



State of Colorado  
Department of  
Health Care Policy  
and Financing  
2009 Annual Report



Colorado Department of Health Care Policy and Financing  
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# Letter from the Executive Director

Much has happened since our first annual report published this time last year, which covered calendar years 2007 and 2008. The accomplishments reflected in this 2009 report are credited primarily to the ongoing work and commitment of the Department of Health Care Policy and Financing employees who serve the public with dedication and who strive to improve health and health care in Colorado. But we would not have been successful without the support of the Governor and his senior staff, the Legislature, county partners, stakeholders, providers, private sector partners and our clients. We have advanced the progress toward achieving our mission by expanding coverage in public health insurance programs, establishing innovative policies to improve service delivery, simplifying access to care and by moving toward a model of care coordination that improves outcomes and reduces per capita costs in the health care system.

We write this report as the country works through the worst economic crisis since the Great Depression. Health care programs have been impacted in a most dramatic way, with Medicaid enrollment at the highest it has been in the history of Medicaid in Colorado. As people lose jobs and their employer-based coverage, or they are unable to pay for dependent coverage, they turn to public programs for help—albeit temporarily—and are asking for this help for the first time in their lives.

Most of the caseload growth here in Colorado has been the enrollment of children. The growth has put extraordinary pressure on the state budget in the current fiscal year and will continue to for at least two more years. The Department has had to modify and reduce the budget four times in the past 12 months to manage to the revenue challenges. We will continue to focus on managing benefits and utilization of services, aggressive detection of waste, fraud and abuse, and recovery and rebate efforts and work with providers to get more value for the dollar.

This year, 2010, will bring new challenges as well. Project teams are moving forward on the implementation of the Colorado Health Care Affordability Act, enabling us to provide coverage to another 100,000 individuals without using General Fund revenue. As we speak, staff and stakeholders are discussing the program design, benefits and new outreach strategies that will be needed to identify and educate these newly eligible populations. We were successful in bringing in over \$50 million in federal and foundation grants that will help us get our work done, again without General Fund revenue.

While we await decisions and direction from Washington on what national reform will look like, our work has not slowed down at all. In fact, if we don't see new policy from Washington this year, the pressure on states to find customized solutions for covering the uninsured will only mount, and challenge us to be even more creative and collaborative.

All of us who work in health policy, in the service delivery system, or who have advocated for health reform in Colorado can be proud of where we are today. The foundation for improving health and health care is strong, and designed to handle more growth and change in the next few years. As Winston Churchill said, "A pessimist sees the difficulty in every opportunity; an optimist sees the opportunity in every difficulty." We look forward to working with all of you through these difficulties and opportunities.



Joan Henneberry  
Executive Director



**"COLORADO IS ONE OF THE**  
states best positioned to move  
forward with health care delivery  
system reforms and coverage  
expansion necessary to both  
increase access to care and help  
bend the cost curve."—*Len  
Nichols, PhD., New America  
Foundation*

## Introduction

Colorado Medicaid enrollment is at its highest since the inception of the program in 1969—41 years ago. As of December 31, 2009, 485,000 Coloradans were receiving Medicaid benefits and 70,000 children and pregnant women were covered by Child Health Plan *Plus*. Colorado has been nationally recognized for its innovation and tenacity for the progress we have made in keeping up with the increased demand.

In 2009, the Colorado legislature passed the most significant health care reform measure in the last 40 years—the Colorado Health Care Affordability Act.

Implementation of the Colorado Health Care Affordability Act will provide health care coverage for more than 100,000 additional Coloradans; secure increased and sustainable funding for expanding access; improve the quality of health care for clients served by public programs; and reduce cost-shifting to private payers.

This report highlights the progress the Department has made in reforming Colorado health care from January 2007 to December 2009.

# Department Mission, Goals and Principles

The mission of the Department of Health Care Policy and Financing, the Department, is to improve access to cost-effective, quality health care services for Coloradans. The goals are to:

- ▶ Increase the Number of Insured Coloradans.
- ▶ Improve Health Outcomes.
- ▶ Increase Access to Health Care.
- ▶ Contain Health Care Costs.

The principles used by all Department leaders and employees that guide decision-making and policy development include:

- ▶ Empower clients to make good health care choices incorporating prevention and early intervention.
- ▶ Purchase and manage medically necessary and appropriate services to achieve value for the clients and the public.
- ▶ Treat providers, clients, advocacy groups, counties and other units of government as partners.
- ▶ Provide honest and complete information to the public and to each other.
- ▶ Focus on the Colorado Promise with accountability and efficiency.
- ▶ Assess, evaluate and continuously improve the quality of our work.

## FEDERAL OVERSIGHT

The Department is federally regulated by the Centers for Medicare and Medicaid Services, or [CMS](#). The Department is the federally designated Single State Agency to receive Medicaid (Title XIX) funding from the federal government and also receives State Children's Health Insurance Program (Title XXI) funding from the federal government for Colorado's Child Health Plan *Plus*, or CHP+. The [Medicaid State Plan](#) and the [Child Health Plan \*Plus\* State Plan](#) are the agreements with CMS as to what services are provided.

# Increase the Number of Insured Coloradans

IN FY 2009-10, \$80 MILLION of new money will be available to Colorado hospitals through provider fees and the federal match.

## COLORADO HEALTH CARE AFFORDABILITY ACT

[The Health Care Affordability Act](#), HB 09-1293, sponsored by Representatives Riesberg and Ferrandino and Senators Keller and Boyd, will cover more than 100,000 uninsured Coloradans and generate approximately \$600 million state funds and \$600 million federal funds for a total of \$1.2 billion annually when fully implemented. All expansions are dependent upon waiver approval by CMS, which is expected by April 2010.

[Medicaid](#) and [Child Health Plan Plus](#), or CHP+, eligibility expansions will be implemented through an amendment to Colorado's Medicaid and CHP+ State Plans. Medical benefits for low-income adults without dependent children will be implemented through a demonstration waiver under Section 1115 of Title XIX of the Social Security Act.

### Timeline

Spring 2010 – [Medicaid eligibility for parents](#) from 60% to 100% of the federal poverty level (FPL) and CHP+ eligibility for children and pregnant women to 250% FPL.

Summer 2011 – [Medicaid buy-in programs](#) for people with disabilities up to 450% of the FPL.

Early 2012 – Medical benefits for [adults without dependent children](#) up to 100% of the FPL.

Spring 2012 – [Continuous Medicaid eligibility](#) of 12 months for children.

### Increase Funding for Hospitals

- Medicaid hospital inpatient rates up to 100% of Medicare rates.
- Medicaid hospital outpatient rates up to 100% of costs.
- Colorado Indigent Care Program, or [CICP](#), hospital rates up to 100% of costs.

## Improve Quality of Health Care

The HQIP is the Colorado Health Care Affordability Act Hospital Quality Incentive Payment committee. The goal of HQIP is to incent hospitals serving clients on Medicaid for delivering high-quality care that yields positive health outcomes. The Department is working with community partners to develop measures specific to the unique needs of the population served by publicly funded health care programs while aligning with the Department's goals of increasing access to health care, improving health outcomes and containing health care costs.

## Reduce Cost-Shifting

The implementation of the Act will reduce the need for hospital providers to shift uncompensated care costs to private payers in the following ways:

- Higher rates for public insurance clients: By raising the rates paid to hospital providers the need to shift costs is reduced. The hospital provider fee increases rates paid for inpatient and outpatient care for Medicaid clients as well as rates paid for the CACP.
- Reducing the number of uninsured: Fewer uninsured Coloradans leads to lower uncompensated costs by creating a funding source for these clients. In the first year, the hospital provider fee will increase eligibility for parents of Medicaid covered children and children and pregnant women in CHP+.
- Measurement of cost-to-payment ratio by payer: The [Hospital Provider Fee Oversight and Advisory Board](#) authorized a workgroup to determine what data will be collected by hospitals to fulfill the legislative requirement to report the differences between costs and payments for Medicare, Medicaid and private insurance. This workgroup is to convene in spring 2010 and complete its work in time for data to be collected for the January 2011 Oversight and Advisory Board annual report.

