

Department of Health Care Policy and Financing

**AGENDA
FY 2008-09 Joint Budget Committee Hearing**

**Thursday -- December 13, 2007
9:00 a.m. to 5:00 p.m.**

I. 9:00 a.m. to 9:10 a.m. Director Introduction and Opening Comments

A. 9:10 a.m. to 9:30 a.m. Strategic Plan and Direction for the Department for the Next Three Years

1. Given the change in the Administration, have there been any changes to your department's principal goals and objectives since last year?

RESPONSE:

The primary goal of the Department is to improve health outcomes for all clients through the purchase of medically necessary, appropriate and cost-effective services. The Strategic Plan and Budget Request reflect the Administration's initiatives to achieve Department goals and there have been some changes to the Department's principle goals and objectives since last year. A new primary objective is to enroll more children into public health insurance programs who are already eligible, but not enrolled and this will continue to be a performance measure for the Department. In order to improve health outcomes and quality of care, a variety of new programs are being designed including providing children with a "medical home"; enrolling high cost, chronically ill clients into disease management programs; and developing new models for Medicaid managed care.

2. What progress did you make during the last year in achieving your goals?

RESPONSE:

- Aggressive outreach was done in FY07-08 and additional funding is requested for FY 08-09 to refine outreach strategies in order to enroll hard-to-reach populations. Since January 2007, enrollment in the Children's Basic Health Plan has increased by over 10,000 children.
- There are currently 28 medical practices participating in the medical homes program and approximately 10,861 children are currently served in designated medical homes. By July 2008, a 10% increase is expected in the number of children enrolled in a designated, medical home.
- Six new disease management programs were launched in 2007 to serve individuals with asthma, congestive heart failure, chronic obstructive pulmonary disease, high risk pregnancy, telehealth and weight management. A total of 5,805 individuals will be served in these programs.

- The Department is working with various managed care entities to research and develop standards and metrics for outcomes, enrollment strategies, and appropriate payment and incentive policies. It is a long-term goal to enroll most, if not all, Medicaid clients into a managed care program that will improve health outcomes and reduce unnecessary expenditures.

3. How is the additional money provided to your department in FY 2007-08 being used to achieve your goals? What improvements is your department making in its outputs?

RESPONSE:

The Department received additional funding in FY 07-08 for four broad purposes: Base caseload and cost per client growth for the Medicaid program and the Children's Basic Health Plan; provider rate increases; to ensure correct and timely eligibility processing; and, administrative and programmatic efficiencies. Every additional dollar requested by the Department for FY 07-08 was for the purpose of achieving its goals and performance measures, as outlined in the Department's November 1, 2006 Strategic Plan.

Base Growth and Provider Rate Increases

In FY 07-08, the Department received additional funding for base caseload and cost per client growth for the Medicaid program and the Children's Basic Health Plan; and, provider rate increases for providers which were identified as being paid substantially below cost, or critical to the Department's provider network. This funding is used to ensure client access to appropriate, medically necessary health care. This has included maintaining access to inpatient hospital care; emergency and non-emergency medical transportation; and, specialty physicians, such as surgeons, anesthesiologists, and therapists. The Department has engaged different provider communities to determine areas of shortfalls, and continues to work on improving client access to care. Further, the Department is using funding appropriated to maintain its existing managed care network and explore possibilities for managed care expansion.

Correct and Timely Eligibility Processing

In FY 07-08, the Department received additional funding to ensure that eligibility processing for public assistance was timely, and met new requirements in both state and federal law. This included funding for the enforcement of Medicaid eligibility requirements established in HB 06S-1023 and the Deficit Reduction Act of 2005; funding to reduce medical program applications exceeding processing guidelines; and funding to implement the Children's Basic Health Plan Premiums Assistance program. Such funding is used to achieve the Department's goals of supporting timely and accurate client eligibility determinations, and to assure that payments made in support of the program are accurate and timely. With the funding appropriated, the Department is implementing system changes required to comply with the new citizenship requirements in the Medicaid program and is reducing the number of applications exceeding processing guidelines. The Department continues to work towards implementing the Premiums Assistance program.

Administrative and Programmatic Efficiencies

In FY 07-08, the Department received additional funding to ensure that Department programs were administered efficiently. This included funding for the implementation of a preferred drug list, increased audits of certain provider groups, and additional commercial leased space to house Department staff. This funding was requested to support the Department's performance measures related to the accuracy of payments, and to build and maintain a high quality, customer-focused team.

The Department is currently in the process of establishing a preferred drug list, and anticipates implementation in early 2008. The Department has extended the contract of its hospital and federally qualified auditor, who has begun additional site audits of providers. The Department is also in the process of hiring an auditor for the Primary Care Fund programs. Further, the Department has expanded into additional office space, allowing the Department to continue to fill critical vacant positions and improve staff morale by improving working conditions.

- 4. Please identify your department's 3 most effective programs and your 3 least effective programs. Explain why you identified them as such. Explain how your most effective programs further the department's goals.**

RESPONSE:

The three most effective programs are the "Keep Colorado Kids Healthy" Children's Basic Health Plan outreach campaign; medical homes for children; and the Consumer Directed Attendant Support waiver. The Department is hesitant to designate any of its programs as the least effective given the significant impact that all programs have on clients. The Department would like to put forth three programs which could most benefit by a change to how services are delivered. These programs are fee-for-service as a model for providing health care to Medicaid clients; fraud, abuse and waste prevention; and the lack of standardized, predictable rate increases for providers.

The Children's Basic Health Plan outreach campaign has been instrumental in progress toward the goal of enrolling more eligible children into programs. The medical home model is a way to provide care to children. An independent evaluation conducted on a pilot basis demonstrated improved health outcomes for children and savings by reducing costs such as unnecessary emergency department visits through a medical home. The Consumer Directed Attendant Support waiver demonstrated that many clients living in their homes and communities are willing and able to manage their attendant services at a cost equal to, or less than, what the state would pay agencies for the same services. There is a greater level of client satisfaction among the elderly and persons with disabilities who use Consumer Directed Attendant Support services; the consumer-directed option will be incorporated into all home and community based services waiver programs.

Fee-for-service allows clients to seek care from any provider at any time which leads to a lack of coordinated care. The providers do not have the ability to share data or information in a way that coordinates the care, reduces duplication of efforts such as labs and radiology, or prevents unnecessary treatments. A robust, integrated care management program is more cost-effective and likely to produce better health outcomes.

As noted by the findings in the Government Efficiency Management Study, the Department's current efforts on fraud, abuse and waste are primarily focused on events that occur after the fact. The Department does not currently have the proper resources available or statutory authority to focus more on the prevention of fraud, abuse and waste. New statutory authority, technology tools, and additional staff could help improve prevention efforts. The lack of standardized, predictable rate adjustments for providers makes it extremely difficult to recruit and retain providers to serve clients in public health insurance programs. There is a constant churn of providers which increases administrative costs and delays the provision of care to clients.

- 5. Are there programs that your department is required to perform that do not further your department's goals or have outlived their usefulness? If so, what are they and by whom are they required? Why don't they further your department's goals?**

RESPONSE:

No.

- 6. What are your department's principal goals and objectives? What are the metrics by which you measure success or failure? As a department director, how do you judge your department's performance? What key measures and targets do you use?**

RESPONSE:

The mission, vision, goals and objectives are outlined in the Department's FY 08-09 Strategic Plan. The metrics are also specified in the plan as performance measures. The director and the Leadership Team judge performance based on the metrics and benchmarks described in the Strategic Plan, as well as the detailed project plans for each division. The Leadership Team meets monthly and assesses progress on key goals quarterly.

- 7. Please describe what impact the "Colorado Plan" has in determining the Department's goals and priorities for the next three years. Also, please briefly describe major accomplishments or setbacks associated with moving forward with the following four issues that are specifically mentioned in the Colorado Plan (some of these issues may also be discussed more specifically in other issues -- please just give a broad overview here).**
- 7a) What is the Department's current assessment for the loss of Medicaid managed care? What is the status of initiatives or negotiations to attract new managed care plans to the Medicaid market? Is the Department on target to adding one more plan in the Denver Metro area in FY 2007-08 (page N-10 of your strategic plan)?**

RESPONSE:

The loss of Medicaid managed care began in 2003 when managed care enrollment changed from a mandatory program to a voluntary one. Between 2003 and 2006, four of six managed care contracts ended. In FY 06-07, the statutory mandated rate setting methodology resulted in an 11.6% decrease in Medicaid managed care rates despite a widely acknowledged increase in medical costs. The rate decrease, coupled with the artificial statutory cap that managed care organization payments could not exceed 95% of the regular Medicaid fee-for-service costs, put a financial squeeze on the last two managed care organizations still participating in the Medicaid program. As a result, one of the remaining managed care organizations withdrew from the Medicaid program in the summer of 2006. The other continued to participate, but at a reported financial loss. In 2007, only one fully capitated managed care organization is still serving Medicaid clients.

HB 07-1346 substantially changed the Medicaid rate setting methodology. The fiscal cap was raised from 95% to 100% of the regular Medicaid fee-for-service costs. The Department believes that statutory change is an important step to reverse the trend of shrinking participation in the Medicaid managed care program.

The Department is currently in discussions with five managed care organizations that have expressed an interest in entering (or reentering) the Colorado Medicaid market. Of these five, the Department is currently negotiating with one and is involved in the details of program design, rates and contract terms. The Department hopes to complete negotiations to add one more managed care plan before the end of this current fiscal year.

7b) What problems or issues does the Department still have with the CBMS system?

RESPONSE:

One of the stated goals in the Colorado Promise document was to “aggressively work to fix the state’s information technology infrastructure, including the troubled Colorado Benefits Management System (CBMS).”

Executive Order D 005 07 dated February 15, 2007 rescinded Executive Order D 004 05 and dissolved the Office of CBMS. The Colorado Department of Human Services (CDHS) and the Colorado Department of Health Care Policy and Financing (the Department) assumed joint management and control of CBMS. Staff from CDHS and the Department initiated a variety of activities to improve day-to-day operational activities, business processes, communication and coordination to enhance overall CBMS systems functionality.

A major activity and accomplishment focused on prioritizing the work to be completed to “fix the top CBMS issues.” Representatives from CDHS, the Department and the counties formed a workgroup to prioritize these issues and develop a plan to implement the changes within CBMS. The group determined the full working list of CBMS projects, defined an initial set of business case criteria to the projects and linked the top 14 issues to business case criteria. Projects were evaluated based on the impact to noticing/correspondence, accurately determining eligibility, workload/efficiency, fiscal

impact, and number of clients impacted. The top 14 issues were further refined to create a top 8 list. Work groups for each of the top 8 list issues were formed to identify all of the issues, gather requirements, prepare change requests, obtain costs from the CBMS vendor, EDS, and implement the change requests. For example, client correspondence was identified as one of the top CBMS issues based on feedback from clients that notices are sometimes confusing and appear to contain conflicting information. The client correspondence work group identified 80 items to review and anticipate that 41 decision table items and 13 change requests will be implemented prior to June 30, 2008.

A comprehensive and thorough review of CBMS processes is ongoing. A new CBMS Business Requirement Gathering process using a System Wide Analysis Team (SWAT) approach was developed and is currently in use. When a new Change Request is identified to improve system functionality, fix a system defect or implement new legislative mandates, this process ensures that all of the appropriate department, program and technical staff together with EDS staff can craft the best solution to be implemented into CBMS. It also streamlines the process so that change requests can happen more efficiently and accurately.

Because of the ongoing changes made to the system together with the high staff turnover at the counties, the Department and CDHS have invested a significant amount of time and resources to the issue of training. A variety of training materials and methods are currently in place to provide end-users with the best available information to navigate the system and process applications more efficiently.

There will always be inherent challenges and risks associated with a system that is subject to oversight by multiple federal agencies with different policies and requirements. However, under the new leadership of the Executive Directors of the Department and CDHS, much has been accomplished to address CBMS issues. With any complex and dynamic integrated system such as CBMS, system enhancements and improvements are to be expected. With a new plan and focus to direct the activities of CBMS, the Department is confident that the clients who are eligible for program services will be better served.

7c) What is the status of linking the state Medicaid program with the Colorado Regional Health Information Organization.

RESPONSE:

The Colorado Regional Health Information Organization (CORHIO) was incorporated as a non-profit corporation in the spring of 2007. CORHIO's mission is to facilitate the electronic exchange of health information, or health care records, to improve health and health care for all Coloradans. CORHIO is working to launch its initial Health Information Exchange of laboratory data between Denver Health, the Children's Hospital, University Hospital and Kaiser Permanente in June of 2008. The Executive Director of the Department of Health Care Policy and Financing, along with other members of the executive branch, serves as a non-voting ex-officio member of the of the CORHIO Board of Directors to represent the State's interests while supporting the implementation of CORHIO. In this capacity, the Department has participated in CORHIO's development of policies

for data exchange including legal agreements and technology standards.

The Department is also engaged in developing a comprehensive Health Information Technology strategy that will take advantage of CORHIO's eventual statewide Health Information Exchange role and emerging technical services to benefit the Department's Clients and programs.

Finally, the Department is working closely with the State Office of Information Technology to develop the State's working knowledge regarding Health Information Technology and will continue to integrate CORHIO into the State's vision for an effective Information Technology enterprise.

7d) Please briefly describe any quality improvement/disease management programs that the Department is currently pursuing.

RESPONSE:

The Department is pursuing the following quality improvement and disease management programs:

Quality Improvement

- Immunization Registry
- Focused Studies
- Consumer surveys
- Implementation of Medical Home (Senate Bill 07-130) legislation and Senate Bill 07-211
- Provider Profiling
- Quality Intervention
- Performance Measurement
- Return on Investment Forecasting Calculation Tool
- Annual Site Reviews
- Long-term Care & Home and Community Based Services Activities

Disease Management

- Asthma
- Telehealth Pilot Program for Chronic Conditions
- Congestive Heart Failure
- Chronic Obstructive Pulmonary Disease
- High-Risk Obstetrics
- Weight Management

For detail regarding the quality improvement and disease management program please see Attachment 1.

8. What are the five major challenges that the Department will face during this upcoming year?

RESPONSE:

Assessing and implementing programs that emerge from health care reform legislation; developing a comprehensive plan to enroll most, if not all, Medicaid clients into a managed care model; recruitment, retention, and increased satisfaction of providers willing to serve Medicaid clients; designing a strategic plan to improve the long-term care and home and community-based service system; and recruitment, training, and retention of staff at the Department.

- 9. One of the Department's selected performance measurers is to "maintain or reduce the difference between the Department's spending authority and actual expenditures for Medicaid services." Where, if anywhere, does the Department believe improvements could be made in the annual budget process to ensure that over expenditures and reversions are minimized at year-end close?**

RESPONSE:

The Department's budget is largely driven by caseload. Because the process begins 12 to 18 months prior to the fiscal year there will always be an amount of uncertainty since caseload numbers are affected by many factors that are difficult to predict far into the future. However, the Department is working in several areas to produce better and more accurate forecasts. These efforts include working to improve internal communication within the Department on expected programmatic changes and initiatives that would affect forecasts. The Department is improving the training of current staff on processes and programs as well as forecasting methodologies. In addition, the Department is working to retain staff in order to prevent the loss of knowledge due to the loss of experienced and talented personnel with necessary technical skills. The Department is currently developing improved tools to track both the budget process and any changes likely to affect the Department's forecasts as well as actively working to develop or acquire better forecasting tools. The Department is also working to improve internal and external collaboration on forecasts.

The Department supports the recommendation of the Joint Budget Committee Staff (#3 on page 80 of the Briefing document) that Section 24-75-108, C.R.S. (2007) be revised to allow the State Controller to use any General Fund that will revert to first reduce the amount of any administrative, non-statutorily permissible over-expenditures. Furthermore, the Department encourages the evaluation of the Executive Director's Office Long Bill group, as directed in footnote 22 and submitted in the Department's response to the footnote, so that a combination of line items or flexibility across line items limits the administrative burden of managing these appropriations. The Department does not support the use of reversions for statutorily allowable Medicaid program over-expenditures.

II. 9:30 to noon Medicaid (Medical Services Premiums Issues)

A. General Budget Outlook

10. What error rate does the Department believe is an appropriate performance measure when forecasting the original Medical Services Premiums line item?

