 2008);

- FY 2009-10 ES-3, “Department Administrative Reductions” (August 24, 2009);
- annualization of HB 09-1047 “Alternative Therapies for Persons with Disabilities”;
- annualization of HB 10-1323 “Use of Tobacco Litigation Moneys FY 2009-10”;
- FY 2010-11 BRI-2, “Coordinated Payment and Payment Reform” (November 2, 2009), and;
- FY 2010-11 BA-5, “Accountable Care Collaborative” (January 4, 2010).

These items total \$19,045 and 1.9 FTE, and the loss of this funding and FTE would jeopardize the implementation of these initiatives, putting at risk any savings associated with the bills or proposals.

The Department has also diverted numerous grant programs in the Indigent Care Programs long bill group. The grant programs that have been cut or eliminated include the Primary Care grant program, the Health Care Services Fund clinic programs, and the Comprehensive Primary and Preventive Care grant program. These grants are intended to provide funding to clinics for infrastructure to expand access to health care services for low-income under-insured and uninsured Coloradans. If funding were restored to the FY 2009-10 level, the Department would be able to restore these grant programs, thus ensuring that the low-income individuals needing care have access to clinic services.

- 4. How much does the department spend, both in terms of personnel time and/or money, dealing with Colorado WINs or any other employee partnership group? Has the level of resources dedicated to this effort changed in the past five years?**

RESPONSE:

The Department spends no personnel time and no money dealing with Colorado WINs or any other employee partnership group. This has not changed in the past five years.

**10:00 – 10:20: BUDGET GROWTH IN THE DEPARTMENT PROGRAMS**

- 5. Explain the reasons why the Department’s budget has increased by \$1.0 billion since FY 2007-08.**

RESPONSE:

Answered in 6.

**6. Of the Department's recent increases, how much does the Department attribute to the economic downturn and how much does the Department believe resulted from expansion of eligibility.**

RESPONSE:

The Department's budget for the Medical Services Premiums line item has increased by \$1.05 billion total funds from FY 2007-08 to the FY 2010-11 revised request from the November 1, 2010, Budget Request, or approximately 47% (see Row B in the table below). Of this amount, \$829 million is federal funds (78%, see Row C in the table below), and \$374 million is cash funds and reappropriated funds (35%). On the other hand, the Department's General Fund budget for Medical Services Premiums has decreased by \$144 million, a 14% decrease between FY 2007-08 and FY 2010-11. Medicaid is an entitlement program, and the Medicaid populations funded with General Fund are largely at the bare minimum required by federal regulations to participate in Medicaid. All eligibility expansions have been funded with cash funds rather than General Fund, particularly tobacco taxes and the Hospital Provider fee. These expansions were approved by the General Assembly and currently use zero General Fund. With 41% growth in Medicaid caseload since FY 2007-08, the Department has managed to reduce the General Fund expenditures in Medical Services Premiums by 14% through a number of financing mechanisms and improved value of purchased health care services.

Row		Total Funds	General Fund	Other State Funds	Federal Funds
A	Growth FY 2007-08 to FY 2010-11	\$1,059,068,620	(\$144,038,513)	\$373,757,616	\$829,349,517
B	% Growth FY 2007-08 to FY 2010-11	47%	-14%	519%	74%
C	Relative % Growth	100%	-14%	35%	78%

The Department has seen unprecedented growth in Medicaid caseload since FY 2007-08. As can be seen in the table below, total Medicaid caseload is projected to increase by 41% from FY 2007-08 to FY 2010-11. Of this, the eligibility expansions from the tobacco tax and the Hospital Provider fee together represent 31% of the increase in Medicaid caseload (see Row C in the table below). Similarly, 69% of the growth is projected to occur in the General Fund funded populations, which tend to be the lowest income Medicaid populations. The Department cannot identify how much of this growth in low-income caseload can be attributed to the economic downturn. Over the last three years, the Department and many community-based organizations have been performing intensive outreach activities to enroll all individuals that were eligible but not enrolled.

Row		Total Increase	General Fund Populations	Tobacco Tax Populations	Hospital Provider Fee Populations	Other State Funded Populations
A	Growth FY 2007-08 to FY 2010-11	159,608	109,357	22,740	27,270	241
B	% Growth FY 2007-08 to FY 2010-11	41%	32%	49%	-	70%
C	Relative % Growth	100%	69%	14%	17%	0%

**7. Identify the legislation that has resulted in higher costs to the Department since 2005.**

RESPONSE:

Please see attachment A for a list of legislation that has resulted in higher costs to the Department. The Department has only included bills with a General Fund impact or potential future General Fund impact. Legislation with sustainable cash and/or federal fund resources have not been included; therefore, only legislation with unsustainable or insufficient cash fund resources have been included in this analysis (for example, the Children's Basic Health Plan Trust or the Health Care Expansion Fund). The Department has also included bills that have a net impact resulting in savings but require additional administrative resources in order to achieve those savings. The attachment only includes legislation that has resulted in ongoing Department costs; legislation with one-time funding needs have not been included in this analysis.

**8. Can any of this legislation be suspended or repealed? Are there any federal restrictions limiting the Department's ability to suspend recently passed legislation at the state level.**

RESPONSE:

Please see attachment A for which bills could be suspended or repealed without violating any federal provisions. The Patient Protection and Affordable Care Act (ACA) requires the State to maintain eligibility standards until the state exchange is available in January 2014. In order to comply with this requirement, the State must apply Medicaid eligibility standards, methodologies, and procedures that are no more restrictive than those in effect under the State plan (or any waiver or demonstration project) as of the effective date of ACA (March 23, 2010). Therefore, all eligibility categories as of the enactment of ACA must be maintained, including both mandatory populations required by the federal government as well as optional populations Colorado has chosen to serve through its Medicaid State Plan. In addition, the State must also maintain eligibility standards for children in Medicaid and the Children's Basic Health Plan until 2019.

Since 2005, there has been legislation creating or expanding some optional services benefits. Many of these optional services provide a cost savings to the State. These services are an integral aid for clients to maintain and improve their overall health to avoid the need for more costly care. Eliminating client access to these services would likely result in a significant increase in emergency department visits, other hospitalizations, and other cost shifts to other areas of Medicaid. While repealing these bills would not violate any federal provisions, removal of optional Medicaid services will drive an increase to the Department's budget as the increased costs for higher utilization of institutional care would significantly outweigh any savings realized by cutting the optional services.

**10:20-10:30: BREAK**

**10:30 – 12:00: RECENT BUDGET COST CONTAINMENT INITIATIVES**

**9. Please update the Committee on the status and results for the following cost containment measures:**

- a. Implementation of Accountable Care Collaborative. Please provide information regarding savings anticipated if clients are assigned to a primary care provider.**

**RESPONSE:**

First proposed in the Department’s October 31, 2008 FY 2009-10 DI-6 “Medicaid Value-Based Care Coordination Initiative,” the Accountable Care Collaborative Program (ACC) is a hybrid model that adds characteristics of a regional accountable care organization to the primary care case management system. The ACC Program is designed to address the two central goals of improving health outcomes and controlling costs by integrating the principles of a patient-centered medical home model, applying best practices in care coordination and medical management, and combining unprecedented access to client data to move away from the current system of fragmented volume-driven, sick care and towards an outcomes-based, efficient, health improvement model of care.

Additionally, the Patient Protection and Affordable Care Act, passed March 23, 2010, contains provisions for health homes and pediatric accountable care organizations. Under these provisions, the Department believes that certain services provided through the ACC will qualify for enhanced federal financial participation, further reducing the cost of the program.

The Department’s efforts in designing and implementing this program have elicited interest on a national level. Many states are watching and monitoring Colorado’s progress in implementation of the ACC Program.

The Department has made significant advances in implementation of the ACC Program. In August 2009, the Department issued a Request for Information (RFI) to gather information from practitioners, provider associations, clients and client advocates, service delivery system experts, and other stakeholders. Eighty-one responses were received. The Department, with the help of a consultant, integrated the feedback gathered through the RFI process into the overall development and design of the ACC Program. Once the structure of the program was developed, the Department began working on the two major procurement projects necessary for successful implementation.

There will be seven Regional Care Collaborative Organizations (RCCOs) whose responsibilities will include care coordination, medical management, provider support and network management, and sharing accountability with providers for client health outcomes and costs. The Request for Proposals (RFP) for the seven RCCOs was posted and the review of submitted proposals was recently completed. *The Department has published its intent to award, but the awards will not become final until the protest period has ended.* Notices of Intent to Award have recently been issued as follows:

- Region 1: Rocky Mountain HMO
- Region 2: Colorado Access
- Region 3: Colorado Access
- Region 4: None (solicitation was not successful, region was not awarded)
- Region 5: Colorado Access
- Region 6: Colorado Access
- Region 7: Community Health Partnership

In addition to selection of the RCCOs, the Department has posted the RFP for the Statewide Data and Analytics Contractor (SDAC). Critical to the success of the ACC Program, the SDAC will serve as the central data repository for the RCCOs and the medical home providers, will provide in-depth and actionable data analytics and reporting through a central web portal on a client-specific, practice-specific, regional, and statewide level, and will help establish accountability for health outcomes and costs through detailed data tracking, monitoring, and continuous improvement efforts. The Department is currently in the process of reviewing the submitted proposals and a selection will be made shortly.

The Department is also making significant progress on the additional activities involved in implementation:

- Necessary modifications are being made to the Medicaid Management Information System (MMIS). These modifications will allow for the loading and payment of the RCCOs, the loading and payment of the medical home providers, enrollment of clients into the ACC Program, the transfer of data to the SDAC, and the transfer of data to the Enrollment Broker.
- Contract amendments to the Enrollment Broker contract have been drafted.
- Contract amendments are in progress with the External Quality Review Organization (EQRO).
- The Readiness Review process for RCCOs is being finalized.
- Client educational materials are being drafted.
- The client selection process is being programmed and automated.

The ACC Program is designed to create savings (see the Department’s January 4, 2010 FY 2009-10 S-6 BA-5 “Accountable Care Collaborative,”) by providing every client with a focal point of care to promote comprehensive primary and preventive care, by coordinating care and services for clients to streamline access to necessary services and decrease duplication of services, and by emphasizing shared accountability through careful monitoring of claims data and health outcomes.

**b. Implementation of the Benefits Collaborative.**

RESPONSE:

Since its inception, the Benefits Collaborative initiative has focused on developing Medicaid benefit policies that lead to appropriate utilization, evidence-guided care, and cost efficiencies. Calling on the best available clinical evidence, as well as best practices found in benefits policy management, this initiative has made significant progress in reaching its primary objective of aligning appropriate utilization with cost efficiency.

In the past year, the Benefits Collaborative has begun work on defining medical tests and radiology benefits, areas that many public and private insurers are looking at to improve health outcomes and create cost efficiencies. Specifically, the Benefits Collaborative has defined three substantial radiology policy limitations: 1) three ultrasounds per normal pregnancy; 2) one echocardiogram per client and two test readings per 12-month period; and 3) one cardiac stress test procedure per year. These benefit limitations were placed into Medicaid policies as a result of research on evidence-guided care and the Benefits Collaborative process. Not only does the Department anticipate that these changes will achieve cost efficiencies, the policies also have the potential to improve quality of care because they will decrease unnecessary exposure to radiation. The Veterans Administration has recently adopted these policies, lending further validation that the Department is moving in the right direction with the policies and overall vision of the Benefits Collaborative.

The Benefits Collaborative is a transparent, stakeholder-driven, collaborative process that allows the Department to work with the provider and client communities alike, which helps ensure that the policies are connected to the practical realities of administering and receiving the benefits. Because medical terminology and clinical criteria can be complex and nuanced, working with stakeholders to maximize clarity and comprehension is critical. Better defined clinical criteria help to prevent inappropriate utilization, generate faster prior authorization decisions, and increase program compliance with government regulations. With clear benefit policies in place, the Department is better prepared for the expansion programs that are being created by state and federal legislation. The Department also believes that defining evidence-based coverage policies will increase the Department's success in defending service coverage determinations before administrative law judges, because the judges will have better policy guidance for adjudicating the case.

The policies that have been vetted and approved through the Benefits Collaborative process include the children's dental benefit policy, women's reproductive health services, and echocardiogram policy. Additional policies that are nearing completion include speech therapy & audiology, low back imaging, bone density screening, and oxygen. The Department plans to continue defining the benefit policies that need to be better defined or revised, creating policies for any new benefits, and reviewing policies to ensure that the best clinical evidence and medical management practices are reflected in them. Attachment B includes a draft schedule for the policies scheduled to go through the Benefits Collaborative process in 2011.

- c. **Consolidating Utilization Review. Please provide any information regarding if the Department believes additional savings would result from better prior authorization of radiology services. If so, what's the Department's plan to accomplish this?**

RESPONSE:

The Department was given authority to consolidate utilization-management functions within a single vendor as well as the appropriated resources necessary to modernize utilization-management systems and processes through the Department's November 2, 2009 FY 2010-11 BRI-1 "Prevention and Benefits for Enhanced Value (P-BEV)" and January 25, 2010 FY 2010-11 BA-12 "Evidence Guided Utilization Review (EGUR)."

The Department's goal is to have a single utilization-management vendor that manages utilization for all State Plan services. This vendor will modernize the utilization-management program by focusing on using available technology, evidence-guided clinical practices, and innovative management practices to reduce unexplained variations in care, ensure client safety, and improve health outcomes. At the same time, the Department seeks to manage costs and minimize the administrative burden on providers in an effort to attract and retain them as partners, ultimately expanding client access to appropriate care. In addition, the Department would like to have a robust utilization-management program to support Medicaid reform and the Accountable Care Collaborative Program.

To move toward these goals, the Department contracted with a consultant in fall 2009 to research best practices for utilization review in other Medicaid programs and private insurance plans and make recommendations for program design to the Department. The Department formed a multi-disciplinary team to design a utilization-management program that is comprehensive and innovative but still feasible within the Department's technical systems and operational constraints.

Based on the authority provided by the budget items, the consultant's research, and work of the Department's multi-disciplinary team, the Department has drafted a Request for Proposals for a utilization-management vendor, which is scheduled to be posted and awarded by spring 2011.

In 2009, the American Board of Radiology Foundation held a national summit to discuss causes of and potential solutions to overutilization of radiology. Acknowledging that imaging services and costs have grown disproportionately to overall health care costs—and that some portion of the costs are likely attributable to applying imaging procedures in circumstances where they were unlikely to improve patient outcomes—the American Board of Radiology Foundation listed a number of potential methods to curb overutilization. Among these methods were prior approval systems or prior authorizations. The Department believes prior authorization of non-emergent radiology services is a key area of focus that could provide savings. In summer 2009, the Department began prior authorization reviews of non-emergent radiology services provided by free-standing radiology facilities. The Department's intent was to apply this prior authorization policy to hospital outpatient departments as well, but a claims system

issue prevented implementation from taking place as quickly as desired. The Department still plans to implement the policy at these sites and is working on solving the claims system issue.

**d. Colorado Regional Integrated Care Collaborative.**

RESPONSE:

Colorado is one of several states participating in a national collaborative sponsored by the Center for Health Care Strategies. The Colorado Regional Integrated Care Collaborative (CRICC) is a partnership among the Department, the Center for Health Care Strategies, local health plans and providers, consumer organizations and other stakeholders. The goal is to improve the quality of care received by Colorado Medicaid's highest-need, highest-cost clients by better coordinating the currently fragmented physical health, mental health, and substance abuse services.

Colorado Medicaid's highest-need, highest-cost clients have been identified as Medicaid clients who:

- are age 21 years and older and are in the Aid to the Needy Disabled/Aid to the Blind (AND/AB) eligibility category, or;
- are pensioners under age 65 (OAP-B) eligibility category who are not eligible for Medicare, enrolled in any Home- and Community-Based Services waiver program (other than the Mental Illness program), and live in one of the targeted counties.

Colorado has implemented two CRICC projects within the Medicaid program with Colorado Access and Kaiser Permanente.

Colorado Access implemented their program in April 2008 as a fully capitated at-risk contract. Colorado Access' analysis of program expenditures early in the project showed that the costs of providing services were exceeding the capitation, which put into question their ability to continue with the program. To facilitate their continuing participation and continue receiving the benefits of the work Colorado Access has put into the project, the Department converted the Colorado Access contract from a fully capitated at-risk to a no-risk enhanced primary care case management (PCCM) contract. The Department included an adjustment for this transition in its February 15, 2008 FY 2008-09 S-1 "Request for Medical Services Premiums." Under the PCCM model, the Department pays a per-member per-month fee to Colorado Access for case management services, and medical services are reimbursed directly to the provider on a fee-for-service basis.

Colorado Access has been successful in identifying eligible clients to participate in the CRICC program and now has 1,918 enrolled clients. The services provided to these clients include coordinating all medical benefits and services, facilitating collaboration among providers, and communicating care decisions with the client, caregivers, and client representatives. They are designed to provide a client-centered approach to integrating care across providers and types of care, thereby reducing or preventing

incidences of emergency room visits, hospitalizations, secondary disabilities, and institutionalizations.

The second CRICC project implemented by the Department is with Kaiser Permanente. This project was implemented in August of 2009, and Kaiser currently has 506 enrolled clients. Kaiser provides services similar to those provided by Colorado Access – assisting members with coordination of medical benefits and services and improving collaboration among providers, the client, caregivers, and client representatives. Kaiser has made several enhancements to the data tools that help them understand members' level of need, including the triage questionnaire and health risk assessment.

Because the study was developed to assess the effectiveness of intense care management over the duration of the pilot program, information about the effectiveness of the interventions as well as potential cost savings will not be available until the end of the study.

Both Colorado Access and Kaiser self-report trends that show decreased emergency room utilization in their populations. Both parties feel this is a direct result of the enhanced PCCM services and are hopeful that these results will be confirmed by the formal analysis and evaluation.