## CO-CHAMP

In September 2009, Colorado was awarded a \$43 million, five-year, competitive federal grant to support health care expansion efforts. The federal Health Resources and Services Administration, or HRSA, awarded \$70.9 million in grants to 13 states under the State Health Access Program, or SHAP. The [HRSA SHAP](#) grant is a new federal opportunity to support state efforts to significantly increase health care coverage as part of a plan for comprehensive health care reform.

The Colorado Comprehensive Health Access Modernization Program, or [CO-CHAMP](#), includes a variety of projects. Several CO-CHAMP projects are linked to the implementation of the Health Care Affordability Act.



**"EXPANDING THE NUMBER** of children in Colorado who now have access to health care coverage has given us the ability to provide more comprehensive care ensuring the long-term health of our kids. This type of investment in the health and well-being of our children is an investment in the long-term success of Colorado. The expansion of CHP+ allows us to treat kids beyond the emergency room and gives kids crucial access to primary and specialty care."—Jim Shmerling, CEO, The Children's Hospital





**OVER 90 PERCENT OF LOW-** income parents say they would enroll their uninsured child if he or she was eligible; but around half do not know that their child is eligible, do not know how to apply, or find the application processes difficult.—*Urban Institute November 2009 report*

CO-CHAMP will support the following activities:

- **Maximizing Outreach, Retention and Enrollment, or MORE:** Activities in Year 1 include an outreach needs assessment and the distribution of MORE grants to community-based organizations to conduct outreach.
- **Eligibility Modernization: Streamlining the Application Process:** The Department plans to create interfaces with other state and federal databases to electronically verify required client documentation. Year 1 projects include creating interfaces with the Vital Statistics and the Income and Eligibility Verification System.
- **Benefit and Program Design:** Potential program designs will be developed for the adults without dependent children and the Medicaid buy-in program for people with disabilities.
- **Premium Assistance Project:** Through federal authority, public health insurance programs for children can help eligible persons pay the premiums required to enroll in any private health insurance that is available to them. The Department will expand its pilot premium assistance program, CHP+ at Work, statewide.

**Three-Share Community Projects:** A three-share health coverage plan is a basic plan that brings together employers, workers without coverage and outside funding to create a coverage plan for those workers who have no other access to health insurance.

- **HRSA SHAP grant funds will support two, three-share community projects:**

**Pueblo Health Access Program, or HAP:** HAP is a community-based non-profit organization created to provide high quality and affordable health care coverage for the uninsured who work for employers based in Pueblo County. Funds will be used to increase participation in HAP through the development of a strategic marketing plan.

**San Luis Valley Health Access Program:** The goal of the San Luis Valley Health Access Program is to provide a health coverage program aimed at the working uninsured in employer groups where the median hourly wage is \$15 per hour or less and the employer group does not provide health insurance. Grant funding will be used to initially fund the community share in this pilot program.

- **Evidence-Based Benefit Design Project:** The Department will develop an evidence-based design tool that could be offered to a targeted population of uninsured Coloradans through a pilot program.



## COLORADO PEAK

Colorado continues to improve the eligibility determination process. [Colorado PEAK](#) is a web-based portal designed to provide clients and community partners with a modern and easily accessible tool to apply for public assistance benefits. It puts control of benefits and the application process back in the hands of the client.

The implementation of PEAK Phase 1 allows individuals to determine if they are potentially eligible for food stamps, cash assistance, Medicaid or CHP+ through the “Am I Eligible” function from any location that has an Internet connection. The PEAK Web site walks a potential client through a process and then provides useful information about their eligibility and how to apply. The PEAK “Check My Benefits” function allows existing clients the ability to check on benefits.

PEAK Phase 2 will allow individuals to apply for benefits online and is scheduled to be released in spring 2010.

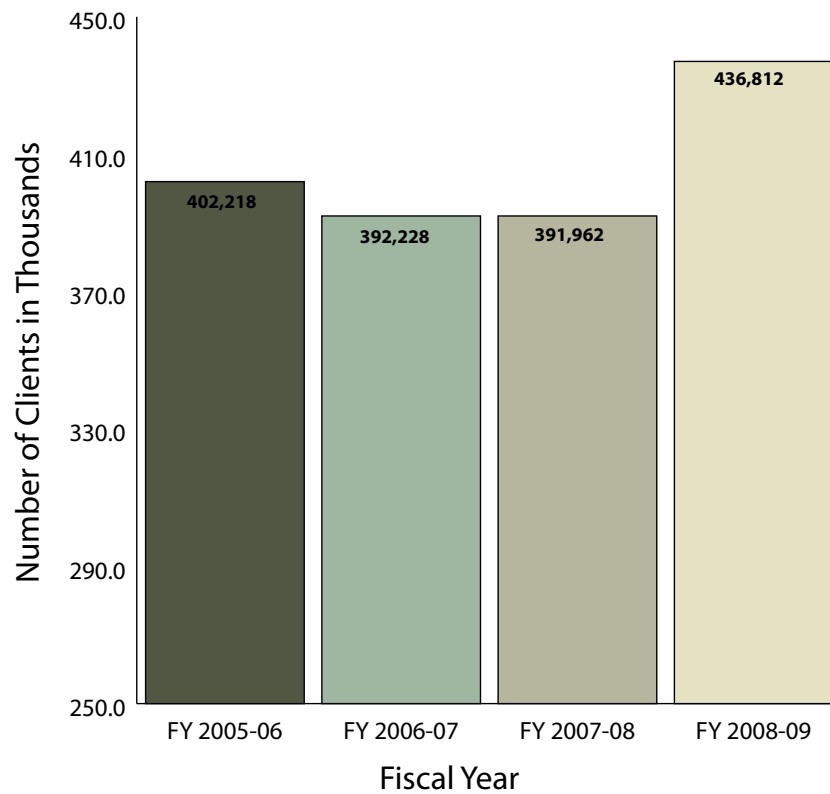
## COMMUNITY OUTREACH EXPANSION

In partnership with the Colorado Trust, the Department has expanded statewide outreach efforts to educate Medicaid and CHP+ clients, providers and Coloradans about the services available through Medicaid, CHP+ and participating providers. The concerted outreach effort introduces new clients and providers to Medicaid and CHP+ and eases the process of enrolling. Outreach is most effective when conducted at the community level and collaboration with the Colorado Trust has made it possible to reach more Coloradans.

Community-based organization staff work to establish and sustain valuable partnerships and provide personal assistance for hundreds of professionals and potentially eligible Coloradans in helping them navigate the application process and educating them on the importance of a Medical Home.

The Department provides technical assistance to organizations engaged in outreach activities through a dedicated outreach specialist.

