

An Overview of Medicaid in Colorado

Health Management Associates and The Wertz Group were funded by the Colorado Trust to provide an assessment of the Medicaid program in Colorado. The project received support from the Colorado Hospital Association and the Colorado Medical Society and was encouraged by the director of the Colorado Department of Health Care Policy and Financing. The assessment that follows is a brief and high-level review of the program's eligibility, service and reimbursement policies. Suggestions for program improvement are included, and current Medicaid redesign activities within the state are also discussed.

Medicaid Law and Regulations

The Medical Assistance (Medicaid) program, Title XIX of the Social Security Act, was signed into law in 1965 and is sometimes described as a state and federal partnership. The basic structure for Medicaid, including what a state must do and what it can do at its option, is spelled out in federal law and supporting regulations. The program is funded jointly with federal and state funds, and in some states counties are required to contribute a portion of the state share of funding as well. The level of federal funding is dictated by a formula spelled out in law and Colorado receives the minimum amount available to states, 50 percent. See more about Federal Financial Participation below.

Federal law requires states to cover some eligibility groups and services and gives states broad discretion in choosing additional groups and services for coverage. Across the country states have made very different decisions about eligibility and services, for reasons unique to their priorities, traditions, cultures, healthcare delivery systems and budget constraints. As a result no two state Medicaid programs are entirely alike. However, an individual that meets the eligibility criteria for coverage in a particular state is "entitled" to the benefits covered by that state.

The federal Centers for Medicare & Medicaid Services (CMS) within the US Department of Health and Human Services (HHS) oversees state Medicaid programs just as it oversees the intermediaries and contractors that administer the Medicare program. Each state is required to designate a "single state agency" responsible for the Medicaid program even if multiple agencies provide services that qualify for Medicaid funding or participate in program administration. The single state agency in Colorado is the Department of Health Care Policy and Financing (HCPF). Medicaid is administered by each state through a contract with CMS called a "State Plan for Medical Assistance," which includes the state's choices relative to eligibility, benefits and reimbursement methodology. States must submit a "State Plan

Amendment” for CMS approval if they wish to change the parameters of their contract.

The State Plan is often described as the “contract” between the state and the federal government: the state fulfills its part of the “contract” by fulfilling the conditions included in the State Plan; and the federal government fulfills its part of the “contract” by providing the federal matching funds for the expenditures that the state makes in accordance with the State Plan.

States also have the option to request waivers of provisions in federal law and their State Plan. These waivers are commonly referenced by the section of the Social Security Act waived. A waiver may relate to delivery of services, e.g., a Section 1915(b) waiver is required to mandate that a Medicaid beneficiary obtain healthcare services through a risk-based managed care organization or have services authorized by a primary care physician gatekeeper. A Section 1915(c) waiver is required to fund home and community-based services delivered as an alternative to nursing facility care. A Section 1115 waiver, including the special Health Insurance Flexibility and Accountability (HIFA) waiver, is required to implement initiatives designed to expand the availability of healthcare coverage for the uninsured or, in some instances, to vary program benefits by Medicaid coverage group.

Deficit Reduction Act of 2005

Changes in federal law and regulations over the years have increased states’ flexibility in administering their Medicaid programs, however other changes have tightened federal controls on and restricted the availability of federal Medicaid funding to the states. The Deficit Reduction Act (DRA) of 2005, signed into law by President George W. Bush in February 2006 merits mention because its provisions fit both criteria. There are many sections in the DRA that impact Medicaid; only a few are mentioned here.

The DRA allows states to implement new beneficiary cost sharing and benefit options through amendments to their State Plan rather than through the cumbersome Section 1115 waiver process. Cost sharing amounts may vary based on income, with families having income greater than 150 percent of the Federal Poverty Level (FPL) – \$2,581 per month for a family of four in 2007 – able to be charged as much as 20 percent of the cost of their care. Benefit packages may vary for differing segments of the Medicaid population and states are able to implement pilot programs such as Health Opportunity Accounts that replace the defined Medicaid benefit model with a defined contribution healthcare model.

The DRA also includes a provision requiring proof of citizenship for Medicaid eligibility, a requirement that many say has been overly burdensome and that has resulted in many American citizens being denied access to healthcare services

through the Medicaid program. Access to institutional long-term care services may be impacted by another provision of the DRA, which changed the way that assets/resources are reviewed for purposes of Medicaid eligibility.

SCHIP Law and Regulations

The State Children's Health Insurance Program (SCHIP) was created by the Balanced Budget Act of 1997 as Title XXI of the Social Security Act. Aptly named, SCHIP provides federal funding to help states insure more children, specifically those living in families with too much income for Medicaid eligibility but too little to afford private health insurance for the children. The program is targeted toward children under age 19 living in families with income below 200 percent of the FPL.

Like Medicaid, there are also federal regulations for SCHIP and states must receive CMS approval of their SCHIP State Plan. States have the option to provide SCHIP coverage as an expansion to their Medicaid program, or as a separate program, or they may have a combination of the two. In 2006, 11 states and the District of Columbia had Medicaid expansion SCHIP programs, 18 states had separate programs, and 21 states had a combination of the two.¹ However, a child that meets Medicaid criteria for coverage must be determined eligible for that program and cannot opt for SCHIP benefits instead.

In 2002, CMS issued a regulation that revised the definition of a child under the SCHIP program to include an unborn child. This regulation opened the door for several states to add pregnant women to their SCHIP rolls if applicable eligibility criteria are met. Other states have received federal waiver approval to use their unspent SCHIP allocations to provide healthcare coverage to pregnant women and other uninsured low-income adults, generally the parents of children covered by Medicaid or SCHIP.

Colorado operates a separate SCHIP program, alternatively called Child Health Plan Plus (CHP+) and Children's Basic Health Plan. The program covers children and pregnant women living in families with income below 200 percent of the FPL.

Federal Financial Participation

Medicaid

A state's Federal Medical Assistance Percentage (FMAP) represents the percentage of federal funds available for services rendered through its Medicaid program. They currently range from a statutory minimum of 50 percent to a high of 76 percent (in

¹ *The State Children's Health Insurance Program: Past, Present, and Future*, Jeanne Lambrew, George Washington University, prepared for The Commonwealth Fund/Alliance for Health Reform, January 2007. Available at: http://www.cmwf.org/usr_doc/991_lambrew_schip_past_present_future.pdf

Mississippi) and cannot exceed 83 percent.² FMAPs are calculated from a three-year average of per capita income; e.g., state FMAPs for Federal Fiscal Year (FFY) 2007 used per capita income from calendar years 2002 through 2004. Basing a state's FMAP on historical data often means that the rate of federal financial participation available to a state is disproportionate to the state's need in that it may be lower during an economic downturn and higher after the state's economic picture has improved.

Colorado's FMAP for FFY 2007 (and for FFY 2008) is set at the minimum rate of 50 percent, reflecting a relatively high per capita income during the measuring period. The FMAP was at this level throughout the 1980s but was a little higher during the 1990s, peaking at 54.79 percent in FFY 1992. Colorado's FMAP has been at 50 percent since FFY 2000.³

For FFY 2007 only 12 states, including Colorado, have FMAPs set at the minimum rate. For FFY 2008 an additional state, Wyoming, will be added to the list for the first time in 20 years. The other six states touching Colorado's border all have higher FMAP rates for both years, with New Mexico and Utah's rates above 70 percent.

The federal financial participation rates for state administrative expenses are established in statute as well but do not vary by state. Certain activities are eligible for 75 percent federal Medicaid funding but most receive 50 percent.

SCHIP

States receive an enhanced FMAP for SCHIP, which also may vary each year. The formula for the SCHIP rate uses the Medicaid FMAP as the base. In Colorado, the enhanced FMAP for SCHIP is 65 percent, as it is for all states with a 50 percent Medicaid FMAP.

Special Financing

The Colorado Indigent Care Program (CICP) distributes federal and state funds to partially compensate providers for uncompensated costs associated with services rendered to the indigent population. Under this program, providers render discounted healthcare services to citizens and documented immigrants with income below 250 percent of the FPL who are not eligible for either Medicaid or CHP+. Funding for the CICP comes from Colorado's Disproportionate Share Hospital (DSH)

² One exception to this relates to family planning services for which every state is entitled to 90 percent federal funding.

³ For a period of five calendar quarters in 2003 and 2004, Colorado's FMAP was raised to 52.95 percent as required by a special provision in the Jobs and Growth Tax Relief Reconciliation Act of 2003 that temporarily added 2.95 percent to each state's FMAP.

Allotment and the Upper Payment Limit for inpatient hospital services (Inpatient UPL), which are financed through state and federal funds as well as Certification of Public Expenditures (CPEs). Colorado's federal DSH allotment, as set by Congress, for each year since FFY 2004 has been \$87,127,600, and is expected to remain at this level until FFY 2010.

Approximately \$56.5 million in federal fund payments was provided through the Inpatient UPL during SFY 2006. As a result hospital providers received more than \$156.1 million through this program during SFY 2006, including \$12.5 million in state general fund dollars.

