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2012 Legislation in Review

June 2012

The Colorado Health Institute's Legislative Services Program

CHI provides a suite of services to contribute to an informed, evidence-driven legislature. The program includes one-on-one sessions to help lawmakers understand health policy options; responses to specific requests for information; publications on health policy topics; an annual series of Legislative Roundtables for interactive learning and discussion; weekly updates on health policy legislation during the session; year-end wrap-ups and pre-session primers; presentations to constituent groups; and a biennial "Hot Issues in Health Care" symposium for new and returning lawmakers. In addition, CHI is designing a year-long program to help lawmakers especially interested in health policy develop expertise in systems thinking and adaptive leadership.

About CHI

CHI is a trusted source of independent and objective health information, data and analysis for the state's health care leaders. CHI, celebrating its tenth anniversary in 2012, is funded today by the Caring for Colorado Foundation, Rose Community Foundation, The Colorado Trust and The Colorado Health Foundation.

Acknowledgments

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Colorado's 2012 legislative session wasn't filled with grand new health policy initiatives – or big setbacks, either. Instead, lawmakers on both sides of the aisle rolled up their sleeves and worked on improving the state's existing health care system while setting the stage for future innovation.

A breather in the budget battles allowed legislators to turn their attention from reductions in health spending to more fundamental systemic changes, focusing on adjustments designed to provide better care for Coloradans while chipping away at the inexorable rise in health care costs.

The legislature tackled payment reform, asked for creative solutions in the Medicaid program and built a foundation for bipartisan efforts aimed at solidifying Colorado's role as a leader in smart solutions for tough health problems.

Lawmakers worked to help ease the cost of hospital care for uninsured families. They relaxed some burdensome regulations that were adding costs without improving health outcomes. And they found $3 million to provide dental services for a good number of low-income seniors.

Notable as well was what didn't happen. Efforts to repeal the law that created the Colorado Health Benefit Exchange and to roll back state-mandated Medicaid expansions were defeated. School-based health centers retained their funding levels. And co-payment levels for Medicaid enrollees didn't head higher.

Crafting sound health care policy is challenging at any time. The system is complicated, the problems can seem overwhelming and any changes affect real people, often in profound ways. But as the economic downturn continues to take its toll and the nation awaits a decision by the U.S. Supreme Court on the constitutionality of federal health reform, this work can be even more difficult.

The Colorado legislature showed during its 2012 session that, with determination and strong leadership, progress is possible.

Health Care 2012 and the Four "E"s

The health policy work undertaken during the 2012 legislative session falls within the framework of the four "E"s:

- **Easing** of the budget.
- **Experimentation** with existing programs and services.
- Improving governmental **Efficiency**.
- The looming **Elections**.

With an uptick in revenue, balancing the budget became less painful for lawmakers. As a result, they focused on experimenting with pilot projects to make current state health care programs work better and cost less.

Heeding a call from Governor John Hickenlooper, legislators targeted governmental inefficiencies that had bogged down health care delivery. And, finally, the session played out in the shadow of the November elections, when all 65 House seats and 20 Senate seats will be up for grabs, as will control of both bodies and leadership of the House and Senate health committees.

This is CHI's synthesis of the health care policy work of the 2012 legislative session.

Easing of the Budget

A better-than-expected revenue projection in March pre-empted a partisan fight over a property tax break for older Coloradans called the Senior Homestead Exemption and allowed lawmakers to keep education funding stable for the first time since FY 2008-09, among other funding decisions.

With a solidly bipartisan vote of 94-6, the legislature approved a $20.5 billion budget for FY 2012-13, including a 6.4 percent increase in the general fund, which reached $7.7 billion.

Medicaid continues to be a source of scrutiny as enrollment and costs rise as the result of the slow economic recovery and expanded eligibility. Still, the higher revenues allowed legislators to:

- **Avoid** a proposed $44,000 (4.5 percent) funding reduction for school-based health centers, which provide medical and behavioral health care on school grounds, especially where access to care is limited.
- **Retain** co-payment levels for Medicaid clients rather than increase them. The co-pays are for emergency and urgent care, in-patient and out-patient hospital services and routine office visits.
- **Raise** the monthly allowance to $725 a month from $699 a month for low-income seniors in the Old Age Pension (OAP) program.
- **Authorize** $3 million in funding for dental services for eligible seniors ages 60 and older through **HB 12-1326**.
- **Stop** the annual trend of lowering Medicaid provider reimbursement rates.
- **Maintain** funding levels for local public health agencies.

