AGENDA and RESPONSES
FY 06-07 Joint Budget Committee Hearing
Department of Health Care Policy and Financing
Thursday, January 5, 2006
9:30 am to 5:00 pm

9:30 – 10:00 General Comments and Introductions

1. **General Comments and Introductions**

2. **To what extent is the Department fulfilling its obligation to provide service to the citizens of the state?**

RESPONSE:
The population table below depicts our Medicaid eligibility caseload. Over the years the Department has had increasing caseloads even though extensive budget cuts were occurring. The primary measurement the Department uses to assess whether it is fulfilling obligations to provide services to the citizens of the State are how many of the citizens it serves.

	Program	FY 00-01	FY 01-02	FY 02-03	FY 03-04	FY 04-05
1	Medicaid	275,399	295,413	327,395	362,531	402,802
2	Children's Basic Health Plan	29,305	39,843	49,216	46,694	41,101
3	Children's Basic Health Plan Prenatal	0	0	398	119	557
4	Home Care Allowance	5,757	5,642	5,060	4,052	3,461
5	Adult Foster Care	122	87	73	57	27
6	Old Age Pension-State Medical Program	3,212	3,782	3,794	4,261	4,766
7	Colorado Indigent Care Program	160,145	155,928	160,989	175,080	179,129
8	Comprehensive Primary and Preventative Care Grant Program - Medical	NA	41,986	12,607	9,443	10,010
9	Comprehensive Primary and Preventative Care Grant Program - Dental	NA	5,242	3,000	3,290	7,130
10	Total	473,940	547,923	562,532	605,527	647,887

Source:
1 - Annual average caseload from Nov. 15, 2005 Exhibit B. Based on the COLD 464600 reports. Does not include retroactivity.
2 - Annual average caseload, from Nov. 15, 2005, Vol. I, Attachment 1, pg. 9. Includes retroactivity.
3 - Annual average caseload, from Nov. 15, 2005, Vol. I, Attachment 1, pg. 11. Includes retroactivity.
4-5 - Annual average caseload from the Nov. 15, 2005 Budget Request Volume II Assumptions and Calculations, pages M-221 through M-224.
6 - Annual average caseload from Nov. 15, 2005 Budget Request Volume II Assumptions and Calculations pg M-218.
7 - Medically Indigent and Colorado Indigent Care Program Annual Reports for FY 00-01 through 03-04. The FY 04-05 figure is preliminary and may be revised.
8-9 - Comprehensive Primary and Preventive Care Grant Program Annual Report, November, 2005. The initial grants started in April of 2001 and they were for a fifteen month period. The number of clients served during these three months of FY 00-01 is included in the FY 01-02 totals.
10 - Due to clients being served in more than one program, some duplication exists in total.

Starting in FY 01-02 and continuing through FY 04-05, extensive budget reductions were made in the Department. However, the Department avoided reductions that:

1) Eliminated eligibility for clients. In fact, the only proposed reduction that eliminated eligibility for Medicaid clients was the elimination of full Medicaid for certain legal immigrants, through SB 03-176. However, this reduction was never implemented and was repealed through HB 05-1086. Children and pregnant women were affected by enrollment caps for the Children's Basic Health Plan in FY 03-04.

2) Eliminating services for clients. Several cuts were achieved by utilization controls, and non-emergency medical transportation was reduced significantly, but nearly all Medicaid services remained stable during the reductions.

3) Eliminated types of providers. Rate reductions did occur, but in attempting to protect as many services as possible, the Department avoided eliminating categories of providers.

Instead, the Department sought allowable federal financings, accounting changes, and rate reductions to avoid as much impact to clients and providers as possible. Indeed, the vast majority of the Department's $3.4 billion budget is for Medicaid mandatory services, and it is very difficult to make reductions that do not affect those services.

In **FY 01-02**, the Department was required to take a 1.5% cut in General Fund, exempting Medical Services Premiums. This was less than $900,000. The Department actually provided $4,020,557 in reductions, 83% of that reduction was from federal financings, and the remainder was from administration reductions. No reductions were proposed that affected clients or providers.

At the Department's December 17 and 18, 2002 Joint Budget Committee Hearing, the Department presented its **FY 02-03** reductions, sorted by type of cut. Those tables are provided below. The only reduction that affected clients' eligibility was capping the Home Care Allowance program. As the Department has expressed in several Change Requests, due to the growth and availability of Home and Community Based Services since the implementation of Home Care Allowance, this has not been identified as a program needed to increase to meet the needs of the citizens of the State. However, this program is a contributor to the SSI Maintenance of Effort, and its appropriation has been maintained after the reduction for that purpose.

Health Care Policy and Financing 4% Reduction Plan
Grouping by Impact for FY 02-03

#	Item	Total Funds	General Fund
	Items that Limit Utilization		
22	Target High Risk Therapeutic Classes	($494,550)	($247,275)
23	Home Oxygen Therapy Programs	($422,356)	($211,178)
25	Changes in Home Health	($3,216,468)	($1,608,234)
28	Discharge clients from Private Duty Nursing	($444,007)	($222,004)
29	CBLTC Part 1: Enrollment cap on HCBS and raise ULTC score	($8,584,244)	($4,292,122)
30	CBLTC Part 2: Single Entry Point Review of Long Term Home Health	($644,485)	($322,242)
31	CBLTC Part 3: Review of high cost clients	($2,659,364)	($1,329,682)
31a	PACE Cost for #31	$518,494	$259,247
	Subtotal Limiting Utilization	**($15,946,980)**	**($7,973,490)**
	Items that Decrease the Cost of Services		
15	Suspend 1% Hospital Increase	($1,387,521)	($693,761)
16	Suspend 1% Acute Care Providers Increase	($830,725)	($415,363)
17	Reduce Emergency and County Transportation, Lab/X-ray and DME by 5%	($3,891,477)	($1,945,739)
18	Reduce Rates for Inpatient Hospitals	($15,768,246)	($7,884,123)
19	Reduce Rates for Pharmacy	($8,426,800)	($4,213,400)
20	Reduce Psychotherapy Crossover to 60% of Medicare	($1,123,532)	($561,766)
24	Suspend 1% CBLTC Providers	($946,882)	($473,441)
26	5% Reduction in Rates Paid for PDN	($709,163)	($354,582)
	Subtotal Decreasing Cost of Services	**($33,084,346)**	**($16,542,75)**
	Items that Decrease Caseload		
33	Cap Home Care Allowance	**($2,578,149)**	**($2,449,241)**
	Items with No Impact to Utilization, Services, or Caseload		
1	Suspend 1% increase for UR and EQRO contractors	($19,458)	($4,979)
2	Reduce 4% from Department Operating Expenses	($39,832)	($19,677)
3	Reduce 4% from Department Personal Services	($480,046)	($218,475)
4	Eliminate MMIS Contract Inflation increases and Encounter Claims Overage	($225,417)	($56,354)
5	Administrative Impacts in the Nursing Facility Area	($548,534)	($193,664)
6	Reduce MMIS contract	($656,000)	($164,000)
6a	Add ongoing PAR costs for #22, Target High Risk Classes	$24,300	$6,075
6b	One time MMIS costs $20,000 (160 hrs at a rate $125/hr) for #22	$20,000	$5,000
7	Reduce EQRO Contract by 9.4%	($83,807)	($20,952)
8	Reduce UR Contract with Single Entry Point agencies	($11,445)	($2,861)
8a	One time Correct Fund Split for PCP Credentialing	$0	($28,925)
9	Reduce UR contracts with PRO	($75,953)	($18,988)
10	Reduce Enrollment Broker contract by 6.5%	($69,260)	($34,630)
11	Contingency Fee--Third Party	($3,482,475)	($1,741,237)
12	Contingency Fee Recoveries--QI post payment review	($1,262,554)	($631,277)
13	Contingency Fee Recoveries--QI Facility Credit Balance Audit	($1,500,000)	($750,000)
14	Apply HMO Family Planning Savings to FY 02-03	$0	($1,446,109)
14b	One time SB 01-78 Nursing Home Quality of Care Contract Costs	($68,524)	($34,262)
23a	Hospital UPL	$31,131,470	($13,289,026)
23b	Home Health UPL	$996,511	($498,256)
27	Increase delay between NF cost report and payment date	($5,017,796)	($2,508,898)
23c	UPL for Two New Nursing Facilities	$4,259,790	($2,129,895)
	Subtotal No Impact to Utilization, Services, or Caseload	**$22,890,970**	**($23,781,390)**
	GRAND TOTAL 4% BUDGET BALANCING	($28,718,505)	($50,746,296)

Health Care Policy and Financing 4% Reduction Plan Grouping by Impact for FY 02-03			
#	Item	Total Funds	General Fund
Items that Limit Utilization			

Health Care Policy and Financing 3% Reduction Plan Grouping by Impact for FY 02-03			
#	Item	Total Funds	General Fund
1	Credit from "Reductions applied to November 2002 3% Target" from 4% Budget Balancing	$52,081,537	($13,827,005)
Items that Limit Utilization			
4	Control Number of Drugs (8 simultaneous prescriptions then screen)	($1,056,000)	($528,000)
4a	Costs to Control Number of Drugs	$679,200	$169,800
13	Reduce Home Care Allowance reimbursement level -- legislative change in definition of Home Care Allowance program is sought	$0	$0
11	Legislative change to Private Duty Nursing to make it for children only for one year	$0	$0
Items that Decrease the Cost of Services			
3	Remove UPL Offset to Providers in Att 26, November 14 4% Budget Balancing	($1,517,806)	($1,517,806)
5	Legislative change to pay FQHCs PPS methodology as allowed by federal regulations instead of current 100% of cost	$0	$0
6	Eliminate Remaining Nursing Facility Incentive	($1,525,271)	($762,635)
7	Nursing Facility Legislative Change to Property Valuation methodology ("FRV Rental Rate", per statute)	$0	$0
12	Reduce HMO reimbursements to not more than 93% of fee-for-service {statutory change needed}	$0	$0
Items with No Impact to Utilization, Services, or Caseload			
2	HMO Recovery	($14,983,648)	($7,491,824)
8	HIPAA Fund Split Savings	$641,852)	($1,226,558)
9	Long Bill Line Item - Other Case Mix (administrative costs)	($42,000)	($12,000)
10	Hospital Tab Runs	($5,400,000)	($2,700,000)

[#11 revised from “Item to Decrease Caseload” based on recalled testimony]

Transitioning to cash accounting, like the State employee’s pay date shift, saved the State $77 million in General Fund due to an accounting change that resulted in no impact to clients, providers, or consumers. In fact, the Department believes it to be an administrative efficiency as well.