Privately owned CICIP hospitals received 28.7 percent of their indigent care costs in SFY 2006 while publicly owned hospitals received 57.9 percent. Payments were higher for some publicly owned hospitals due to the process by which the federal government provides matching funds for Medicaid losses incurred by public providers, without increasing the appropriation of state general funds. This approach, called a Certified Public Expenditure, or CPE, is permitted for federal match because the federal rules count most sources of public support, including losses incurred by public hospitals in serving the indigent, as an acceptable "non-federal share" that can be used to receive federal matching support. Payments to privately owned hospitals are limited by available general funds.⁴

Payments to qualifying providers are based on specified criteria and a formula contained in state statute.⁵ Under the current methodology CICIP payments may reduce a hospital's ability to qualify for federal Medicare disproportionate share payments - an unintended consequence of the current approach.

TABOR

In 1992, Colorado adopted the TABOR amendment (Taxpayers' Bill of Rights) to limit revenue growth for state and local governments. TABOR permitted the State to retain from all sources (except the federal government) an amount equal to the allowed collections from the previous year plus an adjustment equal to the percentage growth in population and the inflation rate. Any revenues greater than this amount had to be returned to the public unless they voted to permit the State to retain the excess. This had a great impact on the State during the recession of a few years ago because the State had been unable to establish a "rainy day fund" and was forced to make significant reductions in services. In the November 2005 election,

⁴ Much of the information provided was taken from the state's web site, from a Joint Budget Committee Presentation made March 12, 2007, available at:

<http://www.chcpf.state.co.us/HCPF/cicp/cmsRule.asp>. >> JBC Presentation Outline 3-12-07.

⁵ Applicable State Medicaid Rules are found at 10 CCR 2505-10. See Rule 8.900. Rules are available on the state's web site at: <http://www.chcpf.state.co.us/HCPF/StateRules/newToc2.asp>.

Colorado voters narrowly approved Referendum C, giving the State a five-year time-out from TABOR's requirements (from July 2005 through June 2010) and permanently eliminating some of the most constrictive aspects of the law. TABOR is mentioned here in light of its potential future impact, which must be considered during any Medicaid and broader healthcare reform discussions.

Information Technology

Medicaid Management Information System

Colorado has used the same fiscal agent, ACS State Healthcare LLC, to administer its Medicaid Management Information System (MMIS) since 1996. The contract with ACS was renewed following a competitive procurement in 2006. ACS also has a contract with the state for responsibilities associated with the CHP+ program, including call center services, application processing, premium collection, correspondence and complaint adjudication. The CHP+ contract runs until the summer of 2007 following a one-year extension approved in August 2006.

Colorado Benefits Management System

A separate contractor, EDS, is responsible for the state's eligibility and payment system for social services, health care and other benefits. EDS was awarded a contract in 2000 to update the Colorado Benefits Management System (CBMS), and to assure a smooth implementation and timely resolution of issues an Office of CBMS was established within the Governor's Office in 2005. In mid-February 2007, Governor Bill Ritter issued an executive order dissolving the Office of CBMS and returning joint administrative responsibility for the system to DHS and HCPF.

The current contract to manage the CBMS expires in July 2008.⁶ Whether EDS will continue its role is dependent upon the outcome of the re-procurement process.

Payment Error Rate Measurement

The Improper Payment Act of 2002 requires federal agencies to annually review and estimate the amount of improper payments for Medicaid and SCHIP. To comply with this law, CMS implemented the Payment Error Rate Measurement (PERM) program to measure the accuracy of each state's Medicaid and SCHIP eligibility determinations and resulting healthcare service payments. CMS has contracted with organizations to conduct audits of every state on a three-year rolling cycle and Colorado was chosen for its first review during FFY 2007. Accordingly, HCPF issued a Request for Proposals for a contractor to perform eligibility verification functions

⁶ On April 13, 2007, HCPF and DHS collectively released a Request for Proposals (NCRS703042CBMS) for maintenance and operation of the CBMS. As of July 12, 2007, results of the re-procurement had not yet been posted on the State's web site

necessary for compliance with federal PERM requirements.⁷ The contract will run through June 2008. Improper payments may result in disallowances, i.e., refunds of federal Medicaid and/or SCHIP funds.

School Health Services

HCPF released a Request for Proposals in April 2007 for a contractor to assist in implementing recent federal recommendations related to school health services, including program monitoring and oversight, development of a new reimbursement methodology, cost settlement process and an annual reconciliation process of Certified Public Expenditures.⁸

School health services are provided to children with disabilities and in accordance with their Individualized Education Program or Individualized Family Services Program. For children who have Medicaid eligibility, a public school district can receive program reimbursement for medical services rendered by school staff, including rehabilitative therapies, nursing services, targeted case management and specialized non-emergency medical transportation. In 2004, a statewide revenue maximization project was initiated that resulted in HCPF submitting a retroactive corrected claim to CMS for more than \$11 million in additional federal Medicaid funds. CMS rejected the claim as well as a subsequently submitted State Plan Amendment (SPA 05-006). HCPF continues to negotiate with CMS over the State Plan Amendment.

In recent years CMS has been closely scrutinizing claims from state Medicaid agencies for school health services and has issued guidance to the states regarding acceptable program parameters. The purpose of this RFP is to assist HCPF in efforts to assure that school health services rendered are eligible for and that the State is able to take full advantage of federal Medicaid matching funds.

Beneficiary Services

HealthColorado

In December 2006, HealthColorado (owned by MAXIMUS) was again awarded a contract to provide managed care education and enrollment services for Colorado's Medicaid program. The company was first awarded a contract as the state's

⁷ The Request for Proposals (HCPFJC0704PERM) was released on April 17, 2007, with responses due May 17, 2007. As of July 12, 2007, results of the procurement had not yet been posted on the State's web site.

⁸The Request for Proposals (HCPF0704SHSP) was released on April 18, 2007, with responses due May 18, 2007. The initial contract period will be one year, commencing on July 1, 2007, and four additional one-year extensions will be possible. As of July 12, 2007, results of the procurement had not yet been posted on the State's web site.

enrollment broker in 1998, with the term of the most recent contract running to 2011. HealthColorado also serves as the state's ombudsman for managed care, assisting beneficiaries with healthcare issues related to their physical and/or behavioral health plan enrollment.

School-Based Medical Assistance Sites

Former Governor Bill Owens signed a provision into law in June 2006 that established a demonstration project to authorize qualified personnel to make determinations of students' eligibility for Medicaid and CHP+ at designated public school Medical Assistance sites. The purpose of the legislation was to make it easier for parents to enroll their eligible children into these healthcare programs, thereby reducing the number of uninsured children in the state.⁹ In response to this legislation, HCPF issued a solicitation for proposals that were due in February 2007.

Family Healthline

The Family Healthline is a statewide information and referral service that helps callers, especially pregnant women and their families, find needed health care for themselves and their children. The toll-free telephone line is available during regular business hours and services may also be requested via email.

Colorado's Medicaid and SCHIP Caseload

Colorado's population has increased more than 20 percent over the last decade and is expected to continue growing. Further, the median age increased over this period by 2.13 years, perhaps due to increased longevity or fewer births or perhaps because a large number of retirees have moved to Colorado. It is projected that Colorado has the fastest aging population of all the states.¹⁰

Medicaid Caseload

The average monthly Medicaid caseload in Colorado grew from about 237,600 in State Fiscal Year (SFY) 1999 to about 402,800 in SFY 2005, an increase of almost 70 percent in six years and indicating that about 9 percent of the state's population is covered by Medicaid (lower than the national average of about 14 percent, no doubt because Colorado does not include the "medically needy" eligibility group - see more about this below). The total caseload has slowly dropped since 2005 and

⁹ As of July 12, 2007, results of the solicitation had not yet been posted on the State's web site.

¹⁰Colorado Department of Health Care Policy and Financing; FY 06-07 and FY 07-08 Budget Request; Medicaid Caseload. Available on the HCPF web site at:
http://www.chcpf.state.co.us/HCPF/Budget/atch_0207/Medicaid%20Caseload.pdf.

enrollment in May 2007 was 383,061.¹¹ The average monthly caseload projection for SFY 2008 is about 391,000.¹² Currently, children comprise about 57 percent of the caseload, a rate that is somewhat higher than the national average. The elderly and disabled, including low-income Medicare beneficiaries for whom the Medicaid program is obligated to cover some of their out-of-pocket healthcare expenses (such as coinsurance and deductible amounts and/or Medicare premiums), comprise about 26 percent of the caseload, a rate that is fairly close to the national average. The remaining 17 percent of the caseload is primarily low-income adults, including Expansion Adults who gained Medicaid eligibility beginning in July 2006.¹³

Medicaid caseload projections for children are expected to drop over the next two years as the economy improves, while projections for the elderly, disabled and other adult categories of eligibility are expected to show modest increases. The result across the total caseload is expected to be a slight decrease.

SCHIP Caseload

The Colorado CHP+ caseload in May 2007 included 56,898 children. More than 53,000 of the children were in the base population (living in families with income at or below 185 percent of the FPL), and the remaining children were in the expansion population (with family income up to 200 percent of the FPL). Program enrollment has been growing slowly but steadily, with most of the growth in the expansion population.