RESPONSE:

As stated in the Department's Strategic Plan in its November 1, 2007 Budget Request, the Department has set a performance measure to reduce the difference between the Department's spending authority and actual expenditure for Medicaid services to 1.0% in FY 07-08. Although this is a Department-wide measure, the Department believes that 1.0% is an appropriate performance measure when forecasting the Medical Services Premiums.

Historically, the Department's forecasts for the Medical Services Premiums have varied between - 8.04% and 3.68%. These figures are shown in the table below. There are a large range of issues that can affect the final expenditures for the Medical Services Premiums. Under cash accounting, expenditure is recorded in the period in which the claim is paid, leading to a large measure of uncertainty in budget forecasts. For example, a claim for dates of service in FY 06-07 paid in FY 07-08 will be recorded against the FY 07-08 appropriation. This is also true of recoupments, settlements, or other requirement payments (such as payments which were made as a result of health maintenance organization lawsuits). Such payments do not always follow well-defined expenditure patterns.

Additionally, month-to-month variation in caseload can be unpredictable. For example, in September 2007, non-retroactive caseload suddenly decreased by 3,308 clients. In the next month, caseload increased by 4,073. While such events can be incorporated into trend models, if such an event happens in the last two months of a fiscal year, it can have a significant impact on the total expenditure. Such events cannot be incorporated in either the Department's February 15th Supplemental Budget Requests or the Figure Setting process. Because of the unpredictability of caseload and expenditure patterns, the Department does not support a tighter performance measure than 1.0%.

It should also be noted that in the last two years, the Department's final Supplemental Budget Requests for Medical Services Premiums have been within 0.15% and 0.22% in FY 05-06 and FY 06-07 respectively. The Department hopes to continue its current trend of accurate forecasts, but is also aware that there can be significant programmatic or policy issues which can decrease the accuracy of the forecast.

Medical Services Premiums Comparison - Final Request to Actual

Fiscal Year	Request Source		Final Request	Actual	Percent Difference
	Date	Page			
FY 95-96	1/10/1996	52	\$1,001,635,337	\$982,847,134	1.88%
FY 96-97	2/14/1997	44	\$1,033,428,216	\$1,055,622,198	-2.15%
FY 97-98	2/13/1998	51	\$1,047,325,384	\$1,079,585,406	-3.08%
FY 98-99	2/15/1999	148	\$1,151,048,879	\$1,188,864,156	-3.29%
FY 99-00	2/15/2000	117	\$1,217,696,398	\$1,315,569,367	-8.04%
FY 00-01	2/15/2001	118	\$1,415,376,242	\$1,405,080,749	0.73%
FY 01-02	2/15/2002	EN-2	\$1,559,787,150	\$1,536,804,691	1.47%
FY 02-03	2/15/2003	EN-1	\$1,654,546,803	\$1,651,670,874	0.17%
FY 03-04	2/16/2004	EO-1	\$1,779,651,115	\$1,841,738,922	-3.49%
FY 04-05	2/15/2005	EO-1	\$1,965,567,432	\$1,893,285,567	3.68%
FY 05-06	2/15/2006	EO-1	\$1,979,334,907	\$1,982,396,076	-0.15%
FY 06-07	2/15/2007	EO-1	\$2,043,868,954	\$2,048,437,415	0.22%

- Totals do not include Upper Payment Limit financing.
- Actuals from FY 00-01 and prior are taken from the February 14, 2003 Final Request, Exhibit F.
- Actuals are taken for FY 01-02 and beyond from the November 1, 2007 Budget Request, Exhibit N, pages 1 and 2.
- Actuals do not include mental health capitation, with the possible exception of FY 95-96. Research for FY 95-96 could not conclude if mental health capitations are included. Based on the size of the request, it was assumed that it was included. Since it cannot be separated out, the FY 95-96 actuals include mental health capitation.
- FY 96-97 to FY 99-00 make specific exclusions from totals to account for Old Age Pension State –Only Medical Program. Actuals exclude Old Age Pension State –Only Medical Program.
- FY 01-02 and FY 02-03 were projected on an accrual accounting basis, although actuals are presented under cash accounting. The Department's last presentation of actuals in the Final Request binders under the accrual system was FY 00-01.
- FY 05-06 final request includes \$6,240,000 from the Department's Supplemental Bill HB 06-1369, to allow for a more accurate comparison. The original total from February 15, 2006 is \$1,973,094,907.

11. Can the Department identify the specific caseload impact that resulted from the Deficit Reduction Act of 2005 requirement that low-income populations have their citizenship or legal status documented before they can receive eligibility?

RESPONSE:

Until changes to the Colorado Benefits Management System have been fully completed for the purpose of implementing the Deficit Reduction Act of 2005, the Department is unable to identify the specific caseload impact. Some of the original programming requirements for compliance with the Deficit Reduction Act of 2005 have been revised as a result of coordination with the Department of Human Services and policy clarifications from the Centers for Medicare and Medicaid Services. The release date of these system changes is March 29, 2008.

12. Does the Department have any concerns that economic conditions could worsen in the near future causing a greater increase to the Medicaid caseload forecast in FY 2008-09?

How confident is the Department that caseload growth will remain below 1.0 percent for FY 2008-09?

RESPONSE:

Medicaid caseload is projected each year in both November and February for the Department's annual budget request. Historic caseload data are used in conjunction with economic data to project caseload, as economic indicators help partially explain why some Medicaid caseload trends occur. Since Medicaid is a needs-based program where clients must meet income and resource limits, it follows that caseload for families and children should be countercyclical to economic conditions. The Department believes that the improving economic conditions are the driving factor in the recent decrease in Medicaid caseload. Should economic conditions worsen, the Department would adjust caseload projections accordingly. The Department's current total Medicaid caseload forecast is for growth to remain at approximately 0.9% through FY 09-10.

The Department's caseload projection for the Medicaid program in its November 1, 2007 Budget Request was 379,715 (November 1, 2007 Budget Request, Section E, Exhibit B, Page EB-1). Through October 2007, the Department's actual average monthly caseload was 382,694, a difference of 0.78%. The Department does not believe there is sufficient information at this time to conclude that either the final average monthly caseload for FY 07-08 or FY 08-09 will differ significantly from the forecast from the November 1, 2007 Budget Request. However, the Department will reforecast Medicaid caseload in its February 15, 2008 Budget Request.

13. Why is the CBMS system still unable to identify optional legal immigrants?

RESPONSE:

The Colorado Benefits Management System (CBMS) has been able to identify optional legal immigrants for new clients since October 2006 for the Family Medical program, and since August 2007 for Adult Programs. All optional legal immigrants entered into the CBMS after those dates include the designation of optional legal immigrant status. For those clients who were previously entered into the CBMS, optional legal status is being identified during the annual redetermination process. Consequently, optional legal immigrant status is identified for all clients enrolled in the Family Medical program, because that application change was implemented in October 2006 and annual redeterminations were complete on all Family Medical clients by October 2007. For clients in Adult Programs, the application change identifying optional legal immigrant status was implemented in August 2007. Annual redeterminations reflecting this application will be complete for all clients in Adult Programs by August 2008. The decision to implement the optional legal immigrant application as clients are entered into the CBMS or when eligibility is redetermined was made to avoid potential disruptions in client eligibility that could occur if all clients were redetermined at once.

14. If a FY 2007-08 General Fund supplemental is needed for the Medical Services Premiums line item, does the Executive have suggestions on how the JBC can avoid being over the 6.0 percent appropriations limit?

RESPONSE:

The Governor will submit an FY 08-09 budget request that is balanced to the 6% limit on January 2, 2008. This request will contain the statewide initiatives for maintaining the 6% appropriations limit. The Department does not have direct control over or the responsibility for maintaining the 6% limit. If the Department's analysis shows that any of its program areas are over-funded, a negative change request will be submitted. Although the Department is sensitive to State expenditure caps, it has never been the Department's role to find corresponding reductions in the budget to offset growth in caseload and utilization of services in this federally mandated program. The Department believes that it would be a conflict of interest to have to balance caseload and utilization growth with corresponding reductions. Otherwise, the Department will be glad to work with the Joint Budget Committee on any initiatives that it identifies.

B. Cost Containment Issues -- (Disease Management, Prescription Drugs, Recoveries, Breast and Cervical Cancer Treatment Fund, and other issues)

15. Please describe for the Committee how the Department plans to use the roll-forward authority for the H.B. 05-1262 disease management programs in FY 2007-08? Briefly elaborate on the quality improvement and disease management initiatives that the Department is administering or pursuing in the near future.

RESPONSE:

The Department is using the roll-forward authority for the following disease management programs:

- Congestive Heart Failure
- Chronic Obstructive Pulmonary Disease
- High-Risk Obstetrics

For complete information on the quality improvement and disease management initiatives that the Department is administering or pursuing in the near future, please see Attachment 1.

15a. Please describe the Department's past efforts and current efforts on trying to offer programs that will control the cost of diabetes? What are the health care costs for Medicaid clients with diabetes on an annual basis?

RESPONSE:

From October 2002 through June 2007, the Department offered a diabetes management program that included telephonic case management, client education and care plans developed with clients. The Department determined that program costs exceeded overall cost savings and chose not to renew the contract for an additional year. In July 2007, the Department developed a new program for diabetes disease management that uses a much more aggressive approach. Clients are provided with biometric home monitors that measure blood glucose levels and transmit the results along with self-reported symptoms to a remote nurse station on a daily basis. The evaluation for this program will be available in December 2009.

Part of the Department’s evaluation of this new program will be to establish Colorado-specific baseline data on costs. In FY 05-06, 6,791 Medicaid clients were identified with a diagnosis of diabetes. The national average for enrollees with diabetes is \$16,967 per capita (Kaiser Commission on Medicaid and the Uninsured, “An Overview of Medicaid Enrollees with Diabetes in 2003,” October 2007).

15b. Please provide information on how much the Department spends on individuals who are in a persistent vegetative state.

RESPONSE:

According to the International Statistical Classification of Diseases and Related Health Problems (ICD), “vegetative state refers to the neurocognitive status of individuals with severe brain damage, in whom physiologic functions (sleep-wake cycles, autonomic control, and breathing) persist, but awareness (including all cognitive function and emotion) is abolished.” Based on claims data, the Department has identified 75 clients who are in a persistent vegetative state. The Department identified these clients either through diagnosis codes in the client’s claim records, or information provided directly from the Minimum Data Set (MDS) used in calculating the acuity portion of Nursing Facility rates.

In FY 06-07, the Department spent \$6,991,632 total funds on care for clients who were identified as being in a persistent vegetative state. The table below shows expenditure for clients by age range:

Clients and Costs by Age	Number of Unique Clients	Total
Young - less than 35	24	\$2,099,408
Middle age - between 35 and 64	42	\$4,547,261
Elderly - 65 or greater	9	\$344,963
Total	75	\$6,991,632

The table below breaks out the total number of clients and expenditures by placement in a Skilled Nursing Facility:

Clients and Costs by Age	Number of Unique Clients in a Skilled Nursing Facility	Expenditures for Clients in a Skilled Nursing Facility	Number of Unique Clients Not in a Skilled Nursing Facility	Expenditures for Clients Not in a Skilled Nursing Facility
Young - less than 35	5	\$726,050	19	\$1,373,358
Middle age - between 35 and 64	20	\$2,878,553	22	\$1,668,708
Elderly - 65 or greater	5	\$194,715	4	\$150,248
Total	30	\$3,799,318	45	\$3,192,314

16. What is the Administration's position on allowing a permanent statutory annual transfer of \$2.0 million from the Prevention, Early Detection, and Treatment Fund to the Department of Health Care Policy and Financing each year? Are there any drawbacks from such a statutory change?

RESPONSE:

A permanent transfer would allow continuity of disease management programs and allow the necessary timeframes required to achieve the desired results. Permanent funding would also allow the Department to plan ahead each fiscal year in regard to contract amendments, modifications and program expansions in order to continuously improve upon the programs offered to clients on Medicaid.

If the transfer were made permanent, the Department would request broader authority to select disease management programs based on best practices and emerging service delivery models. This flexibility would require a statutory change. For example, the Department would like the flexibility to use such a transfer to fund a comprehensive managed care program for all disease management issues as opposed to specific appropriations for diabetes.

17. Please provide the Committee with an update on the implementation of H.B. 07-1021.

RESPONSE:

HB 07-1021, codified at Section 25.5-5-507, C.R.S. (2007) created the prescription drug information and technical assistance program to provide advice on the prudent use of prescription drugs to Medicaid clients who receive prescription drug benefits. The Prescription Drug Information and Technical Assistance Program rules were presented to the Medical Services Board for initial approval on November 9, 2007. The rules are scheduled to be presented to the Medical Services Board for final adoption on December 14, 2007 and will become effective on February 1, 2008.

In September 2007, the Department hired an FTE to implement and manage the program. As a part of the implementation, the Department has identified over 400 fee-for-service clients who receive prescription drug benefits, are high utilizers of prescription drugs, and are at risk of complications from drug interactions for voluntary participation in the program. Additionally, the Department has contacted pharmacists across the State to determine whether or not they are interested in participating in the program. The effort to identify interested pharmacists is on-going. The Department anticipates that it will have a final list of interested pharmacists by the end of December 2007. In January 2008, the Department will be entering into contracts with the pharmacists and will match clients with contracted pharmacists based on physical location. At the same time, Department staff will contact clients in writing and by telephone to explain the purpose of the program as well as how they may benefit from the program.

Based on the appropriation, the Department anticipates serving 226 clients per year at a cost of \$75 per consultation. The Department anticipates that the consultations will begin in February 2008.

18. What savings impact, if any, does the Department anticipate from the CMS final rule for the DRA 2005 related to pharmacy reimbursement? What impact does the Department believe the rules will have on independent pharmacies participating in the Medicaid program?

RESPONSE:

The Deficit Reduction Act of 2005 requires several adjustments to the calculation of federal upper payment limits for drugs. Any of the changes could impact the savings to the Department and the reimbursement to the pharmacies. Since the Centers for Medicare and Medicaid will not release the new federal upper limits or the new average manufacturer prices until December 30, 2007, there is not reliable information available to determine if savings will be realized or how much the new limits will affect independent pharmacies.

According to the December 2006 Government Accountability Office Report, the new calculation would reimburse pharmacies an average of 36% less than their acquisition costs. However, this report was written before the rules implementing this portion of the Deficit Reduction Act were finalized in July 2007. Thus, it does not take into account the changes that were made to the calculation of the average manufacturer price and the federal upper limit.

The new federal upper payment limit will adjust monthly. The Department is concerned that pharmacies could be reimbursed less or more than their acquisition cost on particular drugs at a particular time. The Department is currently investigating ways to minimize the fluctuations of reimbursement rates caused by monthly adjustments and other uncertainties created by the Deficit Reduction Act.

For additional information on the Deficit Reduction Act related to pharmacy reimbursement, please see Attachment 2.

19. Please update the Committee on the implementation on the preferred drug list.

RESPONSE:

An Executive Order was signed in January 2007, directing the Department to establish and maintain a preferred drug list. The Department anticipates placing the first drugs on the preferred drug list by April 2008.

The Executive Order gave the Department the authority to implement a preferred drug list after evaluating various methods of implementation and determining the best option for Colorado. As a part of this process, the Department formed a Pharmacy and Therapeutics Committee responsible for evaluating clinical data and evidence on all drugs under consideration for inclusion in the preferred drug list. In addition, the Department evaluates and pursues supplemental rebates to further facilitate providing pharmaceuticals for Medicaid clients at the lowest possible cost.

In April 2007, the Department held several public meetings across the state to obtain input on the implementation process. In addition to these meetings, an open comment period was extended to the public to allow interested parties to express suggestions, issues or concerns with the creation of the preferred drug list. The Department used this information in combination with information gathered through its own research to create the preferred drug list program.

The Pharmacy Benefits Section hired a Preferred Drug List Coordinator to assist in the implementation and management of the preferred drug list, a pharmacist to be the clinical lead on all clinical issues, and a rate/financial analyst to perform pharmacoeconomic analysis related to the preferred drug list.

Rules were drafted to establish the framework of the preferred drug list and to create and define the role of the Pharmacy and Therapeutics Committee. The Pharmacy and Therapeutics Committee Rules were approved by the Medical Services Board on September 14, 2007 and became effective on November 1, 2007. The Preferred Drug List Rule was approved by the Medical Services Board on October 12, 2007 and became effective December 1, 2007.