The Department's third-party evaluation and analysis group, MDRC, is scheduled to complete an interim evaluation of Colorado Access by April 2011 with a final evaluation completed early 2012. MDRC is scheduled to complete an interim evaluation of Kaiser's client data by July 2011 with a final evaluation completed in late 2013. The time differential between interim and final evaluations is subject to a number of variables. Colorado Access, being the first to implement the program and the first to complete enrollment, has had to address program issues concerning data. For this reason, the interim report was delayed, creating a smaller period of the time between interim and final evaluation. Rather than schedule the Kaiser interim and final evaluations to conform with Colorado Access' timeline, the Department felt the original schedule should be maintained.

- e. **Recent Payment Recovery and Fraud Detection Activities. Please explain the differences in recoveries on a yearly basis. Please provide information on how the Department matches records with other records such as death certificates to ensure the payments are not made improperly. Please provide how the Department interacts with the Attorneys General Office.**

RESPONSE:

There are several different mechanisms within the Department to conduct payment recoveries and several approaches for detecting and deterring fraud in the Medicaid program. The payment recoveries and fraud detection mechanisms are described below. Attachment C outlines the payment recoveries for FY 2006-07 through FY 2009-10 and explains the variances over the past several fiscal years. Several of the Department's payment recovery activities are conducted by vendors who specialize in specific areas

such as date of death matches, contingency based payment error contracts and many of the payment reconciliations.

### Recovery Projects: Benefits Coordination Section

The Benefits Coordination Section at the Department pursues responsible third parties for payment of medical costs for Medicaid eligible clients. The areas of recovery are described as follows:

- *Estate Recovery*  
The Estate Recovery project is a federally mandated program that requires the State to recover the cost of benefits paid on behalf of a Medicaid client from their estate. Liens are placed on property owned by the Medicaid client if it has been determined that this individual is unlikely to return home from a nursing facility. In addition, upon the death of certain Medicaid clients, claims are filed against the estate of this client for the Medicaid benefits paid on their behalf. The recoveries are almost exclusively the result of home sales and depend upon the real estate market which explains the fluctuations from year to year.
- *Trusts (Repayment)*  
This activity involves the recovery of funds where the Department is the beneficiary of trusts established for Medicaid eligibility. Income Trusts, Home- and Community-Based Services Trusts, and Disability Trusts, are established so Medicaid clients may receive medical assistance benefits when the clients do not meet the standard income and resource requirements for Medicaid eligibility. The Department is the beneficiary of these trusts and is to receive the remainder of trust account balance, up to the amount of benefits paid by Medicaid either at the time the client no longer meets the criteria or after the death of the client.

Repayment occurs when a client with excess resources exercises their option, as part of their spend-down, to repay Medicaid for benefits already paid on their behalf. The repayment of Medicaid expenditures is an acceptable and allowable means of spending down excess resources to meet Medicaid eligibility resource requirements to retain Medicaid eligibility. This repayment of Medicaid expenditures is often preferred over the option of losing Medicaid eligibility and using the excess resources for private pay and then reapplying for Medicaid once the excess resources have been utilized for the client's care and the client's eligibility resource requirement is again met.

- *Tort & Casualty Recovery*  
The Tort and Casualty recovery project recovers the cost of benefits paid on behalf of a Medicaid client related to an accident or other tort action where a third party was liable for these payments. Recoveries are made from statutory liens the Department has on a Medicaid client settlements. Recoveries have steadily improved due to better education of the trial bar concerning the need to notify the Department of tort actions. In addition, rate increases for providers over the years may be reflected in these recoveries.

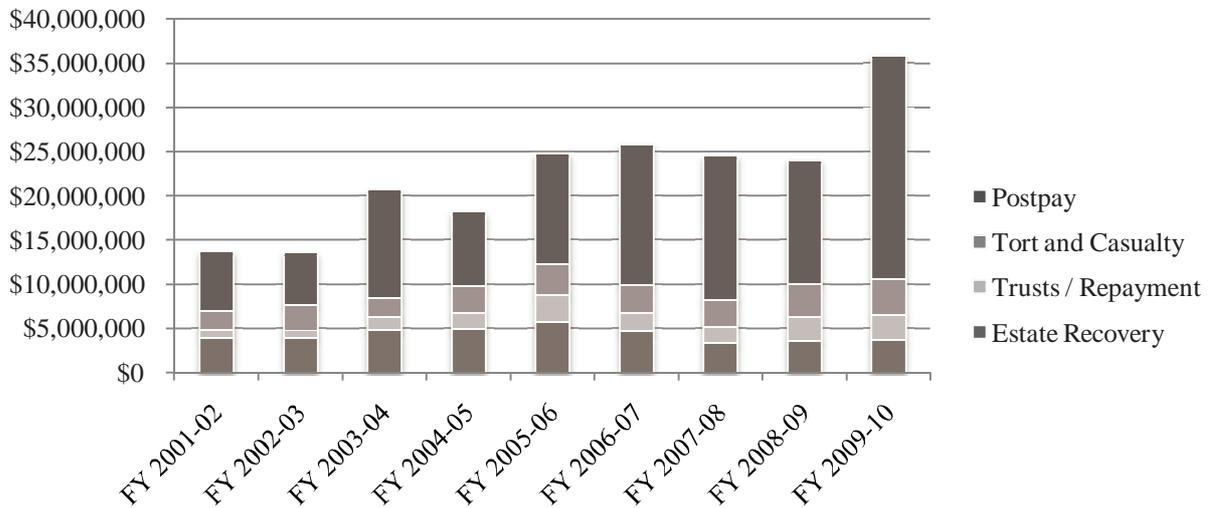
- *TPL Post-Pay Recovery*

The third-party liability (TPL) Post-Pay Recovery project recovers the cost of benefits paid on behalf of a Medicaid client where a third party was liable for these payments. This recovery project encompasses several separate and distinct recovery programs. The post-pay recovery projects currently include the following: Medicare Recoveries, Commercial Insurance Recoveries, Provider Retractions, Date-of-Death Recoveries, and Cost Avoidance. These recoveries have improved markedly from year to year due to implementation of special recovery projects, as well as population expansion which brings more private insurance coverage into play.

**Benefits Coordination Recoveries  
FY 1992-93 through FY 2009-10**

<b>FY</b>	<b>Estate Recovery</b>	<b>Trusts / Repayment</b>	<b>Tort and Casualty</b>	<b>TPL Post-Pay Recovery</b>	<b>Total</b>
<b>FY 1992-93</b>	\$5,575	\$0	\$0	\$0	\$5,575
<b>FY 1993-94</b>	\$418,224	\$0	\$0	\$0	\$418,224
<b>FY 1994-95</b>	\$883,217	\$404,876	\$0	\$0	\$1,288,093
<b>FY 1995-96</b>	\$1,989,421	\$648,822	\$2,304,640	\$0	\$4,942,883
<b>FY 1996-97</b>	\$2,559,513	\$775,644	\$1,473,386	\$0	\$4,808,542
<b>FY 1997-98</b>	\$2,727,744	\$780,075	\$2,222,052	\$0	\$5,729,871
<b>FY 1998-99</b>	\$2,596,736	\$893,068	\$1,606,242	\$0	\$5,096,047
<b>FY 1999-00</b>	\$3,376,330	\$679,796	\$2,226,093	\$0	\$6,282,219
<b>FY 2000-01</b>	\$4,904,163	\$1,122,958	\$2,005,849	\$0	\$8,032,971
<b>FY 2001-02</b>	\$3,845,730	\$985,794	\$2,072,609	\$6,760,553	\$13,664,686
<b>FY 2002-03</b>	\$3,878,211	\$877,556	\$2,896,459	\$5,924,334	\$13,576,559
<b>FY 2003-04</b>	\$4,810,033	\$1,449,835	\$2,172,858	\$12,266,943	\$20,699,670
<b>FY 2004-05</b>	\$4,918,434	\$1,766,756	\$3,073,386	\$8,393,451	\$18,152,028
<b>FY 2005-06</b>	\$5,740,617	\$3,036,907	\$3,502,154	\$12,446,404	\$24,726,081
<b>FY 2006-07</b>	\$4,656,903	\$2,049,119	\$3,161,970	\$15,933,332	\$25,801,324
<b>FY 2007-08</b>	\$3,349,036	\$1,801,392	\$3,045,847	\$16,332,211	\$24,528,486
<b>FY 2008-09</b>	\$3,555,977	\$2,675,299	\$3,800,728	\$14,013,844	\$24,045,848
<b>FY 2009-10</b>	\$3,682,865	\$2,800,403	\$4,030,094	\$25,364,406	\$35,877,768
<b>TOTALS</b>	<b>\$58,869,010</b>	<b>\$24,042,261</b>	<b>\$41,069,896</b>	<b>\$125,720,365</b>	<b>\$249,701,532</b>

## Benefits Coordination Recoveries FY 2001-02 through FY 2009-10



### *Data Matching*

The Department’s third-party liability vendor Health Management Systems (HMS) employs data matching with a variety of databases to determine whether or not another payor exists to ensure Medicaid is the “payor of last resort.” HMS matches records with the following databases: workers compensation benefit claims files; department of motor vehicle files; police department accident reports; commercial health insurance and casualty carriers; private health plans and managed care organizations eligibility data; long-term care carrier data; Medicare – original and managed care data; pharmacy benefit managers; child support databases; probate court filings; state court administrators office records; real property ownership and tax records. In the case of ensuring that claims are not being paid following the date of death, HMS uses several sources to determine the appropriate date of death including: MMIS; Vital Statistics; Social Security Death Master (SSD);and, Medicare Eligibility Database (EDB).

### Recovery Projects: Program Integrity Section

The Program Integrity Section is located in the Audits and Compliance Division of the Department. Program Integrity coordinates Medicaid fraud, waste and abuse control activities of Medicaid enrolled providers rendering/supplying covered services/items for eligible Medicaid clients. Program Integrity, through audit, investigative, fraud detection and enforcement efforts, recovers state and federal funds that have been inappropriately claimed by providers. Assuring that providers meet Medicaid quality and compliance standards for delivering covered services or items to eligible Medicaid clients in a system free of waste, fraud and abuse is an important component of the Department’s mission to improve access to cost-effective, quality health care services for Coloradans. Federal law mandates that the single state agency have program integrity responsibilities and that

Program Integrity be structured within the single state agency that has the overall administrative responsibility for the Medicaid program.

### Provider Recoveries

#### *Contingency-Based Contractor*

The Department's contingency contractor, Health Management Systems, focuses on the review of diagnosis-related groups (DRG) hospital claims. These reviews include, but are not limited to:

- transfer errors (i.e., billing for the entire DRG when the billing should be prorated because the client was transferred from another hospital which also billed for services);
- readmission errors (i.e., billing for a second hospital stay that is less than 24 hours after the first);
- coding and grouping errors (e.g., upcoding, duplicate claims, using the wrong codes);
- correct setting errors (i.e., billing for an inpatient DRG level of care when the order was for outpatient observation level of care), and;
- unbundling errors (i.e., billing separately for several different procedures when one consolidated procedure should be billed instead).

The contingency contractor also conducts ongoing provider education that includes:

- providing explanatory exit conferences prior to mailing the initial overpayment notice letters;
- supplying providers with written rationale for each claim overpayment and with suggestions for avoiding the mistakes in the future, and;
- publishing newsletters that highlight broad descriptions of audit results as a way to communicate common errors to the provider community.

#### *Medicaid Recovery Audit Contract Program*

The Medicaid Recovery Audit Contract (RAC) is a federal requirement arising out of section 6411 of the Patient Protection and Affordable Care Act. It requires all states to establish programs similar to the Medicare RAC program by December 31, 2010. The proposed rules for the state-Medicaid RAC program would require each state to have at least one contingency contractor assigned to review its Medicaid claims for overpayments, underpayments, fraud, waste and abuse. The Department is currently in the process of procuring a private vendor to be Colorado's Medicaid RAC.

#### *Medical Record Review*

The Claims Investigation Unit (CIU) is a sub team contained in the Program Integrity section dedicated to the review of claims submitted by providers. CIU may conduct site

reviews, desk audits, medical records reviews, claims and data mining reviews. Federal and State regulations mandate that any identified overpayments shall be recovered. If fraud is suspected, those cases are referred to the Medicaid Fraud Control Unit (MCFU), an oversight agency that functions out of the Colorado Department of Law in the state Attorney General's office.

CIU conduct audits and reviews of Medicaid providers to ensure compliance with program requirements and to determine the amount of any overpayments made. CIU staff have experience in a broad range of health care programs, and have subject matter expertise about various types of medical providers. This affords the Department the opportunity to organize and coordinate statewide projects to address the broad spectrum of Medicaid-covered services. Audits and reviews of Medicaid providers are performed by state staff, augmented by Department contractors, and the contractors of federal partners.

#### *Data Analysis and Data Mining*

Statistical analysts support external investigations with data analytics. The statistical analysts also conduct large data reviews to identify overpayments. These projects often identify many providers with large cumulative total overpayments. Even though the project identifies large dollars overpaid, each individual provider has the same due process rights that can take months and months to conclude. Data projects also identify system edit errors, corrupt data, artifacts in data, and incorrect data in the system. System corrections result from these findings which contribute to cost avoidance.

Further, in FY 2008-09 the Department was appropriated funding to purchase fraud detection software called the Enterprise Surveillance Utilization Reporting System, or ESURS. This software is an upgrade of the Surveillance Utilization Reporting System previously utilized. This functionality marks a significant departure from the previous system which allowed only for monthly reporting which was utilized by only a small number of Department employees. Utilization reports are used to identify statistically deviant behaviors in billing patterns. Transition to the new system marked a paradigm shift for the Department; with ESURS, the Department can now proactively identify potential fraud, errors and abuse rather than responding only to external fraud and abuse referrals. Further, the system's statistical reporting capabilities allow the Department to build stronger cases against those abusing the Medicaid system.

#### Global Settlements

A global settlement is a legal agreement that addresses or compromises both civil claims and criminal charges against a corporation or other large entity. Currently the Medicaid Fraud Control Unit coordinates the Global Settlement activity.

#### Cost Avoidance, Taskforces, And Provider Education

Many of Program Integrity's initiatives do not always see "dollars" in recoveries but result in cost avoidance and improving the integrity of the Medicaid program. This

occurs by terminating unlicensed or excluded providers, conducting provider education and partnerships with other agencies that are geared toward deterring fraud. These initiatives are described below.

- *Colorado Healthcare Fraud Taskforce*

The Department is joining with health care entities across the state in a collaborative effort to identify fraud. These entities include but are not limited to the Office of the Inspector General (OIG), Federal Bureau of Investigation (FBI), Immigration and Customs Enforcement (ICE), Drug Enforcement Agency (DEA), United States Attorney's Office (AUSA), Medicaid Fraud Control Unit (MFCU), the State Attorney General's Office, TriCare and Medicare. As providers that commit fraud impact multiple entities, the entities benefit by sharing information when fraud is discovered. The Department believes that this partnership will not only allow for the detection of fraud that might not otherwise be detected, but will additionally serve as a deterrent to fraud.

- *Partnership with the Medicaid Fraud Control Unit (MFCU)*

PI maintains a close working relationship with the MFCU. The MFCU is located in the Attorney General's Office. There is a dedicated 0.5 FTE to liaison with the MFCU and other investigative partners.

When fraudulent activities are suspected by PI staff, a referral is made to MFCU. If the activities are not provable as criminal activity, MFCU also now has a false claims unit which will also evaluate the referral for civil prosecution. PI supports MFCU by responding to requests for data, personnel specialty and contact information, provider agreements, and rule citations. PI staff are available to testify if needed during any MFCU prosecution in court.

The Department also actively partners with MFCU to educate managed care organizations in how to detect and report provider fraud. While managed care organizations are legally bound to report provider fraud within the organization, this was not occurring prior to the Department working with MFCU to educate organizations. Since the Department has joined with MFCU in educating managed care organizations, multiple fraud referrals have been generated.

In addition, with the passing of Colorado's False Claims Act in 2009, MFCU has both a criminal and civil section so referrals to MFCU are vetted for criminal and civil false claims investigations. This expands the ability to prosecute providers for false claims.

- *Monitoring for Excluded Providers*

PI also monitors to ensure that federally excluded providers are not participating and receiving Medicaid payments. PI has identified some excluded providers that have attempted to receive reimbursements. These providers are terminated from participation and referred to law enforcement for violation of their excluded status. This monitoring activity results in cost avoidance.

- *Monitoring Professional Licensing Sanctions*

If Medicaid participating providers are required to maintain a current and active professional license to practice in Colorado, PI monitors those Colorado licensing boards' disciplinary actions. When a Medicaid provider's license is revoked, has a summary suspension, is relinquished, or limited in any way, PI takes appropriate action to limit or exclude their participation in the Medicaid program. Since offenders cannot practice in Colorado nor receive Medicaid reimbursement, PI will limit the procedure codes they can bill or terminates them from participation if licenses are not valid or current. In this manner, PI is preventing payments going to non-qualified providers. This equates to additional cost avoidance.

- *External Investigative Support*

PI supports investigations of Medicaid providers conducted by the OIG, FBI, ICE, DEA, MFCU investigators, the AUSA, and the State Attorney General's Office. PI staff provide subject matter expertise, expert testimony, data analytics, records review, professional opinions, and Medicaid specific documentation needed for the investigation. Supporting external investigations does not equate to overpayment recoveries but it does support getting aberrant providers out of the program, which contributes to more cost avoidance.

- *Provider Education*

PI analyzes cumulative desk and data review findings. When a trend in errant provider behavior is identified, PI works with policy staff to devise methods of educating providers on how to correct the issues which will prevent overpayments and recoveries. The "issue" is monitored by PI to determine if errant provider behaviors resolves and the overpayments are reduced or stopped. In this manner, PI is further contributing to cost avoidance.