With the stabilization of Home Care Allowance, the prevention of the legal immigrant reduction, and the expansion of the Children’s Basic Health Plan and Medicaid through Amendment 35 and HB 05-1262, the Department’s obligation to its clients appears to be made whole after a period of major reductions. However, what remains a subject of debate is the rates paid to the Medicaid providers. This issue probably goes back as far as the program does, but it is a real issue. Nobody seems to be in favor of extensive profit for Medicaid providers, but the idea of them

being reimbursed at less than cost (when performing efficiently and effectively) is not readily acceptable as well. This issue is a subject of subsequent Hearing questions, so it will not be discussed at length here, but it is fair to say that multiple provider rate reductions occurred in FY 02-03 through FY 04-05. Some attempt has been made to return primary care providers to a more favorable reimbursement level, but on a provider-wide basis the issue largely remains. In summary, the Department does believe that increasing rates for providers so they can deal with the costs of inflation and technology is necessary and appropriate.

What is less of debate but nearly as important is the string of years that the Department's administrative contractors have gone without any increase. In the late 1990s, it was common for the Department to request cost of business increases for administrative contractors. A few contractors do receive increases either through contractually required adjustments or via the competitive bid process, but this is a growing concern in the Department. The Department believes that 3% increases for contractors that have been without should also be considered.

Estimated Cost of a 3% Cost of Business Adjustment for Administrative Contracts Based on FY 05-06 Costs

	Appropriation Code	Program Description	Amount	Amount with 3% Increase	Amount of 3% Increase
1	100	Actuary	$362,580	$373,457	$10,877
2	100/118	Ombudsman	$132,376	$136,347	$3,971
3	196	Enrollment Broker	$921,345	$948,985	$27,640
4	163	External Quality Review	$812,193	$836,559	$24,366
5	165	External Quality Review Mental Health	$352,807	$363,391	$10,584
6	157	Acute Care Utilization	$1,318,386	$1,357,938	$39,552
7	166	Drug Utilization	$648,025	$667,466	$19,441
8	160	Long Term Care Utilization	$1,744,966	$1,797,315	$52,349
9	149	HIPAA Web Portal	$312,900	$322,287	$9,387
10	151	Medical Identification Cards	$383,716	$395,227	$11,511
11	169	Early and Periodic Screening, Diagnosis and Treatment Program	$2,468,383	$2,542,434	$74,051
12	172	Nursing Facilities Audits	$1,097,500	$1,130,425	$32,925
13	202	Disability Determination Services	$1,173,662	$1,208,872	$35,210
14	178	Pre Admission Screening and Annual Resident Reviews	$1,010,040	$1,040,341	$30,301
15	265	Non-Emergency Medical Transportation	$4,455,988	$4,589,668	$133,680
16	330	Children's Basic Health Plan Administration	$4,181,207	$4,306,643	$125,436
		TOTAL	$21,376,074	$22,017,356	$641,282

Source:
1 - FY 05-06 Existing Personal Services Contract
2 - FY 05-06 Existing Personal Services and Operating Contract
3-16 - FY 05-06 Appropriation, SB 05-209 plus Special Bills

3. If the need is being fully met, who is bearing the costs of meeting the need? Is the cost being born by the state or has there been a shift in costs to another entity (citizens, counties, municipalities, etc…)

RESPONSE:
Response to question 3 has been combined with question 4.

4. **If the need is not being fully met, what resources are necessary to meet the need? Develop a proposal to either reduce the service or increase the funding over a period of five years to bring our service in line with the obligations of the department**.

RESPONSE:
The Department looked at each program administered to determine the requirements to bring services in-line with the obligations of the Department. The requirements of the programs varied from preventing enrollment caps to ensuring that providers would not leave programs due to lack of funding. Other issues involved bringing payment levels to parity with the private sector (market rate) and Medicare. The following items are areas in the Department that were identified as needing monitoring or possibly needing more funding to return the program to previous levels.

Children's Basic Health Plan

Due to budgetary pressures, the Children's Basic Health Plan ceased marketing for new members in March, 2003 and is just beginning a new marketing campaign. An enrollment cap was in place for children from November 1, 2003 through June 30, 2004, and new enrollment was capped for pregnant women under Colorado's existing section 1115 Health Insurance Flexibility and Accountability demonstration program from May 2003 through June 30, 2004. There was an overall decrease in enrollment in the program. Enrollment has still not reached the levels that were in place before the enrollment cap. However, the long term funding for the program is now secure with the passage of Amendment 35, the Tobacco Tax. At some point in the future, as enrollment grows in both the children's and pregnant women's components, the state will need to address the fixed funding available for the program from the federal government's allotment for the State Children's Health Insurance Program (SCHIP).

Non-Emergent Medical Transportation

In FY 02-03 the General Assembly reduced a $7.6 million from non-emergent medical transportation services. In the following year, FY 03-04, the Department received legislative authority via HB 04-1220 to administer non-emergent medical transportation as an administrative expense rather than an optional Medicaid service. As a result of this action $4,400,778 was transferred from the Department's Medical Services Premiums Long Bill group and used to create a new line item titled "Non-emergent Medical Transportation Services". Changing non-emergent medical transportation from an optional service to an administrative expense gave the Department greater flexibility in meeting federal requirements but also placed these expenditures outside of the Medicaid over-expenditure authority with all of the accompanying constraints to remain within the appropriation.

The Department has an obligation to ensure non-emergent medical transportation to and from covered Medicaid services for clients that do not have other means of transportation available. The Department employs two different mechanisms to meet this need. In 56 counties within the state, the counties are responsible for receiving client requests for non-emergent medical transportation by authorizing and arranging the transportation. In eight front-range counties, the

Department contracts with a broker to coordinate and arrange for the provision of non-emergent medical transportation. The non-emergent medical transportation provided in the eight front-range counties accounts for approximately 74% of the non-emergent medical transportation provided in the state.

In FY 04-05 the Department issued a Request for Proposals for a broker to administer the non-emergent medical transportation program in the eight front-range counties. Two national vendors submitted letters stating that they were interested in working with the Department but did not feel the funding was adequate, thus they would not be submitting proposals. One vendor did submit a proposal and was awarded the contract, but then did not sign the contract due to concerns that the funding was inadequate given spikes in utilization. This resulted in a failed procurement. The Department is currently meeting its obligation to provide non-emergent medical transportation for a limited period of time under an emergency contract. The Department is planning to issue another Request for Proposals in the first week of January 2006. The proposal will ask interested vendors to submit a cost proposal identifying the level of funding needed to complete the scope of work. This may result in some delay in awarding the competitively–bid contract, but should inform the General Assembly and the Department if fundamental issues will prevent contracting under the current level of appropriation.

Colorado Indigent Care Program (CICP)

To the extent of available appropriations, the Colorado Indigent Care Program (CICP) allocates limited funding to assist with the uncompensated costs that participating hospitals incur to provide medical services to low income, uninsured residents who do not qualify for Medicaid or Children's Basic Health Plan reimbursement. This funding for private-owned hospitals is from the General Fund and federal funds. The State share of payments must be from the General Fund for the private-owned hospitals because the certification of public expenditures financing mechanism the Department uses as the State share for payments to public-owned hospitals is not permitted under federal regulations for private-owned hospitals. Thus, where the State match that increases allocations to public-owned hospitals can be funded from Cash Funds Exempt from certification of public expenditures, reimbursement to private-owned hospitals is limited to the amount of General Fund available to match federal fund revenue. Over the last five fiscal years, uncompensated costs incurred by participating hospitals has grown an average of 17.3% overall and 28.7% for private-owned hospitals. Unless General Fund appropriations increase over time, the rate of reimbursement to private-owned hospitals compared to their uncompensated costs will decrease.

At some point, the ability and willingness of private-owned hospitals to absorb an increasing share of the costs of serving indigent clients will diminish and some providers may choose to no longer participate in the Colorado Indigent Care Program. In a number of areas of the state, private-owned hospitals are the only hospitals that provide a safety net for medically indigent clients. The Department does not attempt to achieve parity with the level of reimbursement paid to public-owned hospitals. In large part, the public-owned hospitals receive a higher rate of reimbursement because they serve a much higher proportion of Medicaid and low income patients compared to the private-owned hospitals. However, unless the General Fund appropriation for the Safety Net Provider Payments line item is increased periodically, there is a

risk that private-owned hospitals will feel a need to cease their participation in the Colorado Indigent Care Program or to reduce the amount of services they provide to medically indigent clients in order to control uncompensated costs and maintain financial viability.