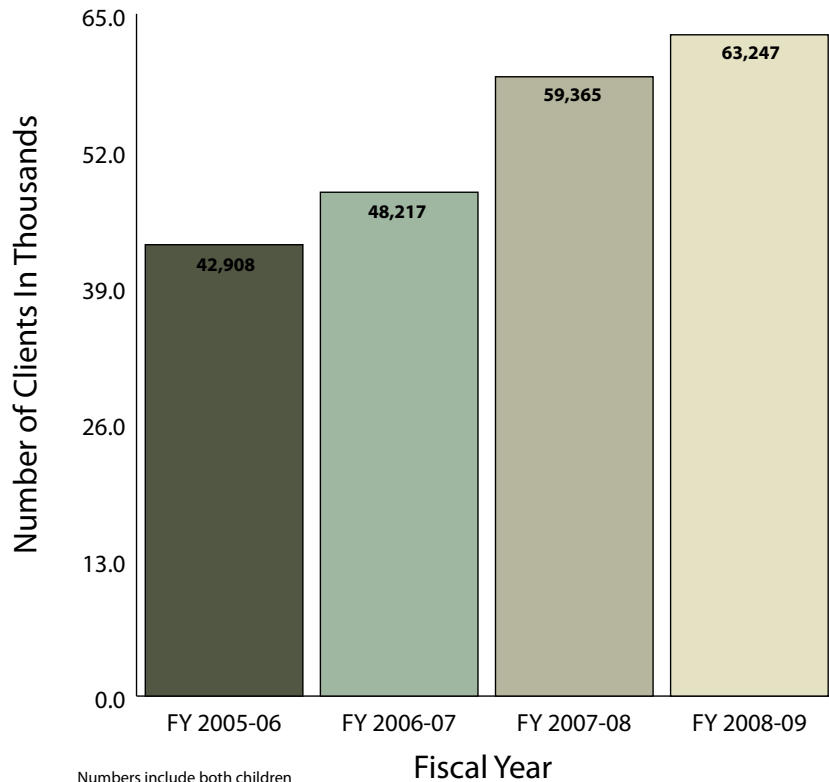
## Medicaid Clients Fiscal Years 2006-2009



Source: FY 2010-11 Department Budget Request, November 6, 2009

The official start of the recession in the U.S. was December 2007. The total Medicaid enrollment for FY 2006-07 was 392,228 and the Department estimates that Medicaid enrollment will total 511,411 in FY 2009-10 (Department of Health Care Policy and Financing, FY 2010-11 Budget Request, November 6, 2009). This represents an enrollment increase of approximately 30 percent over that period of time.

## Child Health Plan *Plus* Clients Fiscal Years 2006-2009

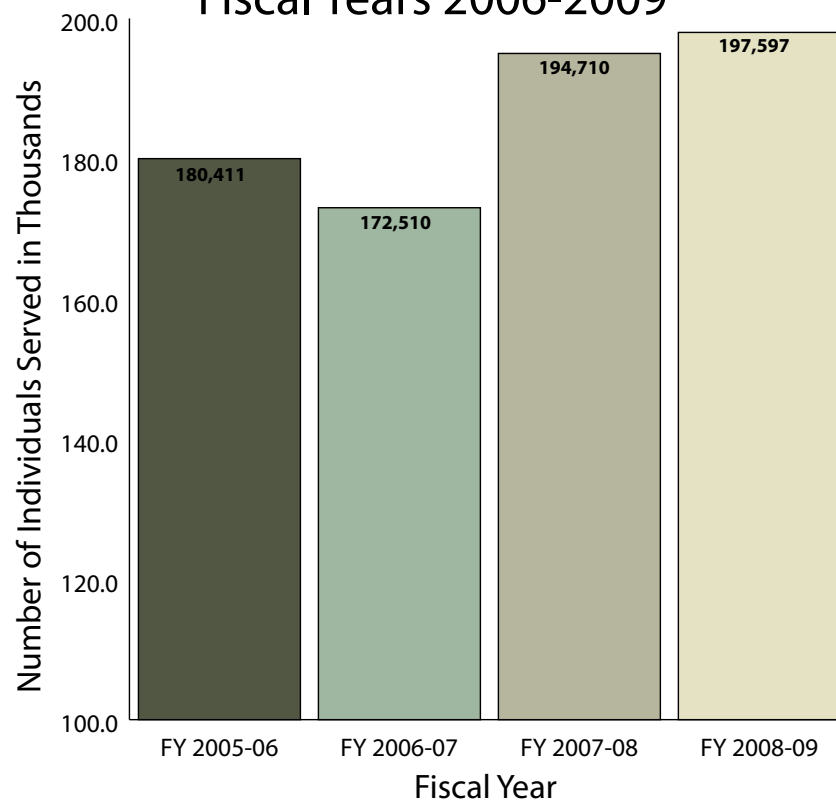


Source: FY 2010-11 Department Budget Request, November 6, 2009

CHP+ enrollment was 48,217 in FY 2006-07 and is estimated to equal 72,159 in FY 2009-10 (Department of Health Care Policy and Financing, FY 2010-11 Budget Request, November 6, 2009). This represents an increase in enrollment of approximately 53 percent over that period of time.



## Colorado Indigent Care Program Number of Individuals Served Fiscal Years 2006-2009



Source: Medically Indigent and Colorado Indigent Care Program Fiscal Year 2008-09 Annual Report

# Improve Health Outcomes

## CIVHC

The [Center for Improving Value in Health Care](#), or CIVHC, was established by Executive Order D 005 08 signed by Governor Ritter in February 2008 as part of the Building Blocks to Health Care Reform Plan. The Center was created to establish an interdisciplinary, multi-stakeholder entity to develop and implement statewide strategic initiatives that will improve the health of Coloradans, contain costs and ensure better value for health care received.

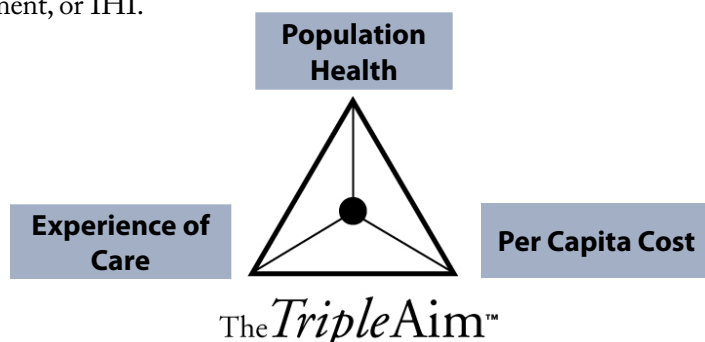
In April of 2009, the Center's board was established. Governor Ritter appointed a diverse group of board members representing health care consumers, physician and hospital providers, businesses, insurance companies, state and federal agencies and health care policy experts. The board has established five-year goals in the areas of cost containment; consumer engagement; health and access; and accountability and transparency.

To achieve these five-year goals, CIVHC is working on a series of interim strategies: creating a statewide All Payer Claims Database; developing quality and cost initiatives aimed at transforming payment and delivery systems; and engaging consumers and businesses in efforts to improve the health of Coloradans while maximizing value and quality of health care received.

CIVHC is using the Triple Aim™ concept with three critical components:

- ▶ Improve population health.
- ▶ Enhance the experience of care.
- ▶ Decrease per capita cost.

The Triple Aim™ concept is an initiative of the Institute for Healthcare Improvement, or IHI.



**"THE ROOT OF THE PROBLEM**  
in health care is that the business models of almost all U.S. health care organizations depend on keeping these three aims separate. Society, on the other hand, needs these three aims optimized simultaneously."  
—Tom Nolan, PhD, IHI



**"WE AT THE ROCKY MOUNTAIN**  
Youth Clinics truly appreciate the efforts of the Department to encourage and support the Medical Home philosophy throughout the state. We also appreciate being 'rewarded' with prompt payments and a functional electronic claims system!" —Larry Wolk, MD MSPH, Founder and Executive Director, The Rocky Mountain Youth Clinics

## ACCOUNTABLE CARE COLLABORATIVE

The [Accountable Care Collaborative](#) is part of the Department's Medicaid reform effort. It is designed to create a regional model of accountability for improving health, functioning and self-sufficiency of all Medicaid clients while controlling costs, reducing unexplained variation in care, improving timely access to care, enhancing client and provider satisfaction and coordinating care across provider settings and social services. The goal of the Accountable Care Collaborative is to improve health outcomes for Medicaid clients through a coordinated, client-centered, outcomes-focused system while supporting providers and protecting safety-net providers.