The CHP+ caseload also included 1,256 pregnant women in May 2007. Only 222 of the women were in the expansion population (with family income up to 200 percent of the FPL). Program enrollment grew steadily from July 2006 (when the expansion was implemented) through November but has dropped off slightly in the months since.¹⁴

¹¹ *Joint Budget Committee Monthly Reports*, Colorado Department of Health Care Policy and Financing. Available on the HCPF web site at:

http://www.chcpf.state.co.us/HCPF/Budget/JBC%20reports/rpt_index.asp

¹² *Medicaid Caseload Forecast*, Colorado Department of Health Care Policy and Financing. Available on the HCPF web site at: http://www.chcpf.state.co.us/HCPF/Budget/atch_0207/MSP%20EB.pdf.

¹³ HB 05-1262, the Tobacco Tax bill, provided funding for the expansion of income guidelines for parents of children eligible for Medicaid or CHP+ up to 60 percent of the FPL. The bill also expanded CHP+ eligibility for pregnant women and children up to 200 percent of the FPL, re-established presumptive eligibility for Medicaid pregnant women, eliminated the Medicaid asset/resource test and expanded the number of children able to be enrolled in home and community-based and extensive support waiver programs.

¹⁴ *Joint Budget Committee Monthly Reports*, Colorado Department of Health Care Policy and Financing.

Medicaid Eligibility Policies

Federal law and regulations specify certain population groups for mandatory coverage under Medicaid and others that may be covered at state option. Mandatory groups are primarily low-income families with children (called 1931 Family Medicaid in Colorado), persons receiving federal Supplemental Security Income (SSI) benefits (although some states have more restrictive requirements than the SSI program), pregnant women and children under age 19 living in families with income below specified levels, recipients of adoption assistance and foster care under Title IV-E of the Social Security Act, and persons who are dually eligible for Medicare and Medicaid.

Some of the optional coverage groups include low-income aged and disabled persons, the “medically needy” (persons with higher income than permitted by a mandatory coverage group but with high medical expenses), children in need of institutional care but who may be served in their home less expensively, pregnant women with higher income than permitted under the mandatory coverage group, certain persons who receive care in nursing facilities or through a state’s home and community-based waiver who are not otherwise Medicaid eligible, Medicaid buy-in program participants including those authorized through the Ticket to Work and Work Incentives Improvement Act (TWWIIA), and women participating in the Breast and Cervical Cancer Treatment Program. Colorado is one of only about 15 states that do not offer Medicaid eligibility to the “medically needy” and only one of about a dozen states that hasn’t implemented a Medicaid buy-in program for working disabled persons.

Medicaid law sets maximum income thresholds, using FPL guidelines, for many categories of Medicaid eligibility and permits states at their option, with approval from CMS, to use higher levels. In some instances these higher levels may be approved through submission of a State Plan amendment and others require a federal waiver. CMS approval is also required for any “disregards” that a state wishes to include in its Medicaid eligibility determination process.¹⁵ Medicaid law also sets thresholds for the amount of assets (or resources, such as money in savings accounts) that an individual may keep and still qualify for coverage.

It is not uncommon for the uninsured or under-insured¹⁶ to be admitted to a hospital and, with mounting medical bills, turn to Medicaid to help cover the cost. Hospitals

¹⁵ A disregard is a deduction applied to gross income before subjecting it to the mandatory income threshold. Disregards include such items as a shelter allowance, health care premiums and child care expenses. Although most states use many of the same disregards, the values may vary significantly.

¹⁶ So called “high-deductible plans often produce large amounts of uncompensated care because the individual cannot afford to pay the large up front cost. This can also lead to delayed necessary treatment.

have a vested interest, i.e., payment, in helping these individuals to obtain Medicaid eligibility, and staff is often assigned to assist them in the Medicaid application process. Federal Medicaid law provides for the receipt and initial processing of Medicaid applications from pregnant women and children at locations other than state “welfare” offices. At a minimum, “outstation locations” are to be made available at each Disproportionate Share Hospital (DSH) and participating Federally Qualified Health Center (FQHC) in the state; outstationed staff is often located at local health departments and Indian Health Service clinics as well. State Medicaid agencies are to assure that qualified staff is available at these sites to assist Medicaid applicants with the application process. Outstationed staff may be employees of the state agency designated to determine Medicaid eligibility or they may be staff employed by the entity, i.e., the hospital or FQHC, that have been trained in Medicaid eligibility policies. If the latter, which is the process in Colorado, the outstationed staff forward completed Medicaid applications to the designated state agency for final determination of eligibility. If the former, which is the process in Texas for example, additional state staff are hired and placed in DSH hospitals where they are able to both provide education and enrollment assistance for Medicaid applicants and are also able to determine eligibility on site. Hospitals provide the state share of funding for the staff and, in return, realize the benefits of expedited enrollment and reduced accounts receivable.

State agencies are required to process Medicaid applications within timeframes specified in federal regulations, called the “standard of promptness” (45 to 90 days, depending on category of eligibility) but are permitted additional time if the documentation provided on or with the application is incomplete. Outstationed workers expedite this process by determining eligibility on-site or by helping to assure that Medicaid applications are complete when submitted for eligibility determination.

Medicaid eligibility generally begins on the first day of the month that an application is filed but may be made retroactive as many as three months earlier if the applicant has unpaid medical bills and meets all applicable financial and non-financial eligibility criteria during that period.¹⁷

¹⁷ In states that include the “medically needy” optional coverage group (Colorado does not), if an applicant has higher income than is allowed but has offsetting medical expenses, eligibility may be approved but with a requirement that the excess income be used for incurred medical expenses before the eligibility is effective. This “spenddown” requirement typically occurs monthly. For approved beneficiaries residing in an institutional setting, the excess income is paid to the institution as a “patient pay amount” or “patient payment” and reduces the amount paid by the Medicaid program for care rendered in the facility.

Although Medicaid eligibility has been extended to a few expansion populations, Colorado has one of the more conservative programs in the country relative to the population it serves:

- Children under age one who live in families with income below 133 percent of the FPL must be covered by the state's Medicaid program, and this is the income threshold used in Colorado. Included in this category is "Kid Care" children (living in families with income above an established cash assistance standard but below the specified upper limit). Many states provide coverage for these very young children up to 185 percent of the FPL and some even higher. The states surrounding Colorado are a mix - Idaho, Utah and Wyoming also use 133 percent of the FPL; Arizona uses 140 percent and Kansas uses 150 percent; Nebraska, Oklahoma and Texas all use 185 percent; and New Mexico has set its upper limit at 235 percent of the FPL through use of higher income disregards.
- Children over age one and under age six who live in families with income below 133 percent of the FPL must also be covered by Medicaid and this is the income threshold used in Colorado. There are "Kid Care" children in this coverage group as well. Many states provide coverage up to 150 percent of the FPL and several even higher. The states surrounding Colorado largely use 133 percent as well; however, Oklahoma has set its income threshold at 185 percent and New Mexico uses 235 percent of the FPL for this eligibility group as well.
- Children age six through eighteen who live in families with income below 100 percent of the FPL must be covered by Medicaid and this is the income threshold used in Colorado - many states provide coverage up to 150 percent of the FPL and several even higher. The states surrounding Colorado largely use 100 percent as well; however, Nebraska and Oklahoma have set their income thresholds at 185 percent and New Mexico uses 235 percent of the FPL.
- Pregnant women who live in families with income below 133 percent of the FPL must be covered by the state's Medicaid program. Unless they meet other criteria for Medicaid coverage beyond pregnancy and income, these "Baby Care Adults" as they're called in Colorado lose their eligibility two months following the end of their pregnancy. The state has received federal HIFA waiver approval from CMS to cover pregnant women living in families with income up to 200 percent of the FPL. These women also lose Medicaid coverage after 60 days of postpartum care. This threshold is higher than any of the states surrounding Colorado; four of these states use the minimum 133 percent, one uses 150 percent and four use 185 percent of the FPL. Colorado has implemented a presumptive eligibility policy for pregnant women, as have 30 other states including all of the surrounding states with the exception of Arizona and Kansas. Colorado also eliminated the asset test for pregnant women as of July 2006 through state rule change (Section 25.5-5-201,

C.R.S.). Of the surrounding states, only Idaho and Utah still require pregnant women to meet an asset test for Medicaid eligibility.