The Colorado Indigent Care Program does not reimburse hospitals for 100% of their costs incurred to provide medical services to indigent persons. Although allocation of funds to Colorado Indigent Care Program hospitals is based on their actual utilization, historically only a portion of indigent care costs have been covered. The estimated percentage of indigent care costs covered by the program has varied from year to year and has been dependant upon a number of factors including:

- Available appropriations,
- Changes in the level of disproportionate share hospital federal funds (subject to annual caps since 1997),
- The ability of the Department to generate additional federal funds through various financing mechanisms such as Medicare Upper Payment Limit, and
- Certification of public expenditures subject to approval by the federal Medicaid agency Centers for Medicare and Medicaid Services.

In some cases, one-time financing mechanisms have impacted the percent of covered indigent care costs in a given year. Further, the percent of covered indigent care costs varies from hospital to hospital depending on the proportion of Medicaid and low income persons served. In recent years, the overall percent has been dropping each year. As demonstrated in the table below, in FY 00-01 the percent of covered indigent care costs for private-owned hospitals was 49.4%, while in FY 04-05 the rate was 18.4%.

Estimated Percent of Indigent Care Costs Covered by the Colorado Indigent Care Program			
	Private-Owned Hospitals	Public-Owned Hospitals	All Hospitals
FY 00-01	49.4%	71.2%	66.8%
FY 01-02	29.7%	54.4%	48.8%
FY 02-03	22.6%	45.8%	41.4%
FY 03-04	25.6%	50.1%	42.8%
FY 04-05	18.4%	46.5%	38.4%

Assuming the previous five year average growth rate of uncompensated covered indigent care costs incurred by participating private-owned hospitals (28.7%) and a continuation of the current level of General Fund at $12,576,646, the Colorado Indigent Care Program's percent of covered indigent care costs is estimated to stand at 19.0% in FY 05-06 and 14.8% in FY 06-07. The percent of covered indigent care costs increased from the FY 04-05 to the FY 05-06 level because the General Fund in the Safety Net Provider Payments line item was increased from $9,432,484 to $12,576,646.

Old Age Pension (OAP) Health and Medical Program

The Old Age Pension Health and Medical Fund was established through Article XXIV of the Colorado Constitution and 26-2-117(2) C.R.S. to provide a health and medical program to persons who qualify to receive old age pensions but who are not eligible for Medicaid, and who are not patients in an institution for tuberculosis or mental diseases. Pursuant to SB 03-022, on July 1, 2003, the Department became fully responsible for the administration of the Old Age Pension Health and Medical Fund and Supplemental Old Age Pension Health and Medical Fund. HB 02-1276 established the Supplemental Old Age Pension Health and Medical Fund, which provided additional resources since July 1, 2002. Together, these two funds provide necessary medical services under the Old Age Pension Health and Medical Program, within the constraints that expenditures shall not exceed appropriations by the General Assembly. For FY 03-04 and FY 04-05, appropriations for the Old Age Pension Health and Medical Fund and the Supplemental Old Age Pension Health and Medical Fund were $10,000,000 and $750,000 respectively. HB 05-1262 annually increased funding to the Supplemental Old Age Pension Health and Medical Care Fund. The Department estimates this increased funding at $943,500 for FY 04-05 and $2,538,000 for FY 05-06. The increased funding is available to the Old Age Pension Health and Medical Program by appropriation from the General Assembly. The Department has submitted a Supplemental Request to authorize the spending authority of $2,538,000 related to the HB 05-1262 for FY 05-06.

Historically, reduction actions were necessary when expenditures under the Old Age Pension Health and Medical Program were expected to exceed the available spending authority. With the passage of HB 05-1262, the Medical Services Board approved an increase in the reimbursement rates effective July 15, 2005. The reimbursement rate was increased from 82% of the Medicaid rate to 100% of the Medicaid rate for the following expenditure categories: practitioner/ physician services, medical supplies, home health care services and supplies and transportation. Additionally, the reimbursement rate was increased from 50% of the Medicaid rate to 100% of the Medicaid rate for dental and independent laboratory claims. Finally, outpatient claims reimbursement was increased from 50% to 62% of the Medicaid rate. The reimbursement rate for pharmacy benefits remained at 100% of the Medicaid rate, while reimbursement for inpatient hospital benefits remained at 10% of the Medicaid reimbursement rate.

Current analysis shows that expenditures for the Old Age Pension Health and Medical Program continue to increase as the caseload has increased 10.2% from December 2004 as shown in Attachment 1. The Department predicts that the reimbursement to providers will need to be reduced again in late FY 05-06 or early FY 06-07 to remain within the available spending authority, even with the additional funds provided under HB 05-1262. As shown in Attachment 2, FY 05-06 expenditures are expected to exceed the available funding by $767,857 and to maintain the current reimbursement rates, an additional $2,765,267 of General Fund is required for FY 06-07. By FY 10-11, the General Fund required to maintain the current reimbursement level grows to $7,183,055.

As shown in Attachment 2, to increase the inpatient hospital reimbursement to 30% of the Medicaid reimbursement rate, increase the outpatient services reimbursement from 62% to 100%

of the Medicaid rate, and maintain all other reimbursement rates at 100% of the Medicaid rate will require an additional $6,343,106 of General Fund in FY 06-07. By FY 10-11, the General Fund required to maintain these reimbursement levels will grow to $11,846,476.

To increase the inpatient hospital reimbursement to 100% of the Medicaid reimbursement rate, increase the outpatient services reimbursement from 62% to 100% of the Medicaid rate, and maintain all other reimbursement rates at 100% of the Medicaid rate, an additional $11,484,824 of General Fund in FY 06-07 will be required. By FY 10-11, the General Fund required to maintain these reimbursement levels grow to $19,007,907. The required General Fund necessary to fund this scenario by fiscal year is summarized in the table contained in Attachment 4.

Comparison of Rate Adjustments in Old Age Pension State Medical Program

Rate Adjustment	Short FY 06-07	Short FY 10-11
Current is inpatient rates are at 10%, outpatient rates are at 62%, and the remaining rates are at 100% of Medicaid	($2,756,267)	($7,183,055)
If inpatient rates are at 30%, outpatient rates are at 100%, and the remaining rates are at 100%	($6,343,106)	($11,846,476)
If all rates are at 100%	($11,484,824)	($19,007,907)

Hospitals Rates

In FY 02-03, all hospitals, except for Critical Access Hospitals (CAH), received a rate reduction in order to achieve a required $11 million in savings. Rural, non-Critical Access Hospitals received a rate reduction of 2%, and all urban, rehabilitation, and pediatric hospitals received a rate reduction of 6.98%.

FY 03-04 was the first year the new inpatient hospital rate-setting methodology was implemented. Instead of the inpatient hospital rates being based on Medicare cost reports, inpatient hospital rates became based on current Medicare rates. However, a budget neutrality clause was implemented that ties each year's inpatient hospital rates to FY 02-03 rates which does not allow for any inflationary increase such as Medicare's hospital market basket without a budget action. Therefore, the cuts that were implemented in FY 02-03 impact inpatient hospital rates in FY 03-04 and every year thereafter.

Inpatient hospital rates were set at 97.914% of Medicare's rates in FY 03-04. It is estimated that in order for hospital reimbursement to equal 100% of the Medicare rates for FY 03-04, it would have cost an additional $3,346,000 ($1,673,000 General Fund).

Inpatient hospital rates were set at 92.6% of Medicare's rates in FY 04-05. There was an additional 1% cut applied to each hospital's rate. It is estimated that in order for hospital reimbursement to equal 100% of Medicare's rates for FY 04-05, it would have cost an additional $15,702,000 ($7,851,000 General Fund).

For FY 05-06, the Department paid 90% of Medicare's rates. The Department estimates that it would have cost an additional $25,845,910 ($12,923,000 General Fund) in order to bring

Medicaid rates up to 100% of Medicare's rates. Based on projected caseload forecast numbers and projected increases in Medicare's rates, the Department estimates that for FY 06-07, an additional $40.5 million ($20.25 General Fund) would be needed to bring Medicaid rates up to 100% of Medicare's rates.

Since there is not an inflationary factor built into budget neutrality, inpatient hospital rates do not receive a cost of living adjustment, and any rate reductions made in previous years are carried forward.

Health Maintenance Organization and Behavioral Health Organization Rates

As discussed in #2 above, the Department is concerned about rate increases in general for its fee-for-service providers. When the General Assembly appropriates increases or decreases in funding fee-for-service programs, there is a parallel impact on the Department's managed care capitation rates. The final element in the Medicaid capitation rate setting process is a public policy adjustment to set the capitation rate in actuarial conformance with the change to the fee-for-service benefit. The Department's budget actions that impact fee-for-service programs include a component attributed to the conforming managed care rate change. If the General Assembly should decide to restore funding to services which have been decreased in the past, the increase in fee-for-service rates would flow through to the managed care capitation rate to retain actuarial soundness.

Home and Community Based Services

Based upon authorized waiver capacity and waiting list information, the Department believes that the State is meeting the majority of need for home and community based services (HCBS). There are certainly geographic differences in the availability of service providers to meet the need, an issue that is related to both Medicaid reimbursement rates and challenges in serving remote areas. Having said that, available waiver resources continue to be an issue with the Children's HCBS, the Children's Extensive Support (CES), and the Developmentally Disabled Comprehensive and Supported Living Services (SLS) waivers. Funds from the Tobacco Tax were allocated to the Children's HCBS and CES waivers to reduce waiting lists, essentially adding capacity to match the children waiting as of January 1, 2005. This funding allowed enrollment for an additional 478 children to be served under the Children's HCBS waiver and an additional 157 children to be enrolled in the CES waiver. One year later, both of these programs again have waiting lists of 141 and 38 children, respectively.