Upon the effective date of the rules, the Department began reviewing the first class of drugs. The first class, Proton Pump Inhibitors (PPI), was announced on November 2, 2007. The Pharmacy and Therapeutics Committee reviewed the first drug class at the meeting on December 4, 2007. The Department collected supplemental rebate bids from the manufacturers of drugs in that class. Pursuant to the rules, the Executive Director has been presented with the recommendations from the Pharmacy and Therapeutics Committee, public comments, and pharmacoeconomic data and has selected the preferred and non-preferred agents for the first class. The Drug Utilization Review Board will be considering the prior authorization criteria for the non-preferred drugs at its next meeting on December 18, 2007.

November 19, 2007 the Department announced additional classes of drugs that will be considered at upcoming Pharmacy and Therapeutics Committee meetings including statins and sedatives/hypnotics.

The Department anticipates that the first three drug classes will be reviewed and preferred agents will be added to the preferred drug list no later than April 1, 2008.

In addition, the Department is looking at the possibility of obtaining the clinical data currently provided through a contractor with the Drug Effectiveness Review Project (DERP) beginning in FY 08-09. The Drug Effectiveness Review Project is a collaboration of organizations, including 13 states, which compile the best available clinical evidence on prescription drug effectiveness and safety by drug class. Clinical reports on drug classes go through a rigorous process using a series of comprehensive, up-to-date and unbiased reviews conducted by evidence based practice centers (EPCs). The results of this research are used to make informed decisions in public policy. Participating entities provide equal financing to the project and participate in the operation through a self-governing process. In addition, the Drug Effectiveness Review Project would provide technical assistance within the review process, ensures that timelines are met and manages communications with pharmaceutical companies.

19a. Please explain how the preferred drug list will effect anti-psychotics. Will Medicaid clients continue to be able to stay on the drug combinations that are treating their conditions.

RESPONSE:

The Department has established a moratorium which is a designated period of time set forth in the Department's rules during which the Department cannot consider particular drug classes for inclusion on the preferred drug list. The atypical and typical antipsychotics are included in the drug class moratorium. Per the rules, the moratorium period will expire on December 31, 2008. After this date, atypical and typical agents could be considered for inclusion on the preferred drug list but would not automatically be included. The pharmacy and therapeutics committee would be consulted before the Department could include these drugs. In addition, the Department considers many clinical factors before placing a drug class on the preferred drug list. These factors include the vulnerability of the population treated with that class of drugs and the relative ease with which those drugs may be interchanged.

The Department has also implemented rules for exclusion of individuals from the preferred drug list. The exclusion of individuals is authorized for patients who have a focal point of care and who meet specific clinical criteria. With this exclusion, a client can receive non-preferred drugs without a prior authorization. This is an innovative approach to meeting the medication needs of fragile clients. It allows clients who are particularly vulnerable and who are receiving good medical care through a particular provider to continue to receive the drugs prescribed by that provider. For those clients who are not receiving consistent care, the goal is that the preferred drug list can provide a checkpoint to ensure that the clients are receiving the best drugs for their conditions. The Department is currently developing an individual exclusion process for clients with schizophrenia as well as AIDS and developmental disabilities.

20. Please explain the Department's proposed legislation for limiting pooled trusts? Please explain the Department's estimated fiscal impact of the proposed legislation and any controversy that would associated with the proposal.

RESPONSE:

The Colorado Promise reflects the Administration's vision to be a good steward of public funds. This legislation would focus limited resources on Coloradans with the greatest needs allowing the Department to better meet its mission. Medicaid is the payor of last resort. The Department's proposed legislation regarding trusts is designed to strike a balance between allowing clients with long term care needs to retain assets and promoting personal responsibility by requiring clients to contribute to the cost of their own care. The Department's proposed legislation addresses three different types of trusts that allow individuals with income or assets greater than typical eligibility requirements to receive long term care funded by Medicaid. The types of trusts are Income, Disability, and Pooled trusts.

Income Trusts

Background

Pursuant to State and federal law, an Income Trust may be established by an individual to overcome financial eligibility limits and qualify for long-term care services funded by Medicaid. This includes nursing facility services or home and community based services. Generally, to qualify for Medicaid long term care an individual must be (1) either disabled or over 65, (2) require institutional care, and (3) have a gross income that does not exceed 300% of the Supplemental Security Income limit (\$1,869 per month in 2007). For individuals whose gross income exceeds the Supplemental Security Income limit, but is less than the average private pay rate for nursing home care in the individual's region (\$5,073 to \$6,181 per month in 2007), they can attain financial eligibility for Medicaid by establishing an Income Trust.

Income Trust Medicaid clients are required to deposit their monthly income into the trust, or pay their income directly to their nursing facility, in exchange for Medicaid long term care services. Clients are permitted to retain monthly personal need stipends appropriate for their treatment setting. Once the individual is no longer eligible for Medicaid, any funds remaining in an Income Trust must be used to reimburse Medicaid up to the total amount of medical assistance provided to the individual. For patients receiving long term care through Home and Community Based Services, they are permitted to spend the Social Security Income limit, (\$1,869 per month), and are directed to put their remaining income into the Income Trust. Current statutes and regulations do not protect the Trust assets, which are frequently unavailable to the Department when Medicaid eligibility ends. Said another way, when the Trust is empty, the Department is not refunded the cost of care.

Trusts may not have any funding when the client is no longer eligible for Medicaid if trustees for Income Trusts do not establish separate trust accounts or do not ensure that the Medicaid client's income is deposited into the Income Trust. The Department has identified situations where trustees

have spent the funds in the Trust or not deposited client's income into the Trusts. As a result, the Trusts are underfunded and the Department is unable to recover the full amount of reimbursement required under the statute.

Summary of Proposed Major Changes

- 1) Require direct deposit of all income assigned to the Income Trust, when it is legally permissible, into an account titled to the trust. This change would help protect the Medicaid program by insuring required deposits into Income Trusts.
- 2) Require Home and Community Based Services long term care clients to remit accumulated funds in an Income Trust to the Department upon the Department's request but no less frequently than quarterly. This change would minimize risk of depletion of Income Trust funds, alert the Department to any compliance problems for Income Trust clients, and would equalize the oversight and management of client income for long term care clients in nursing homes and Home and Community Based Services.

Fiscal Impact

The Department currently does not systematically track the amount of income trust recoveries that are lost due to improper trust administration. The proposed changes should reduce the instances of improper trust administration and increase the amount of income trust recoveries.

Risk of Controversy

Opponents of the proposed changes may argue that the federal statute governing the treatment of income trusts for Medicaid eligibility purposes does not require reimbursement until the trust terminates and that this provision is more restrictive than federal law allows. This assertion would be incorrect. Federal law requires establishment of Income Trusts but delegates to States the authority to define limits of such Trusts to reflect a State's ability to fund long term care of people with high incomes. State restrictions on Income Trusts were upheld by the 10th Circuit Court of Appeals in Keith v. Rizzuto.

Disability Trusts

A Disability Trust is a trust that is established by a disabled individual under the age of 65 to hold the personal assets of the disabled individual in order to secure eligibility for Medicaid long term care coverage. The assets in a Disability Trust are considered exempt for Medicaid eligibility purposes and may be used to provide for the disabled individual's supplemental needs that are not covered by Medicaid. Once the individual is no longer eligible for Medicaid, any funds remaining in the trust must be used to reimburse Medicaid up to the total amount of medical assistance provided to the individual. If Disability Trusts' assets are not managed or spent appropriately, such funds may be exhausted inappropriately and prevent the Department from collecting any reimbursement for care

provided to a client with significant personal means. The proposed legislation is not designed to, and would not, guarantee that the Department can recover 100% of Medicaid expenses for every client with a Disability Trust, but could improve recoveries and reduce current incentives for individuals with significant personal wealth to shield that wealth so the Medicaid program will cover the cost of their long term care.

The Department looks forward to working with the members of the Joint Budget Committee to identify improvements to Disability Trusts. Our goal is to provide young disabled Medicaid clients some flexibility to personally hold assets combined with reasonable monitoring of those assets to avoid fraud.

Please note nothing in the proposed changes would prohibit a third party from creating and funding a trust for the benefit of a Medicaid client. Rather, the changes would clarify standards for expenditures from a Disability Trust on behalf of a Medicaid client, and could limit the enrollment of some disabled individuals into Medicaid if they have substantial personal assets that could cover the costs of their long term care.

Summary of Proposed Major Changes

- 1) Consider limiting the source of funding of disability trusts to personal injury settlements or retroactive Supplemental Security Income payments. Consider capping the amount of money that can be deposited into a Disability Trust. Individuals with assets above the cap would likely fail to meet financial eligibility requirements.
- 2) Require a Disability Trust's trustee to submit a spending plan to the Department describing how the trust fund will be administered and disbursed for review and approval. Require a trustee to report modifications to the spending plan and give advance notice of material modifications for Department review and approval. Require trustees to report any additional deposits made into the trust or material unplanned expenditures within ten days.
- 3) Clarify what distributions are permissible from Disability Trusts.

Currently, there are no restrictions on the source of funds that may be used to fund a Disability Trust, and the Department has had cases of individuals who would otherwise be ineligible for Medicaid based on excess resources funding trusts with inheritances, gifts, home sale proceeds, and other significant personal assets. Capping the amount of funds that can be deposited into a disability trust will limit their use as an asset protection vehicle by individuals who have sufficient resources to pay for their care.

Specifying what distributions are permissible from disability trusts, requiring trustees to submit a spending plan of how the trust will be administered and disbursed, and requiring the trustee to provide advance notice of material modifications to the spending plan may help prevent some inappropriate expenditures before they occur. There are currently no clear statutory provisions governing what

expenditures are or are not appropriate for these trusts, and the Department has observed many cases where Trust funds were used for items and services that were not for the sole benefit of the disabled individual, such as the costs of a party, or airline travel for four people other than the Trust beneficiary. The Department has also identified specific examples of questionable spending of trust assets to pay family members for care giving or companion services.

Without limitations on the funding source, amount and use of Trust assets, Trusts may be established for individuals who are not truly needy, or the assets may be exhausted prior to the client's termination of Colorado Medicaid eligibility. Consequently, the Department may be caring for individuals who have sufficient personal resources to pay for needed care and has been unable to recover the full amount of reimbursement required under the statute.

Fiscal Impact

The Department does not have the authority required to systematically track the scope or amounts of inappropriate or questionable disbursements from Disability Trusts, so it is not possible to quantify the fiscal impact of the reporting provisions. The proposed changes should help reduce the instances of inappropriate or questionable spending which could result in increased recoveries from these trusts.

The scope of financial limitations on Disability Trusts will drive the fiscal impact. The Department has articulated one scenario, and its potential fiscal impact in its answer to question 20a.

Risk of Controversy

The provisions limiting funding sources for Disability Trusts may be controversial. Funding for Disability Trusts was previously limited to personal injury settlements and retroactive Supplemental Security Income payments, but those limitations were removed by HB 00-1375 in 2001. Opponents may again argue that the federal statutes which govern the treatment of Disability Trusts for Medicaid eligibility do not impose any caps or restrictions on the source of funds that may be used to fund the trusts.

Pooled Trusts

A Pooled Trust is a trust that is established by a disabled individual of any age that is managed by a non-profit association that pools an individual's funds with funds from other disabled individuals for investment and management purposes. The assets in a Pooled Trust are considered exempt for Medicaid eligibility purposes and are used to provide for the disabled individual's supplemental needs that are not covered by Medicaid. The motivation for Pooled Trusts was to allow clients to pool their trust resources and reduce administrative fees.

Unlike Disability Trusts, once the individual is no longer eligible for Medicaid; any funds remaining in the trust may be retained by the Pooled Trust at its option. There is likely to be no reimbursement available to the Medicaid program.

Summary of Proposed Major Changes

- 1) Consider limiting the source of funding of pooled trusts to personal injury settlements or retroactive Supplemental Security Income payments. Consider capping the amount that can be deposited into a Pooled Trust. Individuals with assets above the cap would likely fail to meet financial eligibility requirements.
- 2) Require a Pooled Trust's trustee to submit a spending plan to the Department describing how the trust fund will be administered and disbursed for review and approval. Require a trustee to report modifications to the spending plan and give advance notice of material modifications for Department review and approval. Require trustees to report any additional deposits made into the trust or material unplanned expenditures within ten days.
- 3) Clarify what distributions are permissible from Pooled Trusts.
- 4) Limit formation of Pooled Trusts to individuals under the age of 65 to track federal requirements for Disability Trusts.
- 5) Specify that the Department is entitled to reimbursement from the client's Pooled Trust account when the Medicaid client is no longer eligible.

Currently, the Department does not receive any reimbursement from a Pooled Trust when an individual becomes ineligible for Medicaid. The funds that remain in an individual's Pooled Trust account are retained by the Pooled Trust organization. Requiring Pooled Trusts to reimburse the Medicaid program from the client's account when the client is no longer eligible for Medicaid will help to offset some of the State's cost in providing care to these clients.

Fiscal Impact

Identification of the fiscal impact of this provision is difficult, but the Department does have some data available regarding the assets of Pooled Trusts, and claims history for clients whose Medicaid eligibility was secured through the creation of such trusts. The Department has records of 238 pooled trusts being established through October 31, 2007. The actual number established during this period is certainly higher. During the seven year period between November 1, 2000 and October 31, 2007, the Department paid a total of at least \$47.4 million in Medicaid claims for the individuals whose assets funded these trusts. The actual amount is higher, as the Department does not have complete paid claims data for all pooled trusts. These 238 trusts exempted a total of at least \$6.7 million in assets. The actual total is higher because the Department does not have funding amount data for several trusts. In addition, some trusts may have had subsequent additions that were never reported.

The Department does not have the authority required to track the scope or amounts of inappropriate or questionable disbursements from pooled trusts, so it is not possible to quantify the fiscal impact of the reporting provisions.

Risk of Controversy

The provisions limiting the source or amount of Pooled Trusts may be controversial. Like Disability Trusts, funding for Pooled Trusts was previously limited to personal injury settlements and retroactive Supplemental Security Income payments, but those limitations were removed by HB 00-1375 in 2001. The provision limiting pooled trusts to individuals under 65 and requiring reimbursement to the Medicaid program when a Pooled Trust client is no longer eligible for Medicaid may also be controversial. Opponents may argue that the federal statutes which govern the treatment of pooled trusts for Medicaid eligibility purposes do not impose any caps on funding amounts, restrictions on funding sources, age limitations, or reimbursement requirements. Finally, the requirement that Pooled Trust assets be used to repay Medicaid may be viewed negatively by trust administrators or other beneficiaries of Pooled Trusts.

20a. For the discussion in question 20 above, please bring specific examples (court cases or situations that the Department is aware of) of what the change in legislation would prevent in the future.

RESPONSE:

The proposed trust legislation would likely have prevented the following situations:

- 1) A client with an Income Trust has been eligible for Medicaid Home and Community Based Services for nearly five years. All gross income earned by the client in excess of the patient allowance was to accumulate in the Trust. The county has discovered that the Income Trust has not been funded by the client or the trustee. There are no funds in the trust account. Consequently, the client was not eligible for Medicaid services for this period. The county will issue a Notice of Proposed Action to the client, terminating Medicaid eligibility. Medicaid has paid more than \$220,000, an average of \$3,400 per month, in medical assistance benefits for this client. If the Trust agreement had been followed, a total of \$52,783 should have accumulated in the trust account, and the client's eligibility would be preserved.
- 2) In one instance, a disabled adult receives a monthly annuity payment of approximately \$18,000 per month. Annuity payments are to go to Disability Trusts. Each month, the full amount of the annuity payment is disbursed to a home health care company that is owned and controlled by the disabled client's sibling. Funds in the disability trust were used to purchase a home valued at \$1.2 million for the benefit of the disabled child. Title to that home was later transferred from the trust to the sibling's name.
- 3) A family member paid herself more than \$52,000 in one year from a Disability Trust for "supplemental care/support" provided to an individual in a nursing home.

The Department has reviewed the Disability Trust data we have available to provide an example of the potential impact of legislative change. For discussion purposes, we have assumed an asset limit of \$50,000, but seek the Committee's input for the right asset limitation amount.

The Department has records of 247 disability trusts established by Medicaid clients that were funded with more than \$50,000. These 247 trusts exempted at least \$77.9 million in assets, representing

91.43% of the total known value of assets exempted by disability trusts. The Department paid more than \$46.3 million in Medicaid claims for these 247 individuals over the seven year period from July 1, 2000 through June 30, 2007. This represents 33.14% of the total Medicaid paid claims for individuals with disability trusts.

