COLORADO
Department of Health Care Policy & Financing

1570 Grant Street
Denver, CO 80203

The Summer Health Cabinet Summit: Questions & Answers

Event Slides, Reports, and Materials Access

Will the slides/recording/links/reports be shared after the event?

Yes! We will post the materials as soon as possible on the Department's Affordability Matters website: https://hcpf.colorado.gov/affordability

Where can I find the data dashboards that were referenced?

The Colorado Department of Public Health & Environment (CDPHE) COVID-19 Data Dashboard can be accessed here.

How can I access the PSAs?

Each PSA video includes messages from one or more state agencies:

1. Opening PSA - run time 5:03
2. Break One PSA - run time 3:07
3. Break Two PSA - run time 3:05
4. Break Three PSA - run time 3:04

Visit HCPF's YouTube Channel for additional videos.

Visit CDHS' YouTube Channel for additional videos.

Visit CDPHE's YouTube Channel for additional videos.

Hospitals

Do we know what percentage of Colorado hospitals are actually in compliance with the new transparency laws?

This is unknown for Colorado hospitals at this time. However, as of July 16 of this year, the nonprofit group PatientRightsAdvocates.org released a report that assessed a national random selection of 500 hospitals' compliance with the Jan. 1, 2021, federal hospital transparency order. In this report, the organization found that only 5.6% of hospitals in their

sample were compliant with federal guidelines. There is a significant opportunity and a need for hospitals to comply with federal transparency laws in order to facilitate more equitable health care systems.

Does Medicaid still reimburse hospitals about 30% on the dollar?

Using House Bill 19-1001 Hospital Transparency data, the Department's 2021 CHASE Annual Report reports that Medicaid reimburses $0.75 on the dollar and has been above $0.70 on the dollar since 2010 when the hospital provider fee was first implemented. Note this data is provided directly by hospitals and the findings in the report have been approved by the CHASE Board, which includes a Colorado hospital association and several hospital representatives.

How can non-profit health systems, who provide benefits for their non-profit status, provide more access to charity care?

Hospitals can better ensure their financial assistance programs are communicated clearly to patients and the community. This is also an opportunity for hospitals to engage with community members on this subject at one of their annual community benefit engagement meetings.

Won't the drive to decrease health care costs decrease the quality of care for patients?

More affordable health care does not have to mean that the quality of the health care decreases. In fact, in many cases, costs of a hospital or procedure do not necessarily correlate to better care at all. The Department and the Governor's Office are simultaneously trying to improve the quality of health care while getting the most value for taxpayers, employers, and patients. More information can be found at the Department's Affordability Matters website, in the Department's A New Path Forward In Health Care, and on page 55 of the Hospital Cost Price and Profit Review.

There is a need to build capacity within the community to pull data and translate the data into visuals we can use to drive local actionable work across stakeholder organizations and to empower consumers to self advocate. Can any of the speakers provide guidance on how to build this capacity?

The Department of Health Care Policy & Financing is working to provide more tools as we expand our transparency. For example the Hospital Reporting Hub has an interactive feature.

Pharmaceuticals and the Prescriber Tool

Can community pharmacies leverage the prescriber tool?

The prescriber tool is available through Electronic Health Records (EHRs). Pharmacies that have access to Electronic Health Records may be able to access the tool. Regardless, the

prescriber tool will benefit pharmacy workflows and efficiencies by providing upfront indications to prescribers regarding patient-specific non-preferred drugs, preferred drug options, and enabling providers to more easily submit for prior authorization. This should reduce delay in filling prescriptions and lessen pharmacy necessity for contacting prescribers.

What is the prescriber tool uptake among providers?

Approximately 85% of Medicaid's 24,459 prescribers have the tool already in their EHR. More than 6000 Medicaid prescribers are using the tool as of September 2021.

How does a provider get information on how to access the Prescriber Tool?