County Administration

These questions ask about obligations of the Department. We would like to mention that the Department has been considering our obligations as the Single State Agency in regard to administering the medical assistance programs for which it is responsible. The Department believes that it is necessary to take a more direct role with counties in regard to issues under the authority of the Single State Agency, rather than addressing these issues through another state agency. Involved in this discussion are activities such as eligibility determination and case management. We believe that some statutory clarification would be prudent for administering

these programs. To that end, we are considering a bill to relocate certain statutory references that are currently in the Department of Human Services (Title 26) to the Health Care Policy and Financing (Title 25.5) and to clarify Health Care Policy and Financing's role in regard to county oversight.

5. **Are there investments that can be made up front that will have the effect of decreasing costs and improving outcomes within an area of service over a period of three years? Does your department have an IT disaster recovery plan? Do you anticipate that your department will request an appropriation for disaster recovery within the next few years?**

RESPONSE:
The Department interprets this question as related to information technology investment. The Department has been planning to make investments in the internal Local Area Network (LAN) to improve employees' workstation performance. Through the investment of updating the LAN our staff will be able to perform their work more efficiently. The Department believes it can absorb this cost within its Operating Expenses appropriation.

The Department has a disaster recovery plan that was updated in the last fiscal year. All of the major systems: Colorado Benefits Management System, Medicaid Management Information System, Colorado Financial Reporting System, and the Department's web portal are maintained by vendors that are obligated to have disaster recovery sites. Due to the relatively small size of the Department, the business continuity plan would enable the Department to restore services on virtually any set of hardware.

The Department is assessing the possible need for funding next year or thereafter to complete the LAN upgrades and enhance the capability to handle disaster recovery.

10:30 AM to 11:30 AM – Medical Services Premiums

6. **Last year, the Department requested a final FY 2004-05 supplemental for the Medical Services Premiums (MSP) line item of $58.2 million total funds. Of this amount, $34.2 million was requested from the General Fund. During the 2005 Session, the General Assembly ultimately approved $32.3 million in total fund changes to the original FY 2004-05 appropriation (total changes from S.B. 05-112, H.B. 05-1086, and S.B. 05-209). Of this amount, $21.1 million was from the General Fund. As it turns out, the entire supplemental funding from the General Fund was unneeded and reverted at the end of the fiscal year. At the time the supplemental funding was approved, the Department had stated to the Committee in their supplemental request, *"We reiterate throughout the request that we expect a significant increase in expenditures to still hit the Medicaid Management Information System in the next few months. . . The Department believes that if the requested supplemental funding is not expended in FY 2004-05, then it will be necessary to utilize the funding in FY 2005-06 to pay for an anticipated surge in expenditures."* Please explain why there wasn't a significant increase in expenditures as originally assumed by the Department. Please update the Committee on any outstanding implementation issues with the Colorado Benefits Management System**

(CBMS) that might impact the reporting of monthly Medicaid caseload and expenditures.

RESPONSE:
The Department would like to respond to each question specifically. The first is an explanation of the two main reasons the Department assumed there would be an increase in expenditures when presenting the February FY 05-06 Supplemental Request for the Medical Services Premiums: provider feedback and high caseload. The second is a description of the current CBMS issues potentially affecting caseload reporting.

As the Committee is aware, in the winter of 2004 and the spring of 2005, providers began to complain about not receiving timely payments. This was thought to be due to the Colorado Benefit Management System (CBMS) eligibility information not reaching the Medicaid Management Information System (MMIS). In fact, on February 28, 2005, the Department found 2,785 clients that were eligible in CBMS but had not reached the MMIS. In March, there were still 2,325. There are still some cases each month that do not get to MMIS from CBMS in a timely manner. As of December 29, 2005, 63 clients had not reached MMIS. This is a decrease of 96%.

On March 16, 2005, Larry Wahl of the Colorado Hospital Association testified to the Colorado Joint Committees on Health and Human Services that hospitals were experiencing significant delays in payment due to Medicaid eligibility pending. The Department received letters from various types of providers about delayed payments. Nursing facilities stated that they were not receiving expected payments and the Department approved advances starting in February 2005. Federally qualified health centers (FQHCs) also testified on March 16, 2005 of delays and met with the Department on April 28, 2005 to see if there was some way to obtain assistance for them. The Department did initiate a special project to check eligibility for FQHC clients. Through the CBMS Emergency Call Center, clients were sent "Notices of Action" if staff found that CBMS identified the client as eligible but MMIS did not. The Department heard repeatedly at county meetings (CSSDA - County Social Services Directors Association) that clients were eligible but providers were not being paid.

The Joint Budget Committee was concerned about these comments, as was the Department. On more than one occasion, Karen Reinertson showed the Committee and the Medical Services Board that the Department was tracking expenditures (see Attachment 3). While there were some peaks and valleys, nothing in the Colorado Financial Report System payments was showing the dramatic decrease in payments that the providers were describing. This is not to say that there were not issues; there were and there still are. But the Department now knows that what we thought would be fairly large in the spring turned out in the summer to be minimal. While we still need to intervene to help certain providers, and still need to fix some issues, provider complaints have greatly diminished. Client complaints have also decreased; emergency calls to the Department's CBMS Call Center have declined from 2,681 in January 2005 to 538 in November 2005.

Increasing caseload supported the provider comments. The Committee has been briefed that FY 04-05 caseload rose 11.11% over FY 03-04 to 402,802. This is the largest increase since FY 91-

92. The Department was expecting an economic downturn and was surprised at the high caseload. Reconciliations in CBMS, starting in June 2005 show that caseload will not sustain at that level of growth, and the December 19, 2005 report to the JBC indicates an average caseload in FY 05-06 so far as 395,656. Consequently, it seemed reasonable last spring that expenditures may be lagging. Despite the 11.11% growth in caseload, it turns out that expenditures grew only 8.26%. The Department believes that the higher caseload was a result of necessary reconciliations in CBMS; we tried to account for that in the February 15, 2005 Budget Request with lower per capitas, but it was not sufficient. The Department did make an adjustment of a similar nature in the November 15, 2005 Budget Request when another drop in caseload was experienced in July 2005.

The Department has focused a large amount of attention on the data quality within CBMS. This effort has a direct impact on the caseload and thus expenditures that are reported from MMIS. The Department has performed many reconciliations and data fixes to synchronize the eligibility and enrollment data between CBMS and MMIS. Since implementation, the major accomplishments improving data quality are:

- Clients were missing client county information causing them to be disenrolled from managed care plans, or to show the address of the Department of Human Services as their residence address. The problems were found and corrected in September 2004.
- Foster care eligibility information was missing for some clients who also had a history of eligibility in other medical assistance programs. The missing information was restored in October 2004. Issue was permanently fixed in CBMS January 2005.
- Case information (addresses) was missing for some clients, causing problems with clients synchronizing with MMIS. The problem was found and corrected in October 2004.
- All Child Health Plan Plus (CHP+) clients should have managed care enrollment spans that match to their eligibility dates. An interim fix was implemented in September 2004, and a complete fix was in place at the end of July 2005.
- The "baby due date" field was corrected in March 2005, so that prenatal benefit clients in both Medicaid and CHP+ receive appropriate services.
- Clients who were assigned State IDs after their eligibility was determined were not sent to MMIS. Majority of problem cases were fixed in March 2005. As other clients are identified, their eligibility is sent to MMIS.
- During the conversion from the legacy systems into CBMS, 11,425 ineligible clients were converted incorrectly as eligible into a part of CBMS called Medical Eligibility Span tables. After months of research, in June 2005, 9,382 of these clients were closed in CBMS and the closed records were sent to MMIS. There are still about 2,000 of these clients who are not eligible in one part of CBMS and eligible in another part. These will be closed soon in CBMS and removed from MMIS.

The Department has not accepted CBMS for the primary reason that the data quality is not where it was expected to be. Additional efforts to ensure client data are accurate and synchronized are captured in what are known as Acceptance Items. The Department continues to work with Electronic Data Systems (EDS) and the Office of CBMS to assure that all known data issues are resolved.

The remaining items from the Acceptance Items are to correct Child Health Plan Plus (CHP+)

enrollments and synchronize the data within CBMS itself. The clients whose Medicare information was missing have been corrected (see question 31). There are continued efforts to finalize the synchronization between CBMS and MMIS. In December, the Department identified a new issue where CBMS is classifying clients as eligible yet not assigning State identification numbers (approximately 141). Without IDs, the MMIS cannot recognize their eligibility.

7. **Does the Department anticipate that the there will be a federal recoupment for covering people on Medicaid who may have been ineligible for Medicaid due to the benefit freeze during the transition to CBMS? If so, how much can be anticipated?**

RESPONSE:
As discussed in the CBMS hearing question #55, the Department does not expect any federal penalties related to the court order. Because the Centers for Medicare and Medicaid Services (CMS) have been closely involved in the Colorado Benefits Management System (CBMS) project and transition, the Department does not expect any penalties related to the federal rule.

As background, the executive directors of this Department and the Department of Human Services decided to implement a benefit freeze for these clients to allow counties sufficient time to update client information and perform the Eligibility Determination and Benefits Calculation in CBMS. It was understood that some clients would lose eligibility sometime after conversion and prior to the time a worker entered the client information into CBMS. These are the clients that the State has exposure with. In January of 2005, a review of the number of clients who had lost eligibility was about 11,600 or roughly 3% of the caseload.

The Centers for Medicare and Medicaid Services (CMS) was aware that the Department would protect the clients with a benefit freeze during the transition. There is no written communication that the Department has related to their concurrence. CMS was directly involved and monitored the transition daily; the Department has also sent the Conversion Freeze Flag report detailing the number of clients that remain in a "protected status" to CMS on a monthly basis. The Department has not received any communication from CMS expressing concerns on the subject.