If changes to Disability Trusts had been in place, these 247 individuals would have been expected to use their \$77.9 million in assets to pay for the cost of their own care before they could be eligible for Medicaid. Since July 1, 2001, the Department has recovered a total of \$3.2 million from disability trusts. The Department has opened a total of 137 recovery cases and collected on 63 of them (45.99%).

If the proposed legislation had been in place during this time, it would have defined how trust funds can be used, required supervision of payments for companion services, and would have required trustees to submit spending plans to the Department for review. Such additional oversight could have helped reduce the frequency and extent of inappropriate or questionable spending. This could have protected Disability Trust assets and improved the Department's rate of recovery after a client's eligibility for Medicaid has ended.

21. Please explain the Department's proposed legislation for estate recovery? Please explain the Department's estimated fiscal impact of the proposed legislation and any controversy that would associated with the proposal.

RESPONSE:

The Colorado Medical Assistance Estate Recovery Program, established in 1992, requires the State of Colorado to recover Medicaid expenditures paid on behalf of Medicaid clients, after the death of that client, or the death of the client's spouse. State law requires the client's assets remaining after death to be used to repay the Department for the cost of the client's medical assistance. The estate recovery program was established to allow clients to retain some assets while living, and enables the client to share in the cost of care without impoverishing the client or spouse during their lifetimes.

The department estimates that the combined impact of the various components of this legislation could be in excess of \$1 million in costs recovered. However, the department would need to complete a more thorough analysis such as the one that would be completed for a fiscal note in order to provide a more accurate figure.

The proposed legislation addresses several different aspects of the Medical Assistance Estate Recovery Program:

1. Specifies that the Department is a "known creditor" for estate recovery purposes.

If personal representatives and attorneys do not send a Notice to Creditors to the Medicaid Agency

giving the creditor deadline, then Medicaid claims are not barred by notice deadline and are subject to the one year deadline.

2. Specifies that capitation payments made on behalf of Medicaid recipients are considered medical assistance and are recoverable.

This proposed addition would provide added support to the Centers for Medicare and Medicaid Services' and the Colorado Attorney General's position on this topic. This question is asked by attorneys frequently.

3. Clarifies that the printout of the medical claims paid by Medicaid on behalf of the Medicaid recipient are prima facie evidence that services were paid for by Medicaid.

The provision would clarify that the Medicaid medical paid claims data is satisfactory evidence for the State Medicaid Agency to prove that services were rendered; the debt was incurred and correctly paid. This would provide that the burden of proof is on the party questioning or objecting to Medicaid claims data to prove that services were not provided, not correctly paid, or the debt was not incurred, and provide that their standard of proof is clear and convincing evidence.

4. Clarifies that Medicaid claims arise before death but are recoverable upon death.

The claim arising before death provision should prevent a personal representative from successfully claiming that the four month limitation for filing claims arising on or after death do not apply to recoveries.

5. Clarifies personal representatives' notice responsibilities.

This provision requires the personal representative to give notice to the Department of the opening of an estate. This will help ensure the Department's awareness of estates and provide for the ability to timely file claims.

Provisions 1 through 5 above are estimated to have no material fiscal impact. These provisions would increase efficiency, decrease legal expenses, and may be decisive in a few cases, but are more technical clarifications to improve the Department's legal standing than policy initiatives.

6. Allow the Department to foreclose on Tax Equity and Fiscal Responsibility Act 1982 liens after the death of a Medicaid recipient.

Currently Medicaid TEFRA liens are not foreclosable; meaning if an estate is not opened the lien can remain sitting against the real property indefinitely. It would be beneficial to foreclose on liens after the death of the Medicaid client as long as the recovery criteria are met.

No estimated fiscal impact.

7. Allows for the Department, through the county human service departments, to file for recordation of a request for notice of transfer or encumbrance of real property of a Medicaid recipient.

With this addition Medicaid, through the counties, would be notified when a living/deceased client's real property is being transferred or encumbered. Such notification would be helpful in identifying circumstances where a living client's interest in real property is being diminished which could affect a client's eligibility and/or help identify situations where a client may have been financially exploited by someone using a power of attorney.

It is estimated that between 1-20 improper transfers, with an estimated average property transfer value of up to \$50,000 in assets, could be eliminated with this provision. The post eligibility transfer of assets is a Medicaid eligibility issue that affects a client's continued eligibility that often goes undetected, resulting in the overpayment of benefits because of ineligibility and the loss of ability to make a recovery from the estate.

8. Adopts the expanded definition of estate for the potential recovery of assets that are not part of the Medicaid client's probated estate.

Provides that Medicaid estate recovery may pursue assets included in expanded definition of estate such as property held in joint tenancy, life estate property, living trust, etc.

The expanded definition of estate could curtail certain types of estate planning involving the transfer of the client's properties. Additional recoveries may be available by avoiding certain transfers and recovering directly from the expanded definition of assets. This provision would not harm a spouse or child's right to remain in the property following the death of a Client.

The legislation would provide that Medicaid estate recovery may pursue assets included in expanded definition of estate such as property held in joint tenancy, life estate property, living trust, etc. In 2006, 102 separate estate recovery claims were dismissed for either a jointly owned exemption or a sibling living in the home exemption. It is estimated that up to 50% of these exempted estate recovery cases could result in an average of \$12,000 per exempted estate. The \$12,000 average is based on 50% client ownership with the average estate recovery claim being \$24,000.

9. Allows for the recovery of assets owned by the Medicaid client at the time of death after the death of the surviving spouse or child living in the house.

Under current Colorado estate recovery provisions, recovery is permanently waived if, at the time of death, there is a surviving spouse, child under 21, or a disabled child. The provision would provide that recovery could occur upon the death of the surviving spouse, or at such time as there no longer is a minor or disabled child living in the house.

Estimated fiscal impact -- In 2006, 204 separate estate recovery claims were dismissed for a spousal exemption. It is estimated that up to 50% of these exempted estate recovery cases could result in approximately \$10,000 recovered per exempted estate.

10. Allows for after death liens.

Federal Medicaid law allows for post-death liens, which prevents the estate from being settled and the property distributed to the recipient's heirs before all claims against it, including Medicaid's estate recovery claims, are satisfied. Post death liens could secure the property, so recovery can be made rather than a transfer outside of probate. If there is no expanded definition, then the liens could be placed and foreclosed which would be included in the proposed foreclosable lien provision .

11. Provides the ability to better pursue non-real property estates, excess burial funds, and Unclaimed Funds accounts.

This provision would allow for the recovery of assets that are often too low in dollar amount to go through probate; however, these assets could add up substantially.

Estimated fiscal impact difficult to quantify on an annual basis.

Potential Controversy

The proposed Estate Recovery legislation will create some controversy. The principle opponents will probably include Estate Planners, Elder Law attorneys, and possibly Probate attorneys.

The most controversial changes are expected to be those pertaining to the expanded definition of estate (items #8 and #9).

21a. For the discussion in question 21 above, please bring specific examples (situations that the Department is aware of) where the proposed language would help the Department recover additional funds in the future.

RESPONSE:

Case #1

The sister of a Medicaid client called to report the death of the client. The client was eligible for medical assistance for approximately six years. In the last five years, Medicaid paid a total of \$51,434 in medical benefits on behalf of the client.

The client's sister had a Power of Attorney (POA) for the client. In October 2002, the sister transferred the property to herself and another sibling. This transfer of the client's asset was never reported to the county. Due to the transfer of the client's property the client would have been ineligible for Medicaid benefits. Because of the transfer of the property there is no probate estate on which to file an Estate Recovery claim.

Case #2

A family member of a Medicaid client contacted the Department to report the death of the client and the transfer of the client's property. Medicaid paid a total of \$21,821 in medical benefits on behalf of the client.

The family member reported that the client's daughter transferred the property shortly prior to the death of the Medicaid client. This family member acknowledged that the family and specifically the

client's daughter were aware of the Medical Assistance Estate Recovery Program. This transfer of the client's asset was never reported to the county. Due to the transfer of the client's property the client would have been ineligible for Medicaid benefits. Because of the transfer of the property there is no probate estate on which to file an Estate Recovery claim.

Case #3

The Department received a letter from an attorney representing a Medicaid client's heir. He was making an inquiry about the distribution of the client's assets. The client was eligible for medical assistance for more than one year. Medicaid paid a total of \$69,724 in medical benefits on behalf of the client.

The Medicaid client's property was sold about 12 months prior to receiving Medicaid eligibility. This sale and the resources from the sale were not reported to the county at the time of application for medical assistance. The proceeds from the sale were given to a daughter who held them for her mother. These are the assets in the client's estate which are now to be distributed. These remaining funds in the estate are in excess of \$80,000.

The attorney stated that the client died just over a year prior to his correspondence. He said that the client's Will has not yet been submitted to probate and that no probate has been opened. He wanted assurance that there would be no issues with respect to the family member he represents accepting distribution from the estate.

This client was not eligible for medical assistance due to excess resources. No probate was opened within a year after the death of the client. No assets were made available to file an Estate Recovery claim.

Case #4

County contacted the Department/contractor to report the death of the client and the transfer of the client's property. Medicaid paid a total of \$122,584 in medical benefits on behalf of the client.

The client's property was transferred by quit claim deed into joint tenancy with the client's son during the period of Medicaid eligibility. While still on Medicaid, the remaining joint interest held by the client in the property was transferred to the client's son. These transfers of the client's asset were never reported to the county. Due to the transfer of the client's property the client would have been ineligible for Medicaid benefits. Because of the transfer of the property there is no probate estate on which to file an Estate Recovery claim.

- 22. Please explain the Department's proposed legislation for third party recoveries? Please explain the Department's estimated fiscal impact of the proposed legislation and any controversy that would associated with the proposal.**

RESPONSE:

The proposed legislation addresses two aspects of third party recovery. First, it codifies the principle that Medicaid is the payor of last resort as required by federal law. This addition to statute would clarify the intent of the General Assembly and the requirements of Coloradans to contribute to the cost of their care. Second, the legislation codifies the requirements for third party recoveries included in the Deficit Reduction Act of 2005.

Section 6035 of the Deficit Reduction Act of 2005 requires a state to provide assurances to the Centers for Medicare and Medicaid Services that it has laws in effect for third party data matching and recoveries as required in the Act. The assurances are provided to the Centers for Medicare and Medicaid Services through a state plan amendment.

The Department's proposed legislation closely follows the language of Section 6035, which modifies 42 U.S.C. 1396a(a)(25) – (1) to expand the definition of providers required to share information with state Medicaid programs, (2) to tighten requirements for providers to share information, (3) to add a new requirement that providers accept claims submitted by Medicaid within three years of the date of medical service, and (4) to give Medicaid programs six years to adjudicate a claim.

Colorado must enact these provisions to provide the necessary assurances to the Centers for Medicare and Medicaid Services that the state meets the requirements for Section 6035 of the Deficit Reduction Act of 2005.

Most insurers operating in Colorado already comply with the requirements of Section 6035. There are, however, one or two insurers who are not in compliance with these requirements. Passing this legislation will help bring those insurers into compliance. The fiscal impact will likely result in savings to the state through a reduction of Medicaid expenditures for individuals with private insurance. It is difficult to determine the full impact of this savings until the Department establishes some trends from the non-complying insurers. The savings are likely to be insignificant since most insurers are already complying.

Secondary fiscal impact risk attaches if third party recovery legislation is not passed. Insurers already complying with the federal law may discontinue providing information to the Department. This would be especially true for those providers who meet the new definition of provider under the proposed legislation but claim they did not meet the definition of provider prior to Section 6035 of the Deficit Reduction Act of 2005.

The Centers for Medicare and Medicaid Services, Region VIII, also sent the Department a letter clarifying that state recovery requirements are a condition of participation in the federal Medicaid program:

“Section 1902(a)(25)(I) does not directly mandate that health insurers provide State with the necessary information. Rather, Section 1902(a)(25)(I)(i) directs States as a condition of receiving federal financial participation to have laws in effect that in turn, require health insurers doing business in their State to provide the State with the requisite information.”

The current contribution by the federal government to Colorado's Medicaid program is approximately \$1.7 billion (approximately 50% of total costs).

From 2001 when the original data matching statute was passed into law, the Department has recovered \$44,879,731 through June 30, 2007 (excluding Medicare recoveries). Additionally, once a match has been made, the Department enters the third party insurance information into its system and cost-avoids future claims on those individuals. Since FY 02-03, the Department has cost avoided over \$40,000,000 (excluding Medicare cost avoidance). As discussed above, passage of this law is anticipated to bring only a few insurers into this program and is unlikely to create significant additional recoveries.

Potential Controversy

Insurers may argue against sending their eligibility files to the Department or its vendor because the files contain protected health information. This argument is unfounded. Both the Department and the insurers are covered entities under the Health Insurance Portability and Accountability Act (HIPAA).

As covered entities, the insurers are authorized to disclose protected health information to another covered entity, such as the Department, to carry out treatment, payment, or health care operations (45 C.F.R. 164.506(c)). Additionally, a covered entity is authorized to allow a business associate to receive protected health information on the covered entity's behalf, as long as a business associate agreement is in place (45 C.F.R. 164.502(e)(1)). The Department has an appropriate business associate agreement with its third party vendor which requires it to safeguard all protected health information as defined and required by HIPAA.

10:30 to 10:40 Break

10:40 to 11:00 Provider Rate Increase Issues

- 23. What obstacles exist to implementing a physician fee schedule that is based on the Medicare Resource-Based Relative Value Scale system in a cost-neutral manner (i.e. all Medicaid rates would remain at the same percentage of Medicare rates as they are now but we would use the Medicare methodology to set the rate and then use a multiplication factor (i.e. 23 percent, 85 percent, etc. of the Medicare rate) to ensure budget neutrality). This question is attempting to understand the obstacles involved in establishing a more rationale, albeit inadequate, rate methodology in order to address the Task Force's observation that "the current fee schedule does not have a rational basis and Medicaid should consider RVU alternatives" (Colorado Provider Rate Task Force, Medicaid Physician and Other Practitioners Reimbursement Analysis, page 12).**

RESPONSE:

The Department is very interested in developing a long term, rational, and fair approach to rate setting for providers to create stability and predictability. Based on discussions with the Colorado Provider Rate Task Force, there is not a general agreement that moving to the RBRVS system accomplishes that goal. It is an unrealistic expectation that a rational and fair approach can be

achieved while maintaining budget neutrality. Rate determination should not be done in isolation; it should be part of an overall effort to improve health care quality and outcomes.

Until there is consensus between the Administration, General Assembly and providers on a long term solution, the Department's efforts will continue to focus on improving client access to care through targeted rate increases and correcting payment disparities where they exist.

24. While the study indicated that Arizona, Idaho, Nebraska, and Wyoming have rates that are a higher percentage of the Medicare rate (sometimes exceeding them) than are the Colorado rates, how does Colorado's per capita costs for acute care services per aid group (i.e. children, pregnant women, etc.) compare to these states?

RESPONSE:

The Department strongly urges caution when comparing per capita costs between states, and the value of the comparison may be limited. The Department contacted the Medicaid programs in each of Arizona, Idaho, Nebraska, and Wyoming. However, only Idaho and Nebraska were able to provide information in time for inclusion in this response. Expenditure, caseload, and per capita cost are provided in the table below.

There a number of factors which make such comparisons imperfect. For example:

- Idaho was unable provide average monthly caseload by aid category; the Department used information provided by the Centers for Medicare and Medicaid services to perform the comparison.
- Nebraska caseload and expenditures for its 'Children' population incorporate both pregnant women who would appear in the Colorado Baby Care Adults category and foster care children who would appear in the Department's Foster Care population.
- The most recent expenditure and caseload information Nebraska could provide was from FY 05-06.
- Neither state has a separate population for Disabled Adults 60 to 64. Rather, both states have a single combined 'Disabled' population.

For clarity in comparison with the Department's Budget, the Department has used its own titles for aid categories. Because of differences in the way other states aggregate caseload, the Department has attempted to select the most comparable populations to provide an accurate comparison. However, some of the differences shown are likely due to differences in covered populations. There are also benefit package and provider network differences which are inherently included in this comparison.

Further, it must be noted that all figures presented are in total funds, and that both Nebraska and Idaho receive an enhanced federal financial participation rate. Idaho's federal financial participation rate is 69.87%, and Nebraska receives a 58.02% federal financial participation rate.

