Colorado Quarterly Report

Title Line One – Colorado Adults without Dependent Children (AwDC) Demonstration

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Demonstration Year: 3 (07/1/2013 – 12/31/2013)
Federal Fiscal Quarter: 1 (10/2013 – 12/2013)

I. Introduction

The Colorado AwDC Medicaid Section 1115 Demonstration (Demonstration) was approved on March 30, 2012. The State of Colorado's Department of Health Care Policy and Financing (the Department) began accepting and processing applications on April 1, 2012. In May 2012, all applicants who had been found eligible and approved for AwDC benefits were enrolled and began receiving benefits effective May 1, 2012.

The Demonstration provides comprehensive health care benefits for up to 21,691 eligible adults. Eligible adults are ages 19 through 64 years who are not pregnant, who do not have a Medicaid-eligible dependent child living in the household, who have family income at or below 10 percent of the Federal Poverty Level (FPL), and who are ineligible for Medicaid State Plan benefits under any other category, the Children's Health Program *Plus* (CHP+) or Medicare. Currently, the State-established income eligibility standard is 10 percent of the FPL; however, the Department has the option to increase the income standard up to 60 percent of the FPL and/or increase enrollment capacity as State funding allows. In the meantime, all individuals who apply and are found eligible for the Demonstration are placed on a waitlist for randomized enrollment as enrollment slots become available.

The Demonstration population receives State Plan benefits through the Department's Accountable Care Collaborative (ACC) program. All Demonstration-enrolled individuals are mandatorily enrolled in the ACC, which consists of seven Regional Care Coordination Organizations (RCCOs) throughout the state. Clients enrolled in the ACC are associated with a RCCO based on their county of residence. The RCCO is designed to assist individuals in coordinating care and improving health outcomes. In addition to coordinated care through the ACC, Demonstration-eligible individuals may also receive mental health services through mandatory enrollment into the Prepaid Insurance Health Plan (PIHP) serving their region of residence. Demonstration-enrolled individuals with co-occurring mental health and substance use disorders may receive treatment for both conditions provided under the PIHP contract.

The Department's goals under the Demonstration are to:

- Provide health care coverage for up to 21,691 previously uninsured Coloradans;
- Ensure that services are effective and coordinated through an accountable care structure;
- Ensure that appropriate services are provided in a cost-effective manner for this population;

- Provide comprehensive coverage for individuals who were previously uninsured and served through the Colorado Indigent Care Program (CICP), a State-only program that provides low-cost health care services to low-income individuals who are not eligible for Medicaid or CHP+; and
- Study trends in beneficiary needs, provider capacity, and care delivery to assist in preparations for the implementation of provisions of the Affordable Care Act in 2014, including the coverage for the group described in section 1902(a)(10)(A)(i)(VIII) for individuals under age 65, regardless of disability status, with income at or below 133 percent of the FPL.

II. Enrollment Information

A. Enrollment Counts

Note: *Enrollment counts should be person counts, not member months*

Demonstration Populations	**Current Enrollees** (as of Dec 2013)	**Disenrolled in Current Quarter**
AwDC	17,092	3,279

The number of current enrollees is the official caseload number of clients. It is a count of anyone who had a final eligibility type of AwDC for at least one day in the last month of the quarter, December 2013.

The number of clients disenrolled in the current quarter indicates the number of clients who were enrolled for at least one day in the last quarter, but were not enrolled at all during the current quarter.

B. Enrollment Cap/Wait List

The enrollment cap for this quarter decreased. As discussed in our approved transition plan, the State's switch to the MAGI eligibility rules engine meant that we could not undertake any AwDC waitlist enrollments in October, November, or December. Instead, we increased the waiver's final enrollment in September to put in additional clients to account for the slots that would open in the final three months of 2013. In other words, we "frontloaded" our September enrollment to account for expected attrition. We created a model of enrollment and attrition to estimate the number of clients we needed to enroll in September to achieve the same number of member months CMS had approved through December 31, 2013.

For the final enrollment in September, we raised the enrollment cap to 21,691. Because we were no longer doing waiver enrollments, our caseload declined in this quarter to 19,168 in October, 17,976 in November, and 17,092 in December. Clients who were disenrolled from the waiver were automatically checked for eligibility for other categories. Clients who were eligible as MAGI Adults for the January 1, 2014, Medicaid expansion were automatically flagged for re-enrollment in January without having to re-apply.

