DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
FY 2018-19 JOINT BUDGET COMMITTEE HEARING AGENDA

Wednesday, December 13, 2017
1:30 p.m. – 5:00 p.m.

1:30-1:45 Commission on Family Medicine

COFM Presenters:
Barbara Brett - Chair of the Commission on Family Medicine
Blaine Olsen, M.D., CAFMR Chair and Director of St. Joseph's Family Medicine Residency
Kim Marvel, Ph.D., Executive Director of COFM/CAFMR
Lynne Jones, Incoming Executive Director

1. **Provide some history on how the new family residency programs at Sky Ridge and Peak Vista developed. If these residency programs developed organically, why do they now need state funding?**

RESPONSE FROM THE COMMISSION ON FAMILY MEDICINE:

Colorado has two new family medicine residencies: Peak Vista in Colorado Springs and Sky Ridge in Lone Tree. For FY 2018-19, The Commission on Family Medicine (COFM) is requesting an increase in base funding of $600,000 ($300,000 general fund, $300,000 match of federal Medicaid), so the two new programs receive equal base funding as the existing family medicine residencies.

The two new family medicine residencies will add 16 more family physician graduates per year.

There are two principle reasons COFM is requesting state funding for these two new programs:

a) Although these two new programs were started two years ago, they did not receive accreditation from the Single Accreditation System (the Accreditation Council of Graduate Medical Education, or ACGME) until this current year. Before requesting state funds, COFM wanted to be sure the new programs would be accredited, reflecting the quality standards of all Colorado family medicine residencies.

b) Now that the two new programs are accredited by the Single Accreditation System, they qualify for full participation in the Commission on Family Medicine; statute does not give the commission the authority to limit new residency programs The base funding from the General Assembly is shared equally among all family medicine residencies that meet the quality standards of COFM. For the past 20 years, the base funding has been shared equally by the 9 family medicine residencies. Unless the base funding is increased, with 11 programs sharing equally, each of the original 9 programs will receive $66,000 less per year. They will be forced to make reductions in staff, such as eliminating care coordinators or decreasing faculty time, thereby decreasing the quality of the programs. Increasing the base funding by $300,000 (general fund) will enable all 11 programs to continue with

the traditional base funding, without making cuts to the 9 original programs, while adding 16 more family physicians per year.

1:45-2:00 Introductions and Opening Remarks

HCPF Presenters:
Tom Massey, Interim Executive Director
John Bartholomew, Chief Financial Officer
Josh Block, Budget Director
Gretchen Hammer, Medicaid Director
Chris Underwood, Health Information Office Director
Dr. Judy Zerzan, Chief Medical Officer

2:00-2:25 General Program, Eligibility & Benefits

2. **Please provide an overview of the Colorado Indigent Care Program (CICP), including a discussion of the fund sources and uses of the money.**

RESPONSE

The Colorado Indigent Care Program (CICP) allows Coloradans with incomes up to 250 percent of the Federal Poverty Level ($30,150 per year for an individual or $61,500 for a family of four) to receive discounted, sliding fee health care services at participating hospitals, community health centers, and safety net clinics. To qualify for CICP, individuals must be lawfully present in the state and not be eligible for coverage through Medicaid or the Child Health Plan *Plus* (CHP+). CICP clients may have Medicare or private health insurance, in which case they pay the lesser of the CICP co-payment or their Medicare or insurance co-payment and deductible.

Payments to CICP participating providers help offset uncompensated costs associated with serving low-income patients. The funding for participating CICP community health centers and clinics is appropriated under the Indigent Care Program, Clinic Based Indigent Care line. The current appropriation is $6,119,790 total funds and is comprised of General Fund and federal matching funds, drawn using upper payment limit financing.

The funding for participating CICP hospitals is appropriated under the Safety Net Provider Payments line. These payments are funded using the Healthcare Affordability and Sustainability Fee (formerly hospital provider fees) and federal matching funds under the federal Disproportionate Share hospital (DSH) allotment and upper payment limit financing. As noted in the Department's response to the Legislative Request for Information #4 provided to the JBC on February 1, 2017, the Safety Net Provider Payments line funds two different payments to hospitals. The first payment reimburses hospitals that participate in the CICP, while the other reimburses CICP and other hospitals for uncompensated care costs incurred serving Medicaid and uninsured patients. The current Safety Net Provider Payments appropriation is $311,296,186 total funds.

More information about the CICP can be found in the CICP Annual Report delivered to the JBC each February 1.

3. **With the decrease in the number of uninsured people in Colorado, how has the function and role of the CICP changed? Why has the funding not decreased? Should the CICP continue? What would happen to the CICP if Congress repeals the individual mandate?**

RESPONSE

The Colorado Indigent Care Program (CICP) is not an insurance program, but rather a financial vehicle for providers to recoup some of their costs for providing medical services to the low-income Coloradans who are not eligible for Medicaid or Child Health Plan *Plus* (CHP+). The services offered at a discount vary from provider to provider and there is no defined benefit package.

At its peak, the CICP reimbursed clinics and hospitals for approximately 225,000 Coloradans in FY 2010-11 who were uninsured or underinsured. Today, more than 49,000 Coloradans receive services through the CICP annually. While the number of persons receiving services has decreased since the implementation of the Affordable Care Act (ACA), the CICP remains an important safety net for low-income Coloradans who are not eligible for Medicaid or Child Health Plan *Plus* (CHP+) and who cannot afford their out of pocket health care costs. The CICP remains a valuable program for low-income Coloradans and safety net providers alike and it should continue.

The total available amount of funding remains unchanged because participating CICP hospitals and clinics continue to incur uncompensated costs in serving low-income Coloradans even as the available CICP funding covers more of those costs than before. In FY 2016-17, for example, clinics were reimbursed approximately 52 cents per dollar spent on services provided to CICP clients.

Nevertheless, the Department has made changes through the rule making process regarding how the available CICP funds are used. Recognizing that many CICP clients became eligible for Medicaid following the implementation of the ACA, CICP and non-CICP hospitals receive the upper payment limit financing portion of the Safety Net Provider Payments for uncompensated care incurred serving Medicaid and uninsured patients, while only CICP hospitals are eligible to receive the Disproportionate Share Hospital payment portion of the Safety Net Provider Payments line. In addition, beginning in FY 2018-19, distribution of funding to CICP clinics will be based in part on quality metric scores on preventive and screening measures to improve quality of care.

The Department made additional changes to the CICP through the rule making process following more than 12 months of work with stakeholders. These changes improve administrative efficiency while maintaining access to care for clients. Changes include considering income only when determining CICP eligibility and allowing providers to mirror their internal charity care programs if they fit within the CICP's guidelines, such as using an alternate sliding fee scale if it is equivalent or lesser than the traditional CICP scale.

Through rule making the Department also created a formal CICP Stakeholder Advisory Council appointed by the Department's executive director. The advisory council includes representatives of rural and urban hospitals, community health centers, safety net clinics, and consumers or consumer advocates. The advisory

council advises the Department on policies for the CICP and makes recommendations to improve program effectiveness.

If Congress repeals the individual mandate, the Department assumes that some low-income Coloradans who have private health care coverage will lose or choose to discontinue their coverage and will begin to utilize CICP for health care services. Today, the Department has the same number of CICP participating hospitals and nearly as many participating clinics as it did prior to the implementation of the ACA. Because the funding and number of providers is stable, and because the Department has improved administrative efficiency and formalized an advisory council to help the Department adapt to changes in the health care market, the Department believes that the CICP will be able to serve as a safety net for more Coloradans if needed.

4. **Please explain the purpose of the Pediatric Specialty Hospital program. Is the served population not in Medicaid?**

RESPONSE

The Pediatric Specialty Hospital line item was created following a recommendation during a Joint Budget Committee meeting on March 24, 2005.

This line item provides funding to the state's only pediatric specialty hospital, Children's Hospital Colorado, to help offset the costs of providing care to large numbers of Medicaid and indigent care clients. Children's Hospital Colorado is a high-volume Medicaid and Colorado Indigent Care Program (CICP) hospital with more than 60 percent of their inpatient patient care days provided to Medicaid clients and uninsured patients.

The payment is a Medicaid payment and is comprised of General Fund and federal Medicaid matching funds using upper payment limit financing.

5. **Is the Department maximizing opportunities to draw a federal match for certified public expenditures (CPE)? Where does the Department currently use CPE?**

RESPONSE

The Department maximizes opportunities to draw federal Medicaid matching funds using certified public expenditures (CPE). The Department currently draws federal matching funds using CPE for the following program areas: Public School Health Services, Nursing Facilities, Home Health, Denver Health Ambulance, Public High-Volume Hospital, Physician Supplemental, and Connect for Health Colorado Systems. The Department's FY 2018-19 budget request includes a request to use CPE for an Emergency Medical Transportation payment.

The table below reflects the budget amounts in total funds for each payment for FY 2017-18 and the requested amounts for FY 2018-19.

Certified Public Expenditure Appropriations			
Row	**Description**	**FY 2017-18**	**FY 2018-19**
A	Public School Health Services	$93,022,977	$99,599,702

B	Nursing Facility Payment	$3,472,724	$3,678,209
C	Home Health Payment	$455,736	$653,988
D	Denver Health Ambulance Payment	$5,875,449	$6,355,256
E	Public High-Volume Hospital Payment	$8,279,309	$1,166,763
F	Physician Supplemental Payment	$14,118,236	$10,886,400
G	Connect for Health Colorado Systems	$5,144,208	$5,144,208
H	Emergency Medical Transportation Payment (1)	$0	$18,139,431
I	**Total**	**$130,368,639**	**$145,623,957**

(1) From the Department's R-16 "CPE for Emergency Medical Transportation Providers" budget request submitted November 1, 2017

In addition, the Department is currently exploring opportunities for federal matching funds using CPE for local agencies where other states have been successful. If the Department identifies any additional opportunities, the Department would use the regular budget process to request new spending authority.

6. **Compare the eligibility criteria for Medicaid with other major public assistance programs, including food stamps. How do work requirements for other public assistance programs, such as food stamps, interact with Medicaid?**

RESPONSE

Medicaid, the Supplemental Nutrition Assistance Program (SNAP), and Cash Assistance are three of the major public assistance programs in Colorado. Each of these programs operates under different federal rules for eligibility determinations. As a result, the other programs have a number of requirements different from those used for Medicaid, including different policies for household composition, countable income, communications regarding eligibility, and use of electronic interfaces. For example, SNAP income limit is 130 percent of the Federal Poverty Level (FPL) while Medicaid’s income limit is 133 percent FPL for adults and 143 percent FPL for children. SNAP’s household composition is based on individuals that purchase and prepare meals together while Medicaid’s household composition for adults and children is based on tax dependency status.

SNAP and Cash Assistance have various work requirements. These work requirements do not impact Medicaid eligibility. Other than the Medicaid Buy-In for Working Adults with Disabilities program, Medicaid does not have work requirements.

7. **Compare the maximum co-pays Colorado could charge for Medicaid under federal regulation with current co-pays. How much would it save to increase co-pays to the maximum? Why is the Department not charging the federal maximum co-pays? How do Colorado's co-pays compare to other states?**

RESPONSE

Federal regulations exempt certain populations from out of pocket costs, including co-pays. Examples include children, pregnant women and American Indians and Alaska Natives. In addition, some services are

also exempt, including emergency services, pregnancy-related services and preventive services for children. Medicaid premiums and cost sharing incurred by all individuals in the Medicaid household may not exceed an aggregate limit of 5 percent of the family's income.

The following table provides a comparison of Colorado's current co-pays to the maximum allowed under federal regulations.

Comparison of Colorado Co-pays to Maximum Allowed under Federal Regulation				
Service	**Current Medicaid Co-pay Amount[1]**	**Federal Maximum for Individuals with Family Income…**		
		…Less than 100% of the FPL	**…Between 101-150% of the FPL**	**…Greater than 150% of the FPL**
Outpatient Hospital visit	$4	$4	10% of the cost the agency pays	20% of the cost the agency pays
Physician (M.D. or D.O) office or home visit	$2	$4	10% of the cost the agency pays	20% of the cost the agency pays
Rural health clinic visit	$2	$4	10% of the cost the agency pays	20% of the cost the agency pays
Brief, individual, group and partial care community mental health center visits except services which fall under Home and Community-Based Services programs visit	$2	$4	10% of the cost the agency pays	20% of the cost the agency pays
Pharmacy	$3	Preferred drugs $4; non-preferred drugs $8	Preferred drugs $4; non-preferred drugs $8	Preferred drugs $4; non-preferred drugs 20% of the cost the agency pays
Optometrist visit	$2	$4	10% of the cost the agency pays	20% of the cost the agency pays
Podiatrist visit	$2	$4	10% of the cost the agency pays	20% of the cost the agency pays
Inpatient hospital visit	$10.00 per day up to 50% of the Medicaid rate for	$75	10% of total cost the agency	20% of total cost the agency

Comparison of Colorado Co-pays to Maximum Allowed under Federal Regulation				
Service	**Current Medicaid Co-pay Amount[1]**	**Federal Maximum for Individuals with Family Income…**		
		…Less than 100% of the FPL	**…Between 101-150% of the FPL**	**…Greater than 150% of the FPL**
	the first day of care in the hospital		pays for the entire stay	pays for the entire stay
Durable medical equipment/disposable supply services, per date of service	$1	$4	10% of the cost the agency pays	20% of the cost the agency pays
Laboratory services, per date of service	$1	$4	10% of the cost the agency pays	20% of the cost the agency pays
Radiology services, per date of service	$1	$4	10% of the cost the agency pays	20% of the cost the agency pays
Non-emergency Use of the Emergency Department	$6	$8	$8	No Limit

Footnotes:
(1) Co-pay amounts as of 1/1/2018

The Department estimates it would save $32,174,631 total funds, including $10,425,505 General Fund to implement new co-pays and increase existing co-pays to the federal maximum. Please refer to the table below for the breakdown in impact between new and existing co-pays.

Item	Total Funds	General Fund
Savings from Increasing Existing Co-pays[1]	($7,285,511)	($1,135,554)
Savings from New Co-pays[2]	($24,889,120)	($9,289,951)
Total Full Year Impact	**($32,174,631)**	**($10,425,505)**

Footnotes:
(1) Estimated savings account for increases in co-pays for the following services: pharmacy, physician services, federally qualified health centers, rural health centers, inpatient services, durable medical equipment, lab and x-ray.
(2) Estimated savings account for new co-pays for the following services: anesthesia, NEMT, dental, acute home health, long-term home health, private duty nursing, and waiver services.

In this analysis, the Department assumes a uniform co-pay increase to the amounts listed in Table 1, "Federal Maximum for Individuals with Family Income Less Than 100% of the FPL," for clients of all Federal Poverty

Levels (FPLs), including those above 100 percent FPL.[1] Medicaid premiums and cost sharing incurred by all individuals in the Medicaid household may not exceed an aggregate limit of 5 percent of the family's income. Further, please note that this is not a complete fiscal estimate; the Department may have additional administrative costs (such as for system changes and provider outreach and noticing) that have not been included in this analysis.

Why is the Department not charging the federal maximum co-pays?

Changing co-pays would cause a fiscal impact, and would need to be approved by the General Assembly. The most recent action by the General Assembly (SB 17-267) directed the Department to require recipients to pay:

- For pharmacy, at least double the average amount paid by recipients in state fiscal year 2015-16; or
- For hospital outpatient services, at least double the amount required to be paid as specified in the rules as of January 1, 2017

Increases in co-pays cause a corresponding reduction in payments from the Department to providers. Pursuant to federal regulations, the agency must reduce the payment it makes to a provider by the amount of a beneficiary's cost sharing obligation, regardless of whether the provider has collected the payment or waived the cost sharing.

In addition, charging higher co-pays may adversely impact client health and access to care. According to a 2017 Kaiser Family Foundation report[2]:

> …a growing body of research has found that cost sharing is associated with reduced utilization of services, including vaccinations, prescription drugs, mental health visits, preventive and primary care, and inpatient and outpatient care, and decreased adherence to medications. In many of these studies, co-payment increases as small as $1-$5 can effect (sic) use of care. Some studies find that lower-income individuals are more likely to reduce their use of services, including essential services, than higher-income individuals. Research also suggests that co-payments can result in unintended consequences, such as increased use of other costlier services like the emergency room…

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[1] If the Department establishes different cost sharing charges for different FPL tiers, 42 CFR 447.52 (g) "Income Related Charges" states the Department must ensure that lower income individuals are charged less than individuals with higher income. In instances where 10% or 20% of the cost of service is less than the co-pay for individuals with FPLs less than 100%, the Department assumes it must require clients to pay the lesser co-pay, regardless of FPL. For example, if the Department reimburses $30 of outpatient hospital services for a client with income that is 120% FPL, the client's maximum co-pay would be $3, which is less than the $4 co-pay assessed on individuals with incomes less than 100% FPL. In this example, the Department would need to make sure that all clients are assessed the $3 co-pay for the $30 outpatient service, regardless of their FPL, and therefore would collect $1 less in co-pays on all outpatient services reimbursed at $30. For this reason, the Department assumes total co-pays may go up or down under a co-pay maximum that is based on a percentage of the cost of the service.

[2] https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/

> Numerous studies find that cost sharing has negative effects on individuals' ability to access needed care and health outcomes and increases financial burdens for families. For example, studies have found that increases in cost sharing are associated with increased rates of uncontrolled hypertension and hypercholesterolemia and reduced treatment for children with asthma. Increases in cost sharing also increase financial burdens for families, causing some to cut back on necessities or borrow money to pay for care. In particular, small co-payments can add up quickly when an individual needs ongoing care or multiple medications. (Citations and emphasis omitted.)

How do Colorado's co-pays compare to other states?

Compared to the 37 other states for which co-pay information was readily available, Colorado generally charges at or below the median.

Service	States with Co-pays	Median Co-pay	Colorado Co-pay
Outpatient hospital visit	19	$3	$4
Physician (MD or DO) office or home visit	24	$3	$2
Rural health clinic visit	12	$3	$2
Pharmacy	30	$2	$3
Optometrist visit	21	$2	$2
Podiatrist visit	20	$3	$2
Durable medical equipment/disposable supply services, per date of service	12	$3	$1
Laboratory services, per date of service	7	$2	$1
Radiology services, per date of services	6	$1	$1
Non-emergency use of emergency department	16	$6	$6

8. The Department's annual report on the Senior Dental Program indicates:

. . . the demand for this program is greater than available funds can cover. As with last fiscal year, several grantees ran out funds and began waiting lists for FY 2017-18. More than half of the grantees indicated the need for more funds to alleviate waiting lists and provided suggestions to assist with this.

a) What is the funding amount for this program and how has it changed over the years?
b) How many seniors does the program serve and what is the annual cost per senior?
c) What has the Department heard from providers and other stakeholders about the need for additional funding?
d) How many seniors are in need of services who are not able to get them and how much more funding would the Department need to serve them?
e) Are there some areas with no participating providers? Would additional funding result in more provider participation in more communities?

RESPONSE

a) Program Funding History
The Colorado Dental Health Care Program for Low-Income Seniors (Senior Dental Program) was created with the enactment of SB 14-180 and funding for grants began in FY 2015-16. The program's appropriation for grants has been $2,962,510 General Fund in each of its three years since inception. The Department fully expended grant funds in FY 2015-16 and FY 2016-17 and expects to fully expend the available funds again this year.

b) Seniors Served and Annual Cost per Senior
In FY 2015-16, a total of 2,828 seniors received dental services through the Senior Dental Program with an average expenditure of $982 per senior. In FY 2016-17, a total of 2,734 seniors were served with an average expenditure of $1,083 per senior.

c) Provider and Stakeholder Feedback
In FY 2016-17, thirteen of the 21 grantees informed the Department that the demand for dental services for qualified seniors was greater than the available funds. In that year, 15 of the 21 grantees exhausted their grant funds before the end of the year and began waiting lists for both new and current patients.

To date in FY 2017-18, seven of 23 grantees have requested more funds because their grant amounts are not expected to provide services to all seniors in need of dental care. Of those, three grantees have informed the Department that they cannot accept any new seniors for services at this time within available funds and have started waitlists.

d) Number of Seniors in Need of Services and Funding Required
In FY 2016-17, Senior Dental Program grantees reported a total of 1,110 seniors on waiting lists with an estimated cost for services of $1,175,628 for an average unmet need of $1,059 per senior. The Department does not have data on the number of seniors currently on waitlists for services this fiscal year. Since three grantees have already begun waitlists, the Department assumes there is at least the same unmet need this year.

e) Areas without Participating Providers and Additional Funding
There are no Senior Dental Program grantees in the following 12 counties: Archuleta, Baca, Cheyenne, Dolores, Huerfano, Kiowa, La Plata, Las Animas, Montezuma, Ouray, Prowers, and San Juan. If additional funds were appropriated to the program, the Department would solicit grant applications for these areas where there are no current grantees. Following that recruitment effort, the Department would use any remaining additional funds to increase grant awards to current grantees to reduce waitlists.

9. **Identify optional Medicaid eligibility categories and benefits provided in Colorado. Estimate the savings if optional eligibility or benefits were reduced.**

RESPONSE

There are many optional benefits covered under Colorado's Medicaid program, as listed in section 25.5-5-202, C.R.S. (2017). These include prescribed drugs, clinic services, home and community-based services, adult dental care, and others. Because they are not mandatory benefits per the Social Security Act, the state could choose to reduce or eliminate them. However, the Department does not believe that doing so would

result in cost savings to the state, especially in the long term, and could have a negative impact on quality of care to enrollees. Most of the benefits are substitutes for other, often more expensive benefits. For example, eliminating the pharmacy benefit could have serious impacts on an enrollee's health and result in increased use of the emergency room and hospitalizations. If the state no longer offered home and community-based services, enrollees who need long-term services and supports would be more likely to be served in a nursing facility or other institutional setting, which are much more expensive to the state.

There are also many optional eligibility categories served under Colorado's Medicaid program. These categories are described in section 25.5-5-201, C.R.S. (2017). The eligibility reductions that are possible would either not save a significant amount of General Fund, or would have drastic consequences for the people affected. For example:

- The eligibility expansions authorized under SB 13-200 are funded via the Healthcare Affordability and Sustainability (HAS) Fee Fund, not the General Fund, and have disproportionately high federal match rates. To illustrate the consequences: If the General Assembly eliminated eligibility for MAGI Adults in FY 2018-19, state savings would only be 6.5 percent of the total funds reduction; a reduction of $1.7 billion would achieve only $112 million in savings to the HAS Fee, and forgo $1.6 billion in federal funds.
- The state optionally covers the elderly and individuals with disabilities with income up to 300% of the Supplemental Security Income (SSI) limit; to qualify for this category, individuals must qualify for services in a nursing facility (although services can be provided at an individual's home). If this eligibility category were eliminated, these individuals would be responsible for procuring their own services and supports, which would be difficult as most insurance plans do not cover these services. These individuals would be required to liquidate and spend their remaining assets (such as their homes), potentially forcing spouses or dependent children into poverty. Ultimately, it is likely that these individuals would then qualify for Medicaid again after their assets are depleted.

Below is a table of all optional eligibility groups and estimates of expenditure for those groups in FY 2018-19. These are high-level estimates of each population; they do not account for all eligibility criteria nuances within each category that could impact the savings estimates.

Summary of Optional Medicaid Eligibility Groups and FY 2018-19 Estimated Expenditure				
Eligibility Groups	**C.R.S. Citation**	**FY 2018-19 Projected Expenditure**	**General Fund**	**FMAP**
Expansion Parents/Caretakers to 133% of FPL	25.5-5-201 (1)(m)	$278,287,810	$0	93.50%
Expansion Adults without Dependent Children to 133% of FPL	25.5-5-201 (1)(p)	$1,717,329,456	$0	93.50%
Non-Expansion Parents/Caretakers Over 35% of FPL	25.5-5-201 (1)(m)	$115,556,346	$39,753,727	50.00%

Elderly and Disabled Individuals Above the Supplemental Security Income Limit to 300% of FPL	25.5-5-201 (1)(g)	$723,529,999	$361,764,999	50.00%
Foster Care Children - Do Not Meet the Requirements of Title IV-E of the SSA	25.5-5-201 (1)(l)	$6,772,406	$3,386,203	50.00%
Legal Immigrant Prenatal	25.5-5-201 (4)	$8,398,150	$4,199,075	50.00%
Medicaid Pregnant Adults Over 133% - SB 11-250 Eligible Pregnant Adults	25.5-5-201 (1)(m.5)	$24,630,169	$2,955,620	88.00%
Breast and Cervical Cancer Treatment Program	25.5-5-308 (2)	$846,557	$0	65.00%
Buy-In for Individuals with Disabilities	25.5-5-206	$69,870,629	$0	50.00%

10. How many able-bodied adults under 35 are on Medicaid? How many are transient? What percent do they represent of the total Medicaid population and how much do we spend on them?

RESPONSE

In FY 2016-17, average caseload for Medicaid clients ages 19 to 34, excluding clients eligible with disabilities, was 322,304. This represents approximately 23.94 percent of the Medicaid population in FY 2016-17 and includes both traditional populations (low-income parents/caretakers, pregnant adults, foster care, etc.) and clients eligible through the Affordable Care Act (ACA) expansion. In response to the transient question, the Department does not have data on why people enter or leave the state. The Department estimates that expenditure in FY 2016-17 for this population was approximately 20.20 percent of service expenditure, or $1.2 billion total funds, of which approximately $213 million was General Fund.

FY 2016-17 Caseload and Expenditure for Medicaid Clients Ages 19 to 34 without Eligibility Determinations for Medicaid Populations with Disabilities				
Row	**Item**	**FY 2016-17 Average Caseload[1]**	**FY 2016-17 Average Per Capita[2]**	**FY 2016-17 Estimated Total Expenditure**
A	Traditional Medicaid Low-Income Parents/Caretakers	84,409	$2,977.09	$251,293,190
B	Traditional Medicaid Children	2,361	$1,185.18	$2,798,210
C	Traditional Medicaid Foster Care	3,513	$5,419.74	$19,039,547
D	Traditional Medicaid Pregnant Adults	13,496	$9,995.42	$134,898,188
E	Traditional Medicaid Non-Citizens Emergency Services	1,889	$15,431.99	$29,151,029
F	ACA Medicaid Expansion Parents/Caretakers	43,423	$2,641.43	$114,698,815
G	ACA Medicaid Expansion Adults	173,213	$3,992.19	$691,499,206
H	Total	322,304	$3,857.78	$1,243,378,185

11. Do trends in the Medicaid penetration rate over time differ for rural and urban communities? Please provide an appendix with Medicaid penetration rates over time by county.

RESPONSE

Trends in the Medicaid penetration rates differ between urban and rural communities. Rural and frontier communities have a larger share of Medicaid clients as a percentage of total county population, and have experienced larger increases in the share of Medicaid clients compared to urban communities over the last four years, as demonstrated in the table below. The increase in the last fiscal year, however, was roughly equivalent between frontier, rural, and urban counties. Please see Appendix A for more information.

Percentage of County Population Enrolled in Medicaid by Fiscal Year			
Year	**Urban Counties**	**Rural/Frontier Counties**	**All Counties**
FY 2013-14	14.1%	15.5%	14.2%
FY 2014-15	21.0%	23.6%	21.4%
Change from FY 2013-14 to FY 2014-15	**7.0%**	**8.1%**	**7.1%**
FY 2015-16	23.1%	25.8%	23.4%
Change from FY 2014-15 to FY 2015-16	**2.1%**	**2.2%**	**2.1%**
FY 2016-17	24.0%	26.6%	24.3%
Change from FY 2015-16 to FY 2016-17	**0.9%**	**0.8%**	**0.9%**
Change from FY 2013-14 to FY 2016-17	**9.9%**	**11.1%**	**10.1%**

12. Why is Colorado Medicaid's enrollment of people with disabilities increasing faster than the Colorado population under 65? Is there a similar trend in other states? What are the policy implications of the trend in Colorado?

RESPONSE

Individuals who receive Supplemental Security Income (SSI) are guaranteed Medicaid eligibility. Individuals receiving SSDI may or may not be eligible for Medicaid following a full eligibility determination. A national trend shows enrollment of people with disabilities in Social Security programs, outpacing the growth of the population since the 1970s. The Social Security Administration (SSA) estimates that[3]:

- The working-age population of the United States (ages 15–64) grew 49 percent between 1970 and 2000, from 125 million to 186 million.
- Over that same period, the number of disabled-worker beneficiaries increased nearly 240 percent, from 1.5 million to more than 5 million.

