

COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING; FY 08-09 BUDGET REQUEST

Schedule 13

Change Request for FY 08-09 Budget Request Cycle

Decision Item FY 08-09 **Base Reduction Item FY 08-09** **Supplemental FY 07-08** **Budget Request Amendment FY 08-09**

Request Title: Increase Health Maintenance Organization Rates to 100% of Fee-for-Service

Department: Health Care Policy and Financing **Dept. Approval by:** John Bartholomew *JB* **Date:** November 1, 2007

Priority Number: DI-12 **OSPFB Approval:** *[Signature]* **Date:** 10/17/07 for 11/1/07

		1	2	3	4	5	6		8	9	10
	Fund	Prior-Year Actual FY 06-07	Appropriation FY 07-08	Supplemental Request FY 07-08	Total Revised Request FY 07-08	Base Request FY 08-09	Decision/ Base Reduction FY 08-09	November 1 Request FY 08-09	Budget Amendment FY 08-09	Total Revised Request FY 08-09	Change from Base (Column 5) FY 09-10
Total of All Line Items	Total	2,061,396,808	2,147,858,908	0	2,147,858,908	2,147,626,990	4,372,996	2,151,999,986	0	2,151,999,986	4,537,748
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	633,377,714	652,421,500	0	652,421,500	651,512,742	2,186,498	653,699,240	0	653,699,240	2,268,874
	GFE	343,100,000	343,900,000	0	343,900,000	343,900,000	0	343,900,000	0	343,900,000	0
	CF	0	38,256	0	38,256	38,256	0	38,256	0	38,256	0
	CFE	48,860,206	76,001,368	0	76,001,368	76,794,167	0	76,794,167	0	76,794,167	0
	FF	1,036,058,888	1,075,497,784	0	1,075,497,784	1,075,381,825	2,186,498	1,077,568,323	0	1,077,568,323	2,268,874
(2) Medical Services Premiums	Total	2,061,396,808	2,147,858,908	0	2,147,858,908	2,147,626,990	4,372,996	2,151,999,986	0	2,151,999,986	4,537,748
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	633,377,714	652,421,500	0	652,421,500	651,512,742	2,186,498	653,699,240	0	653,699,240	2,268,874
	GFE	343,100,000	343,900,000	0	343,900,000	343,900,000	0	343,900,000	0	343,900,000	0
	CF	0	38,256	0	38,256	38,256	0	38,256	0	38,256	0
	CFE	48,860,206	76,001,368	0	76,001,368	76,794,167	0	76,794,167	0	76,794,167	0
	FF	1,036,058,888	1,075,497,784	0	1,075,497,784	1,075,381,825	2,186,498	1,077,568,323	0	1,077,568,323	2,268,874

Letternote revised text:

Cash Fund name/number, Federal Fund Grant name: FF: Title XIX

IT Request: Yes No

Request Affects Other Departments: Yes No **If Yes, List Other Departments Here:**

CHANGE REQUEST for FY 08-09 BUDGET REQUEST CYCLE

Department:	Health Care Policy and Financing
Priority Number:	DI-12
Change Request Title:	Increase Health Maintenance Organization Rates to 100% of Fee-for-Service

SELECT ONE (click on box):

- Decision Item FY 08-09
- Base Reduction Item FY 08-09
- Supplemental Request FY 07-08
- Budget Request Amendment FY 08-09

SELECT ONE (click on box):

Supplemental or Budget Request Amendment Criterion:

- Not a Supplemental or Budget Request Amendment
- An emergency
- A technical error which has a substantial effect on the operation of the program
- New data resulting in substantial changes in funding needs
- Unforeseen contingency such as a significant workload change

Short Summary of Request:

This Change Request increases funding for the Department's Medical Services Premiums Long Bill Group by \$4,372,996 total funds to increase capitation rates paid to physical health managed care organizations from 95% of fee-for-service costs to 100% of fee-for-service costs. This funding would enable the Department to retain its sole physical health managed care organization in the Medicaid managed care program.