Experimentation

Lawmakers approved a number of proposals to change how health care is paid for and delivered in Colorado. Much of this experimentation builds on the state's forward-looking Accountable Care Collaborative (ACC), which was launched in 2011 with the goal of improving care coordination and reducing costs in the state's Medicaid program.

The legislature during 2012 approved a recommendation from the Department of Health Care Policy and Financing (HCPF) – the state agency in charge of the Medicaid and Child Health Plan *Plus* (CHP+) programs – to pay providers a share of any financial savings from improved care coordination. This gainsharing incentive program will begin with clients assigned to Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs)

and Behavioral Health Organizations. This proposal is anticipated to reduce the state's share of Medicaid expenditures (General Fund) by $461,000 in FY 2012-13.

Understanding the ACC

Under the ACC model, patients are assigned to a "medical home," which is a primary care team comprised of clinicians and other providers. The team coordinates a patient's care with the goal of saving money and improving care quality. Seven Regional Care Collaborative Organizations (RCCOs) manage the program under the direction of HCPF. Besides traditional fee-for-service payments, the primary care providers and RCCOs receive per-member, per-month fees to run the program and to reach cost-saving goals. Approximately 125,000 of the state's 600,000-plus Medicaid clients were enrolled in the ACC as of April 2012.

HCPF plans to extend the ACC to Coloradans who are eligible for Medicare and Medicaid, the "dual eligibles" who often have multiple chronic conditions and need more costly care, including long-term services and supports (LTSS).

Three bills aimed at helping this population get the right care at the right location won passage:

- **SB 12-023** requires case managers and state agency staff members who work with dual eligible clients to provide information about the Program of All-Inclusive Care for the Elderly (PACE), an integrated model of care that's already in place for Medicaid and Medicare enrollees.
- **SB 12-127** permits LTSS providers to contract with RCCOs as medical homes or to provide some or all of the services provided by RCCOs. Medical homes may be defined as a team of primary care providers, behavioral health care providers or LTSS providers.
- **SB 12-128** creates a Medicaid three-year pilot program that helps move qualified "dual eligibles" from nursing homes to alternative care facilities in their communities.

Finally, unrelated to the Medicaid program, **HB 12-1017** continues Health Access Pueblo, a pilot program by employers, employees and community organizations to provide affordable health care for adults who are employed but uninsured.

And **SB 12-134** provides protection for uninsured Coloradans who need hospital services. Hospitals must disclose information about their charity care policies to low-income uninsured patients. They will be prohibited from sending bills to collection agencies until after they have offered a reasonable payment plan and the patient is over 30 days late. They must charge those patients a rate similar to the rates paid by insurance companies.

Efficiency

Lawmakers approved a number of health care bills supporting Governor Hickenlooper's goal of making Colorado government "more efficient, more effective and more elegant."

- **HB 12-1041** creates an electronic death registration system to allow information to be shared more quickly and with less paperwork.
- **HB 12-1054** simplifies HCPF's process to sign up health care providers by reducing the number of contracts required to participate in Medicaid, CHP+, the Colorado Indigent Care Program (CICP) and school-based health centers.
- **HB 12-1058** transfers the responsibility to treat newborns with eye drops containing antibiotics (to protect them from a mother's possible gonorrhea) from the Colorado Department of Public Health and Environment (CDPHE) to the health care provider presiding at the birth.
- **HB 12-1268** transfers the inspections of health care facilities for building and fire safety standards from CDPHE to the Colorado Department of Public Safety, which performs similar reviews of public school buildings.
- **HB 12-1294** modifies laws on licensing and regulating health facilities. The bill, brought forward by a coalition of health facilities, aims to reduce regulatory burdens while assuring patient safety doesn't suffer.
- **HB 12-1339** appropriates $23 million and 22 FTEs to improve the Colorado Benefits Management System (CBMS), the state's troubled computer system for Medicaid and other financial assistance programs. It also increases legislative oversight of CBMS.
- **SB 12-037** allows for electronic transfer of prescriptions for controlled substances. Currently, a pharmacy is prohibited from dispensing a prescribed schedule II, III, IV or V controlled substance without a written prescription from the practitioner.
- **SB 12-161** allows correctional facilities to return certain unused medications, medical devices and medical supplies to be re-dispensed to another patient.