[3] https://www.ssa.gov/policy/docs/chartbooks/disability_trends/sect03.html

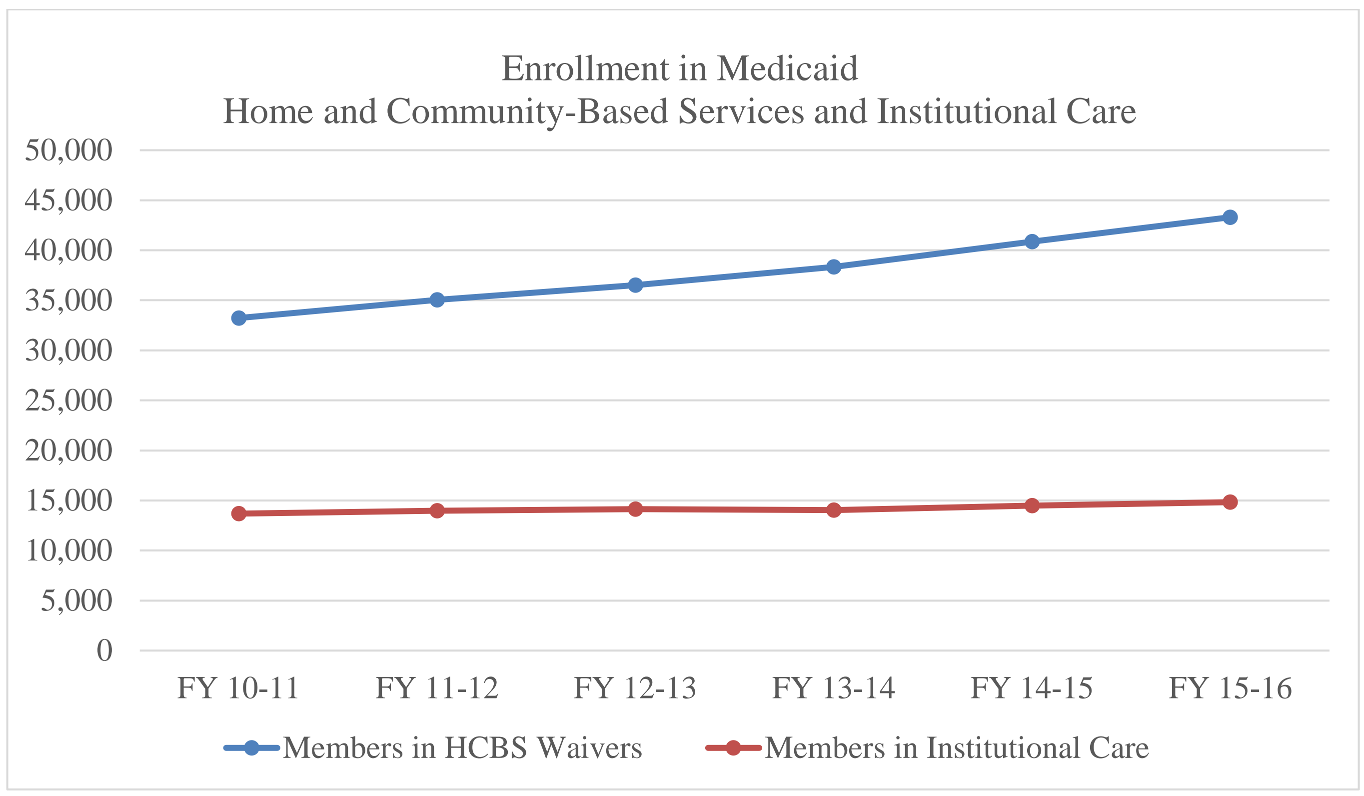
- The Supplemental Security Income (SSI) program did not exist until 1974, but the population of blind and disabled adult SSI recipients aged 18–64 increased 150 percent, from 1.5 million in 1974 to 3.7 million in 2000.

The SSA identifies several things that affect the relationship between the size of the population and the number of people enrolled in disability programs, including the change in the age distribution due to the baby boomers, the health of the population, improvements in medical treatments, economic circumstances, and changes in disability policy.

To understand and respond to shifting demographic trends in Colorado, the Department has been an active participant in the Strategic Action Plan on Aging for Colorado and has regular meetings with colleagues at the Departments of Human Services, Public Health and Environment, and Local Affairs, Division of Housing. Participating in these meetings informs policy and program design to ensure we are developing programs to appropriately meet the needs of Coloradans.

One example is the Medicaid Buy-In Program for Working Adults with Disabilities, which allows adults to pursue work but retain critical services through Medicaid by paying a monthly premium to "buy-in" to the Medicaid programs. The Department projects that it will spend $64.6 million on Medicaid services for individuals enrolled in this program in FY 2018-19.

One metric of impact we are tracking is the utilization of services. Over the last six years, as enrollment by people with disabilities has grown, the Department has been successful at continuing to serve clients with disabilities in the community. Community services tend to be less expensive than institutional services. The chart below shows enrollment in Home and Community-Based Service waivers growing over time, while those clients enrolled in facilities remains relatively stable.



Note: "HCBS Waivers" includes enrollment in all 11 HCBS waivers. "Institutional Care" includes enrollment in skilled nursing facilities and private intermediate care facilities (ICFs).

13. Approximately how many people in Colorado have disabilities?

RESPONSE

Total Population and Total Population with a Disability, Ages 0-64, 2016				
2016	**US**		**CO**	
	Total	**Percent of Total**	**Total**	**Percent of Total**
Total Population (ages 0-64)	266,565,868		4,670,415	
With Disability (ages 0-64)	23,693,679	9%	345,299	7%

Source: U.S. Census Bureau, 2016 American Community Survey (ACS) 1-Year Estimates

Note: The ACS definition of disability is based on six questions. A person is coded as having a disability if he or she or a proxy respondent answers affirmatively for one or more of these six categories:

1. **Hearing Disability** (asked of all ages): Is this person deaf or does he/she have serious difficulty hearing?
2. **Visual Disability** (asked of all ages): Is this person blind or does he/she have serious difficulty seeing even when wearing glasses?

3. **Cognitive Disability** (asked of persons ages 5 or older): Because of a physical, mental, or emotional condition, does this person have serious difficulty concentrating, remembering, or making decisions?
4. **Ambulatory Disability** (asked of persons ages 5 or older): Does this person have serious difficulty walking or climbing stairs?
5. **Self-care Disability** (asked of persons ages 5 or older): Does this person have difficulty dressing or bathing?
6. **Independent Living Disability** (asked of persons ages 15 or older): Because of a physical, mental, or emotional condition, does this person have difficulty doing errands alone such as visiting a doctor's office or shopping?

14. Please describe interactions between federal disability income and Medicaid eligibility. Are people on Medicaid also eligible for federal disability income and vice versa?

RESPONSE

There are several types of federal disability income including Veterans Benefits and Railroad Benefits; however, the two that most frequently interact with Medicaid eligibility are Social Security Disability Insurance and Supplemental Security Income:

1. Social Security Disability Insurance (SSDI) is countable as unearned income in the Medicaid eligibility determination. Since individuals receiving SSDI may be over the income eligibility limit for Medicaid, they may or may not be eligible for Medicaid following a full eligibility determination.

2. Supplemental Security Income (SSI) is a means tested program that has income and resource limits. Since the income and resource limits for SSI are approximately 73 percent of the Federal Poverty Level, the state allows for those who qualify for SSI to be automatically qualified for Medicaid.

15. Can data be exchanged between the federal VA, HCPF (Medicaid), and the DMVA to help identify veterans who are eligible for VA benefits? What is the feasibility of adding veteran status information in CBMS and Medicaid records?

RESPONSE

(a) Currently, the Department receives some data on enrollment in veterans' benefits from the federal VA through a database called the Public Assistance Reporting Information System (PARIS). Upon approval and executed data use agreements from the federal VA and the DMVA, additional data could be exchanged to help identify veterans who are enrolled in VA benefits. The resources and time needed for this implementation would be dependent on the specific policy goals and objectives.

(b) CBMS currently stores some veteran status information that is reported by applicants. Information about veterans' benefits is also accessible through the federal PARIS database on a case-by-case basis, which can be manually accessed by eligibility workers. The feasibility of adding additional veteran status information in CBMS and Medicaid records would depend on the specific information sought and any related system changes required to automate and store the information.

16. **The Department of Military Affairs indicated that Washington has a pilot called PARIS and a Veterans Benefit Enhancement Project which tracks this information and asks these questions. DMVA believes Colorado may be part of a related three-year pilot. Please confirm the status of any related pilot.**

RESPONSE

Washington state's Public Assistance Reporting Information System (PARIS) pilot program commenced in 2003 and has been a fixture of the state's operations since that time. Colorado does not have a pilot program similar to Washington's program. Washington's program focuses on maximizing access to veterans' benefits through the U.S. Department of Veterans Affairs (VA) by Medicaid recipients.

The Department does use information from PARIS to determine if individuals who are eligible for Medicaid in Colorado are also eligible for public assistance in other states. SB 10-167 added a requirement for HCPF to access PARIS data "for the purpose of ensuring that duplicate benefits are not being paid improperly to persons identified pursuant to [PARIS]." The Department participates in PARIS by exchanging data and has one employee to coordinate the use of the data identified by PARIS matches by county eligibility sites. The Department's November 1, 2017 budget request R-8, "Medicaid Savings Initiatives," addresses the Department's use of the data matches with other states based upon its participation in PARIS. The Department requested funding to streamline and automate the PARIS interstate match process, and provide internal resources to improve the process to prevent inappropriate expenditures. The Department estimated that, by directing additional resources to this area, it would achieve savings of $1.0 million total funds, $312,000 General Fund in FY 2018-19, growing to $2.9 million total funds, $754,000 General Fund in FY 2019-20.

2:25-2:35 Electronic Visit Verification

17. **The General Assembly has worked to increase rates for Personal Care and Home Health services in recent years, but the Department's R6 Homecare visit verification projects a decrease in payments to these providers. Explain how billing procedures will change with the new system. Could the savings be used to increase the hourly pay for Personal Care and Home Health providers?**

RESPONSE

With the implementation of Electronic Visit Verification (EVV), the Department does not project a decrease in payments to providers for valid claims. Colorado currently relies on providers to bill the Department for services rendered based on the provider's self-reported hours. Agencies track service provision via multiple methods, including paper timesheets, electronic timesheets, or EVV systems. The current billing policies and procedures do not require real-time verification of service provision. The proposed EVV system would require providers to clock in and out when they begin and finish providing services using a combination of telephone and internet-based resources. The savings outlined are estimated from a reduction in visits and

units billed per-visit for all services in which EVV is implemented, due to efficiencies gained through more accurate billing practices, and mitigation of fraud, waste, and abuse.

The Governor submitted a balanced budget on November 1, 2017, which contained the Executive Branch's priorities for rate changes. The Department cannot provide additional recommendations for rate increases outside of the established budget process.

Should the General Assembly want to increase hourly pay for personal care and home health providers, additional information from the Department's rate setting and rate reviewing work may be of interest. As of October 1, 2017, the Department is using a new rate methodology that complies with the Centers for Medicare and Medicaid's (CMS) requirements for the following HCBS waivers: Elderly, Blind and Disabled, Brain Injury, Community Mental Health Supports, Spinal Cord Injury, and Children's Home and Community-Based Services. The methodology incorporates factors including indirect and direct care requirements, facility expense expectations, administrative expense expectations, and capital overhead expense expectations. Any proposed rate increases will require the Department to identify and justify which components of the service the rate increase impacts. Accordingly, additional scrutiny must be given to potential rate increases to ensure they are justifiable and ultimately approvable by CMS.

Additionally, Home Health service rates and Personal Care waiver service rates were evaluated through the Department's rate review process, in 2016 and 2017 respectively (2016 Medicaid Provider Rate Review Analysis Report,[4] pp.57-58; 2017 Medicaid Provider Rate Review Analysis Report – HCBS Waivers,[5] p.19, p.79, p.102). Information on the impact of current rates on access, service utilization and quality as well as how current rates compare to identified benchmarks can be found in these reports.

18. Please describe the implementation plan for the home care visit verification project. How much has the Department utilized the expertise of the Office of Information Technology in planning the system? What are the plans for testing and does the implementation schedule allow for sufficient testing and stakeholder feedback?

RESPONSE

The Department's goal is to implement a fully functional Electronic Visit Verification (EVV) service by January 1, 2019. Assuming the Department receives supplemental funding in April, this timeline leaves approximately 9 months for the Department to coordinate with an EVV vendor to design, disseminate, and train providers to use an EVV service. During this time, the Department would also need to oversee the integration of the EVV service with the current Colorado interChange. In order to meet this deadline, and meet the goal of minimally disrupting provider operations and client quality of care, the Department is requesting FTE resources to form teams that would oversee implementation, which will include testing and stakeholder feedback. As provided in the budget request, the Department's current high-level timeline for implementation is as follows:

- Stakeholder outreach (September 2017 - ongoing)

[4] https://www.colorado.gov/pacific/sites/default/files/2016 Medicaid Provider Rate Review Analysis Report.pdf
[5] https://www.colorado.gov/pacific/sites/default/files/2017 Medicaid Provider Rate Review Analysis Report - HCBS Waivers.pdf

    - First EVV stakeholder meeting held September 18, 2017
- Hire Project Manager and Business Analyst (March 2018 – April 2018)
- Draft contractor scope of work (April 2018 – June 2018)
- Hire all staff (July 2018)
- EVV contractor implements EVV service and trains providers (July 2018 – December 2018)
- Colorado interChange integration with EVV service interfaces (July 2018 – December 2018)
- Department engages in statewide targeted stakeholder outreach (July 2018 – December 2018)
- Department drafts and implements rule changes (July 2018 – December 2018)
- Department submits State Plan Amendment to CMS (July 2018 – September 2018)
- Department submits Implementation Advance Planning Document to CMS (October 2018 – December 2018)
- Department submits Waiver Amendments to CMS (October 2018 – December 2018)
- EVV Service Go-Live (January 1, 2019)

The FTE requested in the budget request will establish a detailed implementation plan. The implementation plan will describe how the new contracted service will be deployed and will contain an overview of the service, a brief description of the major tasks involved in the implementation, the overall resources needed to support the implementation effort, and any other implementation requirements. The implementation plan can be shared with stakeholders once it has been established.

The Department will partner with the Governor's Office of Information Technology (OIT) and engage in the OIT project gating process for the visit verification project and will employ best practices to achieve accurate reporting of the status and risks throughout the deployment. The Department is technically contracting for a service and not a visit verification IT system that will be administered by the Department or OIT. The Department will also partner with OIT to ensure that any data handled by the vendor and all interfaces to existing state systems meet state cyber security requirements.

The Department and selected vendor will ensure the implementation plan includes sufficient time for user acceptance testing (UAT). During UAT, the Department and vendor will engage with the users, staff and stakeholders to test the new service to make sure it can handle required tasks in real-world scenarios. Any defects or issues identified will be resolved before the service is deployed.

19. What federal regulation requires the home care visit verification system? Is there any wiggle room to not implement the system, or implement it in a different way? What are the penalties for non-compliance with the regulation?

RESPONSE

The implementation of an Electronic Visit Verification (EVV) system is required by H.R. 34 of the 114th Congress, also known as the 21st Century Cures Act (the Act). The Act was signed into law on December 13, 2016, and mandates that all states implement an EVV system for Personal Care services by January 1, 2019, and for Home Health services by January 1, 2023. The sole source of formal guidance on this mandate is encompassed in Section 12006 of the Act. The Act states that if EVV is not implemented by the deadlines

outlined, the state will incur incremental reductions in its federal medical assistance percentage (FMAP) which compound until EVV is implemented. Specifically, for Personal Care services, FMAP would be reduced by: 0.25 percentage points in 2019 and 2020; 0.5 percentage points in 2021; 0.75 percentage points in 2022, and; 1 percentage point in 2023 and each year thereafter. For Home Health services, the reductions in FMAP are the same and applied on the same interval, but the schedule begins in 2023.

The Act indicates that if a state has made a "good faith effort" to comply with the EVV requirement, which includes taking steps to adopt the technology used for an EVV system *and* that implementation has encountered an unavoidable system delay, then the reduction of FMAP will not be applied for the first year of the mandates (2019 for Personal Care and 2023 for Home Health). It is unclear, however, what the Centers for Medicare and Medicaid Services would consider an unavoidable system delay.

20. Why does the Department need 8.0 FTE to implement the home care visit verification? What duties will the FTE perform?

RESPONSE

The Department requested 8.0 FTE to aid in implementation and ongoing oversight of Electronic Visit Verification (EVV). Of these FTE, 4.0 are requested as permanent staff and 4.0 are requested as term limited positions through June 30, 2021.

The Department's goal is to implement a fully functional EVV system by January 1, 2019. If the Department receives supplemental funding in April, this timeline leaves approximately nine months for the Department to coordinate with an EVV vendor for system design, software dissemination, and provider training. During this time, the Department would also need to oversee the integration of the newly designed EVV system with the current Colorado interChange system. To meet this deadline, and meet the goal of minimally disrupting provider operations and client access to care, the Department is requesting significant FTE resources to form two teams that would oversee implementation from a systems perspective, and a programmatic perspective focused on provider/client experience. The first team would be focused on systems implementation and includes 5.0 FTE and the second would be focused on policy and stakeholder engagement and includes the remaining 3.0 FTE. A detailed description of the positions below.

FTE Descriptions

Position Name	Position Classification	Number of FTE	Description
Program and Policy Operations Staff			
Home and Community-Based Services Policy Specialist	Administrator IV	1.0	The Policy Specialist would be responsible for ongoing oversight and administration of EVV system. The position would be responsible for tracking and maintaining compliance with all regulatory and statutory policy. The position would ensure coordination and collaboration with systems, providers, and pay sources. The position would work closely with inter- and intra-Departmental teams as well as external stakeholders to create, review, and update policy as needed. The position would coordinate with case management entities, as well as participant directed organizations, to provide guidance when necessary. This position would be the subject matter expert on EVV for all HCBS waiver services. This position would be responsible for the ongoing federal and state administration of policy and regulatory requirements.
Quality Assurance Specialist	Administrator III	1.0 (term limited through June 30, 2021)	The Quality Assurance Specialist would be responsible for ensuring compliance with all quality and performance requirements. The position would use data to understand potential areas of concern and highlight audit risks when appropriate. The EVV system will identify instances of potential fraud/waste/abuse by flagging claims that do not comply with EVV requirements. This position would review and investigate client and provider patterns of fraudulent activity for the purpose of making referrals to the Program Integrity division and recommendations on program improvement through rule revision.
Medicaid Provider Policy Specialist	Administrator IV	1.0	This position would formulate, plan, design, develop, evaluate, and resolve problems for the functions of the EVV system as it applies to the Home Health, Private Duty Nursing, and State Plan Personal Care Benefit areas. Managing these benefits would require the position to research and recommend best practices; identify and address benefit or policy gaps; respond to provider inquiries about EVV; and assess current and future EVV policies to meet the Department's expectations for a high level of efficiency, economy, and quality of care. This position would act as subject matter expert on programs not covered under an HCBS waiver.

Systems Implementation and Maintenance Staff			
Project Coordinator	Project Coordinator	1.0 (term limited through June 30, 2021)	The Project Coordinator would oversee the implementation of the EVV system. This position would coordinate EVV implementation while monitoring the effect on the overall MMIS system, coordinate recording of modifications for management control, and manage compliance of solutions with federal legislation or rules for the Department. This position would provide program and project management expertise to Department staff, business associates and contractors in developing appropriate business solutions for implementing federal mandates and Department initiatives. Mandates include MMIS changes under Health Insurance Portability and Accountability Act (HIPAA), Medicaid Information Technology Architecture (MITA), and other regulatory and/or strategic initiatives related Health IT/Health IE (Information Exchange).
Business Analyst	Analyst III	1.0 (term limited through June 30, 2021)	The EVV tool is a new system component that must be fully developed and integrated with the Colorado interChange. This requires a Business Analyst to work with the vendors in the requirements elicitation process. Due to the timeframe for completing initial Design, Development, and Implementation (DDI) of the EVV subsystem, allocation of this FTE would be central to the project's success. The Department would need permanent, ongoing support from this FTE to ensure smooth integration between the Colorado interChange system components as future enhancements are implemented, specifically to fully capture downstream subsystem requirement impacts. This requires specialized, ongoing knowledge of the business analysis capabilities of the technical functions and integration points of the EVV tool with the larger Colorado interChange system, as well as maintained awareness of potential federal and state regulation or rule changes that could affect daily EVV processes.
Testing Analyst	Analyst III	1.0 (term limited through June 30, 2021)	The Testing Analyst (TA) would validate that the scope of the developed EVV functionality fully meets Department business requirements. This position would work with the Policy Analysts to understand the requirements of the EVV system based on provider feedback and federal regulation. This position would identify systemic shortfalls before implementation and would

			work with other systems staff to remedy these issues. The position would ensure the functionality of ongoing system updates.
Operations Analyst	Analyst III	1.0	The Operations Analyst position would manage, analyze, and resolve escalated EVV transactions processed by the Colorado interChange to ensure ongoing EVV functionality. The Operations Analyst would review escalated claims and prior authorizations established by the EVV system. The Operations Analyst would regularly provide clarification and education to Fiscal Agent monitoring staff, public and private partners, and contractors when questions about EVV systems functionality arise. The position would follow up with written and verbal responses to resolve all issues that surface during the review of escalated transactions.
Data Analyst	Statistical Analyst III	1.0	The role of the Data Analyst would be to understand the structure of the EVV database, and to understand the EVV system's integration into the MMIS database management system, in order to provide reliable and useful ad-hoc reports. These ad-hoc reports would be used by other FTE on the EVV to monitor provider service delivery behavior and to prevent fraudulent billing. This position would be required to utilize business intelligence software to write complex queries to extract data from the EVV system directly or through the Department's business intelligence and data management system. The position would write code to manipulate data to provide actionable information to answer very specific questions around the operations and evaluation of the EVV system. The position would summarize the data into understandable reports and communicate findings to internal and external customers. The position would be required to work with the EVV contractor, auditors, and federal and state agencies to produce reports out of the EVV to meet their requests.
Grand Total		**8.0**	

21. How does travel time factor into the rates for personal care and home health services? Do the rates sufficiently account for differences in travel times in rural locations?

RESPONSE

Travel time is not currently incorporated into the rate methodology for any Personal Care services. The rates paid to home health agencies do not explicitly include travel expenses; however, the rates to the agencies are higher than rates paid for similar services provided in office settings.

Through the rate setting and rate review work of the Department there have been multiple conversations about how to sufficiently account for travel times in rural locations. The Medicaid Provider Rate Review Advisory Committee (MPRRAC) has a guiding principle that states the Department should review rates while accounting for differences in geography. Accordingly, the Department will continue to work with the provider community and stakeholders to evaluate rates as necessary including cost associated with travel.

2:35-3:00 Provider Rates & Transportation

22. Please provide a copy of the recommendations from the Medicaid Provider Rate Review Advisory Committee (MPRRAC).

RESPONSE

The Department incorporated the MPRRAC's recommendations for services reviewed in year two of the Department's rate review process within the body of the 2017 Medicaid Provider Rate Review Recommendation Report.[6] The Department also included explanations of where those recommendations do and do not align with Department recommendations (p.4), and provided a full list of MPRRAC recommendations within Appendix A of the report (p.11).

MPRRAC feedback helps to inform Department recommendations, which are submitted to the Joint Budget Committee and the MPRRAC annually. The MPRRAC does not review or provide edits to the Recommendation Report prior to publication on November 1, though the Department takes steps to keep the committee fully informed of planned content ahead of publication. To be as transparent as possible, in both the 2016 and 2017 Recommendation Reports, the Department reported all MPRRAC recommendations, including those that differed from the Department's final recommendations.

MPRRAC and Department discussion summaries related to recommendation development can be found on the Department website,[7] within the May 19, 2017, July 21, 2017, and draft September 15, 2017 MPRRAC meeting minutes.

[6]https://www.colorado.gov/pacific/sites/default/files/2017%20Medicaid%20Provider%20Rate%20Review%20Recommendation%20Report%20November%202017.pdf

[7] https://www.colorado.gov/pacific/hcpf/medicaid-provider-rate-review-advisory-committee

23. Please discuss the rationale of the Department and MPRRAC for why anesthesia rates are too high, and summarize the dissenting view expressed by a minority of members of the MPRRAC.

RESPONSE

The Department's recommendation for a reduction in anesthesia service rates is informed by Department subject matter expert research, MPRRAC feedback, and the findings of the 2017 Medicaid Provider Rate Review Analysis Report – Physician Services, Surgery, and Anesthesia,[8] which revealed Department payments for anesthesia services were 131.64 percent of the benchmark (p.94-100). Based on the information presented, the MPRRAC voted on and approved the recommendation, by a margin of 10-5, that "the Department should bring anesthesia rates from 131.64 percent of the benchmark to 100 percent of the benchmark."

One of the guiding principles for rate review established by the MPRRAC is to use an existing rate benchmark where appropriate. The MPRRAC voted down the recommendation offered by MPRRAC members with a dissenting view, by a margin of 5-10, that "the Department should redo the rate benchmark comparison for anesthesia services using a basket of benchmarks that include market benchmarks."

For a summary of discussions between MPRRAC members leading up to this vote, see the July 21, 2017 MPRRAC meeting minutes.[9]

During the conversations about rates for anesthesia services, a committee member communicated the perspective that Medicare was not an appropriate benchmark for anesthesia services. During the January 20, 2017 MPRRAC meeting, this committee member presented two documents to the MPRRAC and the Department:

- A report prepared by the U.S. Government Accountability Office titled "Medicare and Private Payment Differences for Anesthesia Services" (GAO Report) as support that Medicare was not an appropriate benchmark for the anesthesia services rate benchmark comparison.
- A document prepared by the Colorado Society of Anesthesiologists titled "Addressing the Colorado Medicaid Reimbursement Disparity for Anesthesia Services" (CSA Document), which contained a request for increased anesthesia reimbursement and talking points to support that request.

The Department and the MPRRAC reviewed these documents and concluded that Medicare was, in fact, an appropriate comparator for anesthesia services. Reasons behind this conclusion include, but are not limited to:

- Age of the GAO Report - The GAO Report was published in 2007, using estimates based on 2002 and 2004 data; Medicare has yet to adjust payments for anesthesia services based on the results of this report.

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[8]https://www.colorado.gov/pacific/sites/default/files/2017 Medicaid Provider Rate Review Analysis Report - Physician Services%2C Surgery%2C and Anesthesia.pdf

[9] https://www.colorado.gov/pacific/sites/default/files/MPRRAC Meeting Minutes July 2017.pdf

- The Centers for Medicare and Medicaid Services' (CMS) Response to the GAO Report – While CMS stated that the GAO Report "provides a good summary of information collected from a variety of sources" (GAO Report, p.31), CMS had "concerns about the limitations of the analysis" (GAO Report, p.32). These concerns included that the list of codes used in the GAO's analysis did not align with top codes utilized by Medicare clients (the same applies to Colorado Medicaid clients), and that differentials in payments do not necessarily indicate a deficiency; the Department agrees.

A MPRRAC member within the dissenting minority also stated that access analyses for hospital-based providers, including anesthesiologists, are flawed because such providers cannot determine how many Medicaid clients they serve. The Department notes that most hospitals have the ability to limit the number of Medicaid clients their providers serve, with the exception of emergency services, which are subject to different federal regulations and must be provided by hospitals regardless of a person's ability to pay.

24. How would the proposed changes to anesthesia rates affect nurse anesthetists?

RESPONSE

Under the proposed changes, anesthesia rates paid to Certified Registered Nurse Anesthetists (CRNAs) who independently administer anesthesia will be affected in the same way as payments to anesthesiologists. It is difficult to evaluate the direct impact of a rate change on CRNAs administering anesthesia under the supervision of an anesthesiologist because the Department currently makes one payment for anesthesiology services rendered, irrespective of how many providers are involved.

The anesthesia service recommendation applies to procedure codes 00100-01999. The recommendation does not apply to other services that an anesthesiologist or CRNA may perform, such as pain management and substance use disorder services.

25. When the JBC raised anesthesia rates, were the rates already above Medicare rates, and was this part of the public discussion of the rate increase?