8. **Based on the current FY 2005-06 appropriation, a 1.0 percent change to the MSP line item is $21.8 million total funds and $10.4 million General Fund. Because of cash accounting, the Department is only forecasting the last half of the fiscal year when the final supplemental request is submitted. Given the fact that a small error in projecting the MSP line item can result in millions of dollars being under or over appropriated, would it be a reasonable performance measure to expect the Department's final supplemental request to be within a 1.0 percent error of actual expenditures? If not, what would be a reasonable measure of forecast accuracy?**

RESPONSE:
In the following table, the Department illustrates that it has historically been 0.17% to 8.04% accurate with its Supplemental Request. Supported by 100 plus pages of text and spreadsheets in the Department's requests for Medical Services Premiums, the Department has a very transparent process for projection. In addition, the Department has been open to changes in

forecast methodology from Office of State Planning and Budgeting and Joint Budget Committee staff, and has also warned of changes that could cause the line item more difficult to project. For example, the Department warned in Question #41 of the last year's January 4, 2005 Joint Budget Committee Hearing that breaking Medical Services Premiums into fee-for-service and HMO subdivisions would increase the volatility of the line item and would reduce forecast accuracy.

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

- Actual from FY 00-01 and prior are taken from the February 14, 2003 Final Request, Exhibit F.
- Actual are taken for FY 01-02 and beyond from the November 15, 2005 Budget Request, Exhibit N, pages 1 and 2.
- Actual 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 OAP-State Medical Program. Actuals exclude OAP-State Medical Program.
- FY 96-97 through FY 98-99 final requests has been adjusted to remove mental health capitations.
- FY 01-02 and FY 02-03 were projected on an accrual accounting basis, although actual are presented under cash accounting. The Department's last presentation of actual in the Final Request binders under the accrual system was FY 00-01.

There is a large range of issues that can affect the final expenditures for the Medical Services Premiums. In fact, moving from accrual to cash based accounting increases volatility in expenditures. The payable would tend to smooth out expenditures so that all applicable expenditures for a particular service year would have time to be included, journal vouchered, and balanced. With cash accounting, there is no definable link between expenditures from year to year, except for the point in time in which expenditures were paid. HMO settlements, wrap around payments, recoveries, upper payment limit payments, and pharmacy rebates are all adjustments to the Medical Services Premiums that are not routine expenditures through claims to the Medicaid Management Information System. Therefore, they are not subject to regular expenditure patterns. These factors are all amplified by the fact that since retroactivity has been removed from caseload, caseload is also more unpredictable. It is, in fact, the size of the premiums itself that lends itself to the level of predictability that we enjoy today.

In summary, the Department provides a significant number of resources and time to ensure that the Medical Services Premiums is as robust as possible and as clear as possible to outside readers. The Joint Budget Committee could set a performance measure for the Department to be a certain percentage within actual payments. Nevertheless, it is doubtful that such a measure will do much to affect the accuracy, since the Department always has and will continue to attempt to be as accurate as possible and to explain areas of uncertainty.

9. **The Department is currently forecasting that the MSP line item will revert $38.6 million in General Fund at the end of FY 2005-06. Because the November 15, 2005 budget request is not an official supplemental request, the Governor's budget does not include a plan on how to reallocate any possible reversion from the MSP line item. Please provide information on how the Governor plans to allocate this funding (Please note, the hearing is after official supplementals are due. Therefore, if the plan is to allocate this money to other state supplemental needs, then it should be public information by the time the hearing is scheduled).**

RESPONSE:

The Governor's Office responded that:

The volatility of the Medicaid caseload and expenditures does not allow for an accurate estimation of a potential Medicaid over-appropriation/reversion at this time. Additionally, the estimates referred to in the Briefing were developed without an analysis of current year data. As such, it would not be appropriate to base new expenditures on this information. The Department will have an opportunity to analyze current year data and develop a more accurate estimate for the February 15, 2006 official Medicaid supplemental request.

10. **Please provide the Committee with an update on the implementation of H.B. 05-1066, Obesity Treatment Under Medicaid. H.B. 05-1066 prohibits the use of General Fund monies to support the obesity pilot program. Please inform the Committee of the amount and source of any gifts, grants, and donations that have been received by the Department for this program.**

RESPONSE:
During the 2005 legislative session, the Department supported House Bill 05-1066 Obesity Treatment Under Medicaid. In discussions with the House sponsor and representatives of Abbott Laboratories and Sanofi-Aventis, the Department understood that Abbott Laboratories was willing to donate pharmaceutical products and that Sanofi-Aventis would seriously consider funding a behavioral intervention program as a companion piece. The University of Colorado Health Sciences Center has an existing obesity program that was interested in participating as a partner in the project. After HB 05-1066 was enacted, the Department held a discussion to plan for the implementation of the Obesity Treatment Program with representatives from Abbott Laboratories, Sanofi-Aventis and the University of Colorado Health Sciences Center. Subsequent to the discussion there appears there is no longer interest by the pharmaceutical manufacturers to provide gifts, grants or donations for this program. To date there have been no gifts, grants or donations received by the Department for the Obesity Treatment Program.

11. Please update the Committee on the implementation of H.B. 05-1243, Consumer Directed Care Under Medicaid. How many Medicaid recipients are participating in this program? Please explain how the cost savings for the program are calculated.

RESPONSE:
The Department implemented the Consumer Directed Attendant Support (CDAS) 1115 waiver in December 2002. There are currently 167 Medicaid clients enrolled in this waiver. The Department submitted a formal request to the Centers for Medicare and Medicaid Services (CMS) on November 30, 2005 to amend the 1115 waiver to remove the 12 month utilization criteria and add an option for an authorized representative as directed in HB 05-1243. The Centers for Medicare and Medicaid Services (CMS) approved the change for the 1115 waiver on December 13, 2005. Revisions to Medicaid rules to incorporate these changes will be presented to the Medical Services Board in February 2006. New client enrollment will be immediate upon passage of the Medicaid rules.

The Department is in the process of completing the steps to add the consumer directed care service benefit to all existing Home and Community Based Services (HCBS) waivers as directed in HB 05-1243. Per technical assistance guidance from the Centers for Medicare and Medicaid Services, the Department will submit the Home and Community Based Services – Elderly Blind and Disabled waiver first to ensure all the Centers for Medicare and Medicaid Services issues are addressed, followed by submission of the Home and Community Based Services People Living with AIDS, Mental Illness, Brain Injury, Supported Living Services, Developmentally Disabled, the Children's Home and Community Based Services, and Children's Extensive Support waivers, not necessarily in the order listed. The Home and Community Based Services – Elderly Blind and Disabled waiver was selected first because it will allow an estimated 17,000 clients to participate upon approval.

The fiscal note assumed the consumer directed attendant support service benefit would be implemented in January 2006. The bill was signed in June 2005 and the Department hired the program administrator October 2005. The Centers for Medicare and Medicaid Services are requiring submission of a completely new waiver application for each Home and Community Based Services waiver amendment. The new waiver application is more detailed and expansive than the previous application format. The Department was not aware of the new application format during the writing of the fiscal note, so it was not taken into consideration when establishing the projected implementation date. The Department anticipates submitting the first waiver amendment in January 2006.

Due to the lengthy process of waiver application approval, the Department is estimating the Centers for Medicare and Medicaid Services approval date for the Home and Community Based Services – Elderly Blind and Disabled waiver by June 2006. Once approval is given, the Department will implement Medicaid Management Information System changes and present rules to the Medical Services Board. The Department is anticipating a September 2006 date that clients will begin participation. Additional waiver submission and responses should be expedited once the Elderly Blind and Disabled waiver is approved.

12. Please update the Committee on the implementation of H.B. 05-1131.

RESPONSE:
Currently, the Department is monitoring the actions of the Colorado State Board of Pharmacy, which will meet Thursday, January 19, 2006 to hold a rulemaking hearing to consider adopting changes in regulation necessary to implement HB 05-1131 for all licensed facilities covered under the legislation. If the Colorado State Board of Pharmacy adopts the regulation changes, the Department will promptly proceed to implement HB 05-1131 in relation to Medicaid. The Department will implement any needed regulation and billing instructions to allow pharmacists to redispense specified unused medications in relation to Medicaid as directed under HB 05-1131. If determined necessary, the Department will present regulation changes to the Medical Services Board on February 10, 2006.

13. **Please discuss the Department's efforts on developing mechanism to track the Amendment 35 caseloads and expenditures? Specifically describe the difficulties in developing fields within the CBMS and MMIS systems to track the different eligibility categories added by H.B. 05-1262 (legal immigrants, breast and cervical cancer treatment patients, clients eligible because the asset test is eliminated, adults up to 60 percent of FPL, children eligible because of increased CBHP marketing activities, uncapped children in the Home and Community-Based waiver programs).**

RESPONSE:
The Department is currently working to develop effective ways to track the "actual" expenditures for Amendment 35 caseloads. However, it is not possible to track the actual expenditures for some of the provisions of HB 05-1262.

For example, HB 05-1262 appropriates funding for the purpose of marketing the Children's Basic Health Plan. In the Colorado Benefits Management System, applicants are simultaneously tested for eligibility in both the Children's Basic Health Plan and Medicaid. It is expected that marketing the Children's Basic Health Plan will cause the Medicaid caseload to increase because some applicants who are interested in the Children's Basic Health Plan due to marketing efforts will be found eligible for Medicaid instead. There is no way to identify these clients, or their claims. As the Committee can imagine, we cannot quantify whether someone came onto Medicaid due to the specific marketing funded by the Tobacco Tax, or came on to the program through some other means.

For expenditures such as this, there are really only two options:

a. Develop an allocation method to pay for a portion of the Medicaid population with tobacco tax, or

b. Pay for the increase in expenditures with General Fund because the "actual" expenditures can not be identified.