Background and Appropriation History:

At the beginning of FY 02-03, the Department contracted with five risk-based managed care organizations to provide acute care services to Medicaid clients: Colorado Access, Community Health Plan of the Rockies, Kaiser Foundation Health Plan, Rocky Mountain HMO, and United Health Care. At the time, roughly 50% of Medicaid clients were enrolled in one of these five plans. However, beginning in FY 02-03, the Department's managed care program began to change.

In November 2002, Kaiser Foundation Health Plan and United Health Care exited the program. Community Health Plan of the Rockies ceased providing services in February 2003. In July 2003, Rocky Mountain HMO ended its risk-based contract with the

Department, and entered into a non-risk administrative services contract with the Department for clients on the Western Slope. By the beginning of FY 03-04, approximately 22% of Medicaid clients were enrolled in a risk-based managed care plan.

During that same period, the Department was engaged in litigation and arbitration with four out of five of the managed care plans who had served Medicaid clients during that time, regarding the adequacy of the capitation rates paid to the plans. Between FY 02-03 and FY 04-05, the Department paid an additional \$77,810,395 to managed care plans as a result of judgments against the Department (FY 06-07 Joint Budget Committee Hearing, January 5, 2006, page 40). In response to the litigation, the General Assembly passed HB 02-1292, which significantly changed the managed care statute, and required that managed care organizations certify that capitation rates are actuarially sound, and that those rates are sufficient to assure the managed care organization's financial stability. Capitation rates were restricted to "ninety-five percent of the direct health care cost of providing these same services on an actuarially equivalent Colorado Medicaid population group" [25.5-5-408 (1) (b), C.R.S. (2007)], and therefore did not include any specific allowance for administrative services.

In May 2004, Denver Health formed a managed care organization known as Denver Health Medicaid Choice, and began providing services to Medicaid clients under a risk-based contract. Still, by the beginning of FY 04-05, enrollment in risk-based managed care had shrunk to approximately 15% of Medicaid clients. Enrollment reached a low of approximately 12.5% of Medicaid clients in April 2006.

On May 1, 2006, the Department initiated passive enrollment in Adams, Arapahoe, Denver, and Jefferson counties. Under passive enrollment, newly eligible clients were notified of their option to choose a Medicaid managed care plan or the Medicaid fee-for-service plan. Clients who did not actively make a decision were passively enrolled into either Colorado Access or Denver Health Medicaid Choice. In addition to newly eligible clients, existing fee-for-service clients from these four counties were given the same options, although the Department limited participation to a portion of the clients per

month. Under passive enrollment, enrollment in risk-based managed care plans almost doubled between May and August 2006.

However, on September 1, 2006, Colorado Access ended its participation in the Medicaid managed care program. Now, less than 10% of Medicaid clients are enrolled in a risk-based managed care organization. No new managed care organization has joined the Department since 2004. There is no risk-based managed care option outside the Denver-metro area.

During the 2007 Legislative Session, the General Assembly passed HB 07-1346, which removed the requirement that the Department pay no more than 95% of the direct health care cost of providing the same services on an actuarially equivalent population (HB 07-1346, Section 4, revising 25.5-5-408 (1) (b), C.R.S.). Further, the requirement that managed care organizations submit a proposal at or below the 95% level was modified to require the managed care organization to submit a proposal at or below 100% of the direct health care cost.

The Department did not receive an appropriation to increase rates to the 100% level. The Legislative Council fiscal note for HB 07-1346 stated that "...no state funds will be used to increase capitation rates" (Legislative Council Fiscal Note, HB 07-1346, May 30, 2007, page 3).