Per Capita Comparison	Adults 65 and Older	Disabled Individuals	Low Income Adults	Baby Care Program - Adults	Eligible Children
Colorado					
FY 05-06					
Acute Care Expenditure	\$119,353,133	\$440,659,063	\$194,256,328	\$39,291,428	\$349,142,777
Caseload	36,219	53,613	57,754	5,050	229,911
Per Capita	\$3,295.32	\$8,219.26	\$3,363.51	\$7,780.48	\$1,518.60
FY 06-07					
Acute Care Expenditure	\$83,069,760	\$426,384,710	\$205,337,996	\$47,585,089	\$376,439,368
Caseload	35,977	54,609	56,335	5,123	222,771
Per Capita	\$2,308.97	\$7,807.96	\$3,644.95	\$9,288.52	\$1,689.80
Nebraska (FY 05-06)					
Acute Care Expenditure	\$84,682,908	\$316,699,448	\$101,306,003		\$390,285,415
Caseload	18,370	29,682	23,556	N/A	129,062
Per Capita	\$4,609.85	\$10,669.75	\$4,300.65		\$3,024.01
Percent Difference from Colorado	39.89%	29.81%	27.86%		99.13%
Idaho (FY 06-07)					
Acute Care Expenditure	\$10,338,150	\$159,415,800	\$40,235,221	\$102,602,615	\$114,694,201
Caseload	9,993	28,011	14,303	5,683	123,877
Per Capita	\$1,034.54	\$5,691.19	\$2,813.06	\$18,054.30	\$925.87
Percent Difference from Colorado	-55.19%	-27.11%	-22.82%	94.37%	-45.21%
Disabled Individuals includes the Department's Disabled Adults 60 to 64 and Disabled Individuals to 59 aid categories.					
Low Income Adults includes the Department's Categorically Eligible Low Income Adults and Expansion Adults populations.					
Nebraska figures include Baby Care Program - Adults in its Eligible Children population.					

25. What is the cost to implement the Task Force's recommendations to move durable medical equipment and drugs that are not self-administered based on the Medicare fee schedule?

RESPONSE:

The cost to implement rates for durable medical equipment based on the Medicare fee schedule as recommended by the Provider Rates Task Force would be an increase of \$13,851,966 total funds. This estimate was calculated by comparing Medicaid payments for durable medical equipment in FY 06-07 to the 2007 Medicare fee schedule for durable medical equipment. The estimates assume no change in utilization.

The cost to implement rates for drugs that are not self-administered based on the Medicare fee as recommended by the Provider Rates Task Force would be an increase of \$1,855,350 total funds. This estimate was calculated by comparing Medicaid payments for drugs that are not self-administered in FY 06-07 to the 2007 Medicare fee schedule for drugs that are not self-administered. The estimate assumes no change in utilization.

The total cost to implement rates for both durable medical equipment and drugs that are not self-administered based on the Medicare fee schedule would be an increase of \$15,707,316 total funds.

26. What is the cost to make sure that no acute care provider rate (including in-patient hospitals) fall lower than that the current percent the Medicare rate for the same service for FY 2008-09?

RESPONSE:

The response to this question is separated into two sections since acute care provider rates and inpatient hospital rates are calculated using different methodologies.

It would cost approximately \$485,830 to ensure that the acute care provider codes for which both Medicare and Colorado Medicaid pay do not fall lower than the FY 06-07 percent of Medicare for the same service in FY 08-09.

Based on the Department's calculation of the estimated budget neutrality expenditure threshold for FY 08-09, an additional 0.5%, or approximately \$1.35 million, would be needed to maintain Colorado hospitals at 91.3% of the Medicare rate for the FY 08-09 Medicaid inpatient hospital rate.

Detail and assumption on the Department's calculations can be found in Attachment 3.

- 27. Would it be possible to include a special "incentive payment or grant program" for any acute care provider whose practice exceeded more than 30, 40, 50, 60 percent Medicaid (similar to what we do for Children's Hospital in the Indigent Care division) - i.e. a high volume Medicaid practice adjustment to reimbursement rates?**

RESPONSE:

The Department believes this program would be possible, but would require approval from the Centers for Medicare and Medicaid Services, and a significant budget action. The Department believes such a program should only be considered as part of any overall rate reform.

- 28. Please provide an update on the implementation on S.B. 07-130.**

RESPONSE:

The Department is working collaboratively with the Colorado Department of Public Health and Environment to define a "medical home" by setting standards. The standards for SB 07-130 will not be used to measure the quality of care a client receives. Rather, the SB 07-211 performance measure advisory group will make recommendations to the Department for clinical performance measures for specified clinical activities.

The Department in collaboration with the Colorado Department Public Health and Environment's Colorado Medical Home Initiative Advisory Board has focused on implications for the Initiative and Advisory Board as a result of the passage of SB 07-130. Over 40 people representing various agencies, families, hospitals, providers, health plans, organizations and policy-makers have been meeting monthly to assist in the implementation of SB 07-130. Additionally, the existing Task Forces were modified to better align their activities with SB 07-130. The highlights and implementation timeframes related to SB 07-130 are as follows:

The Evaluation Task Force is developing and implementing the standards for the medical home. These standards will be used to "verifiably ensure" medical homes. Draft standards are currently under review and will be included in a report to be delivered to the Colorado General Assembly in

January of 2008.

The Provider Task Force is formulating a plan on how best to provide information and resources to providers and assist in the implementation of the medical home concepts into primary care practices.

The Department is also meeting with the appropriate systems and data business analysts to finalize plans to modify the Medicaid Management Information System to flag those providers that meet the medical home standards in an effort to measure the number of children enrolled in both Medicaid and the Children's Basic Health Plan that have medical homes.

29. If Medicaid rates for the Prenatal Plus program actually covered the cost of the program, would additional women be able to be served using funding from the Maternal Block Grant or local funds? If more women were served under this program, would the state anticipate greater savings in the Medicaid program?

RESPONSE:

The Colorado Department of Public Health and Environment is the recipient of the federal Maternal and Child Health block grant. The Department does not have discretion over how the Maternal and Child Health block grant money is disbursed. However, the Colorado Department of Public Health and Environment has informed the Department that, according to a recent cost analysis, on average the Prenatal Plus provider reimbursement rates cover only 45% of provider costs. The Colorado Department of Public Health and Environment distributes Maternal and Child Health block grant funds to providers to supplement the Medicaid reimbursement. The Department has requested \$500,000 in total funds for rate increases to cover approximately 69% of provider costs (November 1, 2007 FY 08-09 Budget Request, DI-6 "Provider Rate Increases").

If Medicaid reimbursement rates for Prenatal Plus more closely matched providers' costs, the Department assumes that the Colorado Department of Public Health and Environment would no longer have a need to supplement Medicaid reimbursement and could potentially utilize the Maternal and Child Health block grant funds to serve additional women in Prenatal Plus or other health programs administered by the Colorado Department of Public Health and Environment.

If Medicaid rates for this program more closely matched the providers' actual costs, it is likely that Prenatal Plus provider retention and provider enrollment would increase. A broader network of Prenatal Plus providers would allow Medicaid clients greater access to the service. The Colorado Department of Public Health and Environment reports in its 2006 Prenatal Plus annual report that limited reimbursement is a barrier to increasing the number of providers for Prenatal Plus and is most often the reason agencies choose to discontinue services. Two agencies terminated participation in 2006 due to a lack of financial resources and low program enrollment.

The Department agrees that by raising provider reimbursement rates for Prenatal Plus, the resultant increase in provider participation and client access would lead to better birth outcomes and healthier babies, thereby generating a greater cost savings to Medicaid.

- 30. When the substance abuse outpatient benefit was initially added, it was assumed that there would be some offsetting savings in the Medical Services Premiums line item. Does the Department anticipate that higher rates and a correspond forecasted increase in utilization, will result in savings elsewhere in the Medical Services Premiums line item? If so ho much savings does the Department anticipate?**

RESPONSE:

The Department continues to believe that the outpatient substance abuse treatment benefit will result in savings in the Medical Services Premiums. The Department has requested \$750,000 in total funds for rate increases and utilization growth as a result of more providers anticipated to participate in the substance abuse outpatient program (November 1, 2007 FY 08-09 Budget Request, DI-6 “Provider Rate Increases”). The Department does not anticipate that an increase in rates and the corresponding increase in utilization will affect the cost savings per client. However, the Department does anticipate that more widespread use of the benefit and increased access will result in greater overall savings to the Department. By increasing access, the Department believes that more clients will benefit from substance abuse treatment services, reducing the costs of more serious substance abuse related illnesses that may develop in the future. The costs and savings to the Department of providing the outpatient substance abuse treatment benefit are scheduled to be assessed by the State Auditor’s Office on or before January 1, 2011 through a systematic evaluation of the program.

- 30a. How much would it cost to assure that Home and Community-Based Services rates remain at 90 percent of Medicare for FY 2008-09? Why wasn’t HCBS services included in the Department’s rate plan for FY 2008-09? Will the increase in minimum wage impact the ability of agencies to hire and retain the non-skilled employees providing HCBS services?**

RESPONSE:

The Department focused its provider rate increase request for FY 08-09 to those areas of greatest need, targeting providers or procedures that were significantly below 90% of Medicare. As noted in the JBC staff briefing home care services, including Home and Community Based (HCBS) services and skilled home care services, received rate increases in FY 05-06 and FY 06-07 to approximately 90% of Medicare rates. An additional common policy rate increase of 1.5% was appropriated and implemented for FY 07-08. Estimating the fiscal impact of maintaining home care services rates at 90% of Medicare requires analysis and a follow up response, which the Department will provide by January 18, 2008. It should be noted that comparison to Medicare rates is not precise as Medicare’s reimbursement methodology for skilled home care is under a prospective payment system (PPS) and Medicare does not cover unskilled home care services.

The Department does not have any data to support a concern that the increase in minimum wage will directly impact the ability of agencies to hire and retain the non-skilled employees providing HCBS services. Anecdotally the Department has been informed by the provider community that agencies are paying more than minimum wage to compete with other employment options for unskilled workers. The current reimbursement rate for HCBS unskilled care is \$14.28/hour, slightly more than double

the minimum wage.

11:00 a.m. to 12:00 noon Other Cost Driving Issues

31. Please give the Committee an update on the implementation of H.B. 07-1346 and attracting new managed care providers to the State Medicaid program?

RESPONSE:

HB 07-1346 had five components relevant to Medicaid managed care program. The legislation: (1) authorized the Department to “enter into prepaid inpatient health plan agreements”; (2) raised the fiscal cap on the maximum amount that could be paid to a managed care organization from 95% to 100% of the regular Medicaid fee-for-service costs; (3) created minimum solvency requirements; (4) authorized a study of prepaid inpatient health plan agreements; and (5) authorized the insertion of a quality incentive payment into a prepaid inpatient health plan agreements. The first and third components did not require any implementation actions. The second component, raising the fiscal cap, was used last June to increase the rates paid to an existing managed care provider, Denver Health and Hospital Authority, and is likely to be used again to set the rates paid to a probable new managed care provider before the end of the fiscal year.

The fourth component, the study, is in the procurement phase of soliciting vendors to bid on the project. This will be accomplished by posting the scope of work on the state’s bidding system. The Department believes the study is on track for work to begin in January 2008, with an expected completion, and final report delivery, before the end of the fiscal year.

The fifth component (prepaid inpatient health plan incentive arrangements) requires formal rule making. The Department has prepared a draft amendment to the current quality improvement rule and anticipates getting stakeholder input and presenting it to the February 2008 Medical Services Board meeting for its initial reading. The draft rule proposes quality measures based upon care processes, care outcomes, client satisfaction, access to care, effectiveness of care, operational efficiency, operational effectiveness, and use of an electronic medical records system. These proposed measures would be flexible and could be customized based upon the Department’s then-current priorities, legislative directives, as well as the perceived strengths and weaknesses of the contracted prepaid inpatient health plan.

31a. What issues, including current rate problems, does the Department believe still exists for the ability to attract new managed care contracts to the Medicaid program? What is the status of the H.B. 07-1346 study on ASO agreements?

RESPONSE:

Including current rate problems, the Department has identified four issues that it believes still exist and tend to inhibit the Department’s ability to attract new managed care contracts to the Medicaid

program. These are: voluntary enrollment, the statutorily required use of fee-for-service data in rate setting, the Centers for Medicare and Medicaid Services regulatory requirements, and the adaptability of the Medicaid Management Information System.

Enrollment into Medicaid managed care plans is voluntary on the part of clients. Clients upon becoming eligible for Medicaid are fee-for-service and may choose to remain so or choose to enroll in a managed care plan. The vast majority of these clients chose to remain in fee-for-service Medicaid. The voluntary nature of the Medicaid managed care program causes problems for health plans trying to get enough covered lives to reach critical mass at various stages of the plan's development. The first problem is encountered when the health plan enters the Medicaid program. Since enrollment is voluntary, the Department cannot give the plan a certain number of enrollments to "get them started". The health plan must acquire enrollments through the monthly client notification and enrollment process. This process makes it difficult for the health plan to manage the risk inherent in a capitated risk arrangement from the onset of their contract. As the health plan continues in the Medicaid program the challenge of getting and maintaining enough covered lives to achieve critical mass and adequately spread their risk is an ongoing issue. The Department would be required to submit a waiver to the Centers for Medicare and Medicaid Services to mandate managed care enrollment for some populations.

The Department has attempted to mitigate the difficulties health plans have in achieving critical mass, by implementing an "opt-out" enrollment system for enrollment in Denver County. Enrollment on an "opt-out" basis means that absent an objection, or the selection of a different managed care plan, clients are enrolled into Denver Health's Medicaid Choice managed care program. Denver Health has approximately 36,000 enrolled members; yet, nearly an equal number have chosen to opt-out of Denver Health to stay in fee-for-service Medicaid over that period.

The statutory mandate that the Department utilize fee-for-service data in rate setting has implications that may be inhibiting the expansion of managed care. Colorado statute requires that managed care rates are based on Medicaid fee-for-service claims. However, fee-for-service experience may not adequately reflect the actual cost of providing services to clients in a managed care setting. This methodology creates a disincentive for managed care organizations to participate in the Medicaid program.

Further, if managed care were to grow large enough to provide services to most or all of the Medicaid enrolled population, recent and reliable fee-for-service data would no longer exist and the Department would be unable to meet the requirements of the statute. The Department believes that policies and statutes that are consistent with a long-run stable commitment to managed care, such as allowing other data sources, would remove a barrier to managed care expansion.

The regulatory requirements of the CMS make significant demands on the resources of contractors. In addition to actual operational requirements, compliance, monitoring and reporting activities are time and resource intensive and that demand on resources creates additional administrative expenses.

The Department is working with existing and potential contractors to identify ways in which contracting, reporting and compliance monitoring activities can be made more efficient and effective while reducing the demand on resources.

The Medicaid Management Information System was purchased in 1996 and was designed to assist in bringing managed care mandatory enrollment to the 75% level at the time. The Department was able to do that. Over the years, there have been new models of managed care developed that have not lent themselves easily to the current system; but modifications have been made to allow for proper enrollment of clients and payment of capitation amounts. The Department continues to be challenged in bringing new methods of service delivery into the system.

Obtaining claims and encounter data from Prepaid Inpatient Health Plans that meet MMIS requirements is a challenge. The HB 07-1346 study will identify these issues and potential solutions.

The HB 07-1346 study is in the procurement phase of soliciting vendors to bid on the project. This will be accomplished by posting the scope of work on the state's bidding system. The Department believes the study is on track for work to begin in January 2008, with an expected completion, and final report delivery, before the end of the fiscal year.

32. If the Joint Budget Committee rescinded its request for the Department to delay implementation of the quality incentive grant program, would the Department be able to make the payment before the end of 2007? In the Department's opinion, what would be the advantageous or disadvantageous for making these quality incentive payments?

RESPONSE:

Yes, the Department believes it will be able to make the payment before the end of 2007. The only quality payment remaining to be paid is to Denver Health, who achieved all of the required quality measures. The Department requires review and approval from the Centers for Medicare and Medicaid Services regional office before making this payment. The Department has been communicating with the regional office staff, who have agreed to conduct this review prior to the end of 2007. Approval is not assured, but the Department believes it is very likely. It would be advantageous to our continuing relationship with Denver Health as a key partner in serving our clients if we honor the agreement to pay them the incentive payment in a timely manner.