Providers should contact their respective IT support staff, EHR training team or EHR vendor to access the "Real-Time Prescription Benefit" or "Real-Time Benefit Check" module in their respective EHRs. Providers should also look to their respective teams for training and educational materials. For more information, please visit the website: https://hcpf.colorado.gov/prescriber-tool-project. The website will be updated with the latest information and resources as they become available.

How does the prescriber tool reduce drug cost?

Prescription drugs are the leading contributor to rising health care costs, but that challenge impacts more than just the financials. One in three Coloradans either cannot fill a prescription, cut pills in half, or skip doses because of the cost. Those facts led the General Assembly to pass SB18-266, which directs the Department to provide information on the cost of available pharmaceuticals to Medicaid prescribers. The Prescriber Tool does just that--it empowers providers with real-time information on prescription drug costs and affordable alternatives. Prescribers now have rapid insight into preferred medications from the Medicaid preferred drug list and with lower cost drugs from commercial payers, empowering prescribers with drug affordability and cost options. The "Real-Time Prescription Benefit" or "Real-Time Benefit Check," when requested, offers providers two lower cost alternatives to the selected drug therapy based on cost to the plan. By selecting a lower cost alternative, the state saves money via Medicaid and consumers save money via lower co-pays and coinsurance. To further propel use of the tool, the Prescriber Tool affordability module is a statewide effort under the Hospital Transformation Program (HTP); all hospitals are expected to implement and use the tool. In addition, the Department plans to reward prescribers beginning fiscal year (FY) 2022-23 for using the tool and generating savings during this current FY 2021-22.

Can Colorado pass on pharmaceutical rebates and discounts directly to patients so out-of-pocket costs don't continue to go up for the people who need these treatments the most?

Yes. But pass-through policy design needs to drive the **appropriate** consumer incentives overall, not just benefit individual consumers on their individual high cost drug purchases.

Specifically, rebate pass-through policy that reduces patient out of pocket costs for high cost drugs and causes an increase in the inappropriate use of these high cost drugs over less expensive brand name and generic drugs will cause an increase in the overall cost of health care. We need to avoid such policies. It is no surprise that the drug manufacturers who are pushing the use of these high cost drugs prefer this sort of policy. Please refer to page 49 of the Department's Prescription Drug report for more information on rebates and rebate pass-through and their potential for saving costs.

A program was put in place to reduce the cost of insulin. Is there anything being done for other drugs that are also very common and very expensive?

In Colorado, three important programs are underway to reduce drug prices: the prescriber tool noted above, Canadian drug importation and the Prescription Drug Affordability Board. Additional information can be found at the links and in the Prescription Drug report link in the question/answer immediately above.

Why can't the U.S. negotiate lower drug prices like other countries do?

If Federal elected officials made a decision to pass this sort of policy, then negotiating the prices of drugs across the U.S. would become a reality, similar to other nations. One of the U.S.'s largest purchasers of prescription drugs is the Medicare program, which is prohibited by law to negotiate with manufacturers to lower drug prices. Other federal opportunities to better control prescription drug costs include learning from Medicaid policy; drug importation from Canada and other countries beyond Canada and importation policy that is expanded to include biologics; patent and exclusivity reform of laws/regulations that prevent competition; expedition of approvals for generic drugs to enter the market (patent reform); and limits direct-to-consumer advertising. For more information on this, please see page 26 of the Department's report, *Reducing Prescription Drug Costs in Colorado*.

Why are we solving this cost issue by creating another middleman (other countries), rather than solving the issue of cost through other means, such as rebate reform?

Reducing prescription drug costs requires a multi-pronged approach, including importation, the prescription drug affordability board, rebate pass-through, passing through best prices to employers, and more. Importation from Canada can save more than 60%; importation from other high income countries can save even more. For more information on solutions to high prescription drug costs, please see the Department's report *Reducing Prescription Drug Costs in Colorado*.

Prescription Drug Affordability Board (PDAB) responses were completed by the Dept. of Regulatory Agencies. For more information please visit the Division of Insurance website https://doi.colorado.gov/prescription-drug-affordability-review-board

If the PDAB is appointed by the Governor, doesn't that mean it's not an independent board?