RESPONSE

Before the JBC raised rates for anesthesia in FY 2015-16, Medicaid payments were at 94.64 percent of Medicare considering service utilization. The targeted rate increase was applied to the anesthesia rates used for the payment calculation. The below chart outlines rate comparisons pre- and post- targeted rate increase, and with and without the additional 0.5% across-the-board (ATB) rate increase factored in:

Comparison of FY 2015-16 Approved Medicaid Rate Increases to Medicare and FY 2014-15 Medicaid Rates	Total Estimated Payments[1]	
	As a Percent of 2015 Medicare	Percent Increase over FY 2014-15 Medicaid
FY 2014-15 Medicaid Rates	94.64%	0.00%
FY 2014-15 Rates with $12.8 million Targeted Rate Increase	128.44%	35.70%
FY 2014-15 Rates with $12.8 million Targeted Rate Increase and 0.5% ATB Increase[2]	129.07%	36.37%

[1] Total estimated payments are calculated for each anesthesia service (FY 2014-15 Medicaid rate, FY 2014-15 Medicaid rate with an additional $12.8 million, FY 2014-15 Medicaid rate with an additional $12.8 million and a 0.5% rate increase, 2015 Medicare rate) and the percentages in these columns reflect the comparison between the estimated totals.
[2] This is the final approved amount after the 0.5% ATB rate increase was applied on top of the $12.8 million.

On May 25, 2015, the Department released a public notice including information regarding the targeted rate increases and requested comments to be submitted to the Health Programs Office Director of the Department. However, the Department does not believe that the anesthesia targeted rate increase was the result of a public discussion, given that the Department was asked for the rate evaluation after the JBC had already acted to include this rate increase in SB 15-234, the FY 2015-16 Long Bill. As a reference, SB 15-228, which created the Medicaid Provider Rate Review and Advisory Committee, was signed on 6/5/2015.

26. How are Emergency Medical Transportation (EMT) providers reimbursed? Does the reimbursement methodology adequately compensate providers for drugs used, such as drugs for opioid overdoses? Does the reimbursement methodology inadvertently drive over-transportation or inappropriate utilization of EMT services?

RESPONSE

Ground ambulance Emergency Medical Transportation (EMT) providers are reimbursed a base rate for each one-way trip, plus mileage. Current EMT rates are found on the Provider Rates & Fee Schedule section of the Department's website.[10]

When a client is transported to a facility, EMT providers are compensated for drugs administered according to the Department's fee schedule. This compensation is distinct from transportation compensation. If EMT providers administer drugs and the client refuses transport to a facility (also known as "treat and release"), EMT providers are not reimbursed.

[10] https://www.colorado.gov/hcpf/provider-rates-fee-schedule

The Department does not believe the reimbursement methodology drives inappropriate utilization or over-transportation. If the EMT provider receives an emergency call, they must respond. However, the provider cannot transport the client via EMT unless they have a critical or unknown illness or injury that demands immediate medical attention to prevent permanent injury or loss of life. Additionally, transportation must be to the closest, most appropriate facility. These regulations are in place to ensure appropriate utilization of EMT services.

27. What does the MPRRAC recommend as the goal for Emergency Medical Transportation service rates? What would it cost to achieve that goal?

RESPONSE

The MPRRAC recommended first bringing Colorado Medicaid rates to parity with surrounding states, then bringing rates to parity with Medicare (2016 Medicaid Provider Rate Review Recommendation Report,[11] p.24). As reported in the 2016 Medicaid Provider Rate Review Analysis Report (pp.75-80),[12] EMT and Non-Emergent Medical Transportation (NEMT) service payments were 30.74 percent of the benchmark, which included Medicare and other states. Within the same report, the Department estimated that increasing FY 2014-15 payments for EMT and NEMT services to 100 percent of the benchmark would have cost approximately $74.1 million in additional total funds and $25.2 million General Fund. Based on this analysis, the Department estimates the FY 2018-19 cost of increasing EMT and NEMT rates would be $92.2 million total funds, $31.3 million General Fund.

Last year, the General Assembly appropriated $4,882,669 additional total funds, including $1,647,446 General Fund for transportation services. The Department was supportive of this appropriation, which resulted in a 7.01% rate increase for all transportation services, including EMT services, effective on July 1, 2017. In its November 1, 2017 budget request R-16, “Certification of Public Expenditure for Emergency Transportation Providers,” the Department has also requested additional funds to provide supplemental payments to EMT providers to partially offset the uncompensated costs associated with providing EMT services.

28. How is the Department coordinating with the Department of Transportation in identifying alternative forms of transportation for Medicaid recipients?

RESPONSE

In recent months, the Department has been working with the Department of Transportation (CDOT) to discuss needs for additional bus routes for long distance buses (e.g., Bustang) and have even discussed alternative forms of transportation such as providing bicycles through Non-Emergent Medical Transportation (NEMT).

As part of the Department’s November 1, 2017 Budget Request R-8, “Medicaid Savings Initiatives,” the Department proposes using discounted bus fares which would allow the Department to begin offering bus

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[11] https://www.colorado.gov/pacific/sites/default/files/2016 Medicaid Provider Rate Review Recommendation Report.pdf
[12] https://www.colorado.gov/pacific/sites/default/files/2016 Medicaid Provider Rate Review Analysis Report.pdf

passes for Non-Medical Transportation as a less costly alternative to other means of transportation. The Department is collaborating with RTD in the Denver Metro Area, which has the greatest number of Medicaid recipients, as a starting point. Once the program is developed within Denver metro area, Department staff will begin exploring and reviewing options for a statewide expansion.

The Department also has an appointed representative and is an active participant in the Teller and El Paso County Transportation Committee created by SB 17-011. The Department is prepared for the results of the report and plans on further collaboration to continue to improve transportation access for people with disabilities.

Finally, the Department is open to exploring utilization of Transportation Network Companies (TNCs), such as Uber and Lyft, for NEMT and NMT. The Department is planning to host a Benefits Collaborative in January 2018 which will include NEMT and the Request for Proposal (RFP) for the NEMT Broker in the Denver metro area. In that discussion, the Department is requesting feedback on the addition of a TNC option in NEMT.

29. How do the recommendations of the Department and the MPRRAC regarding Home and Community-Based Services rates relate to the Department's efforts to consolidate waivers?

RESPONSE

The rate review process is an opportunity to systematically review certain rates paid by the Department for services. The rate review process has brought new transparency and stakeholder engagement opportunities to the evaluation of whether currently established rates are sufficient to allow for provider retention, client access and high-quality services. The work has helped the Department and stakeholders better understand the rates we pay and how service delivery is impacted by rates.

Rate setting work is informed by what is learned through rate reviewing, but includes additional information gathering and often has additional requirements for compliance with state and federal requirements. Rate setting is also prospective, determining what will be paid in the future, not what has been paid in the past.

The Department is committed to leveraging all information learned through the rate review of Home and Community-Based Services to inform the management of all home and community-based services and the specific work to consolidate waivers. However, additional work will need to be done as part of the actual rate setting work to ensure compliance of the rate methodology in the final waiver.

30. Please compare rates for the Program for All-inclusive Care for the Elderly (PACE) with rates for nursing homes over time.

RESPONSE

The table below summarizes changes in PACE and nursing facility average rates since FY 2011-12.

Table 1: Comparison of PACE and Nursing Facility Rates Over Time[1]				
Fiscal Year	**Average Daily PACE Rate**	**Percent Change in PACE Rate**	**Average Nursing Facility Per Diem**	**Percent Change in Nursing Facility Per Diem[2]**
FY 2011-12	$114.17	-	$149.54	-
FY 2012-13	$111.12	-2.67%	$153.84	2.88%
FY 2013-14	$120.04	8.03%	$162.51	5.64%
FY 2014-15	$122.37	1.94%	$165.36	1.75%
FY 2015-16	$123.74	1.12%	$172.29	4.19%
FY 2016-17	$123.33	-0.33%	$179.49	4.18%
Cumulative Change		8.03%		20.03%

Footnotes:
(1) These rates do not include patient payment collected by the PACE organization or nursing facility. Patient payment in nursing facilities is approximately $35 per day and patient payment in PACE is approximately $8.
(2) Average nursing facility rates may not increase exactly by 3% per HB 08-1114 due to year over year changes in case-mix between facilities with different rates.

31. **While the Governor's budget process is confidential, a change to nursing rates would have a large impact on providers and clients. Why did the Department not consult with stakeholders, including the relevant legislative committees of reference, prior to requesting legislation to reduce nursing home rates? What is the Department doing to engage stakeholders now that the request is public?**

RESPONSE

As mentioned in the question, the Governor's budget process is confidential and the Department is unable to discuss budget requests or the potential need for legislation with external stakeholders prior to the budget's November 1 release. The Executive Branch budget process involves many deliberative decisions and the 2 percent cut exercise required by SB 17-267 contributed to, but was not the deciding factor in, this recommendation.

The Department already received preliminary inquiries from stakeholders regarding the change to Skilled Nursing Facility rates. The Department plans to cover this topic during the January 2018 Nursing Facility Advisory Council (NFAC) monthly meeting. The NFAC is the Department's primary venue for stakeholder engagement and covers 95 percent of the Medicaid-participating Skilled Nursing Facility providers, either through association representation or individual participation.

Concurrently, the change to Skilled Nursing Facility rates is also on the agenda for the Provider Fee Advisory Board (PFAB) in January. The Department anticipates that discussion will be focused on how the proposed rate cut will impact the Provider Fee fund.

The Department participates in a quarterly Colorado Certification Collaborative (CCC) meeting with stakeholders, Centers for Medicare & Medicaid Services (CMS), and Colorado Department of Public Health & the Environment (CDPHE). The group next meets in February; the Department will provide rate change updates to this additional group of stakeholders.

Finally, the Department will conduct targeted outreach to stakeholders throughout December and January to ensure people have a forum to ask questions or discuss concerns.

32. **Why do nursing homes get a special three percent statutory increase? What year was the nursing home rate increase established in statute? What other providers of 24/7 care or in-home care receive annual rate adjustments?**

RESPONSE

Section 25.5-6-202, C.R.S. requires the Department to establish a rate for each nursing facility based on a combination of the costs of the individual facility and statewide nursing facility costs. The statutory methodology contains a limitation at section 25.5-6-202(9)(b)(I) that effectively limits rate increases to three percent per year; however, because nursing facility costs continue to grow, most facilities receive a three percent rate increase each year. At the time of the original legislation, the General Assembly found that "…certain components of the current Colorado Medicaid system of reimbursement for class I nursing facility providers threaten the receipt of adequate health care and other services for the state's Medicaid recipients who reside in class I nursing facilities" (HB 08-1114, Section 1, Legislative declaration). Prior to 2008, statute provided for annual rate increases for nursing facilities based on both individual and statewide costs without an overall restriction on rate growth.

The current nursing facility rate methodology was originally established in statute in 2008, via HB 08-1114; subsequent legislation altered and reorganized the statute, but did not substantively change the rate methodology. This legislation also established the Nursing Facility Provider Fee.

No other providers of 24/7 care or in-home care are statutorily required to receive annual rate adjustments.

33. **Please explain the relationship between the nursing facility provider fee and nursing home rates.**

RESPONSE

The Department reimburses nursing facilities for services provided to Medicaid residents through a per diem rate comprised of General Fund and federal matching funds and through supplemental payments comprised of provider fees and federal matching funds.

The growth of the General Fund per diem rate is capped in statute. Supplemental payments funded with provider fees help make up the difference between the General Fund growth limited per diem rate and a nursing facility's full per diem rate.

The nursing facility provider fee amount is also limited by statute. Supplemental payments are funded according to a hierarchy established in statute to the extent provider fees and federal matching funds are available. Under the hierarchy, supplemental payments for acuity or case-mix of residents, payments for quality performance, and payments for residents with moderate to severe mental conditions, cognitive dementia, or acquired brain injury are funded before payments for the difference between the General Fund limited per diem rate and the full per diem rate.

34. Last year the General Assembly increased funding for certain home health and LPN private duty nursing rates equal to one third of the cost to increase these rates to 90 percent of Medicare's Low Utilization Payment Adjustment (LUPA) rate. What would it cost to fund the second third this year? Why did the Department not include the additional money in the request?

The Department estimates the cost to fund the second third of the increase to 90 percent of the LUPA rate to be $6,155,034 total funds, including $2,937,529 General Fund and $49,036 cash funds in FY 2018-19.

The Department did not request additional funding in the November 1, 2017 (FY2018-19) budget for this increase because the Department did not recommend increased funding for certain home health and LPN private duty nursing services last year and does not recommend further increasing funding for these services this year.

As summarized in the 2016 Medicaid Rate Review Analysis Report[13] (p.57-58,42), the Department found that rates for these services were sufficient to allow for provider retention and client access.

Further, the Department did not recommend increasing home health service rates to 90 percent of LUPA because the Department's analysis concluded that Medicare's LUPA rate is not an appropriate comparator (2016 Medicaid Rate Recommendation Report,[14] p.14). Reasons included, but were not limited to:

- Client eligibility – Medicare clients must be confined to the home to receive home health services; Health First Colorado clients do not have to be confined to the home to receive home health services.
- Utilizer characteristics – Medicare provides services for the elderly, while Health First Colorado provides home health services to other populations as well, including children and adults under 65, who have different diagnoses and health care needs.
- Unit designations - Health First Colorado has some tiered payments based on visit type' Medicare does not.

The Department notes that the Medicaid Payment Advisory Commission's (MedPAC) response to CMS's proposed rule "Medicare and Medicaid Programs; CY 2018 Home Health Prospective Payment System Rate

[13] https://www.colorado.gov/pacific/sites/default/files/2016 Medicaid Provider Rate Review Analysis Report.pdf
[14] https://www.colorado.gov/pacific/sites/default/files/2016 Medicaid Provider Rate Review Recommendation Report.pdf

Update and Proposed CY 2019 Case-Mix Adjustment Methodology Refinements; Home Health Value-Based Purchasing Model; and Home Health Quality Reporting Requirements" indicates MedPAC believes Medicare home health rates are too high.

Additionally, the MPRRAC's recommendation to increase rates to 90 percent of LUPA applied only to home health services, not to private duty nursing services.

3:00-3:15 R8 Medicaid Savings Initiatives

35. One of the proposals in R8 Medicaid savings initiatives is new prior authorization review (PAR) requirements. How will the Department ensure the PARs do not delay treatment for individuals with medically eligible services?

RESPONSE

The Department has many ways to ensure client care is not delayed due to PAR requirements. The Colorado PAR vendor is contractually required to process each PAR within a four-day turnaround time. Additionally, PARs are processed within a two-day turnaround time when PARs meet urgent review criteria. Prior authorization is not required when needed services are emergent.

When developing PAR criteria, the Department evaluates the impact of PAR requirements on providers and client access to care. Changes to prior authorization requirements often necessitate changes to Department rules and amendments to the State Plan. Stakeholders may provide input and feedback during structured forums such as Benefits Collaborative meetings, Public Rule Review meetings, testimony at the Medical Services Board, and other Department convened forums when PAR policy changes are proposed. The Department also conducts extensive provider outreach and education to ensure providers are aware of new PAR requirements so that they can integrate PARs into their processes without negatively impacting timely treatment.

36. What cosmetic surgeries are authorized under Medicaid?

RESPONSE

Medicaid does not cover cosmetic surgeries, but does cover medically necessary surgeries, such as reconstructive surgeries. Per 5 CCR 2505-10 8.011.11, which is generally referenced in regard to the exclusion of services for purely cosmetic reasons, "Excluded from coverage are items and services which generally enhance the personal comfort of the eligible person, but are not necessary in the diagnosis of, nor contribute meaningfully to the treatment of an illness or injury, or the functioning of a malformed body member; this exclusion does not apply to inoculations and immunizations provided." Services that are provided must adhere to Department policies and medical necessity regulations as specified at 10 CCR 2505-10 8.076.1.8.

It is important to note that some surgical procedures can be medically necessary or elective depending on the clinical needs of the patient. For example, rhinoplasty is a covered service when medically necessary to treat clinically significant nasal deformities, but is a non-covered service when performed for purely cosmetic reasons. The Department's November 1, 2017 budget request R-8, "Medicaid Savings Initiatives" proposed prior authorization of surgeries that are sometimes elective and sometimes medically necessary, to ensure appropriate utilization of covered services.

37. In R8 Medicaid savings initiatives the Department proposes, among other things, using discounted RTD bus fares to reduce Medicaid costs. How would this affect RTD's already overburdened finances?

RESPONSE

The Department has been collaborating with RTD on the feasibility and implementation of the required discounts within the Non-Medical Transportation (NMT) and Non-Emergent Medical Transportation (NEMT) programs. They are both aware of and prepared to offer these discounts pending legislative approval.

The discounted fares for NMT and NEMT would only be available to clients who are 65 and older and/or have a disability. RTD is currently conducting a study to evaluate their existing pass programs. Regardless of the outcomes of the study, RTD will continue to provide half-rate fares to the people 65 and older and people with disabilities as required by the Federal Transit Administration, 49 CFR §609.23.

38. How will the Department's request address transportation in communities outside the boundaries of RTD? Is the Department doing anything to utilize alternate providers, such as Uber or Lyft?

RESPONSE

Through the programs for Non-Emergent Medical Transportation (NEMT) and Non-Medical Transportation (NMT), the Department pays for qualified transportation in areas outside of RTD boundaries. The Department is collaborating with RTD in the Denver Metro Area on the potential NMT service expansion, which has the greatest number of Medicaid recipients, as a starting point. Once the program is developed within the Denver metro area, Department staff will begin exploring and reviewing options for a statewide expansion of bus passes for NMT.

The Department has been exploring the utilization of Transportation Network Companies (TNCs), such as Uber and Lyft, for NEMT and NMT and has identified some significant hurdles to implementation. This is a preliminary list of steps that would need to be taken to implement the use of TNCs in NEMT and NMT:

- Create a process to ensure that NEMT trips are only for covered services and locations.
- Create a process to ensure NMT trips do not exceed the member's authorized limit.
- Create an eligibility verification mechanism for the transportation provider to be able to see if the person is eligible for NEMT or NMT services.
- Create rates, regulations, and provider requirements for TNCs, including driver requirements to ensure the safety of vulnerable populations.

- Create a TNC provider type or specialty in the MMIS.
- Create a payment mechanism with the TNC to bill the MMIS.
- If TNCs were added within the Denver metro area, the broker contract would need to be amended to account for reduced trip counts or add TNC as a provider type.
- Create a process to ensure the least costly mode of transportation, suitable to the client's condition, is utilized for NEMT and not just the most convenient.

The Department is planning to host a Benefits Collaborative in January 2018 which will include NEMT and the Request for Proposal (RFP) for the NEMT Broker in the Denver metro area. In that discussion, the Department is requesting feedback on the addition of a TNC option in NEMT.

39. Please provide an update on efforts to reduce regulation and get more non-emergency transportation providers in the market, pursuant to H.B. 16-1097. Have these efforts been effective?

RESPONSE

HB 16-1097 created a new category of "limited regulation carriers," Medicaid Client Transport (MCT) Permit which is valid for one year after issuance by the Public Utilities Commission (PUC), and must be renewed annually. The permit allows providers of Non-Emergent Medical Transportation (NEMT) and Non-Medical Transportation (NMT) to operate under an MCT Permit rather than a certificate of public convenience and necessity. The PUC began issuing MCT Permits on December 1, 2016. As of December 7, 2017, 109 companies were issued MCT Permits. Each company can have multiple vehicles and drivers. The new permit type has been effective in allowing more NMT and NEMT providers to enter the market while maintaining appropriate levels of regulatory oversight.

40. How does the Department's request relate to the Department of Transportation's pilot study on different forms of transportation due on December 30?

RESPONSE

The Department has an appointed representative and is an active participant in the Teller and El Paso County Transportation Committee created by SB 17-011. The Non-Emergent Medical Transportation (NEMT) and Non-Medical Transportation (NMT) portions of the Department's FY 2018-19 budget request R-8, "Medicaid Savings Initiatives," aligns with the intent and purpose of the group as it seeks to improve transportation access for people with disabilities. The Department is prepared for the results of the report and plans on further collaboration to continue to improve transportation access for people with disabilities.

41. Please describe the Department's proposal in R8 Medicaid savings initiatives to increase trust recoveries. Are these disability trusts? Are the Department's policies with regard to trusts changing, or just the degree of enforcement of those policies? What will the impact be on families of people with disabilities?

RESPONSE

The Department's November 1, 2017 budget request R-8, "Medicaid Savings Initiatives," included funding for 2.0 FTE to increase staffing to review trust compliance issues and identify additional recoveries that the Department is currently unable to respond to due to limited staff resources. The Department estimated that it would achieve General Fund savings of $1.3 million in FY 2018-19, and $1.6 million in FY 2019-20 with these resources. The Department's proposal is aimed at the trust compliance in general and is not solely focused on disability trust compliance.

The Department's policies regarding trusts are not changing. The Department's rules require that all trusts be submitted for review. The unit that performs these reviews has not grown proportionately with the increase in Medicaid enrollees. The Department's proposal is intended to correct this and facilitate the Department's legal duty to review and monitor trusts.

Disability trusts require oversight by the Department, so while the policies are not changing, the Department's ability to provide this oversight will be facilitated by the proposal. Families of people with disabilities may notice greater oversight, but this will ultimately benefit recipients by ensuring trustees are following the law and conserving trust assets for Medicaid recipients' benefit.

42. How will outcomes for clients change by implementing the initiatives proposed in R8 Medicaid savings initiatives? How do these initiatives connect to the Department's goals and objectives?

RESPONSE

The initiatives as proposed in the Department's FY 2018-19 R-8 "Medicaid Savings Initiatives" would improve client choice and ensure that services and supports are provided at the right time, in the right setting, and for the right duration, which leads to better health outcomes for Medicaid clients.

Utilization management is a core component of the administration of health insurance benefits. The resources requested in R8 will support a high quality prior authorization request (PAR) process in Colorado Medicaid. The resources will ensure the appropriate use of clinical expertise, nationally-recognized medical necessity criteria, stakeholder-informed benefit coverage policies, and evidence-based policies. Appropriate access to services and timely care will improve health outcomes and limit unnecessary or duplicative services for clients.

The Benefits Collaborative process is a structured research and stakeholder engagement process that aids in the development of benefit coverage policies. This process allows the benefits of the Medicaid program to be adapted as medical evidence changes and ensures that the benefits of Medicaid are structured to meet the unique needs of Medicaid enrollees.

The Non-Medical Transportation (NMT) benefit to include bus passes will improve client independence and choice in accessing services, which aligns with recommendations from the Community Living Advisory Group on transportation.

The initiatives in this request align with the mission of the Department to improve health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources. They also align with many of the Department's FY 2017-18 Performance Plan strategies to increase client engagement

and health literacy, implement cost containment strategies, improve efficiency of business processes and promote compliance with federal and state regulations.

43. What will the parental fees, proposed in R8 Medicaid savings initiatives, for the Children's Home and Community-Based Services (CHCBS) waiver look like? Will they be on a sliding scale based on income?

RESPONSE

The Department worked with CHCBS stakeholders to design three potential sliding scale models for the parental fee. If the request is approved, the Department would perform actuarial analysis and select the most appropriate one to create fairness and equity in the context of this waiver and the Children's Medicaid Buy-In program. For purposes of this request and to estimate potential revenue, the Department has selected one of the models developed, which represents the lowest revenue estimate of all developed models.

The selected model has six tiers based on the household's Federal Poverty Level (FPL).

Example Fee Tiers and Monthly Premium		
Tier	**FPL**	**Premium**
1	0-275%	None
2	276-400%	2.5% of income
3	401-525%	3.0% of income
4	526-650%	4.0% of income
5	651-899%	5.0% of income
6	900% and above	6.0% of income

44. Would implementing a parental fee for the Children's Home and Community-Based Services (CHCBS) waiver require new legislation? If not, what is the existing statutory authority for the Department to implement a parental fee?

RESPONSE

New legislation is not required. The statute authorizing operation of the Children's Home and Community-Based Services (CHCBS) waiver, section 25.5-6-902(9), C.R.S., provides the Department with the authority to "charge and collect co-payments from parents for services rendered."

3:15-3:30 Break

3:30-3:50 Program Innovation

45. What portion of Medicaid services does the Department finance through managed care versus fee-for-service? Are there opportunities to increase the utilization of managed care to contain costs and achieve better health outcomes?

FY 2016-17 Enrollment and Expenditure				
Physical Health				
Item	**Accountable Care Collaborative**	**Capitated Managed Care (RMHP Prime, ACC Access KP, Denver Health Medicaid Choice)**	**Other (Fee-for-Service)**	**Total**
Enrollment	960,956	135,260	249,958	1,346,174*
Expenditures	$146,273,678	$408,450,059	$4,998,181,075	$5,552,904,812

Behavioral Health			
Item	**Managed Care**	**Other (Fee-for-Service)**	**Total**
Enrollment	1,302,629	7,096	1,309,725
Expenditures	$603,888,725	$7,793,561	$611,682,286

* Enrollment for physical health is higher than behavioral health because Partial Medicare-Medicaid Enrollees and Non-Citizen/Emergency Services Only are eligible for some physical health services but not eligible for behavioral health services.

The Department is enrolling all clients into the Accountable Care Collaborative (ACC) which is a managed care program. The Department will be increasing the utilization of managed care by enrolling all Health First Colorado clients into the ACC with the passage of HB 17-1343, and the approval of the Department's FY 2017-18 Budget Request R-6, "Delivery System and Payment Reform." The Regional Accountable Entities (RAEs) will receive administrative and capitated payments to serve a single managed care entity managing a network of primary care physical health providers and behavioral health providers within their ACC region. Once fully implemented, all clients will be enrolled in a managed care program which will promote coordination of care across disparate providers that is expected to generate cost savings and improve health outcomes. With the approved legislation and budget request, the Department has included a reduction of $100.1 million total funds, $40.9 million General Fund in its current forecasts, which reflect the increased participation in a managed care program and program requirements for providers to better integrate physical and behavioral health care service delivery.

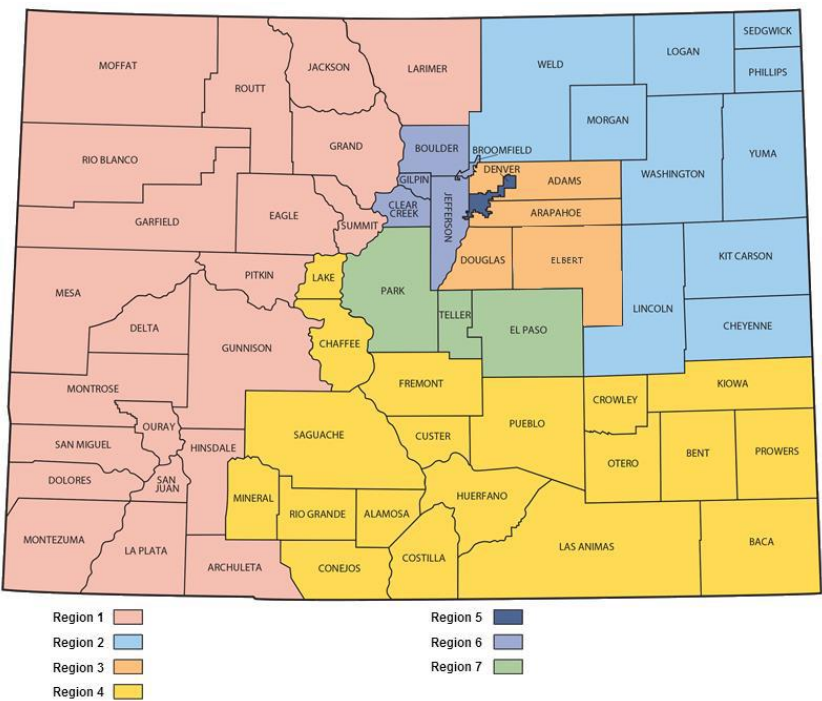
46. Please compare the Accountable Care Collaborative (ACC) regions with the previous behavioral health organization regions. Why is Larimer County part of the western slope ACC region? If a county wishes to be in another region, what steps would they follow?