It is the Department's position that implementing the provisions of HB 05-1262 will increase expenditures, and that the Tobacco Tax revenues should be used to offset the increase in expenditures wherever possible. For this reason, the Department recommends using an allocation

method wherever it is not possible to track the actual expenditures.

There are several population expansions from HB 05-1262 for which it is difficult or impossible to track actual caseloads and expenditures. The following expenditures have been analyzed to see if some form of allocation is necessary:

Health Care Expansion Fund

A. Remove the asset test under Medicaid for children and families - probable allocation

This population will not be uniquely identifiable from the base population because asset information will no longer be collected once this provision is implemented. The Department is currently researching ways to approximate the portion of the Medicaid clients that become eligible due to the removal of the asset test. It is possible that we could use asset test information, when provided for other programs, to create a proportion that can be applied to the population.

B. Pay for enrollment increases above the FY 03-04 level for CBHP - allocation planned

The intent of this provision is to not pay for individual clients who are new to the program since FY 03-04, but instead to secure a baseline of funding from traditional sources, then use Tobacco Tax funding to grow the program. This will require an allocation of total expenses based on the ratio of total average monthly enrollment vs. the FY 03-04 average monthly enrollment.

C. Increase Medicaid caseload by marketing the CBHP program - allocation planned

As discussed above, this population cannot be uniquely identified. The Department is currently researching ways to approximate the portion of the Medicaid population that is attributable to marketing within the Children's Basic Health Plan. One idea is to survey a group of new applicants once or twice a year to decipher as best as possible the reason for their application. Survey results would then be extrapolated to the entire new applicant population.

D. Presumptive Eligibility for Pregnant Women under Medicaid - actuals

This provision was implemented by utilizing the Presumptive Eligibility process in place for the Children's Basic Health Plan with the Anthem self-funded network. The actual expenditures will be billed separately by Anthem which will allow the Department to track the expenditures on an actual basis.

E. Expand Children served under Home and Community Based Services Waivers - actuals

This provision has been implemented to expand the capacity available to enroll children on these waiver programs by the number of children on the waiting list as of January 1, 2005. There will be churn within the program due to natural attrition as some clients leave the program and others come on. By making the assumption that the capacity funded with traditional sources are filled

and refilled first, the Department will be able to define which children are in the expansion population and isolate the expenditures for this population.

F. Expand eligibility to parents up to at least 60% FPL (starts July 1, 2006) - actuals

This eligibility expansion will be implemented July 1, 2006 and tracked as a separate eligibility group. Therefore, the actual caseload and costs will be trackable.

G. Fund Medical assistance to legal immigrants - probable temporary allocation

In the Colorado Benefits Management System, citizenship status is collected and it is possible to determine which applicants are categorized as legal immigrants and which are illegal (have no documentation). The illegal immigrants are eligible for only emergency benefits. Legal immigrants with 5 or more years of residency and 40 or more work quarters are a mandatory Medicaid population receiving full benefits provided they meet the eligibility requirements other than citizenship status. The optional Medicaid legal immigrants also receive full medical benefits. CBMS does not have the capability to discern who is a mandatory legal immigrant and who is optional, and this was clearly expressed in the fiscal note for SB 03-176. When SB 03-176 passed, it was intended to eliminate full Medicaid benefits for optional legal immigrants and provide only emergency services. When HB 05-1086 reinstated the benefits, these optional legal immigrants (along with legal immigrants in a State-Only Prenatal program) never lost their full Medicaid.

The Department is currently researching ways to modify the system to enable an accurate tracking of these clients and expenditures. We are still hopeful that some CBMS change could allow us to report actuals at a later time.

H. Expand Eligibility in the Children's Basic Health Plan from 185% to 200% of the federal poverty level for children and pregnant women - actuals

This population can be uniquely identified and expenditures can be accurately tracked in the Medicaid Management Information System. In the Colorado Benefits Management System, client records for the Children's Basic Health Plan include an income rating code which indicates the client's income bracket. This is because clients at lower income levels are not required to pay annual enrollment fees and co pays. The Department set up a new income rating code in the Colorado Benefits Management System to track the expansion clients from 186% to 200% of the federal poverty level. Modifications to the Medical Management Information System that will allow for monthly reporting of this population are near completion. This will run retroactively back to July 1, 2005.

Prevention, Early Detection and Treatment Fund

Breast and Cervical Cancer Program - allocation

A portion of the Prevention, Early Detection and Treatment Fund is dedicated to increasing the number of cancer screenings performed by the Department of Public Health and Environment.

HB 05-1262 provides additional funding to the Department to pay for increased caseload as a result of increased screenings. There is no increase in eligibility, so the expansion clients, in this case, may be indistinguishable from the clients traditionally served in the Breast and Cervical Cancer Program. The Department is researching if it is possible to connect clients to specific eligibility sites for expenditure allocation. It is likely that the Department will have to allocate a portion of the total Breast and Cervical Cancer Program costs to Tobacco Tax revenue rather than track a unique population.

Summary

The Department will propose more specifics about its allocation methodology in its February 15, 2006 Budget Request. An extensive new set of spreadsheets was added to the Medical Services Premiums Exhibits so the proposed financing would be completely clear. The Department's methodology is public, published on the Department's web site, and subject to scrutiny from many entities. This process that should assure the public that the funds are being used as intended.

14. **If Amendment 35 caseloads can not be distinctively tracked from other Medicaid caseload, please explain how the Department will know which fund source to charge expenditures? How will the Department be able to verify to the Committee and the public that the Amendment 35 monies are expended for only the purposes listed in the Constitution?**

RESPONSE:
See question 13 for response to this question.

15. **Based on current budget estimates for the Medicaid and CBHP program, the overall cost per serving children are approximately the same for both programs. However, children in the CBHP program have a "medical home" either through the self-insured network or through the HMO network. However, only 31 percent of Medicaid children have a "medical home" from the Primary Care Physician Program or HMO network. Please discuss any barriers to care that may exist for the Medicaid children compared to CBHP children.**

RESPONSE:
There exist certain differences in how the Colorado Medicaid program and the Children's Basic Health Plan are structured that can influence access to health care. The primary difference is that children enrolled in the Children's Basic Health Plan have a guaranteed, stable 12 month period of eligibility while Medicaid eligibility can be redetermined as frequently as monthly if there are changes in family income or circumstances. Another key difference is that children enrolled in the Children's Basic Health Plan are required to select a managed care health plan, unless their geographic location is covered only by the State's self-funded managed care network. Enrollment in a managed care health plan for Medicaid-eligible children is strictly voluntary, allowing for greater movement into and out of the plans. In addition to these differences in eligibility and enrollment, the limitation of providers willing to accept new Medicaid clients present a barrier to care.

Since 2002 there has been a decrease in the number of managed care health plans participating in the Medicaid program and individual providers do not always chose to participate. Some providers cite poor reimbursement levels, burdensome administrative requirements, and poor client compliance as reasons why they do not wish to be enrolled Medicaid providers.

The Department would be remiss if it failed to note that a "medical home" is not synonymous with enrollment in a managed care health plan or the primary care physician program. Some Medicaid clients in unassigned fee-for-service do experience a medical home by accessing services through a consistent physician. This is particularly true in certain geographic regions of the state.

16. Does the Department have any explanation on why the growth rate for acute care services slowed to 1.28 percent in FY 2004-05?

RESPONSE:
The Department believes that there are a number of reasons why the acute expenditure growth was less than normal in FY 04-05.

At the end of FY 02-03, the Department held $46.7 million in Medicaid payments and paid them in FY 03-04. As a result, FY 03-04 totals are higher than might otherwise be expected. The 1.28% change in FY 04-05 is compared to the FY 03-04 expenditures plus $46.7 million of FY 02-03 expenditures. When the FY 02-03 expenditures are excluded from the FY 03-04 total, the Department estimates the actual percentage change from FY 03-04 to FY 04-05 is 3.92%.

		Amount	Notes and Formulas
A	FY 03-04 Acute Subtotal	$1,176,036,912	November 15, 2005 Budget Request, page EN-2
B	FY 03-04 Medical Services Premiums Total	$1,841,738,922	November 15, 2005 Budget Request, page EN-2
C	FY 03-04 Acute as a Percent of Total	63.9%	Row B ÷ Row A
D	FY 02-03 Expenditures in FY 03-04	$46,700,000	FY 04-05 JBC Staff Budget Briefing (HCPF), page 77
E	Calculated Acute Portion of Row D	$29,820,146	Row D * Row C
F	Revised Acute total	$1,146,216,766	Row A – Row E
G	FY 04-05 Acute Subtotal	$1,191,114,826	November 15, 2005 Budget Request, page EN-2
H	Revised Percentage Change	3.92%	(Row G ÷ Row F) – 1

Compared to growth in FY 03-04 (12.07%), FY 02-03 (10.21%), and FY 01-02 (6.55%), the 3.92% is still lower than normal.

A $2.4 million lower expenditure is attributable to non-emergency transportation being moved into an administrative line item in FY 04-05. It is also possible that increased use of administrative service organizations (which grew by nearly 300% in FY 04-05) may have

contributed to lowered growth in other areas. The Department is still assessing this possibility. It is also suspected that with the temporary discontinuation and restart of Presumptive Eligibility, hospital payments for some deliveries are slower due to emergency Medicaid eligibility now being verified instead of guaranteed. Hospital expenditures were down 2.65% in FY 04-05.

Other significant factors influencing the low acute care growth include a 1% rate reduction to inpatient hospitals; no rate growth for physicians or other ambulatory service providers; continued and extended disease management, and the continuation of the Department's pharmacy management programs, including the generic mandate, drug utilization reviews, and limits on drug utilization above manufacturer guidelines. FY 04-05 was the first year of single digit growth for pharmaceuticals (5.69%) since FY 99-00 when rates were reduced. Pharmaceuticals, after rebate, are the second largest acute care services expenditure at $209,274,224.