As of September 30, 2013, 9,233 clients remained on the waitlist. Since we did not do any further waiver enrollments after September, these clients were flagged for enrollment in the January 2014 expansion. Individuals who applied during this quarter and were eligible according to the waiver criteria were flagged for enrollment in the January Medicaid expansion. Childless adults who did not meet waiver income eligibility but met expansion income eligibility were also flagged for January 1 expansion enrollment.

C. State-Established Income Eligibility Standard

The current Department-established income eligibility standard is at 10 percent of the FPL. The Department did not consider changing the income eligibility standard given the size of the waitlist. However, on January 1, 2014, the income eligibility for childless adults rose to 133% FPL as part of the Medicaid expansion.

D. Collection and Verification of Encounter Data and Enrollment Data

The Department has not encountered any issues, activities or findings related to the collection and verification of encounter and enrollment data.

III. Benefits Information

Demonstration clients received the standard State Plan Medicaid benefit. The Department received approval during the 2013 legislative session to add an enhanced substance abuse benefit and an adult dental benefit to the State Plan, but neither of these benefits was implemented before the Demonstration ended.

However, AwDC waiver clients transitioned to the Medicaid expansion on January 1, 2014. The expansion requires that clients be given an alternative benefit package (ABP), so the benefit package was enhanced with several new services, effective January 1. In early December, the Department sent notices to all enrolled waiver clients advising them of the upcoming new services, including enhance substance abuse, additional preventive services, and habilitative services. The dental benefit will not begin until later in 2014, so noticing for that benefit will take place closer to implementation.

IV. Assignment of a Primary Care Medical Provider and Virtual Network

Demonstration Populations	New RCCO Enrollees for the Quarter	New Enrollees Assigned a PCMP
AwDC	4,116	1,170

The number of new RCCO enrollees is the number of new AwDC clients who had a RCCO enrollment span and for whom a PMPM payment was made to a RCCO.

The number of new enrollees assigned a PCMP is the number of new AwDC clients who had a PCMP enrollment span in this quarter and for whom a PMPM payment was made to a PCMP. PCMP assignments are effective the first day of the month after a selection is made. Therefore, PCMP enrollment was effective on October 1 for clients who selected a PCMP in September. At the end of the quarter, 51.9% of waiver clients were assigned to PCMP, an increase over the previous quarter (42.5%). This increase is mostly attributable to the fact that we did not enroll new clients during this quarter, so the gains in PCMP selection were not being off-set by the enrollment of brand-new clients with no previous provider relationship.

For all ACC program clients, including Demonstration clients, the RCCOs continue to work with primary care providers and with the community mental health centers in their regions to help clients select a PCMP. As noted in the previous quarterly report, many providers are using a fax enrollment form whereby the provider works with the client and then faxes the PCMP selection to the Department's enrollment broker to create the PCMP enrollment span.

The Department continues its re-attribution process. Clients enrolled in the ACC who did not or do not have an established relationship with a provider (both Demonstration and non-Demonstration enrollees) are not initially attributed to a PCMP. In the re-attribution process, claims are analyzed for clients who have remained unassigned to a PCMP but have accumulated a claims history. If the claims history indicates a relationship with a provider has been established, the client is attributed to that PCMP. Once a PCMP is assigned or selected, clients (including Demonstration enrollees) continue to have the option of selecting a different PCMP by contacting our enrollment broker. The Department's Statewide Data and Analytics Contractor (SDAC), Treo Solutions, conducts the re-attribution process, which has resulted in an increased share of AwDC clients becoming attributed to a PCMP.

The Department and RCCOs focused on provider recruitment during the final months of 2013 in preparation for the Medicaid expansion. The Behavioral Health Organizations also focused on provider recruitment, especially of substance use providers. The RCCOs continue to outreach to the providers in their region and have indicated increases in both formal networks of PCMPs and informal networks of specialists. Also, formal partnerships between the RCCOs and larger specialty networks are in place in the various regions.

V. Outreach/Innovative Activities

This quarter's outreach activities focused on the transition to the Medicaid expansion on January 1. These included email communications sent to stakeholders, advisory committee members and community partners on a regular basis. The emails included Demonstration updates and links to resources posted on the Demonstration web page. Department staff worked closely with stakeholders to draft the transition plan in plain language. After the Department received CMS approval on the transition plan, it was distributed broadly along with sample eligibility notices that stakeholders had also helped to draft.