RESPONSE

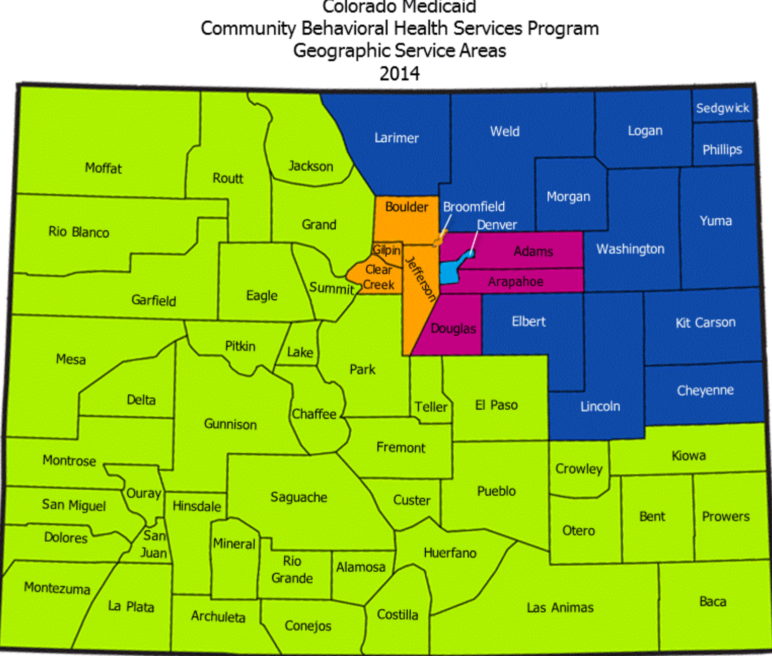
The map for ACC Phase II will align with the current seven regions of the Regional Care Collaborative Organizations (RCCOs) except that Elbert County will be a part of Region 3 rather than Region 7. The major differences between the Behavioral Health Organization (BHO) map and the ACC regional map for Phase II are: the single BHO currently covering the western and southern counties will be divided into three Regional

Accountable Entity (RAE) regions (ACC regions 1, 4, and 7); Elbert County will be in Region 3; and Larimer County will be in Region 1. Maps are included below for reference.

ACC Phase II: Regional Accountable Entity Map



BHO Regional Map



Larimer County has been part of Region 1 since the Accountable Care Collaborative originated in 2011. This original decision was made in response to stakeholder recommendations. For Phase II, the Department decided to keep Larimer County in Region 1.

Counties do not have the option to change ACC regions. However, clients are able to seek care outside of the county where they live. The RAEs will be responsible for contracting with a robust network of primary care and behavioral health providers that meet the service needs of its enrolled population and that meets compliance with access standards in their contract. In addition, the RAE is responsible for participating in and/or developing community-based infrastructure to engage the full range of Medicaid providers and non-medical community services to improve client health.

47. What appeals or legal challenges might be occurring with the procurement for the ACC?

RESPONSE

All appeals and legal challenges related to the reprocurement of the ACC were successfully resolved as of November 21, 2017. There is no opportunity for any new appeals or legal challenges in accordance with state procurement rules.

48. Please provide an update on the western slope pilot program demonstrating the effectiveness of integrating physical and behavioral health. How do the findings from the pilot program inform the Department's plans and projected cost savings for Phase II of the ACC?

RESPONSE

The program known as ACC: Rocky Mountain Health Plans Prime (RMHP Prime) features a capitated physical health payment. Behavioral health services are not included in the capitation and continue to be paid for by the regional Behavioral Health Organization. RMHP Prime has chosen to leverage the flexibility of the capitated payment to provide practice transformation support and financial incentives to improve the coordination of physical and behavioral health care. Analysis of the first full year of the program (July 1, 2015 – June 30, 2016) has identified some positive overall results. For example, RMHP Prime clients accessed behavioral health care at a greater rate than the rest of the population that uses the Behavioral Health Organization in that region (20 percent compared to 15 percent of the population). Also, the program has surpassed targets set for quality outcomes, including: Body Mass Index assessment; HbA1c (blood sugar) poor control; antidepressant medication management; and, implementation of the Patient Activation tool. Additional information is available in the report submitted to the General Assembly on April 15, 2017.[15] The Department will submit an updated report on RHMP Prime in April 2018.

In the fall of 2014, the Department asked for stakeholder feedback for the design of the next phase of the Accountable Care Collaborative. The responses identified opportunities to improve the integration of physical and behavioral health. At the same time there is growing evidence about the interrelationship between physical and behavioral health and the need for integrated care. Both the launch of the RMHP Prime

[15] https://www.colorado.gov/pacific/sites/default/files/HB12-1281%20Year%202.pdf

pilot, with a focus on improving coordination of physical and behavioral health, and the final design for Phase II are aligned with the stakeholder feedback and national data supporting integration of services.

The findings from the first year of RMHP Prime validate the direction the Department has taken for ACC Phase II. The Department's projected cost savings for ACC Phase II are based on the program's historical performance as well as national, peer-reviewed reports of different models that coordinate behavioral health and physical health services.

49. For each of the organizations that won a bid to act as a Regional Accountability Entity (RAE) in the ACC, please describe the ownership structure. Do these organizations also own and operate other businesses within the healthcare delivery system, such as Community Mental Health Centers, primary care offices, or case management services?

RESPONSE

The table below shows the ownership structure of each of the Regional Accountable Entities (RAEs).

Region	Vendor	Ownership Structure	Business Affiliations
1	Rocky Mountain Health	United HealthCare Services Inc., (a Minnesota corporation, which is a wholly owned subsidiary of UnitedHealth Group Incorporated, a Delaware corporation.)	• Rocky Mountain Health is a regional insurance company that operates commercial and public plans • United HealthCare Services is a national insurance company that operates commercial and public plans
2	Northeast Health Partners	Corporate members: Plan de Salud de Valle Inc., North Range Behavioral Health, Centennial Mental Health Center, Sunrise Community Health (Own 25% each)	• All ownership partners are service providers (federally qualified health centers and community mental health centers)
3	Colorado Access	Corporate members: University of Colorado Health and University of Colorado Medicine (collectively, the University), Children's Hospital Colorado, and the Colorado Community Managed Care Network	• Colorado Access is a state insurance company that operates publicly-funded plans and serves as a Single Entry Point • Corporate members are service providers or provider associations
4	Health Colorado, Inc.	Owners: Valley-Wide Health Systems, Inc., Health Solutions, Beacon Health Options Inc., San Luis Valley Behavioral Health Group, Solvista Health Group, Southeast Health Group (Own 16 2/3 % each)	• Beacon Health Options is a national company offering behavioral health solutions for health plans • All other owners are service providers
5	Colorado Access	Corporate members: University of Colorado Health and University of Colorado Medicine (collectively, the University), Children's Hospital Colorado, and the Colorado Community Managed Care Network.	• Colorado Access is a state insurance company that operates publicly-funded plans and serves as a Single Entry Point • Corporate members are service providers or provider associations

6	Colorado Community Health Alliance	Members: Colorado Community Health Alliance, LLC (a partnership between Physician Health Partners, LLC, Primary Physician Partners, LLC, and Centura Ventures, LLC), and Anthem Partnership Holding Company, LLC, a wholly owned subsidiary of Anthem, Inc.	• Colorado Community Health Alliance is a partnership of provider associations and health care providers • Anthem is a national insurance company that operates commercial and public plans
7	Colorado Community Health Alliance	Members: Colorado Community Health Alliance, LLC (a partnership between Physician Health Partners, LLC, Primary Physician Partners, LLC, and Centura Ventures, LLC), and Anthem Partnership Holding Company, LLC, a wholly owned subsidiary of Anthem, Inc.	• Colorado Community Health Alliance is a partnership of provider associations and health care providers • Anthem is a national insurance company that operates commercial and public plans

50. Could the Department use per capita expenditures and utilization patterns in other states that do not have an equivalent to the Accountable Care Collaborative (ACC) to evaluate the performance of Colorado's ACC in reducing costs and improving health outcomes?

RESPONSE

In part, yes, the Department can and does compare Colorado utilization and per capita costs to other states to evaluate program performance. However, there is a critical obstacle to creating an 'academic' estimate of savings for the Accountable Care Collaborative Program by comparing it to other states because other states are guaranteed to have differing circumstances that make isolating Colorado's program's impact difficult. With additional time and resources to create a robust academic model for cost savings that accounts for the vast array of possible differences in comparison populations, provider reimbursement, and benefits covered, this is an option that could be explored.

Within existing administrative constraints, the Department evaluates the program from a variety of different angles and the conclusion is generally consistent – the Accountable Care Collaborative is an effective tool for managing care and delivering outcomes at a far lower price than traditional managed care where efficiencies are captured by a managed care entity rather than taxpayers. This is illustrated by example below.

Table 1 provides a per capita cost comparison to several other states. These states are selected for comparison because they are ranked in the top 12 as the healthiest states in the nation (except for Tennessee; Tennessee is included because it is a 100% MCO state). The purpose of this comparison is to illustrate attainment of high health status relative to the cost of attaining it.

Table 1: Share of Medicaid Population Covered under Different Delivery Systems by State as of July 1, 2015 and Relative Per Capita Costs					
	Types of Managed Care in Place	**Percent of Medicaid Population in MCO**	**Percent of Medicaid Population in PCCM**	**Percent of Medicaid Population in FFS**	**FFY 2014 Per Capita***
Colorado	MCO and PCCM	9%	65%	27%	$6,014.28
Connecticut	FFS	-	-	100%	$9,783.97
Massachusetts	MCO and PCCM	52%	21%	28%	$10,248.81
Minnesota	MCO	73%	-	27%	$9,910.35
Oregon	MCO	93%	-	7%	$7,804.56
Tennessee	MCO	100%	-	-	$7,091.97
Washington	MCO and PCCM	79%	1%	20%	$7,462.43

Source: Vernon K. Smith, Kathleen Gifford, and Eileen Ellis, Health Management Associates; and Robin Rudowitz, Laura Snyder, and Elizabeth Hinton, Kaiser Commission on Medicaid and the Uninsured. [Medicaid Reforms to Expand Coverage, Control Costs and Improve Care: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2015 and 2016](http://kff.org/medicaid/report/medicaid-reforms-to-expand-coverage-control-costs-and-improve-care-results-

Definitions: "MCO" refers to risk-based managed care; "PCCM" refers to Primary Care Case Management; "FFS" refers to Medicaid beneficiaries whose care is paid for on a fee-for-service basis.

* Per Capita figures based on FFY 2014 data from CMS 64 Forms compiled by the Kaiser Family Foundation (http://kff.org/statedata/)

Table 2 highlights key areas where Colorado has achieved above average performance in the Medicaid program for things that improve client outcomes while having a high likelihood of reducing total cost of care.

Table 2: 2016 Colorado Medicaid Program Performance Relative to National Average Performance			
HEDIS Measure	**2016 HCPF Performance**	**National Average**	**2016 Performance Relative to National Average**
Ambulatory Care: Emergency Dept Visits/1000 (Total)	**59.12**	**64.67**	Outperform (lower is better)
Ambulatory Care: Outpatient Visits/1000 (Total)	**274.59**	**359.05**	Outperform (lower is better)
Asthma Medication Ratio (12-18)	**59.87**	**59.13**	Outperform
Asthma Medication Ratio (19-50)	**50.74**	**49.05**	Outperform
Asthma Medication Ratio (5-11)	**70.83**	**70.15**	Outperform
Asthma Medication Ratio (51-64)	**59.64**	**51.9**	Outperform
Asthma Medication Ratio (Total)	**60.71**	**59.7**	Outperform
Controlling High Blood Pressure - Total	**58.89**	**54.7**	Outperform
Medication Management for People With Asthma: Medication Compliance 75% (12-18)	**41.17**	**26.33**	Outperform
Medication Management for People With Asthma: Medication Compliance 75% (19-50)	**47.97**	**37.82**	Outperform
Medication Management for People With Asthma: Medication Compliance 75% (5-11)	**45.92**	**28.33**	Outperform
Medication Management for People With Asthma: Medication Compliance 75% (51-64)	**58.23**	**50.04**	Outperform
Medication Management for People With Asthma: Medication Compliance 75% (Total)	**46.21**	**32.82**	Outperform
Use of Imaging Studies for Low Back Pain	**77.16**	**73.6**	Outperform

While precisely measuring savings attributable to the Accountable Care Collaborative is a technically challenging, resource intensive exercise, there is sufficient anecdotal evidence to reasonably conclude that the program is a highly cost-effective way to manage care in Medicaid without compromising outcomes.

51. How confident is the Department in the forecast of expected savings from Phase II of the ACC? What happens if the savings do not materialize? How will the Department measure and validate that the savings occurred?

RESPONSE

The Department estimated savings due to the implementation of ACC Phase II in two major areas: clients who were previously not enrolled but will be enrolled into the ACC under mandatory enrollment, and savings for clients with severe and persistent mental illness (SPMI) and substance use disorders (SUDs) receiving better coordinated behavioral and physical health care under the Regional Accountable Entities (RAEs). In both cases, the Department used conservative assumptions based on its own experience with the ACC and peer-reviewed and industry research to estimate savings, and therefore feels confident that they are reasonable estimates.

- Mandatory Enrollment: The Department assumed per capita savings for each incremental enrollee based on savings incurred by existing clients in the ACC, as reported in the November 1, 2015 Legislative Request for Information #7, Accountable Care Collaborative[16]. The Department assumed that there would be a six-month delay before realizing savings to account for factors such as the time for patients to have their first visits and billing lag.
- Integration of Behavioral and Physical Health: The Department assumed per capita savings for the population with SPMI and SUD based on studies on the impact of integrated care on service costs. To be conservative, the Department reduced the savings assumptions significantly and factored in a six-month delay before realizing savings. In addition, the Department anticipates that having a single entity accountable for both physical and behavioral health will be beneficial for clients who do not have SPMI and SUD and may incur savings outside of those populations, but did not include them in the savings calculations.

If savings do not materialize in the same magnitude or under the same timeframe that the Department projected, the Department would work with the RAEs on identifying areas in which more coordinated care could achieve both better health outcomes and more cost-effective care, particularly for clients with SPMI and SUD. The Department would true up its estimates through the regular budget process.

One way the Department will monitor the RAE impact on costs is through a pay-for-performance incentive payment for potentially avoidable costs. This measure will be reviewed every six months and can be used as an indicator of whether the program is on track for achieving the projected cost savings. In addition, the Department will use the annual Legislative Request for Information process to analyze client utilization and expenditure data in the ACC program to calculate savings that occurred after the implementation of ACC Phase II.

[16]https://www.colorado.gov/pacific/sites/default/files/Health%20Care%20Policy%20and%20Financing%20FY%202015-16%20RFI%207.pdf

52. What strategies do other states employ to reduce Medicaid costs? Which strategies are promising for Colorado or not appropriate for Colorado, and why?

States employ a spectrum of strategies to reduce Medicaid costs but all strategies fall into one of 6 categories: eligibility, benefits, provider payments, beneficiary responsibilities, delivery system, program integrity. While an exhaustive list of states' efforts at cost containment would be impossible to compile, the Department has a few examples of some strategies from other states that are either promising for Colorado or confirm the direction Colorado has taken to contain costs.

There are two states taking a promising approach to containing prescription drug costs which account for a large share of Medicaid spending. Both Massachusetts and Arizona have asked the Centers for Medicare and Medicaid Services (CMS) for an 1115 waiver to deploy some cost containment tools utilized by commercial payers. While commercial payers can elect whether or not to cover drugs based on clinical efficacy and affordability, Medicaid programs are required to cover any drug for which the manufacturer participates in the federal Medicaid rebate program. Both Arizona and Massachusetts are asking for federal approval to exclude coverage for drugs with limited or inadequate clinical efficacy. The Department's November 1, 2017 budget request R-10 "Drug Cost Containment Initiatives" includes a request for funding to explore drafting a waiver similar to the ones filed by Arizona and Massachusetts.

Many states are taking innovative approaches changing delivery systems to managing populations with complex needs who can be high utilizers of health care. The National Governors Association recently released a study on 10 states, including Colorado, that are experimenting with approaches to managing people with complex needs. According to the report "States pursuing the three-part aim of improved health, high quality care, and reduced costs often start with programs for complex care populations. These programs target high-need, high-cost Medicaid enrollees who are the most frequent users of costly sites of care, such as emergency departments and inpatient settings, but whose needs are often best met in the community… Effective complex care programs prioritize increased access to primary care, timely transitions from acute care settings and a multidisciplinary approach which prioritizes care coordination and includes pharmacy, behavioral health and social support services in the community (such as housing, employment and transportation)."[17] The Department is heartened to see evidence that other states who are utilizing many of the components of the Accountable Care Collaborative (the emphasis on primary care, integration of behavioral and physical health and emphasis on connecting people with needed community supports) are also seeing success in containing costs and improving health. In 2017, the General Assembly passed HB 17-1343, which authorized Phase II of the Accountable Care Collaborative, which will further the efforts to integrate physical and behavioral health, generating savings.

Within federal guidelines, states make choices around eligibility policy. For example, some states have chosen not to expand Medicaid under the Affordable Care Act. Colorado funds 100 percent of the state costs of the expansion population through federal funds and the Colorado Healthcare Affordability and Sustainability Enterprise and would therefore not realize any savings to the state General Fund as a result of eliminating the expansion population. Colorado has achieved an increase in the number of insured as a result

[17] https://www.nga.org/cms/building-complex-care-programs

of the Medicaid expansion and believes that health insurance coverage is vital to achieving our goal of being the healthiest state in the nation.

53. Is there a way to accomplish more cost savings and do Medicaid better, such as privatization or cost savings accounts?

RESPONSE

The Department appreciates the recognition of the dual goals of containing costs in the Medicaid program and achieving better health outcomes for clients. In its November 1, 2017 budget request, the Department has submitted a package of budget items with the goal of reducing spending, incentivizing high-value services, improving health outcomes and promoting beneficiary responsibility.

The Department is currently working on an array of strategies that will achieve these goals. For example, in 2017 the General Assembly passed HB 17-1343 which authorized Phase II of the Accountable Care Collaborative. From the Accountable Care Collaborative's inception in 2011 to June 2016, the Department estimated net costs avoided of $139 million[18]. In FY 2016-17, the Department estimates an additional $22 million in net costs avoided[19], for a total of approximately $161 million in net costs avoided since the program's inception. In Phase II of the Accountable Care Collaborative, the RAE structure of a single managed care entity managing a network of primary care physical health providers and behavioral health providers will promote coordination of care across disparate providers that is expected to generate additional cost savings and continued improvement in health outcomes.

At the same time the Department is transforming the delivery system through the Accountable Care Collaborative, the Department is also changing payment to incent value over volume. An example of this is the implementation of the Alternative Payment Model for Primary Care (APM) approved by the Joint Budget Committee last year in the Department's FY 2017-18 budget request R-6, "Delivery System and Payment Reform," which will provide a long-term sustainable investment in primary care by rewarding providers with higher reimbursement for delivering care that improves patient health.

In the Department's FY 2018-19 budget request R-8, "Medicaid Savings Initiatives," the Department has requested a net reduction to its appropriation to implement or improve policies that will reduce the state's costs while maintaining access to quality care. For example, R-8 includes funding for additional prior authorization requirements. The prior authorization request (PAR) process utilizes nationally-recognized medical necessity criteria to ensure that services and supports are provided at the right time, in the right setting, and for the right duration, as well as limiting unnecessary or duplicative services and supports. PARs allow for more effective management of fraud, waste, and abuse, and ultimately result in reducing costs. If approved, the Department would add prior authorization requirements to the following benefits: oxygen, back surgery, medically necessary cosmetic surgery, outpatient speech therapy, orthotics, prosthetics, adult long-term home health, and vision.

[18] 2016 Legislative Request for Information #3 for the Accountable Care Collaborative (goo.gl/pABcJv)
[19] 2017 Accountable Care Collaborative Implementation Report (goo.gl/WGe33U)

The Department's R-8 budget request also includes savings for the increased use of public transportation benefits, the implementation of a parental fee for the Children's Home and Community-Based Services waiver program, additional recoveries from trusts, and implementation of an automated process to terminate eligibility for people who reside in other states. In total, the Department requested a reduction of $1.4 million total funds, including $2.2 million General Fund in FY 2018-19, and a reduction of $4.1 million total funds, including $4.2 million General Fund in FY 2019-20.

In addition to R-8, the Department's budget requests also include savings from: implementing an Electronic Visit Verification System (R-6); establishing a permanent benefit to transition people out of nursing facilities back into the community (R-7), and; establishing prior authorization criteria for physician-administered drugs (R-10).

In addition to its new proposals, the Department uses existing resources to help ensure that clients are connected to appropriate services at the right time. Clients are often unsure of the appropriate level of care for their own or their family member's medical condition, and may seek care at a level that is higher or lower than what is clinically needed, which may lead to more costly care. An example of how the Department directs clients to the appropriate level of care is the Nurse Advice Line. The Nurse Advice Line (NAL) provides Health First Colorado clients free around-the-clock access to medical information and advice. A recent analysis of Health First Colorado clients showed that the NAL is very effective at diverting clients from unnecessary higher-cost services. For example, NAL callers who thought they needed to go to the emergency room but received a recommendation to access a lower level of care from the NAL complied with that recommendation 73 percent of the time.

a. If the Department had a magic wand to act independent of state and federal regulations, what would the Department do to save money?

The General Assembly has supported many of the innovative ideas the Department has put forth to achieve cost savings and improve Medicaid. The Department has contemplated other ways to improve the program but has faced constraints due to federal regulation. If the Department had a magic wand to waive federal regulations we would be interested in further exploring the following:

- Innovative ways to address the social determinants of health (housing, transportation, food insecurity, education, etc) since there is mounting evidence that these life circumstances have a far greater impact on health than medical care
- Using tools available to commercial carriers or private payers like directing clients to providers and facilities that have proven high quality and lower cost
- Changes to cumbersome eligibility provisions that prevent better alignment with other federal programs and Connect for Health Colorado

54. If federal rules changed to give block grant funding to states, what freedom would this generate to do other types of services savings?

RESPONSE

The recent federal legislative proposals (such as the American Health Care Act, Better Care Reconciliation Act, and the Graham-Cassidy-Heller-Johnson Amendment) allowed for states to elect to receive federal Medicaid funding as a block grant. A block grant would provide a fixed amount of federal funding for each fiscal year, and states would be required to manage their Medicaid expenditures within that amount. Federal funds would not be available for any expenditures above the block grant amount. Block grant funding would only be available for non-elderly, non-disabled adults.

For a state which elected block grant funding, these bills specifically waived core provisions of the Social Security Act (the Act) including:

- Statewideness – the requirement that a state Medicaid program cannot exclude enrollees or providers because of where they live or work in the state;
- Comparability – the requirement that a Medicaid-covered benefit generally must be provided in the same amount, duration, and scope to all enrollees;
- Freedom of choice – the requirement that all beneficiaries must be permitted to choose a health care provider from among any of those participating in Medicaid.

In addition, the Secretary of Health and Human Services would also have the authority to waive most other provisions of the Social Security Act, if so requested by a state. Under a block grant, Colorado might be able to reduce expenditures on medical services by reducing the amount, scope, and duration of benefits provided to clients.

However, because these block grants would severely reduce available federal funding, it is not clear that the state could retain sufficient spending authority to make innovative changes to the Medicaid program. For example, the Kaiser Family Foundation[20] found the that Graham-Cassidy-Heller-Johnson amendment would reduce Colorado's available federal funds by $2.9 billion between 2020 and 2026. With the proposed restrictions in federal funding, Colorado would be forced to reduce rates, benefits, and/or eligibility immediately upon implementation in order to stay within the available grant. Further, the limit on federal funding would restrict the state's ability to leverage federal funds for routine activities, such as provider rate increases and the implementation of new programs. Finally, because the block grants would be effective on federal fiscal years, the General Assembly would be out of session at the end of each funding period. If the state was on track to exceed available federal funds, the Department might be required to administratively reduce benefits without consulting the General Assembly.

[20] https://www.kff.org/health-reform/issue-brief/state-by-state-estimates-of-changes-in-federal-spending-on-health-care-under-the-graham-cassidy-bill/

55. Generally, what is the Department doing to address fraud in the Medicaid system and how cost-effective are these measures?

RESPONSE

The Department has ongoing efforts to address fraud in the Medicaid Program. The Department has internal resources dedicated to combating fraud and also addresses fraud via partnerships with the Attorney General's Office, federal agencies, and counties. The Department uses separate strategies to address provider fraud and client fraud.

Provider Fraud

Fraud is intentional deception, such as when a provider knowingly bills for services or supplies that were not provided.[21] Once possible provider fraud is detected, the Department conducts a preliminary investigation to determine if the allegation is credible, and if so, the Department is required to refer this information to the Medicaid Fraud Control Unit (MFCU) within the Attorney General's Office. The MFCU is responsible for investigating and prosecuting provider fraud.

The Department meets frequently with the MFCU. The purpose of these meetings is to discuss cases, leads and concerns. A close working relationship between the MFCU and the Department is essential for combating fraud. The Department participates in a fraud taskforce which includes personnel from the MFCU, United States Attorney's Office, the Federal Bureau of Investigation, and the United States Department of Veterans Affairs among others. The goal of this group is to identify and share leads among the agencies. The Department also participates in a fraud taskforce which includes private insurance companies. The goal of this group is also to share leads with similarly situated entities. If a provider is fraudulently billing other health care plans, they could also be fraudulently billing Medicaid.

In addition to working with MFCU and other state and federal partners, the Department has a multifaceted approach to detecting possible fraud. These include but are not limited to:

- Fraud referral hotlines – a toll free telephone number and an email hotline. These hotlines allow anyone to report fraud.
- Data Investigations Unit (DIU) – the DIU runs claims algorithms to detect aberrant behavior which could be indicative of fraud.
- Program Integrity Reviewers – Department staff research and examine high risk areas and areas where potential programmatic weakness may exist. Suspected fraud is escalated through the Department's protocol.
- Recovery Audit Contractor (RAC) – the Department is required by federal law to have a RAC. The RAC is tasked with performing recoveries. When the RAC detects an issue that appears to be possible fraud, they are required to report the information to the Department.

[21] Not all overpayments are fraud. Most of the recoveries made by the Department are the result of unintentional overpayments, such as when a provider overbills. When overbilling is identified, Department staff work with providers to resubmit bills or adjust payments going forward.

- Department contractors, such as Single Entry Points, Community Centered Boards, and managed care entities are required to report possible fraud.

The Department is also implementing sophisticated data analytic tools to detect fraud. With the procurement of the new Business Intelligence Decision Management System, the Department will have access to more sophisticated data analytic tools. This should improve the Department's ability to detect fraud through data analysis. Once the Department becomes familiar with these tools, it will assess if additional tools are necessary and if pre-payment predictive analytics should be implemented. Pre-payment predictive analytics is the use of data, statistical algorithms and approaches to identify the likelihood of future outcomes based on historical data. Pre-payment predictive analytics can discover erroneous claims and prevent payments from being made.

The full cost-effectiveness of this multifaceted approach is difficult to measure. For provider fraud, the MFCU has reported results for federal fiscal year 2016 ending in September 2016 of $899,190 for criminal cases and $4,413,980 for civil cases. In addition, they have participated in global civil monetary settlements resulting in $9,304,300 for the state. These are the ordered repayments and do not represent the dollars received by the Department as there may be payment terms over time. In addition to these amounts resulting from fraud investigations, there is a greater impact of a conviction, or in a civil recovery action creating a deterrent effect for providers who are engaged in fraudulent activities. It also serves to educate providers who do not possess a fraudulent intent, but are billing inappropriately.

Client Fraud

Historically, client fraud was solely the responsibility of the County Departments of Social Services. Last fiscal year, the Department expanded its efforts by pulling from multiple positions to provide the necessary resources to assist with combating client fraud. Through approval of the FY 2017-18 R-7, "Oversight of State Resources," the Department was appropriated two full time staff who will be working with the counties on investigations and trainings and conducting their own investigations. The state also offers a grant program in selected areas to incentivize counties to prosecute fraud. This year, two counties and one regional group of counties are using the grant to develop fraud investigation programs. The Department anticipates that these allocated resources will be very beneficial to the counties who are unable to pursue fraud, as well as those who already are.

Other ways that the Department is combatting client fraud include:

- Working on establishing a Best Practices Guide to assist counties with their client fraud investigations
- Chairing the National Beneficiary Fraud Technical Assistance Sub Group in conjunction with the Centers for Medicare and Medicaid Services (CMS). The Department initiated and then worked with CMS to start a national group on client fraud with participants across the country to learn from other states as well as share Colorado's experiences
- Reviewing state rules regarding fraud to determine ways to increase counties' abilities to prosecute client fraud
- Working with the Colorado Welfare Fraud Council and attending its yearly conference; the conference brings together fraud investigators and eligibility technicians, ensuring that eligibility

technicians are aware of fraud issues and the consequences of clients receiving benefits they don't qualify for.