The drive to improve governmental effectiveness produced three bills designed to develop and maintain a qualified health care workforce:

- **HB 12-1052** establishes a process to collect data through the state licensure process to assist in planning for future health care workforce needs.

- **HB 12-1059** authorizes military spouses to practice all health professions except physician, physician assistant or optometrist for one year if he or she is licensed, registered or certified to practice in another state and agrees to be governed by Colorado law.
- **HB 12-1300** updates and modernizes the Colorado Professional Review Act (CPRA), which is used to provide peer reviews of the quality of patient care provided by physicians. The bill also authorizes the professional review of physician assistants and advanced practice nurses.

Three bills aim to redirect resources from criminal prosecution to longer-term solutions for substance abuse treatment:

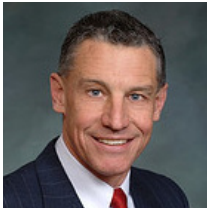
- **HB 12-1100** prohibits information about illegal drug use obtained through a pregnancy test or prenatal care to be used criminally against a pregnant woman.
- **SB 12-020** allows immunity from arrest and criminal prosecution for someone who reports an emergency drug or alcohol overdose and remains at the scene until law enforcement or emergency medical responders arrive.
- **SB 12-104** consolidates three major state funding sources for substance abuse treatment into a correctional treatment cash fund. A correctional treatment board will prepare an annual treatment plan.

Elections

The session began with hard feelings about a legislative reapportionment process that ended up before the Colorado Supreme Court and ended with legislators focused on the November elections, when all 65 House seats and 20 Senate seats will be decided in Colorado. Throw in term limits and Colorado's role as a swing state in the presidential election, and politics were ever-present during the 2012 session, though a good deal of bipartisan work was accomplished.

During the fall elections, Republicans will try to protect their 33-32 majority in the House while Democrats will work to keep their 20-15 majority in the Senate.

Betty Boyd



Ken Summers

Health care leadership will see a significant changing of the guard as well.

Democrat Betty Boyd, the chair of the Senate Health and Human Services Committee, is term-limited and won't be returning. Republican Ken Summers, chair of the House of Representatives Health and Environment Committee, has opted to run for the Senate in the wake of redistricting.

During this election year, all of these bills were introduced – and defeated:

- **SB 12-032** would have required HCPF to seek a federal waiver so Colorado could determine its own eligibility levels for Medicaid and other health programs and to reinstate asset tests.
- **SB 12-053** would have repealed the Colorado Health Benefit Exchange Act in the event that the federal Affordable Care Act (ACA) is repealed or the U.S. Supreme Court rules that any or all of the ACA is unconstitutional.
- **SB 12-085** would have lowered eligibility and services in the Medicaid and CHP+ programs to 2006 levels.

These defeated bills offer a glimpse of debates that may play out during the election season, especially related to the relationship between Colorado and the federal government in terms of controlling Medicaid costs as well as the state's overall implementation of the ACA.

Anatomy of a Bipartisan Health Care Bill

HB 12-1281 *– the Medicaid Innovation bill – is a case study of the session's health care policy work, showcasing innovation, foundation-building for future improvements, political negotiation, collaborative fine-tuning and, ultimately, strong bipartisan support.*

The law calls for pilot projects that could change the way Colorado pays for Medicaid services. The state hopes to move from traditional fee-for-service payments, which often reward providers for volume rather than quality, toward global payment and other models that share risk and provide incentives for controlling costs and improving health outcomes.

The bill started with a rookie Democratic lawmaker, Rep. Dave Young of Greeley. Rep. Young has a personal connection with Medicaid as the co-guardian, with his wife, of his developmentally disabled sister. But it was at the suggestion of the House Minority Leader, Rep. Mark Ferrandino (D), that Young began researching and writing the bill.