SB21-175 creates a five-person Prescription Drug Affordability Board (PDAB) that is authorized to undertake certain actions related to the affordability of prescription drugs. The Governor appoints PDAB members, who must have expertise in clinical medicine or health economics. The board is also subject to senate confirmation.

The PDAB is transferred within the Division of Insurance (DOI) as a type 1 transfer. The transfer creates a relationship in which the PDAB is administered under the direction and supervision of the DOI, but will exercise its powers, duties, and functions independently. The most important powers the PDAB retains as a type 1 transfer are the promulgation of rules and standards and the rendering of administrative findings, orders, and adjudications. Any powers, duties, and functions not specified by statute as belonging to the PDAB are performed under the direction and supervision of the DOI.

Do PDAB members have to disclose conflicts of interest?

Yes, Board members are required to disclose conflicts of interest. Beginning Jan. 1, 2022, all conflicts of interests disclosed to the Board will be posted on a website maintained by the Division of Insurance.

In regards to the PDAB, who has been designated to audit the carriers with regards to transparency and pricing and rebate accuracy?

Carriers will be required to submit data to the All Payers Claim Database administered by the Center for Improving Value in Health Care (CIVHC) who will evaluate data for quality and accuracy.

What metrics will the PDAB use to assess the "net benefit" of a particular drug?

The statute sets forth parameters for what must be considered as part of an affordability review and in setting an upper payment limit. For an affordability review, CRS 10-16-1406(6)CRS 10-16-1407(2) lists the considerations for the Upper Payment Limit (UPL) methodology. The Board has the authority to further define metrics in rulemaking.

Why are pharmaceutical drugs so costly for Americans, especially given that the federal government subsidizes pharmaceutical research?

The pricing around pharmaceuticals is complex. Please refer to page 18 of the Department's report, *Reducing Prescription Drug Costs in Colorado*.

What does HCPF spend on drugs net of discounts and rebates versus gross?

Please refer to page 46 of the Department's report, *Reducing Prescription Drug Costs in Colorado*.

Are most PBMs owned by their respective commercial payers? If so, doesn't that incentivize them to keep prices high?

Please refer to page 29 of the Department's report, *Reducing Prescription Drug Costs in Colorado*. PBM ownership/alignment with commercial carriers is increasingly common and concerning. As seen on pages 49 - 50 of the Department's report, there is a heightened need for increased rebate transparency, and a potential solution lies in efforts toward rebate pass-through. Also, on pages 57 and 58, the report illustrates that carriers/PBMs are not always passing along the prices they contract with pharmacies, keeping a "markup" to drive increased revenue and profits--a markup that the employer is often not aware of. In that sense, the higher prices--driven by rebates often retained by the PBM/carrier and a markup on pharmacy contracts--does indicate that the carriers may be profiting from these industry norms, which fuel the higher prices of prescription drugs.

Health Equity and the Social Determinants of Health

Do you have any data about vaccination rates for people experiencing homelessness?

The Department is able to identify members experiencing homelessness using Medicaid application data. This means that a member may have been unhoused at the time of application but has since gained housing or they were housed and are now experiencing homelessness. Taking this caveat into account, the Department is tracking the vaccine rate of members whose application indicates they are experiencing homelessness. The partial/full vaccination rate for members experiencing homelessness through July 26 was 24.2%, versus a rate of 43.3% for housed members.

Are all COVID vaccines administered to Medicaid beneficiaries being billed? Are all providers receiving reimbursement for administering the COVID vaccine to Medicaid beneficiaries and children covered under the Vaccines for Children program?

The COVID-19 vaccine is not being distributed through the Vaccines for Children Program. However, the Department changed its reimbursement rules so all providers can be reimbursed for administering COVID-19 vaccines. All COVID-19 vaccines administered to our members are eligible for reimbursement from Health First Colorado.