Department staff continued to attend various community engagement meetings. Department staff also participate on the HIV Resources Planning Council for Denver's Ryan White grant. A workgroup of Ryan White and Medicaid care coordinators, along with Department staff, began meeting in the final quarter to discuss the transition of Ryan White participants and to create linkages between the two systems.

During this quarter, the Department increased its outreach activities to advise community partners, potential clients, and other stakeholders of the open enrollment season. Since we had completed the final waiver enrollments, the messaging focused on applying for January 1 Medicaid enrollment through the expansion. This outreach included advisories through Department newsletters; emails to stakeholders; promotional materials created by the Department for community partner distribution; and announcements by Department staff at stakeholder meetings and public events, including announcements by our Medicaid Director and our agency's Executive Director. At the same time, Colorado's state-based health marketplace also intensified its advertising.

We believe that our outreach and messaging were largely successful. Some AwDC waiver clients did contact case workers with questions, but we were able to transition them seamlessly into the expansion. Outreach to new clients was also successful: 86,000 new adults gained Medicaid coverage in Colorado on January 1, 2014, and another 15,000 joined the Medicaid rolls by January 15.

VI. Operational/Policy Developments/Issues

Operational issues and policy developments in this quarter include the following, which are summarized below: 1) the conclusion of waiver enrollments; 2) the administrative transition of waiver clients to MAGI Adults; 3) the determinations of clients for the Medicaid expansion; and 4) submission of the ABP SPA and messaging to waiver clients about their new expansion benefits.

1) Per previous agreement with CMS, the Department stopped enrolling clients into the waiver after September. Instead, we did an extra-large enrollment in September to make up for the expected attrition in the final three months of the year. This change in our enrollment strategy was required because with the switch to MAGI on October 1, our eligibility system could no longer handle enrollments of waitlisted waiver clients who had applied under the old rules. All waitlisted waiver clients on September 30 were transitioned to a "flagged for January 1" status along with those who applied during October, November, and December.

2) Colorado received approval to use MAGI rules early, beginning October 1, rather than waiting for January 1. In October, all enrolled waiver clients were transitioned from AwDC to MAGI Adults. This transition was invisible to the clients; it was accomplished administratively in our eligibility system without requiring clients to re-apply. Because we did not have full tax information on these clients, we sought and received CMS approval to delay collection of additional MAGI information until each client's next

scheduled redetermination. Because the income eligibility for the waiver is so low, we have a high confidence that we can assume they are non-tax-filers.

3) During the first part of the Demonstration, applicants who were determined eligible as AwDC were placed on a waitlist and then were subject to a monthly random selection process. During the final quarter, when the waitlist functionality no longer existed, all applicants determined eligible for the Medicaid expansion were given a "flagged for January 1" status. This group included all applicants who would have been eligible according to the waiver criteria. The "flagged" clients initially received a denial since they couldn't be enrolled immediately, and then they received a "hang on" letter advising them that they would be Medicaid eligible in January. Enrolled waiver clients who became ineligible due to income but were still under 133% FPL were automatically "flagged for January 1" without needing to re-apply. At the end of November, the Department ran the list of "flagged" clients for January eligibility, and those clients received notices of Medicaid approval effective January 1, 2014.

   There was an operational obstacle during this process that required a manual workaround. Clients denied for Medicaid were automatically passed to the marketplace for consideration of tax subsidized private coverage. We had expected that our eligibility system could suppress the names of clients below 133% FPL, but it ended up passing all client denials to the marketplace, including those who would be eligible for Medicaid in January. Instead, we sent the marketplace a list of "flagged" clients to ensure that they did not go through the purchase process. We heard of one "flagged" client who slipped through and purchased private coverage in the fall, but her purchase was refunded and she was re-routed back to Medicaid.

4) In November, the Department submitted its Medicaid expansion ABP SPA to CMS for approval. Colorado decided to use its base Medicaid plan as the basis for its ABP. To meet essential health benefits requirements, the Department had to add habilitative services, additional substance use, and additional preventive services on top of the base package. All enrolled waiver clients were sent notices in December advising them of the new benefits that would be available January 1, 2014. All waiver and waitlisted clients received the ABP, unless they had experienced some change in circumstance that made them eligible for a traditional category.