In June 2007, the Department was informed by Denver Health Medicaid Choice that unless capitation rates were increased to the 100% level, that it would leave the Medicaid managed care program. In response, the Department submitted a 1331 Emergency Supplemental to the Joint Budget Committee requesting permission and funding to raise rates to the 100% level. The Joint Budget Committee did not approve the Emergency Supplemental, but sent a letter to the Department stating:

The Joint Budget Committee has reviewed the Department's FY 2007-08 emergency supplemental request to increase health maintenance organization (HMO) rates to 100 percent of the fee-for-service costs for direct health care services. At this time,

the Committee has not approved a change to the Department's appropriation for the Medical Services Premiums (MSP) line item. The Committee will address all funding changes to the MSP line item, including the funding needed for this issue, during the March 2008 supplemental review. Although a change to the appropriation has not been approved at this time, **the Committee gives a favorable review to the Department's plan to negotiate HMO rates for Denver Health Medicaid Choice up to 100 percent of the fee-for-service costs** pursuant to Section 25.5-5-408 (9), Colorado Revised Statutes, (2007).

The Committee is fully aware that a favorable review of the Department's plan will have an eventual appropriation impact. (**Emphasis** added).¹

Based on the letter from the Joint Budget Committee, the Department entered into a contract with Denver Health Medicaid Choice effective July 1, 2007 to pay rates at an increased level to ensure that Medicaid clients continued to have adequate health care coverage.

General Description of Request:

The Department requests \$4,372,996 total funds to increase capitation rates from the 95% of fee-for-service level to the 100% level for FY 08-09 and beyond. The Department is permitted to pay rates up to the 100% of fee-for-service level by HB 07-1346, Section 4, although the Department did not receive any funding to raise capitation rates. Increasing capitation rates to the 100% level is a significant policy change that will increase expenditure. Because the Department cannot implement such a policy change without additional funding, this request seeks an appropriation from the General Assembly for the purpose of raising capitation rates to the 100% level. This request would allow the approximately 36,500 clients enrolled in Denver Health Medicaid Choice, to remain in the same medical home. If Denver Health Medicaid Choice were to exit the Medicaid managed care program, these clients would transition from managed care to fee-for-service.

¹ Letter from the Joint Budget Committee to Joan Henneberry, Executive Director, Department of Health Care Policy and Financing. June 20, 2007.

In September 2006, when Colorado Access ceased providing services as a physical health managed care organization, a significant number of clients were able to select Denver Health Medicaid Choice as their new medical home. This mitigated the impact of Colorado Access leaving the program, as clients were able to choose an alternative pre-existing network of providers. However, because Denver Health Medicaid Choice is the last remaining Medicaid physical health managed care organization, clients currently enrolled in managed care will immediately move to the fee-for-service population. This is a major change for clients who receive services in the managed care program.

The Department does not believe that a significant number of clients will transition to the primary care physician program. When Colorado Access exited the Medicaid managed care program in September 2006, the Department enrollment in the primary care physician program did not increase. Enrollment in the primary care physician program is not only a function of client need, but also of the ability of providers to take on additional caseload. As was seen after Colorado Access left, there does not appear to be either the capacity or the willingness to accept new clients in the program.

The Department does not require any additional administrative resources to implement the change. The Department, in consultation with its actuary, has determined that rates at the 100% level fall within the range required to maintain actuarial soundness for FY 07-08, and therefore are expected to be sound in FY 08-09 and beyond. The Department can implement the change immediately upon approval of the Change Request, which would affect capitation rates paid for July 1, 2008.

Additionally, if new providers enrolled, the Department would pay any new health maintenance organizations at the 100% of fee-for-service levels. The Department does not anticipate any additional costs or savings from increasing the number of providers, as the Department already pays 100% of fee-for-service rates to fee-for-service providers.

This Request does not seek any funding for paying rates at 100% of fee-for-service for FY 07-08. The Department may choose to submit a separate budget action at the appropriate time to account for changes to the program in FY 07-08.