The Department held public forums over the spring and summer of 2009 and issued a Request for Information in August 2009 to get feedback from stakeholders on the design of the collaborative. Over 80 responses were received and are posted on the [Department's Web site](#).

There will be two Requests for Proposals, or RFPs, posted in 2010—one for the Regional Care Coordination Organizations and the other for the Statewide Data and Analysis entity.

### Pay-for-Performance

The Patient-Centered Medical Homes for adults and Medical Homes for children will continue to be eligible for a pay-for-performance increase. The payments that participating providers in this program receive will not be impacted by the ACC program.

The anticipated start date for the program is November 2010 and will include 60,000 Medicaid clients.

## MEDICAL HOMES

The Department implemented a Medical Home program for low-income children enrolled in Medicaid and CHP+. Certified Medical Homes include safety-net and private providers across the state. A total of 504 providers are qualified to serve as Medical Homes, serving 236,000 publicly insured children.

To be certified as a Medical Home, primary care providers must have 24 hour, 7 day per week access, convenient scheduling and provide care-coordination. After becoming certified by the Department, providers are eligible for pay-for-performance payments based on the timely access of well-child care visits.

A non-profit organization, the Colorado Children's Healthcare Access Program, or [CCHAP](#), was created to provide private practices with support services such as social services, care-coordination, application assistance, cultural competence training and funding for patient transportation.

### Improved Quality and Lower Costs

Seventy-two percent of children in Medical Home practices have had well-child visits, compared with 27 percent of children in the control group based on a preliminary evaluation of the pilot project.

Median annual costs were \$785 per child served through a Medical Home compared with \$1,000 for children in the control group. The cost difference is due to reductions in emergency room visits and hospitalizations. In an evaluation specifically examining children in Denver with chronic conditions, children in a Medical Home had lower median costs—\$2,275—than those not enrolled in a certified medical home practice—\$3,404.

### PACE

The Program of All-Inclusive Care for the Elderly, or **PACE**, is a Medicare and Medicaid managed care system that provides health care and support services to persons 55 years of age and older and who meet nursing facility level of care guidelines. PACE centers assist frail individuals to live in their communities as independently as possible by providing comprehensive services based on their specific needs.

Colorado Medicaid contracts with three PACE programs for a total of eight PACE centers: Total Longterm Care, Volunteers of America PACE and Rocky Mountain PACE. Centers are located in the Denver-Metro area, Colorado Springs, Montrose, Delta County and Pueblo. An additional center will be opening in Pueblo by spring 2010.

Approximately 2,000 clients are being served by a PACE center as of December 2009.

### HEALTH POLICY CHANGES

#### Prenatal Care

Research has shown that prenatal vitamins, specifically folic acid, are essential to the proper development of a growing fetus. Folic acid is most effective during the first 28 days after conception. The Department is encouraging all women of child-bearing age to ask their provider about prescriptions for these vitamins.

In order to positively affect the health of girls, pregnant women and their babies, the Department eliminated the need for a prior authorization to fill prescriptions for prenatal vitamins and folic acid. Pregnant women and women under the age of 18 do not have a copay for prenatal vitamins or folic acid. Women over the age of 18 and who are not pregnant must pay a nominal copay.



**SEVENTY-TWO PERCENT**  
of children receiving care in  
Medical Homes had well-  
child visits compared with 27  
percent of children in a control  
group.



## Smoking Cessation

Studies show that it takes an average of seven attempts to quit smoking and that the health and economic benefits outweigh the cost of medications. Medicaid has increased how often smoking cessation medications may be prescribed to help clients quit smoking. This common-sense policy change results in improved health for clients and decreased Medicaid costs by decreasing hospitalizations and provider visits.

The expanded benefit gives providers the option to prescribe up to two, 90-day drug therapy treatments each year to aid in smoking cessation. This is an increase from one 90-day drug therapy per lifetime.

By providing additional tools for clients to achieve their smoking cessation goals, the probability of success increases significantly. Colorado Medicaid's goal is to improve the health and functioning of our clients in a cost-effective manner. Increasing the pharmacological options for providers to help clients quit smoking supports this goal.

## Nursing Home Pay-For-Performance

To ensure quality of care and the quality of life of residents, the Department adopted a [Pay-for-Performance Program](#) that offers financial incentives to nursing homes to provide higher levels of care. The payment is made to support policies that create a resident-centered and resident-directed model of care in a home-like environment.

The program is designed to be financially appealing to providers, simple to administer, contain easily accessible data to determine compliance and is built around measures that are important to nursing home residents, families and consumers.

The measures are centered on two domains: Quality of Life and Quality of Care.

Quality of Life is measured by the services that are offered supporting residents' personal lifestyles, for example, providing more than two entrée choices for meals; assisting residents in developing their own daily schedules—when to rise, bathe, go to bed; and involving residents in the external community and having the same care givers over time.

Quality of Care is measured by incidences such as the number of falls, the use of restraints, chronic pain and staff stability.

Facilities must apply every year. In the first year of the Pay-for-Performance Program, 84 nursing homes applied and were approved for the rate increase. In the second year, 97 facilities have applied and been approved for the rate increase into the program.



**THE DEPARTMENT ADOPTED**  
a Pay-for-Performance Program  
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to nursing homes to provide  
higher levels of care.

# Increase Access to Health Care

## PRIMARY CARE FUNDS

The [Primary Care Fund](#) provides an allocation of moneys to health care providers that make basic services available in an outpatient setting to Colorado residents who are considered medically indigent.

Since 2007, the Department has awarded \$80 million to health care providers statewide, serving the uninsured through grants from the fund.

- 2007 - Over \$31 million awarded to 32 providers.
- 2008 - Over \$32 million awarded to 29 providers.
- 2009 - Approximately \$17 million awarded to 32 providers.

In FY 2008-09, these providers served 198,069 unique medically indigent clients. Providers have an average case mix of 71 percent Medicaid, CHP+ or medically indigent clients.

## PROVIDER RECRUITMENT AND RETENTION

The Department has made great strides in recruiting and retaining providers. A streamlined application, together with increased provider support and training around billing, has strengthened our partnership with our provider community.

### Application Process

- The provider application is accessible in an electronic format allowing providers to complete it online.
- Department staff is available to assist providers with the application process.