17. Please update the Committee on the Department's efforts last summer to reform nursing home reimbursement methodology.

RESPONSE:
The Department requested participation by members from Colorado Health Care Association (CHCA) and Colorado Association of Homes and Services for the Aging (CAHSA) and independent nursing facility providers to give input on how best to reform the nursing facility reimbursement methodology. The intent of the Department was to address the needs of the provider community as a whole. Five meetings were held over a period of five months (March 2005 through mid-July 2005).

In the process of discussing how to develop a new reimbursement methodology, the work group jointly identified components of the existing reimbursement regulations that would work, components that did not work and components that required adjusting. The work group also identified a variety of quality measures. The Department emphasized that the quality components needed to be objectively measurable in order to assure the appropriate payment audit trail.

On July 11, 2005, the Colorado Association of Homes and Services for the Aging sent a letter to the Department stating that they were no longer willing to participate in the reimbursement work group. Because the intent of the Department was to reach a sound methodology within all of the nursing facility provider community, the work group was disbanded. Although the Department remains committed to working with the nursing facility providers to develop a new reimbursement methodology, the Department has informed the providers that the Department will not proceed until all parties are willing to participate at which point the work group will be reconvened.

18. The Department's budget request assumes that new PACE sites will open next year. What is the basis of the Department's assumptions?

RESPONSE:
The Department based its budget request assumptions on the historical patterns of program expansion by the existing Program of All-inclusive Care for the Elderly (PACE) provider, Total

Long Term Care and written intent from potential new providers. The existing PACE provider operates at five sites in the greater Denver metropolitan area. Based upon interest from entities in both El Paso and Pueblo Counties, the Department is hopeful that a new Program of All-inclusive Care for the Elderly site will open next year.

Rocky Mountain Health Care Services submitted an application in October 2005, to operate a Program of All-inclusive Care for the Elderly site in El Paso County. The application is currently being reviewed by the Centers for Medicare and Medicaid Services, through an offer of technical assistance, and the Department.

Pikes Peak Behavioral Health Group sent a letter of intent in November 2005 to operate a Program of All-inclusive Care for the Elderly program in both El Paso and Pueblo Counties.

19. Please update the Committee on the disease management programs that the Department is currently implementing.

RESPONSE:
The Department has conducted six pilot disease management programs since 2002: asthma, diabetes, schizophrenia, high-risk neonates, chronic obstructive pulmonary disease and intensive case management. The schizophrenia, high-risk neonate and intensive case management programs were not continued because the cost of these programs exceeded the savings or because of low client enrollment. The vendor evaluation for the chronic obstructive pulmonary disease program was recently received and is undergoing Department review.

The Department has two disease management programs currently in operation: asthma and diabetes. National Jewish Medical and Research Center is contracted to perform the asthma program and also conducted the asthma pilot program. The current National Jewish contract is for $317,000 and up to 500 clients in the program. At the current time there are 488 clients in the asthma program. McKesson Health Solutions is contracted to perform the diabetes disease management program. McKesson also conducted the diabetes pilot program. The current McKesson contract allows up to 300 clients at a cost not to exceed $681,735. There are currently 211 clients in the diabetes program.

In response to the appropriation for disease management programs in HB 05-1262, the Department performed an evaluation to identify additional conditions that may benefit from disease management. This evaluation looked at the most frequent and most costly conditions for Medicaid clients and matched the conditions to commercially available disease management programs. The Department is also working with a national disease management vendor on a similar analysis to obtain vendor recommendations regarding expansion of the disease management programs.

20. Please provide caseload figures for the last five years on the number of clients served in each community-based waiver program, the PACE program, Class II Nursing Homes.

RESPONSE:
The tables below provide unduplicated client counts for the last five years on the number of

clients served in each Home and Community Based Waiver program, the PACE program, and Class I and II Nursing Facilities. Due to the way Medicaid Caseload is calculated on a cash accounting basis and without retroactivity, the numbers below cannot be considered a subset of Medicaid caseload. These numbers also do not necessarily equate to waiver capacity.

Unduplicated Client Count by Home and Community Based Waiver FY 00-01 to FY 04-05

Fiscal Year	Elderly Blind and Disabled	Children's Home and Community Based Services	Children's Habilitation Residential Program	Brain Injured	Mentally Ill
FY 00-01	14,082	645	264	310	1,717
FY 01-02	15,160	643	280	384	1,934
FY 02-03	15,634	642	240	404	2,070
FY 03-04	15,425	625	214	368	1,976
FY 04-05	15,219	616	205	325	1,807

Unduplicated Client Count by Home and Community Based Waiver FY 00-01 to FY 04-05

Fiscal Year	Persons Living with Aids	Supportive Living Services	Developmentally Disabled	Children's Extensive Support	Total HCBS*
FY 00-01	112	2,975	3,648	194	23,947
FY 01-02	115	2,978	3,785	225	25,504
FY 02-03	103	3,061	3,900	235	26,289
FY 03-04	79	3,120	3,963	225	25,995
FY 04-05	81	3,116	3,996	230	25,595

*Unduplicated client count is fiscal year date of service based with 6 month payment runout from service claims.

Unduplicated Client Count by PACE and Nursing Facilities FY 00-01 to FY 04-05

Fiscal Year	PACE**	Class I Nursing Facilities	Class II Nursing Facilities	Total Nursing Facility
FY 00-01	467	N/A	N/A	N/A
FY 01-02	605	15,125	16	15,141
FY 02-03	760	14,807	17	14,824
FY 03-04	1,036	14,397	16	14,413
FY 04-05	1,199	14,545	17	14,562

** PACE unique client count is from MMIS subsystem query of managed care enrollment spans, 12/23/2005
HCBS client count comes from CMS 372 lag reports, which are the figures, reported to Centers for Medicare and Medicaid Services.
Figures include retroactively enrolled clients.
Figures are not calculated on a cash basis to ensure comparability from year-to-year. Year-to-year comparability would be skewed because each year would have a different amount of runout.

11:30 AM – 12:00 noon – Amendment 35 Implementation

21. **Please provide an updated five-year fund balance analysis for the Health Care Expansion Fund at their hearing. Specifically, when does the Department anticipate that expenditures from the Health Care Expansion Fund will exceed the revenues into the Fund?**

RESPONSE:
The table in Attachment 4 roughly projects the revenues, costs, and fund balance of the Health Care Expansion Fund for the next five years. The projection indicates that expenditures will exceed revenues in FY 07-08, at which time, funding will be required from the reserve.

The Department will be submitting a late Supplemental and Budget Amendment Request in February 2006 to update assumptions about HB 05-1262, specifically the asset test. The table in Attachment 6 has not been updated for these assumptions, therefore should be considered as temporary. The Department will attempt to update the Health Care Expansion Fund balance projection at that time, based on the new assumptions.

Assumptions:

A. The Department used the revenue projections provided by the Legislative Council on December 29, 2005. The projected costs are the same estimates used for FY 05-06 and FY 06-07 in the Department's November 15, 2005 Budget Request Schedule 11 with one exception. As CMS approval has not been obtained for the implementation of the asset test removal, the Cash Funds Exempt cost of this provision was removed from the FY 05-06 projection ($16,030,736).

B. The Department assumed 3% interest earnings on the beginning balance of the Fund for each fiscal year.

C. The Department assumed that the Cash Funds Exempt costs for the expansion of eligibility to parents up to 60% of the federal poverty level would double ($5,972,782 * 2) in FY 07-08, as FY 06-07 is the first year of this program expansion. The Department is uncertain how quickly this caseload will grow or how many clients will ultimately enter this program.

D. The Department assumed a 4.9% annual growth rate in Medicaid costs from FY 06-07 to FY 09-10. The projected per capita growth from FY 05-06 to FY 06-07 for the Categorically Eligible Low Income Adults and the Eligible Children in the November 15, 2005 Budget Request, Exhibit F (page EF-1) was between the 2.05% and 2.51%. The projected caseload growth for these populations was between 3.21% and 2.05% from FY 06-07 to FY 07-08 (November 15, 2005 Budget Request, Exhibit B (page EB-1). These figures were used to estimate annual per capita growth of 2.3% and annual caseload growth of 2.6% for the affected Medicaid population as the majority of the expansion clients are children and parents.

E. Caseload growth for the Children's Basic Health Plan is assumed to be 5% from FY 06-07 to FY 09-10. The Department anticipates that enrollment growth will slow as marketing the program increases the penetration rate of eligible clients. The cost per client is assumed to increase by 8.4% that has been the historical average rate increase from FY 01-02 to FY 05-06.

22. Please update the Committee on the status of the state plan amendment to remove the Medicaid asset test. Has CMS approved the plan? If not, when does the Department anticipate receiving approval from CMS? Will the change be retroactive back to the date of application?

RESPONSE:
The Centers for Medicare and Medicaid Services approved Colorado's State Plan Amendment to remove the Medicaid asset test on December 27, 2005 with an effective date of July 1, 2006. House Bill 05-1262 included the provision that the Department seek federal approval to allow children eligible under the Children's Basic Health Plan who would become Medicaid eligible due to removal of the asset test to continue to receive benefits through the Children's Basic Health Plan until July 1, 2006. The Department engaged in numerous conversations with the federal authorities on this issue and received a formal written reply on December 12, 2005. The written reply from the Centers for Medicare and Medicaid Services indicates that Colorado must conduct a new eligibility determination for each child and the Department has concluded that this determination should be conducted in the context of the client's annual redetermination. Consequently, the Department has requested a July 1, 2006 effective date for removal of the asset test.