For more information about the Department's efforts on Client Fraud and cost-effectiveness, please see the Department's 2017 Improving Medicaid Fraud Prosecution Report.

56. What is the implementation schedule for the performance payments that will replace the primary care rate bump? What will happen to primary care rates until the Department implements performance payments?

RESPONSE

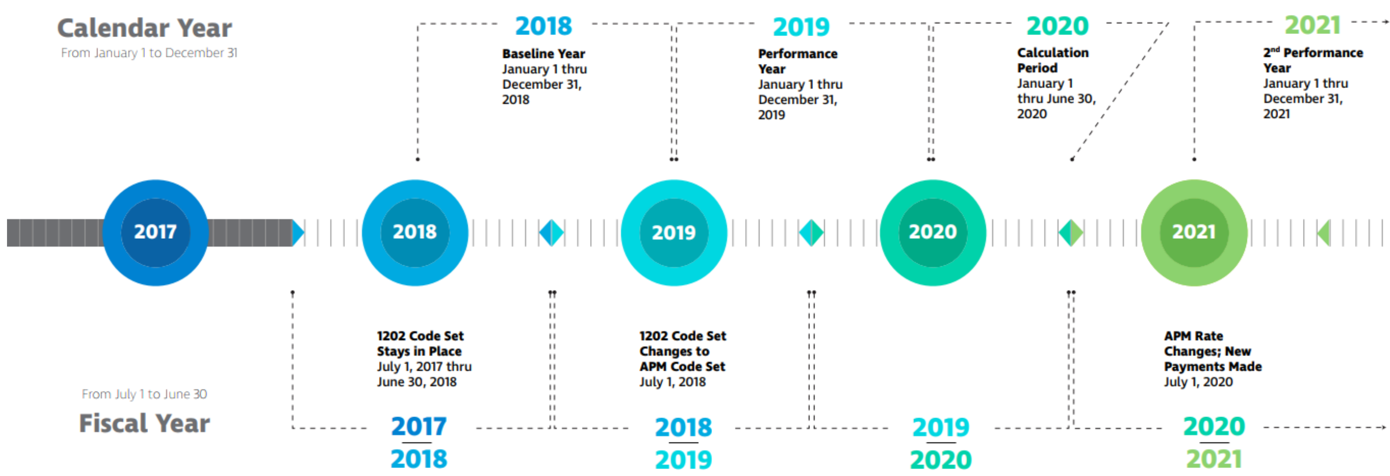
Implementation of the Alternative Payment Model (APM) for Primary Care, described in the Department's FY 2017-18 budget request R-6, "Delivery System and Payment Reform," and approved by the General Assembly, has begun. Performance payments to providers are scheduled to begin in July 2020. At that time, high performing practices will be able to earn up to 102.6 percent of today's rates. Lower performing practices or practices that do nothing could earn as little as 97.1 percent of today's rates. In subsequent years, the amount available to raise rates for the highest performing practices will depend on the amount of funding that is available to reallocate from lower performing practices. The Department anticipates that rates for the highest performing practices may approach 105 percent of current rates.

Beginning in July 2018, the Department will adjust the codes eligible for the primary care rate bump to align with the implementation of the APM and rebalance rates accordingly. The redistribution of funds from that switch will raise rates on the new APM code set to an estimated 101.1 percent of today's rates.

Currently, PCMPs are selecting the quality measures they will be evaluated on by filling out an online survey that will close on January 31, 2018. Calendar year 2018 will serve as the baseline year for PCMPs, meaning that PCMPs will be measured against their performance in this period. The performance year is calendar year 2019 and practice performance will be evaluated again on their baseline to determine levels of reimbursement for each PCMP beginning July 2020. The Department will update the APM reimbursement each year as new performance data is collected.

Alternative Payment Methodology

Calendar Year and Fiscal Year Timelines



Primary Care Payment Changes

Fiscal Year	Event	High Performing Practices	If You Do Nothing	Excluded Practices (Low Volume)
FY 2016-17	Current Year	100.00%	100.00%	100.00%
FY 2017-18	No Change	100.00%	100.00%	100.00%
FY 2018-19	Redistribution of 1202 Funds to APM codeset	101.10%	101.10%	101.10%
FY 2019-20	No Change - Performance Measurement Year	101.10%	101.10%	101.10%
FY 2020-21	Payment Adjustment - 4.0% at risk	102.60%*	97.10%	101.10%
FY 2021-22	Payment Adjustment - 5.5% at risk	104.60%*	95.60%	101.10%
FY 2022-23	Payment Adjustment - 7.0% at risk	104.60%+*	94.10%	101.10%
FY 2023-24	Payment Adjustment - 8.5% at risk	104.60%+*	92.60%	101.10%
FY 2024-25	Payment Adjustment - 10.0% at risk	104.60%+*	91.10%	101.10%

*The amount of additional funding for high performing practices will depend on how much funding is available to reallocate from poor performing practices.

57. Why did the Department remove neonatology rates from the primary care performance payments? What will happen to neonatology rates and what is the fiscal impact?

RESPONSE

The Primary Care Alternative Payment Model (APM) has been designed around non-facility based primary care providers designated as a Primary Care Medical Provider (PCMP) in the ACC. In the Department's approved FY 2017-18 budget request R-6, "Delivery System and Payment Reform," the Department wrote: "Providers that are PCMPs in the Accountable Care Collaborative Phase II and meet certain criteria and performance standards would also be eligible to earn higher reimbursement equivalents in aggregate to what they could have earned under the provider rate bump." Neonatologists do not qualify as PCMPs under the current ACC program or Phase II and are therefore not eligible for the APM funding.

The code set for the APM will change in July 2018 as described in the timeline in question 56. At that time, the neonatal codes will return to the rates in place in FY 2012-13, prior to the implementation of the primary care rate bump. The Department projects the FY 2018-19 impact to keep the neonatal codes at the current level of 87.3 percent of Medicare will be $1,784,294 total funds in FY 2018-19.

Estimated Fiscal Impact to Keep Neonatal Codes at Current Level						
Code Group	**Codes**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**Percent of Medicare**
Critical Care Visit - Neonatal and Pediatric	99466-99476	$865,583	$426,510	$1,769	$437,304	87.30%
Newborn	99460-99465, 99477-99486	$918,711	$442,507	$1,023	$475,181	87.30%
Total		**$1,784,294**	**$869,017**	**$2,792**	**$912,485**	**87.30%**

3:50-4:05 Pharmacy

58. Of Colorado's increasing obligation under the Medicare Modernization Act, how much does enrollment, increased utilization, and pharmacy inflation contribute?

RESPONSE

The Medicare Modernization Act (MMA) State Contribution Payment is based on two factors: 1) caseload (enrollment), and 2) per member per month (PMPM) rate, which is determined by the federal Centers for Medicare and Medicaid Services (CMS).

Every month, the state reports caseload of persons who are eligible for, and enrolled in, both Medicaid and Medicare to CMS. CMS then invoices the state for what CMS determines is the state's obligation of per capita prescription drug costs for these individuals, as Medicare has already paid for the entirety of these costs up front. This invoiced amount is calculated by multiplying the caseload data by the PMPM, which is derived from a complex formula established in federal statute. This formula incorporates a baseline PMPM rate, calculated using Colorado-specific data from prior to the implementation of the Medicare Part D benefit in 2006, and applies growth rates in prescription drug expenditure data to account for pharmacy inflation, but does not specifically account for actual utilization. The Department has long had concerns with how the state's contribution was originally calculated.

Tables for caseload and PMPM individually are included in the FY 2018-19 R-4 Medicare Modernization Act State Contribution request. The following table shows the impact both caseload and PMPM rate have on overall expenditures for MMA between FY 2012-13 and FY 2019-20. On average, caseload and PMPM rate are each responsible for approximately half of the overall increase in expenditures, although individual years can vary greatly.

Medicare Modernization Act (MMA) State Contribution Payment				
Total Paid Invoices			**% Change Attributable to:**	
Year	**Total Funds**	**% Change**	**Caseload**	**Rate**
FY 2012-13	$99,717,855	N/A	N/A	N/A
FY 2013-14	$106,376,992	6.68%	8.07%	-1.39%
FY 2014-15	$107,620,224	1.17%	4.64%	-3.47%
FY 2015-16	$114,175,926	6.09%	1.53%	4.57%
FY 2016-17	$129,807,096	13.69%	0.93%	12.76%
FY 2017-18 Estimate	$146,635,899	12.96%	4.91%	8.05%
FY 2018-19 Estimate	$153,834,714	4.91%	2.52%	2.39%
FY 2019-20 Estimate	$164,976,430	7.24%	2.59%	4.65%
Average		**7.54%**	**3.60%**	**3.94%**
% of Average			**47.75%**	**52.25%**

59. Describe the Department's ongoing efforts to contain pharmacy costs. How does the Governor's request fit with those efforts?

The Department continues to pursue reductions in pharmaceutical expenditures by using all of the tools available to Medicaid programs under federal law. These mechanisms include enforcing limits on certain drugs, placing prior authorization requirements on certain drugs, and selecting drug classes for the Preferred Drug List. The Department uses these utilization mechanisms to control costs while ensuring access to medications for clients who need them. In its November 1, 2017 budget request R-10, "Drug Cost Containment Initiatives," the Department requested funding to accelerate these efforts; the requested funding would allow the Department to implement prior authorization criteria for physician-administered drugs and perform research into alternative payment methodologies to address the rising costs of specialty drugs.

In addition to clinically managing the utilization of drugs, the Department manages costs through appropriate, cost-based reimbursement for point-of-sale pharmacy dispensed drugs. To ensure providers are paid appropriately but not overpaid, the Department moved to an Average Acquisition Cost reimbursement methodology in 2013. This reimbursement methodology is based on the actual costs incurred by pharmacies to purchase medications and their costs associated with dispensing medications. The Department updates rates on a weekly basis using this methodology.

The Department is investigating other cost savings opportunities. As an example, in concert with similar efforts across the Department related to other Medicaid benefits (see question 52 for more details), the Department is investigating alternative payment models. Under these models, the Department seeks to tie more payments to quality and value within the pharmacy benefit. The Department is participating in several efforts to further explore these options as well as researching these options independently. The Department is also monitoring efforts by other states in this area. States are looking at options such as value based contracting, closed formularies, exclusion of coverage of drugs with minimal value, and alternative supplemental rebates.

Under current Federal law, if a manufacturer enters into a rebate agreement with the Federal government, Medicaid programs must cover that drug product when medically necessary. Medicaid programs are allowed to set some limits on coverage including quantity limits, day supply limits, prior authorization criteria, and a preferred drug list. The alternative payment models and other ideas being pursued by other states may require additional federal approval via a section 1115 demonstration waiver, as these methodologies and options may not be specifically authorized in the Social Security Act. The Department's budget request includes some administrative funding for assistance with this assessment process.

The Department is in the process of restructuring the physician-administered drug (PAD) benefit and is looking to use many of the same tools utilized in the point-of-sale pharmacy benefit. For FY 2017-18, the Department requested and received funding to hire an FTE to manage the PADs. The Department's budget request (R-10) would assist with the continued process of further management of the PADs. The Department aims to implement a prior authorization system for PADs. As outlined in the request, the Department needs funds to implement the program but estimates that the costs avoided through prior authorizations would cover those implementation and operation costs. Finally, the Department wants to consider alternative payment models based on value for certain PADs in addition to other pharmaceuticals and requested funds to assist with that process.

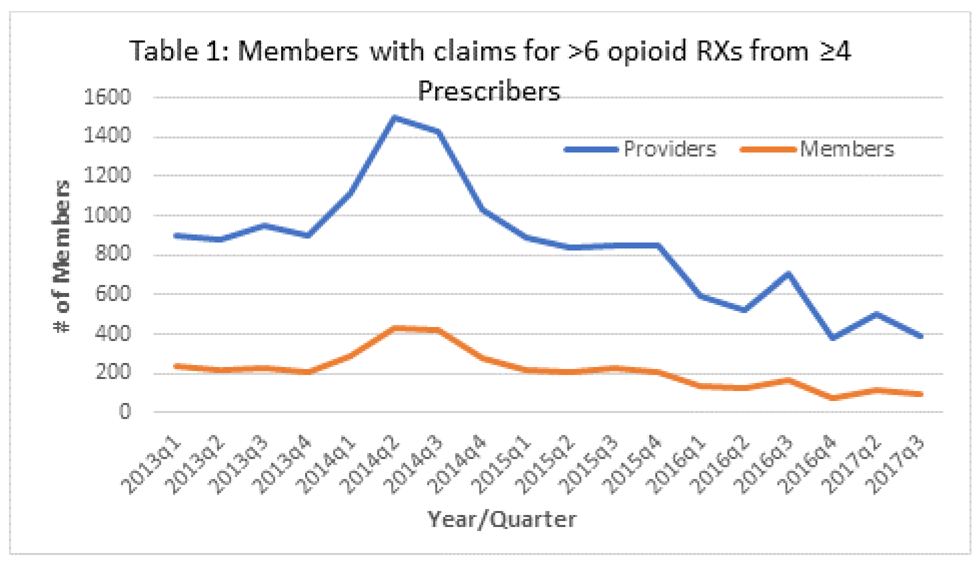
60. Specifically, what is the Department doing to prevent Medicaid recipients from gaining excessive access to opioids by going to different providers in different communities?

The Department has the ability to monitor and collect data on Medicaid clients' opioid prescriptions reimbursed by Medicaid and uses that ability to address clients going to different providers for opioids. The Department utilizes edits in the claims system that identify and deny multiple claims for the same drug, early refills of drugs, and excessive combined doses of multiple drugs. The Regional Care Collaborative Organizations (RCCOs) reach out to clients with claims evidence for potential overutilization for care coordination. The Department also utilizes the services of its Drug Utilization Review (DUR) contractor to

address this issue. The DUR contractor identifies Medicaid clients who have filled six or more opioid prescriptions from four or more providers in a calendar quarter. The providers involved in these patients' care then receive a letter identifying those patients and alerting providers to the fact that a client has been seeing different providers and receiving opioids. As an example, DUR sent 462 letters in July 2017 and 449 letters in December 2017. These efforts have resulted in a steady decrease since 2014 in the number of clients obtaining opioid prescriptions from multiple providers (see Table 1). The Department plans to expand this project by sending letters to prescribers to show how their opioid prescribing practices compare to their peers in the state.

The limitation that the Department experiences in trying to prevent clients' use of multiple prescribers is that the Department only has access to its own claims. This prevents any monitoring or data collection of "out of pocket" or "cash" payments. In essence, clients may work around any Department policy including seeing multiple prescribers in different communities, by choosing to pay out of pocket for prescriptions and the Department does not have a way to track this since the Department does not have access to the statewide Prescription Drug Monitoring Program (PDMP).

If the Department had access to the PDMP data, the Department could use that data to track issues such as this. While most health care professionals (dispensing pharmacists and prescribers) can query the PDMP prior to writing the prescription and dispensing the medication at the pharmacy to instantly verify patient fill records, Department staff, including health care professionals who otherwise may utilize this tool in a different setting, do not have access to this patient level information. Therefore, under current law, this information cannot be obtained to better manage this opioid issue.



Note: 2017q1 data currently unavailable

61. In R10 Drug cost containment the Department proposes new prior authorization review criteria for physician-administered drugs. What drugs does the Department consider "physician-administered"? Do these include drugs administered by a nurse or physician's assistant under the supervision of a physician?

RESPONSE

Physician-administered drugs are typically administered by a medical professional in a physician's office, clinic or hospital outpatient setting. Medical professionals such as physicians, advanced practice nurses or physician's assistants prescribe and can administer the medications; however, some medications can be administered by a nurse. These drugs are generally injectable, implantable, or intravenous (IV) infused products.

62. Why is the Department implementing changes to office-administered drug rates retroactively?

RESPONSE

The Department is implementing the methodology change to office-administered drug rates effective July 1, 2017 to come into compliance with the Covered Outpatient Drug Final Rule, which required the Department to define its reimbursement methodology for office-administered drugs. The Department was required to submit a State Plan Amendment (SPA) for the methodology change to come into compliance with the Final Rule to be effective April 1, 2017, but delayed until July when the methodology change would be approved in the Long Bill and the Department would have state spending authority for it. The Department submitted the SPA with an effective date of July 1, 2017 to come into compliance as soon as possible with the Final Rule. Now that the SPA has been approved, the Department will retroactively true-up the rates for all office-administered drug claims incurred since July 1, 2017 to ensure that it is in compliance with its approved State Plan.

63. How will the implementation of the federal 21st Century Cures Act affect rates for durable medical equipment?

RESPONSE

Per section 1903(i)(27) of the Social Security Act, there will be a limit on the available federal financial participation for state Medicaid fee-for-service expenditures for durable medical equipment. The 21st Century Cures Act changed the effective date of this requirement to January 1, 2018. The limit is calculated in the aggregate based on the amount that Medicare would have paid for the same items through the Medicare fee schedule, or, as applicable, the Medicare competitive bidding program. The limit applies to items of durable medical equipment that are covered by both Medicare and Medicaid, and does not impact Medicaid's ability to provide durable medical equipment that is not covered by Medicare. Medicaid expenditures for prosthetics, orthotics, and supplies, will not count towards calculation of the limit. There is no mandate that states pay Medicare rates for any Medicaid durable medical equipment.

The Department has been working with a contractor to forecast whether total Medicaid durable medical equipment expenditures for calendar year 2018 will be under limit; however, completion of the analysis is

pending as the Department is awaiting formal federal guidance on how to calculate the limit. For example, the Centers for Medicare and Medicaid Services is expected to post within the coming weeks a list of the specific items (and corresponding billing codes) that are subject to the limit. Once the analysis is completed, the Department will be able to determine if any rate changes are required.

64. How does the Department's request for anesthesia rates relate to the Department's comments during the Opioid and Other Substance Use Disorders Interim Study Committee regarding the importance of nurse anesthetists? Has the Department's position on nurse anesthetists changed?

RESPONSE

The Department recommended a reduction in anesthesia service rates from 131.64 percent to 100 percent of the rate comparison benchmark, which is the 2016 Medicare conversion factor, to ensure efficient use of the Department’s resources. The Department will perform continued analysis of reimbursement at the new rate to determine if it is adversely impacting the anesthesia provider network.

The Department’s position on nurse anesthetists and the services provided by them has not changed, and the Department does not treat them differently from other provider types. The Department is committed to having the full continuum of providers at different professional levels available to treat Medicaid clients. The anesthesia service request applies to procedure codes 00100-01999. The request does not apply to other services that an anesthesiologist or CRNA may perform, such as pain management.

65. Please provide an update on the Department's new policies regarding Hepatitis C coverage and the estimated change in expenditures due to the new policies.

RESPONSE

The Department just completed its routine, annual review of the hepatitis C class and as a result, effective January 1, 2018, the coverage criteria policy will change for hepatitis C medications. The Department updated the preferred agents and the prior authorization criteria related to all of the hepatitis C products. These changes were based on the growing and evolving nature of the clinical evidence regarding the use of the products, and the costs associated with these medications. Among other changes, the new criteria will no longer use a fibrosis score to determine if a patient will be approved for treatment. In addition, there are modified requirements of certain general lab values to verify a chronic hepatitis C diagnosis. The Department also removed the policy that patients could receive approval for one completed treatment course of hepatitis C medications per lifetime. Now the Department will review requests for a second course of treatment on a case-by-case basis.

The tables below show the estimated impact on expenditure due to the policy changes. Table 2 shows the difference from current expenditure, and Table 1 shows the difference from the amount currently included in the Department’s FY 2017-18 appropriation and FY 2018-19 base spending authority for hepatitis C treatment. The Department estimates that the policy change will reduce expenditure by $73.4 million total fund, $17.5 million General Fund in FY 2018-19. The Department will include the budget impact of the change in policy in its February 2018 forecast for Medical Services Premiums.

Table 1: Estimated Budget Impact for Hepatitis C Treatment				
Row	**Item**	**FY 2017-18**	**FY 2018-19**	**Source**
A	Current Appropriated Funding for Hepatitis C Treatment Criteria Change	$93,321,196	$93,321,196	R-1 "Medical Services Premiums"
B	Net Estimated Costs	$24,084,064	$19,909,868	FY 2017-18: Table 2, Row J + Row L FY 2018-19: Table 2, Row J
C	**Estimated Budget Impact**	**($69,237,132)**	**($73,411,328)**	**Row B - Row A**
D	General Fund	($16,526,903)	($17,523,284)	Row C - Row E - Row F
E	Cash Funds	($1,433,209)	($1,519,614)	Calculated based on cash fund source by eligibility group
F	Federal Funds	($51,277,020)	($54,368,430)	Calculated based on FMAP by eligibility group

Table 2: Estimated Costs for Hepatitis C Treatment Under Proposed Policy				
Row	**Item**	**FY 2017-18**	**FY 2018-19**	**Source**
A	Current Annual Number of Clients Completing Hepatitis C Treatment	673	808	Number of clients who finished treatment between October 1, 2016 and September 30, 2017
B	Percentage Increase Due to Removing Fibrosis Criteria	20.00%	3.01%	FY 2017-18: Assumed based on experience of other states opening criteria FY 2018-19: Medicaid caseload growth from R-1 "Medical Services Premiums"
C	Estimated Number of Clients Completing Treatment Under New Policy	808	832	Row A * (1 + Row B)
D	Average Cost of Drugs Per Client	$46,926.97	$46,926.97	Based on assumed treatment cost for clients by drug
E	Average Rebate Percentage	49.00%	49.00%	Percentage of actual rebates for all drugs received in FY 2015-16
F	Percentage of Year in Effect	50.00%	100.00%	Assumes implementation date of January 1, 2018
G	Estimated Costs Under Proposed Criteria Change	$9,668,833	$19,909,868	Row C * Row D * (1- Row E) * Row F
H	Historical Number of Clients Eligible for Retreatment	94	-	Number of clients who did not finish treatment since 2013
I	Additional Costs for Covering Retreatment Under New Policy	$2,249,679	$0	Row H * Row D * (1 - Row E)
J	**Total Net Estimated Costs Under Proposed Policy**	**$11,918,512**	**$19,909,868**	Row G + Row I
K	Expenditure Under Current Policy	$47,708,047	$47,708,047	Total expenditure for hepatitis C treatment between October 2016 and September 2017

L	Total Net Estimated Costs Under Current Policy	$12,165,552	$24,331,104	Row K * (1 - Row E) * Row F
M	**Difference**	**($247,040)**	**($4,421,236)**	Row L - Row J

66. Has the Department restricted opioid prescriptions to seven days? What is the expected fiscal impact of restricting opioid prescriptions to seven days?

The Department instituted a new opioid policy on August 1, 2017 for clients who have not received any opioids in the past 12 months. These clients are termed "opioid treatment naïve" and this policy applies only to them. The policy allows up to 8 pills per day and up to a 7-day supply (56 pills) for up to 3 fills. Then a prior authorization is required for continuation. The new policy does not apply to those who have been on opioids in the last year. When the Department implemented the policy, it did not anticipate any significant fiscal impact.

The Department manages the pharmacy benefit and makes routine changes such as preference for more cost-effective medications over others, coverage policies to ensure appropriate use (based on evidence of safety and efficacy), and utilization management strategies relating to dosing, pill quantities, or days supply. The Department has authority to make these changes as part of their standard process under the Colorado Code of Regulations and the State Plan with CMS. The standard process includes gaining input from stakeholders and independent advisory groups such as the Drug Utilization Review Board.

Long acting opioids (used by patients with chronic pain) will not be allowed for a treatment naïve client. If their use is needed, the case will be evaluated via a prior authorization. Exceptions may be granted for certain clinical settings (for example: newly diagnosed cancer patients, post-operative surgery, etc.). The Department also contracts with a pain management specialist who can conduct peer to peer consultations for difficult cases.

The main goal of the opioid naïve policy is to reduce the possibility of a client transitioning to chronic therapy with an opioid from an acute pain scenario (i.e. surgical procedure, trauma) when it is not medically needed and potentially becoming addicted. The correlation of a longer days' supply of the initial fill of an opioid prescription to longer-term opioid use has been shown in a large Morbidity and Mortality Weekly Report (MMWR)[22] population analysis. The authors noted from their findings, "The rate of long-term use was relatively low (6.0 percent on opioids one year later) for persons with at least one day of opioid therapy, but increased to 29.9 percent when the first episode of use was for ≥31 days."

There are other states and programs that are implementing similar limited day supply policies. Arizona[23], for instance, has a statewide implementation of a seven-day prescription limit on the initial fill and refill of

[22] MMWR Morb Mortal Wkly Rep 2017;66:265–269. DOI: http://dx.doi.org/10.15585/mmwr.mm6610a1
[23] https://pharmacy.az.gov/sites/default/files/documents/files/ahcccsMedicalPolicyManual310V_0.pdf

an opioid. CVS[24] has also recently released plans to make a similar policy change. Seventeen states have implemented or plan to implement an opioid-limiting policy.[25]

67. Do some local governments administer drugs in jails for opioid overdoses? What is the funding stream? Are the drugs used consistent with best practices and national recommendations? Should state policy guide these practices, and who would set the state policy?

The Department does not fund nor oversee the use of opioid overdose products in jails, and does not have a recommendation as to how or if state policy should guide these practices. Federal law prohibits Medicaid from paying for services for people who are incarcerated. The Department reached out to the Department of Corrections, the Department of Local Affairs, and the Department of Public Safety, and found that policies may differ on a jail-to-jail basis. A broader conversation would be required to determine the sources of funding and if there are policy recommendations.

The Department is aware that the Office of Behavioral Health (OBH) in the Department of Human Services uses Correctional Treatment Fund dollars to support the education and distribution of naloxone to individuals deemed to be at high risk for overdose upon release. This is done through OBH's Jail Based Behavioral Health Services (JBBS) programs, which serve 43 counties. Studies consistently show that people with an opioid use disorder are at a greatly increased risk of overdose after incarceration. Several counties have implemented programs to train and distribute naloxone to these high-risk individuals and other counties are in the process of developing such programs.

4:05-4:15 Financing & COMMIT

68. Why is the Department unable to connect corrected bills to the original bills to calculate the payment shift attributable to the transition to a new billing system? Could the Department use dates of service to connect the bills and calculate the payment shift? Does the Department's billing system lack features commonly available in private billing systems to connect denied and paid bills?

RESPONSE

The Department does have the ability to connect denied claims and paid claims, although manual analysis is required to identify all claims (denied and paid) by a provider, as many claims that are denied are resubmitted using updated information, which makes analysis more difficult. The Department intends to use this data to compare the time between when a claim was incurred (date of service) and when the claim was paid; the Department would then use this analysis to calculate a more precise estimate of the payment shift by comparing the result to other time periods. The Department intends to provide a revised estimate of the payment shift in its February 2018 forecasts for Medicaid Services Premiums and other Medicaid programs.

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[24] http://www.cnn.com/2017/09/22/health/cvs-prescription-restrictions-opioids-bn/index.html

[25] https://www.washingtonpost.com/politics/with-drug-overdoses-soaring-states-limit-the-length-of-painkiller-prescriptions/2017/08/09/4d5d7e0c-7d0f-11e7-83c7-5bd5460f0d7e_story.html?utm_term=.61d408d615e9

The Department is not aware of any features commonly available in private billing systems to connect denied and paid bills that are not available in the new system or that could not be performed through data analysis.

69. How much of the reversion in FY 2016-17 is attributable to the new billing system preventing fraud and unauthorized services and how much is legitimate charges that providers have to float until they can get paid?

The Department cannot calculate how much of the revision was attributable to the new billing system preventing fraud and unauthorized service that was not captured in the old billing system or recovered in a post- payment review. The new billing system does contain edits and controls that prevent incorrect payments that were not fully functional in the old billing system, which may have allowed claims to be paid incorrectly and required the Department to recover those payments in a post-payment review. The Department does not have a calculation on the number of denied claims in FY 2016-17 that were eventually paid in FY 2017-18 due solely to system changes that occurred after implementation. Those claims may have been directly reprocessed by the Department or resubmitted by the provider. If the provider resubmitted the claim, the Department would not have the ability to know if the exact same claim was denied and then eventually paid without a resource intensive analysis.

4:15-4:35 CHIP

70. Why did the Department send letters to families and appear on local media discussing the end of the Children's Basic Health Plan (CHP+) prior to consulting with the legislature?