### Provider Training

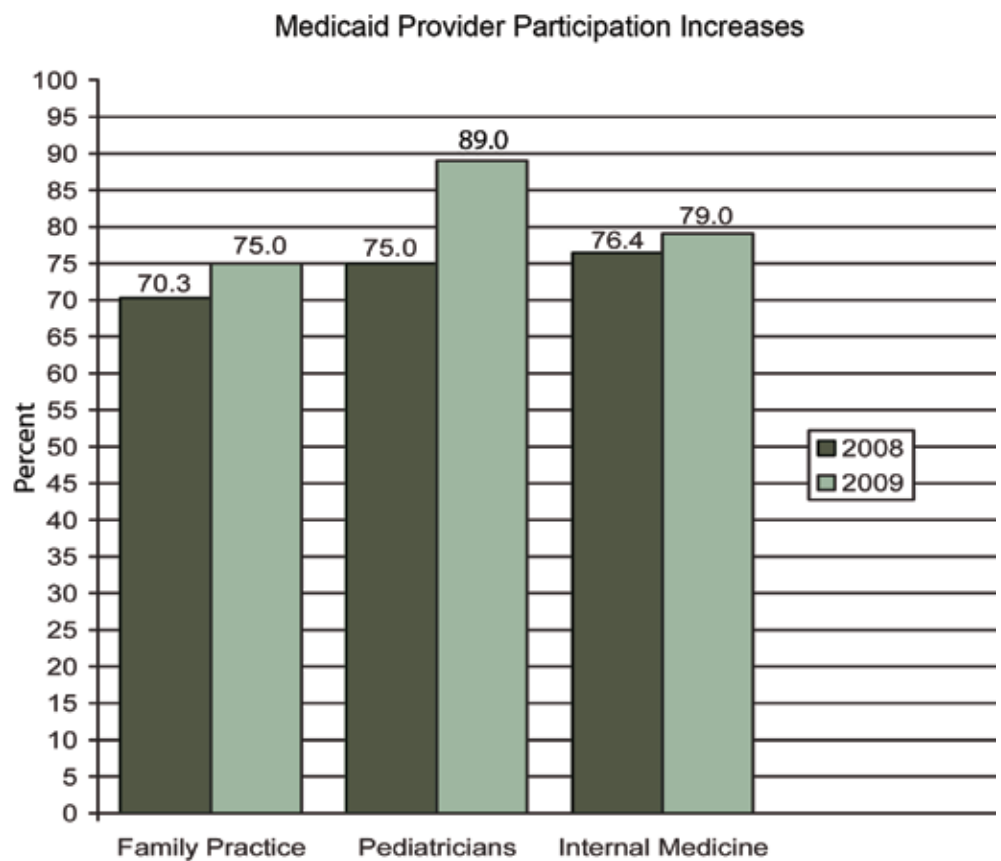
- WebEx training is available increasing statewide access.
- Trainings have been added to the schedule throughout the year.
- One-on-one training is an option for providers who want training tailored to their individual needs.
- Ninety-two training workshops were conducted in 2009.



**"MCPN HAS BEEN INCREDIBLY grateful for being able to expand its services to the uninsured in Colorado through the Primary Care Fund," said Dave Myers, executive director of the Metro Community Provider Network. "Since the first grant award, we have been able to increase the number of people served by 30%. There are a significant number of people receiving health care who would otherwise not have access were it not for the Primary Care Fund."**



**PROVIDER PARTICIPATION**  
rates have increased in spite  
of the economic environment  
due to improved processes and  
recruitment activities.



# Contain Health Care Costs

## FRAUD, WASTE AND ABUSE DETECTION

The Department aggressively safeguards federal and state dollars spent on Colorado Medicaid. The following is a description of the activities involved in recovering dollars owed to the state.

- The Program Integrity Unit monitors providers for appropriate use of federal and state funds. The unit, and Department-managed contractors, conduct post-payment reviews to identify fraud, waste and abuse and to recover overpayments. Suspected fraud is referred to the Medicaid Fraud Control Unit in the Department of Law for criminal investigation and possible prosecution.
- Rebates are collected from drug manufacturers that participate in the Federal Drug Rebate Program.
- Client fraud investigation and recoveries are completed by the counties.
- Nursing facilities are audited by internal staff and overpayments are collected.
- Medicaid can be identified as the beneficiary for trusts in order for the applicant to become eligible for Medicaid. The state collects the remainder of the trust balance, up to the cost of benefits received, upon death of the client or when the client is no longer eligible for Medicaid. Upon the death of a client, the state recovers the cost of benefits from their estate.
- Medicaid is the payer of last resort. The Department conducts a data match of its eligibility files with those of private insurers and Medicare. If there are matches, payments to the providers are recouped, or the recovery is pursued directly from the health insurer or Medicare.
- When an individual causes an accident or harm to someone that requires assistance from Medicaid as a result of a tort, Medicaid pursues a recovery against the responsible party for up to the amount of costs incurred by Medicaid.

### COLORADO MEDICAID

recovered over \$373 million through aggressive recovery and best pricing activities from July 2007 through June 2009.

### BECAUSE OF COLORADO'S

success in collecting recoveries, Colorado has been selected by the federal government to participate in a pilot project to identify provider fraud and improve the efficiency of recoveries.



**OVER 5,000 PATIENTS**  
scheduled primary care  
appointments as a result of  
follow-up phone calls made by  
Peak Vista staff to patients who  
visited the emergency room.

## DECREASING EMERGENCY ROOM UTILIZATION

### Regional Projects

In 2008 the Department received grant funding from CMS to explore ways to improve access to primary medical care so that Medicaid clients could avoid improper use of hospital emergency rooms.

The Department sub-granted these funds—totaling \$1.8 million over two years—to Valley-Wide Health Systems and to Peak Vista Community Health Centers. Valley-Wide operates federally qualified health center clinics across much of southern Colorado. Peak Vista provides federally qualified health center clinic services in Colorado Springs.

In November 2008 Valley-Wide opened a Convenient Care Community Clinic close to the San Luis Valley Regional Medical Center. The clinic offers evening and weekend hours and the availability of walk-in visits. Community acceptance of the clinic has been immediate and sustained averaging over 1,000 visits per month since it opened. Many of the visits are for conditions which would otherwise have been presented in the emergency room less than a mile away. The Medical Center refers clients who do not need emergent care to the clinic. In general, over a third of visits to the clinic are Medicaid clients.

The Department will evaluate the cost-savings and effectiveness of this strategy for reducing unnecessary emergency room visits.

Peak Vista collaborated with Memorial Hospital to station Peak Vista staff in the hospital's emergency room during the busiest hours of the week. After clients have been seen by emergency room personnel, the Peak Vista staff explain the availability of primary health care at the clinic and offer to arrange follow-up appointments. Clients are educated about how primary care improves overall health and reduces the need for emergent care.

Peak Vista staff follow-up with phone calls which have demonstrated success with 90 percent of clinic appointments being kept. In one year, over 5,000 individuals have scheduled primary care appointments as a result of the phone calls. Over 300 children have received immunizations on follow-up visits, most of them returning for additional immunizations required by standards of care. Over 100 people with diabetes have come to the clinic for blood testing in order to improve management of their disease.

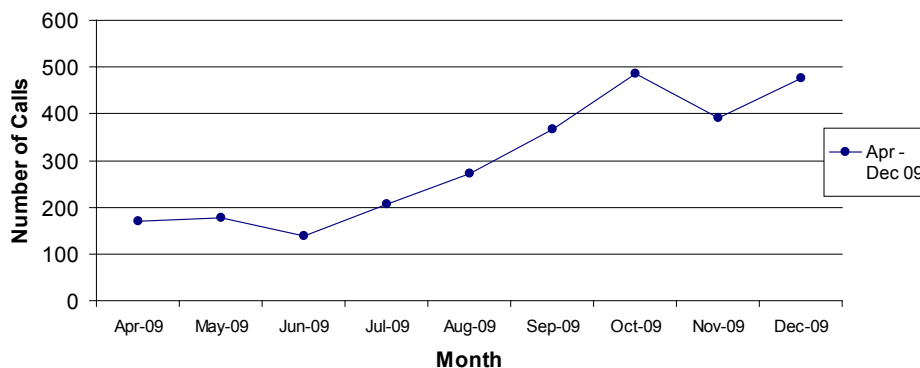
## NURSE ADVICE LINE

A survey conducted in nine hospital emergency rooms determined that approximately 80 percent of respondents said they would talk to a nurse over the telephone about their condition before going to the hospital. The Department contracts with a service staffed by registered nurses 24 hours per day, 7 days per week, to answer questions about health care. Non-emergent emergency room visits are avoided through the availability of the Nurse Advice Line.