33. The Department states that it supports the recommendations of the S.B. 06-131/H.B. 07-1183 work group on nursing home reimbursement changes. However, staff is unaware of any place in the Executive's budget that sets aside the necessary funding for the legislative changes involved. Please clarify if funding exists in the Executive Budget for this proposal.

RESPONSE:

The Executive Budget does not include a request for funding this proposal, as the Department can only budget to current law. The charge to the work group was to develop a better methodology to reimburse nursing facilities. The Department agrees with the changes to the methodology recommended in the report. As the recommended change in reimbursement methodology requires statutory changes and an additional appropriation, the Department believes the proper avenue to implement such findings are through the legislative fiscal note process.

33a. Please comment any challenges the Department anticipates from assessing a provider fee in order to pay for the state match for the proposed rate increases for nursing homes.

RESPONSE:

The Department anticipates the greatest challenge to be concerns raised by nursing facility providers who have little or nothing to gain by the provider fee because they either have no Medicaid clients or very few. Provider fees are a bona fide and legal funding source eligible for federal matching funds, but fees may not include credits, exclusions, or deductions aimed at returning all or part of fees to providers as 'hold harmless'. Since the provider fee must not include direct or indirect hold harmless provisions guaranteeing repayment of fee to providers in Medicaid rates or other payments, some nursing facility providers will pay more than what they receive.

34. Given the costs of the proposal, does the Department have any priorities on the components of the plan that the Department believes should be addressed first? Please discuss the specific components of the proposal and why the Department supports the changes proposed.

RESPONSE:

The Department's first priority is the recommended change for the administrative and general (A&G) price component. When the legislature introduced a cap on the rate of increase for the administrative and general component in 1997 to the lesser of actual cost or 6%, there was no mechanism to re-base these costs. Ten years later, 65% of all nursing facilities are limited by the 6% cap. At the same time in 1997, caps were also placed on the health care component of the rate that was held to the lesser of actual cost or 8%. As of July 1, 2000 the health care caps were lifted when case-mix reimbursement began, and these caps were not reinstated until July 1, 2005. The health care component was rebased when the caps were put back into place with a new base amount at that time.

The Department supports a cost-based health care component that is case-mix adjusted for acuity because of the wide variation of services provided to Medicaid beneficiaries in nursing facilities. Facilities that serve primarily elderly clients have significantly different resource needs than facilities that primarily serve the mentally ill, brain-injured, Alzheimer's clients or clients with debilitating diseases. The case mix acuity adjustment allows the Department to identify the resource utilization of the Medicaid resident to assure that payments made reflect the care given.

As part of SB 06-131, the Department is required to include an adjustment for facilities that serve clients with moderately to severely impaired cognitive skills. Two populations have been identified

with behaviors that are related to cognitive loss/dementia or major mental illness diagnoses. Care for these populations is not adequately addressed in the case mix system. An analysis of residents with various mental illness diagnoses revealed that facilities with the highest population of these clients tended to have lower case mix indices. The proposal is for a two-tiered system that provides an adjustment for clients with a major mental illness that score as a PASRR Level II to be provided specialized services, and an adjustment for cognitive loss/dementia based on the Cognitive Performance Scale. Approximately 38% of the PASRR Level II clients are under 65 years of age, and it is anticipated that the additional specialized services provided will increase these clients' opportunity to return to the community. The adjustment for cognitive loss/dementia will provide the additional staff resources needed to serve these clients.

Inclusion of a quality allowance is also a part of SB 06-131. Pay for performance is a strategy to align incentives in the reimbursement system to reward facilities that achieve improved health outcomes of clients. These monetary incentives to provide quality care may reduce the rate of certain types of hospitalizations such as respiratory infection, urinary tract infection and congestive heart failure. Improving quality may reduce overall nursing facility expenditures and may provide more clients with the opportunity of transitioning from the facility and returning to the community.

35. Given the past history of discontinuing other programs that tried to reimburse nursing homes for quality, what challenges does the Department believe exists in developing a "pay-for-performance" reimbursement methodology for nursing homes?

RESPONSE:

The current proposal for a pay for performance incentive payment is for well-defined measures that are sustainable over time, are under the provider's control, and are to be verified by an onsite evaluation. A reimbursement system's support of quality is in the system design features and administrative effectiveness. Add-on incentive payments will emphasize the use of accountability measures such as staffing, occupancy, staff retention, survey deficiencies and customer satisfaction. The primary difference between historical attempts at reimbursing quality and the current proposal are the prerequisites for participation in the program and the specificity of what facilities must accomplish in the areas of Quality of Life, Quality of Care and Facility Management to earn points for reimbursement.

36. Please provide the Committee with a list of the facilities that would have their nursing home rate for A&G frozen for the next several years due to being above 105 percent of 110 percent of the medium costs for A&G. Please provide the Committee with a list of the facilities that would have their nursing home rates increased as a result of the A&G changes proposed.

RESPONSE:

Under the proposal, there are 20 facilities (9.7%) whose rates would be frozen over the next several

years due to being above 105% or 110% of the medium costs for administrative and general. There are an additional 31 facilities whose rates would initially be frozen but would transition over the course of the four-year phase in to be increased. Their rates are higher than the price at year one and lower, or at, the price in year four. This facility listing is at Attachment 4. There are 134 facilities that would have their nursing home rates increased as a result of the administrative and general changes proposed, and that list is provided at Attachment 5.

37. What would be the costs for an independent commissioned study on the frailty of PACE clients compared to the fee-for-service population?

RESPONSE:

If the Department were able to find a vendor to perform a study similar to the 2004 PACE frailty study, the anticipated cost could be between \$100,000 and \$150,000 for the current PACE provider, Total Longterm Care. This is significantly more expensive than the cost of the 2004 study, borne by Total Longterm Care, because the Centers for Medicare and Medicaid Services requires that any future frailty study be independent of any involvement of the PACE provider staff. Other organizations have submitted applications to be PACE providers, and each PACE provider would need its own study. However, as these additional providers are not going to be as large as Total Longterm Care, the cost would likely be less for those additional studies. Based upon the Department's conversations with the regional office of the Centers for Medicare and Medicaid Services, these studies would need to be repeated annually for at least the first few years.

38. What is the current status of the Department's with CMS on the PACE rates for FY 2007-08? How long can the Department continue to operate without a signed contract and receive federal match?

RESPONSE:

The Department is in the process of executing a contract with Total Longterm Care, the current Program of All-Inclusive Care for the Elderly (PACE) provider, and that contract contains the FY 07-08 rates. However, federal match is not assured until the Centers for Medicare and Medicaid Services has approved the rates.

Originally, the Department submitted PACE rates to Centers for Medicare and Medicaid Services in the fall of 2006 to be effective January 1, 2007. The Centers for Medicare and Medicaid Services had concerns with the methodology used to set those rates, principally the use of the 2004 Colorado Foundation for Medical Care (CFMC) Frailty Study. The Department asked for and received a six month extension through June 30, 2007 to address the Centers for Medicare and Medicaid Services' concerns. Near the end of the six month extension period, the Department discovered an additional issue with its data regarding the classification of clients who were dually eligible for Medicare and Medicaid. This forced the Department to completely reset the PACE rates with the corrected data. The Department's staff had to set Health Maintenance Organization rates before they were able to reset the PACE rates, as Health Maintenance Organization rates may not be applied retroactively, and PACE rates may. A significant amount of negotiation between the Department and its actuaries, and

Total Longterm Care and its actuaries was required to arrive at rates that would be acceptable to all sides, and that were expected to be approved by the Centers for Medicare and Medicaid Services.

The Department submitted PACE rates to the Centers for Medicare and Medicaid Services regional office on October 24, 2007. The regional office of the Centers for Medicare and Medicaid Services has notified the Department that it may not approve the FY 07-08 PACE rates. Additionally, the regional office has mentioned the possibility of a deferral of federal funding for the PACE program if the rates are not approved. There is also a possibility that federal funds will be deferred during the rate review process. Regional office staff have indicated they are, at a minimum, several months away from completing a review of the FY 07-08 PACE rates. The Centers for Medicare and Medicaid Services has stated that the reason for a possible deferral or disapproval of the rates is regarding the Department's continued use of the 2004 CFMC frailty study. However, this continued use of the frailty study is limited to a FY 07-08 phase out period.

39. Please discuss any issues the Department believes the Committee should understand in order to find a solution to the PACE rate dispute with CMS and the provider.

RESPONSE:

The fundamental dispute is how to come to an agreement on a method to measure and control for selection bias in the Program of All-Inclusive Care for the Elderly (PACE) enrolled population relative to the fee-for-service benchmark population. Should the PACE enrolled population be relatively more frail or needy than the fee-for-service benchmark, then the PACE provider incurs an adverse selection bias. Both state and federal law allow for an adjustment to account for the differences in need and expected cost between the two populations. The Department believes it is not only legally possible, but actuarially appropriate to make such an adjustment. However, the Centers for Medicare and Medicaid Services requires that such an adjustment be based on cost predictive data. Absent such an adjustment, the federal guidance is that the rate must remain at an amount no greater than the unadjusted fee-for-service benchmark.

The Department is not aware of any other state where a PACE rate setting process includes a 'frailty study' similar to the 2004 study commissioned by Total Longterm Care. This fact concerns the Department, as the Centers for Medicare and Medicaid Services may have difficulty approving a methodology for rate setting that has no other precedent. Even if approved by the Centers for Medicare and Medicaid Services, a repetition of the prior 'frailty study' model would be an expensive and ongoing commitment of resources. To ensure federal approval, the Department would certainly obtain prior approval from the Centers for Medicare and Medicaid Services regarding the choice of vendor performing the study and the structure of the study design. Based upon the Department's previous experience in this area, the Department assumes that procuring the study would be a contentious and time-consuming three-way negotiation between the Department, the PACE provider, and the federal government.

However, there are alternative means of constructing an adjustment that fairly and consistently measures the selection bias incurred by the PACE enrolled population relative to the fee-for-service

benchmark. The Department has considered several of these alternatives:

- Measuring the functional status of PACE's enrollees as a cost predictor.
- Measuring the share and expense of the last several months of life for which PACE providers are responsible.
- Subdividing rate cells to isolate the cost experience of the 'oldest old'.
- Diagnosis based risk adjustment.

Each of these models for controlling selection bias in the rate setting process has strong theoretical justification. The Department has no concerns about defending the results of these models to the Centers for Medicare and Medicaid Services. Furthermore, such models could more easily be applied to new PACE providers, and the Department believes could be more cost effective than the frailty study model.

Indigent Care

1:30 to 2:15 CBHP

40. Please describe how the Department will track actual expenditures from the CBHP Trust Fund Account in order to know how much, if any, should be swept back into the Innovative Health Care Grant Fund at the end of each fiscal year?

RESPONSE:

The Supplemental Tobacco Litigation Settlement Account was set up in the Children's Basic Health Plan Trust Fund in SB 07-097. The account receives 5% of the portion of Tobacco Litigation Settlement funding that remains after all original programs, services, and funds that receive such funding is completed, with any unexpended money in the account at the end of the fiscal year to be transferred to the Short-term Innovative Health Program Grant Fund. Over the course of the 2007 Legislative session, the following bills drew funding from the Supplemental Tobacco Litigation Settlement Account for the noted purposes:

- SB 07-097 (Allocation of Tobacco Litigation Settlement Moneys): To increase eligibility in the Children's Basic Health Plan from 200% of the federal poverty level to 205%; 100% of the required Cash Funds Exempt are to come from this account.
- SB 07-004 (Early Intervention Services): To provide physical, occupational, and speech therapies for children under the age of 3 who have developmental delays; 100% of the required Cash Funds Exempt are to come from this account.

The caseload and expenditures for the expansion population to 205% of the federal poverty level will be tracked separately from the rest of the Children's Basic Health Plan, so are easily identifiable. The expansion of early intervention services is not directly measurable as it is included in the actuarially developed capitation rates. For FY 07-08, the Department's contracted actuary developed a separate per member per month cost for these services. From this, the Department has estimated the percent

of the total children's per capita that is due to this expansion of benefits, (which is used to calculate the amount of actual expenditure) coming from the Supplemental Tobacco Litigation Settlement Account. Because the actual per member per month cost for the implementation of SB 07-004 is significantly higher than that estimated in the fiscal note, the Department expects expenditures from the Supplemental Tobacco Litigation Settlement Account to exceed revenues, and that no money will be transferred to the Short-term Innovative Health Program Grant Fund. Please see the Department's November 1, 2007 DI-3, page G-14 for more details on the per member per month cost, and Exhibit C-4 for the calculation of Children's Basic Health Plan State funding splits.

41. Please describe why there are still children with family incomes under 100% FPL on the CBHP program.

RESPONSE:

Depending on the family structure and types of income and expenses, Medicaid and the Children's Basic Health Plan program calculate financial eligibility differently for each program. It is possible for a family to be considered over 100% the Federal poverty level based on the Medicaid calculations and under 100% the federal poverty level based on the Children's Basic Health Plan calculations. Therefore, a client may be reported as under 100% the federal poverty level for the Children's Basic Health Plan although the client was denied as over income for Medicaid.

Additionally, because the Deficit Reduction Act does not apply to the Children's Basic Health Plan, the Department implemented a procedure to allow clients to be determined eligible for the Children's Basic Health Plan when they are unable to provide the required citizenship and identity documentation per the interim Deficit Reduction Act guidelines. Therefore, a client may be reported as under 100% the federal poverty level for the Children's Basic Health Plan although the client was denied for Medicaid because they did not provide the required citizenship and identity documentation.

In July 2007, the Centers for Medicare and Medicaid Services issued the final regulations regarding the implementation of the Deficit Reduction Act, which disallows Children's Health Plan Plus+ enrollment for children who do not have a completed Medicaid application. The Department is currently working with the Centers for Medicare and Medicaid Services to create new policies and procedures to adhere to the final July 2007 regulations.

42. The Department's budget request indicates a large supplemental for the CBHP program in FY 2007-08. While some of this increase is related to higher than projected caseload, the request also reflects substantial changes for PMPM rates than originally requested by the Department in November 1, 2006. Please describe in detail why these rates have increased over the original Department estimate.

RESPONSE:

The Department's February 15, 2007 Budget Request was completed based on rate development

prior to the end of the 2007 Colorado Legislative session. As a result, the original rate development process did not incorporate any impact of changes affecting benefits and eligibility that were implemented during the 2007 Legislative session.

Subsequent to the completion of the February 15, 2007 Budget Request, several additional laws were passed that affect the financial projections for the Children's Basic Health Plan. The two with the most significant impact are:

- SB 07-004 (Early Intervention Services): To provide physical, occupational, and speech therapies for children under the age of 3 who have developmental delays, and;
- HB 07-1301 (Cervical Cancer Immunizations): To provide coverage for cervical cancer immunizations and mandates coverage for the full cost of cervical cancer vaccination for all females for whom a vaccination is recommended.

Additionally, the rate development used in the February 15, 2007 Budget Request was based on an assumption that children under 101% of the federal poverty level would become eligible for Medicaid due to the removal of the Medicaid asset test. It was later determined that although the asset test would be removed, there would continue to be children in the Children's Basic Health Plan below 101% of the federal poverty level category due to the reasons outlined in the response to Question 41. Adding this category back into the population increased the base FY 07-08 rates (prior to legislative impacts) by approximately 3.8%.

43. Please explain why the FY 2008-09 per capita costs for the CBHP Adult Prenatal program are higher than the estimated FY 2008-09 acute care per capita costs for the Medicaid Baby Care pregnant women.

RESPONSE:

In the Department's November 1, 2007 Budget Request, the Department forecasts an average of 1,497 prenatal members in the Children's Basic Health Plan Adult Prenatal program in FY 08-09. The prenatal medical per capita cost is estimated to be \$12,723.22. This cost includes projected administration fees of \$32.75 per member per month paid to the Children's Basic Health Plan's administrative vendor to manage the State's network. Medicaid services are provided on a fee-for-service basis and therefore there are no administrative fees incorporated into the per capita costs.

In addition to the administrative cost, there are several other factors that also contribute to the higher per capita costs for the Children's Basic Health Plan Adult Prenatal program. First, provider reimbursements are higher in the Children's Basic Health Plan program. Hospitals providing services to the Children's Basic Health Plan prenatal members are generally reimbursed at 65% of billed charges. Alternatively, hospitals providing services to members in the Baby Care Program under Medicaid are reimbursed at a significantly lower rate. Services provided on an inpatient basis for prenatal members are the largest contributor to the prenatal programs' per capita costs.