"He said this is an issue we need to address, but up to this point all we've been doing is talking about needing to address it," Young said. "It was time we did something about it."

The issue was the ever-increasing

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Rep. Dave Young (D), describing how a suggestion from House Minority Leader Mark Ferrandino (D) led to the creation of HB 12-1281.

cost of the state's share of the Medicaid program, which counts 600,000-plus enrollees, eats up about a quarter of the general fund and is expected to continue expanding during the tough economy.

Young said that a crucial consideration was working within the framework of the ACC set up by HCPF.

"We didn't want to change the good work already done, but the ACC was built mostly on fee-for-service. The question was how to move the dial forward without upsetting the work already done."

A number of stakeholders helped refine the bill, including medical providers, insurance companies, hospitals, consumer groups and others. Then Rep. Cheri Gerou, a Republican from Evergreen, indicated she wanted to be a co-prime sponsor, an important step forward. Sen. Pat Steadman (D) and Sen. Ellen Roberts (R) signed on as sponsors in the Senate, another seal of approval for a bill from a first-year lawmaker.

"In a political year, it's tough sledding for a freshman legislator to get bills passed," Young said.

HB 12-1281 passed the House by a vote of 51-14 and the Senate by a vote of 28-7 – on the last day of the general session. (Even with bipartisan support, it should be noted that not everyone approved of the bill. All 21 no votes came from Republicans.) Gov. Hickenlooper signed it June 4.

HB 12-1281: A Primer

- Current ACC contractors may submit proposals for payment reform pilot projects that include, but are not limited to, global payments, risk adjustment, risk sharing and aligned payment incentives such as gainsharing.
- HCPF will select the pilot projects by July 2013. They will run two to three years.
- The pilots will be evaluated on a range of criteria, including how the payment model drives provider performance and participation and its impact on quality measures, health outcomes, cost, provider satisfaction and patient satisfaction.
- HCPF will open the current RCCO contracts for competitive bid in 2015, based on the original ACC timeline.
- $213,079 is allocated for the project – half from the state's general fund and half from federal funds.

Health Care Spending

Health care had a good year, budget-wise. But it ranks as a large part of the state's operating budget and, as such, will continue to be scrutinized for cost savings.

Health care accounts for the second largest portion of Colorado's general fund budget, after education. The growth rates of Medicaid and K-12 education spending have been identified as the main drivers behind a growing budget gap faced by the state, the reason both areas are targeted during budget-cutting times.

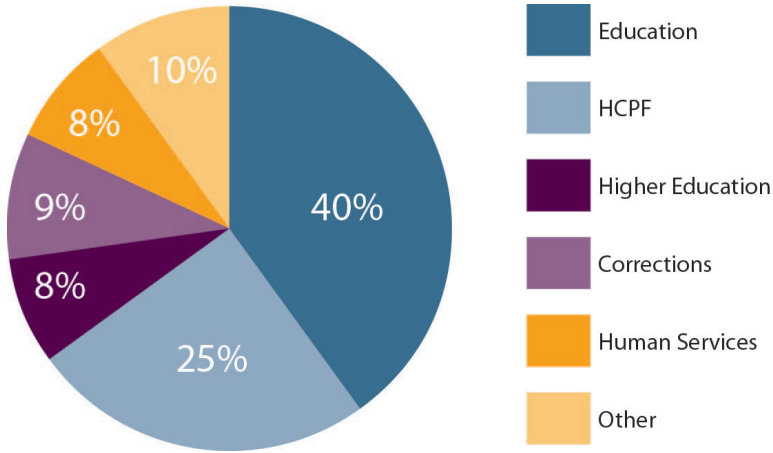
During the toughest years, traditional tools were used to stabilize spending, including reducing provider payments and limiting services. But this year's increased revenue forecast allowed for the budgets of all three of the state's health-related departments to increase:

- HCPF won approval for a budget of $1.86 billion, an increase of 9 percent. HCPF's budget takes up a quarter of the total state general fund budget.
- The Colorado Department of Human Services (CDHS) was approved for a general fund budget of $642 million, a 3 percent increase. This department accounts for 8.5 percent of the general fund budget. CDHS provides services for low-income families, individuals with developmental disabilities and the elderly, and individuals who need treatment for mental illness or substance abuse.
- CDPHE makes up 0.4 percent of the general fund budget. Its FY 2012-13 budget is about $31 million, an 11 percent increase.