RESPONSE

The Department has updated the legislature regularly over the last year about the potential end of federal funding for the Children’s Health Insurance Plan (known as Child Health Plan *Plus* Or CHP+ in Colorado).

- **December 14, 2016:** The Department included slides about the potential end of federal funding for the CHP+ program during the Department’s Joint Budget Committee hearing
- **January 6, 2017**: The Department discussed the issue during the SMART Act Presentation
- **March 3, 2017**: The Department sent a memo to Joint Budget Committee staff outlining the problems that would occur if Congress does not reauthorize funding for CHP+ in FFY 2017-18, and potential options the state could take in that event (see Appendix B).
- **March 8, 2017**: Joint Budget Committee staff provided a memo with a section titled “Contingency Planning for the” to Committee members during Figure Setting for the Department.[26] The Committee took no action at that time.
- **May 3, 2017:** The Department sent a letter to Colorado’s US congressional delegation urging them to continue funding for the program and copied members of the Joint Budget Committee and Senate and House health committee members.

[26] http://leg.colorado.gov/sites/default/files/fy2017-18_hcpfig1.pdf

- **May 15, 2017:** Status update in the legislative newsletter
- **August 15, 2017:** Status update in the legislative newsletter
- **September 20, 2017:** The Department requested and was granted the opportunity to present to the Joint Budget Committee on the status of federal funding of the CHP+ program. The Department informed legislators that if Congress failed to act the Department would start sending notices to clients. A copy of the Department's presentation can be found on our website.
- **November 15, 2017**: Status update in the legislative newsletter, including a copy of the letter sent to clients

On September 12, 2017, the future of CHP+ was on the agenda with the Member Experience Advisory Council. The purpose of the council is to help the Department integrate person and family centered approaches into the Department business practices, policies, and partnerships. The Department convenes and supports the council as part of its commitment to developing and maintaining a culture of person-centeredness by engaging with clients and family members/caretakers.

During the conversation with the council the members advised the Department to communicate early with families about the potential loss of coverage. Members shared that their first reaction to the potential loss of federal funding were "anxiety, panic, fear and shock." They advised that the Department proactively communicate with families and address all possibilities and uncertainties. They shared that the most important thing for them if they were facing a change in coverage would be the ability to keep their health care provider. They advised that the Department should communicate early with families because they would need time to try to reach their provider and find out what other health plans the provider accepts and to research their other coverage options using through their employer, a health insurance broker in their community or Connect for Health Colorado. Acting on this guidance, the Department crafted an informational letter to send to families. A draft of the letter was shared with the Council on October 10, 2017 for their feedback and edits.

Without Congressional action by the Thanksgiving recess, the Department, acting in accordance with the guidance from the Council, sent the informational letter to families about the potential end of the program and changes to their health insurance coverage. A copy of this letter can be found in Appendix C or on the Department's website: CO.gov/HCPF/child-health-plan-plus-chp-member-letters.

71. Please compare the average cost per child and per pregnant woman on CHP+ versus Medicaid. What would it cost to cover the CHP+ population on Medicaid?

RESPONSE

The Department forecasts that per capita expenditure for children on Medicaid will be $1,875.27 in FY 2018-19, compared to $2,406.13 for all children on the Children's Basic Health Plan (CHP+) for the same period.

The Department forecasts that per capita expenditure for pregnant women on Medicaid will be $10,416.12 in FY 2018-19, compared to $12,742.74 for pregnant women on CHP+ for the same period[27].

The per capita costs for the two programs are different because they use different delivery and payment systems. The costs for most Medicaid clients are paid on a fee-for-service basis and are coordinated through the Department's Accountable Care Collaborative. In contrast, CHP+ children are enrolled in managed care plans that receive actuarially-sound, monthly capitation payments for each member to cover the costs of providing services to that client. CHP+ pregnant women are paid a medical advance on expected costs through a capitation payment, but the Department reconciles those payments to cost at the end of the fiscal year. Due to the differences in the delivery systems, comparing the per capita costs between the programs is not directly equivalent as managed care plans have administrative costs not incurred in a fee-for-service system.

If eligibility were to be expanded to cover all CHP+ clients under the Medicaid, the Department estimates it would result in a reduction of $28,576,910 total funds and an increase of $88,849,385 General Fund in FY 2018-19. The General Fund impact would be lower if the General Assembly chose to offset General Fund costs with the balance of the CHP+ Trust Fund. The projected caseload accounts for clients currently enrolled in CHP+ in addition to individuals who were within the FPL limits but were not eligible for CHP+ due to having other insurance, but would be eligible for Medicaid. The Department assumes it would receive the standard Medicaid match and the state share would be primarily funded with General Fund.[28]

Table 1: Projected Cost to Cover CHP+ Population on Medicaid in FY 2018-19

Population	Projected Caseload	Per Capita Costs	Estimated Cost	General Fund	Cash Funds	Federal Funds
Children	83,741	$1,875.27	$157,037,229	$78,518,615	$0	$78,518,614
Pregnant Women	949	$10,416.12	$9,884,898	$4,942,449	$0	$4,942,449
Admin Costs			$10,776,642	$5,388,321	$0	$5,388,321
Estimated Total Cost	**84,690**	**$1,970.98**	**$177,698,769**	**$88,849,385**	**$0**	**$88,849,384**
CHP+ Request Amount including Admin			$206,275,679	$0	$26,199,325	$180,076,354
Incremental Difference			**-$28,576,910**	**$88,849,385**	**-$26,199,325**	**-$91,226,970**

[27] Medicaid per capita costs are those forecasted for former CHP+ clients eligible for Medicaid through SB 11-008 and SB 11-250 as they most closely resemble the CHP+ population. Average per capita costs for all children and pregnant women will differ slightly when lower income children and pregnant women are factored in.

[28] The Department currently receives an allotment from the tobacco master settlement agreement which is currently used to offset costs in the CHP+ program. These funds could continue to be used to support children in the Medicaid program. Annual allotments are about $14,022,000. The HAS Fee Fund could also be used to pay for the same population in Medicaid as it currently funds in CHP+, with enabling legislation.

72. If Congress does not reauthorize federal funding for CHP+, please describe the options available to the General Assembly. How could the General Assembly finance the increased costs for the Medicaid program? What could the General Assembly do to mitigate the negative impacts on the CHP+ population?

RESPONSE

Options Available if Congress Does Not Reauthorize Funding
If Congress fails to act regarding the Children's Health Insurance Program (CHIP) and all available federal funding is exhausted, there are four options the Department has identified that the General Assembly could take to mitigate the negative impacts on children and pregnant women enrolled in Child Health Plan *Plus* (CHP+).

Option 1
The General Assembly could choose to let the CHP+ program end when federal funds run out. Clients would need to look for alternative health insurance, either through Connect for Health Colorado or elsewhere. The Department is preparing to implement this option. The Department's appropriations for CHP+ are restricted by the (M) headnote in the Long Bill, which prevents the Department from using state funding when federal funding is unavailable. As a result, the Department has no spending authority to continue the program once federal funding runs out.

Option 2
The General Assembly could choose to operate the CHP+ program as a state-only program for all or some of the populations currently enrolled in the program. This option would give the General Assembly the flexibility to create a different type of state-only program to cover the people who would lose coverage. The estimated impact compared to the Department's current request for the CHP+ program to implement this option would be $57.4 million General Fund and $16.9 million CHP+ Trust Fund and a reduction of $3.5 million Healthcare Affordability and Sustainability Fee (HAS Fee) Fund in FY 2017-18, and an increase of $192.3 million General Fund and reductions of $3.2 million CHP+ Trust Fund and $9.1 million HAS Fee Fund in FY 2018-19[29].

Option 3
The General Assembly could choose to expand Medicaid up to 250 percent of the Federal Poverty Level (FPL) for children and pregnant women with a statute change. This option would allow all CHP+ clients who lose coverage to enroll in Medicaid if they choose. The estimated impact compared to the Department's current request for the CHP+ program would be $1.7 million General Fund, $16.9 million CHP+ Trust Fund, and $9.0 million HAS Fee Fund in FY 2017-18, and $45.5 million General Fund and a reduction of $3.1 million CHP+ Trust Fund and $20.3 million HAS Fee Fund in FY 2018-19. The fund splits assume that enabling legislation would allow for the HAS Fee Fund to pay for the same population in Medicaid as it currently funds in CHP+. If that statute change does not occur, the full amount of the HAS Fee Fund in each year would be General Fund.

[29] The Department cannot use the HAS Fee Fund without matching federal dollars, per 25.5-4-402.4(5) C.R.S (2017).

Option 4
The General Assembly could pursue a combination of expansion and creation of a buy-in option. With a statute change, the General Assembly could expand Medicaid for children up to 185 percent of the Federal Poverty Level to align eligibility between children and pregnant women. The General Assembly could then support the development of a buy-in program, already authorized in the CHP+ statute for children and pregnant women between 186 percent and 250 percent FPL. Since the buy-in program could be structured in a variety of ways, the Department is not able to provide fiscal estimates for this option. Should this be an option to pursue, the Department is committed to work collaboratively with members of the General Assembly to refine fiscal estimates.

Options to Finance Increased Costs for the Medicaid Program
If funding is not reauthorized, the state will need to continue to cover the children and pregnant women on Medicaid who are currently funded with the enhanced CHP+ match, regardless of what happens with the standalone CHP+ program. In addition to appropriating General Fund, the state could use the CHP+ Trust Fund to offset a portion of the increased costs for the Medicaid program, assuming it is not used to extend CHP+ in some form. Current statute allows for the use of the CHP+ Trust Fund for costs associated with children enrolled in the medical assistance program whose family income is more than one hundred percent but does not exceed one hundred thirty-three percent of the Federal Poverty Level[30]. As such, the Department would be able to offset costs in the Medicaid program with the balance of the CHP+ Trust Fund in FY 2017-18, which is currently projected to be $23.7 million in that year, and use the annual allocation of about $14 million annually from the Tobacco Master Settlement Agreement for the same purpose. Based on current Department estimates and using the CHP+ Trust fund as an offset, the Department would need about $2.2 million General Fund in FY 2017-18 and $46.7 million General Fund in FY 2018-19.

The General Assembly could also choose to use other cash fund sources, such as the Healthcare Affordability and Sustainability Fee Cash Fund, to offset costs, but that option would require a statute change.

Options to Mitigate the Negative Impacts on the CHP+ Population
To mitigate the negative impact on the CHP+ population, the General Assembly could authorize options two through four listed above. The second option would allow current enrollees to retain health insurance coverage through Medicaid and not require federal approval of program changes, although it would still require some systems changes for the state. Options three and four would also require systems changes and would require engagement with the federal government to obtain the appropriate approvals to implement.

73. Please provide a copy of communications sent to CHP+ recipients about the potential end of the program.

RESPONSE

The communications sent to CHP+ recipients about the potential end of the program is included as Appendix C of the hearing responses. The Department has made samples of the Informational Notice in

[30] 25.5-8-105, C.R.S (2017).

English and Spanish available on our website: colorado.gov/ hcpf/child-health-plan-plus-chp-member-letters.

As of December 6, 2017, the Department has mailed one letter to Child Health Plan *Plus* (CHP+) clients. An Informational Notice was sent in late November 2017 and tells clients:

- CHP+ may end January 31, 2018 if Congress does not act,
- they can continue to use their CHP+ benefits, and
- they will receive a CHP+ coverage termination notice at the end of December 2017, if Congress does not act.

The Department has also shared the sample Informational Notice with our county and community partners, advocates, stakeholders, providers, health plans, and Connect for Health Colorado.

4:35-4:50 Miscellaneous

74. Who are the private grantors no longer supporting the All-Payer Claims Database (APCD)? Why are these grantors no longer willing to support the APCD?

RESPONSE

The Colorado Health Foundation (CHF) and the Center for Improving Value in Health Care (CIVHC) provided input regarding this question. The intent of the funders who have provided grant funding to the APCD (including CHF) was to support the start-up of the database, and was never intended to provide perpetual ongoing support. The Colorado Health Foundation's support of the APCD was intended to create a structure that provides accurate, consistent, and timely data about what health care services cost, how they are utilized and the connection between cost and quality. Further, the APCD would allow consumers and purchasers to draw statistically significant conclusions about the cost and quality of the care delivered by health care providers. Since the launch of the APCD, the Colorado Health Foundation and others have openly communicated that the APCD would need a revenue base and diversified funding, allowing the funders to redirect community dollars to other community needs and innovations within Colorado. CIVHC's current general operating grant with the Colorado Health Foundation continues through December 2018. The APCD is a valuable asset to Colorado. The reduction of grant funding is not intended to reflect the value the APCD provides, but rather the reality that grant funding cannot be expected to support the APCD in perpetuity.

75. How many legislators have used the scholarship for research using the APCD?

RESPONSE

There has been one specific APCD request from a legislator. In addition, there have been requests from the Colorado Commission on Affordable Health Care that were funded through the scholarship. Outside of the scholarship requests for research, CIVHC has responded to several requests for information from legislators

by creating publicly available datasets at no charge. Further, legislators at both the state and the federal levels have used publicly available APCD data to inform policy.

76. The APCD annual report from March 2017 describes a 2016 budget for the APCD of $3.8 million, compared to the assumption in the Department's request that the APCD requires $5.0 million annually. Please explain the difference. Why does the APCD need more money going forward?

RESPONSE

The $3.8 million in the 2016 APCD Annual Report was associated with the APCD operating expenses for CIVHC's FY 2015-16. APCD operating expenses were $4.4 million in FY 2016-17, $4.9 million projected for FY 2017-18, and $5.0 million in FY 2018-19. In late 2015 through early 2016, CIVHC implemented key strategies to strengthen APCD data, including additional quality assurance, adding self-insured and dental claims, and increasing data management. In 2017, CIVHC transitioned to a new data vendor, migrated from quarterly to monthly data updates, enhanced the data portal access, website, and public reporting capabilities, as well as new customer tools. The increased activities and transition to a new vendor have increased the costs related to the administration of the APCD starting in FY 2016-17 and ongoing when compared to the FY 2015-16 budget reported in the 2016 APCD Annual Report. The transition has also increased the data accuracy and improved analytics.

77. Regarding the All-Payer Claims Database (APCD):

a) Does the Department pay for services from the APCD?
b) How do other states fund APCDs?
c) Who currently funds the APCD public website and reporting?
d) What are some ways the state could expand the use of the APCD?
e) How many organizations have benefitted from the APCD?
f) How many were out of state?
g) Do all requests have to benefit Medicaid or Colorado?

RESPONSE

a) Does the Department pay for services from the APCD?

Yes, the Department contracts with CIVHC for specific APCD data and analyses. The annual amount of this contract is $263,200. The Department does not pay CIVHC to administer the APCD.

b) How do other states fund APCDs?

Eighteen states have legislatively mandated APCDs. Of these, five are funded exclusively by their state, seven receive Medicaid matching funds (state funding plus federal Medicaid matched funds), four receive state appropriations and assess fees on submitters, and two rely on grant funding. The table below shows a summary of how the 18 states with APCDs fund their APCDs, and a detailed description by state.

Summary of State APCD Funding		
Type of Funding	**Number of States**	**Percent of Total**
A. All State Funded (including contributions from state agencies)	5	27.8%
B. Medicaid Match and/or Contribution	7	38.9%
C. Grants	2	11.1%
D. State Appropriations and Assessments	4	22.2%
Total	18	100.0%

Detailed Description by State	
Arkansas	All state funded (A)
Connecticut	State appropriations and assessments through the state Health Marketplace (D)
Delaware	Initial funding through Health Information Exchange and State Innovation Model (SIM) grants; ongoing funding TBD (C)
Florida	Medicaid match (B)
Kansas	All state funded (A)
Massachusetts	Agency as a whole funded by assessments on hospitals and insurers (D)
Maryland	All state funded, with contributions from state agencies for specific projects (A)
Maine	No state funds, only assessments on providers and payers ($1.6M) and data use fees (up to $300K) (D)
Minnesota	All state funded (A)
New Hampshire	Medicaid match (B)
New York	Funding from Medicaid, Dept of Financial Services, Dept of Health/Child Health Plus and state appropriations (A)
Oregon	Medicaid match (B)
Rhode Island	Medicaid match (1 year at 90/10, 4 years at 75/25) (B)
Tennessee	Medicaid match (B)
Utah	Medicaid match (B)
Virginia	Medicaid contribution (20% of total) (B)
Vermont	SIM funds, state appropriations, assessment on insurers (D)
Washington	Center for Consumer Information and Insurance Oversight (CCIIO) grants funding start up through 2018 (C)

c) Who currently funds the APCD public website and reporting?

There are no allocated dollars to support CIVHC's state mandated public reporting or website. CIVHC has produced the existing public reports of APCD data and analyses and funded the website from general operating revenue and grant funding.

d) What are some ways the state could expand the use of the APCD?

State agencies have been using APCD data to improve health care in Colorado since 2013. These projects include:

- Performing insurance rate setting analysis
- Investigating regional cost variation

- Demonstrating the case for closing care gaps and lowering costs for the uninsured population
- Determining a return on investment for services provided by the Area Agency on Aging
- Pinpointing where to target interventions to improve medication adherence
- Reporting for the State Innovation Model, Transforming Clinical Practices Initiative, and others.

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

- Improve outcomes for vulnerable patients
- Lower costs for procedures
- Improve reimbursements and increase access to care
- Evaluate the effectiveness of policy changes

Additional state uses could include:

Public Reporting and Data Literacy

- Research and publication of new spot analyses and/or datasets comparing Medicaid, Commercial, and Medicare markets.
- Ongoing public reporting including interactive maps and charts as well as online publications on the health burden of chronic conditions like diabetes and asthma across the state.
- Development of new population health metrics to show immunizations, preventive care, and associated costs by county.
- Detailed reports at the individual provider level on costs, utilization, and quality.
- Publication of expanded APCD Annual Reports including additional insights for the governor, legislators, and communities.
- Design and development of educational programs and opportunities to increase data literacy in communities across Colorado.
- Development and execution of the Data Academies – a program designed to help promote data understanding and comprehension of health care cost, quality, and utilization measures.

Support Services for Colorado Medicaid and Other State Agencies

- Generate analyses comparing cost and utilization analyses of new care delivery models.
- Data and analytics to support health plan rate setting.
- Development of a secure, online portal for customers to access APCD data.

APCD Infrastructure and Operations

- Continued quality improvement of data submissions and data extracts.
- Development of additional standard products to meet the needs of stakeholders and reduce the cost to access APCD data (readmission reports, drug cost trend analyses, quality measures).
- Generate monthly data quality documents including a detailed review of underlying data.
- Track and document all APCD requests to create a library of uses and methodologies.
- Continue to develop and support new ways to pay for care and improving public access to the APCD data and analyses.

e) How many organizations have benefitted from the APCD?

As of December 1, 2017, approximately 250 requests have been fulfilled since 2013.

f) How many were out of state?
Fifteen requests from the APCD have been for out-of-state recipients.

g) Do all requests have to benefit Medicaid or Colorado?
Data requests do not need to directly benefit Medicaid; however, each data request is required to outline how the project will improve health care or public health outcomes for Coloradans. Data is not released unless it satisfies this requirement. The APCD regulation explicitly states that "…[a] state agency or private entity engaged in efforts to improve health care or public health outcomes for Colorado residents may request a specialized report from the APCD…"

78. What is the Department's position on the JBC staff recommendation to make the Healthcare Affordability and Sustainability Fee subject to annual appropriation?

RESPONSE

The Department is neutral on the recommendation to make the Healthcare Affordability and Sustainability Fee subject to annual appropriation, and would not oppose a bill.

79. The JBC staff presented some arguments for additional analysis of hospital expenditures and revenues that differ from the published justification provided in the Department's R15 CHASE administration. How would the Department spend the money requested in R15 CHASE administration, and to what extent would the Department's expenditures address the issues raised by the JBC staff?

RESPONSE

The Department agrees with JBC staff in that there is a need for increased analysis of hospital utilization, revenue, and expenditures. In fact, the Department's November 1, 2017 budget request R-15, "Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) Administration," is intended to devote resources to the issues raised by JBC staff and justify the funding for such resources.

Specifically, JBC staff raised three issues in this briefing: 1) The Department may be under-resourced to calculate the healthcare affordability and sustainability (HAS) fee accurately; 2) Opportunities that exist to improve cost efficiency, improve clinical effectiveness, and decrease inappropriate utilization in the hospital setting could provide significant savings for public and private insurers; and 3) Understanding the cost shift from Medicaid to private insurance could help policy makers understand and address private insurance costs.

Resources to Calculate the Provider Fee Accurately
The Department believes that it is under-resourced in administering the HAS fee and requests additional resources to address this need. In turn, the Department will benefit from the additional resources by improving its operations.

The Department's request includes analytical staff and software to improve the Department's calculation of the HAS fee as well as auditor staff to improve internal practices and controls. Moreover, to make sure the Department has sufficient resources dedicated to the administrative functions, the request includes contract management, budget, accounting, and procurement staff.

Currently, such administrative functions are performed in part by senior staff. However, considering the added workload, senior staff is dedicating more time to ensuring the completion of tasks as opposed to ensuring the accuracy and quality of the work product. Addressing such limitations will allow senior staff the opportunity to spend adequate time and energy overseeing and directing the HAS fee, therefore improving the Department's work product and performance.

Regarding funding, the CHASE Act established an administration funding limit of 3 percent of the CHASE's expenditures. The Department's R-15 request results in administration funding well below this limit at a projected 2.23 percent of total expenditures.

Improve Hospital Efficiency and Effectiveness
The Department agrees that opportunities exist to provide savings for public and private health care payers by improving the efficiency and effectiveness of hospital care and reducing inappropriate hospital utilization. The CHASE Act directs the Department to seek any federal waiver necessary to develop a delivery system reform and incentive payment (DSRIP) program as soon as October 2019. The DSRIP program will improve hospital effectiveness, efficiency, and utilization by improving care coordination and integration through outcome-based measurement.

To implement the DSRIP successfully, the Department is requesting hospital policy and quality staff as well as staff devoted to analyzing hospitals' Community Health Needs Assessment reports. Further, to generate buy-in and support from the hospital and stakeholder community, the Department is requesting project management and stakeholder relations staff.

Cost Shift Analysis
The Department agrees that additional resources are needed to research and analyze why the hospital payment to cost ratio for private payers is not improving despite increased reimbursement and health coverage under the HAS fee. Therefore, to help policy makers understand and address this issue, the Department's request includes funding for contracted health care consultants to monitor and analyze the HAS fee's impact on the health care market. The requested additional analytical staff and software resources will also assist in this effort by performing calculations and liaising between contract staff, the Department, and the Division of Insurance.

80. **Please provide an update on implementation of the recommendations of the Respite Care Task Force, as authorized by H.B. 16-1398, including the estimated cost of the work.**

RESPONSE

The Respite Care Task Force is an initiative run through the Colorado Department of Human Services. The Respite Care Task Force began work in February 2017 with Easter Seals Colorado as a subcontractor to the Colorado Department of Human Services to implement the recommendations. The recommendations included a cost-benefit study of respite care, alignment of Medicaid waiver respite regulation, creation of a caregiver outreach campaign and improvements to the caregiver website, and development of a training database.

The Department has been working with the Task Force and its subcontractors as they work toward implementation of the recommendations. As part of the implementation, Easter Seals Colorado has contracted with Health Management Associates and the Bell Policy Center to help carry out some of the recommendations. Health Management Associates is conducting a cost-benefit study of respite care to evaluate the economic impact that respite services provide to the state. The Bell Policy Center is developing recommendations to help streamline Medicaid waiver respite services, primarily working on increased access and utilization of services. Last, Easter Seals is improving Colorado's Respite Coalition website and conducting a caregiver outreach campaign, as well as developing a training database of respite and caregiving trainings across Colorado. The work is currently funded through June 2018, when the reports will be shared. The Department will continue to assist with this work and collaborate with stakeholders to implement recommendations once finalized.

81. The National Bureau of Economic Research released an analysis of the Oregon Health Insurance Experiment, a Medicaid expansion for low-income, uninsured adults that occurred via random assignment. Please summarize and discuss the findings of the analysis and the implications for Colorado's Medicaid program. The report is available here: http://www.nber.org/papers/w21308.pdf

RESPONSE

In their 2015 working paper titled "The Value of Medicaid: Interpreting Results from the Oregon Health Insurance Experiment," coauthors Amy Finkelstein, Nathaniel Hendren, and Erzo F.P. Luttmer use results from the Oregon Health Insurance Experiment to examine and attempt to quantify who benefits from additional Medicaid spending by the government.

There are critical limitations when analyzing this paper that must be considered before evaluating the results. Specifically:

- The 2015 working paper has been substantially revised since it was posted to the National Bureau of Economic Research's (NBER) website. A new version was released in November 2016 and is accessible via the website of one of the co-authors.[31] The conclusions in the new version are different than the original analysis.
- This is a "working paper." As noted on the cover page of the 2015 version "…working papers are circulated for discussion and comment purposes. They have not been peer-reviewed or been subject to the review by the NBER Board of Directors that accompanies official NBER publications."
- Per the website of one of the principle researchers, the working paper has not yet been accepted for publication.[32]
- The 2015 working paper was posted to the NBER website by the authors, and disclaims that "the views expressed… are those of the authors and do not necessarily reflect the views of the National Bureau of Economic Research."

[31] https://economics.mit.edu/files/12407
[32] https://economics.mit.edu/faculty/afink/working

Given these limitations, the Department urges extreme caution in using either version of this working paper in making public policy decisions. These working papers represent work-in-progress, and the final publication, if any, may differ greatly from the existing drafts.

Given that the paper has been revised, the Department has reviewed the most current version. In the most recent version of the paper, the authors' primary conclusion is that "the monetary transfers from Medicaid to external parties are quantitatively important relative to the welfare benefits of Medicaid to recipients." In lay terms, this means that a significant part of the value of providing Medicaid to people accrues to providers of health care that were previously treating the newly eligible before they had insurance. The authors estimate that this transfer component of the benefit is larger than the benefit to recipients, which reflects that providers deliver a significant amount of uncompensated care to the insured.

Depending on the assumptions used in the authors' models, the value of Medicaid to recipients varies from about $0.50 to $1.20 per dollar of net cost (the average increase in medical spending induced by Medicaid plus the average decrease in out-of-pocket spending due to Medicaid). The authors note that prior research estimated that recipients of the Earned Income Tax Credit – a different low-income population – value the EITC at $0.88 per dollar of net cost.

Other published results from the Oregon Health Insurance Experiment, as detailed on NBER's website, indicate that in its first one-to-two years:

> Medicaid coverage resulted in significantly more outpatient visits, hospitalizations, prescription medications, and emergency department visits. Coverage significantly lowered medical debt, and virtually eliminated the likelihood of having a catastrophic medical expenditure. Medicaid substantially reduced the prevalence of depression, but had no statistically significant effects on blood pressure, cholesterol, or cardiovascular risk. Medicaid coverage also had no statistically significant effect on employment status or earnings.

More information about these results can be found on the NBER's website.[33]

This paper does not provide any implications for Colorado's Medicaid program as it is not concerned with health outcomes and does not make any public policy recommendations. The results appear to be in line with the Department's experience: that providing a funding source for the previously uninsured provides value for the recipients who gain insurance and for the providers who were providing uncompensated care.

82. Please discuss all bills the Department is asking the JBC to carry and why they are necessary.

RESPONSE

The Department is requesting the Joint Budget Committee run two bills with corresponding budget requests:

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[33] http://www.nber.org/oregon/3.results.html

R-7 HCBS Transition Services Continuation and Expansion
The Department has saved over $2.8 million by transitioning 274 individuals out of long-term care facilities back into home and community-based settings since April of 2013 through Colorado Choice Transitions (CCT), a federally-funded demonstration program of the national Money Follows the Person Initiative (MFP).[34]

The federally-funded demonstration is ending in 2018 and the Department wants to build upon the transition process infrastructure created by the CCT demonstration and continue to fund some of the transition services that proved most effective during the demonstration. Investment in transition services is a cost-containment initiative that improves health outcomes and client quality of life.

Legislation is needed to allow General Fund to pay for transition services previously funded through grant dollars and modify the list of benefits outlined in statute in some of the home and community-based waivers (Section 25.5-6-307, C.R.S.)

R-12 Children's Habilitation Residential Program Transfer
The Children's Habilitation Residential Program (CHRP) provides residential services for children and youth in foster care who have a developmental disability and very high needs. CHRP is the last remaining Medicaid waiver administered by the Department of Human Services.