- The state's income thresholds for non-working parents and for working parents of children enrolled in Medicaid or CHP+, at 67 percent and 60 percent of the FPL, respectively, after disregards are considered, are more generous than in many states. These income thresholds were new as of July 2006 and enacted through a state rule change (Section 25.5-5-201, C.R.S.). Of the surrounding states, only Arizona, New Mexico, Oklahoma and Utah have higher rates and those are in place as the result of federal waiver approval. Colorado plans to eliminate the asset test for low-income families in July 2007 as it did for pregnant women in 2006.
- Colorado operates under a "1634 Agreement" with the federal government and as such provides Medicaid coverage to persons meeting the disability criteria for federal SSI cash assistance, both medically and financially (income is limited to about 74 percent of the FPL). Colorado also provides supplementary assistance payments to these disabled Medicaid beneficiaries (about half of the states offer this benefit).
- Colorado does not offer Medicaid eligibility to the optional group of Medically Needy individuals, those with income greater than Medicaid thresholds but with medical expenses that, if "spent down," might make them eligible for program benefits. Of the surrounding states, only Kansas, Nebraska, Oklahoma and Utah offer such coverage.
- The state did not implement the Omnibus Budget Reconciliation Act (OBRA) of 1986 option to provide Medicaid coverage to Aged and Disabled persons with income up to 100 percent of the FPL - Colorado is not alone in this decision as 30 other states do not provide such coverage either (although three of the surrounding states - Nebraska, Oklahoma and Utah - do provide coverage).¹⁸

Eligibility thresholds could, of course, be reduced to the minimum levels required under federal law for the few groups currently served at higher income levels however this action would obviously increase the state's uninsured population and would surely be met with opposition by advocacy groups.

Current Medicaid Expansion Possibilities

One of the simplest Medicaid expansion opportunities available to HCPF would be to re-activate its request of the US Department of Health and Human Services (HHS)

¹⁸ Most of the eligibility information provided in this section was taken from tables available on the Kaiser Family Foundation's web site, available at: <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi>. Other information was found on the state's web site.

for a Section 1115 Family Planning waiver. A federal Medicaid disallowance prompted the state to withdraw the waiver application in early 2004, however it should be reconsidered.¹⁹ It would seem that the previously submitted application could be used as a template and revised with more current data. Colorado's Medicaid program has established a relatively high income threshold for coverage of pregnant women and expanded coverage for family planning services up to the same income level would, as it has in other states where such a waiver has been implemented, very likely produce not only cost savings related to expenditures for pregnancy-related services but also a reduction in the incidence of unintended and closely spaced pregnancies. There are currently 25 states with approved family planning waivers, including four of the states bordering Colorado (Arizona, New Mexico, Oklahoma and Texas); five states out of the 25 have been approved within the last two years.²⁰ One of the major financial advantages to such a waiver is the availability of a 90 percent federal matching rate for family planning services. Any cost savings associated with implementing a waiver could, of course, be used to extend Medicaid coverage to additional population groups, or add one or more of the services not currently available to Medicaid-eligible adults, or enhance the state's reimbursement rates.

Two-thirds of the states in the country have implemented a Medicaid buy-in program for disabled Medicaid beneficiaries who are able to join the work force. Colorado is not in this group. Under federal law, specifically the Balanced Budget Act (BBA) of 1997 and the Ticket to Work and Work Incentives Improvement Act (TWWIIA) of 1999, states have the option of creating a Medicaid buy-in program that enables employed persons with disabilities to keep their Medicaid coverage even if their income is greater than what is normally permitted. The objective of both laws is to give persons with disabilities an opportunity to enter the workforce without fear of losing healthcare coverage. The two referenced laws have slightly different provisions but generally apply to disabled persons between the ages of 16 and 65 with existing Medicaid coverage (often through SSI eligibility) and require income-based premiums.

Medicaid Benefits

As is the case with Medicaid eligibility, there are certain services that must be covered in state Medicaid programs, and there are others that may be offered at a

¹⁹ Colorado's waiver application was submitted to CMS in early 2000 and withdrawn two years later prior to a final decision by CMS. The withdrawal letter noted a disallowance of a little more than \$2.5 million following a CMS audit of family planning expenditures. Such a disallowance is preventable through appropriate checks in the state's federal claiming process.

²⁰ *State Medicaid Family Planning Eligibility Expansions*, State Policies in Brief, May 1, 2007. Guttmacher Institute. Available at: http://www.guttmacher.org/statecenter/spibs/spib_SMFPE.pdf.

state's option. The following table reflects these Mandatory Benefits and the most commonly offered Optional Benefits.

Mandatory Medicaid Benefits	Optional Medicaid Benefits
Inpatient Hospital Services (excluding services for mental diseases)	Critical Access Hospital Services and/or Emergency Hospital Services in Non-Medicare Participating Facilities
Outpatient Hospital Services	Physician-Directed Clinic Services, including services in Public Health Clinics, Mental Health Clinics and Freestanding Ambulatory Surgery Centers
Federally Qualified Health Center (FQHC) Services	Mental Health Rehabilitation/Stabilization
Rural Health Clinic Services (State law permitting)	Intermediate Care Facility Services for Developmentally Disabled (ICF/MR)
Laboratory and X-ray Services (rendered outside a hospital or clinic)	Inpatient Psychiatric Care for under age 21 and/or Care in Institutions for Mental Diseases (IMD) for under age 21 and over age 65
Nursing Facility Services (age 21 and older)	Nursing Facility Services (under age 21)
Physician Services (MD or DO)	Prescription Drugs
Certified Pediatric and Family Nurse Practitioner Services (State law permitting)	Medical Equipment/Supplies and/or Orthotic and Prosthetic Devices
Nurse Midwife Services	Ambulance Services
Family Planning Services and Supplies	Therapy Services (occupational, physical and/or respiratory)
Pregnancy-related Services (through delivery and 60 days postpartum)	Speech, Hearing and Language Disorder Services
Medical and Surgical Services of a Dentist (comparable to a Physician Service)	Dentist Services
Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT)	Medical Care by other Licensed Practitioners, e.g., Certified Registered Nurse Anesthetist s, Podiatrists, Chiropractors or Psychologists
Home Health Services (intermittent or part time, for beneficiaries entitled to skilled nursing facility care)	Home Health Services (for other beneficiaries)
	Optometrist Services
	Dentures, Eyeglasses and/or Hearing Aids
	Non-emergency Medical Transportation
	Hospice Care
	Personal Care Services
	Private Duty Nursing Services

Federal requirements related to covered services for children are more stringent than for adults. The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) regulations require states to cover services determined medically necessary through an EPSDT screening, e.g., a well-child exam, even if the services are not covered for

adults. Examples of such services are dental, vision and hearing care. Similarly, states are required to provide pregnancy-related services (necessary for the health of the pregnant woman and the fetus) as well as services for other conditions that might complicate pregnancy, both during the pregnancy and for 60 days after the pregnancy ends. As such, most service limitations in state Medicaid programs apply only to non-pregnant adults.

Within the federal Medicaid requirements there is considerable latitude given to states to establish and maintain their benefit structure. With CMS approval, they are able to set service limits, establish prior authorization and other utilization control mechanisms and establish cost sharing requirements for beneficiaries. As a result, no two Medicaid programs in the country are the same, especially where services for non-pregnant adults are concerned. Some of the service limitations established for the Colorado Medicaid program, with comments, follow:

- Colorado limits several services for its adult Medicaid population. Hearing aids and dental care, including dentures, are not covered; the services of chiropractors are not covered; and eyeglasses are only covered following surgery. These restrictions on coverage are not uncommon across the country.
- The state covers private duty nursing services for technology-dependent adults for as many as 16 hours per day. While this is in keeping with the Olmstead philosophy, many states do not offer this benefit for adults.²¹
- The state covers services in Institutions for Mental Diseases for the 65 and older population. This benefit is also not a universal coverage.
- The state covers the services of podiatrists for adults with no apparent limits beyond medical necessity. Some states have eliminated this benefit, or set visit limits, or only cover services for adult Medicaid beneficiaries with certain systemic conditions such as diabetes.
- Occupational and physical therapy services are covered for adults with prior authorization required for more than 24 units of service (a unit of service is 15 minutes). The therapists are able to bill and receive direct reimbursement. A number of states require prior authorization to initiate these services. Some states

²¹ *Olmstead v LC*, 527 US 581 (1999). The *Olmstead* decision of the US Supreme Court interprets the obligations of public entities, such as state agencies operating Medicaid programs, under the Americans with Disabilities Act. This decision requires state Medicaid agencies to make reasonable modifications when necessary to avoid discrimination on the basis of disability, e.g., when medically appropriate to honor a Medicaid beneficiary's choice to receive home and community-based services rather than nursing facility care. Since *Olmstead*, states have significantly expanded their home and community-based services waiver programs to provide care in the "least restrictive setting" of choice.

have discontinued direct reimbursement to the therapists, thereby limiting the benefit to institutional settings or through a home health agency.