Consequences if Not Funded:

If the Department's request is not approved, Denver Health Medicaid Choice would likely exit the Medicaid managed care program. Approximately 36,900 clients would transition from managed care to fee-for-service. The Department may experience increased costs as a result of paying the full fee-for-service rates, as the Department was previously paying 95% of the fee-for-service cost for these clients. The Department anticipates that it would see increases in more expensive emergency services, as clients' access to primary and preventive care would likely be disrupted. Furthermore, with reduced access to primary and preventive care offered through managed care, the quality of care of patient care could deteriorate, resulting in additional costs.

Further, the Department's ability to encourage new risk-based managed care organizations to participate in the Medicaid program will remain at its current low level. Other than Denver Health Medicaid Choice, the Department has not had a new physical health managed care organization enter the program since August 1997.

The Department estimates that the increased cost of these clients transitioning to the fee-for-service population would be equal to or greater than the cost of increasing capitation rates to the 100% level. If the Department experienced increased costs as a result of the transition, the Department would request additional funding as part of the normal Budget Request for Medical Services Premiums on November 1, 2008.

Calculations for Request:

Summary of Request FY 08-09	Total Funds	General Fund	Federal Funds
Total Request (Matches column 6, Schedule 13)	\$4,372,996	\$2,186,498	\$2,186,498
(2) Medical Services Premiums (Matches column 6, Schedule 13)	\$4,372,996	\$2,186,498	\$2,186,498

Summary of Request FY 09-10	Total Funds	General Fund	Federal Funds
Total Request (Matches column 10, Schedule 13)	\$4,537,748	\$2,268,874	\$2,268,874
(2) Medical Services Premiums (Matches column 10, Schedule 13)	\$4,537,748	\$2,268,874	\$2,268,874

Source for Summary of Request located in Table 2, on page 12.

Assumptions for Calculations:

The Department has calculated the impact of increasing capitation rates to the 100% level using the most current figures for Denver Health Medicaid Choice enrollment. Enrollment figures have been adjusted to reflect estimated caseload growth, using trend factors from the Department's November 1, 2007 Budget Request for Medical Services Premiums (page EB-1). To the extent that actual enrollment varies from the forecast, the Department may require more or less funding in FY 08-09 and subsequent years. If the Department experiences increased costs as a result of the transition, the Department would request additional funding as part of the normal Budget Request for Medical Services Premiums on November 1, 2008.

Impact on Other Government Agencies:

None.

Cost Benefit Analysis:

Return on Investment Analysis

The Department anticipates that increasing capitation rates will enable the Department to retain Denver Health Medicaid Choice as a physical health managed care organization. This will increase client access to primary and preventive care. Without this access, clients may experience adverse health outcomes from preventable illnesses which would have been avoided if clients had expanded access to primary and preventive care. As clients

experience adverse health outcomes, the Department is required to purchase more expensive treatments, likely increasing state expenditure on these clients by at least 10% above the 100% of fee-for-service level.

Investment:	Cost Avoidance
Additional cost of increased capitation rates	Possible higher incidence of preventable illness and adverse health outcome.
	Increased capitation rates due to higher risk accepted by the managed care organization potentially avoided.
\$4,372,996 Total FY 08-09 requested funds	Approximately \$4,810,296
	ROI = 1.10

Implementation Schedule:

The Department would implement new capitation rates on July 1, 2007.

Statutory and Federal Authority:

25.5-5-402, C.R.S. (2007). Statewide managed care system.

(1) The state board shall adopt rules to implement a managed care system for Colorado medical assistance clients pursuant to the provisions of this article and articles 4 and 6 of this title. The statewide managed care system shall be implemented to the extent possible.

25.5-5-408, C.R.S. (2007) [as enacted by HB 07-1346]. Capitation payments - availability of base data - adjustments - rate calculation - capitation payment proposal - preference - assignment of medicaid recipients.

