June 1331 MCO Rates

Schedule 13
1331 Emergency Change Request for FY 07-08 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 for JB	**Date:** June 20, 2007
Priority Number:	N/A	**OSPB Approval:**		**Date:** 6/7/07

	Fund	1 Prior-Year Actual FY 06-07	2 Appropriation FY 07-08	3 1331 Supplemental Request FY 07-08	4 Total Revised Request FY 07-08	5 Base Request FY 08-09	6 Decision/ Base Reduction FY 08-09	7 November 1 Request FY 08-09	8 Budget Amendment FY 08-09	9 Total Revised Request FY 08-09	10 Change from Base (Column 5) FY 09-10
Total of All Line Items	**Total**	0	2,147,624,708	4,178,940	2,151,803,648	0	0	0	0	0	0
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	0	652,304,400	2,089,470	654,393,870	0	0	0	0	0	0
	GFE	0	343,900,000	0	343,900,000	0	0	0	0	0	0
	CF	0	38,256	0	38,256	0	0	0	0	0	0
	CFE	0	76,001,368	0	76,001,368	0	0	0	0	0	0
	FF	0	1,075,380,684	2,089,470	1,077,470,154	0	0	0	0	0	0
(2) Medical Services Premiums	**Total**	0	2,147,624,708	4,178,940	2,151,803,648	0	0	0	0	0	0
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	0	652,304,400	2,089,470	654,393,870	0	0	0	0	0	0
	GFE	0	343,900,000	0	343,900,000	0	0	0	0	0	0
	CF	0	38,256	0	38,256	0	0	0	0	0	0
	CFE	0	76,001,368	0	76,001,368	0	0	0	0	0	0
	FF	0	1,075,380,684	2,089,470	1,077,470,154	0	0	0	0	0	0

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:	N/A
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 $4,178,940 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. (2006)], 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. As of September, 2006, 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.

General Description of Request:

The Department requests $4,178,940 total funds to increase capitation rates from the 95% of fee-for-service level to the 100% level. The Department is permitted to pay rates at 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 36,900 clients enrolled in Denver Health Medicaid Choice in May 2007, 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.

Under the proposed methodology, Denver Health Medicaid Choice would receive an estimated increase in revenue of 12.3% over FY 06-07 estimated expenditure. Of this increase, a portion is already included in the Department's appropriation for FY 07-08. If rates were held at the 95% level, Denver Health Medicaid Choice would receive an estimated increase in revenue of approximately 7.3% over FY 06-07 estimated expenditure due to allowable base trend adjustments, if it remained in the Medicaid managed care program. These base trend adjustments were included in the calculations for the Department's February 15, 2007 Budget Request for Medical Services Premiums.

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.

As part of the rate-setting process, the Department has calculated rates at both levels, and therefore 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. Therefore, the Department would not experience any additional costs or delays by required rate calculations to be recertified by its actuaries. The Department can implement the change immediately upon approval of the Change Request, which would affect capitation rates paid for July 1, 2007.

Consequences if Not Funded:

If the Department's request is not approved, Denver Health Medicaid Choice would 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 for patients could deteriorate, resulting in additional costs.

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, 2007.

Calculations for Request:

Summary of Request FY 07-08	Total Funds	General Fund	Cash Funds	Cash Funds Exempt	Federal Funds	FTE
Total Request (Matches column 8, Schedule 13)	**$4,178,940**	**$2,089,470**	**$0**	**$0**	**$2,089,470**	**0.0**
(2) Medical Services Premiums (Matches column 8, Schedule 13)	$4,178,940	$2,089,470	$0	$0	$2,089,470	0.0

Source for Summary of Request located in Table 1, on page 10.

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 February 15, 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 07-08. 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, 2007.

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.
$4,178,940 Total FY 07-08 requested funds	**Approximately $4,596,834**
	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. (2006). 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. [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).

Table 1: Estimate of Increase in Expenditure Due to Increase in Capitation Rates

Column		A	B	C	D	E	F	G
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**	**Estimated FY 07-08 Monthly Enrollment**	**Estimated Increase in FY 07-08 Monthly Expenditure**
Categorically Eligible Low-Income Adults (AFDC-A)	Female	$189.80	$199.79	$9.99	4,086	-9.53%	3,697	$36,933
Categorically Eligible Low-Income Adults (AFDC-A)	Male	$168.19	$177.04	$8.85	733	-9.53%	663	$5,868
Baby Care Program Adults		$196.67	$207.02	$10.35	219	-0.46%	218	$2,256
Eligible Children (AFDC-C/BC)	Age 1 and Over	$60.75	$63.95	$3.20	19,373	-3.12%	18,769	$60,061
Eligible Children (AFDC-C/BC)	Under 1	$183.53	$193.19	$9.66	2,513	-3.12%	2,435	$23,522
Foster Care		$239.13	$251.72	$12.59	141	1.85%	144	$1,813
Adults 65 and Older (OAP-A)	Non-Institutional, Medicaid Only	$405.42	$426.76	$21.34	734	0.99%	741	$15,813
Adults 65 and Older (OAP-A)	Non-Institutional, Third Party Coverage	$176.13	$185.41	$9.28	2,697	0.99%	2,724	$25,279
Adults 65 and Older (OAP-A)	Institutional, Medicaid Only	$623.62	$656.44	$32.82	24	0.99%	24	$788
Adults 65 and Older (OAP-A)	Institutional, Third Party Coverage	$186.98	$196.82	$9.84	171	0.99%	173	$1,702
Disabled Individuals and Adults (OAP-B and AND/AB)	Non-Institutional, Medicaid Only	$663.32	$698.23	$34.91	4,311	1.32%	4,368	$152,487
Disabled Individuals and Adults (OAP-B and AND/AB)	Non-Institutional, Third Party Coverage	$172.91	$182.01	$9.10	1,811	1.32%	1,835	$16,699
Disabled Individuals and Adults (OAP-B and AND/AB)	Institutional, Medicaid Only	$1,362.65	$1,434.37	$71.72	65	1.32%	66	$4,734
Disabled Individuals and Adults (OAP-B and AND/AB)	Institutional, Third Party Coverage	$189.74	$199.73	$9.99	29	1.32%	29	$290
Total					36,907		35,886	$348,245
Formula/Notes		(1)	(1)	B - A	(2)	(3)	D * (1 + E)	C * F

(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, from May 2007

(3) Estimated trend taken from the Department February 15, 2007 Budget Request, Exhibits for Medical Services Premiums, page EB-1. For the purpose of this analysis, the Department : enrollment trends will reflect overall Medicaid caseload tren