### Client Communication

- ▶ The Nurse Advice Line telephone number is listed on the Medicaid client identification cards.
- ▶ Nurse Advice Line wallet cards are included in enrollment packets that are sent to newly enrolled clients in Family Medicaid.
- ▶ Posters have been distributed to federally qualified health centers, in English and Spanish, reminding clients to call the Nurse Advice Line.
- ▶ All client eligibility correspondence includes the Nurse Advice Line telephone number.
- ▶ Letters are sent to clients who have visited an emergency room at least six times in nine months informing clients of the value of calling the Nurse Advice Line.

**Nurse Advice Line Calls**



The number of calls to the Nurse Advice Line increased by almost 300 percent from April 2009 through December 2009.



**THE NUMBER OF CALLS TO**  
the Nurse Advice Line  
increased by almost 300  
percent in nine months.



**OVER 6,000 MIDDLE-INCOME** families purchased affordable, quality long-term care insurance, reducing the need for families to rely on public programs.

## COLORADO LONG-TERM CARE PARTNERSHIP

The Colorado Long-Term Care Partnership policies enable Colorado residents who purchase policies to have more of their assets protected if they later need Medicaid to help pay for their long-term care. The Partnership gives citizens greater control over how they finance their long-term care and help support the public safety-net given the demographic pressures associated with an aging population.

The [Colorado Long-Term Care Partnership](#) is comprised of partners from the Department of Human Services, the Department of Regulatory Agencies, advocates and long-term care insurers.

As of December 2009, over 6,000 Colorado Long-Term Care Partnership policies have been sold.

## COST-CONTAINMENT POLICY CHANGES

- ▶ At the direction of Governor Ritter, Medicaid no longer pays for medical errors. These medical errors are referred to as Never Events. This policy results in improved patient safety and decreased Medicaid costs.
- ▶ In January 2007, Governor Ritter signed an executive order to implement a Preferred Drug List, or PDL, for Medicaid. The PDL promotes clinically appropriate utilization for pharmaceuticals in a cost-effective manner. The PDL saved Medicaid over \$4 million in the first year and \$9.3 million in FY 2008-09. Twenty drug classes are on the PDL.
- ▶ Medicaid has adopted a policy of denying payment for hospital readmissions that occur within 24 hours of discharge for a related condition. This policy encourages better patient support during and after a hospital discharge and saves taxpayers money.
- ▶ In August 2009, Medicaid began requiring all outpatient clinics to obtain prior-authorization for non-emergent CAT scans and non-emergent MRI procedures and for all PET scans.



## BALANCING THE BUDGET

The Department implemented a variety of provider rate policies since the beginning of the fiscal year including targeted rate reductions, strategies for limiting utilization and volume, administrative pricing and billing modifications and across-the-board rate reductions when necessary.

Effective July 1, 2009, a two percent across-the-board reduction in provider rates was necessary. The Department began an unprecedented outreach effort to solicit recommendations from providers, clients, advocates and other stakeholders for targeted initiatives to reduce unnecessary utilization, control volume, increase efficiency and promote cost-effective practices to offset direct provider rate reductions. Dental providers and Durable Medical Equipment providers avoided the across-the-board reduction in July by supporting policy and pricing changes.

The Department was able to exempt preventive health visits from the reduction in July, as well as rates for Home Health certified nurse's aides, personal care services and homemaker services provided through Home and Community-Based Services waivers.

Additional budget shortfall estimates required further reductions. A one-and-a-half percent across-the-board rate reduction for all physical health services and a two-and-a-half percent reduction of Behavioral Health Organizations capitations was required effective September 1, 2009. A further one percent across-the-board reduction was implemented December 1, 2009 in order to meet reduction targets. Encounter reimbursement rates paid to FQHCs, pharmacies and managed care organization capitation rates were reduced.

The Department explored alternatives that would increase efficiencies and generate cost-savings and viewed provider rate cuts as a last resort. Other expenditure-reduction initiatives implemented since July that helped to avoid rate reductions of greater magnitude, included eliminating payment for services resulting from Never Events in hospitals and readmissions within 24 hours of discharge; implementing prior-authorization requirements for non-emergency CAT scans, MRI procedures and PET scans; placing limits on non-medical transportation provided through Home and Community-Based Services; expanding the number of therapeutic drug classes covered by the PDL; reducing the number of benefits that require manual pricing of each individual claim by assigning fee schedule rates for more efficient, automated processing; realigning pricing for codes previously reimbursed at rates above Medicare; suspending some supplemental payments to certain types of hospitals; and modifying provider payment timing for a short period of time at the end of the fiscal year.

Despite the recent reimbursement reductions, the FY 2009-10 rates for all categories of providers remain higher than they were during the last economic downturn in FY 2003-04. Following is a table that outlines the rate increases between FY 2003-04 and FY 2009-10 for select provider categories.



### THE PDL SAVED MEDICAID

\$4 million in the first year and \$9.3 million in FY 2008-09.

## Provider Rate Increases FY 2003-04

Provider Category	Total Rate Increases from FY 2003-04 through FY 2009-10
Inpatient Hospital	5%
Physician	9%
Children's Physician	14%
Federally Qualified Health Centers	6%
Dental	19%
Home and Community-Based Services	11%
Home Health	17%

Source: Department of Health Care Policy and Financing, Budget Division

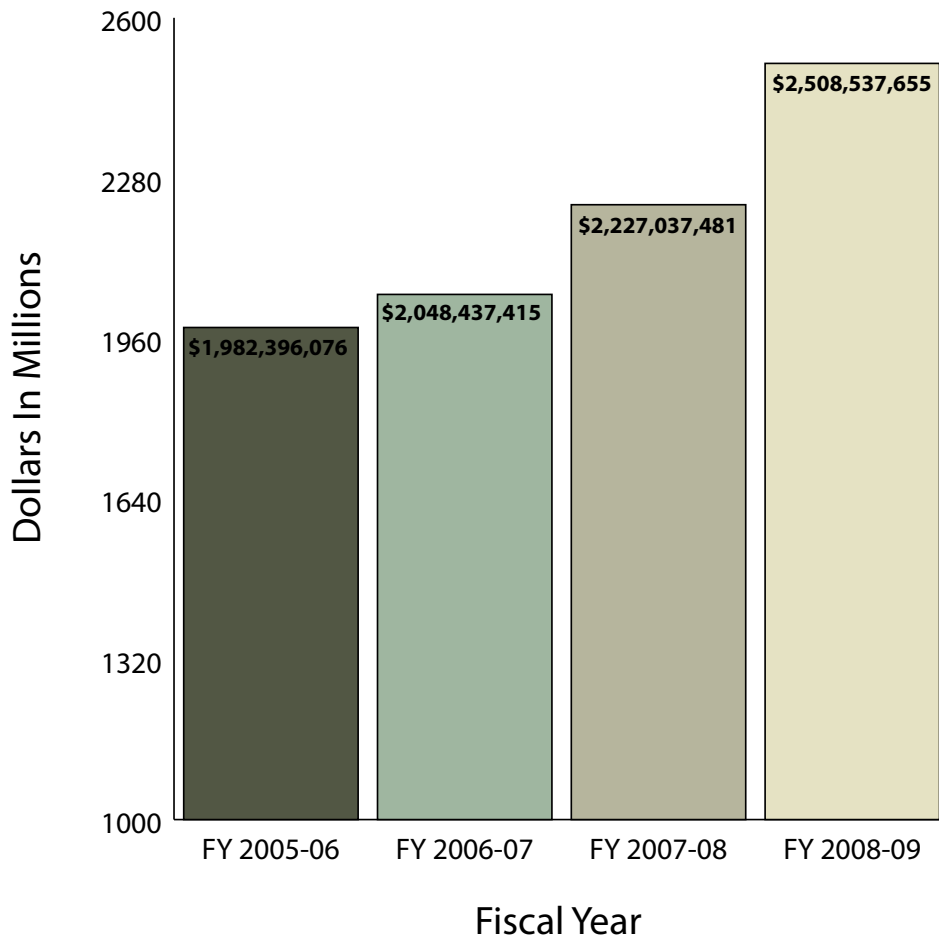
Note: Rate change calculations are based on all providers within a given service category in the state.