In each desk audit case summary, providers receive education on the issues identified in the review that resulted in overpayment identification. With each review conducted, PI looks in the archives of the past five years of cases to determine if the provider in review has been individually educated previously. Providers who receive education but continue to disregard the rules, bulletins, billing manuals or other instructions are referred for false claims or fraud investigation, and may have their payments withheld or could be terminated from participation for good cause.

PI participates in education of provider coalition groups, professional associations, at conferences and by Medicaid Provider Bulletin articles. These activities do not bring in dollars nor equate to cost avoidance, but contribute to the "sentinel effect." The sentinel effect theory is that it prevents providers from committing fraud or submitting false claims. Just knowing they are being watched is enough to prevent bad behavior.

#### Recovery Projects: Controller Division, Accounting Section

The Controller Division's Accounting Section at the Department receives and deposits recoveries from a variety of sources. The Accounting Section not only receives and

deposits provider recoveries but also client recoveries. The areas of recovery are described as follows:

- *Client Fraud*

All 64 counties in Colorado have County Fraud investigators that audit claims having been paid throughout the State. The Department of Human Services also conducts fraud investigations. The Department is actively investigating methods of improving detecting and recovering client fraud. The Department does not currently have any FTEs specifically allocated to this task and is currently utilizing internal audit staff. The Department believes that it would be beneficial to have additional staff that could utilize data mining and investigative techniques to deter client fraud.

Currently, when a determination has been made that clients received Medicaid services fraudulently, the investigators process a recoupment through the system that the original claim was paid/processed. Claims are paid/processed through the TRAILS System or the Medicaid Management Information System. When the recoupment is entered into these systems, at month-end the county financial management system (CFMS) is updated. Collections are handled at the same rate they were originally paid out. In the majority of instances this is a 50% General Fund and 50% Federal match.

The CFMS system is closed mid-month and reports are generated so that the Department reimburses the counties for the recoupments they have made on behalf of the Department.

- *Collections And System Generated Accounts Receivables*

Account Receivable (AR) balances are created from system adjustments related to rate adjustments, audit findings, and provider internal audits and take backs. Most often these ARs are established in the Medicaid Management Information System (MMIS) through documented requests from the Department to its fiscal agent Affiliated Computer Systems (ACS). Providers may also adjust their own claims from the Web Portal and can setup take backs from future claims.

Providers are sent to Collections when ARs in MMIS are found to be over 60 days overdue. Each provider has to be reviewed in order to prove that the AR due to the State is legitimate and should be processed further or adjusted as appropriate. Providers may also be sent to Collections based on requests made by the Department's Program Integrity Section and Long-Term Care Benefits Division.

- *TPL/ACS Recoveries*

These recoveries are sent to the Department by its fiscal agent, ACS. This type of recovery may occur when a provider identifies a billing error through its own internal audit and returns payment with a record of the associated claims to ACS in order to correct the error. ACS will void the associated claims in the MMIS and then sends the payments with the necessary supporting documentation to the Department's Accounting Section so the provider payment can be deposited and the corresponding

expenditures can be adjusted in the State's financial system, the Colorado Financial Reporting System (COFRS). Accounting has no control over the volume of these types of recoveries since these types of recoveries are provider driven. The Accounting Section is just the depositor and recorder of these funds.

#### Recovery Projects: Rates and Analysis Division

The Rates and Analysis Division conducts reconciliation for capitated managed care programs and the Department's hospital program.

#### *HMO/PACE Recoveries*

For Managed Care Organizations (MCO) contracted with the state, the Department audits capitation payments by fiscal year. At the end of every fiscal year a monthly client eligibility snapshot is created which allows the Department to calculate the monthly capitation amounts that should have been paid to the MCO on behalf of eligible clients. These amounts are decided by a number of client details that may or may not be determined retroactively, including eligibility categorization, institutionalization, third party liability, date of birth, date of death, etc. A corrected aggregate capitation payment amount is then compared to the amount of actual capitation claims processed and paid as provided by Medicaid Management Information System (MMIS). Any differences are annotated and submitted to the MCO for settlement.

#### *Hospital Cost Settlements*

Outpatient hospital claims are paid at a percentage of costs; however, because actual cost is not known until after the hospital cost reports are audited (up to two years later), hospitals are first paid an interim rate based on the hospital's cost-to-charge ratio. After the cost reports have been audited by Medicare and the claims data is available from the MMIS, the Department initiates a financial audit process to settle the difference. In a majority of cases, hospitals owe the Department money as a result of the financial audit process and a recovery is initiated. All outpatient hospital services are paid in this manner except physical therapy, occupational therapy, and laboratory services which are paid either on a fee schedule or submitted charges, whichever is lower.

#### *Mental Health Reconciliations*

The Department permits retroactive enrollment in a Behavioral Health Organization (BHO) if a client is retroactively determined to be Medicaid eligible. Once a client is determined to be retroactively Medicaid eligible and BHO enrolled, the Medicaid Management Information System (MMIS) automatically reimburses the BHO. However, the MMIS does not automatically recover payments made for clients that are retroactively determined to be ineligible for Medicaid. Therefore, the Department must manually recover capitation payments paid to the BHOs for retroactively ineligible clients during a fiscal year. Additionally, the Department reviews the file of retroactively eligible clients and reimburses the BHOs if MMIS, in error, did not automatically reimburse the BHOs.

### Recovery Project: Long-Term Care Benefits Division

The Department is statutorily required to audit costs as reported by Medicaid nursing facilities and any overpayments to providers must be recovered. The Department conducts billing audits each year of facilities to ensure the patient personal needs allowance and the patient payment amount are calculated properly. In addition, the auditors review the Post Eligibility Treatment of Income calculation which allows clients to pay for medically necessary items that are not covered by Medicaid. The Department's auditors evaluate these items to identify inaccuracies and determine the amount of recoveries due.

### Recovery Projects: Pharmacy Section

#### *Drug Rebate*

The Drug Rebate Program is a federal program that was established with the enactment of, section 4401 of the Omnibus Budget Reconciliation Act of 1990, Publication L. Number 101-508, and section 1927 of the Social Security Act, 42 U.S.C. 1396s. Beginning in 1991, all states except Arizona (all managed care) bill quarterly all drug manufacturers that supply Medicaid recipients with their drugs, a rebate roughly equivalent to the average manufacturer price. The invoices reflect the totals of the drug, utilization, prescriptions, third-party payments, and total pharmacy reimbursement. With the new federal health care reform, the manufacturer now supplies the unit rebate amount to complete the billing. The invoices are mailed out 60 days after the end of the calendar quarter and monies are due 37 days after receipt of the invoice. In 1996, the Department received approximately \$20 million from drug rebates. The program has grown dramatically with over 700 manufacturers and now rebates total well over \$100 million.

### **10. Please provide information regarding the implementation of S.B. 10-167 (Colorado Medicaid False Claims Act).**

RESPONSE:

#### *Implementation by the State Attorney General*

The Attorney General's Office has hired a First Assistant Attorney General (AG) and two investigators to develop and track false claims litigation, regardless of where the action is pending. The AG has been tracking approximately 40 cases that have been brought under the Colorado State False Claims Act (CSFA). Most of these cases were pending before passage of the CSFA, but the plaintiffs have amended their complaints since passage to allege a claim as a Colorado whistle-blower. So far this fiscal year, six global settlements have brought in \$2,350,939. Last year's recoveries totaled \$4,153,017 for 11 global settlements. These amounts do not include the additional 10% federal share dependent upon certification of the statute by the Office of the Inspector General (OIG).

### *Status of OIG Certification*

While the Department's bill was being considered for passage by the General Assembly, at the national level, Senator Charles Grassley penned a strongly-worded letter to the Department of Justice where he decried the pernicious effects of "1st to file" provisions in state *qui tam* laws and urged the Justice Department to advise the OIG to disapprove state false claims statutes that contained the offensive provision. His justification is that such provisions keep plaintiffs from coming forward to report fraud.

The CSFA contains a "1st to file" provision which was designed to prevent the State from paying multiple *qui tam* awards for outing the same fraudulent acts. OIG guidance leading up to the FFY 2009-10 session seemed to accept "1st to file" provisions, and the OIG technical guidance team assigned to Colorado specifically stated that if the clause had been interpreted to be at odds with the certification requirements, the OIG would have pointed that out in its correspondence.

The impact of Senator Grassley's letter has been to delay the OIG approval process. In response to monthly queries regarding progress, assigned OIG technical representatives have told the Department that it must wait until the end of the year to obtain a status on the certification of the CSFA by the OIG.

### *HIBI*

The Department is negotiating with its Third Party Liability (TPL) contractor to perform this work. Assuming that a contract is executed and Department data is successfully transferred to the contractor by March 1, 2011, the Department anticipates enrolling 1,000 of the targeted 2,000 HIBI participant ceiling set forth in MEA.

### *PARIS*

The Department is working with the Governor's Office of Information Technology to make changes in the Colorado Benefits Management System reporting to allow for a matching of PARIS data to verify that Medicaid enrollment is limited to Colorado residents.

### *Pharmacy*

The Coordination of Benefits Manager will allow the Department's TPL vendor to check for other coverage on pharmacy claims prior to those claims being paid by the Medicaid Management Information System (MMIS), thus expediting coordination of benefits for pharmacy claims. This project is currently in the queue with the other projects requiring systems changes to the MMIS. The Department's fiscal agent estimates that the project will be completed in summer 2011.

### *Implementation of National Correct Coding Initiative (NCCI)*

Due to the passage of the federal Patient Protection and Affordable Care Act of 2010 on March 23, 2010, and subsequent guidance from the Centers for Medicare and Medicaid

Services (CMS) on September 1, 2010, the Department was required to alter its implementation of NCCI. Under SB 10-167, the Department patterned its initiative on some portions of the then-federal False Claims Act. Colorado proposed using two methodologies of medical claims edits and that it would have its system operational by March 2011. However, the federal mandate requires states to incorporate five methodologies of medical claims edits containing approximately 1.3 million edits per calendar quarter into their MMIS effective for claims filed on or after October 1, 2010.

Based on the earlier implementation date and with understanding from CMS, the Department is currently working with its fiscal agent to implement an interim solution in early calendar year 2011 that would meet some of the requirements of the federal mandate. The interim solution would remain operational until the Department and MMIS fiscal agent implement a full development solution meeting all the requirements of the federal mandate by July 2011.

**11. Has the Department ever reviewed whether serving clients through FQHCs save funding in other areas of the budget?**

RESPONSE:

The Department is in the process of completing a study to compare hospital and emergency room use among clients cared for by FQHCs and clients cared for through fee-for-service delivery. In the study, the Department controls for the fact that the FQHC population is different from the fee-for-service population because FQHCs serve more children under age 5 and fewer disabled clients.

The data collection and analysis are not yet complete, but initial results appear to indicate that FQHC clients do have lower rates of hospital and emergency room use. In interpreting the cost implications of these results, it is important to consider that FQHCs are not paid from the Medicaid fee schedule, but at an encounter rate based on their total cost of providing services.

The Department anticipates the article will be published in spring 2011 and looks forward to providing the outcome to the Joint Budget Committee at that time.

**12. Please provide information on Disease Management programs that the Department has implemented in the past. Which programs were cost effective and which programs were not and why not?**

RESPONSE:

Between 2002 and 2009, the Department entered into contracts for ten disease management programs: asthma, chronic obstructive pulmonary disease, diabetes, heart failure, high-risk obstetrics, intensive care management, neonatal intensive care, schizophrenia with medical conditions, telehealth and weight management. The programs ran for various lengths of time. The diabetes and asthma programs were in place for the longest amounts of time, five and seven years, respectively. The other programs were in place for one to three years.

Neither the diabetes program nor the schizophrenia with medical conditions program showed cost effectiveness after vendor and independent evaluations. The balance of the programs, except for the neonatal intensive care program, was evaluated solely by the vendors. The programs were shown to decrease emergency room visits and hospital admissions, however savings above program costs were not always evident. There are several different methods to calculate expenditure reduction attributable to disease management programs. Each method contains inherent problems primarily because of benefit changes over time and because claims costs for some conditions are cyclical – for example, a costly hospitalization may occur once every year or two, creating a false view of cost savings or cost increases.

All programs encountered challenges in keeping clients engaged longer than three to six months, obtaining accurate client contact information to reach the entire affected client population, and maintaining a connection with the client via the telephone.

Although the cost effectiveness of these programs is inconclusive, the Department has determined that disease management programs that focus solely on a single disease or subpopulation are not in keeping with the Department's new direction. Instead, the Department is moving toward integration of services and treating the whole client, for which there is more evidence of success in the health care management literature. As a result, the Department is pursuing delivery system reform like the Accountable Care Collaborative Program that integrates traditional medical management and disease management functions into the overall responsibilities of the accountable care organizations. Programs such as these will likely bring better and more consistent health outcomes, as well as success in cost management.

**13. Should the State look at going back to a managed care model for the entire Medicaid program? What would be the impact of this? Is it feasible?**

RESPONSE:

The Department is returning to a managed care model with the implementation of the Accountable Care Collaborative (ACC) Program. Historically, the fully capitated risk contract model has not been effective in Colorado Medicaid. The ACC Program design supports a paradigm shift from a volume-driven, fee-for-service model to a coordinated outcomes-based system that will control costs in a responsible manner. It is a new managed care model for coordinating care that works within the fee-for-service system. The ACC Program is designed to improve health outcomes of Medicaid clients through a coordinated, client/family-centered system that proactively addresses clients' health needs, whether simple or complex, and controls costs by reducing avoidable, duplicative, variable and inappropriate use of health care resources.

The ACC Program differs from a traditional capitated managed care program by investing directly in community infrastructure to support care teams and care coordination. It creates aligned incentives to measurably improve client health and reduce avoidable health care costs. The ACC Program makes the people and organizations that actually provide the care accountable for the quality and the cost of that care. The fundamental premise of the ACC Program is that communities are in the best position to make the changes that will address the

cost and quality problems resulting from our system of fragmented care, variation in practice patterns and volume-based payment systems. The ACC Program strengthens the infrastructure necessary to make this paradigm shift.

Implementation of a managed care system such as the ACC Program is underway. Please see the Department's response to Question 9b.

**12:00-1:30: LUNCH BREAK**

**1:30 – 2:30: IMPACT OF RECENT AND PROPOSED BUDGET REDUCTIONS TO THE MEDICAID PROGRAM**

*Overview of Provider Rate Reductions*

**14. Please describe how the Department has implemented the provider rate reductions since the downturn? Were the rate reductions across the board or did they hit certain providers harder? Please provide how rate reductions have impacted services to elderly or the children populations?**

RESPONSE:

The Department has made substantial efforts to find alternative measures to provider rate reductions, including streamlining rates to create savings with efficiencies. However, at times, these methods were not adequate to address the full savings requirement, and provider rate reductions were necessary. These rate cuts were then implemented using two forms of rate reductions:

- *Across-the-Board Rate Reductions*  
Beginning in July 2009, these rate reductions were administered incrementally and affected nearly all providers equally. Rate decreases were applied in this fashion to maintain parity and fairness to providers. The incremental impact of the four rate reductions since July 2009 has been 5.39%.

<b>Across-the-Board Cuts</b>	<b>Rate Reduction</b>
<b>FY 2009-10</b>	
July 2009	2.00%
September 2009	1.50%
December 2009	1.00%
<b>Total FY 2009-10</b>	<b>4.44%</b>
<b>FY 2010-11</b>	
July 2010	1.00%
<b>Total FY 2010-11</b>	<b>1.00%</b>
<b>Total Rate Cuts to Date</b>	<b>5.39%</b>

\* Please note that rate cuts are multiplicative, so will not *add* to the total.

- Exempt Groups: Some provider groups, such as Nursing Facilities and Hospice providers, have rate methodologies provided in statute and are less flexible to immediate change. While it is still possible to implement savings initiatives within these programs, direct changes to the rates require legislation. Since rate reductions to other services can be made more expeditiously, services with rates outside of statute often bear a disproportionate share of the responsibility of meeting short-term savings targets through across-the-board rate reductions.
- *Other Rate Reductions*  
These rate changes were in response to mandated appropriation reductions and part of the Department's January 15, 2009 FY 2009-10 S-25 "Provider Rate Cuts." These cuts were used to target specific services that were not aligned appropriately with similar services under Medicare. In particular, the Department requested to limit payment for procedure codes to a maximum of 100% of the Medicare rate. Any procedure code paid above the Medicare rate was reduced. However, some exceptions were made. For example, certain pediatric cardiology procedures were being paid at a rate much higher than Medicare. After discussions with provider groups, the Department reduced rates by only half of the difference between the Medicaid and Medicare allowable rate in order to prevent a hardship to these providers. These codes are still being reimbursed at a rate higher than Medicare.

The Department recognizes that any cut has an impact on the provider community. The Department's strategy for implementing rate reductions has been to minimize the impact by spreading the reduction across the entire spectrum of providers when possible. While the Department has received some general complaints from providers regarding rate reductions, the Department has not received an increase in complaints from the client community regarding changes in services as a result of the cuts.

The Department has not identified a quantifiable decrease in provider enrollment or the provision of services to the children or elderly population as a direct result of the rate reductions. However, the Department does not believe that there has been a disproportionate impact on either population. For example, the Department has not seen an overall decrease in the number of providers willing to serve Medicaid clients. See response 15 for further information.

**15. Has the Department had any indications that providers will leave the Medicaid program because of lower reimbursement rates?**

RESPONSE:

The Department continues to see consistent increases in the number of enrolled Medicaid providers. Between November 2008 and November 2010, provider enrollment has increased 14%. While new providers continue to enroll, the Department is concerned that further reimbursement rate decreases could potentially have a negative effect on provider enrollment

and the willingness of enrolled providers to see new Medicaid clients. However, to date, the Department has not seen a decrease in providers willing to care for Medicaid clients or an increase in client complaints regarding access to care.

