Schedule 6
1331 Emergency Change Request for FY 05-06

Department:	Health Care Policy and Financing	**Dept. Approval by:**	Lisa Esgar	**Date:**	September 19, 2005
Priority Number:	N/A	**OSPB Approval:**		**Date:**	
Program:	Office of Medical Assistance, Office of Operations and Finance	**Statutory Citation:**	26-4-406.5, C.R.S. (2004); SB 05-162		
Request Title:	Medicare Modernization Act Funding for the Counties				

	Fund	1 Prior-Year Actual FY 04-05	2 Appropriation FY 05-06	3 Supplemental Request FY 05-06	4 Total Revised Request FY 05-06	5 Base Request FY 06-07	6 Decision/ Base Reduction FY 06-07	7 November 1 Request FY 06-07	8 Budget Amendment FY 06-07	9 Total Revised Request FY 06-07	10 Change from Base in Out Year FY 07-08
Total of All Line Items	**Total**	0	8,797,377	1,264,864	10,062,241	0	0	0	0	0	0
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	0	3,299,017	632,432	3,931,449	0	0	0	0	0	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	0	0	0	0	0	0	0	0	0
	FF	0	5,498,360	632,432	6,130,792	0	0	0	0	0	0
(6) Department of Human Services - Medicaid-Funded Programs	**Total**	0	8,797,377	1,264,864	10,062,241	0	0	0	0	0	0
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
(D) County Administration - Medicaid Funding	**GF**	0	3,299,017	632,432	3,931,449	0	0	0	0	0	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	0	0	0	0	0	0	0	0	0
	FF	0	5,498,360	632,432	6,130,792	0	0	0	0	0	0

Letter Notation:

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

IT Request: ☐ **Yes** ☑ **No** (If yes and request includes more than 500 programming hours, attach IT Project Plan)

Request Affects Other Departments: ☑ **Yes** ☐ **No** (If Yes, List Other Departments Here: Department of Human Services)

1331 EMERGENCY CHANGE REQUEST for FY 05-06
EFFICIENCY AND EFFECTIVENESS ANALYSIS

SELECT ONE (click on box):

☐ Decision Item
☐ Base Reduction Item
☑ Supplemental Request — Criterion: Emergency
☐ Budget Request Amendment — Criterion:

Priority Number:	N/A
Change Request Title:	Medicare Modernization Act Funding for the Counties
Long Bill Line Item(s)	(6) DHS Medicaid-Funded Programs, County Administration – Medicaid Funding
State and Federal Statutory Authority:	26-4-406.5, C.R.S (2004), 42 CFR Parts 400, 403, 417, and 423; SB 05-162

Summary of Request (Alternative A): On January 1, 2006, the federal Centers for Medicare and Medicaid Services (CMS) will be responsible for the Medicare Part D prescription drug benefit that will replace Medicaid prescription drug coverage for dual eligibles. This Request is for funding in the amount of $1,264,864 to cover the cost of additional responsibilities that the counties will now assume due to the implementation of the Medicare Modernization Act of 2003 (MMA) that were not requested at the time of the Department's Figure Setting.

Alternative A {Recommended alternative}:

Problem or Opportunity Description: The Medicare Prescription Drug, Improvement and Modernization Act (MMA), signed into law in December 2003, creates a new drug benefit known as Part D of Medicare. All Medicare beneficiaries are eligible for this benefit which is anticipated to begin January 1, 2006, including all dual eligible Medicaid beneficiaries (those individuals that are both Medicare and Medicaid eligible). For the dual eligible population, this will be the only coverage for all Part D drugs, as states will no longer be able to receive a federal match for these prescription drugs after January 1, 2006 for dual eligibles.

The Part D drug benefit will be administered by private health plans, called prescription drug plans. In October, Medicare will notify dual eligibles of the upcoming transition and

inform them of the prescription drug plan in which they will be automatically enrolled, as well as their ability to opt-out and enroll in another. Auto-enrollment costs will be borne by the Centers for Medicare and Medicaid Services (CMS).

Low-income Medicare beneficiaries will be eligible to participate in the new drug benefit's low-income subsidy program. Although subsidies are available based on certain federal poverty level incomes, the Medicaid dual eligibles, such as the following, will be automatically deemed eligible for low-income subsidies:

- Full benefit dual eligibles (on both Medicare and full Medicaid);
- Qualified Medicare Beneficiaries, those entitled to Medicaid coverage of the Part B premium and all Medicare cost-sharing;
- Specified Low-income Medicare Beneficiaries, those entitled to Medicaid payment of their Part B premium (but not Medicare cost-sharing); and
- "Qualifying individuals," for whom states receive a 100% federally matched grant to pay the Part B premium.

