COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

1570 Grant Street, Denver, CO 80203-1818 • (303) 866-2993 • (303) 866-4411 Fax

John W. Hickenlooper, Governor • Susan E. Birch MBA, BSN, RN, Executive Director

November 1, 2011

The Honorable Mary Hodge, Chair
Joint Budget Committee
200 East 14th Avenue, Third Floor
Denver, CO 80203

Dear Senator Hodge:

The Department of Health Care Policy and Financing respectfully submits this response to the Legislative Request for Information from the Joint Budget Committee, regarding cost sharing:

> **Department of Health Care Policy and Financing, Medical Services Premiums** – The Department is requested to submit a report by November 1, 2011, to the Joint Budget Committee providing information on the costs and savings of increasing co-payments in the Medicaid program to the maximum amount allowed under federal law.

This response explains the federal regulations and restrictions on co-payments, the estimated costs and savings of increasing current co-payments, and other options for adding and increasing co-payments.

In addition, this report coincides with the Department's submitted FY 2012-13 budget request, R-7, "Cost Sharing for Medicaid and CHP+." The request describes the Department's proposal for budget savings by increasing current Medicaid co-payments and implementing co-payments for additional services as well as increased fees for CHP+ clients.

Please note that the Joint Budget Committee requested that the Department submit a total of 11 different requests for information on November 1. These reports are in addition to the Department's FY 2012-13 Budget Request, which is also due on November 1. Due to the volume of information due concurrently, the Department has not been able to submit all reports simultaneously. The Department hopes to work with the Joint Budget Committee in future years to alleviate some of the issues caused by the concurrent deadlines.

Please direct any further questions to Suzanne Brennan, Director of the Medical and CHP+ Program Administration Office, at suzanne.brennan@state.co.us or 303-866-5929.

Sincerely,

Susan E. Birch MBA, BSN, RN
Executive Director

Cc: Representative Cheri Gerou, Vice-Chairman, Joint Budget Committee
Senator Pat Steadman, Joint Budget Committee
Senator Kent Lambert, Joint Budget Committee
Representative Jon Becker, Joint Budget Committee
Representative Mark Ferrandino, Joint Budget Committee
Senator Brandon Shaffer, President of the Senate
Senator John Morse, Senate Majority Leader
Senator Mike Kopp, Senate Minority Leader
Representative Frank McNulty, Speaker of the House
Representative Amy Stephens, House Majority Leader
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Response to Legislative Request for Information
Regarding the Costs and Savings of Increasing Medicaid Co-Payments
November 2011

This response explains the federal regulations and restrictions on co-payments, the estimated costs and savings of increasing current co-payments, and other options for adding and increasing co-payments.

In addition, this report coincides with the Department's submitted FY 2012-13 budget request, R-7, "Cost Sharing for Medicaid and CHP+." The request describes the Department's proposal for budget savings by increasing current Medicaid co-payments and implementing co-payments for additional services as well as increased fees for CHP+ clients. The calculations for figures presented in this report, along with a detailed description of any administrative components, are contained in the R-7 request.

Federal Regulations Restricting Co-Payments Amounts

The authority for co-payments contained in section 1916 of the Social Security Act [42 U.S.C. 1396o] allows the state to impose co-payments as long as the amounts are not above nominal amounts specified in federal regulation. Maximum nominal amounts are determined annually by the Secretary of the United States Department of Health and Human Services. Under this authority, providers may not deny services to a client who does not pay the co-payment if the client is at or below 100% of the Federal Poverty Level (FPL).

Co-payment amounts are based on the amount the Department reimburses for services and inflated yearly by the percentage increase in the medical component of the Consumer Price Index - All Urban Consumers (CPI-U).

Table 1 below illustrates current federal co-payment maximums.

Table 1
Nominal Co-Payment Amounts

Reimbursement Amount for Service	FFY 2012 Federal Maximum Co-Payment Amount
$10 or less	$0.65
$10.01 to $25	$1.30
$25.01 to $50	$2.55
$50.01 or more	$3.80

Based on this guidance, the Department selects services that are subject to a co-payment and sets the co-payment to be within the federal maximum, based on the Department's typical reimbursement amount for the service. Federal regulations describe the following example to illustrate this authority: "...if the agency's typical payment for prescribed drugs is $4 to $5 per

prescription, the agency might set a standard co-payment of $0.65 per prescription." The Department uses this authority to charge standard co-payments for most services. The Department last set its co-payment amounts in 2003.

Current and Maximum Colorado Medicaid Co-Payments

Table 2, below, shows the services for which the Department currently imposes a co-payment, the current amount of the co-payment, and the federal maximum co-payment.

Table 2
Current and Maximum Co-Payment Rates by Service

Service	Current Co-Payment	FY 2012 Maximum Co-Payment
Inpatient Hospital Services	$10 per covered day or 50% of the averaged allowable daily rate, whichever is less.	$12 per covered day or 50% of the averaged allowable daily rate.
Outpatient Hospital Services	$3.00 per visit	$3.80
Practitioner Services (MD, DO, NP, PA)	$2.00 per visit	$2.55
Optometrist Visit	$2.00 per visit	$2.55
Podiatrist Visit	$2.00 per visit	$2.55
Psychiatric Services	$.50 per unit of service (1 unit = 15 minutes)	$0.65
Community Mental Health Center Services	$2.00 per visit	$2.55
Rural Health Clinic/ FQHC Services	$2.00 per date of service	$2.55
Durable Medical Equipment	$1.00 per unit or period of service, depending on the item.	$1.30
Laboratory	$1.00 per date of service	$1.30
Radiology (X-ray) Services	$1.00 per date of service. (Dental x-rays do not have a co-pay.)	$1.30
Prescription Services (each prescription or refill)	Generic drugs - $1.00 Brand name drugs - $3.00	Generic: $1.30 Brand name: $3.80

State and Federal Regulations Restricting Populations and Services Subject to Co-Payments

Federal regulations prohibit imposing a co-payment on the following populations and services:

- Children under 18 years of age;
- Services to pregnant women;

- Services furnished to individuals who are inpatients in a hospital, nursing facility, intermediate care facility for the mentally retarded or other medical institution that requires them to spend down their assets to be there;
- Emergency services;
- Family planning services;
- Services to an individual receiving hospice care; and,
- Native Americans.