Is someone tracking the number of COVID-19 vaccines administered to pregnant women?

For members in our pregnancy eligibility categories, the COVID-19 vaccination rate is 30.7%, which is lower than the overall Medicaid age 12+ vaccination rate of 45.1%. (These rates include vaccine service dates up to Aug. 22, 2021.)

What kinds of support are available for pregnant people with substance use disorders?

Colorado's Medicaid benefit covers a full continuum of substance use disorder (SUD) services, including inpatient and residential treatment, for all members who need them. Additionally, there are specialty providers that serve pregnant and postpartum people.

These providers are certified by the Office of Behavioral Health to be trauma-informed and gender-responsive for the unique needs of this population, and several of them also allow children to remain with their parents when possible.

What do we know about vaccine hesitancy among Spanish-speaking populations?

For Spanish-speaking Medicaid members (age 12+), the COVID-19 vaccination rate is 56.7%, which is actually higher than the overall Medicaid age 12+ vaccination rate of 45.1%. (These rates include vaccine service dates up to Aug. 22, 2021.) For more information about vaccine hesitancy among Hispanic adults on a national level, refer to Kaiser Health Network's study.

What can community leaders do to increase vaccine rates in their communities?

Community leaders such as Primary Care Providers can enroll in vaccine programs such as the COVID-19 Primary Care Vaccination Program (COPCPVax) and Vaccine for Children (VFC) Programs which pay providers to build critical infrastructure such as pharmaceutical grade refrigeration and funding for staffing. COPCPVAX equips primary care providers (PCPs) with the resources they need to acquire and administer COVID-19 vaccine to Coloradans statewide.

The Vaccine for Children (VFC) Program is a federal program that does everything from providing equipment to funding for administration and is a longer-term program intended for all childhood vaccines.

Providers should also enroll in the Colorado Department of Public Health & Environment (CDPHE) CDC COVID-19 Vaccination Program. CDPHE is working to enroll providers as part of its efforts to quickly mobilize additional COVID-19 vaccine providers across the state and to increase access to COVID-19 vaccination for all Coloradans.

Non-clinical community leaders can encourage their community to get vaccinated by reaching out to their primary care providers or helping individuals by scheduling an appointment at a participating provider. Please see Where You Can Get Vaccinated.

Questions about the COVID-19 Primary Care Vaccination Program? Please contact the grant administration team at covidvax@coloradohealthinstitute.org.

Questions about enrolling in Colorado's COVID-19 Vaccine Program? Please contact CDPHE at cdphe_covidvax@state.co.us. Or, please visit their webpage for more information.

Behavioral Health

What is the state doing to address this lack of access to the workforce? In regards to the workforce development goals, are there any connections with CDLE and local workforce centers?

Workforce development has continuously been a challenge in behavioral health, and COVID-19 impacts to the workforce have created new challenges. This is going to be a significant topic in the interim legislative Behavioral Health Transformational Task Force. Currently, the Department of Human Services Office of Behavioral Health is leading a lot of the workforce development efforts for the behavioral health workforce, with a focus on integrated care training and addiction counselor training funds; the independent placement and support program; and peer training and funding programs. The Colorado Dept. of Public Health & Environment also has a Health Service Corps loan repayment program, which has been expanded through state funding in recent years.

How will the BHA work with integrated primary care practices? How were they represented in the stakeholder efforts?

The Behavioral Health Task Force had 100 members including the main task force and subcommittees. These members included representatives from health systems, large providers and primary care providers. The Behavioral Health Blueprint included recommendations to further expand integrated care efforts, which will be a priority of the Behavioral Health Administration.

What are legislators and other panelists doing to increase the training and credentialing process for BIPOC therapists?

In partnership with the Colorado Department of Higher Education, the Office of Behavioral Health is administering approximately $9M in funding provided by SB 21-137 to provide full funding of behavioral health related degrees to individuals identified as being part of underrepresented communities across Colorado including historically economically disadvantaged populations.