(9) The rate-setting process referenced in subsection (6) of this section shall include a time period after the MCOs have received the direct health care cost of providing these same services on an actuarially equivalent Colorado medicaid population group consisting of unassigned recipients and recipients in the primary care physician program provided in section 25.5-5-407, for each MCO to submit to the state department the MCO's capitation payment proposal, which shall not exceed one hundred percent of the direct health care cost of providing these same services on an actuarially equivalent Colorado medicaid population group consisting of unassigned recipients and recipients

in the primary care physician program provided in section 25.5-5-407. The state department shall provide to the MCOs the MCO's specific adjustments to be included in the calculation of the MCO's proposal. Each MCO's capitation payment proposal shall meet the requirements of section 25.5-5-404 (1) (k) and (1) (l).

Performance Measures:

This Change Request affects the following Performance Measures:

- Increase the number of clients served through targeted, integrated care management programs.
- Improve access to and the quality of Medicaid health care as demonstrated through improvements in the Medicaid Health plan scores on Health Plan Employer Data Information Set (HEDIS) measures.
- Survey customer satisfaction with managed care using the Consumer Assessment of Health Plans Survey (CAHPS).

The Department believes that increasing health maintenance organization rates to 100% of the fee-for-service level will increase overall access to health care, thereby increasing customer satisfaction and quality of health outcomes.

COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING; FY 08-09 BUDGET REQUEST

Table 1: Estimate of Increase in Expenditure Due to Increase in Capitation Rates FY 07-08 Impact									
Column		A	B	C	D	E	G	H	I
Aid Category	Rate Subcategory	FY 07-08 Rate 95% of Fee-for-Service	FY 07-08 Rate 100% of Fee-for-Service	Difference	Estimated FY 06-07 Monthly Enrollment	Estimated Trend from FY 06-07 to FY 07-08	Estimated FY 07-08 Monthly Enrollment	Estimated Increase in FY 07-08 Monthly Expenditure	Estimated Increase in FY 07-08 Expenditure
Categorically Eligible Low-Income Adults (AFDC-A)	Female	\$183.71	\$193.38	\$9.67	4,015	-11.94%	3,535	\$34,179	\$410,148
Categorically Eligible Low-Income Adults (AFDC-A)	Male	\$162.31	\$170.86	\$8.54	720	-11.94%	634	\$5,416	\$64,992
Baby Care Program Adults		\$180.89	\$190.41	\$9.52	215	6.44%	229	\$2,180	\$26,160
Eligible Children (AFDC-C/BC)	Age 1 and Over	\$58.08	\$61.13	\$3.06	19,027	-6.47%	17,796	\$54,397	\$652,764
Eligible Children (AFDC-C/BC)	Under 1	\$191.73	\$201.82	\$10.09	2,468	-6.47%	2,308	\$23,290	\$279,480
Foster Care		\$213.20	\$224.42	\$11.22	139	11.01%	154	\$1,728	\$20,736
Adults 65 and Older (OAP-A)	Non-Institutional	\$231.95	\$244.16	\$12.21	3,369	-1.96%	3,303	\$40,323	\$483,876
Adults 65 and Older (OAP-A)	Institutional	\$214.79	\$226.10	\$11.30	191	-1.96%	187	\$2,114	\$25,368
Disabled Individuals and Adults (OAP-B and AND/AB)	Non-Institutional, Medicaid Only	\$726.00	\$764.21	\$38.21	4,234	1.62%	4,303	\$164,419	\$1,973,028
Disabled Individuals and Adults (OAP-B and AND/AB)	Non-Institutional, Third Party Coverage	\$186.45	\$196.26	\$9.81	1,779	1.62%	1,808	\$17,742	\$212,904
Disabled Individuals and Adults (OAP-B and AND/AB)	Institutional, Medicaid Only	\$1,585.23	\$1,668.66	\$83.43	63	1.62%	64	\$5,340	\$64,080
Disabled Individuals and Adults (OAP-B and AND/AB)	Institutional, Third Party Coverage	\$181.89	\$191.47	\$9.57	28	1.62%	28	\$268	\$3,216
Total					36,248		34,349	\$351,396	\$4,216,752
Formula/Notes		(1)	(1)	B - A	(2)	(3)	D * (1 + E)	C * F	G * I