Secondly, the Children's Basic Health Plan prenatal provider network is much larger than that of the Baby Care Program's prenatal network. As a result, members in the Children's Basic Health Plan prenatal program may more easily access prenatal care services than their Medicaid counterparts, leading to higher utilization rates and therefore higher per capita costs.

Lastly, the Department believes that the Children's Basic Health Plan prenatal members begin accessing services earlier than members in Medicaid's Baby Care Program for adults. It is estimated that Children's Basic Health Plan members begin receiving services during their pregnancy approximately two months earlier than Medicaid members, leading to higher utilization in the Children's Basic Health Plan.

44. Please provide the Committee with an update of the school districts selected to participate in the H.B. 06-1270 pilot program. What is the initial feedback on the effect this program has had on CBHP and Medicaid enrollment.

RESPONSE:

The Department began contract negotiations with three school districts, Pueblo City Schools, Jefferson County Schools and Adams Arapahoe 28-J Schools, in April 2007. The final execution of the contracts for these three school districts took longer than expected. While waiting for signature on the contracts, the school district workers attended Colorado Benefits Management System (CBMS) training, Medicaid eligibility, operations and policy training and began preparing for the project. The Free and Reduced Lunch Programs at each of the school districts began their standard process of determining eligibility for these programs and sorting through the approved applications for families interested in learning more about Medicaid and the Children's Basic Health Plan. The Department expects all three school districts to start processing applications through CBMS in December 2007. At this time, the Department is unable to report any feedback on the effect of this program on enrollment. To provide more detail on the implementation of this program, the Department has provided Attachment 6, which was prepared as an update for the Advisory Committee Members on the School-Based Medical Assistance Sites Demonstration Project.

45. Will the Department be ready to implement presumptive eligibility for children in the CBHP and Medicaid on January 1, 2008? The Department's budget request does not include any specific additional caseload or cost adjustments for presumptive eligibility.

RESPONSE:

The Department will be ready to implement presumptive eligibility for children immediately after the program is placed in the Colorado Benefits Management System (CBMS). The current projected date for the CBMS implementation is January 19, 2008. In the fiscal note for SB 07-211, the Department did not forecast a caseload impact for children who will be presumptively eligible and presumed that any additional costs will be addressed through the annual budget process. If a child is placed in presumptive eligibility and later found eligible, there is no net fiscal impact, simply an acceleration of services. If a presumptively eligible child is later found ineligible, there would be a fiscal impact to the State. However, because the CBMS does not track the number of individuals that

are denied eligibility because they are over income, the Department had no data to use to estimate how many people this would constitute. Until the program is implemented and reliable caseload data is available, the Department is unable to make any additional caseload or cost adjustments for presumptive eligibility.

46. Is additional outreach funding the most cost-effective means for reducing the number of eligible uninsured children? Would providing 12 months of continuous Medicaid eligibility for children have a greater impact? How would this impact the number of uninsured?

RESPONSE:

The Department believes that marketing and outreach is the most effective means for reducing the number of eligible but not enrolled children. The Children's Basic Health Plan experienced a reduction in enrollment growth when marketing and outreach dollars were removed from the program in FY 02-03. Since marketing and outreach was reinstated in April, 2006, the program has experienced an enrollment growth of approximately 10,000 children despite a reduction in caseload of approximately 4,300 children who became eligible under Medicaid due to the removal of the asset test for determining eligibility.

The Department does not believe that providing 12 months continuous Medicaid eligibility would have a greater impact on reducing the number of uninsured eligible children. Currently, if a child exits Medicaid, they are doing so because they are no longer eligible for the program, and would not be considered 'eligible but not enrolled'. Thus, providing guaranteed eligibility would help in retaining current enrollees as opposed to enrolling those children who are currently eligible but not enrolled. Providing 12 months continuous Medicaid eligibility would also have a fiscal impact that the Department has not fully analyzed.

47. Why doesn't the Department's request include an increase for adults on Medicaid for this decision item (3A)? Wouldn't it be safe to assume that there would be additional eligible adults that would be enrolled if more eligible children are found?

RESPONSE:

The income range for parents to be eligible for Medicaid is much smaller than that for children. According to recent research by The Lewin Group, of the uninsured individuals that are eligible but not enrolled in Medicaid or the Children's Basic Health Plan, approximately 82.5% are children. In the past, the Department has attempted to estimate woodwork effects from policy changes (for example with the Medicare Modernization Act). These caseload impacts, however, have been rarely realized. The Department believes that any impact to the adult caseloads due to additional children's outreach will be nominal and, if necessary, the Department can address any increase in the adult caseload through the normal budgetary process.

- 48. Please describe the most recent federal guidelines for screening for Medicaid eligibility before a child can be determined CBHP eligible. Can a child be CBHP eligible without the necessary Medicaid citizenship or legal status documentation?**

RESPONSE:

Federal guidelines require clients to be screened for Medicaid eligibility before they are determined eligible for the Children's Basic Health Plan. The Deficit Reduction Act included provisions requiring proof of citizenship and identity for clients in Medicaid. However, citizenship and identity documentation is currently not a requirement for the Children's Basic Health Plan. The Department implemented a procedure to allow clients to be determined eligible for the Children's Basic Health Plan when they are unable to provide the required citizenship and identity documentation per the interim Deficit Reduction Act guidelines. In July 2007, the Centers for Medicare and Medicaid Services issued the final regulations regarding the implementation of the Deficit Reduction Act. The Department is currently working with the Centers for Medicare and Medicaid Services to create new policies and procedures to adhere to these final regulations.

- 49. The S.B. 07-211 Advisory Committee made several preliminary recommendations in their November 1, 2007 report for data collection within the Department on the number of children eligible for these programs but not enrolled. What is the status of the Department's response to the S.B. 07-211 Advisory Committee's initial recommendations.**

RESPONSE:

The Department is working with the Colorado Health Institute to provide technical assistance to determine a data methodology to identify children who are eligible but not enrolled in Medicaid and the Children's Basic Health Plan. This committee also will advise the Department on new and effective ways to identify and enroll hard-to-reach children. A Colorado Health Institute senior research analyst has joined the committee as a data advisor. The Department anticipates the results of a new data methodology will assist the advisory committee in addressing their concerns regarding why children repeatedly gain and lose eligibility.

2:15 – 2:30 Uninsured Assistance Programs

- 50. What contingency plans should the State pursue if the CMS rule, "Medicaid Program; Cost Limit for provider Operated by Units of Government and provisions to Ensure the Integrity of Federal-State Financial Partnership" should become effective on September 1, 2008?**

RESPONSE:

The Department is researching and considering alternative financing mechanisms in order to provide the State share for the estimated loss of \$142.2 million in federal funds, as reported in the Department's presentation to the Joint Budget Committee on March 12, 2007, if this Centers for

Medicare and Medicaid Services (CMS) rule becomes effective. These federal funds include Supplemental Medicaid payments and the \$87.1 million made available to the State through the Disproportionate Share Hospital Allotment. If the Centers for Medicare and Medicaid Services implements this rule, the Department will lose its ability to have participating Colorado Indigent Care Program hospitals certify their uncompensated costs as the State share for federal financial participation as a majority of these public-owned hospitals will become redefined as private-owned hospitals.

Concerning retaining the federal funds under Supplemental Medicaid payments, the primary plan the Department has been researching is a provider assessment which federal regulations allow to be made on nineteen classes of services (42 CFR Section 433.56). Under the authority of SB 06-145, the Department is implementing three provider assessments for private-owned facilities. The Department expects to receive approval of two State Plan Amendments authorizing the assessments for inpatient and outpatient hospital services by June 2008. If the Centers for Medicare and Medicaid Services' rule is implemented and a majority of public-owned hospitals are redefined as private-owned hospitals, the Department will have the ability to use the provider assessment to draw the State share and maintain Supplemental Medicaid payments.

Further, the Department is researching various mechanisms, such as a broader provider assessment or a low-income pool that would be supported by donations from counties and hospital taxing districts, which could be utilized for providing the State share to draw the federal funds available through the Disproportionate Share Hospital Allotment.

50a. What additional assistance does the Department believe could be available to help offset the losses the Children's Hospital experiences because of their large volume of Medicaid clients?

RESPONSE:

The Department's current inpatient rate methodology includes a Pediatric Specialty Hospital adjustment to allow Children's Hospital to be paid in a manner different than other hospitals. This methodology provides Children's Hospital with an inpatient base rate that is higher than any other Medicaid participating hospital. This adjustment could be further increased. If this increase was unaccompanied by additional general fund, it would cause lower rates for all other hospitals under the current inpatient rate setting structure, which is constrained by a budget neutrality calculation. If the increase to the adjustment were accompanied by additional general fund, there would be no impact on other hospitals.

The Department does not have a mechanism to independently measure the losses incurred by Children's Hospital. Generally, the Department compares its inpatient rates to Medicare rates to judge the adequacy of inpatient reimbursement. This process does not work well for Children's Hospital, because it is a very low volume Medicare provider. The Department believes that implementing a Medicaid specific cost report for Children's Hospital would provide a benchmark for evaluating the adequacy of the current inpatient Medicaid reimbursement rate.

It may be possible for the Children's Hospital to receive additional funding through a Supplemental Medicaid payment provided through a provider assessment on inpatient and outpatient hospital services. This mechanism would require neither general fund nor would be subject to budget neutrality. Please refer to the response in Question 50.

2:30 to 3:00 Blue Ribbon Commission -- Health Care Reform
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51. Does the Department support using the Lewin Group's estimate of the number of uninsured in Colorado? If not, why not?

RESPONSE:

The Department and the Governor's Office are working with the Lewin Group to conduct additional in-depth modeling analysis of the proposals presented by the 208 commission and to translate the analysis into Colorado-specific budgeting terms and processes. The Department supports using the Lewin Group's methodology to estimate the number of uninsured; however, the dataset used by the Lewin Group to estimate the number of uninsured is not entirely comparable to the Department's data used for forecasting caseload. The Department and the Lewin Group have been working together and the Lewin Group recently provided the Department with data that is comparable to the data the Department reports and uses in budgeting.

The Department intends to create its own data set in order to estimate the number of uninsured that will effectively compare to current data used for forecasting caseload. The Department anticipates there may be a need for external subject matter experts to assist with the process of creating the data set to estimate the number of uninsured individuals in Colorado.

52. What concerns, if any, would the Department have with merging the Medicaid and CBHP programs into one program for all parents, childless adults and children (excluding the aged, disabled, and foster care eligibles) with the appropriate EPSDT services maintained (see 208 Commission recommendations).

RESPONSE:

The Department is currently reviewing all potential policy options from the 208 commission proposals regarding merging the Medicaid and the Children's Basic Health Plan programs. If Medicaid and the Children's Basic Health Plan were merged into one program, the Department would want to ensure that there is some improvement in cost-effectiveness, benefits, access to services or health outcomes. In addition, because EPSDT is a federally mandated requirement of the State Plan, the Department must ensure any policy options include maintaining the EPSDT services.

53. **What are the Department's cost estimates if *all* currently eligible children and adults were enrolled in Medicaid/CBHP?**
54. **How much does the Department estimate it would cost if Medicaid clients were provided one-year continuous eligibility.**
55. **How much would it cost to expand coverage for low-income adults on Medicaid to 100 percent of poverty?**
56. **How much does the Department estimate it would cost to expand Medicaid/CBHP to cover all uninsured legal residents of Colorado up to 205 percent of FPL (Please breakdown this estimate into Children, Parents of Eligible Children, Adults without Dependent Children).**

RESPONSE TO QUESTIONS 53-56:

The Department has been working closely with the Governor's Office of Policy and Initiatives and the Office of State Planning and Budgeting to thoroughly evaluate and estimate costs for the proposals from the 208 commission. The cost estimates from this collaborative effort will be made available to the public once the full analysis is complete.

57. **Does the Department believe that CMS would grant the necessary waivers to cover all uninsured legal residents of Colorado up to 205 percent of FPL?**

RESPONSE:

The Centers for Medicare and Medicaid Services have approved similar waivers to expand Medicaid and Children's Basic Health Plan eligibility for families. Under the 1115 Research and Demonstration Program, it is possible for the Centers for Medicare and Medicaid Services to grant a similar waiver to cover all uninsured legal residents of Colorado up to 205% of federal poverty limit. Section 1115 of the Social Security Act gives the U.S. Department of Health and Human Services Secretary broad authority to authorize research, pilot, or demonstration projects that are likely to assist in promoting the objectives of the Medicaid program. Under such demonstration projects, states have broad flexibility to test substantially new ideas in expanding coverage and service delivery.

Under a Section 1115 demonstration, states can obtain federal Medicaid matching funds to provide services that Medicaid otherwise could not cover and/or to cover individuals who otherwise would not be eligible for the Medicaid program. For instance, states today use these demonstrations to expand coverage to people otherwise unable to obtain health insurance, to provide greater access to primary care services, and to increase their use of managed care.

The demonstration is to be budget neutral over the project's life, meaning that federal taxpayers would not be expected to pay more under the demonstration than they would without it. For example, states in the past have expanded their reliance on managed care in a demonstration to generate savings to support the waiver's expanded coverage or eligibility. Demonstrations are typically approved for a five-year period and may be renewed.

58. What concerns, if any, does the Department have with the 208 Commission's health care reform recommendations as they relate to the Medicaid/CBHP program?

RESPONSE:

The Department is currently reviewing all potential policy options and recommendations from the 208 commission. The Department will analyze and comment on any recommendations through the 2008 legislative session. The Department would want to ensure that there is some improvement in cost-effectiveness, benefits, access to services or health outcomes.

3:00 to 3:10 Break

3:10 to 3:25 Old Age Pension Program

59. If Health Care Reform goes to the ballot in 2008, what is the Administration's position on the following issues related to the Old Age Pension program:

59a) Should the Constitutional requirement for the Old Age Pension Medical Program (in place since 1957) be eliminated and this population be rolled into any future program that would provide subsidies to low-income uninsured to purchase health care insurance (or be rolled into a waiver expansion of Medicaid as a state-only population)?

59b) If the Old Age Pension Medical Program is retained, should the Constitutional limit for the program be changed from the \$10.0 million cap to a more realistic amount with the ability to be adjusted upward based on caseload and medical inflation growth? (Please note: the non-Amendment 35 revenues for this program are counted against the TABOR revenue limits but are outside the 6.0 percent appropriation limits).

RESPONSE:

At this time, the Department is unable to comment on the administration's position regarding any ballot initiative regarding health care reform. The Department understands the Committee's comments and will consider the Old Age Pension Medical Program under any comprehensive health care reform package.

60. Please provide the Joint Budget Committee with the detailed analysis for the Department's estimate that it would cost an additional \$16.7 million to provide rates for the OAP Medical program at 100 percent of Medicaid rates for the same service (page 10 of the footnote report includes this estimate but without any supporting detail).

RESPONSE:

The detailed analysis for the Department's \$16.7 million estimate is provided in Attachment 7.

- 61. Please explain why this program reverted \$1.6 million in FY 2006-07. Please explain why the Department's budget request for FY 2008-09 does not request using any of the available \$2.4 million fund balance in the OAP Supplemental Medical Fund to increase provider rates for this program in FY 2008-09 (See page M-14 of the Department's request).**

RESPONSE:

The Old Age Pension State Medical Program's expenditures must be managed to a fixed appropriation. Unlike the Medical Services Premium line item, there is no over-expenditure authority for the Old Age Pension State Medical Program line item. Expenditures must come in at or under the appropriation every year. As such, the Department is conservative in its forecast, as unexpected upward shifts in caseload or utilization could cause an over-expenditure of the appropriation.

The \$1.6 million reversion resulted because of the Department's conservative forecast and desire to avoid an over-expenditure of the appropriation. In addition, there is a significant lag effect between when rates are increased to a corresponding expenditure increase. The Department proposed a rate increase at the April 2007 meeting of the Medical Services Board in order to better utilize the program's FY 06-07 appropriation. The effective date of this rate increase, May 1, 2007, did not allow enough time for the rate increase to substantially impact the program's expenditures before fiscal year-end.