- Speech/language therapy services are covered for adults without prior authorization although the services are limited to 5 units of service (a unit of service is 15 minutes) per day. The therapists are able to bill and receive direct reimbursement. A number of states require prior authorization for these services, if not initially after a short period of treatment, and others have discontinued direct reimbursement to the therapists, thereby limiting the benefit to institutional or clinic settings.
- The services of psychologists are covered and direct reimbursement is allowed, although it appears that in the majority of circumstances services are billed through employers, e.g., intermediate school districts. Psychologists may directly bill and receive reimbursement for outpatient substance abuse treatment, for which limits have been established relative to the number of sessions allowed during a fiscal year. Similar to the therapies just mentioned, some states do not directly reimburse psychologists and only cover their services through other providers, e.g., community mental health clinics.
- Substance abuse treatment coverage was extended to all Medicaid eligible adults meeting specified diagnosis criteria in July 2006 and, effective January 1, 2007 postpartum substance abuse benefits were extended from two months to twelve months.²² Further, for beneficiaries participating in the Primary Care Physician (PCP) program, referrals from the PCP are no longer required for substance abuse treatment. While HCPF has established limits on the number of covered treatment sessions per year, the department may want to consider either a prior authorization requirement or enhanced post-payment monitoring to assure that only medically necessary services are billed.
- At this time the state allows eight prescriptions per month (with authorization required for any additional). This limit is higher than in several states, but many states don't specify a prescription limit at all in their Medicaid State Plan. The state's current reimbursement rate for drug cost is comparable to the rates used in surrounding states, and uses a deeper discount from average wholesale price of the drug products than in many others across the country.²³

²² The Colorado Special Connections Substance Abuse Treatment Program was approved through an amendment to the state's Community Mental Health Services Section 1915(b) waiver.

²³ *Medicaid Benefits Study - Policies in Place October 1, 2004*, conducted by Health Management Associates for Kaiser Family Foundation. Available at: <http://www.kff.org/medicaidbenefits>. The tables on this web site provide information about Medicaid covered services, cost sharing requirements and reimbursement methodologies for all services and all states and are useful for state policy makers and others interested in assessing possible changes for State Medicaid programs. The

As noted in the bullets above, there are some changes that the state could contemplate to possibly reduce costs.

A more dramatic approach would be to implement varying benefit packages for differing segments of the Medicaid population, as permitted by the DRA of 2005 or through a Section 1115 waiver. It may be appropriate to note, however, that only a couple of states (Idaho and Kentucky) have chosen to use the DRA provisions for Medicaid program redesign. It appears that this avenue for change has not proven as popular as Congress envisioned it would be.

Medicaid Payment for Services

Colorado's Medicaid program pays for most non-institutional services with a state-established fee schedule. Physicians received their first rate increase in several years during SFY 2006 when fees for the top nine Evaluation and Management (E & M) procedure codes were raised to 80 percent of Medicare's reimbursement rates. Another increase occurred for SFY 2007 when fees for the top 25 E & M codes saw another 3.25 percent increase.

Pharmacies are paid an amount to cover drug cost with an additional amount for dispensing services. Pharmacies saw deeper discounts on drug cost reimbursement in SFY 2004, which have not been relaxed since.

Most inpatient hospital services are paid through a prospective reimbursement system using Diagnosis Related Groups (DRGs). The Medicare grouping methodology is used as the base for the system with modifications as appropriate to reflect issues specific to Medicaid. Grouper Version 24.0 (the most current version) was installed for admissions on or after October 1, 2006. A hospital-specific Medicaid price is calculated from the Medicare base price with adjustments, including a factor to recognize appropriated funds each year. Adjustments also recognize the peer grouping of each hospital. Facilities that are exempt from DRG reimbursement receive prospective per diems. Graduate medical education (GME) costs are paid directly to each qualifying hospital for both fee-for-service and managed care enrollees. Hospitals saw a one percent reduction in reimbursement (valued at \$3.1 million) in SFY 2005 but received increases of two percent in July 2005, one percent in April 2006 and 3.25 percent for SFY 2007.

Outpatient hospital services are paid an interim rate that is 72 percent of the Medicare cost to charge ratio times actual charges. Periodically payments are adjusted to the lower of actual audited cost minus 28 percent or billed charges minus 28 percent. This reimbursement methodology has not changed in several years.

web site should be updated by July 2007 with information reflecting policies in place as of October 1, 2006.

Nursing facilities are paid cost-based and acuity-adjusted prospective per diems with limits.²⁴

Reimbursement rates to Medicaid providers are by no means generous in any states. Only in rare circumstances do states pay *some* of their providers at the same rates that Medicare uses. Although a little out of date, the Kaiser Family Foundation's StateHealthFacts web site provides some interesting comparisons of Medicaid payment rates to physicians across the country.²⁵ When compared to other states, Colorado's Medicaid reimbursement rates for physician services were a little better than average (the rate index was 1.06). The states with the most generous physician payment rates (other than Alaska with its 2.28 index) were Arizona at 1.55, Delaware at 1.49 and Nevada at 1.43. The states with the lowest rates were New Jersey at .56, Rhode Island at .62 and New York at .70. Similarly, when compared to Medicare reimbursement rates, with the national average at .69, Colorado's Medicaid reimbursement rates for physician services were a little above average (at .74). The states with the highest index when compared to Medicare (other than Alaska with its 1.37 index) were Arizona at 1.06, Wyoming at 1.03 and Delaware at 1.01. The states with the lowest rates compared to Medicare were New Jersey at .35, Rhode Island at .42 and New York at .45. Between 1998 and 2003, physician reimbursement rates in state Medicaid programs were increased in most states, with the national average at 27.4 percent. Reimbursement rates were increased as much as 58.4 percent in Iowa and 55.1 percent in South Carolina and decreased by -2.4 percent in the District of Columbia and -.3 percent in Rhode Island. Colorado increased physician reimbursement rates by 5.8 percent over this time period.

For the State's fiscal year that ended June 30, 2007, total Medicaid expenditures, on a cash basis, were approximately \$2,047 million (excluding expenditures for behavioral health services).²⁶ Of that amount, payments to hospitals were approximately 20.5 percent; payments for long-term care services (both institutional and community-based) were about 19.1 percent; payments to physicians were about 7.5 percent; payments to the managed care and administrative services organizations were about 7.2 percent; and payments for prescription drugs (net of rebates) were about 6.6 percent.

²⁴ *Medicaid Rate Methodology Change History*. Colorado Department of Health Care Policy and Financing. Available at: <http://www.chcpf.state.co.us/HCPF/budget/budgetindex.asp> >> Medicaid Rate History Since FY 00-01.

²⁵ *Medicaid Physician Fee Index, 2003; Medicaid-to-Medicare Fee Index, 2003; Cumulative Percentage Change in Medicaid Fees, by Type of Service, 1998-2003*; Kaiser Family Foundation. Available at: <http://www.statehealthfacts.org>. >> Colorado.

²⁶ *Joint Budget Committee Monthly Reports*, Colorado Department of Health Care Policy and Financing.

Ranking of State Medicaid Programs

A recently released report published by Public Citizen Health Research Group, an advocacy organization, ranked state Medicaid programs relative to eligibility, scope of services, quality of care and provider reimbursement. Colorado ranked 43rd overall and in the bottom quarter of all categories except provider reimbursement where its reimbursement rates relative to the rest of the country were slightly higher than average.²⁷ The low ranking in both the eligibility and scope of services categories was attributed to not including the “medically needy” coverage group. The scope of services ranking was also impacted by the state’s non-coverage of a number of services for adults. The quality of care ranking noted deficiencies in nursing facility care and a poor record in childhood immunization.

Primary Care Provider Rates Task Force

The Colorado State Legislature provided funding for a task force to examine issues of reimbursement rate disparity and shortfalls for physician and acute care providers. HCPF staff is working with a contractor to examine existing reimbursement rates and to compare them with benchmark data such as Medicare fee schedules. Three task force meetings are being held with a selected group of Medicaid providers to discuss issues and concerns; the first occurred on April 20, 2007. Initial feedback from physician groups during these meetings included the request for a significant increase in Medicaid reimbursement rates to cover cost of care. They’ve asked that rates be raised to at least Medicare levels, and higher if possible within the limitations in federal law.

Physician Issues

Performance and Health Outcomes

One incentive approach that has received considerable attention over the last couple of years is generally called “pay for performance” or “P4P.” States such as Michigan and New York have included payment incentives in their contracts with managed care organizations for care management, member satisfaction and improved health status. CMS is also proposing incentives for physicians participating in the Medicare program, again directed toward improved health status of program beneficiaries. The state is encouraged to consider such incentives, both for the benefit of Colorado’s Medicaid and CHP+ beneficiaries and for their positive impact on providers of healthcare services.

²⁷ *Unsettling Scores: A Ranking of State Medicaid Programs*, Public Citizen Health Research Group, April 2007. Available at: <http://www2.citizen.org/hrg/medicaid>.

Quality of Care

HCPF has several quality initiatives that are currently underway in their managed care organizations, behavioral health organizations, primary care physician program, and fee for service programs. The Health Services Advisory Group (HSAG) is the external quality review organization for HCPF's managed care contracts and their reviews focus on access, quality, and timeliness as well as HEDIS measures for children, adolescents, women, and adults and CAHPS surveys for beneficiary and provider satisfaction.²⁸

HCPF was recently selected to participate in a quality improvement initiative by the Center for Health Care Strategies (CHCS) that emphasizes "return on investment purchasing". The five disease states included in the CHCS initiative are asthma, diabetes, chronic heart failure (CHF), depression, and high-risk pregnancy. HCPF will use this initiative to support the new direction the State is taking in 2007. The Governor's *Colorado Promise* for health care and his long-term vision is to provide basic healthcare services for all residents, and he is interested in strategically growing the state's programs to ensure they reach those most in need of services.