In addition, the Department finds no evidence that access to care was inhibited in prior years when rate reductions were of a greater magnitude than the decreases applied to most services this state fiscal year. In the last several years prior to the recession, the Department was able to increase rates for many of the most utilized services, including evaluation and management services, as well as surgery and dental services.

The rate reductions implemented this fiscal year bring rates to levels that have, in the past, been adequate in maintaining provider enrollment and client access. The Department therefore anticipates that any impact of the recent rate reductions on provider enrollment or client access to care will likely be minimal.

<b>Average Monthly Unique Providers Submitting Claims by Fiscal Year</b>			
<b>Fiscal Year</b>	<b>All Provider Types</b>	<b>Physicians</b>	<b>Family/Pediatric Nurse Practitioners</b>
FY 2008-09	255,310	91,894	7,232
FY 2009-10	284,731	101,765	8,807
Percentage Change	11.52%	10.74%	21.77%

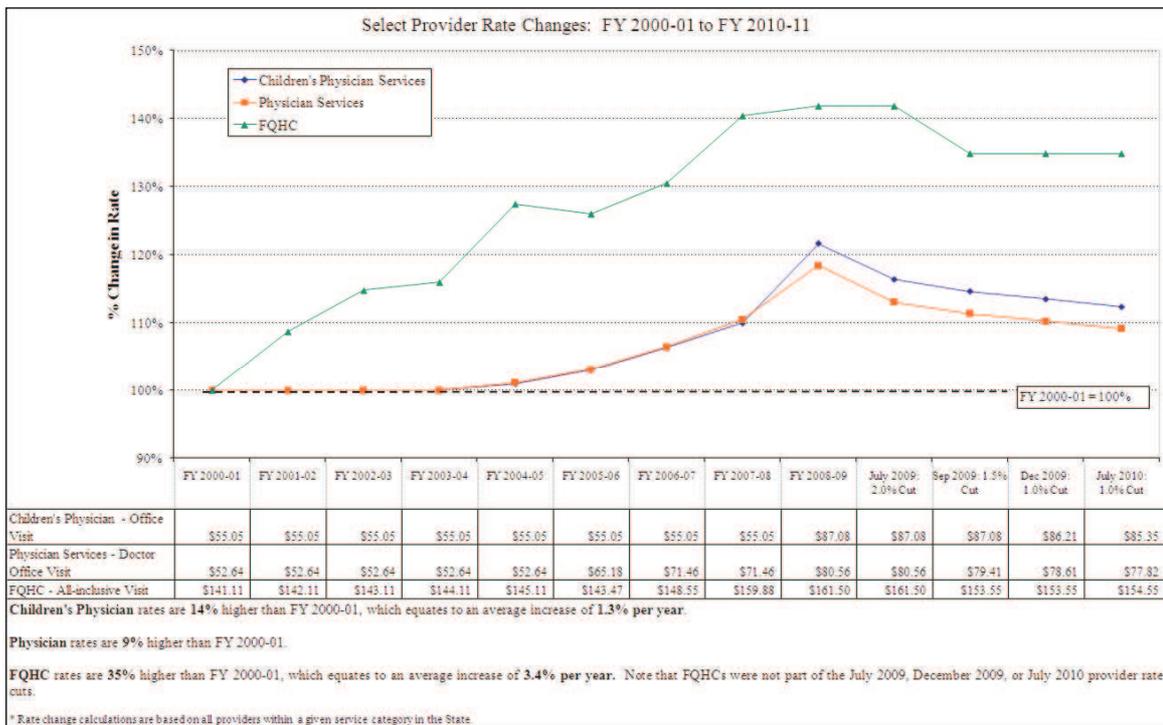
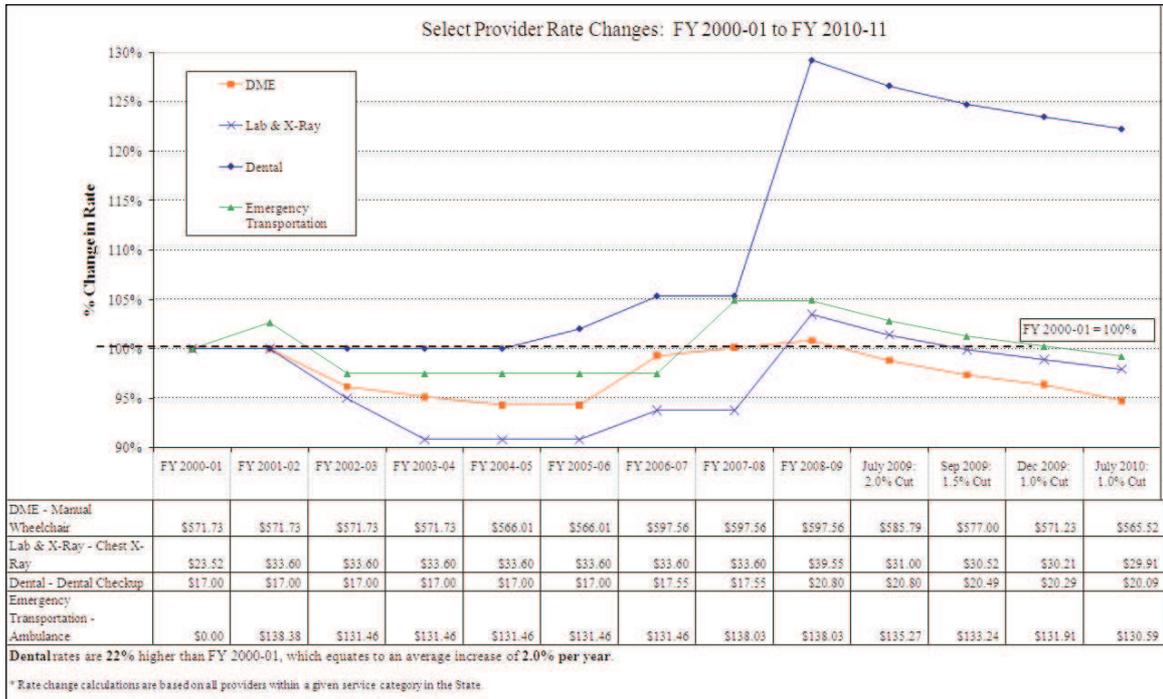
**16. What requirements, if any, do federal law or guidelines require to ensure provider rates are adequate or meet the cost of providing the service? Do the recent provider rate reductions risk Colorado being out of compliance with federal law?**

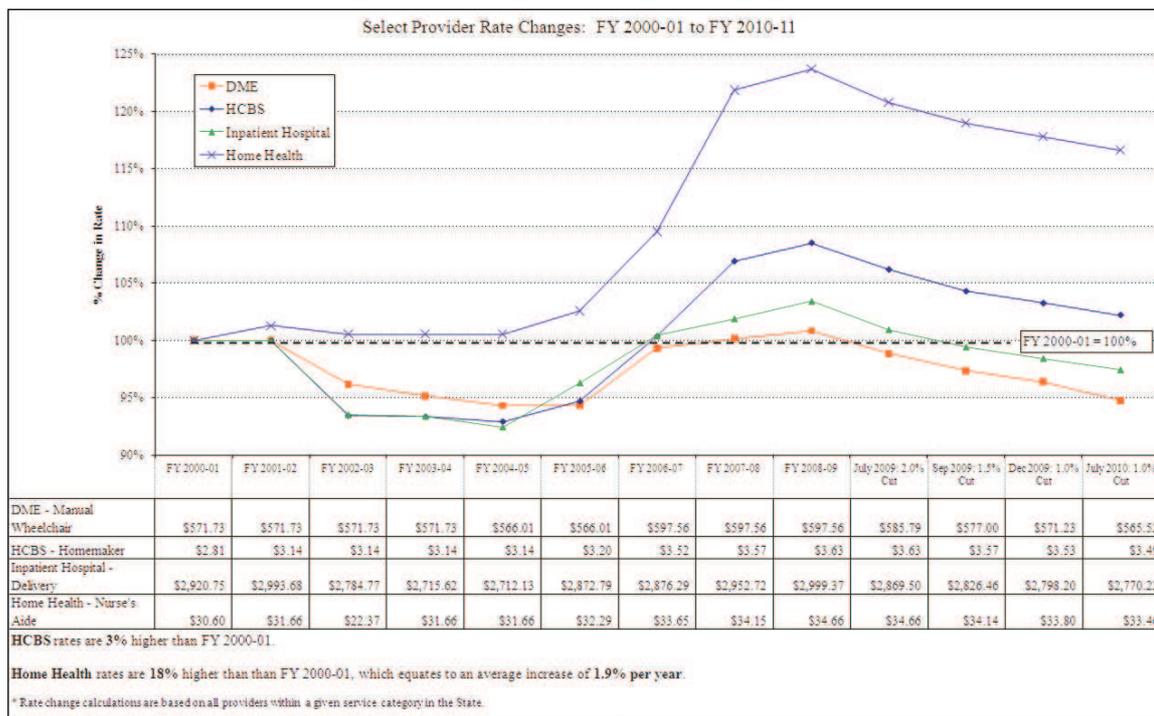
RESPONSE:

Federal law requires that payments for Medicaid be sufficient to enlist enough providers so that services under Medicaid are available to clients at least to the extent that those services are available to the general population (42 CFR 447.204). Except where specifically mandated by law for nursing facilities, hospitals, and other institutional settings (42 CFR 447.250), federal law does not specifically require provider rates meet the cost of providing the service.

**17. Please provide a graphic view of provider rates since FY 2000-01 compared against inflation adjustments for the area of service.**

RESPONSE:





The Department does not believe that standard medical inflation is applicable to Medicaid rates because reimbursement is capped at the Medicare limit. Because Medicare reimbursement does not change according to medical inflation rates, Medicaid rates are artificially capped. Thus, it would be misleading to adjust the Medicaid rates using the consumer price index to gauge the change in costs in real dollars.

**18. Explain how much savings would be achieved by another 1.0 percent provider rate reduction. Please show the results by service area and what the impact would be to providers. Is this a better option than payment delays. Please explain the payment delay impact on providers.**

RESPONSE:

The Department estimates that an additional 1% provider rate cut would result in a reduction of \$25,057,392 total funds, \$11,869,847 General Fund in FY 2011-12 and a reduction of \$27,005,195 total funds, \$12,779,057 General Fund in FY 2012-13. The Department's calculations by service category are included in Attachment D. The Department believes that a payment delay is preferable to provider rate cuts as the delay is a temporary budget action that allows the providers to receive the same payment amount, yet balances the budget. Rate cuts are permanent, which have a permanent negative impact on service providers.

Prior to the FY 2009-10 provider rate reductions, the Department started a state-wide communication effort to inform providers of fiscal limitations and legislative mandate to reduce expenditures. Throughout the discussions, providers and the Department worked together to create utilization/volume containment strategies and efficiency improvements that would generate the savings needed to avoid or reduce the permanent rate cuts. Both

providers and the Department agreed that rate cuts should be used as a means of last resort. Keeping this reaction in mind, the Department has worked to create a more streamlined process for implementing temporary payment delays to providers as an alternative to rate cuts. See question 20 for a description of the steps the Department is taking to mitigate the impact of the proposed payment delay on providers.

The Department has heard from providers that payment delays create cash-flow issues; in particular, small safety-net providers with a 100% Medicaid client base voiced concerns about their ability to make payroll and purchase necessary supplies for their patients. The general consensus, however, was that payment delays were preferable to further rate reductions.

**19. Is the Department aware of any other states that are delaying Medicaid payments as a way to balance their state budget?**

RESPONSE:

The Department used Internet research and posted a question on the National Association of State Medicaid Directors (NASMD) bulletin board to determine how other states process Medicaid claims payments and if they have used or considered using Medicaid payment delays. The information compiled could be summarized into three basic categories:

- 1) States that have neither used Medicaid payment delays in the past nor expect to use them in the near future: IA, ND, NM, TN, TX, WV, MO, NE, and NC
- 2) States that would not consider using payment delays due to losing enhanced federal financial participation after ARRA expires: CT, UT, NV and HI
- 3) States that have used payment delays in the recent past or are currently undergoing payment delays: ID, VA, MA, AL, and IL

For more information about the states in the third category, please see the following:

- Idaho: In a letter from the Idaho Department of Health and Welfare dated March 22, 2010, providers were advised that, due to the state budget situation, the Idaho Medicaid Program will suspend payments to hospitals and nursing facilities for a period of 8-12 weeks. The letter also indicated that all Idaho Medicaid providers will have their payments held for a period not to exceed 30 days. For those providers who do not have the cash reserves to operate without Medicaid reimbursement, Idaho Medicaid will be sending out letters that may be presented to banking institutions and other capitol management business partners to help to procure the necessary funds during the delay period. The letter will provide the average historical payment information for each provider. In an article from the August 28, 2010, Moscow-Pullman Daily News regarding the delays associated with the implementation of a new Medicaid payment system, it is mentioned that the new system was implemented on July 1, 2010, noting that “at that time Idaho enacted a three-week delay in Medicaid payments so the agency could balance its budgets.” Note that, based on

other sources, it seems likely that the July 1 date is when payments began after the three-week delay.

- Virginia: In a Medicaid Memo dated April 30, 2009, Medicaid providers were advised that remittance which would have normally been made June 26, 2009, would be paid on July 3, 2009. The memo also mentions that the Department of Medical Assistance Services anticipates that similar delays will be incorporated into future budgets but will be subject to approval of the General Assembly and the Governor at the appropriate time.
- Massachusetts: An article from the WBUR News and Wire Services on July 23, 2009, indicates that “some Massachusetts hospitals will not receive millions of dollars the state owes them for Medicaid patients until the new fiscal year begins July 1.” Note that the delay is blamed on a “new accounting system” rather than state budget balancing problems.
- Alabama: During most of CY 2008, the State of Alabama sent out the following weekly message: “The Release of direct deposits and checks for this remittance advice depends on the availability of funds. Please verify direct deposit status with your bank.” No evidence of an actual payment delay was found.
- Illinois: In an article that appeared in the 2008 version of Hospitals and Health Networks Magazine, it is reported that the Illinois Department of Healthcare and Family Services averaged 61 days for adjudication of its Medicaid payments in the previous fiscal year. It also mentioned that Illinois stretched out the payment cycle to ease an overall budget shortfall. It is noted that an increase in the state’s Medicaid budget would dramatically improve the payment cycle but at publication lawmakers in the state were still considering a budget that would lengthen the payment cycle from 70 days to 98 days in fiscal year 2009. In an article in the October 2009 issue of Illinois Issues published by the University of Illinois at Springfield, it is noted that Illinois lawmakers repeatedly have “delayed payments to Medicaid providers to free up cash for other expenses. They did it again this year.” It is noted that not all providers will be equally affected: “The delay will particularly affect Medicaid providers that don’t leverage extra federal reimbursements through [ARRA].” Pharmacists are expected to be the hardest-hit with delays of up to 150 days by June 30, 2010. Other hard-hit providers are home health aides for seniors, emergency and non-emergency transportation services, and medical equipment providers. However, hospitals and physicians are receiving Medicaid payments within 30 days. According to the article, the state will “phase in the delays throughout the year.” At the time the article was published, it was speculated that paying providers on time “would be more difficult in 2010, even with federal stimulus funds still flowing.” To help struggling providers, one lawmaker was working on proposals to “create a revolving loan fund to help give providers easier access to lines of credit.”

**20. Please explain the difficulties that result in the Department from implementing payment delays, including additional time needed to adjust forecast models. Please explain any difficulties that are experienced by the provider community when payment delays are implemented.**

RESPONSE:

The estimated hours for the Department's fiscal agent, ACS, to design, develop, and test the system changes in the Medicaid Management Information System (MMIS) which gives the Department the ability to effectively implement payment delay is estimated at 1,193 hours. In addition, provider relations staff at ACS will need to be trained to handle the additional call volume due to the provider payment delay.

The MMIS change for the fee-for-service delay is estimated at 582 hours and the managed care delay is estimated at 611 hours. The Department is currently using "pool hours" under the ACS contract to implement these MMIS changes. Pool hours can be used at the discretion of the Department. Due to the Department's desire to implement the payment delay in phases starting in April and minimize the cash flow impact on providers, the Department proceeded with the necessary MMIS changes required to implement the payment delay using pool hours. The Department's October 22, 2010 FY 2010-11 ES-2 "Fee-for-Service Delay in FY 2010-11" includes a cost of \$126,000 in funding for FY 2010-11 to back-fill the pool hours used to complete the system change and can be used to complete other system changes on the Department's priority list.

Though the Department has competing priorities for the pool hours under the ACS contract, the MMIS change to allow for the implementation of the payment delays has no measureable impact on other projects the Department can provide. It should be noted that the system change in the MMIS to allow the Department to implement the payment delay will be completed by early March 2011, so the pool hours will be used even if the payment delay is not implemented. The MMIS change is flexible enough to allow for a 1, 2 or 3 week delay at no additional cost or pool hours. This allows the Department to implement the payment delay through a transmittal and requires 5 business days notice to ACS.

The payment delay will impact the providers cash flow for the services provided to Medicaid clients. To reduce the impact, the Department has structured the delay to be spread out over a three month timeframe instead of a one-time impact. One of the major complaints the Department received with the payment delay in June 2010 was that providers did not receive enough advanced warning that the payment delay was going to be implemented. Therefore, the Department has proposed an approach that will give providers sufficient notice and recommends that a final decision to implement the proposed payment delay for the 1st week of April 2011 be made in early March 2011 to allow for sufficient noticing to providers.