### FEWER UNINSURED

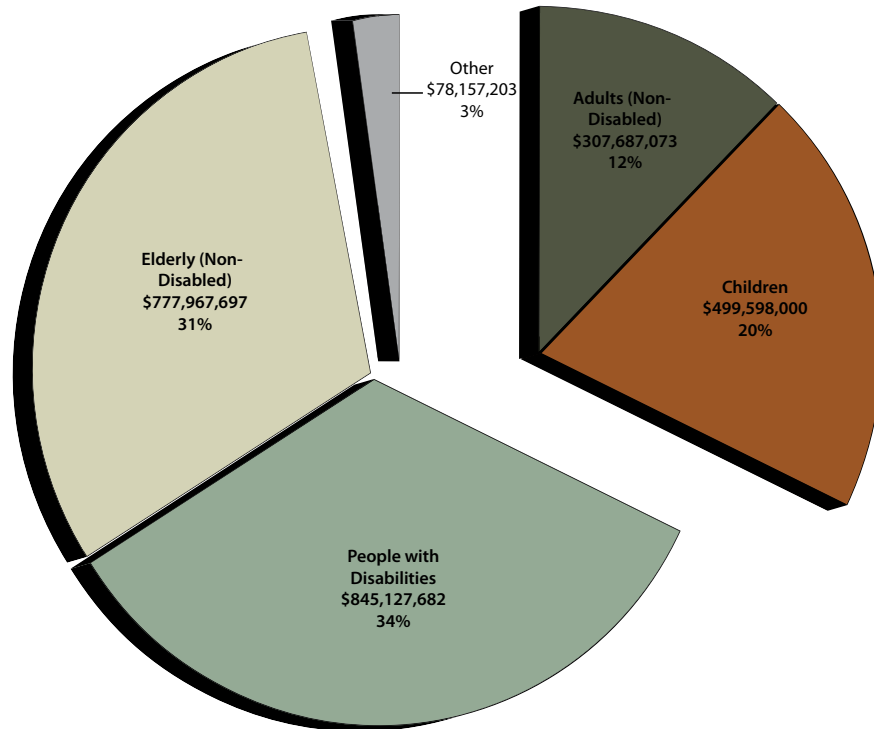
Coloradans leads to lower uncompensated costs by creating a funding source for these clients through the Colorado Health Care Affordability Act. In the first year, the hospital provider fee will increase eligibility for parents of Medicaid covered children and CHP+ children and pregnant women.

## Medicaid Expenditures Fiscal Years 2006-2009



Source: FY 2010-11 Department Budget Request, November 6, 2009

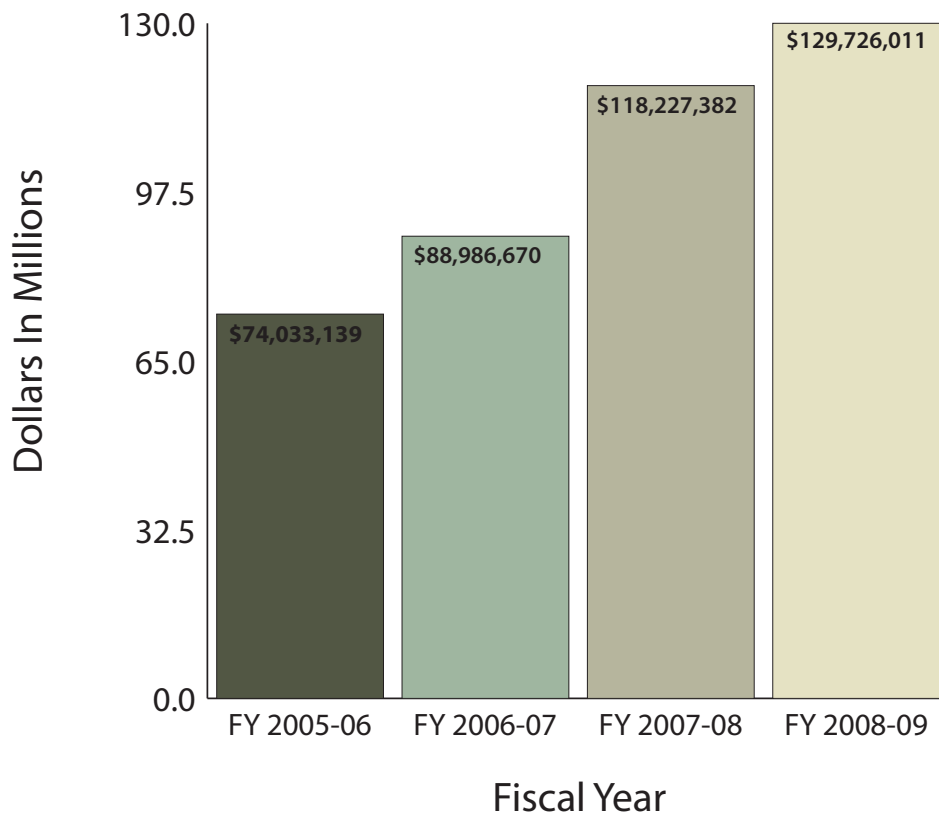
## Medicaid Expenditures Fiscal Year 2008-2009



"Other" includes expenditures for Non-Citizens and partial dual eligibles. Last year Non-Citizens expenditure appeared in the "Adults" category and Partial Dual Expenditures appeared in the "Elderly" categories.

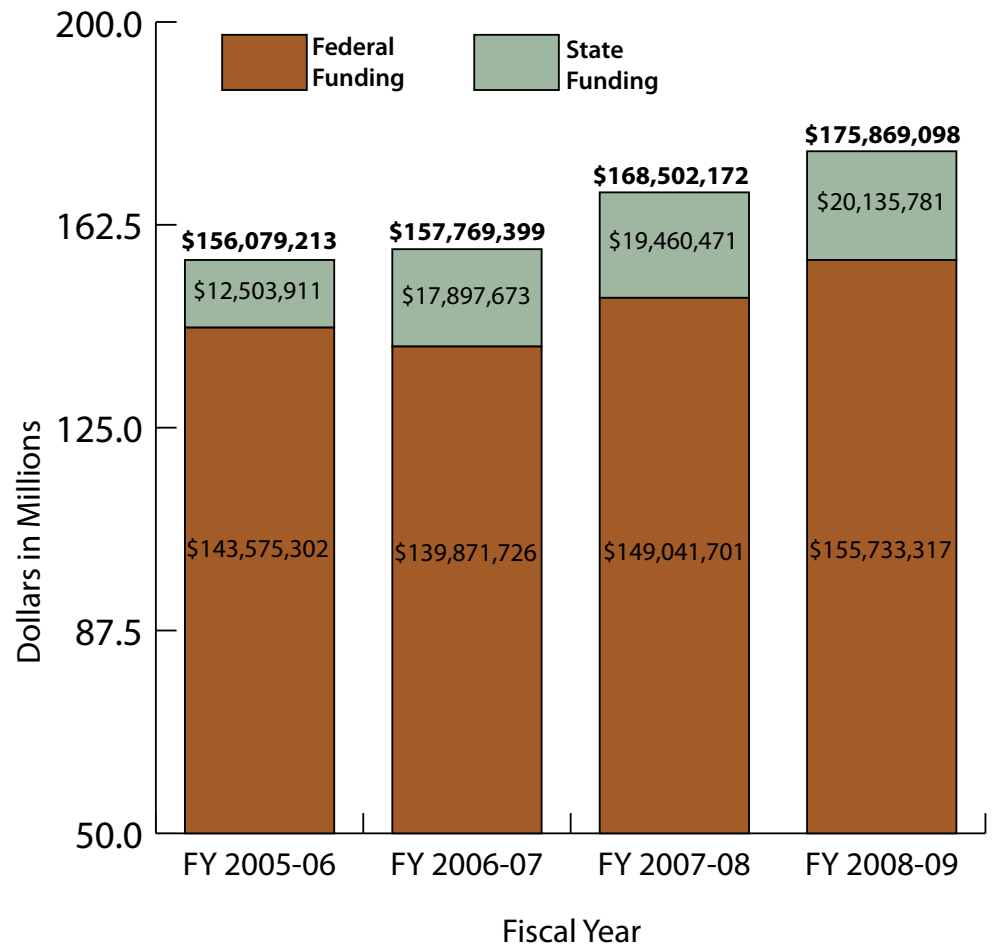
Source: FY 2010-11 Department Budget Request, November 6, 2009