Eligibility for low-income subsidies will be determined by Medicaid eligibility sites or by the Social Security Administration (SSA). States will be required to process subsidy applications for clients that request a "state determination," and to make determinations and redeterminations on those cases and process appeals. However, states may encourage the use of the SSA application process.

There are several places where CMS has indicated that there will be administrative costs for the states. In those cases, the Department will only receive 50% federal match for performing an administrative function for a federal program.

General Description of Alternative:

The Joint Budget Committee approved a number of adjustments to the Department's FY 05-06 Budget during Health Care Policy and Financing's Figure Setting on March 15, 2005. The Department believes that some modifications are necessary in order to cover the additional obligations the State now faces, as mandated by this new federal legislation. Although some of these adjustments may be considered for the regular supplemental cycle, this emergency request is for funding the County Administration appropriation.

Counties perform a critical mandatory role in the implementation of the Medicare Drug Bill and will experience substantially more workload and caseload due to its implementation. This cost was not addressed in Figure Setting and an appropriation was not made. However, the counties' role started as early as June 2005 by helping clients who received letters from the federal Centers for Medicare and Medicaid Services. The counties need this funding now in order to comply with the federal law.

Effective July 1, 2005 counties were expected to be prepared to provide Social Security Administration (SSA) applications for low-income subsidies to clients who request them, and assist them with filling them out. In such cases, SSA is responsible for all redeterminations, appeals, and noticing. Counties are ordering such applications directly from SSA. Applications may also be completed on-line at the www.socialsecurity.gov website, and counties can help clients complete the web application.

However, per federal law, counties must process low-income subsidy applications for those clients who INSIST on using the State process. The Department has in place a manual process to meet these federal requirements. This process was communicated to counties in a July 15, 2005 agency letter. Once the Colorado Benefits Management System (CBMS) has been revised to include the Low Income Subsidy program, counties will be required to process applications for clients who INSIST on using the State process in CBMS. In these cases, the county is responsible for all redeterminations, appeals, and noticing. In essence, the counties have responsibility for a new program and all its administrative functions.

"Medicaid Eligibility Sites" (counties in Colorado) are also required to check eligibility for any client applying for the low-income subsidy for applicable Medicaid and other State assistance programs. For clients who complete an SSA low-income subsidy application, and who are not dual-eligibles, SSA will send notices informing them that they may be eligible for Medicaid and to go to their local Medicaid office for screening. For clients who apply under the State-insisted process, counties will screen these clients for Medicaid through CBMS when they apply for the low-income subsidy.

These activities will increase costs at Medicaid eligibility sites. This amount is comprised of 50% federal funds, and 50% from General Fund, and is requested under the County Administration line item. The Department recommends that as counties gain experience in this program, that the funding be re-evaluated. However, the counties require some immediate relief to mitigate these costs.

Implementation Schedule:

Task	Month/Year
Date that the federal government expects states to process subsidy applications - will have to process manually until CBMS changes are made	July 1, 2005
Date that Medicaid stops prescription coverage for dual eligibles - on a cash basis	January 1, 2006

Calculations for Alternative's Funding:

Summary Request for FY 05-06 Matches Schedule 6, Column 3	**Total Funds**	**General Fund**	**Cash Funds Exempt**	**Federal Funds**
(6) Department of Human Services Medicaid Funded Programs, County Administration	$1,264,864	$632,432	$0	$632,432
Total FY 05-06 Supplemental Request (matches column 3)	$1,264,864	$632,432	$0	$632,432

Department of Human Services Medicaid Funded Programs, County Administration	
A. FY 03-04 Expenditures	$13,819,389
B. FY 03-04 Actual Medicaid Clients	362,531
C. FY 03-04 Actual Non-Citizen Clients (4,604) and Medicare Beneficiaries (9,787)	14,391
D. FY 03-04 Net Medicaid Clients, Excluding Non-Citizens (= B – C)	348,140
E. Estimated FY 03-04 Per Capita Cost for County Administration (= A / D)	$39.69
F. Actual Expenditure Growth Rate in County Administration from FY 02-03 to FY 03-04	7.22%
G. Estimated FY 05-06 Per Capita Cost for County Administration (= E * (1 + F) * (1 + F))	$45.63
H. Projected FY 05-06 Caseload	9,240
I. Factor to Account for Number of Actual Applications Versus Number of Those Found Eligible	3
J. FY 05-06 Supplemental Request (matches column 3) (= G * H * I)	**$1,264,864**

Impact on Other Areas of Government: The amount of $1,264,864 requested in this supplemental would need to be transferred to the Department of Human Services, (4) County Administration as Cash Funds Exempt.