As of the end of this reporting quarter, the Department had not heard of or experienced any major health care delivery issues, there are no expected changes to the structure of the Community Mental Health Services program and the delivery of mental health services by the PIHPs, and the Department is not aware of any issues with enrollment into the PIHPs or access to mental health services. The Department has no concerns about the financial performance of any of our health plans and there is no current legislative activity planned. There are no action plans in place at this time.

VII. Expenditure Containment Initiatives

The Department is not currently undertaking any expenditure containment initiatives that will

affect the Demonstration.

VIII. Budget Neutrality

A. Financial/Budget Neutrality Development/Issues

All population expenditures were identified and were reported on the CMS 64 AwDC Waiver for the quarter ending 12/31/2013. All expenditures meet budget neutrality requirements.

B. Member Month Reporting

i. For Use in Budget Neutrality Calculations

Eligibility Group	October -Month 1	November - Month 2	December – Month 3	Total for Quarter Ending 12/13
AwDC	19,168	17,976	17,092	54,236

Eligibility Group	Total Member Months for the Quarter	PMPM *(Total Expenditures divided by Total Member Months)*	Total Expenditures
AwDC	54,236	$591.75	$32,094,318.73

IX. Consumer Issues

Compared to many states, Colorado's open enrollment period began quite smoothly. Our applications website was able to handle the volume and experienced minimal downtime. Many clients who applied through our web-based application interface, PEAK, received real-time determinations. By the end of December, PEAK was able to provide a real-time determination about 70% of the time, and approved clients could print a Medicaid card from the website.

The influx of clients with questions about eligibility, applications, and benefits led to increased call volume, requiring the Department and several of our vendors to have to expand call center capacity.

During this quarter, the Department's program manager worked with stakeholders in the monthly Advisory Committee meetings to finalize the lessons learned from the waiver program.

X. Quality Assurance/Monitoring Activity

Eligibility staff worked closely with counties, eligibility vendors, and the marketplace to ensure a smooth application process. Through the quarter, real-time PEAK determinations

increased as new fixes were implemented.

RCCOs are required to submit quarterly Behavioral Health Integration Reports to demonstrate their efforts to provide integrated care. The Department is using these reports to help track the challenges around integration, to ensure that RCCOs and BHOs are working together to provide more integrated care, and begin to explore additional opportunities for integration. Demonstration staff continue to work with the Department's Quality Section to ensure the adult quality measures are appropriate for the Demonstration population.

The Department received a grant from CMS Adult Medicaid Quality Measure (AMQM) program. During the previous quarter, the Department received and reviewed grant applications from RCCOs and providers for quality improvement projects related to adult quality measures on depression and diabetes. These grant projects are being implemented by ACC providers for adult ACC clients, including AwDC. The anticipated grant period is April to December, 2013.

XI. Demonstration Evaluation

The Department submitted the draft evaluation plan on July 27, 2012. CMS responded with questions about the evaluation plan in mid-September. The Department responded to those questions on November 23, 2012 and submitted the revised plan on February 8, 2013. The Department received additional feedback on the April 30 quarterly monitoring call and re-submitted the plan on August 1. CMS approved the plan on August 14, 2013. Utilization, enrollment, waitlist, and cost data that will be used in the evaluation are already being collected.

XII. Transition Plan

The Department finalized its transition plan with CMS on October 15, 2013. As described above, the transition was implemented according to plan with few exceptions.

1) Enrolled waiver clients were administratively changed to MAGI Adults. These clients will be asked to provide updated tax information at their next scheduled redetermination. Clients who maintained eligibility transitioned seamlessly and experienced no disruption in services. Clients who lost eligibility due to income but were still within the 133% FPL limit were automatically flagged for January 1 enrollments, experiencing a disruption of about two months at most.

2) Waitlisted clients were flagged for January enrollment without having to re-apply. They received their approval letters in December.

3) New applicants in October and November who qualified as MAGI Adults were sent denials and "hang on" letters. These clients were flagged for January 1 enrollment and received their approvals in December. New applicants in December simply received an approval notice effective January 1, 2014. We are aware of at least one instance of a January-eligible applicant purchasing coverage on the exchange, but we were able to re-

enroll her in Medicaid appropriately.

XIII. Additional Information

A. Enclosures/Attachments

B. State Contact(s)

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C. Date Submitted to CMS

February 28, 2014