Further, due to the precision required in forecasting expenditures one year out under this fixed appropriation, the lag effect on claims, and shifts in caseload, it is difficult for the Department to submit a forecast and budget request in November 2007 that will accurately predict expenditures in FY 08-09. Therefore, a future budget action may be required if the Department determines that additional funding was available in the Supplemental Old Age Pension Health and Medical Care Fund.

- 62. Does the Department anticipate that they will need to cut rates in FY 2008-09 in order to live within the requested appropriation? If so, how much of a funding increase would be necessary to make sure rates remain stable, as a percent of Medicaid rates, through FY 2008-09.**

RESPONSE:

Based on recent projections, the Department may need to reduce rates for the Old Age Pension State Medical Program in FY 08-09 in order to stay within the November budget submission. Due to the precision required in forecasting expenditures over one year under this fixed appropriation, the lag effect on claims, and shifts in caseload, it is difficult for the Department to forecast FY 08-09 with much accuracy for the November 1 budget submission. Further, to stabilize the program, the Department is attempting to minimize the frequency and magnitude of provider reimbursement rate changes throughout the year. The Department may consider requesting additional funding from the available fund balance of the Supplemental Old Age Pension Health and Medical Care Fund to maintain reimbursement rates at their current levels.

- 63. At the rates the Department is currently paying, what providers are participating in the program? In other words, where are the OAP Medical clients receiving care?**

RESPONSE:

Clients enrolled in the Old Age Pension Medical Program can receive care from hospitals (through their Medicaid contract) and Federally Qualified Health Centers that participate in Medicaid. Further, a significant number of these hospitals and all Federally Qualified Health Centers participate in the Colorado Indigent Care Program. This network provides an Old Age Pension Medical Program client with a similar level of access to care as a Colorado Indigent Care Program client.

The Department is aware that rate reductions may limit access to care for Old Age Pension Medical Program clients seeking care from providers who do not participate in Colorado Indigent Care Program. At this time, the Department is not aware of any major issues related to clients not being able to receive necessary treatment from specific provider groups. In addition, the Department cannot identify providers that choose not to provide services to a client enrolled in this program. The Department would only be made aware of this if a client or provider contacted the Department.

3:25 to 3:35 Break

3:35 to 4:50 Administrative/Other Issues

General Budget Issues

- 64. Please explain why the Governor vetoed footnote 21 this year when footnotes similar to this footnote were not vetoed in previous years (2002, 2003, 2004, 2005, and 2006)? (P.S. we have read the Governor's veto letter, please help the JBC understand why all of a sudden this footnote became "administering the appropriation" and "substantive legislation"). Does the Department have suggested language that would still meet the JBC's need to receive this information and not cause a Governor's veto?**

RESPONSE:

The Department believes that issues related to footnote vetoes are most appropriately addressed with the Governor's Office. However, as instructed in the Long Bill veto letter, the Department has been and will continue to comply with this footnote. The Department recognizes the value of this monthly report for the JBC and as a public information document.

- 65. Would the Department rather see a statute requiring the Department to submit this information (and perhaps more information) to Joint Budget Committee in the future? Please describe any difficulties that the Department would have in producing monthly reports with the following information:**

RESPONSE:

The Department is not in favor of a statutory requirement for monthly reporting. Specific

requirements in statute would limit the amount of flexibility the Department would have in providing useful information to the Joint Budget Committee. Under a statutory reporting requirement, if the Joint Budget Committee desired additional reports, a change to the statute would be required.

The Department is committed to ensuring that as much relevant information on the Medicaid program is provided to the Joint Budget Committee, stakeholders, and the general public as possible. The Department is willing to collaborate with the Joint Budget Committee to determine what information can be added to monthly reporting to ensure that the Joint Budget Committee receives timely and relevant information on the Department's programs.

However, as part of any reporting process, the Department must also ensure that the information provided is as accurate and consistent with prior information as possible. In order to ensure that the quality of information being delivered to stakeholders is of acceptable, the development of new monthly reports will require significant amounts of time, and potentially additional resources. For example, the Department has been working on a significant upgrade to one of its existing reports, which the Department hopes will provide some of the new information which is being requested below. Despite being an update to an existing report, this process has already taken close to a year, and is still not complete.

Furthermore, it must also be noted that the Department creates these monthly reports specifically for the Joint Budget Committee. If the Joint Budget Committee requires a large number of additional reports, the Department will likely need to request additional staff to handle the workload. It is unlikely that the Department can continue to absorb this impact and still produce timely reports.

The Department is willing to work with the Joint Budget Committee to prioritize which requests are the most important to ensure that the most useful information can be provided as quickly as possible. To the extent that the Joint Budget Committee requires additional information, the Department can and will consolidate as much time and effort as feasible to minimize both the time required to create the report and the cost associated with the creation process.

For clarity and brevity, specific answers to similar questions have been grouped together. Some questions which have multiple parts have been split up where appropriate.

- 65a Medicaid caseload by aid category (JBC gets this now)**
- 65b Medicaid caseload enrolled in MCOs by aid category (JBC gets this now)**
- 65g Children's Basic Health Plan by aid category (JBC gets this now)**
- 65i Medicaid Medical Services Premiums year-to-date expenditures by service category (get this now)**
- 65k Medicaid Mental Health Capitation year-to-date expenditures**
- 65l Children's Basic Health Plan monthly expenditures (JBC gets this now)**

RESPONSE:

The Department provides this information currently to the Joint Budget Committee each month, and anticipates that it will continue to do so in the future.

- 65c Medicaid caseload by aid category for each BHO (new)**
- 65d Medicaid caseload enrolled in an HCBS waiver program (new)**
- 65e Medicaid caseload qualified for Long-Term Care programs broken-out by HCBS, nursing homes, and PACE (new)**
- 65f Medicaid caseload that are dual eligibles (new)**
- 65h Old Age Pension Medical Program caseload (new)**
- 65m Medicare Modernization's Act State Contribution Payment monthly expenditures (new)**
- 65n Old Age Pension Medical Program expenditures (new)**
- 65o Personal Services expenditures and filled and vacant positions (new)**
- 65p Amount of third party recoveries (new)**
- 65q Monthly expenditures for all other Department line items (new)**

RESPONSE:

The Department believes that it can create standardized reports which provide this information. While some of this information can be easily added to existing reports, some of this information will require the creation of completely new reports. As described above, the creation of new standardized reports may require a significant amount of time and additional resources.

- 65i Medicaid Medical Services Premiums... projected annual expenditures for the fiscal year (new)**
- 65k Medicaid Mental Health Capitation... projected annual expenditures for the fiscal year (new)**

RESPONSE:

The Department does not support a monthly report which contains projected annual expenditures for the fiscal year for either of these Long Bill Groups. As the Committee is aware, the Department's Budget Division spends a substantial amount of time preparing its November 1 and February 15 Budget Requests for Medical Services Premiums and Medicaid Mental Health Community Programs. These Requests require well over 200 pages of spreadsheets, narratives, and tables to adequately justify the Department's expenditure and caseload forecasts. The Department cannot perform these tasks on a monthly basis.

For similar reasons, the Department does not support reporting a "simple" projection. Because of the complexities of the programs, which have demonstrated large and complex seasonal components, the Department believes that a partial forecast has a large potential to materially misstate the actual amount of expenditure expected. Such a projection could be used to alter the Department's appropriations. Because both the Medical Services Premiums and Medicaid Mental Health Community Programs Long Bill groups have overexpenditure authority, an alteration based on incomplete data can have significant budgetary ramifications, not only to the Department, but to other

areas of the state government as well.

65j Medicaid Medical Services Premiums monthly expenditures by aid category and service category (new)

RESPONSE:

The Department currently reports total annual expenditure by aid category in its November and February Budget Requests, in the Request for Medical Services Premiums, Exhibit M. The Department does not support a monthly report with this information. Total expenditure for each service category is derived directly from a report from the Colorado Financial Reporting System (COFRS). However, the Colorado Financial Reporting System does not have any information which would enable reporting by aid category. Rather, the Department uses information derived from the Medicaid Management Information System to determine how expenditure by service category is distributed by aid category. Because of the complexity of this task, this process requires a significant amount of staff time to calculate and verify, and cannot be automated.

The Department would be in favor of providing this information on a less frequent basis, such as quarterly, but cautions that because of the complexity of this manual report, the Department may require additional FTE in order to deliver this report.

66. Please explain why the Department reverted \$450,218 in General Fund from the Department's personal services line item. Please provide the Committee with an explanation on why the Department has reverted funding from this line item for the last three years. Should the JBC consider setting the Department's personal services line item using a different methodology from the "Option 8" calculations in order to realign the appropriation with the Department's actual expenditures?

RESPONSE:

The Department under-expended its FY 06-07 Personal Services appropriation by \$194,855 total funds due to vacancy savings and employee turnover. The reversion of \$450,218 General Fund is the result of the Department's Information Technology Division's ability to obtain an enhanced federal match when its employees work on National Provider Identifier and Medicaid Management Information System issues.

Normally, the Department receives a 50% federal match on salaries for information technology employees. When those employees work on certain federally mandated projects, however, the Department receives an enhanced federal match. In particular, when the employees perform tasks related to National Provider Identifier issues, the Department receives a 90% federal match; when the employees perform tasks related to the Medicaid Management Information System, the Department receives a 75% federal match. Work related to the Medicaid Management Information System and National Provider Identifier issues is generally ad hoc in nature, and the Department cannot always predict that amount of time employees will spend on these issues. The amount of effort expended on these systems fluctuates drastically over time due to federal legislation or mandates. The Department

incorporates any known or expected projects into the forecast methodology, but because of the uncertain nature of the projects, the Department cannot predict all changes. Therefore, the Department does not believe that any changes to the methodology for determining the Personal Services appropriation will result in additional accuracy at this time.

The Department supports the recommendation of the Joint Budget Committee Staff (#3 on page 80 of the Briefing document) that Section 24-75-108, C.R.S. (2007) be revised to allow the State Controller to use any General Fund that will revert to first reduce the amount of any administrative, non-statutorily permissible over-expenditures. Furthermore, the Department encourages the evaluation of the Executive Director's Office Long Bill group, as directed in footnote 22 and submitted in the Department's response to the footnote, so that a combination of line items or flexibility across line items limits the administrative burden of managing these appropriations. The Department does not support the use of reversions for statutorily allowable Medicaid program over-expenditures.

66a. Please describe why the Department's actual FTE count has been lower than appropriated FTE that the Committee has provided.

RESPONSE:

A multitude of factors are contributing to the Department's inability to fully utilize its FTE appropriation. The Department has experienced substantial turnover and prolonged position vacancies. The most prominent factor in the turnover rate is the competition for employees with specific health care knowledge. Employees with knowledge, skills and abilities in the health care industry are in high demand. Thus, they command higher salaries on average than employees without specific health care experience. This makes filling positions more difficult as these employees can be employed by private industry at salaries above that which the Department can offer. Also, when a position is filled, there is no guarantee the employee will remain, as other employers are constantly seeking knowledgeable people and they are willing to offer higher salaries, better benefits and improved working conditions.

In addition, analysis of employee exit interview data shows other significant factors contributing to substantial turnover are rising stress levels, more work than can be accomplished, a lowered sense of staff morale, and erosion of institutional knowledge and experience at the Department.

67. Please explain why the Department reverted \$175,165 in General Fund from the Long-Term Care Utilization Review line item.

RESPONSE:

The Long Term Care Utilization Review line item includes funding for two functions: Long term care functional eligibility determinations conducted by Single Entry Point agencies and Preadmission Screening and Resident Reviews for admission to nursing facilities. In FY 06-07 there was an increase in the Preadmission Screening and Resident Review related activities, which are eligible for a 75% federal financial participation rate. The General Fund reversion is due to the Department's

ability to obtain this enhanced federal match on Preadmission Screening and Resident Review related activities.

The Department made accounting adjustments based on the “M” headnote provision in the annual Long Bill for FY 06-07, HB 06-1385, Section 2, Subsection (d): “In the event that additional federal funds are available for the program, the combined General Fund or General Fund Exempt amount noted as “(M)” shall be reduced by the amount of federal funds earned or received in excess of the Figure shown in the “federal funds” column for that program.” The line item did receive excess federal funds, so the General Fund amount expended was decreased relative to the appropriation.

Long Term Care Utilization Review in FY 06-07				
	Total Funds	General Fund	Cash Funds Exempt	Federal Funds
As appropriated	\$1,744,966	\$598,813	\$38,429	\$1,107,724
As expended	\$1,719,438	\$423,647	\$38,429	\$1,257,362
Under/(over)	\$25,528	\$175,166*	\$0	(\$149,638)

* Amount does not match total reverted due to slight rounding error

The Department supports the recommendation of the Joint Budget Committee Staff (#3 on page 80 of the Briefing document) that Section 24-75-108, C.R.S. (2007) be revised to allow the State Controller to use any General Fund that will revert to first reduce the amount of any administrative, non-statutorily permissible over-expenditures. Furthermore, the Department encourages the evaluation of the Executive Director’s Office Long Bill group, as directed in footnote 22 and submitted in the Department’s response to the footnote, so that a combination of line items or flexibility across line items limits the administrative burden of managing these appropriations. The Department does not support the use of reversions for statutorily allowable Medicaid program over-expenditures.

68. Please explain why the Department reverted \$26,393 from the enrollment broker line item.

RESPONSE:

The Department reverted \$26,393 in FY 06-07 from the Enrollment Broker line item. This reversion was a result of a \$50,000 total funds retainage payment that should have been paid to the enrollment broker contractor with the completion of the FY 06-07 contract. The bill for this was not received until FY 07-08 and no accounts payable were received by accounting to hold these funds.

The Department supports the recommendation of the Joint Budget Committee Staff (#3 on page 80 of the Briefing document) that Section 24-75-108, C.R.S. (2007) be revised to allow the State Controller to use any General Fund that will revert to first reduce the amount of any administrative, non-statutorily permissible over-expenditures. Furthermore, the Department encourages the

evaluation of the Executive Director's Office Long Bill group, as directed in footnote 22 and submitted in the Department's response to the footnote, so that a combination of line items or flexibility across line items limits the administrative burden of managing these appropriations. The Department does not support the use of reversions for statutorily allowable Medicaid program over-expenditures.

Common Hearing Questions to all Departments

Costs and savings from complying with specific bills and orders

69. What are your department's anticipated costs, anticipated savings, and potential benefits from complying with Executive Order D 028 07, Authorizing Partnership Agreements with State Employees?

RESPONSE:

The administration of the partnership agreement will not require the expenditure of any additional state dollars. The Department will continue to spend time supporting state employees, and as has been the case in the past, this support will be absorbed into existing budgets.

70. Provide an estimate of the costs your department will incur in FY 2007-08 in carrying out the provisions of H.B. 06S-1023. Provide an estimate of your department's savings in FY 2007-08 as a result of not providing services to individuals who are in the country illegally.

RESPONSE:

The Department's implementation of HB 06S-1023 is being carried out in connection with its implementation of the federal Deficit Reduction Act of 2005. For both acts combined, the Department estimates it will incur expenses of \$2,967,662 in total funds. A majority of this funding is attributed to implementation of the Deficit Reduction Act of 2005. For example, of the \$2,849,689 in total funds appropriated to the Department's County Administration line item, only \$60,143 was requested for implementation of HB 06S-1023; the remaining \$2,789,546 was requested for implementation of the Deficit Reduction Act of 2005 (November 1, 2006 Budget Request, DI-4 "Implementation of HB 06S-1023 and Deficit Reduction Act of 2005, page G.23). The Department was appropriated funds to implement both acts beginning in FY 06-07 in Supplemental Bill SB 07-163, and received annualized continuation funding in the FY 07-08 Long Bill SB 07-239.

Line item expenditures comprising the \$2,967,662 in total funds estimated to implement both acts in FY 07-08 include:

- \$100,980 in Personal Services for 2.0 FTE
- \$2,610 in Operating Expenses for 2.0 FTE
- \$2,849,689 in County Administration for the increased time it will take counties to verify citizenship or lawful presence when processing applications.

- \$14,383 in Children's Basic Health Plan Administration for the increased time it will take Affiliated Computer Services to verify citizenship or lawful presence when processing applications.

The Department has not made any quantifiable cost savings adjustments in the FY 07-08 budget specifically for the Deficit Reduction Act and HB 06S-1023. However, it is assumed that there has been some reduction in caseload. There is no way to quantify what that caseload decrease may be.

4:50 p.m. to 5:00 p.m. Closing Comments -- Director

Closing Comments