The Department does not anticipate needing additional time or resources to adjust forecast models. The Department has updated its expenditure forecasting methodology to account for payment delays throughout its November 1, 2010 Budget Request, and does not anticipate any major methodological changes which would delay the submission of any standard budget request. Additionally, the Department has provided multiple forecasts for payment delays as

new information has become available. For example, forecasts were completed when the data became available on the actual impact of the two week delay that occurred at the end of FY 2009-10; this new information was used to inform the estimates of future impact. Additionally, as new caseload and per capita forecasts were made as part of the Department's November 1, 2010 Budget Request, the new information was similarly incorporated into new payment delay estimates.

It is of note that the additional federal funds available to the State as a result of the American Recovery and Reinvestment Act (ARRA) are due to expire on June 30, 2010. By delaying payments through the end of the ARRA period, the Department will not receive the enhanced federal medical assistance percentage for those claims that are delayed. As a result, the Department estimates that it would pay an additional \$13,668,180 in General Fund expenditure for those claims: \$8,588,048 for the fee-for-service delay and \$5,080,132 for the managed care delay.

Please see attachment G for more detail regarding payment delays and the MMIS priorities.

**21. Does the Department have any concerns regarding federal regulations requiring prompt payment if the department's proposal is implemented?**

RESPONSE:

The Department does not have any concerns regarding compliance with federal regulations regarding prompt pay requirement related to the Department's proposal to delay fee-for-service claim payment for three weeks and shift managed-care payments to a retrospective payment methodology. The Department's requests were included in FY 2010-11 ES-2 "Fee-for-Service Delay in FY 2010-11" and ES-3 "Managed Care Payment Delay for FY 2010-11," both submitted October 22, 2010.

Under federal regulations at 42 CFR 447.45, the Department is bound to process and pay 90% of practitioner clean claims received by the Medicaid Management Information System (MMIS) on a given calendar day within 30 days and 99% of those practitioner claims within 90 days. The Department anticipates that it would still be able to meet these requirements with the proposed payment delay. However, if the Department is not able to comply, there is no condition that federal financial participation will be reduced or withheld.

The American Recovery and Reinvestment Act (ARRA) expanded prompt pay requirements to hospital and nursing facility claims while the Department receives an enhanced federal medical assistance percentage (FMAP). As a result of these requirements, the Department has developed a standard report for the Centers for Medicare and Medicaid Services (CMS) that verifies that the Department is meeting this requirement. In the event that the requested payment delays are approved, the Department will continue to use these reports in order to ensure compliance with federal regulations.

The Department's requests to delay Medicaid payments is not affected by the prompt payment provisions in ARRA, and the Department is not at risk of losing additional federal funds. Under the requests, the Department will enact a total payment delay of three weeks by

June 2011. Subject to legislative approval, the Department anticipates that it will begin payment delays in April 2011, and that by June 2011, three weeks of FY 2010-11 expenditures will be delayed until FY 2011-12. Because the enhanced FMAP expires on June 30, 2011, the Department is not compelled to meet the enhanced prompt pay requirements for those claims. Department's requests already assume that the enhanced FMAP will not be available for the delayed claims and factors the payment of those delayed claims at the regular FMAP into the calculation.

**22. How do pharmacy rates reductions compare to other rates reductions for other services?**

RESPONSE:

Pharmacy rate reductions are difficult to compare to rate cuts to other services because the reimbursement for many pharmaceutical drugs is based on the Average Wholesale Price (AWP), which has been steadily increasing over the years. The Department has implemented a number of reductions to the reimbursement rates for pharmaceutical drugs paid based on AWP, including:

- Before the initial rate change: AWP minus 13.5% for brand-name and AWP minus 35% for generic medications
- July 1, 2009: AWP minus 14% for brand-name and AWP minus 40% for generic medications
- September 1, 2009: AWP minus 14.5% for brand-name medications and AWP minus 45% for generic medication

The Department estimates that these reductions have resulted in approximately 3.8% savings on pharmaceutical drugs reimbursed based on AWP since July 2009. In addition, there have been adjustments to AWP this year because of a lawsuit finding that AWP prices were inflated. AWP adjusted prices because of the lawsuit and if this change is included plus our AWP rate change the total savings is 6.4%.

The Department has also expanded the number of pharmaceutical drugs paid on the State Maximum Allowable Cost (SMAC) reimbursement methodology. Under this methodology, which was established in December 2009, the final State Maximum Allowable Cost is determined as the acquisition cost plus 18%. In March 2010, the Department put three drugs on SMAC list. The Department estimates that the expansion of SMAC has resulted in savings of approximately 1.0% since March 2010.

In total, the pharmacy rate reduction has been 4.8%, which compares to an average of 5.39% in other provider reimbursement reductions. If the AWP lawsuit, a national change, is also included into the pharmacy rate reduction, the total is 7.4%.

**23. Please describe the methodologies the State uses to reimbursement pharmacy, including the differences between brand and generic drugs? Please explain why the Department plans to achieve more savings from the SMAC in FY 2010-11 than the amount stated in footnote 8a in last year's long bill.**

RESPONSE:

*Rate Methodology*

Pharmacy reimbursement consists of an ingredient cost and a dispensing fee. The Department utilizes a two-step "lesser of" logic to calculate these components.

First, the Department uses a "lesser of" methodology to determine the reimbursement for pharmacy claims. This logic uses the least of five different calculation methodologies to determine appropriate reimbursement. The five methodologies currently in use by the Department are:

1) *State Maximum Allowable Cost (SMAC)*

The current SMAC rates were created based on an acquisition cost survey that the State released to pharmacies approximately one year ago. The highest acquisition cost (excluding outliers) received an 18% markup and this became the SMAC. SMAC is an appropriate pricing methodology to use because it is based on acquisition costs. Other reimbursement rates for drugs are variable in that they are not tied to acquisition costs.

2) *Federal Upper Limit (FUL)*

FUL (also referred to as FedMAC or Federal Maximum Allowable Cost) is a limit developed by the Centers for Medicare and Medicaid Services and is provided to the Department through a vendor.

3) *118% of Direct Cost of Drug*

Direct Cost is a national benchmark supplied by a vendor.

4) *Submitted Ingredient Cost*

5) *Discounted Average Wholesale Price (AWP)*

AWP has been a national benchmark for pharmacy pricing, published annually by a third party vendor based on information from drug manufacturers. AWP is no longer the standard because of lawsuits that found AWP is flawed and inflates pricing. On September 30, 2011, AWP will no longer be available. The Department has been working on an alternative and anticipates submitting rule changes to the Medical Services Board in the first quarter of calendar year 2011.

The discount rate is determined by a combination of factors on the claim. Specifically the brand/generic status of the drug, if the client is in the Old Age Pension State Only (OAP-SO) program and if the pharmacy is categorized as rural. Current discount rates are as follows:

Rural				Non-Rural			
OAP-SO		Non OAP-SO		OAP-SO		Non-OAP-SO	
Brand	Generic	Brand	Generic	Brand	Generic	Brand	Generic
34%	34%	12%	12%	35.88%	58.75%	14.5%	45%

The Department reduces its payment based on any third-party insurance payments and any required client copayment.

Second, the appropriate dispensing fee is added to the claim and this sum is compared to the submitted usual and customary charge. Current dispensing fees are \$1.89 for institutional and 340B pharmacies and \$4.00 for all other pharmacies.

There are, however, some notable exceptions to the above logic in some instances including:

- When a physician receives a brand name prior authorization to the generic mandate, the FUL is removed from the “lower of” pricing. The FUL is based on generic prices in the market and so it was decided that if the Department approved the use of a brand drug then the payment should reflect that as well.
- Rural pharmacies always use the AWP methodology in the first “lesser of” logic. Due to their remote locations, rural pharmacies’ acquisition costs are higher. Therefore, rural pharmacies receive a higher reimbursement that is intended to ensure their continued participation.

After AWP is discontinued, the Department anticipates using a combination of Wholesale Acquisition Cost (WAC) (discounted by a percentage, similar to AWP pricing) and SMAC as a replacement. The Department’s intent is to keep the change from AWP to the new methodology budget neutral. WAC will cover the majority of the drugs, although in some cases either WAC information will be unavailable, or WAC is drastically different from the current reimbursement in some cases. In these scenarios, the Department will create the appropriate SMAC rate and reimbursed based on the lower of the SMAC and the submitted rate.

#### *Savings Estimates*

The Department’s appropriation for FY 2009-10 was reduced by \$285,123 total funds to account for savings from the implementation of SMAC. This amount annualized to \$510,806 total funds savings in the Department’s FY 2010-11 Long Bill appropriation.

During the FY 2010-11 Budget Cycle, the Department submitted BRI-3 “Expansion of State Maximum Allowable Cost Pharmacy Rate Methodology” (November 2, 2009), requesting to expand utilization of S MAC to achieve additional savings. This request was approved; however, Footnote 8a of HB 10-1376 indicates that the assumption of the General Assembly is that the Department will experience \$1,057,450 in cost savings for FY 2010-11 in addition to the \$510,806 total funds savings from FY 2010-11. Therefore, in total, the Department’s FY 2010-11 appropriation for Medical Services Premiums reflects a total reduction of \$1,568,256 for the SMAC program. However, the Department anticipates a greater savings from SMAC in FY 2010-11 than the amount stated in footnote 8a in last year’s Long Bill

because the current SMAC drugs were implemented before the footnote was created. The Department put three drugs on the SMAC list in March 2010 and has not changed the list since then. The amount stated in the budget reduction item was based on utilization estimates. Revised analysis using more current utilization data provides a new estimate of \$2,716,882. The Department will account for any additional savings through the regular budget process.

**24. Please explain any costs or cost savings to the pharmacy program from the Accountable Care Act (ACA).**

RESPONSE:

Section 2501(a) of the Patient Protection and Affordable Care Act (ACA) increased the amount of rebates that drug manufacturers are required to pay under the Medicaid drug rebate program, with different formulas for single-source and innovator multiple-source drugs (brand name drugs), non-innovator multiple-source drugs (generic drugs), and drugs that are line extensions of a single-source drug or an innovator multiple-source drug, effective January 1, 2010. ACA also required that amounts “attributable” to these increased rebates be remitted to the Federal government. As a result, the Department does not anticipate any savings as a result of this provision.

The increase in the minimum rebate percentage will affect the Department’s Preferred Drug List (PDL). The majority of savings from the PDL are achieved through supplemental rebates paid by manufacturers. Although the Centers for Medicare and Medicaid Services (CMS) does not plan to offset the state share of any supplemental rebates received, the increase in the minimum rebate may cause manufacturers to reconsider their willingness to participate in the PDL. In FY 2009-10, the Department received \$4,084,365 in supplemental rebates, of which \$1,568,805 was General Fund. The Department is exploring ways to continue to achieve savings through the PDL and, if necessary, will submit a budget action to account for any reduced savings.

Section 2501(c) of ACA extends the drug rebate program to managed-care providers. However, the Department’s only physical health managed-care provider participates in the federal 340(b) pricing program, which is excluded from the rebate requirements. The Department is currently working with the provider to determine if any pharmacy expenditure will be eligible to receive a rebate. At the present, the Department does not anticipate any savings due to this provision, but the Department will account for any necessary adjustments or actual savings through the normal budget process.

**25. Please explain if there have been any cost savings to the Medicaid program from medical marijuana?**

RESPONSE:

Medical marijuana is not an approved benefit under the Medicaid program. The Department does not track who is accessing medical marijuana and has no way of quantifying whether there are cost savings from the use of medical marijuana.

**26. Please describe the risks and advantages for the Medicaid program reductions that the Department has proposed for FY 2011-12. Specifically cover the following:**

- a. Would denying payments to hospitals for readmission within 48 hours put patients at risk? Aren't the first 48 hours after discharge the most at risk time for post operative infections?**

RESPONSE:

The intent of the Department's readmission policy is to reduce hospitals' incentives to prematurely discharge clients. Premature discharges can lead to complications and subsequent readmissions. Since Medicaid's payment methodology pays hospitals by admission, unnecessary readmissions increase costs to the Medicaid program. By extending the readmission claim denial period from within 24 hours of discharge to within 48 hours of discharge, the Department would further encourage hospitals to focus on a comprehensive provision of health care services during the initial visit, improved discharge planning, and follow-up care in order to improve the outcome of the initial admission.

In general, if a patient requires readmission within 48 hours of the initial discharge, the hospital will readmit the patient and provide the necessary care. However, the hospital will not receive payment for the second admission if it is both to the same hospital and for a related condition or, in other words, if the two separate admissions are for what is considered to be one episode of care. Hospitals maintain the ability to appeal the denial of payment for the second admission, and the Department will evaluate on a case-by-case basis, along with its Quality Improvement Organization, whether the second admission is in fact completely unrelated to the initial admission or unavoidable.

This policy encourages better quality care and thus greater patient safety. This policy is in line with the national initiative by the Centers for Medicare and Medicaid Services (CMS) toward more efficient provision of health care services and care coordination. Finally, the 48-hour window is conservative relative to other state Medicaid programs. For example, Michigan and Pennsylvania each have implemented policies that reduce or deny payments for related readmissions to any hospital up to as many as 15 days after discharge.

While the first 48 hours after discharge are a high-risk time for post-operative infections, there are measures hospitals can implement to decrease the risk of infection. A 48-hour non-payment policy may encourage hospitals to adopt best practices that would ultimately improve health outcomes for clients. For instance, the World Health Organization now promotes a safe-surgery checklist covering items such as the risk of blood loss, antibiotic prophylaxis, and surgical-site marking. Testing the checklist in eight cities around the world in 2007 and 2008, the death rate was cut in half to 0.8%, and complications, including post-op infections, were cut nearly 60%, according to a study in the New England Journal. Also, a group of Michigan hospitals implemented similar activities, including a checklist of infection-

control practices, and their average infection rate dropped 66% after one year. The median central-line infection rate fell to zero per 1,000 catheter days, compared with a national average of 5.2. Three years after the project began, 85 Michigan intensive care units have improved their success. The average infection rate has dropped 86%, while the median central-line infection rate remains at zero.

- b. Please explain any abuse and misuse of the Consumer Directed Attendant Support Service wage rates. How is the Department working with the disabled community to make sure that any reductions in this area do not negatively impact clients.**

RESPONSE:

The Consumer Direct Attendant Support Services (CDASS) program is an important and valuable benefit that has seen dramatic growth since the passage of HB 05-1243 and the subsequent approval of waiver amendments by the Centers for Medicare and Medicaid Services (CMS) in 2007. Since approval to add the CDASS benefit to the Elderly, Blind, and Disabled and Mental Illness Home- and Community-Based Services (HCBS) waivers, the Department’s expenditure related to CDASS has grown 118%, and the number of clients enrolled has grown by 156%. See the table below for year-to-year expenditure and caseload totals and growth rates.

CDASS Client Growth from FY 2007-08 to FY 2009-10						
	FY 2007-08	FY 2008-09	Percent Increase	FY 2009-10	% (From FY 2008-09)	% (From FY 2007-08)
Expenditure	\$20,238,726	\$34,005,153	68.02%	\$44,107,543	29.71%	117.94%
Caseload <sup>(1)</sup>	452	852	88.50%	1,158	35.92%	156.19%

(1) Caseload numbers are slightly understated across all years because they do not include a small number of clients who are enrolled in the Department’s CDASS state plan option.

When the Department observed that CDASS per-capita costs were also expanding during this time period, a workgroup including CDASS clients and advocates was formed to identify and address solutions to develop a cost-effective structure while continuing to meet the needs of clients. The workgroup’s main area of focus was to develop criteria to ensure elimination of overspending on yearly allocations, as had been previously permitted, while also ensuring that consumers continued to have access to this benefit. With the support of clients and advocates, the CDASS rule was amended to address overutilization and was initially adopted by the Medical Services Board on December 10, 2010. The amendments set a wage cap for services and set allocations at those determined by the case manager during assessment.

The Department has requested a reduction to CDASS costs in its November 1, 2010 FY 2011-12 BRI-5 “Medicaid Reductions.” As part of this request, the Department would impose a cap on the wage rate that a client enrolled in the Consumer Directed Attendant Support Services (CDASS) program is allowed to pay attendants. Under the program, clients are responsible for determining the wage within an allocation

that is determined by their case manager. Information provided by the Department's fiscal intermediary has shown that wage rates set by clients are highly variable, and can change as often as weekly. In the three major categories of services, between 12% and 21% of wages are set at \$20 per hour or higher. Further, some clients are setting wage rates far beyond what the Department would otherwise pay for these services – in some cases, as much as \$100 per hour.

The Department estimates that the requested reduction would reduce fee-for-service expenditure by \$1,420,692 total funds, \$710,346 General Fund in FY 2011-12 and annualize to a reduction of \$1,677,708 total funds, \$838,854 General Fund in FY 2012-13.

- 27. Are there other optional services that the State should consider eliminating or reducing? For example, what about organ transplants? What would be the mortality risk rates associated with eliminating this benefit.**

RESPONSE:

Answered in 29.

- 28. Would limiting reimbursement for therapy services to only home health agencies or when provided in an institutional setting (such as hospitals or nursing facilities) create any savings?**

RESPONSE:

Answered in 29.

- 29. Are there any services that other states have reduced in the last two years that Colorado should also consider doing? Specifically, should podiatry services be limited in any way?**

RESPONSE:

The Department remains focused on initiatives and policies that improve health outcomes for clients and decrease average cost per client by encouraging appropriate care based on best evidence and practices. By engaging in activities that center on efficiencies and appropriate care, the Department can realize savings without eliminating or reducing benefits that ultimately result in driving clients toward more costly health care services. Many optional Medicaid services are services that prevent the need for more costly acute care, thereby driving down average costs per client.