# Child Health Plan *Plus* Total Expenditures Fiscal Years 2006-2009



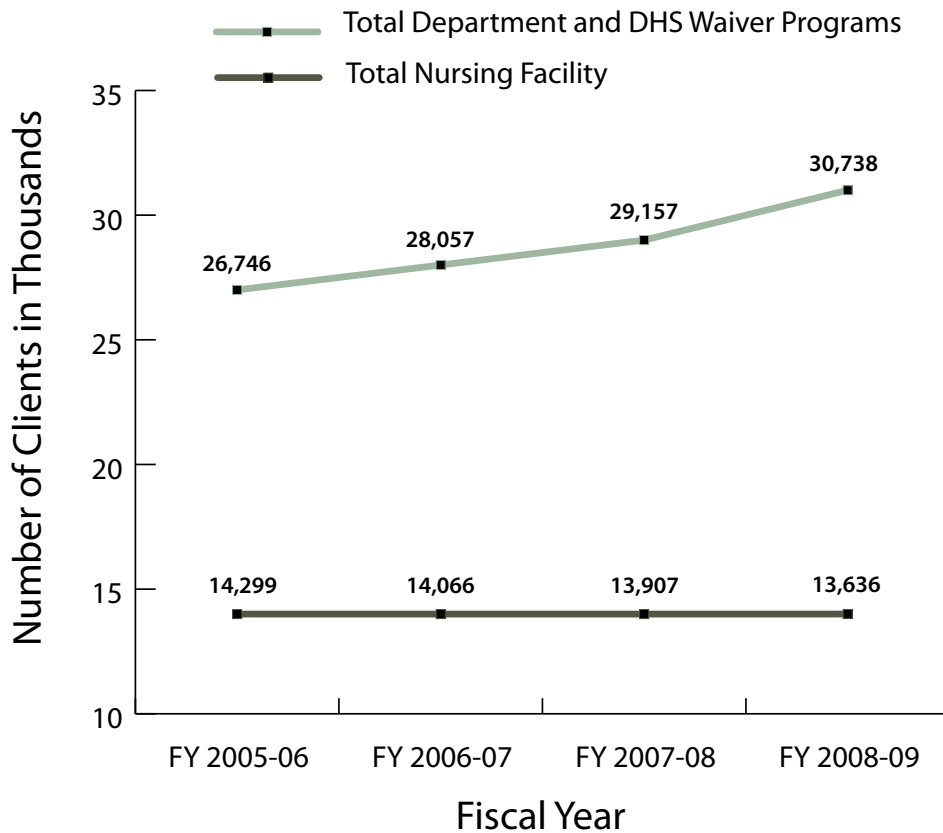
Source: FY 2010-11 Department Budget Request, November 6, 2009

## Colorado Indigent Care Program Hospital Provider Payments Fiscal Years 2006-2009



Source: Medically Indigent and Colorado Indigent Care Program Fiscal Year 2008-09 Annual Report

## Nursing Facility and Home and Community-Based Services Clients Fiscal Years 2006-2009



There are several representations of these figures in the Department Description delivered to the JBC with the 2010-11 budget; the figures on pages B-92 and B-93 have been chosen as the most consistent with past statements.

Source: FY 2010-11 Department Budget Request, November 6, 2009

The Department is committed to supporting clients who desire to be cared for in their home and community near family and friends.

The graph above demonstrates the success of home and community-based programs as the number of clients living in their community continues to rise while the number of nursing home residents has decreased.



# On the Horizon

## WELLNESS INITIATIVES



The Department is developing a long-term strategy to improve the health, functioning and self-sufficiency of clients. The Department has identified areas where it can proactively engage in improving the health of clients: tobacco cessation, obesity prevention, depression identification and management and dental caries reduction. These initiatives represent some of the health indicators most in need of improvement for the Medicaid population. For example, the smoking rate for clients enrolled in Medicaid is almost double that of the general population. Colorado youth lead the country in number of episodes of depression within a year. The obesity rate of low-income children is three times the state's rate for children in higher income groups.

Several prevention and wellness interventions have been identified for implementation over the next few years. Each intervention emphasizes forming a partnership with other state and federal agencies, academic institutions, community-based organizations and health care providers and clients. Examples include:

- Identifying Colorado communities with a high number of public health insurance clients and stratifying by age and health status to appropriately tailor community-based health interventions.
- Partnering with [Baby and Me - Tobacco Free](#), a program that combines smoking cessation support specific to pregnant women with the incentive of free diapers to help motivate the women to stay smoke-free during the first months of the baby's life.
- Promoting 5 Alive!, a collaborative community-wide initiative to provide a supervised wellness program to Colorado 5th graders who have limited access to healthy lifestyle choices for fitness and nutrition.
- Partnering with the Colorado Behavioral Healthcare Council to survey behavioral health providers on their current health promotion activities and interventions; identify improvement areas; and implement and evaluate needed health promotion and wellness interventions.
- Collaborating with the [Colorado Department of Public Health and Environment's Oral Health Unit](#) to recruit and train dental providers.

## Acute Care Utilization Management

The Department is releasing a Utilization Management RFP to address utilization management reform at the state level.

# Medical Services Board

## PROGRAM RULE MAKING AUTHORITY

The [Medical Services Board](#) has the authority to adopt rules that govern the Colorado Medicaid program, the Child Health Plan *Plus* program and the Colorado Indigent Care Program that are in compliance with state and federal regulations. The Board consists of eleven members appointed by the Governor and confirmed by the Senate. Members have knowledge of public health care programs, experience with the delivery of health care and experience or expertise in caring for medically underserved children. The Medical Services Board serves as yet another opportunity for input from the public, assuring that all populations are served appropriately through all public health insurance programs.

## MEDICAL SERVICES BOARD MEMBERS

### FISCAL YEAR 2009-10

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# Department Executive Team

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**Medicaid Director**

**SUE WILLIAMSON**  
**Deputy Director**  
**Client and**  
**Community Relations**

**JOHN BARTHOLOMEW**  
**Deputy Director**  
**Chief Financial Officer**

**LINDY WALLACE**  
**Deputy Director**  
**Project Management**

**PHILIP KALIN**  
**Executive Director**  
**CIVHC**

**JANICE SMUDA**  
**Human Resources Director**

**GINNY BROWN**  
**Legislative Liaison**

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