Assumptions for Calculations: On page 4,486 of the January 28, 2005 Federal Register, CMS states that 1.1 million Medicaid beneficiaries nationally will be added to state rolls in calendar year 2006. "Medicaid Enrollment in 50 States," an October 2004 publication by the Kaiser Commission on the Medicaid and the Uninsured (page 8), states that Colorado had 340,000 of the nation's 40,553,200 Medicaid enrollees in 2003, or 0.84%. Applying this percentage to CMS' 1.1 million estimate yields a rough estimate of 9,240 new Colorado Medicaid enrollees. This is the amount of additional caseload that the Department assumes in this Change Request will result from implementation of the Medicare Drug Bill. It is assumed that the Medicare Drug Bill marketing and state-required processes will push all eligible clients into Medicaid within the first calendar year, except those included in the normal caseload growth trend.

To create a very rough per capita, the Department took actual FY 03-04 County Administration expenditure of $13,819,389, and divided it by 348,140, or the actual FY 03-04 caseload for Medicaid of 362,531 minus the 4,604 Non-citizen Medicaid clients, and minus the Medicare Beneficiaries of 9,787 during that fiscal year. This calculation results in a rough per capita cost of $39.69 per person. Inflated for two years by the rate of actual expenditure increase in County Administration from FY 02-03 to FY 03-04 (7.22%), a FY 05-06 per capita cost is calculated to be $45.63 per person. Caseload (described above) was tripled because the Department expects that counties have to process many more applications than are finally approved. Thus, for FY 05-06, the Department estimates that $1,264,864 will be needed to process additional client applications (9,240 * 3 * $45.63 = $1,264,864).

The federal Centers for Medicare and Medicaid Services has confirmed through regulation that a 50% federal match is allowable for the administration of this federal program.

Concerns or Uncertainties of Alternative: Although the Department has proceeded with a quantifiable request prior to the expected date, there are still many unknowns. The federal government is still developing guidance

to states. In addition, there has never been a new Medicare benefit implemented in this way, and many of the assumptions are based on a lack of experience. If more funding is necessary, the counties will need to submit supporting information.

Alternative B {Status quo; no change in funding; not recommended}:

General Description of Alternative: This alternative would provide no immediate funding for the counties. Counties would still be required to perform the federally mandated functions, and are also likely to continue to assist their clients even where mandates do not exist. However, they would be expected to do so without any increase in their base funding.

Calculations for Alternative's Funding: No change in funding with this alternative.

Concerns or Uncertainties of Alternative: Counties will be hard pressed to meet with basic requirements, continue to adapt to the implementation of the Colorado Benefits Management System (CBMS), and comply with this federal law without additional funding. However, counties would still be expected to comply with the federal requirements.

Supporting Documentation

Analytical Technique: A cost/benefit analysis is used to demonstrate the profitable alternative for the State. Please see below.

Quantitative Evaluation of Performance – Compare all Alternatives:

	Alternative A (recommendation)	Alternative B (status quo)
Costs	$1,264,864	$0
Benefit	Provides funding for increased administration costs as a result of higher application volume due to implementing a federal program. Prevents an unfunded mandate.	No benefits. County eligibility sites would have to comply with a burdensome new requirement without funding to do so. Creates an unfunded mandate.

Statutory and Federal Authority:

26-4-406.5, C.R.S (2005) Prescription drug benefits - authorization - dual-eligible participation. *The state department is authorized to ensure the participation of Colorado medical assistance recipients, who are also eligible for medicare, in any federal prescription drug benefit enacted for medicare recipients.*

SB 05-162 - Concerning Prescription Drug Benefits Under the Medical Assistance Program for a Person who is Enrolled in a Prescription Drug Benefit Program Under Medicare *Notwithstanding the provisions of subparagraph (i) of this paragraph (a), pursuant to the provisions of section 26-4-406.5, prescribed drugs shall not be a covered benefit under the medical Assistance program for a recipient who is enrolled in a prescription drug benefit program under medicare; except that, if a prescribed drug is not a covered Part D drug as defined in the "Medicare Prescription Drug, Improvement, and Modernization Act of 2003", p.l. 108-173, the prescribed drug may be a covered benefit if it is otherwise covered under the Medical Assistance Program and federal financial participation is available.*