Eliminating certain optional benefits, such as coverage for organ transplants, would have an estimated 100% mortality risk rate, because organ transplants are life-saving procedures. However, the Department has no method of determining the mortality risk rates from eliminating the organ transplant benefit because there is no available data on Medicaid

clients who needed but did not receive organ transplants. Without transplants, end-of-life care would increase costs for an indefinite period of time.

Changes to optional benefits like therapy services, which can be provided in different settings, must be evaluated thoroughly to determine potential impact to clients. For example, limiting reimbursement for therapy services to only those therapies provided at home health agencies or institutional settings (such as hospitals or nursing facilities) would cut coverage for therapy services delivered in physicians' offices. However, in-office therapy allows therapists and physicians to work together as a team, exchanging information and sharing ideas, which in turn allows for proper adjustment of therapeutic protocols that improve patient outcomes. A study comparing on-site physical therapy delivered in physician offices versus other sites concluded that patients who receive on-site physical therapy lose less time from work and resume normal duties more quickly. The health outcomes and efficiency associated with providing care in this setting leads to cost avoidance for more acute, expensive care.

Consideration of eliminating or reducing optional benefits, such as podiatry services, often involves examination of its relation to chronic disease. Podiatry services are currently covered by 45 of the 50 states and were not reduced or eliminated by other states in Fiscal Year 2010. This is likely due to the fact that podiatry services are often linked to chronic conditions that would likely cause additional, more costly, health issues if they were eliminated as a benefit. For example, covering podiatry services for clients with diabetes helps maintain continuity of care to prevent amputations and other complications.

It is also worth noting that Colorado Medicaid covers only a limited number of optional services. According to the National Conference of State Legislatures, several states, including Hawaii, Massachusetts, Oregon, and Utah, either eliminated or limited adult dental benefits in Fiscal Year 2010. The adult dental benefit was the only benefit that was consistently reduced or eliminated by other states in the past fiscal year. Colorado Medicaid does not currently cover adult dental benefits.

**30. Are there any budget reductions that were made during the prior downturn (2001-2004) that were restored and the state has not reduced again?**

RESPONSE:

During the prior economic downturn, the primary way that the General Assembly and the Department reduced Medicaid appropriations was through across-the-board rate reductions. Beginning in FY 2006-07, the General Assembly began to appropriate funding for the Department to increase rates. The funding appropriated was not specifically tied to the rate cuts the Department took in FY 2002-03 through FY 2004-05; rather, the Department was appropriated funding more generally in order to increase provider rates. In some instances, specific services, such as primary care services, home health, and Home- and Community-Based Services received targeted increases.

Starting in FY 2009-10, the Department's reductions have applied to all Medicaid providers. As a result, all providers that received an increase in FY 2006-07 through FY 2008-09 have

also received rate decreases during this current period. The Department has reduced most provider rates by 5.39% since July 1, 2009, with some providers taking additional cuts based on specific reductions. See the Department's response in question 14 for further information.

**31. How much money did the State actually save from prior authorizing the oxygen benefit.**

**RESPONSE:**

Through the Department's October 31, 2008 FY 2009-10 BRI-2 "Medicaid Program Efficiencies," the Department was given the authority to restructure the Medicaid oxygen benefit. In the FY 2009-10 Long Bill, the Department was appropriated an FTE to develop rules and regulations to better manage the Department's Oxygen benefit. The Department's expenditure on its fee-for-service oxygen benefit in Medical Services Premiums has grown from \$21.49 million in FY 2006-07 to \$24.05 million in FY 2009-10, growth of 11.9%.

The oxygen benefit accounts for over 25% of durable medical equipment expenditures, making it a high priority for development of an effective and efficient benefit policy. Over the past year through the Benefits Collaborative process, the Department worked with interested parties, including clinicians, client representatives, oxygen suppliers, nursing homes, and other state agencies, to create and implement an oxygen benefit policy. The Department has written a final draft policy which is currently under review by the State Medical Assistance and Services Advisory Council and the Children's Services Advisory Board. The policy has been widely accepted by the provider community, and the Department has received negative feedback from only one nursing facility with outlying oxygen utilization.

The proposed oxygen policy addresses the three main issues identified by the Department, the stakeholders, and the applicable research: 1) appropriate use, 2) correct billing, and 3) controlling liquid oxygen expenditures without affecting patients. The proposed policy does not include a requirement for prior authorization (except potentially in the case of extremely high-volume utilizers) but proposes other methods like clear medical criteria requirements, precise billing standards, and a revised reimbursement structure.

After review, the policy will have a 45 day public comment period and then be reviewed by the Medicaid Director for approval. The Department estimates that the policy will be approved and reimbursement rates changed by March 1, 2011. The Department's preliminary estimates of the impact of the revised policy indicate an annualized reduction of approximately \$880,000. The Department will account for any estimated savings in a future budget request.

## **2:30-3:00: PROVIDER FEE PROGRAMS**

### **32. Will nursing facility providers have problems with the nursing home provider fee?**

#### **RESPONSE:**

In FY 2010-11, the nursing facility provider fee has reached the \$7.50 fee cap imposed by Senate Bill 09-263. This cap prevents the Department from collecting enough fees to fully fund the supplemental payments to nursing facility providers. Without the ability to fully fund the supplemental payments, the Department must limit the payment to providers based on the hierarchy created in Senate Bill 09-263. The payment hierarchy establishes the order that the different components of the supplemental payment will be paid to providers if the available funding is limited by the fee cap. For FY 2010-11, the Department is only able to fully fund the first component of the supplemental payment hierarchy. The remaining components are either partially funded or not funded at all. A consequence of this is the Department is only able to pay providers eighty percent (80%) of the full supplemental payment.

Unlike the Hospital Provider Fee established by House Bill 09-1293, the Nursing Facility Provider Fee is tied directly to the cost-based reimbursement of the facilities. Therefore, the provider fee cash fund is responsible for both the supplemental payments as authorized by the bill and all of the growth in facility costs beyond the general fund growth cap authorized by the General Assembly.

Over the last two years, the general fund growth cap has been limited by the General Assembly to provide savings to the State. Instead of a 3% annual growth cap, the cap was reset to 0% for FY 2009-10 and 1.9% for FY 2010-11. Since nursing facility cost growth is usually about 4% per year, the burden on the cash fund was accelerated over the last two years.

The statutory requirements of the General Fund growth cap and the \$7.50 fee cap have had a ratcheting effect. The general fund growth cap increases the burden on the cash fund by shifting normal cost growth in nursing facilities from the general fund to the supplemental payments. At the same time, the \$7.50 fee cap then limits the amount of money the state can collect to fund the increased supplemental payments. The end result is a cash fund that is insufficient to fund the full supplemental payment as calculated by the provisions in statute. Therefore, the Department must reduce total nursing facility supplemental payments utilizing the hierarchy established in SB 09-263.

Nursing facility providers are likely to react negatively to the high fee (\$7.50 per non-Medicare day) and to the continual decrease in supplemental payments. The providers are also anticipating a drastic reduction in supplemental payments this year due to the upcoming expiration of American Recovery and Reinvestment Act (ARRA) funding, which will reduce the amount of federal funds available to match the collected fee. While this negative reaction is unfortunate, it is a result of statutory requirements that are outside of the Department's direct control.

**33. Please explain how the hospital provider fee impacts patients. How is the fee set and what are its limits?**

RESPONSE:

Per 25.5-5-402.3 (3)(f), C.R.S. (2010), hospitals cannot include the fee as a separate line item in billing statements. The hospital provider fee impacts hospital patients positively and should be measured by the amount of revenue gained by hospitals and the expansion of health care coverage for uninsured patients, not only the amount of fees paid.

The hospital provider fee reduces the uncompensated care cost for Medicaid and Colorado Indigent Care Program (CICP) clients, thereby reducing the shifting of uncompensated care onto private payers and assuring access for Medicaid and CICP clients. The hospital provider fee provides hospitals with a sustainable source of revenue and funds health coverage for many low-income adults and children who would otherwise be uninsured.

As of November 30, 2010, the Department had enrolled approximately 27,000 Medicaid parents, 3,300 CHP+ children, and 230 CHP+ pregnant women into the first health coverage expansions funded by hospital provider fees.

For the five quarters from July 1, 2009 through September 30, 2010, hospitals received net new federal funds totaling \$146 million. For the twelve months beginning October 1, 2010, hospitals will receive new federal funds totaling \$159 million. Therefore, the total net benefit to hospitals from implementation through the first quarter of FY 2011-12 totals more than \$300 million. These are net new federal funds received by hospitals after fees and excluding Disproportionate Share Hospital (DSH) and other CICP funding that would have been received by hospitals prior to the implementation of the Colorado Health Care Affordability Act.

*Hospital Provider Fee Description:*

Fees are assessed on inpatient and outpatient hospital services for all licensed hospitals except free-standing psychiatric hospitals, long-term care hospitals, and rehabilitation hospitals.

For the Hospital Provider Fee Model effective October 1, 2010, fees are assessed on inpatient services at \$83.46 per managed care day (including Medicaid and Medicare managed care) and at \$374.85 for all other days (including fee-for-service, charity care, CICP, and self-pay).

Fees are assessed on outpatient services at 0.484% of total hospital outpatient charges.

High volume Medicaid and Colorado Indigent Care Program (CICP) providers are assessed fees discounted by 47.79% for the inpatient fee and discounted by 0.84% for the outpatient fee. High volume Medicaid and CICP providers are those providers with at least 35,000 Medicaid days per calendar year who provide over 30% of their total days to

Medicaid and CICP clients. Denver Health Medical Center, Memorial Hospital in Colorado Springs, The Children's Hospital, and University Hospital qualify for this discount.

Critical Access and small rural hospitals with less than 25 licensed beds are assessed inpatient fees discounted by 60%. Animas Surgical Hospital, Aspen Valley Hospital, Centura Health - Saint Anthony Summit Hospital, Conejos County Hospital, East Morgan County Hospital, Estes Park Medical Center, Family Health West Hospital, Grand River Medical Center, Gunnison Valley Hospital, Haxtun Hospital, Heart of the Rockies Regional Medical Center, Keefe Memorial Hospital, Kit Carson County Memorial Hospital, Kremmling Memorial Hospital, Lincoln Community Hospital and Nursing Home, Melissa Memorial Hospital, Mount San Rafael Hospital, Pagosa Mountain Hospital, Pikes Peak Regional Hospital, Pioneers Hospital, Prowers Medical Center, Rangely District Hospital, Rio Grande Hospital, Sedgwick County Memorial Hospital, Southeast Colorado Hospital, Southwest Memorial Hospital, Spanish Peaks Regional Health Center, St. Vincent General Hospital District, The Memorial Hospital (Craig), Weisbrod Memorial County Hospital, and Wray Community District Hospital qualify for this discount.

Because the fee assessed to each hospital is a function of Medicaid utilization, with high-volume providers having a discounted fee, providers are incented to increase the access that they provide to Medicaid clients.

*Fee Limitations:*

Per federal regulations, the aggregate amount assessed on providers of a class of services may not exceed 5.5% of the net patient revenue for that class of services, i.e., the inpatient fee cannot exceed 5.5% of net patient revenues for inpatient services. (This limit increases to 6% effective October 1, 2011.)

Also, provider fees must:

- be imposed on a permissible class of health care services, including, but not limited to, inpatient hospital services and outpatient hospital services;
- be broad-based, such that the fee is imposed on all providers within a class;
- be imposed uniformly throughout a jurisdiction, such that all providers within a class are assessed at the same rate, and;
- avoid hold harmless arrangements where the non-Medicaid reimbursement amount is positively correlated to the assessment paid by the provider, either directly or indirectly, or where the Medicaid payments vary based only on the fee amount. In other words, some providers will receive proportionately less in reimbursement compared to their assessed amount.

The Centers for Medicare and Medicaid Services (CMS) may grant waivers of the broad-based and uniformity provisions if the net impact of the fee is generally redistributive, as

demonstrated via statistical tests described in regulation. CMS granted the Department's request for waivers of the broad-based and uniform requirements for its hospital provider fees on March 30, 2010.

**34. Please explain if the hospital provider fee program will replace the need for the indigent care program.**

RESPONSE:

The Colorado Health Care Affordability Act (CHCAA) will reduce the number of uninsured Coloradans but will not eliminate the need for the Colorado Indigent Care Program (CICP).

The CICP allows low-income Coloradans with incomes up to 250% of the federal poverty level (FPL) who are not eligible for Medicaid or CHP+ to obtain discounted health care services at participating providers. Most of the providers who participate in the CICP are public hospitals and Community Health Centers. CICP provides some compensation for the uncompensated costs incurred by providers in serving low-income Coloradans, including those who are uninsured and those who have private health coverage but cannot meet their out-of-pocket expenses.

Two of the health coverage expansions under CHCAA in particular affect CICP clients: 1) the expansion of Medicaid parents up to 100% FPL, and 2) coverage for Adults without Dependent Children up to 100% FPL. While these expansions will provide health care coverage to many clients who would otherwise be eligible for CICP, not all will be covered. Those who are between 100% and 250% FPL will still be eligible for CICP. Also, legal immigrants who have been in the United States fewer than five years cannot be eligible for Medicaid or CHP+ programs and will be eligible for the CICP if they meet income requirements.

When federal health care reform is implemented beginning in 2014, there will still be a need for the CICP. Legal immigrants under the 5-year bar will remain ineligible for Medicaid and CHP+. Also, while most other low-income Coloradans will be covered by either public health care programs or eligible for a federal subsidy to purchase health care, there will still likely be clients under 250% FPL who cannot meet their out-of-pocket-expenses.

While CHCAA does not eliminate the need for the CICP, a significant number of CICP clients will have health care coverage when CHCAA is fully implemented (approximately 95% of all CICP clients are adults and more than half have incomes under 100% FPL). The Department is already engaging stakeholders to explore possibilities for the CICP after expansions under CHCAA and federal health care reform are implemented with the intent of continuing the focus of reducing uncompensated care costs for providers who serve low-income Coloradans.

**35. Please provide information on which hospitals are the winners and loser under the hospital provider fee program? Please explain the current Hospital Provider Fee model and why the FY 2010-11 models generates significantly higher revenues and expenditures then the model originally assumed in the current FY 2010-11 appropriations.**

RESPONSE:

Net gains and losses by provider for the current Hospital Provider Fee Model beginning October 1, 2010 are shown in attachment E. There are 70 providers who net gains and 14 providers who net losses. Of those who net losses, five are not part of a hospital system, six are part of a hospital system that nets a gain, and three are part of a hospital system that nets a loss.

A description of the fees and payments under the 2010-11 Hospital Provider Fee Model is provided in attachment E. There are 13 distinct supplemental payments to hospitals that are designed to increase reimbursement for Medicaid inpatient and outpatient care, to increase reimbursement for hospitals participating in CICP, to reduce uncompensated care for Medicaid and the uninsured, and to improve access for Medicaid clients in metropolitan and rural areas.

Payments for SFY 2010-11 have increased \$155 million, from \$590 million to \$745 million. One of the intentions under CHCAA is to increase payments up to the available upper payment limits (UPLs) for inpatient and outpatient hospital services. The increase in payments to hospitals under the current FFY 2010-11 Hospital Provider Fee Model is a result of a large increase in the available UPL and maximizing payments up to the UPL. The available UPL increased by 15% for the 2010-11 model compared to the previous model. There was \$66 million in remaining UPL room for inpatient and outpatient care after the SFY 2009-10 Hospital Provider Fee model payments; there is \$21 million remaining UPL room in the current model. The current FFY 2010-11 Hospital Provider Fee model is more effectively maximizing payments under the available UPL and reducing uncompensated care.

See attachment.

**36. Please provide the Committee with the Department's recommendations for statutory changes to allow the Hospital Provider Fee to offset General Fund.**

RESPONSE:

The language of Colorado Health Care Affordability Act, as authorized through House Bill 09-1293, was carefully drafted to ensure any change to the use of the hospital provider fee or matching funds could only be effectuated with a statutory change. At this time, the Department does not have any draft language to provide.

The Colorado Hospital Association and hospitals participating under the hospital provider fee have been strong partners, and the continued partnership is valued as we discuss

difficult choices. As legislation is required in order to make the proposed change to the use of the hospital provider fee, enabling legislation will be handled through the new administration, the Colorado Hospital Association, the JBC, and the legislature.