In addition, Department regulation at 10 CCR 2505-10, section 8.754.5 restricts cost sharing for:

- Children under the age of 19; and,
- Services provided under a Community Mental Health Services program and Managed Care programs.

Costs and Savings for Increasing Current Co-Payments to the Maximum Amount

The Department estimates that increasing the co-payments on these services would reduce fee-for-service expenditure by $2,125,138 total funds and $1,037,897 General Fund in FY 2012-13, annualizing to $2,915,917 total funds and $1,424,134 General Fund in FY 2013-14.

Other Options for Increasing Cost Sharing

The Department has also looked at two other options for increasing cost sharing: (1) charging co-payments for services that have no co-payment currently and (2) charging a higher co-payment for non-emergency use of the emergency room.

Co-payments for additional services

The Department could add nominal co-payment amounts to the following services: non-emergency medical transportation, outpatient substance abuse, physical, occupational and speech therapy, home health and private duty nursing services. In order to implement new co-payment amounts, the Department would be required to make system changes to the Medicaid Management Information System (MMIS) to add co-payments for each new service type. The Department estimates this initiative would cost $523,964 total funds, $130,991 General Fund in FY 2012-13 and reduce expenditure by $895,529 total funds, $437,367 General Fund in FY 2013-14.

Increasing co-payments for non-emergency use of the emergency room

Federal regulations allow states to implement higher co-payment amounts for clients who use the emergency room for non-emergency conditions. One way the Department can do this is to charge clients who use these services a co-payment of twice the nominal amount, or $7.60 per episode. This option is based on specific authority in section 1916(a)(3) of the Social Security Act and requires a waiver granted by the Secretary. The state must demonstrate to the satisfaction of the Secretary that clients have access to alternative sources of non-emergency outpatient services. The Department would hire a contractor to determine alternate care sites for clients unwilling to pay the co-payment amounts.

The Department does not know what other restrictions and requirements CMS will include as a condition of approving the waiver, or how likely it is that CMS will approve the waiver. CMS has informed the Department that no state currently has a waiver under this provision. The Department anticipates savings of $16,655 total funds and $7,785 General Fund in FY 2012-13 and $192,050 total funds, $93,795 General Fund in FY 2013-14 from the implementation of this initiative.

The second option the Department has identified is to apply guidance under Section 1916A of the Social Security Act [42 U.S.C. 1396o-1] which allows the Department to implement cost sharing for non-emergency use of the emergency room through a state plan amendment. Under this allowance the Department is allowed to charge a co-payment amount to all clients, including those usually exempt from co-payments, with the following requirements:

- The Department may not charge more than the maximum nominal co-payment amount (currently $3.80);
- The Department may charge double the nominal amount for populations between 100-150% FPL;
- The Department must ensure the co-payment amounts charges to each family does not exceed 5% of family's monthly income; and,
- The Department must ensure that clients who are exempt from all co-payments except this one (for example, children) have access to alternative facilities to receive care without paying the co-payment amount.

The Department currently does not have the mechanism in place to determine the maximum amount a client could be required to pay in co-payment each month. The Department assumes that implementing the proper system functionality may take at least a year to implement. This, however, is not known; because of the complexity of this process, the implementation time could take much longer. Under the assumption of one year to implement, the Department anticipates costs of $539,100 total funds, $193,635 General Fund in FY 2012-13 to make the necessary changes to the Colorado Benefits Management System (CBMS) and the MMIS so that the Department could assure that clients would be charged appropriately. The Department estimates savings of $996,194 total funds, $486,532 General Fund in FY 2013-14 from the implementation of this initiative.

Other Considerations

The Department is committed to looking for ways to make clients more engaged in their health care decisions and more accountable for their use of health care services. There is little research on the effect of co-payments on either utilization or health outcomes, for outpatient or inpatient care. The existing research, such as the RAND Health Insurance Experiment, indicates that cost-sharing does cause people to decrease their health care utilization – both effective and ineffective care. People are not favoring "worthwhile" care over "frivolous" care; they simply reduce all utilization.[1] In order for people to be able to take such responsibility for their care, they would

[1] Gruber, Jonathan , Ph.D. The Role of Consumer Copayments for Health Care: Lessons from the RAND Health Insurance Experiment and Beyond. Kaiser Family Foundation, 2006.

require much more knowledge about health conditions, treatments, and options than the typical health care consumer has.

There is more research available about the effect of co-payments on prescription drug use. Health care consumers are more likely to use generic drugs when cost sharing increases, but they are also more likely discontinue their medications altogether.[2] It is important to take this information into account when making decisions about the costs and benefits of implementing copayments.

[2] Landsman (2005). "Impact of 3-Tier Pharmacy Benefit Design and Increased Consumer Cost-Sharing on Drug Utilization," American Journal of Managed Care, 11, 621-628.