Collaboration Across Stakeholders and Informed Decision Making

HCPF has expressed interest in establishing relationships with all its key stakeholders to encourage public-private partnerships that will lead to efficient programs and the development of a system of care whose foundation is good public policy supported by information technology and quality outcomes. Open communication, involvement of all stakeholders, and expanded review of key data elements to assess the drivers of healthcare costs is critical to the successful development of a system of care that will meet the needs of all Coloradans. Through these efforts public policy decisions can be identified, implemented, and measured to ensure quality health outcomes are achieved.

This position is consistent with the Colorado Promise, presented during Governor Ritter's successful gubernatorial campaign in 2006, which included a promise to develop the Colorado Health Plan. The Plan, to be developed through collaboration with stakeholders, is intended to improve healthcare access, quality and affordability, and to promote healthy lifestyles. The Plan also promises to give high priority to healthcare coverage for the approximately 180,000 uninsured children in Colorado.

²⁸ HEDIS is an abbreviation for Healthcare Effectiveness Data and Information Set and CAHPS is an abbreviation for Consumer Assessment of Healthcare Providers and Systems. HEDIS is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. CAHPS is a public-private initiative to develop standardized surveys of patients' experiences with ambulatory and facility-level care.

Hospital Issues

Emergency Department Utilization Trends

Statistics available on the Kaiser Family Foundation's web site report a rate of 322 emergency room visits per 1,000 population in Colorado in 2005, across all payers, one of the lowest rates in the country. This rate compares with an average for the United States (US) of 387 visits. The states with the lowest rates were California and Hawaii, at 262 and 264 visits, respectively. The District of Columbia had the highest rate, at 615 visits, followed by Mississippi at 573 visits.²⁹

While the above statistic for Colorado is impressive, it must be recognized that at the time more Medicaid beneficiaries were receiving their healthcare services through risk-based managed care organizations than is now the case. Currently, the vast majority of Colorado's Medicaid population receives care on a fee-for-service basis and many of these beneficiaries do not have a medical home or primary care provider. This situation results in high use of hospital emergency department services for common illnesses that can safely, and much less expensively, be treated in a physician's office or clinic setting. An efficient and effective system of care must include a care management component to ensure that individuals, especially those with complex medical needs, are provided necessary care by the right provider, at the right time, and in the right setting.

Inpatient Utilization Trends

Based on a recently released report by The Commonwealth Fund entitled "Aiming Higher: Results from a State Scorecard on Health System Performance", Colorado ranked 15th overall in avoidable hospital use and costs.³⁰ One interesting statistic in the report, the state's rate of hospital admissions in 2002 for pediatric asthma per 100,000 children was 174.9 compared to an average rate across the top five states of 81.3, with the top state at only 54.9.

Statistics available on the Kaiser Family Foundation's web site report a rate of 441 inpatient hospital days per 1,000 population in Colorado in 2005, across all payers, one of the lowest rates in the country. This compares with an average rate for the United States (US) of 665 days. The states with the lowest rates were Oregon and New Mexico with 410 and 419 days per 1,000, respectively. The District of Columbia had the highest rate, at 1,711 days per thousand, followed by South Dakota at 1,326

²⁹ Kaiser Family Foundation, *StateHealthFacts*. Available at:

<http://www.statehealthfacts.org/comparecat.jsp?cat=8>.

³⁰ JC Cantor, C Schoen, D Belloff, SKH How and D McCarthy, *Aiming Higher: Results from a State Scorecard on Health System Performance*, The Commonwealth Fund Commission on a High Performance Health System, June 2007. Available at: <http://www.commonwealthfund.org/publications>.

days.³¹ The Colorado Hospital Association reports that, on average, about 16 percent of all inpatient hospital days are for Medicaid beneficiaries.

Unique Challenges of Rural Areas

Colorado has the same challenges as other states as it relates to access to care in the rural areas of the state. It is difficult to recruit physicians because of disparities in salary and the perceived lack of medical collegiality. A significant majority of the population has income at or below the poverty level with a substantial percentage of payments not covering the cost for the services rendered. Colorado hospitals are a major economic and employer contributor especially in the rural communities. Out of the 64 Colorado counties, 25 counties have critical access hospitals in their rural areas. The Colorado Rural Health Center in collaboration with the Governor's office has a variety of programs to support and enhance the rural communities' access to health care.

Several states have followed the lead of the Medicare program and provide cost based reimbursement for the state's Critical Access Hospitals. Currently Colorado's Critical Access Hospitals do not qualify for DSH payments. The cost of enhancing payments to these necessary providers is usually quite small in terms of the state's budgetary commitment, but the impact in terms of protecting these resources in small communities can be quite large.

Unique Issues in Denver

Over the last few years several inner-city Denver hospitals have relocated partly or completely to the suburbs, thus leaving fewer facilities to provide the vast majority of emergency care to inner city residents, especially low-income Medicaid beneficiaries and the uninsured. Continuation of this process may have a negative financial impact on access to care in Denver because current Medicaid reimbursement rates are below the cost of care and there is a lack of adequate payment for care provided for the uninsured.

An example of Medicaid payments below the cost of care is the current policy that pays hospital outpatient services, including emergency care, at 72 percent of cost (technically 72 percent of the Medicare cost to charge ratio). Additionally, it is often the case that patients, e.g., those who are ventilator dependent, remain in the hospital longer than necessary because low payment rates for alternative services restrict their availability. The Colorado Indigent Care Program (CICP) provides a level of additional assistance, but because the payment rates differentiate between the types of hospitals this may often restrict rather than enhance access.

³¹ Kaiser Family Foundation, *StateHealthFacts*.

Delivery System Approaches

Physical Health

Colorado relies predominantly on a fee-for-service delivery system for Medicaid; including a primary care case management (PCCM) model of care, although this hasn't always been the case. As recently as 2002 there were seven risk-based managed care organizations providing medical services for Medicaid beneficiaries in Colorado. Today, there is one risk-based contractor serving Medicaid beneficiaries in the four-county Denver area, called Denver Health Medicaid Choice.³² Denver Health is an integrated public healthcare delivery system, including a hospital, an ambulatory health center, several FQHCs and school-based clinics and the local health department. Denver Health also serves children enrolled in CHP+ and dually eligible Medicare/Medicaid beneficiaries through its Medicare Advantage Special Needs Plan. Colorado Access, another risk-based managed care organization, which had served Medicaid beneficiaries in 37 counties, cancelled its contract at the end of August 2006 due to an expected rate decrease following a rebasing of capitation rates. A recent news article, however, notes that the new Chief Executive Officer of the plan will attempt to re-enter a Medicaid contract with HCPF.³³

Colorado's primary care case management program – called the Primary Care Physician Program, or PCPP – is administered by HCPF, with the assistance of its enrollment broker, **HealthColorado**, and is available in most counties along with traditional fee-for-service coverage. For six counties in the rural western part of the state, Rocky Mountain Health Plans has an administrative services contract with HCPF to provide or arrange for medical services for both Medicaid and CHP+ beneficiaries.

Collectively, less than 20 percent of the Medicaid population is enrolled in managed care. Stated differently, more than 80 percent of Colorado's Medicaid beneficiaries receive services on a fee-for-service basis. This makes it more likely that many are not receiving care management for chronic conditions. A coordinated and health outcome focused delivery system of care would be beneficial to all and could result in significant cost savings to the State, which could be used to increase reimbursement rates for providers.

³² Narrative provided in an HCPF document relative to the FY 2008-2009 Budget Request Cycle notes that Denver Health has indicated it will discontinue as a Medicaid managed care plan if its capitation rates are not increased to 100 percent of the fee-for-service payment level.

³³ *Colorado Access Selects New CEO, Will Try to Re-enter Medicaid*, AISHealth.com, Accessed May 6, 2007. Available at: http://www.aishealth.com/ManagedCare/Medicaid/MAN_ColoradoAccess_Re-enter_Medicaid.html.

Such a delivery system need not rely on risk-based managed care. There are several states that have implemented programs worthy of further review. One such program has been implemented in North Carolina.

North Carolina's Medicaid program delivers services predominantly through a PCCM model now called Community Care of North Carolina (CCNC) and formerly called ACCESS and ACCESS II and III. Until last summer there was also a risk-based managed care organization (SouthCare) serving Medicaid beneficiaries in Mecklenburg County however that contract was terminated.

The CCNC - Carolina ACCESS program is available statewide, is administered by the state's Division of Medical Assistance (DMA) and relies on direct contracts between DMA and primary care providers (PCPs). PCPs may be allopathic or osteopathic physicians in general or family practice, obstetricians, gynecologists, internists, pediatricians or nurse practitioners, or they may be Federally Qualified Health Centers, Rural Health Clinics or Health Departments. In certain instances specialists may also be designated as PCPs. Physician Assistants may participate through their supervising physician. PCPs set their own enrollment limits, up to a maximum of 2,000 patients, and receive a case management fee of \$1.00 per enrollee per month for coordinating the care of beneficiaries enrolled with their practice.