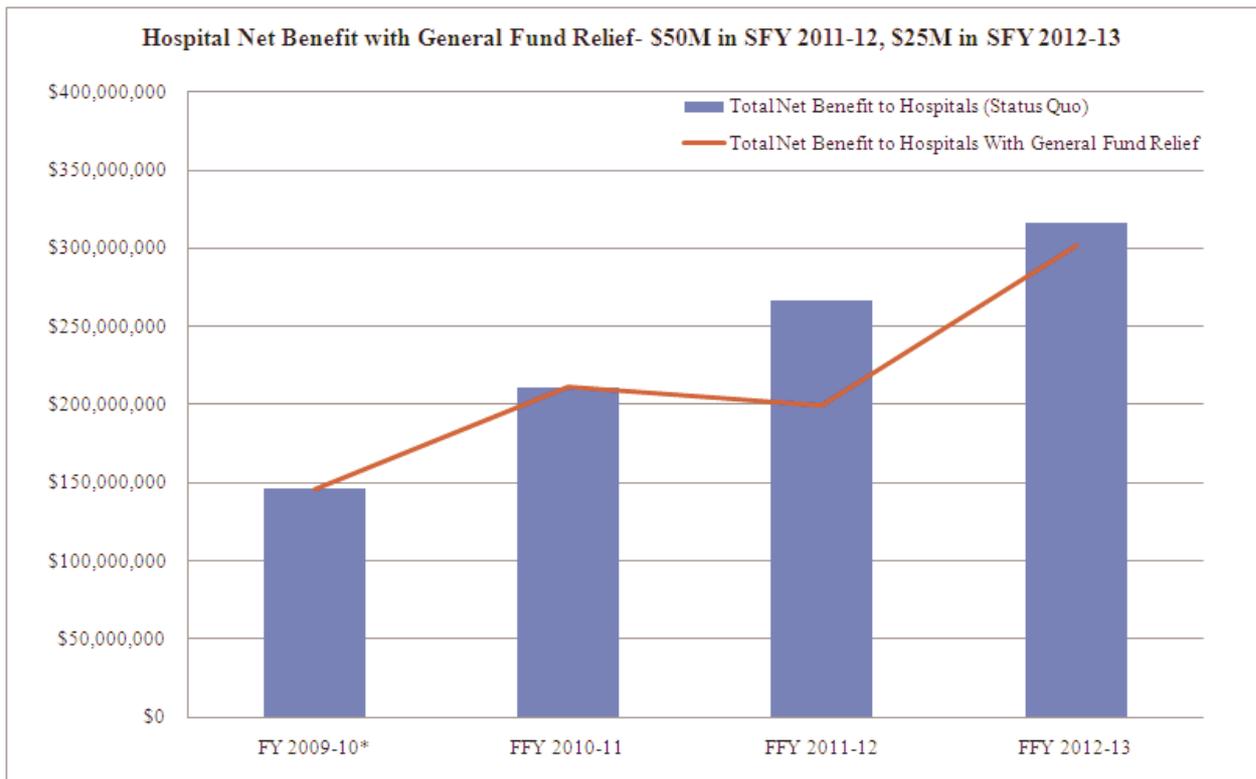
**37. Please provide the Committee an estimate of the FY 2011-12 Hospital Provider Fee model showing the impact before and after the \$50.0 million General Fund offset, by hospital.**

RESPONSE:

The Department sets the Hospital Provider Fee model approximately six months prior to the beginning of the federal fiscal year (FFY), for which the model is to be in place. As a result, the Department does not yet have the FFY 2011-12 model set. The table and chart below show initial Department projections based on the FFY 2010-11 model that is currently being reviewed by the Centers for Medicare and Medicaid Services. Because the distribution of fee collection and payment distribution are based on the most recent available hospital data regarding Medicaid utilization, the Department cannot at this time provide the net benefit at the individual hospital level. The \$50 million financing mechanism holds the aggregate net benefit to hospitals at approximately the same level as FFY 2010-11. The Department will continue to work with the Colorado Hospital Association to ensure that this financing mechanism optimizes the net benefit to all hospitals.

	FY 2009-10*	FFY 2010-11	FFY 2011-12	FFY 2012-13
Total Supplemental Payments	\$737,892,699	\$796,777,807	\$979,928,607	\$1,077,921,468
Less Fee for Payments	(\$385,151,148)	(\$393,093,233)	(\$483,866,741)	(\$532,253,418)
Less Current CICP Payment	(\$203,595,134)	(\$162,876,107)	(\$131,626,107)	(\$128,501,107)
<b>Net Benefit to Hospitals From Rate Increases</b>	<b>\$149,146,417</b>	<b>\$240,808,467</b>	<b>\$364,435,759</b>	<b>\$417,166,943</b>
Less Fee for Administration and Population Expansions	(\$2,936,285)	(\$81,360,824)	(\$189,216,996)	(\$336,129,060)
<b>Subtotal Net Benefit to Hospitals</b>	<b>\$146,210,132</b>	<b>\$159,447,643</b>	<b>\$112,718,763</b>	<b>\$12,287,883</b>
<b>Estimated Benefit to Hospitals from Population Expansions</b>	<b>\$0</b>	<b>\$51,723,613</b>	<b>\$122,397,859</b>	<b>\$269,971,596</b>
<b>Total Net Benefit to Hospitals (Status Quo)</b>	<b>\$146,210,132</b>	<b>\$211,171,256</b>	<b>\$266,366,622</b>	<b>\$316,634,479</b>
Less Fee Collected for General Fund Relief	\$0	\$0	(\$66,666,667)	(\$14,444,444)
<b>Total Net Benefit to Hospitals With General Fund Relief</b>	<b>\$146,210,132</b>	<b>\$211,171,256</b>	<b>\$199,699,955</b>	<b>\$302,190,035</b>

\* FY 2009-10 includes 5 quarters.



**38. If H.B. 09-1293 was repealed would there be any impact to the General Fund?**

**RESPONSE:**

There would be no immediate General Fund impact if HB 09-1293 were repealed, however there would be significant General Fund need once the Patient Protection and Affordable Care Act of 2010 (ACA) is implemented. The eligibility expansion to 100% of federal poverty line for Medicaid Parents and 250% of federal poverty line for the Children's Basic Health Plan that were implemented under HB 09-1293 would be repealed, and the increased hospital reimbursement for Medicaid and the Colorado indigent Care Program that are paid through supplemental payments would be eliminated. The Department would not implement the Buy-In Program for Individuals with Disabilities in 2011 or Continuous Eligibility for Medicaid children, neither of which is required under ACA. Further, the Department would not implement the program for Adults without Dependent Children to 100% of federal poverty line (AwDC) in 2012, which is required under ACA.

Under ACA, states are required to provide Medicaid eligibility to all individuals under age 65 with incomes up to 133% of federal poverty line effective January 1, 2014, including Adults without Dependent Children. If the Department were to repeal the eligibility expansions for Medicaid Parents and Adults without Dependent Children under HB 09-1293, both of which are funded by cash funds rather than General Fund, these populations would become General Fund populations beginning in 2016.

The table below shows the projected costs associated with these expansions in FFY 2014-15 through FFY 2019-20 at the enhanced federal match rates provided under ACA. If HB 09-1293 were to be repealed, these costs would need to be supported with General Fund appropriations. Detailed estimates of state costs for the expansions under CHCAA and ACA can be found at:

<http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251634141864&ssbinary=true>

<b>Estimated General Fund Cost if HB 09-1293 is Repealed</b>						
	FFY 2014-15	FFY 2015-16	FFY 2016-17	FFY 2017-18	FFY 2018-19	FFY 2019-20
Medicaid Parents to 100% FPL	\$0	\$0	\$9,980,000	\$12,630,000	\$15,550,000	\$23,430,000
AwDC to 100% FPL	\$0	\$0	\$23,080,000	\$29,210,000	\$35,950,000	\$54,200,000
<b>Total</b>	<b>\$0</b>	<b>\$0</b>	<b>\$33,060,000</b>	<b>\$41,840,000</b>	<b>\$51,500,000</b>	<b>\$77,630,000</b>
FFP Rate	100%	100%	95%	94%	93%	90%

**39. Why would the Department recommend reducing payments under the Pediatric Specialty Hospital program? Please explain the increased funding that The Children’s Hospital is receiving under the Hospital Provider Fee Program.**

RESPONSE:

The Department requests that the Pediatric Specialty Hospital payment be reduced by \$3 million for a General Fund savings of \$1.5 million. Under the current Hospital Provider Fee model, The Children’s Hospital pays discounted fees and receives supplemental payments directed to increase its Medicaid reimbursement for inpatient and outpatient services and for the Colorado Indigent Care Program (CICP). Additionally, a separate supplemental payment funded by hospital provider fees called the Pediatric Specialty Hospital Provider Fee Payment of \$3 million is paid to The Children’s Hospital, which can be increased in the 2011-12 Hospital Provider Fee model to offset the proposed reduction. In all, the Children’s Hospital receives a net gain from the current Hospital Provider Fee model of \$17.8 million.

**3:00-3:15: BREAK**

**3:15-3:45: CHILDREN’S BASIC HEALTH PLAN**

**40. Please explain any reductions that have been made to the Children’s Basic Health Plan since the recent downturn.**

RESPONSE:

The Children’s Basic Health Plan (CHP+), unlike Medicaid, has an enhanced federal match rate of 65%. Additionally, CHP+ is financed through the Children’s Basic Health

Plan Trust Fund and the Health Care Expansion Fund rather than the General Fund. Because of the funding structure, CHP+ has not had reductions presented through the previous budget cycles; however, the Department has sought to find efficiencies through several administrative initiatives.

CHP+ has initiated changes in provider reimbursement methodology to stabilize health care utilization costs and improve the program's ability to forecast such costs. Additionally, CHP+ has introduced a process to recoup medical claims payment when applicable (e.g., members identified as having health care coverage by other health care insurance carriers).

Effective July 1, 2010, CHP+ changed the State Managed Care Network (SMCN) hospital inpatient and outpatient reimbursement methodology from a billed charges method to one that pays 135% of the current Colorado Medicaid allowable amount. The program projects savings of \$11 million (19%) in the child program and \$4 million (16%) in the prenatal program for FY 2010-11 relative to initial FY 2010-11 budget projections.

Effective December 1, 2009, the SMCN successfully brought provider reimbursement in compliance with the fee schedule, eliminating payment exceptions, and renegotiated acceptable payment agreements with a limited number of essential specialists.

Finally, effective October 2009, the SMCN has been instructed to run retroactive eligibility reports on all members to determine whether alternate carriers are responsible for medical claims paid by the program. When an alternative carrier is identified, the program issues a take-back on claims paid in the form of a credit. To date, more than \$2.7 million has been recovered.

**41. Please explain the proposed reductions to the Children's Basic Health Plan in the FY 2011-12 requests. Specifically address how HMOs will absorb the risk of beginning HMO enrollment on the first day of the month following eligibility determination in order to move more children from the State Managed Care Network to the HMO plans.**

RESPONSE:

The Department is proposing to reduce Children's Basic Health Plan, marketed as Child Health Plan Plus (CHP+), expenditures through five initiatives that are estimated to result in reductions of \$11,416,941 in FY 2011-12 and \$16,745,363 in FY 2012-13. These five initiatives are:

- 1) *Eliminate Inpatient Coverage for CHP+ Prenatal Presumptive Eligibility (PE)*  
To be consistent with Medicaid policy, CHP+ will discontinue coverage of inpatient services for pregnant women during the PE period for those individuals who are later determined ineligible for CHP+.

2) *CHP+ Out-of-Network Reimbursement Changes*

To align CHP+ policy with commercial plan practice, out-of-network, non-emergent care without prior authorization will no longer be reimbursed through the CHP+ State Managed Care Network.

3) *Three-Percent CHP+ HMO Rate Reduction*

Rather than cutting or limiting specific services, the Department is reducing the capitation rate and allowing HMOs the ability to decide how the savings will be achieved, whether through administrative efficiencies, utilization controls, or case management.

4) *Eliminate Reinsurance*

Reinsurance protects insurers from catastrophic claims by paying for claims over a predetermined dollar amount. The change in hospital reimbursement methodology, effective July 1, 2011, will decrease the number of catastrophic health care claims reducing the return on investment of reinsurance. CHP+ reinsurance will be eliminated.

5) *Eliminate CHP+ Pre-HMO and Retroactive Enrollment Periods*

In order to align CHP+ policy with that in private sector systems, the Department will eliminate the pre-HMO period of eligibility and begin HMO enrollment the first day of the month following eligibility determination.

With the elimination of the pre-HMO period, the Department does not anticipate additional risk will need to be absorbed by the HMOs. For children with immediate health care needs, the SMCN will continue to absorb the risk and serve as a safety net through the Presumptive Eligibility (PE) program. According to analysis of prior enrollment data, a very small percentage of the CHP+ population receives PE services prior to enrollment in the program.

**42. Please explain the reasons why this program has been difficult to forecast? Please also provide information to the Committee on where the state is on making reconciliation payments and the reasons for the large increases in per capita costs estimates for both the adult prenatal and children's programs.**

RESPONSE:

*Caseload Forecasts*

Many factors caused unexpected volatility in the traditional children's caseload (up to 185% of the federal poverty level) in FY 2006-07 and FY 2007-08. The Medicaid asset test was removed on July 1, 2006, and was implemented gradually over the course of FY 2006-07 as clients came up for their annual redetermination. The Department anticipated that the asset test would increase the number of low-income children moving from the Children's Basic Health Plan to Medicaid. The number of children exiting the Children's Basic Health Plan did in fact increase in the first three months of FY 2006-07 but decreased in subsequent months.

In addition, two factors were expected to have a positive effect on the traditional children's caseload. First, the citizenship requirements of the Deficit Reduction Act of 2005 may have had a positive impact on the Children's Basic Health Plan caseload. Children who did not provide proper proof of citizenship may not have gained Medicaid eligibility but were still eligible for the Children's Basic Health Plan, which was not subject to the Deficit Reduction Act. The Department issued its final Deficit Reduction Act rules effective January 1, 2008, which prevents such children from enrolling in the Children's Basic Health Plan. Second, marketing of the Children's Basic Health Plan began in April 1, 2006. In addition, numerous community-based organizations have been conducting outreach to eligible children who are not enrolled.

Further, the Department has implemented two eligibility expansions since FY 2007-08. Eligibility was expanded to 205% of federal poverty line effective March 1, 2008, and then to 250% of federal poverty line effective May 1, 2010. Forecasting caseload due to eligibility expansions is particularly difficult, as a large portion of the new caseload in these expansion populations moved from either Medicaid or lower income groups in CHP+, rather than from the uninsured population.

Despite these difficulties, the Department's FY 2008-09 caseload forecast presented in its February 16, 2009, Budget Request was higher than the final actuals by 0.6% for children and 2.9% for pregnant women. Similarly, the Department's FY 2009-10 caseload forecast presented in its February 15, 2010, Budget Request was higher than the final actuals by 2.0% for children and 2.9% for pregnant women.

#### *Per-Capita Costs*

Per-capita costs for the Children's Basic Health Plan exhibited strong growth in FY 2008-09 and FY 2009-10 due largely to trends in the State's Managed Care Network (SMCN), which is administered by a Third-Party Administration (TPA) as a no-risk provider. The CHP+ TPA contract was re-bid for FY 2008-09, and Colorado Access was selected as the new vendor. The State is fully liable for all claims incurred by clients enrolled in the SMCN, which include children during their pre-HMO enrollment period, all presumptively eligible children and pregnant women, children without geographical access to an HMO, and all prenatal women. The CHP+ actuary develops a capitation rate based on prior-year utilization and unit costs trended forward, with the expectation that this monthly capitation payment should cover most if not all claims costs incurred in that month. The capitation payments are reconciled with actual incurred claims to determine any under- or over-payment by the State to the TPA. When Anthem was serving as the CHP+ TPA, reconciliation payments were being made annually. With the change to Colorado Access, reconciliation payments are now being made monthly.

Through FY 2007-08, the Department contracted with Anthem as the TPA for the SMCN. After this contract was transitioned to Colorado Access, the Department continued to pay administrative fees to Anthem in order to finish adjudicating claims incurred within the Anthem contract period. Despite consistent attempts by the Department throughout the year to ensure that Anthem was fulfilling its contractual obligations to process claims, at the end of FY 2008-09, it came to the Department's

attention that a large number of claims had not been properly researched or adjudicated. Rather than resolving these final claims, Anthem passed these claims to Colorado Access to complete the adjudication process. As a result of this, the Department found in FY 2009-10 that it owed approximately \$5.8 million for claims incurred prior to FY 2008-09. Thus, in FY 2009-10, the Department was making reconciliation payments for claims incurred in FY 2007-08, FY 2007-08, and FY 2009-10. All payments for FY 2007-08 and FY 2008-09 are now complete, and FY 2009-10 payments will be completed by February 2011.

Through FY 2008-09, the Department reimbursed inpatient hospitals at an approximate average of 65% of billed charges for the Children's Basic Health Plan self-funded network, whereas Medicaid reimburses at a much lower rate. In response to increasing hospital costs in the SMCN, the Department gave notice of its intent to move to a diagnosis-related group (DRG) methodology based on that used in Medicaid. However, the hospitals were reluctant to change to a CHP+ DRG system in FY 2009-10 and agreed that the savings could be achieved through a reduction to 44% of billed charges in FY 2009-10. In addition to the reduction to 44% of billed charges, the hospital charge masters were supposed to be frozen as of July 1, 2009, to ensure that the State was not seeing increased charges. However, the anticipated savings were not being realized, and the Department and its contracted actuary were able to confirm in May 2010 that hospital charge masters had indeed been increased prior to the implementation of the lower reimbursement rate.

In response to the continuing rise in hospital costs, the Department again changed its facility reimbursement methodology. Effective July 1, 2010, CHP+ will reimburse both inpatient and outpatient hospital services at 135% of the Medicaid DRG. This change will result in predictable hospital reimbursements and will result in more equitable reimbursement across hospitals (i.e., hospitals with relatively low cost-to-charge ratios will no longer receive lower reimbursement due to their charges being lower).

The Department is implementing a number of changes beginning in FY 2010-11 to control utilization and costs to prevent such high trends in the future. First, CHP+ is expanding its HMO coverage to counties that previously had only the SMCN available to enrollees. With this new HMO coverage, there will be only five counties in the State with no HMO coverage. This will reduce the number of children enrolled in the full-risk SMCN. The Department anticipates that this will result in efficiencies and better care coordination for CHP+ clients, as utilization and unit cost trends used for HMOs in the FY 2010-11 rate development are lower than those that the contracted actuaries continue to see in the SMCN.

Second, the Department is implementing a risk mitigation plan for the CHP+ TPA and SMCN. These include, but are not limited to the following:

- bringing all SMCN providers into compliance with the reimbursement schedule;

- establishment of care management policies and procedures, conducting on-site visits with the TPA to review care management cases, and increased reporting of care management in the quarterly reports to assist in oversight efforts, and;
- the program is working with all plans in FY 2010-11, including the SMCN through the TPA, to develop and implement value based contracts that will financially reward contractors when they reach specific health outcome goals for the CHP+ population.