(1) FY 07-08 capitation rates taken from the Department's Actuarial Certification letter

(2) Estimated FY 06-07 Monthly Enrollment based on internal Department figures for Denver Health Medicaid Choice enrollment, using the average of January - June 2007

(3) Estimated trend taken from the Department's November 1, 2007 Budget Request, Exhibits for Medical Services Premiums, page EB-1. For the purpose of this analysis, the Department assumes that enrollment trends will reflect overall Medicaid caseload trends by aid category. For the combined Disabled Individuals category, the Department uses the Disabled Individuals to 59 (AND/AB) trend, as those clients represent the large majority of clients served in this rate group.

Column		A	B	C	D	E	F	G
Aid Category	Rate Subcategory	Estimated Increase in FY 07-08 Expenditure	FY 08-09 Estimated Increase in Per Capita Cost	FY 08-09 Estimated Increase in Caseload	Estimated Increase in FY 08-09 Expenditure	FY 09-10 Estimated Increase in Per Capita Cost	FY 09-10 Estimated Increase in Caseload	Estimated Increase in FY 09-10 Expenditure
Categorically Eligible Low-Income Adults (AFDC-A)	Female	\$410,148	4.92%	-2.31%	\$420,387	4.92%	-0.43%	\$439,173
Categorically Eligible Low-Income Adults (AFDC-A)	Male	\$64,992	4.92%	-2.31%	\$66,614	4.92%	-0.43%	\$69,591
Baby Care Program Adults		\$26,160	2.47%	3.59%	\$27,768	2.47%	2.81%	\$29,253
Eligible Children (AFDC-C/BC)	Age 1 and Over	\$652,764	4.23%	-0.06%	\$679,968	4.23%	0.02%	\$708,872
Eligible Children (AFDC-C/BC)	Under 1	\$279,480	4.23%	-0.06%	\$291,127	4.23%	0.02%	\$303,502
Foster Care		\$20,736	5.02%	4.76%	\$22,814	5.02%	2.12%	\$24,467
Adults 65 and Older (OAP-A)	Non-Institutional	\$483,876	1.63%	0.64%	\$494,910	1.63%	0.71%	\$506,548
Adults 65 and Older (OAP-A)	Institutional	\$25,368	1.63%	0.64%	\$25,946	1.63%	0.71%	\$26,556
Disabled Individuals and Adults (OAP-B and AND/AB)	Non-Institutional, Medicaid Only	\$1,973,028	3.58%	0.41%	\$2,052,041	3.58%	0.10%	\$2,127,630
Disabled Individuals and Adults (OAP-B and AND/AB)	Non-Institutional, Third Party	\$212,904	3.58%	0.41%	\$221,430	3.58%	0.10%	\$229,587
Disabled Individuals and Adults (OAP-B and AND/AB)	Institutional, Medicaid Only	\$64,080	3.58%	0.41%	\$66,646	3.58%	0.10%	\$69,101
Disabled Individuals and Adults (OAP-B and AND/AB)	Institutional, Third Party Coverage	\$3,216	3.58%	0.41%	\$3,345	3.58%	0.10%	\$3,468
Total		\$4,216,752			\$4,372,996			\$4,537,748
Formula/Notes		(1)	(2)	(3)	A * (1 + B) * (1 + C)	(2)	(3)	A * (1 + B) * (1 + C)

(1) From table 1

(2) Estimated per capita growth from November 1, 2007 Budget Request, Section E, Exhibits for Medical Services Premiums, Exhibit F, page EF-4. FY 08-09 trends held constant for FY 09-10.

(3) Estimated caseload trend taken from the Department's November 1, 2007 Budget Request, Section E, Exhibits for Medical Services Premiums, page EB-1. For the purpose of this analysis, the Department assumes that enrollment trends will reflect overall Medicaid caseload trends by aid category. For the combined Disabled Individuals category, the Department uses the Disabled Individuals to 59 (AND/AB) trend, as those clients represent the large majority of clients served in this rate group.