The CCNC - ACCESS II/III program is a community-based enhanced PCCM model that brings PCPs, hospitals, local health departments and departments of social services and other community providers into a network to manage the healthcare needs of enrolled beneficiaries. There are 14 networks currently serving beneficiaries, each with care managers that assist in developing, implementing and evaluating care management strategies at each site. PCPs affiliated with these networks receive \$2.50 per enrollee per month, and each network is directed by a local administrative entity that is paid an additional \$2.50 per enrollee per month to develop and implement care management strategies. The networks are under the joint purview of the DMA and the Office of Research, Demonstration and Rural Health Development.

The DMA provides periodic reports to the PCPs to assist them in managing the care of their enrollees efficiently and cost effectively, e.g., a monthly emergency room management report showing enrollees for whom services were paid, a monthly referral report showing where and when enrollees received services, and a quarterly utilization report showing paid claims detail.

As with most PCCM models, certain services do not require authorization by the beneficiary's PCP, e.g., emergency care; dental, vision and hearing services; family

planning; school based services; hospice and mental health care.³⁴

In a recent American Academy of Family Physicians article, the CCNC's quality improvement director credits community physician involvement in and commitment to the program as the principal reason for its success and for Medicaid cost savings of about \$120 million in 2004. The article notes that North Carolina's Medicaid program pays its physicians at rates that equal 95 percent of Medicare and emphasizes that inadequate payment rates, especially for primary care, make it difficult to engage physicians in the program.³⁵

Behavioral Health

Colorado provides behavioral health services on a capitation basis to Medicaid beneficiaries through five Behavioral Health Organizations, i.e., Prepaid Inpatient Health Plans (PIHPs), one in each geographic region specified by HCPF.³⁶ Medicaid beneficiaries requiring mental health care must obtain services through the PIHPs. The department submitted a proposal for renewal of the federal Section 1915(b) waiver under which these services are rendered on March 30, 2007; the waiver renewal is currently under review for the two-year waiver period beginning July 1, 2007. The waiver renewal includes the Colorado Special Connections Substance Abuse Treatment Program, which provides substance abuse treatment and case management services for pregnant women with substance abuse issues. An amendment to the current 1915(b) waiver for this fee-for-service selective contracting program was approved during the fall of 2006 to extend postpartum substance abuse treatment from two months to twelve.

It has been said that there are access problems in many parts of Colorado. Medicaid beneficiaries, as well as the uninsured, in need of behavioral health services have gone without treatment because funding has not kept pace with the cost of treatment. Care has allegedly been restricted to crisis intervention with little if any therapy and in many instances hospitals have provided care without payment because of liability associated with discharging an individual without intervention. The merits of these allegations should be reviewed and considered in any discussions of healthcare redesign.

³⁴ Information regarding North Carolina's PCCM model of care is available on the state's web site. A good source is the Basic Medicaid Billing Guide, specifically Section 4: Managed Care Provider Information available at: <http://www.dhhs.state.nc.us/dma/bulletin/chapter%204%200407.pdf>.

³⁵ *Medical Homes, Physician-Led Networks Can Improve Care, Cut Costs*, American Academy of Family Physicians, "News Now," March 6, 2007. Available at: <http://www.aafp.org/online/en/home/publications/news/news-now/annarchives/mar07.html>.

³⁶ The five PIHPs are Behavioral Healthcare, Inc.; Colorado Access Behavioral Care; Colorado Health Partnerships, LLC; Foothills Behavioral Health, LLC; and Northeast Behavioral Health, LLC

Care Management

Hospitals often see increased use of their emergency department services by persons without a “medical home” (i.e., a specific physician or clinic that has direct responsibility for access and care for the particular patient) or who don’t know how to manage a chronic condition. Usually the cause of these problems is low payment rates for providers or a scarcity of providers in a geographic area. States have addressed this problem in many ways. One way is to implement care coordination programs focused on specific conditions, (e.g., asthma or diabetes), often with the assistance of a contractor. Other states have relied on their physicians to maintain a medical home and have given them additional compensation to do so. Colorado has relied on the former mechanism. North Carolina, as an example, has invested in their physicians to coordinate care.

Disease Management

In 2002 state legislation was enacted authorizing HCPF “to address over- or under-utilization or the inappropriate use of services or prescription drugs, and that may affect the total cost of health care utilization by a particular Medicaid recipient with a particular disease or combination of diseases.” (Section 26-4-4-408.5(2) CRS). In a Report to the Joint Budget Committee issued in April 2004 an overview of the seven disease management pilot programs administered by a variety of vendors was provided.³⁷ The targeted disease conditions included High-Risk Infants, Asthma, Diabetes, Schizophrenia, Breast Cancer, Cervical Cancer and Chronic Obstructive Pulmonary Disease. Subsequent to the pilot programs, a contract for asthma disease management was continued with National Jewish Medical and Research Center and a contract for diabetes disease management was continued with McKesson Health Solutions, LLC.

Telehealth

During mid-June 2006, former Governor Bill Owens signed SB 165 into law authorizing HCPF to reimburse Medicaid providers for telemedicine services and to make those payments at the same rate as in-person services. Earlier this year HCPF released a Request for Proposals for a Telehealth Pilot Program for Chronic Conditions, specifically congestive heart failure, diabetes and chronic obstructive pulmonary disease. The contract was awarded to Specialty Disease Management Services, Inc. for a one-year term beginning July 1, 2007, with four additional one-year periods possible.

³⁷ Report to the Joint Budget Committee, Disease Management Demonstration Pilot, Colorado Department of Health Care Policy and Financing, April 15, 2004. Available at: <http://chcpf.state.co.us/HCPF/disease2-04report4-7.doc>.

FirstHelp

HCPF offers a 24-hour nurse hotline – FirstHelp – for Medicaid beneficiaries receiving care on a fee for service basis or through the Primary Care Physician program. The nurse hotline assists beneficiaries in assessing medical conditions and determining the most appropriate care and setting for care, thus reducing unnecessary emergency room and physician office visits.

Medicaid Cost Saving Measures

Beneficiary Cost Sharing

Historically federal regulations permitted States to impose cost sharing on Medicaid beneficiaries but included tight parameters for doing so. Enrollment fees and premiums, for example, could not be assessed for population groups considered “categorically needy” and service-based copayment amounts had to be “nominal” and based on the cost of the service. Generally copayments could be no greater than \$3. Higher rates required special approval by CMS, often in conjunction with Section 1115 waivers. In addition, the regulations have precluded states from collecting copayments for family planning services and products, for services rendered to children under age 19 and for services rendered to persons residing in nursing facilities.³⁸ Gradually states were able to receive approval for higher rates related to inpatient hospital admissions and for non-emergency use of hospital emergency rooms.

The DRA of 2005 added new provisions to federal Medicaid law related to cost sharing. It requires CMS to increase the standards for “nominal” cost sharing annually for inflation and gives states the option to increase cost sharing requirements and to impose them on additional population groups. The Tax Relief and Health Care Act (TRHCA) of 2006 further clarified (though some may believe it further confused) the rules related to cost sharing. Cost sharing may now be required for services rendered to children, if those children are living in families with income above specified thresholds, and for otherwise exempt children for non-emergency services in a hospital emergency room if the child has access to an alternative provider. Adults with income below poverty may only be charged nominal cost sharing amounts but those with higher income may be charged higher amounts. States that impose higher cost sharing requirements must assure that such payments do not exceed five percent of family income.

Colorado’s copayment requirements are nominal, including \$2 per visit for physician, clinic or optometrist services; 50 cents for each 15-minute psychiatric service whether rendered by a physician or a psychologist; \$1 per date of service for

³⁸ Many states, but not Colorado, exempt children up to age 21 from copayment requirements.

laboratory tests, x-rays or durable medical equipment and supplies; prescription drug copayments of \$1 for generic or multiple source products and \$3 for brand or single source products; \$3 per visit for outpatient hospital services; and \$10 for each day of an inpatient hospital stay up to one-half the payment rate for the first day of care.

Research has shown that higher cost sharing requirements are likely to cause low-income people to forego necessary healthcare services such as primary care and prescription drugs and result in their use of more expensive forms of care in an inpatient or outpatient hospital setting.³⁹ However, Colorado's cost sharing requirements are lower than in many states and applicable to far fewer services.⁴⁰ Consideration should be given to the cost sharing flexibilities provided through recent changes in federal law.

Prescription Drugs

Governor Ritter issued an Executive Order in January 2007 requiring HCPF to establish a preferred drug list (PDL) for the Medicaid program and to evaluate various methods by which the PDL should be implemented and maintained. The EO also requires the department to obtain supplemental rebates from drug manufacturers and to evaluate the feasibility and cost effectiveness of entering into one of the existing multi-state drug purchasing pools. Savings of \$1.6 million per year were projected. It is understood that HCPF intends to establish the Pharmacy and Therapeutics Committee required in federal law, seek public input into the development of this policy change, and implement the changes by January 2008. There are several PDL policy models around the country that may be evaluated and there are multiple state drug purchasing pools from which to choose.

Utilization Review

Colorado has used the same Quality Improvement Organization (QIO) for its utilization review activities for more than three decades. The Colorado Foundation for Medical Care (CFMC) is also the federally designated QIO for Medicare in Colorado. CFMC is responsible for reviewing Medicaid prior authorization requests for HCPF, including certain surgical procedures, out of state elective hospitalizations, specified durable medical equipment and other medical devices, physical and occupational therapy and home health care for children.