For the budgeting process, the Department utilizes the growth in the actuarially set capitation rates to trend the per-capita costs forward. For the FY 2010-11 rates, the contracted actuary assumed continuing strong utilization trends for high-cost hospital services in both the children and prenatal programs. This resulted in increases to the FY 2010-11 SMCN capitation rates to 12.4% for the child program and 33.1% for the prenatal program, even after incorporating the change in facility reimbursement methodology. However, based on initial data of SMCN claims for FY 2010-11 (incurred from July 2010 through October 2010), these trends do not appear to be occurring. While the prenatal costs do appear to be increasing relative to the FY 2009-10 capitation rate, the child costs seem to have decreased significantly from the FY 2009-10 capitation rate. Due to the six-month run-out period for claims in the SMCN, only two months of claims costs are complete at this time. As such, the Department is not comfortable drawing a trend for the expected full-year FY 2010-11 costs. The Department will, however, continue to closely track the SMCN costs to ensure that all of its cost-containment measures are being followed.

**43. When will the CHIPRA bonus be confirmed?**

RESPONSE:

The Department of Health and Human Services issued an informational bulletin on September 8, 2010, through the Center for Medicaid, CHIP, and Survey & Certification, for States to request and qualify for the Children's Health Insurance Program Reauthorization Act Performance Bonus Payments. The bulletin also stated that the announcement of eligibility for and issuance of the FFY 2010 bonus payments will occur by December 31, 2010. The Department assumes that this schedule will be followed for the FFY 2011 bonus payment, and the initial payment will occur by December 31, 2011. The Department has implemented 5 of the 8 enrollment and retention policies effective July 1, 2010, and assumes that CMS will confirm Colorado's eligibility for the payment in Summer 2011.

### **3:45-4:15: LONG TERM CARE ISSUES**

#### **44. Please explain why nursing facility rates are set in statute while other provider rates are not?**

RESPONSE:

The General Assembly has historically written nursing facility rate methodology into statute. Having provider reimbursement rates in statute interferes with the Joint Budget Committee's responsibility to set the Department's appropriation and interferes with the Executive Branch's responsibility to manage provider reimbursement rates through normal administrative processes. Protection of nursing facility providers, should the rate methodology detail be removed from statute, could be ensured through establishing an oversight and advisory board, as well as through the Medical Services Board.

#### **45. If PACE was expanded to include the disabled population, what kind of cost savings would it drive in the state budget? Is there any way to finance such an expansion without impacting the General Fund.**

RESPONSE:

Current Federal PACE regulations limit PACE enrollees to age 55 and older. The impact to the General Fund from incrementally adding disabled clients over the age of 55 to PACE is difficult to measure. Savings is not guaranteed, as there is currently no reliable method for adjusting for client selection bias when rates are based on equivalent fee-for-service (FFS) costs.

Some states do have other capitated long-term care (LTC) programs that are similar in design to PACE. However, Colorado statute currently prohibits capitated LTC programs beyond PACE. Additional flexibility in statute around program design could allow for fundamental reimbursement reforms with greater General Fund impact.

#### **46. Are there any more strategies that the State could use to make sure as many disabled (especially quadriplegics) are served in the community rather than in nursing facility settings?**

RESPONSE:

Colorado will be applying for the federal Money Follows the Person (MFP) Demonstration Grant. This application is due January 7, 2011. If Colorado is selected, the Department will start work for the grant on April 1, 2011.

A primary focus of the grant is to provide Colorado with the resources to address the barriers faced by people with disabilities who want to transition out of nursing facilities and other long-term care institutions into the community. One of the major barriers is access to affordable and accessible housing. If awarded the MFP grant, the Department will hire a housing specialist in the first year of the grant. This housing specialist will

form and maintain partnerships with the Division of Housing, Supported Housing & Homeless Programs, and local housing authorities throughout the State. Through these more focused collaborations addressing the shortage of housing, the Department, along with the other state agencies, will examine and leverage various tools, such as tax credits to developers, home ownership programs, rental assistance programs, housing inventories and home modification programs, to increase the availability of housing for the disabled community.

The MFP grant will also allow the Department to strengthen Home and Community-Based Services (HCBS) programs by investing in various projects that will create a stronger safety net for people leaving institutional care. By creating a better safety-net with community-based services, the Department will make the HCBS programs and community placement a more viable option for those who are now residing in nursing homes and other long-term care institutions. Some examples of fundable projects include:

- Streamlining access to long-term care services and supports in the community by funding:
  - a marketing campaign to increase awareness of community-based services among the general public (100% federally funded); and,
  - a common information technology platform to better coordinate applications for services across the multiple community agencies people contact to access long-term care services (100% federally funded).
- Strengthening Colorado's Direct Service Worker Workforce (100% federally funded): Recruiting and retaining a qualified workforce to provide direct care to clients is a major challenge in Colorado. The turnover rate among home health aides and personal care providers is high. Through this opportunity, the Department can create a pool of funds that provide small grants or incentives to long-term care service agencies that want to implement the best practices for recruitment, training and retention of qualified direct service workers in our long-term care system.
- Providing a wider array of services to people who are transitioning from institutional settings: Through the MFP grant, the Department can offer new services to people who are transitioning from institutional placements. These new services would be funded at a 75% federal match rate. Such services include life skills training, service animals, assistive technology, employment training and supports and many others. These services will be available to successfully transitioned consumers for one year and then enrolled in current community-based programs.

**47. Please provide the Committee with an update on the status of presumptive eligibility for long-term care services and what are the anticipated savings for this waiver?**

RESPONSE:

HB 09-1103 allowed the Department to seek federal approval for establishing long-term care presumptive eligibility for Medicaid including Home- and Community-Based Services. As the Department moved forward with implementation several issues were identified impacting an applicant's timely approval for services. To address the length of time required to process eligibility, the Department initiated the Colorado Eligibility Process Improvement Collaborative (funded by the Colorado Health Foundation) in mid-2010 to shorten eligibility determination times for family Medicaid and long-term care services.

At this point in implementation, the Department does not anticipate savings from the presumptive eligibility waiver for long-term care services. As other reform initiatives continue the Department may see savings as services shift from nursing home care to lower cost home- and community-based care.

**48. Please provide an update on H.B. 10-1053 regarding the study of long-term care and home-and community-based services waivers (including the use of more assisted living). Did the Department receive sufficient gifts, grants, and donations to have the study performed and will it be submitted to the General Assembly on time?**

RESPONSE:

Alternative Living Facilities (ALFs) are primarily designed to serve older adults and clients with disabilities who don't generally require intensive supervision or medical management. HB 10-1053 authorized the Department to conduct a feasibility study of new payment methodologies that would pay ALFs higher rates to provide services to those clients not typically suited to reside in an ALF. For instance, new payment methodologies may allow clients with dementia or incontinence the option to reside in an ALF rather than a nursing facility or other institutional setting.

The Department did receive sufficient funds through donations from the membership of the Colorado Association of Homes and Services for the Aging and a grant from the Rice Foundation. Originally anticipated to be done by January 2011, the study is now expected to be completed by the end of the first calendar quarter of 2011.

**49. Please provide the Committee with an update on H.B. 10-1005 regarding implementing telehealth for home care.**

RESPONSE:

The Home Care Association recently informed the Department that grant funding had been secured per the requirements of House Bill 10-1005. A cash fund has been created for these grant funds, and the Department is now working on an implementation plan.

Systems changes to allow for the billing of telehealth services have been completed. The Department will next submit rules to the Medical Services Board and will also submit a home health State Plan Amendment that includes the new telehealth service. The Department anticipates minor changes to the model once stakeholder input is incorporated early next calendar year. Pending the approval of the State Plan Amendment, clients could begin receiving telehealth services by mid-to-late spring 2011.

**50. Please respond to the Department of Regulatory Agencies sunset review of the in-home support program. Why is the State not using more in-home support services to reduce the number of clients in nursing facilities?**

RESPONSE:

In-Home Support Services (IHSS) and Consumer Directed Attendant Support Services (CDASS) currently have more than 200 and 1,600 participants, respectively. Both IHSS and CDASS assist an individual in accomplishing activities of daily living including:

- Health Maintenance Activities—Routine and repetitive activities of daily living which require skilled assistance for health and normal bodily functioning;
- Personal Care Services—Routine and repetitive activities of daily living which require non-skilled assistance for health and normal bodily functioning; and
- Homemaker Services—General household activities provided in the home of an eligible client to maintain a healthy and safe home environment when the person ordinarily responsible for these activities is absent or unable to manage these tasks.

CDASS participants are responsible for hiring, training, recruiting, and setting wages. Under IHSS, participants may select their own attendants. Not every CDASS client is cognitively able to effectively direct their care. The Department plans to redirect care for those clients, as appropriate, to IHSS. As the Department continues efforts to increase the transition from nursing facilities to community-based services, the nursing facilities population is declining.

The Department tracks all Home- and Community-Based Services (HCBS) waivers utilization through the Medicaid Management Information Systems (MMIS) claims data. IHSS is an HCBS service. Monitoring MMIS claims data assures the Department that clients are utilizing at least one HCBS service per month is required by the Center for Medicare and Medicaid Services (CMS). The claims data is submitted to CMS annually in the form of a 372 Report. The 372 Report is the tool CMS uses to validate program cost effectiveness and quality. Specific case information as documented by the Single-Entry Point case manager is documented through Benefits Utilization System.

When given the opportunity to review the DORA Sunset Review draft, the Department responded, “HCPF views IHSS as a program with growth opportunities and may serve an important need to clients with limited LTC options.” The Department’s response to the draft DORA Sunset review was not incorporated into the final report.

**51. Has the State ever done a study to determine if the income tax credit for long-term care policies is actually reducing state costs for long-term care services?**

RESPONSE:

The Benefits Coordination Section of the Department is not aware of a study examining either the federal deduction or State of Colorado income tax credit for long-term care partnership policies on the impact on state costs for long-term care services. The sale of partnership policies became effective on January 1, 2008. The number of policies sold at the end of the last reporting period since the effective date equaled 10,970 (as of June 30, 2010).

Any results of such study would predictably be inconclusive due to the nature of long-term insurance purchasing habits. Long-term care insurance pricing is structured to be cost-prohibitive to those who would be utilizing services in the near or immediate future. Similarly, it encourages purchasing by consumers who are not likely to draw from the fund for several years. Given this, any reliable study on long-term care insurance may take years to conduct.

Finally, because the Department does not have data regarding private insurance policies, the Department believes that this question may be best directed to the Division of Insurance, which collects data on this.

**4:15-4:45: HEALTH CARE REFORM AND MISCELLANEOUS**

**52. Please explain the anticipated costs and impact to the Department from the Accountable Care Act (ACA)?**

RESPONSE:

Colorado is ahead of the curve by virtue of having passed the Colorado Health Care Affordability Act (CHCAA) in 2009, which is essentially the State version of the federal Patient Protection and Affordable Care Act of 2010 (ACA). Also, in June 2009, the Department applied to receive grant funding from the federal Health Resources and Services Administration (HRSA) State Health Access Program (SHAP) for the Colorado Comprehensive Health Access Modernization Program (CO-CHAMP). The purpose of this additional grant funding is to augment the funding appropriated under House Bill 09-1293 "Colorado Health Care Affordability Act" and ensure its successful and full implementation. In September 2009, the Department received notice that its application was approved to fund seven comprehensive and interrelated projects totaling \$42,773,029 over the next five years beginning in FY 2009-10.

Because CHCAA and the CO-CHAMP initiative are providing funding for administrative functions to implement the State reform, they are by default funding a lot of the prep work needed to implement ACA. With funding from CHCAA and the CO-CHAMP initiative the Department will be hiring approximately 80 FTE by FY 2011-12, so the Department anticipates that it will have sufficient staffing for the near future. The

Department is not requesting any administrative funding to implement ACA in either FY 2010-11 or FY 2011-12. Please see the Colorado Health Care Affordability Act Update in the Department's November 1, 2010 Budget Request for details regarding administrative funding appropriated from CHCAA.

At this time, Colorado does not know the magnitude of any administrative funding that may be needed in the future. The Department anticipates that modifications to the Colorado Benefits Management System (CBMS) and the Medicaid Management Information System (MMIS) will be required for many of the requirements under ACA, including but not limited to implementing the Medicaid expansions, allowing for the increased enrollee and claims volume from the expansions, and developing the interface with the Exchange. These costs will be addressed in the future through the normal budget process. The Department will be pursuing grant opportunities provided under ACA, and has already received a planning grant for the Money Follows the Person Rebalancing Demonstration Program in the amount of \$200,000.

The Department has estimated the program costs of expanding Medicaid eligibility to 133% of federal poverty line effective January 1, 2014 as required under ACA. These costs can be found on the Department's website at:

<http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251634141864&ssbinary=true>

or in attachment F.

**53. Please explain any outreach the State is providing to the business community regarding the implementation of ACA. Please provide the Committee with any information that the Implementation Board has the economic impact of ACA to the State.**

RESPONSE:

Though the Department is not conducting outreach to the business community regarding the impact of ACA, the State has held a series of outreach meetings throughout the State. Lorez Meinhold, Director of Health Reform Implementation, Steve ErkenBrack, President and CEO of Rocky Mountain Health Plans, and Leo Tokar, Senior Vice President of Lockton Companies did a series of presentations for businesses in Colorado on the health care implementation status in Colorado as well as its ramifications for employers. More information regarding these activities can be found at: [colorado.gov/healthreform](http://colorado.gov/healthreform).

**54. Given that the OAP is an entirely state funded program and requires no federal match, why can't we separate eligibility for OAP from eligibility for Medicaid? What statutory and information technology changes and federal approval (if any) would be required?**

RESPONSE:

Per the Colorado Medicaid State Plan, any individual determined eligible to receive the Old Age Pension payment is eligible for Medicaid if all other eligibility requirements are met, particularly citizenship and length of time in the U.S. Federal regulations require eligibility for the pension payment as a prerequisite for Medicaid eligibility – that is, if the individual receives the pension payment, then they may qualify for Medicaid. During the investigation into whether eligibility for the pension payment could be separated from Medicaid eligibility, some complex federal issues have been uncovered that require additional federal guidance before any state level action. The Department will submit its questions to CMS to determine whether additional federal approval is needed to implement sponsor deeming of income. Once the Department has received the requested federal guidance, it will report its findings to the Joint Budget Committee. The Department anticipates that no additional statutory authority is needed for Medicaid sponsor deeming of income, and only CBMS changes would be required. There are definitely no MMIS changes necessary, and because Medicaid is already federally required to do sponsor income deeming and it is in the State Plan, there is no need for additional state legislation or a SPA.

**55. Please explain how the Department is currently operating without State Medicaid Medical Director? Was it really necessary to increase the salary for this position when increasing the salary does not appear to help the State retain a Medical Director?**

RESPONSE:

The Department was authorized to hire a Chief Medical Officer in SB 07-211 "Improvements to Health Care for Children." The authority and to hire and the qualifications for the position were laid out in C.R.S. 25.5-1-105.5. As a part of its January 2, 2008 FY 2008-09 S-6 BA-1 "Health Care Policy and Financing Medical Director Consortium," the Department requested and was appropriated \$200,000 total funds, \$40,000 General Fund, and \$160,000 federal funds on an annualized basis.

SB 10-167 did not provide any funding for the Chief Medical Officer; it does however, provide a maximum amount of \$17,927 that could be paid per month. The bill also indicated that "the chief medical officer shall receive a salary within the limits of moneys made available to the state department by appropriation of the general assembly or otherwise." This did not increase the Department's appropriation, but allowed the Department to pay more if it had available funds.

As of December 8, 2010, the Department has hired a new Chief Medical Officer. Any savings resulting from the duration of time during which the Department did not have the

Chief Medical Officer filled are considered vacancy savings and that funding has been used to cover other expenditures in the Department's Personal Services line.

**4:45-5:00: CLOSING COMMENTS**

**ADDENDUM: OTHER QUESTIONS FOR WHICH SOLELY WRITTEN RESPONSES ARE REQUESTED**

Please provide:

- 1. [Rep. Gerou] Please provide a table comparing the actual number of department FTEs in FY 2000-01 and the requested number of department FTEs in FY 2011-12, by division or program.**

RESPONSE:

In FY 2000-01 the Department of Health Care Policy and Financing appropriated FTE into 3 Divisions listed below (FY 2002-03 Legislative Budget Request, Schedule 3, November 1, 2001), for FY 2011-12 all FTE are centrally appropriated to the Department's (1) Executive Director's Office, (A) General Administration, Personal Services line item (FY 2011-12 Budget Request, Schedule 3, November 1, 2010).

<b>Division</b>	<b>FY 2000-01 (Actual)</b>	<b>2011-12 (Request)</b>
(1) Executive Director's Office	28.27	312.5
(2) Medical Programs Admin.	126.10	
(4) Indigent Care Program	2.69	
<b>Total</b>	<b>157.06 FTE</b>	<b>312.5 FTE</b>

- 2. [Rep. Gerou/ Rep. Ferrandino] Please provide a table comparing the actual number of FTEs in FY 2008-09 and FY 2009-10 to the appropriated level of FTE for each of those fiscal years, by division or program. If there is a discrepancy of 5.0 percent or more between your FY 2009-10 FTE appropriation and actual usage for that year, please describe the impact of adjusting the FY 2011-12 FTE appropriations to align with actual usage from FY 2009-10.**

RESPONSE:

All FTE in the Department of Health Care Policy and Financing are centrally appropriated to the Department's (1) Executive Director's Office, (A) General Administration, Personal Services line item.

<b>Fiscal Year</b>	<b>Appropriation</b>	<b>Actuals</b>	<b>Difference</b>	<b>% Difference</b>
FY 2008-09	269.2	266.1	3.1	1.15%
FY 2009-10	287.6	276.5	11.1	3.86%

The difference identified for 2009-10 is mainly attributable to the Department's historical turnover rate and the time required to fill positions authorized under HB 09-1293 "Health Care Affordability Act."