Medicaid in Colorado

- Between FY 2010-11 and FY 2013-14, Colorado's caseload is projected to increase by 32 percent to around 740,000.
- The caseload for Medicaid and CHP+ has gone up about 61 percent since the recession began.
- The majority of Colorado's Medicaid clients are children.
- A third of those covered by Medicaid are Hispanic, while 28 percent are white.
- The San Luis Valley and Pueblo County have the highest proportion of Medicaid clients, with one in four residents enrolled in the program.
- Statewide, about 12 percent of the population is enrolled in Medicaid.

General Fund Appropriations for State Departments, Colorado, FY 2012-2013



Source: Colorado Joint Budget Committee, April 27, 2012

The state's Medicaid caseload is projected to grow 10 percent in the next fiscal year, partly due to eligibility expansions. But the overall per capita cost is projected to decline from $5,930 in FY 2010-11 to $5,813 in FY 2012-13. Primarily, the cost reductions are coming from low-income parents, children and pregnant women, who make up the majority of the caseload. A number of factors may be contributing to this projected decline, including policy changes that discourage Caesarean section deliveries as well as an increase in coordinated care. Caseload mix also contributes to the overall decline as more young and healthy children are enrolled.

Amendment 35: The Money Is Back

Public health advocates breathed a sigh of relief this year when higher revenues let the state return Amendment 35 funds to their original purpose of funding health programs.

Voters in 2004 overwhelmingly approved the amendment to Colorado's constitution, which increased the excise tax on cigarettes and other tobacco products. (Today, the tax rate is 4.2 cents per cigarette, or 84 cents per pack.)

Originally, 46 percent of the money went to CHP+ and Medicaid, 19 percent to community clinics, 16 percent to tobacco control, 16 percent to chronic disease prevention grants and 3 percent to the general fund, Old Age Pension (OAP) fund and municipal and county governments.

But for the past three years, the state triggered an escape clause that said the taxes could be diverted to balance the budget.

This will change in FY 2012-13, when about $48 million in Amendment 35 funding will become available – about $15 million for the Primary Care Fund so that safety net health clinics do not see cuts and $32 to $33 million in grants administered by CDPHE.

CDPHE issued Requests for Applications for Amendment 35 funds in late May, followed by a series of webinars.

The grants are expected to include:

- **$19.2 million** for tobacco education, prevention and cessation grants.
- **$9 million** for cancer, cardiovascular disease and pulmonary disease (CCPD) grants.
- **$2.5 million** for the state's health disparities grant program.

Looking Ahead

Colorado's lawmakers will return to a different General Assembly in 2013, but many of their health policy challenges will remain unchanged. They will need to slow the growth in health care spending even as the economy continues to send more residents to public insurance. They will spend more time scrutinizing existing programs and demanding evidence that the changes are producing results – lower costs and better health outcomes.

The governor and the legislators will continue their drive to improve the efficiency and effectiveness of state government, perhaps revisiting two initiatives that stalled in the 2012 session – creating an office of early childhood and youth within the Department of Human Services and redesigning the state's LTSS programs.

Some legislation that appeared to have traction could be resurrected, including a bill that would have expanded oral health care to pregnant women covered by Medicaid, a measure that fell victim to the chaotic end of the session when a proposed civil unions bill stalled a good number of bills.

More measures associated with Health Eating, Active Living (HEAL), an area of great interest to a large portion of the state's health advocates, could emerge. An attempt to ban the sale of any foods containing trans-fat in schools, which started the session as one of the toughest in the nation, passed but with amendments that made it less sweeping.

Finally, Colorado's General Assembly will be dealing with the fallout of the Supreme Court ruling on federal health reform, expected in June. If the ACA is ruled constitutional, Colorado will work on implementing the law's provisions. If all or parts are found to be unconstitutional, that will require the state to consider alternative actions.

To follow CHI's legislative updates, visit **coloradohealthinstitute.org/key-issues/category/legislation-and-policy**

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