The current eligibility requirements for CHRP (namely the requirement that the child be in foster care) force families to decide whether to relinquish their custodial rights over a child so they can qualify for the waiver through the foster care system. Once on CHRP, a child's services are case managed by counties which have repeatedly expressed they do not have the expertise or infrastructure to appropriately serve these children.

The budget request and corresponding legislation would modify the eligibility requirements of CHRP so a child does not need to be in foster care or deemed neglected or abandoned to qualify. The proposal would also move the administration of the waiver from the Department of Human Services to Health Care Policy and Financing and move case management duties from the counties to the Community Center Boards (CCBs).

Legislation is necessary to remove the statutory requirement that a child be involved in the foster care system, references to the Department of Human Services and county case management requirements (section 25.5-5-306, C.R.S.).

4:50-5:00 Closing Remarks

[34] https://www.colorado.gov/hcpf/money-follows-person-mfp

ADDENDUM: OTHER QUESTIONS FOR WHICH SOLELY WRITTEN RESPONSES ARE REQUSTED

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

RESPONSE

Please see Appendix D.

2. **Does the Department have any HIGH PRIORITY OUTSTANDING recommendations as identified in the "Annual Report: Status of Outstanding Audit Recommendations" that was published by the State Auditor's Office and dated June 30, 2017? What is the Department doing to resolve the HIGH PRIORITY OUTSTANDING recommendations? Please indicate where in the Department's budget request actions taken towards resolving HIGH PRIORITY OUTSTANDING recommendations can be found.**

RESPONSE

In reference to the outstanding audit recommendations identified in the Office of the State Auditor's "2017 Annual Report of Audit Recommendations Not Fully Implemented," the Department of Health Care Policy and Financing (the Department) has five recommendations that are considered "high priority" in the report. There are no budget request actions taken towards resolving these High Priority Outstanding Recommendations.

- Both recommendations 2015-051B and 2016-051C relate to Medicaid and the Children's Health Insurance Program (CHIP) provider eligibility. The Department feels both recommendations have been executed with the implementation of COMMIT and are in compliance with federal and state requirements.
- Recommendation 2016-055 concerns personnel costs charged to federal grant programs. Initially, the Department was to be moved onto the statewide KRONOS time tracking system; however, in April 2017 it was decided by the Office of the State Controller and the Office of Information Technology that our Department would be included in the new Human Resource Information System (HRIS) which is expected to be implemented in October 2018.
- Recommendation 2016-056C is related to Health & Safety Certifications and automating the Medicaid Management Information System (MMIS) to deny claims for facilities without current certification. The Department implemented its new Medicaid Management Information System March 1, 2017. Since the reported and the actual facility license expiration dates may vary, and automated claims denial may incorrectly deny claims for facilities that are actually in good standing, the system implementation did not include functionality that would allow for the automated denial of facility claims based on the expiration of facility licensure end dates as noted in the Department's original response. Effective September 2017, the Department has developed a Standard Operating Procedure (SOP) for the management of facility licensure expiration to ensure appropriate monitoring and compliance.

- Recommendation 2016-058 is regarding the Federal Funding Accountability and Transparency Act's (FFATA) reporting requirements for Medicaid and CHIP. A group known as the Community of Practice Contract Management work group has been created. The goal of this work group is to define processes that will address uniform guidance requirements, internal controls, and FFATA. This recommendation is on track to be implemented by December 31, 2017.

Rec No.	Classification	Audit Recommendation	Department's Implementation Status Update	Implementation Date
2016-051b/ 2015-40b	Material Weakness	The Department of Health Care Policy and Financing should improve its controls over the Medicaid and Children's Health Insurance Program provider eligibility determination and enrollment to ensure that it complies with federal and state requirements. Specifically, it should: b) Provide and maintain clear documentation within application records to demonstrate compliance with federal requirements and state regulations.	Implemented** The Department finds that the Colorado interChange is working as designed and that the Fiscal Agent is appropriately enrolling providers. The Department will work with the Fiscal Agent to produce documentation as requested to support that the provider has met the applicable provider screening requirements.	Implemented July 2017
2016-051c/ 2015-40c	Material Weakness	The Department of Health Care Policy and Financing should improve its controls over the Medicaid and Children's Health Insurance Program provider eligibility determination and enrollment to ensure that it complies with federal and state requirements. Specifically, it should: 51c. Establish a process to obtain required information to complete Social Security Administration Death Master File database checks during enrollment and monthly post enrollment checks for owners,	Implemented** The Social Security Administration Death Master File database verification process has been effective upon implementation of the Colorado interChange in March 2017. Though the Department may have been technically out of compliance with the federal regulations	March 2017

Rec No.	Classification	Audit Recommendation	Department's Implementation Status Update	Implementation Date
		agents, and managing employees to ensure that they are not excluded from participating in the Medicaid program.	at the time of the audit, the Department is implementing the regulations based on our available funding and implementation of the Colorado interChange which has been communicated to CMS.	
2016-055/ 2015-33/ 2014-34/ 2013-27	Significant Deficiency	The Department of Health Care Policy and Financing (Department) should develop and implement procedures to ensure that personnel costs charged to federal grant programs are compliant with federal cost regulations issued by the Office of Management and Budget (OMB).	Deferred* Implementing this recommendation is dependent upon the state's new Human Resource Information System (HRIS) implementation. The new HRIS system includes a time tracking system that will be utilized by Department staff to properly allocate their time to the appropriate federal programs. Prior to this, the Department was to be moved onto the statewide KRONOS time tracking system but that migration was delayed by Office of Information Technology (OIT) several times over the	Deferred from December 2017 to October 2018

Rec No.	Classification	Audit Recommendation	Department's Implementation Status Update	Implementation Date
			last three years. In April 2017, it was finally decided by the Office of the State Controller and the OIT that any Department not currently on KRONOS would not be migrated to KRONOS. These Departments would be included in the new HRIS implementation which will begin July 2018 with an expected implementation date of October 2018.	
2016-056c/ 2015-34c/	Significant Deficiency	The Department of Health Care Policy and Financing (Department) should continue to work with the Department of Public Health and Environment (DPHE) to improve internal controls over the monitoring of health and safety certifications by: c. Modifying the Medicaid Management Information System (MMIS) to automate the process for denying claims for facilities without current certifications in place for participation in the Medicaid program.	Implemented** The Department implemented its new Medicaid Management Information System March 1, 2017. The system implementation did not include functionality that would allow for the automated denial of facility claims based on the expiration of facility licensure end dates as noted in the Department's original response. Since the reported and the actual facility license	Implemented September 2017

Rec No.	Classification	Audit Recommendation	Department's Implementation Status Update	Implementation Date
			expiration dates may vary, automated claims denial may incorrectly deny claims for facilities that are actually in good standing and cause unnecessary disruption to direct client care. The Department has now developed a Standard Operating Procedure (SOP) for the management of facility licensure expiration to ensure appropriate monitoring and compliance, effective September 2, 2017. Included in this SOP is a requirement that a License Expiration Report be run monthly on the 22nd of the month by Colorado Department of Public Health Environment. For licenses with expiration dates of over 30 days, Department staff must call the facility administrator to confirm the status of the license renewal. In the event the Department must stop payment to a facility for which a license has lapsed or where	

Rec No.	Classification	Audit Recommendation	Department's Implementation Status Update	Implementation Date
			the facility's license has been recommended for revocation, the Department will stop payment to such facilities. Pursuant to the existing process, this stop remains a manual touchpoint. The Department will track the efficacy of this process and consider whether full automation of claims denial based on licensure expiry is a desired outcome.	
2016-058/ 2015-36/ 2014-33/ 2013-23	Significant Deficiency	The Department of Health Care Policy and Financing (Department) should comply with the Federal Funding Accountability and Transparency Act's (FFATA) reporting requirements for the Medicaid and Children's Basic Health Plan programs.	Deferred* The FFATA Fact Sheet was one piece of the overall solution to implement this prior year audit recommendation. Since our contract managers are the closest to the contracts they manage, the Department is defining a process that will address uniform guidance requirements, internal controls, and FFATA.	Deferred from July 2016 to December 2017

Rec No.	Classification	Audit Recommendation	Department's Implementation Status Update	Implementation Date
			A workgroup known as the Community of Practice Contract Management workgroup has been created. The goal is to have the work group produce a process for review. The Controller Division has reached out to other Departments to discuss their policies and procedures related to FFATA and is on track to implement this audit recommendation by December 31, 2017.	

*OSA considers any deferred recommendations as partially implemented or not implemented.

**The Dept. considers this recommendation as implemented – OSA does not.

The recommendations that the Department said would be addressed through the implementation of COMMIT are indicated with a red dot 🔴 .

3. **If the Department receives federal funds of any type, please respond to the following:**
    a. **Please provide a detailed description of any federal sanctions or potential sanctions for state activities of which the Department is already aware. In addition, please provide a detailed description of any sanctions that MAY be issued against the Department by the federal government during FFY 2017-18 or 2018-19.**

RESPONSE

When discussing Medicaid, the term "sanction" is understood to mean a penalty for an activity that falls outside of the activities allowed by the Social Security Act (SSA). The federal Centers for Medicare and Medicaid Services (CMS) has the power to reduce the state's Federal Financial Participation or to fine the

state as a sanction for these violations. CMS has not penalized or sanctioned the Department in its operation of the Medicaid program in at least the past 10 years.

Federal disallowances can be issued by CMS when they determine that a claim or a portion of a claim is not allowable under the SSA or a program violates CMS rules or regulations. In these situations, the Department may be required to pay back the federal share of the claim(s). The federal disallowances the Department typically encounters are due to disagreements over the administration of various activities. The Department actively challenges and engages with CMS regarding any disallowances by appealing disallowances to the Health and Human Services Departmental Appeals Board (DAB). However, it is unusual for the DAB to rule against CMS' disallowances, even when CMS applies current guidance retroactively or disallows funding for legitimate services provided to eligible clients. Potential risk areas related to CMS findings are represented in the Medical Services Premium narrative in the FY 18-19 Budget submitted on November 1, 2017.

Below are disallowances that were paid during FFY 2017-18.

- The Department has fully exhausted all appeals and is currently repaying the following disallowance:
  - $7.6 million (covering claims from April 2010 to December 2012) related to claims in the "Adult Prenatal Coverage in Children's Health Plan *Plus* (CHP+) and Premium Assistance Pilot Program" demonstration waiver. This is a technical finding following a review of the Department's waiver authority, which allowed CMS to recover funds from the Department for services improperly rendered by providers to CHP+ eligible clients. The Department notified the Joint Budget Committee of this in its February 15, 2015 budget submission and then requested and received funding for this disallowance as part of its November 2, 2015 Budget Request R-3, "CHP+." These funds were repaid on a quarterly basis until September 30, 2017.

- CMS notified the Department on May 11, 2017 of a disallowance in the amount of $1,537,500. This was paid on July 21, 2017.
  - The $1,537,500 claim originates from a lawsuit between the Department and Anthem Blue Cross (Anthem) involving Anthem's administration of the Medicaid presumptive eligibility program from the period June 1, 2005 to June 30, 2008. HCPF and Anthem entered into an agreement to settle the litigation, and as part of the settlement agreement, HCPF agreed to pay Anthem a sum of $3,075,000. On the Form CMS 64 for the QE 12/31/12, the Department claimed a total of $3,075,000 ($1,537,500 FFP) in prior period adjustments. CMS previously communicated to the Department the $1,537,500 FFP in claims are not allowable because they exceed the two-year timely filing limit and do not meet any of the exceptions to such limit. The Department concurred and did not appeal this decision.

The items described below are active deferrals, where CMS has asked the Department for more information about recently reported expenditures:

- External Quality Review Organization (EQRO) contractual activities. CMS asserts that the costs were not properly detailed in the Department's Cost Allocation Plan (CAP) and that some of the activities performed by the vendor did not qualify for enhanced federal financial participation. The Department requested funding in January 2016 as part of the S-12, BA-12, "External Quality Review FFP Adjustment" to address this issue in FY 2015-16 and future fiscal years to account for the new guidance regarding a more narrow interpretation of EQRO requirements but did not request funding for past years in anticipation of appealing CMS determinations on past expenses. The Department believes that the expenses were properly detailed in the Department's CAP and that the activities were within the guidance provided on allowable EQRO activities. Changes to the coding of the EQRO contract on July 1, 2016 at CMS' request resolved the issue. The final deferral was issued in May 2017, and the Department provided their response in July 2017. No further deferrals are expected and the Department awaits CMS' final decision on whether to issue a disallowance on the prior deferrals.

- Claims related to Affordable Care Act (ACA) VIII Group populations (commonly referred to as the expansion populations). CMS has been conducting quarterly audits of the Department's eligibility cases. CMS asserts that some clients were incorrectly placed into the expansion group which caused their services to incorrectly be paid using 100 percent federal funds. The Department contends that these reviews by CMS are de facto Medicaid Eligibility Quality Control (MEQC) pilot project reviews of Medicaid eligibility to identify erroneous payments, which are defined as payments for ineligible persons. Due to changes in the way that states make eligibility determinations under the ACA, CMS directed states to implement new eligibility review pilots for fiscal years 2014–2017 in place of MEQC and the Payment Error Rate Measurement program (PERM) reviews. To facilitate improvements in states' eligibility determinations under ACA, CMS has suspended recoveries—including payment reductions and disallowances—for errors identified through the 2014-2017 MEQC and Children's Health Insurance Program pilots. Beginning in 2013, the Department began modifying the Colorado Benefits Management System (CBMS) to make the required ACA eligibility determinations, including the use of MAGI methodologies for income determinations and household composition. Since then, it has been a process of continually adjusting CBMS as we learn more about how the system makes these new eligibility determinations in conjunction with (or not) preexisting methodologies. This is what CMS sought to address by implementing the policy of the MEQC pilots—to give states the opportunity to come into compliance with ACA by overhauling their eligibility systems without the threat of recovery for erroneous payments made during this trial-and-error process. As such, CMS applied the MEQC pilot recovery policy here and exempted the Department from disallowances. The Department has already implemented changes to CBMS to address errors identified by CMS as the Department identified the issues prior to the CMS review. The Department is working with the Office of the Attorney General regarding the recovery of funds based on these eligibility reviews.

b. **Are you expecting any changes in federal funding with the passage of the FFY 2017-18 or 2018-19 federal budget? If yes, in which programs, and what is the match requirement for each program?**

RESPONSE

No, the Department does not expect any changes in federal funding that are connected to the federal fiscal year 2017-18 and 2018-19 federal budget.

However, Congress has not yet reauthorized funding for the Children's Health Insurance Program (CHIP), referred to as Child Health Plan *Plus* (CHP+) in Colroado. CHP+ currently receives an 88 percent federal match.

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

RESPONSE

If Congress does not renew federal funding, CHP+ in Colorado will end on January 31, 2018. To prepare for this possibility, CHP+ clients were sent letters the week of November 27, 2017, informing them that:

- CHP+ may end January 31, 2018 if Congress does not act,
- they can continue to use their CHP+ benefits until the program ends, and
- they will receive a CHP+ coverage termination notice at the end of December 2017, if Congress does not act.

In December 2017, clients will receive official notification that their coverage will end January 31, 2018, if Congress does not act by that time. The notification will also include information informing clients if they qualify for Health First Colorado (Colorado's Medicaid Program) or may qualify for financial assistance to help purchase private health insurance through Connect for Health Colorado.

4. **Is the Department spending money on public awareness campaigns? If so, please describe these campaigns, the goal of the messaging, the cost of the campaign, and distinguish between paid media and earned media. Further, please describe any metrics regarding effectiveness and whether the Department is working with other state or federal departments to coordinate the campaign?**

RESPONSE

The Department is not currently running any paid public awareness campaigns. The Department does not engage in paid advertising unless it receives a specific appropriation, or private or federal grant funding to support such an effort. The Department regularly does general outreach to providers and clients. One example is our current outreach to Child Health Plan *Plus* (CHP+) clients, health plans and providers about the potential of the program ending.

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

RESPONSE

Below is the Department's FTE turnover and vacancy rate by office. The Department tracks this data by office, and not by division, therefore information for FTE turnover/vacancy by division is not available.

Turnover and Vacancy Rate by Office for FY 2016-17			
Office	Number of Unique Employees	Turnover Rate Since July 2016[1]	Historical Vacancy Rate[2]
Client and Clinical Care	45	11%	10%
Community Living	81	17%	16%
Executive Director's	22	18%	19%
Finance	125	9%	16%
Health Information	131	12%	16%
Health Programs	67	7%	17%
Policy, Communication, and Admin	134	19%	18%
Total	605	13%	16%

[1] Turnover Rate is calculated as the count of the number of times an employee separated from the Department, either voluntarily or involuntarily, divided by the total number of unique employees.

[2] Historical Vacancy Rate is the percentage of months over the past three years that the positions have been vacant.

The Department has recently changed the exit survey process to improve participation and data collection.

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

To attract and retain employees, the Department is focusing on employee engagement beginning with the recruiting process, moving through onboarding, followed by capitalizing on the engagement survey results by developing action plans for addressing identified challenges.

The Department expects that the new guidance from the Department of Personnel and Administration (DPA) allowing in-range adjustment and competency based increases will have a positive impact on the turnover rate.

6. **Please provide an update on the Department's status, concerns, and plans of action for increasing levels of cybersecurity, including existing programs and resources. How does the Department work with the Chief Information Security Office (CISO) in the Office of Information Technology (OIT)? Have your information technology infrastructure and policies been audited for cybersecurity capabilities? If so, was the audit completed by the legislative auditor or an outside entity? Do you have dedicated cybersecurity personnel? How do your cybersecurity staff interact with the CISO in OIT? What unique security issues does your Department have? Do you handle private or sensitive data? What unique cybersecurity processes or tools do you use to protect this data?**

RESPONSE

The Office of Information Security, under the leadership of the state CISO provides security governance, security architecture, risk management, compliance assessment support, and security operations functions for all executive branch agencies (with a few exceptions, such as: CDE, Department of State, Department of Law, Lottery). Agencies, except those mentioned as exceptions, do not have dedicated cybersecurity personnel.

The Office of Information Security has input into the 5-year plans for each Department, and has worked to prioritize projects benefiting each Department, such as: the Enterprise Firewall Refresh project, new quarterly security awareness training, two-step verification, and an enterprise security log collection and correlation engine.

Additionally, the Office of Information Security, within OIT, produces a quarterly risk report card, in which they measure risk for each Department, and have specific goals set, for reducing risk.

Annually, the CISO develops an enterprise information security plan, utilizing input from the Governor's goals, the five-year plans for each department, and the OIT playbook. The information security plan includes communication and information resources that support the operations and assets of each department.

The Office of Information Security, within the Office of Information Technology (OIT), implements enterprise-wide security controls meant to secure sensitive data for each department. Some of these controls are: ensuring encryption is in place to secure data in transmission, utilizing Zix to encrypt sensitive data in email, implementing specific configuration and technologies to encrypt data in storage. Additionally, OIT has implemented two-step verification to add a layer of protection to email, contacts, and data stored within G-Suite. Each department implements additional procedures, such as training, data retention and access control policies, implemented at a department level to further protect and secure sensitive data. These local security procedures augment technical controls implemented by OIT to enhance the department's continued security health.

OIT supports all of the audits that occur for each department. OIT maintains a register of outstanding technology recommendations for each department, and works individually with the department to prioritize and secure funding to implement the recommendations. In addition to performing remediation, OIT continues to implement controls and improve processes in an attempt to proactively (rather than reactively) improve security."

7. What impact do the SMART Act and Lean processes have on your budget requests? Could they be used more effectively?

RESPONSE

The SMART Act provides the framework for a customer-focused approach to the delivery of government goods and services by requiring the use of department performance plans (DPPs) prioritized around strategic policy initiatives (SPIs). In accordance with the SMART Act, the Department prioritizes budget requests that align with and support the Department's SPIs. When budget ideas come in, budget staff work with managers and policy experts to flesh out details of each request, and determine how it specifically ties to the DPP. Every budget request submitted by the Department in FY 2017-18 links directly to the Department's Performance Plan; each request includes specific linkages in the 'Anticipated Outcomes' section. The Department's executive team also uses the DPP to rank and prioritize which ideas move forward.

If a budget request idea includes enhancements to an existing program, the Lean team may be brought in to identify and minimize process inefficiencies before funding is requested. For budget requests that move forward and receive funding, the Lean team is available to assist with process mapping and streamlining implementation plans to ensure the most efficient use of resources across the Department. Priority is given to Lean projects with the strongest alignment to Strategic Policy Initiatives.

8. Does your Department use evidence-based analysis as a foundation for your budget requests? If so, please provide a definition for your use of "evidence-based," indicate which programs are "evidence-based," and describe the evidence used to support these programs.

RESPONSE

Yes, the Department uses evidenced-based analysis as a foundation for its budget requests, where appropriate. The Department uses its own experience, when there are measurable results or prior history, and peer reviewed research or the experience of other states when implementing something new.

Key examples from the Department's November 1, 2017 Budget Request include:

- R-6, Electronic Visit Verification Implementation: Other states that have previously implemented electronic visit verification systems have demonstrated savings from the implementation. The Department estimated a proposed reduction to the budget based on this experience.
- R-7, HCBS Transition Services Continuation and Expansion: The Department's request is based on its own experience with the Colorado Choice Transitions (CCT) program. This experience shows that, when clients are given support, more than 90 percent of transitions from an institution back to the community are successful. The Department further used its experience to create a different benefit package from the CCT program, focusing on the benefits that have been shown to be most effective in helping clients transition back to the community.
- R-8, Medicaid Savings Initiatives: The Department's savings estimates for increased utilization management, increased usage of public transportation benefits, and trust recoveries are based on the Department's historical experience and utilization rates in administering these programs.

- R-10, Drug Cost Containment Initiatives: The Department's savings estimates for increased prior authorization requirements for drugs are based on the Department's experience prior authorizing drugs in other areas of the benefit. The Department's request for funding to investigate a new payment methodology for drugs is based on the experience of other states and research from the Oregon Health & Science University: Center for Evidenced-Based Policy.

9. **Please identify how many rules you have promulgated in the past two years (FYs 2015-16 and 2016-17). With respect to these rules, have you done any cost-benefit analyses pursuant to Section 24-4-103 (2.5), C.R.S., regulatory analyses pursuant to Section 24-4-103 (4.5), C.R.S., or any other similar analysis? Have you conducted a cost-benefit analysis of the Department's rules as a whole? If so, please provide an overview of each analysis.**

RESPONSE

From October 2015 to October 2017, the Department promulgated 71 rules. The Department does cost-benefit and regulatory analyses for each proposed rule prior to its introduction to the Medical Services Board (MSB). The analyses are included in the rule-making document packet that accompanies each rule proposed by the Department. The cost-benefit analysis includes the following components:

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

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

With respect to these rules, no person requested a separate cost-benefit analysis for any of the rules. Section 24-4-103 (2.5), C.R.S., states that anyone may request a cost-benefit analysis within five days of the publication of notice of proposed rulemaking in the Colorado Register. The Department performed a regulatory analysis of all 71 rules pursuant to section 24-4-103 (4.5), C.R.S. The regulatory analysis performed on each rule is compliant with statute and is available to the public for review five days prior to the rule-making hearing on the Department's public website. The Department has not conducted a cost-benefit analysis of the rules as a whole.

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

10. Describe the expected fiscal impact of proposed changes to PERA made by both the Governor's Office and the PERA Board of Directors. In addition to direct budgetary impacts, please describe any anticipated secondary impacts of an increase in employee contribution rates. For instance, does the Department anticipate a need to increase employee salaries to compensate for the increase in PERA contributions?

RESPONSE

The proposed changes to PERA made by the PERA Board of Directors include a 2.0 percentage point increase in employer contributions from 20.15 percent to 22.15 percent, which will have a direct budgetary impact on the Department. DPA will provide a statewide estimate for this impact. PERA's proposal makes this change starting January 2020, thus it will affect the department's budget starting FY 2019-20. The PERA Board proposal also includes a recommendation for contributions to be made on gross pay rather than net pay, which increases the salary base upon which the annual contribution is calculated for both employers and employees. This would have a direct impact on the Department's budget as well as employee take home pay. OSPB and DPA are looking into whether this impact can be estimated, and if so, a statewide response will be provided by DPA. The PERA Board proposal also includes a 3.0 percentage point increase in employee contributions—from 8.0 percent to 11.0 percent of pay—beginning in January 2020. Without an increase in employee salaries, these changes would reduce take home pay for state employees beginning in FY 2019-20.

The Governor's proposed changes to PERA will not have a direct budgetary impact on the Department, with the exception of maintaining the PERA Board's recommendation for employee and employer contributions to be made on gross pay rather than net pay. As mentioned above, this would increase the salary base upon which the annual contribution is calculated for both employers and employees. OSPB and DPA are looking into whether this impact can be estimated, and if so, a statewide response will be provided by DPA. The Governor's proposal includes a 2.0 percentage point increase in employee contributions—from 8.0 percent to 10.0 percent of pay—beginning in January 2019, a year earlier than the PERA proposal. The Governor's budget request includes an across-the-board salary survey increase of 3.0 percent for most state employees beginning July 1, 2018. With the proposed increase in employee contributions, this will average to a take home pay increase of 2.0 percent for the fiscal year. The proposed salary survey increase results in an increase of $1,203,861 total funds, and $453,147 General Fund for FY 2018-19 for the Department.

11. Senate Bill 17-267 required Departments, other than Education and Transportation, that submit budgets to OSPB to propose a budget that is 2.0 percent below the total funds budget in FY 2017-18. Please highlight the following regarding the 2.0 percent reduction:

- **Where these reductions can be found in the Department's request;**
- **What programs are impacted by the reduction; and**
- **Total amount of the reduction.**

RESPONSE

In the course of its statutory duties, the Office of State Planning and Budgeting complied with the provisions of SB 17-267. A provision of the bill required OSPB's consideration of proposed two percent reductions for certain principal department budgets. OSPB found the process to be useful. In recommending the budget

request, especially in the General Fund, while considering each department's budget reduction items, OSPB also took into account the various pressures on spending and needs throughout the state. Additionally, SB 17-267's provisions informed decision making in the request, in particular the recommendation for a decrease in the Budget Stabilization factor in the School Finance Act as well as the recommendation to increase the statutory reserve in the General Fund. With respect to the two percent target of General Fund spending as defined in the bill, these two items exceeded the suggested target.

The Department's budget request does not include any reductions that were submitted to OSPB as part of the requirements of SB 17-267. However, the Department's budget request includes numerous other savings initiatives. The table below answers parts (a), (b), and (c) of the question:

Request	Title	Programs Affected	Total Reduction FY 2018-19
R-6	Electronic Visit Verification Implementation	Medicaid	($777,203) TF ($1,200,233) GF
R-7	HCBS Transition Services Continuation and Expansion	Medicaid	($1,136,406) TF ($703,203) GF
R-8	Medicaid Savings Initiatives	Medicaid	($1,391,380) TF ($2,187,947) GF
R-10	Drug Cost Containment Initiatives	Medicaid	$132,777 TF ($24,407) GF
R-16	CPE for Emergency Medical Transportation Providers	Medicaid	$18,807,725 TF ($620,560) GF

12. Please provide the following information for the Department's custodial funds and continuously appropriated funds:
- **Name of the fund;**
- **Amount of funds received;**
- **Whether the revenues are one-time or multi-year;**
- **Current cash fund balance;**
- **Source(s) of the funds;**
- **A list of FY 2015-16 and FY 2016-17 expenditures from these funds;**
- **Expected uses of the funds in FY 2017-18 and FY 2018-19; and**
- **Legal authorization and restrictions/limitations on the Department's use of these funds.**

RESPONSE

A response to this question will be provided by the Governor's Office at a later date.

13. What is the Department's process for engaging in (or disputing) federal land, environmental, jurisdictional, and/or water policy issues? How do you coordinate with other departments, the Governor's Office, local governments, and/or citizens?

RESPONSE

Not applicable.