The HCPF has had a Medicaid retrospective drug utilization review (DUR) program in place for many years. The department contracts with Health Information Designs, Inc. (HID) to review drug claims for purposes of identifying clinically significant

³⁹ Leighton Ku and Victoria Wachino, "The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings," Center on Budget and Policy Priorities, July 7, 2005.

⁴⁰ Kaiser Family Foundation, Medicaid Benefits: Online Database, available at: www.kff.org/medicaidbenefits.

potential drug therapy problems and also has a collaborative relationship with the University of Colorado at Boulder's Leeds School of Business. A Medicaid DUR Board meets quarterly.

On June 1, 2006, HCPF initiated a two-year pilot project with Comprehensive NeuroScience (CNS) called the Behavioral Pharmacy Educational Program. This program will provide clinical data analysis to HCPF and to prescribers of behavioral health drugs. Educational mailings and consultations are provided to outlier prescribers.

In April 2007, HCPF announced the initiation of a DRG Education and Review Project for all hospitals participating in the Medicaid program, to encourage correct coding and billing practices and to minimize future overpayment situations. A contingency fee contract has been signed with Health Management Systems (HMS) and their subcontractor Permedion. Medicaid DRG claims for the past six years may be examined with medical records reviewed by the contractor as necessary. HCPF will seek recoveries in those instances where the contractor has identified an overpayment and providers will have formal appeal rights.

SCHIP Eligibility Policies

Colorado operates a separate SCHIP program called Child Health Plan Plus (CHP+), alternatively called the Children's Basic Health Plan. Under this program, children under age 19 living in families with income up to 200 percent of the FPL, who don't qualify for coverage by private insurance or by Medicaid, may receive healthcare benefits. An annual premium is required, up to \$35 for a family with more than one child enrolled, and copayments are required for office visits (\$5) and hospital emergency room visits (\$15).

The state has received federal Section 1115 HIFA waiver approval to extend CHP+ benefits to the unborn through provision of prenatal care to pregnant women. The upper limit on income is the same, 200 percent of the FPL, as for children.

SCHIP Benefits

The benefit package for Colorado's CHP+ program mirrors employer-sponsored insurance plans and includes physician services, hospitalization, prescription drugs, dental care and behavioral health services. Pregnant women also receive necessary pregnancy care. CHP+ services are provided through contracted managed care organizations.

Special Programs

There are several healthcare programs through which low-income beneficiaries receive healthcare services in Colorado in addition to Medicaid and CHP+. Brief mention of these programs is warranted.

- The Colorado Indigent Care Program (CICP) – also known as the Medically Indigent (MI) Program – provides a financial vehicle for specified hospital and clinic providers treating indigent patients of any age (with income at or below 185 percent of the FPL) to recoup their medical costs at a discount. These providers (49 hospitals, 18 clinics and 51 satellite facilities) prioritize services rendered – emergency care must be provided, urgent care is provided for conditions posing the most serious threat to health, and then any other care.
- The Comprehensive Primary and Preventive Care Grant Program, also called the Primary Care Fund, was established by state statute a number of years ago to expand primary care and preventive health services to Colorado’s low-income (family income at or below 200 percent of the FPL) uninsured population. The program is funded through tobacco litigation settlement monies. Grants are made to qualified providers of comprehensive primary care services with a “demonstrated track record of providing cost-effective care.”⁴¹ Eight healthcare entities qualified for a combined \$1.7 million for SFY 2007.⁴²
- The Old Age Pension (OAP) Health and Medical Care Program is state-funded and provides a limited benefit to low-income qualified persons. The program requires copayments for the same services and at the same rate as Medicaid; however beneficiaries need not pay more than \$300 per year. Some OAP enrollees receive additional (wrap-around) services through the CICP.
- The State-Only Prenatal Program is a state-funded program of prenatal care for pregnant women who are legal permanent resident immigrants entering the country after August 22, 1996. The group falls under the five-year ban for full Medicaid eligibility. Pregnant immigrant women meeting the “Baby Care Kids Care” income guidelines (income at or below 133 percent of the FPL) receive prenatal care and Emergency-only Medicaid benefits for labor and delivery.
- Colorado Cares Rx was signed into law in February 2007 and is expected to provide as many as 264,000 low-income Coloradans with access to medically necessary drugs at discounted prices. The new law requires HCPF to negotiate lower prices with generic drug manufacturers. The program will be open to uninsured residents with income below 300 percent of the FPL upon payment of a one-time registration fee of \$20.

⁴¹ *Comprehensive Primary and Preventive Care Grant Program*. Colorado statutes, 26-4-1001, et seq. Available at: <http://www.chcpf.state.co.us/HCPF/cppc/CPPCEnablingLegislation.asp>.

⁴² Memorandum from Stephen C. Tool, July 12, 2006. Available at: <http://www.chcpf.state.co.us/HCPF/cppc/FY06-07%20awardees%20announcement%20memo%20071206.doc>.

- CoverColorado was created by the state legislature in 1990 as a safety net for middle-income adults and for children with chronic conditions. The plan covers more than 5,000 persons who have been denied health insurance in the private market and receives federal funding assistance. Premiums vary between 200 and 250 percent of the standard market premium.

Special Initiatives

Commission for Health Care Reform

Passed in 2006, Senate Bill 208 created the Colorado Blue Ribbon Commission for Health Care Reform. The commission is comprised of 27 healthcare providers, consumers and business representatives charged with choosing three to five proposals for comprehensive healthcare reform. Through a procurement process initiated in early 2007, an independent consulting firm (The Lewin Group) was chosen to conduct technical assessments of submitted proposals. Four proposals were initially identified for further evaluation. Each proposed change that would extend healthcare benefits to more Colorado citizens, either through coverage expansions under public programs such as Medicaid or SCHIP or through private insurance with premium assistance for those with low income. More recently, the Commission developed a fifth proposal, a hybrid of the others, and submitted it to Lewin for analysis. Funding for the chosen proposal could be through monies from Referendum C and Amendment 35, through a redirection of DSH funds, through taxes on healthcare providers, through cost sharing by those receiving the benefits or through a combination of these options or others. Hearings will be held across the state and the commission's recommendations are expected by November 2007.

GEM Performance Review

Governor Ritter recently announced implementation of a Government Efficiency and Management (GEM) performance review, intended to examine how state government can more efficiently and cost effectively deliver services. In his press release, issued May 2, 2007, he stated, "GEM is about improving quality, streamlining services and eliminating redundant programs. It's about finding new, innovative and smarter ways of delivering essential service so that we are more efficient and effective in how we manage state government."⁴³ Public policy experts at Public Works LLC will lead the review with the assistance of a team of 20 state employees. The group's recommendations are due by the end of February 2008.

⁴³ Retrieved from Governor Bill Ritter's web site at:
<http://www.colorado.gov/governor/press/may07/government-efficiency-management.html>.

Colorado Family Care

In 2005, HCPF developed a Section 1115 HIFA waiver application that included eligibility expansions, benefit enhancements and purchasing reforms for low-income non-disabled children, pregnant women and families eligible for Medicaid or CHP+. The goal of the proposed program, called Colorado Family Care, was to reduce the number of low-income uninsured individuals in the state while building on the successes of CHP+. The program would have been funded, in part, with unspent federal SCHIP funds allocated to Colorado. After several public hearings, the Colorado General Assembly decided not to approve the initiative. Fortunately, some of the expansions included in the Family Care proposal were subsequently implemented through other measures. Unfortunately, there are no longer unspent SCHIP funds available to resurrect the other aspects of the proposal.

Medicaid and SCHIP Program Administration in Colorado

Department of Health Care Policy and Financing

The single state agency responsible for administering the Colorado Medicaid program is the Department of Health Care Policy and Financing (HCPF), headed by Executive Director Joan Henneberry, appointed to her position in early 2007 by Governor Ritter. The Medical Assistance Office within the department had been under the direction of Barbara Prehmus for some time, however just recently she was appointed to a position in charge of HCPF's new long-term care initiative. A new Medicaid director has not yet been appointed.

Ms. Henneberry's department is also responsible for administering the Child Health Plan Plus (CHP+)/Children's Basic Health Plan. In addition, HCPF administers the Colorado Indigent Care Program (CICP), which distributes federal and state funds to partially reimburse qualified healthcare providers for uncompensated costs associated with services rendered to the indigent population, and the Old Age Pension (OAP) Health and Medical Care Program, a state-funded program for beneficiaries meeting specified criteria and ineligible for Medicaid.

Department of Human Services

A separate state agency has responsibility for Medicaid eligibility determination. The Executive Director of the Department of Human Services (DHS) is Karen Beye, also appointed to her position in early 2007 by Governor Ritter. Her agency oversees the state's 64 county departments of social/human services where Medicaid applications are taken. Ms. Beye is also responsible for the state's public mental health system and its system of services for people with developmental disabilities, the state's juvenile corrections system, and all state and veterans' nursing homes.