APPENDIX A: MEDICAID PENETRATION RATES OVER TIME BY COUNTY

County Information		Percent of Medicaid Clients to the Total Population			
County	**Designation**	**FY 2013-14**	**FY 2014-15**	**FY 2015-16**	**FY 2016-17**
Adams	Urban	19.22%	26.98%	29.23%	30.42%
Alamosa	Rural	28.98%	41.97%	45.48%	46.42%
Arapahoe	Urban	13.98%	20.28%	22.03%	22.73%
Archuleta	Rural	14.25%	23.72%	27.11%	28.60%
Baca	Frontier	20.73%	30.78%	34.99%	38.09%
Bent	Frontier	20.36%	30.84%	32.49%	33.97%
Boulder	Urban	8.96%	14.54%	16.10%	16.77%
Broomfield	Urban	6.40%	10.35%	10.94%	10.69%
Chaffee	Rural	11.88%	19.50%	21.05%	21.65%
Cheyenne	Frontier	13.95%	20.96%	25.00%	27.85%
Clear Creek	Urban	8.98%	17.12%	18.62%	18.32%
Conejos	Rural	29.86%	41.16%	42.53%	44.18%
Costilla	Frontier	32.36%	50.19%	55.69%	54.49%
Crowley	Rural	18.34%	25.16%	26.46%	29.69%
Custer	Frontier	10.79%	18.55%	19.78%	21.29%
Delta	Rural	17.98%	27.84%	32.15%	34.25%
Denver	Urban	18.74%	27.93%	29.84%	30.54%
Dolores	Frontier	14.40%	25.61%	27.20%	29.43%
Douglas	Urban	4.15%	7.03%	7.97%	8.45%
Eagle	Rural	7.43%	12.63%	13.83%	13.28%
Elbert	Urban	6.92%	10.87%	11.61%	12.92%
El Paso	Urban	14.35%	22.18%	25.63%	27.21%
Fremont	Rural	16.98%	25.45%	27.92%	29.49%
Garfield	Rural	14.16%	21.74%	23.75%	23.50%
Gilpin	Urban	9.61%	16.86%	18.17%	17.53%
Grand	Rural	7.45%	14.19%	14.99%	14.19%
Gunnison	Frontier	9.38%	18.27%	20.44%	21.24%
Hinsdale	Frontier	12.47%	19.62%	18.94%	22.19%
Huerfano	Frontier	26.10%	38.75%	43.15%	45.26%
Jackson	Frontier	14.98%	21.85%	23.04%	23.83%
Jefferson	Urban	10.15%	15.68%	17.31%	17.74%
Kiowa	Frontier	17.64%	27.89%	27.93%	32.07%
Kit Carson	Frontier	16.12%	22.86%	24.57%	25.67%
Lake	Rural	15.93%	24.36%	25.48%	23.49%
La Plata	Rural	10.59%	17.48%	20.05%	21.66%
Larimer	Urban	11.07%	17.66%	19.15%	19.74%
Las Animas	Frontier	21.82%	33.54%	37.59%	41.73%
Lincoln	Frontier	15.30%	22.86%	24.42%	25.78%

County Information		Percent of Medicaid Clients to the Total Population			
County	**Designation**	**FY 2013-14**	**FY 2014-15**	**FY 2015-16**	**FY 2016-17**
Logan	Rural	15.10%	21.08%	21.82%	22.14%
Mesa	Urban	17.33%	25.89%	29.27%	30.52%
Mineral	Frontier	7.11%	18.36%	22.37%	24.02%
Moffat	Frontier	17.56%	26.34%	29.93%	29.83%
Montezuma	Rural	20.68%	30.86%	34.05%	36.27%
Montrose	Rural	19.90%	28.01%	29.84%	31.44%
Morgan	Rural	19.92%	27.15%	29.67%	31.21%
Otero	Rural	28.82%	39.69%	42.13%	44.18%
Ouray	Rural	9.43%	16.34%	17.17%	16.85%
Park	Urban	8.49%	16.12%	18.33%	19.52%
Phillips	Rural	16.86%	23.88%	24.11%	24.36%
Pitkin	Rural	2.86%	7.78%	8.80%	9.04%
Prowers	Rural	28.01%	39.04%	44.02%	44.73%
Pueblo	Urban	25.17%	37.09%	41.23%	43.01%
Rio Blanco	Frontier	12.59%	18.03%	18.37%	19.05%
Rio Grande	Rural	27.15%	38.65%	42.38%	42.38%
Routt	Rural	7.65%	14.33%	15.73%	16.37%
Saguache	Frontier	25.97%	40.42%	44.19%	40.46%
San Juan	Frontier	12.81%	24.82%	24.55%	25.93%
San Miguel	Frontier	8.45%	15.32%	15.52%	15.34%
Sedgwick	Frontier	19.50%	28.11%	31.29%	30.48%
Summit	Rural	6.52%	12.62%	14.14%	13.50%
Teller	Urban	11.58%	19.70%	22.71%	24.36%
Washington	Frontier	14.51%	21.11%	24.75%	25.39%
Weld	Urban	16.16%	22.57%	24.04%	25.12%
Yuma	Frontier	17.85%	23.71%	26.06%	27.49%
Total Colorado		**14.24%**	**21.35%**	**23.42%**	**24.29%**

APPENDIX B: MARCH 3, 2017 DEPARTMENT MEMO TO JBC STAFF RE: PROBLEMS IF CONGRESS DOES NOT AUTHORIZE FUNDING FOR CHP+ IN FFY 2017-18

TO: Eric Kurtz
FROM: Department of Health Care Policy and Financing
RE: Future of CHIP Financing and Contingency Plans

There continues to be uncertainty at the federal level about the future of the Children's Health Insurance Program (CHIP). The program is authorized through September 30, 2019, but only financed through September 30, 2017. To prepare for potential changes in federal financing this year, the Department has researched policy issues and coverage options, held stakeholder meetings to discuss policy goals and coverage options, and examined the fiscal implications of different scenarios.

Background

The Department administers the Child Basic Health Plan under the authority of:

> CRS 25.5-1-201. Programs to be administered by the department of health care policy and financing (1) (e) The "Child Basic Health Plan Act", as specified in article 8 of this title.

The Child Basic Health Plan is branded as the Child Health Plan *Plus* or CHP+ for consumers and providers.

In the legislative declaration for the program, 25.5-8-102 (6), the general assembly hereby finds and declares:

(a) That the goal of the "Children's Basic Health Plan Act" is to support low-income, working parents and families in overcoming barriers in obtaining good quality, affordable health care services for their children,

(b) That the health services that low-income children received through the children's basic health plan should be cost-effective, of high quality and promote positive health outcomes for enrolled children;

(c) That the children's basic health plan was designed as, and should continue to be, a private-public partnership that encourages enrollment and seeks every opportunity to operation with the efficiency and creativity that is, found in utilizing private sector systems and business practices while maintaining the highest level of accountability to the general assembly, the executive branch, and the public through administration of the plan by the department

(d) That the children's basic health plan was designed as, and should continue to be, a community-based program that encourages local participation on enrolling children and supporting its goals

Stakeholder Outreach Efforts

The Department hosted a series of meetings with stakeholders about the future of the CHP+ in the summers of 2015 and 2016. Stakeholders concurred with goals outlined in the legislative declaration about the importance of this coverage program for the children and pregnant women who qualify. They agreed that attention must be paid to quality and affordability of the coverage provided by CHP+ and stressed the importance of access to care, improved health and efficient administration of the program. They also discussed the importance of aligning CHP+ with broader health care reform efforts in the state.

Current Caseload Projections

Population	FY 2017-18	FY 2018-19
Kids - Medicaid	69,199	72,116
Kids - CHP+	69,011	73,835
Prenatal - Medicaid	1,803	1,803
Prenatal - CHP+	792	792

Three Scenarios for Congressional Action

There are three scenarios to consider related to the future of CHP+ given the current federal uncertainty.

Scenario I – Reauthorization of federal funding at the current level

This scenario assumes that Congress will act to reauthorize federal funding for CHIP at the current enhanced federal financial participation rate. This enhanced rate for Colorado is 88 percent.

Budget Impact – The Governor's budget submitted on November 1, 2016 (with revised projections submitted February 15, 2017) assumes that there is a continuation of federal funding at the current enhanced federal matching rate and no additional funds beyond the current budget proposal are needed.

Statutory Impact –No state statutes need to be changed to maintain current eligibility levels and funding sources.

Systems and Program Impact – There are no required systems changes under this scenario and the CHP+ program will continue to be administered by the Department as it is administered today.

Scenario II – Reauthorization of federal funding at a reduced federal matching percentage.

This scenario assumes that Congress will act to reauthorize funding for CHIP, but reduce the appropriation to eliminate the enhanced federal matching rate. The traditional match rate for CHIP for the state of Colorado is 65 percent. Under this scenario, since some federal financing is still available,

current federal Maintenance of Effort (MOE) requirements for CHIP are still in place. This means that the state will not have the option to change income eligibility levels until 2019.

Budget Impact – Due to the decrease in federal match rates, new state dollars (General Fund, CBHP Trust, Hospital Provider Fee) would need to be appropriated to account for the increase in state costs to maintain current eligibility levels.

Incremental Change to Funding if Program is Reauthorized at 65% FFP

Item	Total Funds	General Fund	CBHP Trust	Hospital Provider Fee	Federal Funds
FY 2017-18	$0	$47,484,508	$15,143,031	$14,113,578	($76,741,117)
FY 2018-19	$0	$68,588,338	($2,250,727)	$15,311,667	($81,649,278)

Note: CBHP Trust fund balance includes the Colorado Immunization Fund and Health Care Expansion Fund.

Statutory Impact – No state statutes need to be changed to maintain current eligibility levels.

Systems and Program Impact – Children and pregnant women currently covered by CHP+ would retain their coverage and access to services.

Additional Considerations - It is unknown if the General Assembly would have the option to reduce eligibility in lieu of additional state appropriations. Federal law contains a Maintenance of Effort (MOE) requirement that currently prevents the state from reducing eligibility until October 1, 2019. Given that Congress would need legislation to change the CHIP match rates, it is possible that Congress could also weaken or eliminate the MOE requirement.

Scenario III – Federal funding for CHIP is not reauthorized and ends on September 30, 2017

If Congress fails to act and federal funding for CHIP ends on September 30, 2017, there are many ways that the state of Colorado can respond. The federal Maintenance of Effort (MOE) requirements would no longer be in place for Colorado's separate CHIP, so the General Assembly could institute changes to income eligibility levels, benefits, delivery system, provider payments and beneficiary responsibilities within CHP+. Current MOE requirements for Medicaid expansion CHIP, however, remain in place for children through September 30, 2019. The estimates provided for three potential options below assume no changes to the design of the program and reflect estimates as if the program operates in the future as it does today.

a. Spend down current allocation and then coverage ends for many covered by CHP+

Colorado can continue to expend money granted to the state through the CHIP program (Title XXI of the Social Security Act) until the money from the state allocation is exhausted.

Eligibility Impact –
The Department estimates coverage would end for children and pregnant women enrolled in CHP+ in December 2017. Children covered by Medicaid but financed by money from the CHIP program would retain their Medicaid coverage, but at a reduced federal match rate.

Budget Impact – An additional $19.3 million would be needed in FY 2017-18 to account for the reduction in federal financial participation from the enhanced CHIP rate of 88 percent to the traditional Medicaid rate of 50percent. The Department could offset that entire General Fund amount if statute permits the use of the CHP+ Trust fund balance for this case.

Incremental Need to Run Program Until Federal Funds Run Out

Item	Total Funds	General Fund	CBHP Trust	Hospital Provider Fee	Federal Funds
Current Department Request	$333,657,026	$17,093,051	$16,178,615	$8,604,997	$291,780,363
Est. Cost through June 30, 2018	$228,916,393	$36,352,959	$8,089,310	$4,302,500	$180,171,624
Incremental Need	**($104,740,633)**	**$19,259,908**	**($8,089,305)**	**($4,302,497)**	**($111,608,739)**
Offset General Fund with CBHP Trust Balance	$0	($19,259,908)	$19,259,908	$0	$0
Incremental Need	**($104,740,633)**	**$0**	**$11,170,603**	**($4,302,497)**	**($111,608,739)**

Note: CBHP Trust fund balance includes the Colorado Immunization Fund and Health Care Expansion Fund.

Statutory Impact – Without financial authorization, Colorado would have statutes authorizing a program that would not exist. Statutes that guide the administration of the Children's Basic Health Plan may need to be repealed.

Systems and Program Impact – State eligibility systems would need to be reprogramed to end eligibility for those covered by CHP+ once all remaining federal funds have been expended. Anticipated costs for these systems changes have not yet been determined. Individuals currently covered by CHP+ could purchase coverage in the private market, enroll in employer-sponsored coverage, if available, enroll in Medicaid coverage if family qualifies, or become uninsured. Contracts with the administrative service organization and managed care organizations that administer the CHP+ program would be terminated and all related program administration activities would end.

b. Create a temporary funding solution to maintain coverage until the General Assembly reconvenes for the 2018 legislative session.

Colorado state statutes could be changed to allow the Department to continue to cover children and pregnant women, without the availability of federal financial participation until the General Assembly reconvenes in January 2018 and determines the long-term response to the change in federal financing.

Eligibility Impact –

Children and pregnant women covered under the CHP+ program would retain eligibility until February 2018, at which point coverage would be scheduled to end barring additional action by the General Assembly (and/or Congress). Children covered by Medicaid but financed by money from the CHIP program would retain their Medicaid coverage, but at a reduced federal match rate.

Budget Impact –

Incremental Need to Run Program through February 2018 and Continue Covering MCHIP Children

Item	Total Funds	General Fund	CBHP Trust	Hospital Provider Fee	Federal Funds
Current Department Request	$333,657,026	$17,093,051	$16,178,615	$8,604,997	$291,780,363
Est. Cost through February 28, 2018	$263,829,937	$49,853,164	$10,785,746	$5,736,666	$197,454,361
Incremental Need	**($69,827,089)**	**$32,760,113**	**($5,392,869)**	**($2,868,331)**	**($94,326,002)**
Offset General Fund with CBHP Trust Balance	$0	($20,897,618)	$20,897,618	$0	$0
Incremental Need	**($69,827,089)**	**$11,862,495**	**$15,504,749**	**($2,868,331)**	**($94,326,002)**
Offset General Fund with Hospital Provider Fee	$0	($2,868,331)	$0	$2,868,331	$0
Incremental Need	**($69,827,089)**	**$8,994,164**	**$15,504,749**	**$0**	**($94,326,002)**

Note: CBHP Trust fund balance includes the Colorado Immunization Fund and Health Care Expansion Fund.

Children covered by Medicaid but financed by money from the CHIP program would retain their Medicaid coverage and an additional $32.8 million General Fund would be needed in FY 2017-18 to account for the reduction in federal financial participation from the enhanced CHIP rate of 88 percent to the traditional Medicaid rate of 50 percent. As shown in table above, offsets to the General Fund amount could come from the CHP+ Trust fund balance or Hospital Provider Fee.

Statutory Impact – Statutes to authorize the program would need to be changed to give the Department the authority and the appropriation to maintain the program as currently structured through February 28, 2018.

Systems and Program Impact – No systems changes would be immediately required as children and pregnant women currently covered by CHP+ would retain their coverage through February 28, 2018. System changes may be required after that date to incorporate changes to eligibility and/or benefits.

c. Authorize new state-only funding mechanisms to support the continuation of CHP+

Colorado state statutes could be changed to allow the Department to continue to cover children and pregnant women, without the availability of federal financial participation.

Eligibility Impact –

Children and pregnant women covered under the CHP+ program would retain eligibility under a state-only program.[35] Children and pregnant women covered by Medicaid but financed by money from the CHIP program would retain their Medicaid coverage, but at a reduced federal match rate.

Budget Impact –

Incremental need to Run Program through June 2018 for All Populations

Item	Total Funds	General Fund	CBHP Trust	Hospital Provider Fee	Federal Funds
Current Department Request	$333,657,026	$17,093,051	$16,178,615	$8,604,997	$291,780,363
Est. Cost through June 30, 2018	$333,657,026	$136,527,008	$8,089,310	$4,302,500	$184,738,208
Incremental Need	**$0**	**$119,433,957**	**($8,089,305)**	**($4,302,497)**	**($107,042,155)**
Offset General Fund with CBHP Trust Balance	$0	($23,594,054)	$23,594,054	$0	$0
Incremental Need	**$0**	**$95,839,903**	**$15,504,749**	**($4,302,497)**	**($107,042,155)**
Offset General Fund with Hospital Provider Fee	$0	($4,302,497)	$0	$4,302,497	$0
Incremental Need	**$0**	**$91,537,406**	**$15,504,749**	**$0**	**($107,042,155)**

Note: CBHP Trust fund balance includes the Colorado Immunization Fund and Health Care Expansion Fund.

Children and pregnant women covered by Medicaid but financed by money from the CHIP program would retain their Medicaid coverage and an additional $119.4 million General Fund would be needed in FY 2017-18 to account for the reduction in federal financial participation from the enhanced CHIP rate of 88 percent to the traditional Medicaid rate of 50 percent. As shown in table above, the General Fund amount could be reduced with offsets form the CHP+ Trust fund balance and Hospital Provider Fee.

Statutory Impact – Statutes to authorize the program would need to be changed to give the Department the authority and the appropriation to maintain the program as currently structured.

Systems and Program Impact – No systems changes would be required and children and pregnant women currently covered by CHP+ would retain their coverage. System changes may be required after that date to incorporate changes to eligibility and/or benefits.

[35] The General Assembly would also have flexibility to create a different type of state-only program to cover the people who would lose coverage; this memo does not contemplate those options.

SAMPLE END OF NOVEMBER MEMBER LETTER

- If Congress does not act by mid-November, this letter will be sent to all Child Health Plan *Plus* (CHP+) members.
- The letter tells CHP+ members the following:
  - The program may end January 31, 2018 if Congress does not renew federal funding for the program
  - CHP+ benefits have not changed and they can still see their providers
  - What members can expect next if Congress does not renew federal funding for the program
  - What members can do now

Eligibility Technician Name
Address
City, CO ZipCode

Contact information of Member's County Dept. of Human or Social Services or Eligibility Site

FirstName LastName

Address
City, CO ZipCode

Addressed to Head of Household

Tear Here

Eligibility Technician Name
Address
City, CO ZipCode

STATE OF COLORADO

FirstName LastName
Address
City, CO ZipCode

Addressed to Head of Household

1B##### ← Case Number
Eligibility Technician Name
Address
City, CO ZipCode

Important Information About Child Health Plan Plus (CHP+)

You are receiving this letter because these members of your household are enrolled in Child Health Plan *Plus* (CHP+) as of [Date letter is generated]: [Name of Child(ren) and/or Pregnant Woman in CHP+]

If Congress does not renew federal funding, CHP+ in Colorado will end on January 31, 2018.

CHP+ is paid for by a combination of state and federal funding. For CHP+ to continue in Colorado, Congress must pass a law to renew federal funding for the program.

Important Information

- As of today, there are **no changes to your CHP+ benefits.** CHP+ members can continue to go to the doctor and use their benefits, and CHP+ kids can go to the dentist.
- If you or your family receives a letter stating it is time to renew your CHP+ benefits, **follow the instructions in the letter and pay your enrollment fee**, if you owe one.
- Congress can pass a law at any time to renew federal funding for CHP+, but **there is no guarantee** that they will.

If Congress does not renew federal funding for CHP+ by late December 2017, you will get a letter telling you when your CHP+ benefits will end and what else you may qualify for. **We will not know what you qualify for until late December.** At that time your letter will give you information on your options and who you can call for help.

What You Can Do Now

1. Visit CO.gov/HCPF/FutureCHP for updates.
2. If you do not already have a PEAK® account, go to CO.gov/PEAK to sign up.
3. Log in to your PEAK® account and then click on **Report My Changes** to make sure your information is up to date.
4. With your PEAK® account, you can also choose to get an email or text when you have a new letter in the PEAK® Mail Center.
5. Ask your doctor's or dentist's office for the names of the private insurance plans they accept. Write this information down in case you need to shop for a private insurance plan.
6. If any CHP+ members in your family are due or overdue for medical or dental care, make an

Elig. Tech.Name
1B#####/#########

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appointment with your provider as soon as possible. Please remember only CHP+ kids receive dental benefits.

7. For questions about your private health insurance options, to see if you will qualify for financial help to lower your costs, and to find free in-person help, visit ConnectforHealthCO.com, or call the Connect for Health Colorado Customer Service Center at 855- PLANS-4-YOU (855-752-6749), TTY 855-346-3432.

If you have questions about this letter, call [Elig. Tech. Name] at [Elig. Tech. Phone Number].

Thank you,

Colorado Department of Health Care Policy and Financing

Elig. Tech.Name
1B####/#########

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APPENDIX D: LEGISLATION NOT FULLY IMPLEMENTED 2008-2017

Total HCPF Related Bills 2008-2017: 219

Not Fully Implemented 2008-2017: 10

The Department has records of the status of implementation for legislation dating back to 2008. Over the last nine years, the Department has successfully implemented over 209 bills. Since Medicaid is governed as a partnership between the states and the federal government, any new Medicaid programs or changes to the current program that require federal funding must be approved by the Centers for Medicare and Medicaid Services (CMS). Several bills passed during this period were contingent upon federal approval which was denied. Without federal financial participation, the Department was unable to implement these bills.

Legislation	Legislation Summary	Barriers to Implementation	FTE
HB 15-1186 Services for Children with Autism (Young/Steadman)	This bill expands eligibility for the Autism Waiver Program by increasing the age limit from 6 years of age to 8 years of age. If a child enrolls prior to his or her eighth birthday, he or she is eligible to receive services for a total of three full years. The bill removes the existing per child spending cap of $25,000 per year and instead directs the Medical Services Board to set the per child spending cap each year based on available appropriations. The bill eliminates the program waiting list.	The Department cannot implement this bill as written because it was contingent on approval from the federal Centers Medicare and Medicaid Services (CMS). CMS denied the waiver amendment on September 14, 2015. The Department sent communication to parents and a broad scope of stakeholders. The communications informed parents and stakeholders how to access the services available in the Children w/ Autism Waiver through the Early Periodic Screening, Diagnostic, and Treatment Waiver (EPSDT).	0.8 (Temp)
HB 15-1318 Consolidate Intellectual and Dev. Disability Waivers (Young/Grantham)	This bill requires HCPF to consolidate the two Medicaid HCBS waiver programs for adults with intellectual and developmental disabilities.	The Department has reached significant milestones across all components of waiver redesign. Specifically, progress has been made analyzing the breadth of fiscal, operational and programmatic impacts of a redesigned waiver. The Department has nearly finished developing models for quality measures, provider qualifications, service utilization forecasts, individualized budgets with norm referenced service limits, and continues to benefit from the Waiver Implementation Council's ongoing consultation and advice throughout the waiver design and implementation process.	3

Legislation	Legislation Summary	Barriers to Implementation	FTE
		Combining the Supported Living Services (SLS) and Developmental Disabilities (DD) waivers is an extremely complex undertaking, thus the analysis has taken longer than anticipated and additional actuarial work to make decisions and inform next steps for the service delivery option for the Residential Habilitation Service. To accomplish this work, the Department submitted a budget request on November 1, 2017 (R-19, IDD Waiver Consolidation Administrative Funding) with more detail on the barriers to implementing this legislation.	
SB 10-061 Medicaid Hospice Room and Board Charges (Tochtrop, Williams/Soper, Riesberg)	Nursing facilities are to be paid directly for inpatient services provided to a Medicaid recipient who elects to receive hospice care; reimburse inpatient hospice facilities for room and board.	The Department cannot implement this bill as written because it is contingent upon federal financial participation. In order for the state to receive federal financial participation, hospice providers must bill for all services and 'pass-through' the room-and-board payment to the nursing facility. CMS has indicated to the Department that there is no mechanism through State Plan or waiver to reimburse class I nursing facilities directly for room-and-board, or to pay a provider licensed as a hospice as if they were a licensed class I nursing facility. Although licensed inpatient hospice facilities are a hospice provider type recognized by the Colorado Department of Public Health and Environment for the provision of residential and inpatient hospice care, they must be licensed as a class I nursing facility to be reimbursed by the state for room-and-board with federal financial participation.	0
SB 10-117 Over-the-Counter Medications (Foster/Primavera)	This bill adds over-the-counter medications identified through the drug utilization review process to services provided under Medicaid when the medications are prescribed	In order to implement the bill, system changes were needed in the Pharmacy Benefit Management System (PBMS). Those changes were not feasible in the previous claims system and the Department planned to implement the bill in the new claims systems. The Department is now	0

Legislation	Legislation Summary	Barriers to Implementation	FTE
	by a licensed practitioner or a qualified licensed pharmacist	making the system changes to implement the bill. This includes pharmacists enrolling as Medicaid providers. Once they are enrolled, they will be able to prescribe OTC drugs that have gone through the processes outlined in SB10-117.	
HB 09-1103 Presumptive Eligibility Long-Term Care (Riesberg/Newell)	Persons in need of long-term care who declare all of the information necessary to determine eligibility under the Medicaid program shall be presumptively eligible for benefits.	The bill authorized the Department to seek federal approval to allow people who are in need of long-term care to be presumptively eligible for Medicaid. The bill directed the Department to seek federal approval from CMS, which was denied. Without federal approval, the Department was not able to implement the legislation.	0
HB 08-1072 Medicaid Buy-In for Persons with Disabilities (Soper/Williams)	This bill establishes a Medicaid Buy-in Program for people with disabilities who earn too much to qualify for Medicaid and for those whose medical condition improves while participating in the program.	The Medicaid Buy-in Program for people with disabilities has been implemented. The Department has not implemented a buy-in for the “medically improved” group. The goal of the buy-in for the medically improved was to allow clients with improved but preexisting conditions to access health care. Under federal rule, the earliest any of these potential clients could have been covered was March 2013. With SB 13-200 and SB 11-200 these clients will either qualify for Medicaid as part of the expansion population or be able to seek subsidies on private health insurance through Connect for Health regardless of a preexisting condition.	2
SB 08-003 Medicaid Family Planning (Boyd/Riesberg)	This bill provides flexibility in the income eligibility level for the Family Planning Pilot Program. Currently, the income eligibility level is set in statute at 150 percent of the Federal Poverty Level (FPL), but this bill allows the level to be established in the federal waiver sought for the program.	The Department worked extensively with CMS and stakeholders to submit a waiver in order to implement the program. In December 2011, the Department withdrew its application for a waiver after learning that it would cost over $800,000 to make system changes to the MMIS and the earliest the changes could take effect would be January 1, 2014 due to national code freezes. As of January 1, 2014 this population would be covered under the expansion or could access subsidized	0

Legislation	Legislation Summary	Barriers to Implementation	FTE
		private insurance through Connect for Health Colorado.	
SB 08-214 Local Government Medicaid Provider Fees (Shaffer/Frangas)	This bill made changes to legislation enacted in 2006 via SB 06-145, which authorized local governments to implement a provider fee on hospital and home health care agencies to draw federal matching funds to increase reimbursement for services provided to Medicaid clients.	As noted in both bills, imposition and collection of a provider fee by a local government is prohibited without federal approval of a Medicaid State Plan Amendment (SPA) authorizing federal financial participation. The Department filed two SPAs with the federal Centers for Medicare and Medicaid Services (CMS) in 2006 and worked with CMS for more than two years for approval. Ultimately, CMS denied the Department's SPAs, concluding that the Department's reimbursement methodology did not meet the requirements of federal regulations [42 CFR §433.68 (f)] addressing hold harmless arrangements.	0
HB 05-1243 Consumer Directed Care Under Medicaid*	This bill extends the option of receiving Home and Community-Based Services (HCBS) through the Consumer Directed Attendant Support Services (CDASS) delivery model to all Medicaid recipients who are enrolled in an HCBS waiver for which the Department of Health Care Policy and Financing has federal waiver authority. The bill specifies that an eligible person shall not be required to disenroll from the person's current HCBS waiver in order to receive services through the consumer-directed care service model.	The legislation authorized the Department to seek federal approval to expand Consumer Directed Attendant Support Services (CDASS) to all the HCBS waivers but the fiscal note assumed significant savings in order to expand. While a valuable and important delivery model, research and data show that participants in CDASS do not produce significant savings. The Department received funding in FY2017-18 to evaluate the cost-effectiveness of the CDASS program. The Department hopes this work will more accurately estimate the costs and savings of fully implementing this bill. Please note, there are four waivers that do not offer these distinct services available through the CDASS model: Children with Autism, Children with Life Limiting Illness, Persons with Developmental Disabilities,	0.5

Legislation	Legislation Summary	Barriers to Implementation	FTE
		and Children's Residential Habilitation Program.	

*While the Department does not have record of the implementation status of bills prior to 2008, HB 05-1243 was included because the Department is aware that this bill was not fully implemented and would have been included on this list if the Department had a comprehensive record of legislative implementation.