The selection of July 1, 2006 as the effective date is to accommodate the time needed to implement necessary eligibility system changes as the federally allowable method for removing the asset test differs from original expectations. The removal of the asset test cannot be retroactive.

23. The H.B. 05-1262 appropriation clause assumed a FY 2005-06 impacts of $17.2 million from eliminating the asset test? Does the Department have updated budget estimates based on the delay in implementation? Will there be a General Fund impact to the CBHP Trust Fund because CBHP children are not transferring to the Medicaid program as soon as originally assumed?

RESPONSE:
As mentioned in the Department's January 3, 2006 Supplemental Budget Request binder, via letter to the Committee, the Department is recalculating estimates for certain pieces of HB 05-1262 Tobacco Tax funding, such as the removal of the asset test. These new estimates will be submitted via a late Supplemental. We now expect no programmatic impact in FY 05-06 due to the asset test elimination. However, additional system funding may be needed to make the federal government's required changes.

Although we do not expect there to be a General Fund impact for the Children's Basis Health Plan Trust Fund in the near future due to this delay, it does mean that we will use more of our federal allocation (cap) than we had estimated. To remind the Committee, the primary reason we scheduled the asset test as an overnight change was to create relief against the federal cap. The delay in implementation of the asset test removal will draw more against the federal allocation than we had estimated in the fiscal note for HB 05-1262. However, we think there will be substantial offsets due to the Children's Basis Health Plan caseload now being projected lower

than in the fiscal note and the delay in marketing. A new federal allocation projection will be included in the Late Supplemental as well.

24. Please update the Committee on the status of the state plan amendment to increase eligibility for the CBHP program up to 200% FPL. Has CMS approved the plan? If not, when does the Department anticipate receiving approval from CMS? Will the change be retroactive back to the date of application?

RESPONSE:
The Children's Basic Health Plan started serving children between 186% and 200% of the federal poverty level on July 1, 2005, as directed in HB 05-1262. The Centers for Medicare and Medicaid Services approved a State Plan Amendment on December 23, 2005. The amendment is effective (retroactive) back to July 1, 2005.

25. Please update the Committee on the status of the state waiver amendment to increase eligibility for the CBHP program up to 200 percent FPL for pregnant women. Has CMS approved the waiver amendment? If not, when does the Department anticipate receiving approval from CMS? Will the change be retroactive back to the date of application?

RESPONSE:
After the passage of HB 05-1262 (signed by the Governor on June 2, 2005), the Department submitted a Health Insurance Flexibility and Accountability waiver amendment to expand eligibility up to 200% of the federal poverty level to the Centers for Medicare and Medicaid Services (CMS) for pregnant women. The Centers for Medicare and Medicaid Services and the Department have worked closely together to get approval of this amendment. The Department notified the Centers for Medicare and Medicaid Services via a letter on June 15, 2005 of the State's intentions to expand this program. It was indicated to the Department that the process to move from 185% to 200% of the federal poverty level was simple and would occur very quickly, perhaps in a couple of weeks. An amendment to the waiver was submitted on July 1, 2005.

Over time, however, it became clear that it would require much longer for the federal government to approve the request. This expanded population is not eligible for a federal match until granted formal approval. The Department continues to contact CMS frequently in hopes of receiving a decision soon. At the time of this writing, the Centers for Medicare and Medicaid Services have not yet approved this amendment.

26. Please inform the Committee of the year-to-date enrollment in the "state-only" program for pregnant women (eligibility between 185% and 200% FPL) and year-to-date expenditures.

RESPONSE:
These services are currently delivered through the State's self-insured managed care network that is a no-risk contract. Estimated capitation payments are made monthly for enrolled clients, but the actual costs are ultimately cost-settled with the contractor. Estimated capitation payments

made for July through November total $196,814 for pregnant women between 186% and 200% of the federal poverty level.

FY 05-06 Year to Date Expenditures	
July	$6,438
August	$31,269
September	$43,225
October	$39,547
November	$76,334
Total Year to Date Expenditures	**$196,814**

The $196,814 represents a total of 214 estimated capitation payments (or member months). The number of capitation payments is delineated below by date of service (rather than by date of payment) to indicate the caseload trend. Retroactivity will continue to impact these figures for the next six months, showing increasing caseload every month.

FY 05-06 Year to Date Number of Capitation Payments Made					
Jul	**Aug**	**Sep**	**Oct**	**Nov**	**Total**
28	39	51	52	44	214

In addition to the 214 capitation payments above, there were 50 member months for women with presumptive eligibility.

27. Please update the Committee on the status of seeking approval from CMS to increase eligibility in the Medicaid program for adults up to 60 percent FPL. Has the Department already submitted the waiver? Given that the Health and Human Services Committee last summer did not approve the Department's HIFI waiver to streamline health care to families and children, does the Department anticipate that there will be a delay in implementing this provision?

RESPONSE:
The Department has not yet submitted a State Plan Amendment to increase Medicaid eligibility for non-pregnant adults to 60% of the federal poverty level. The Department does not anticipate a delay in implementing the provision and expects to submit the State Plan Amendment shortly requesting an effective date of July 1, 2006.

12:00 noon to 2:00 PM Lunch Break

2:00 PM – 2:30 PM – Medicare Modernization Act

28. Please update the Committee on the transition of dual eligibles to Medicare drug plans. Please describe the administrative costs and efforts that the Department has incurred in ensuring a "smooth" transition of Medicaid clients onto the MMA. What difficulties, if any, does the Department anticipate after January 1, 2006 for transferring Medicaid clients onto the MMA?

RESPONSE:
Beginning January 1, 2006, any Medicaid client that also has Medicare will no longer be able to get prescriptions paid for by Medicaid, unless the prescription is a part of the Medicare Part D excluded drugs that Medicaid covered prior to January 1, 2006. Our Medicaid Management Information System has been set up to allow billing for the Medicare non-Part D drugs for full benefit dual eligibles. These are clients that have both full Medicaid benefits and Medicare benefits. CBMS is being modified to accommodate low-income subsidy applications.

With the implementation of the Medicare Modernization Act (MMA), the Department has implemented a call center to respond to dual eligibles and their concerns. The MMA call center has received over 1,400 calls since November 1, 2005, and the calls range from clients that require assistance with choosing a drug plan to clients that need assistance understanding the new Medicare Prescription Drug Plan Coverage and how it will be affecting their Medicaid benefits. The Department brought on three full-time temporary employees to staff the call center, and may need to increase the staff site in January. The Department has also sent out three letters to full benefit dual eligibles. The letters have informed the clients of the change in benefits, and notified them of an error in the *Medicare and You 2006* handbook that presented incorrect premium payments. The third letter was sent out on December 17-20, 2005 to give the standard 10-day noticing to clients regarding the changes in their Medicaid benefits. The cost of these three letters was approximately $50,000, but all invoices are not in at this time.

The Department has provided training to county technicians on how the Medicare Modernization Act will affect the clients and how they need to assist these clients in the transition. The difficulties anticipated starting on January 1, 2006 will most likely be with the clients that have not been contacted, that did not come through on data matches, or are trying to go into a pharmacy and have their prescriptions filled through Medicaid. Clients unaware of the Medicare changes may contact the Department or the CBMS Emergency Call Center believing it is a problem with CBMS, which may increase the call volume and response time to the calls.

The federal Centers for Medicare and Medicaid Services (CMS) are also doing several things to assist in the transition. CMS informed us on December 1, 2005 that they are requiring a one-time refill by Medicare Prescription Drugs Plans for medications not on their formulary. CMS is also requiring in-network coverage of all nursing facility pharmacies in the plan's region. A point of sale protection system has been installed so that if clients show up at a pharmacy with both Medicaid and Medicare eligibility, they can leave with medications even if they are not in the system. A federal contractor will then verify eligibility and work with the plans to get the client enrolled. Another new system will also allow pharmacies to look up to see where the client should go to get medications for their plan, even if that pharmacy is not in the client's plan. Medicare is also staffed with specially trained operators for dual eligibles at 1-800-Medicare.

29. Please provide the Committee with a detailed cost estimate for continuing the Medicaid coverage for the non-Part D drugs (broken out by drug class and cost). Please inform the Committee if the Department is aware of any non-Part D drug where Medicare will not pay federal financial participation.

RESPONSE:
For all dual eligible Medicaid fee-for-service clients, non-Part D drugs in FY 04-05 cost $3,696,886. The top five drug classes accounted for $3,202,855, or 86% of the non-Part D drug cost. The top ten drug classes accounted for $3,474,046, or 94% of the non-Part D drug cost. Using the two-year annual growth from FY 02-03 to FY 04-05 as an inflationary factor, the estimated FY 06-07 cost for non-Part D drugs for fee-for-service dual eligibles is $4,586,771.

Cost of Non-Part D Covered Drugs for Fee-for-Service Dual Eligibles	
A. FY 04-05 Actual Non-Part D Prescription Drug Expenditures for Dual Eligibles (Pre-rebate)	$3,696,886
B. FY 04-05 Prescription Drug Rebate	$446,331
C. FY 04-05 Non-Part D Prescription Drug Expenditures for Dual Eligibles (Net rebate) (= A – B)	$3,250,555
D. FY 02-03 Total Prescription Drug Costs (Pre-rebate)	$201,539,446
E. FY 03-04 Total Prescription Drug Costs (Pre-rebate)	$265,797,673
F. FY 04-05 Total Prescription Drug Costs (Pre-rebate)	$280,930,899
G. Growth Rate for FY 02-03 to FY 03-04 (= E ÷ D)	31.88%
H. Growth Rate for FY 03-04 to FY 04-05 (= F ÷ E)	5.69%
I. Average of Annual Growth Rates for Last Two Years (=(G+H)÷2)	18.79%
J. Estimated FY 05-06 Expenditure for Dual Eligibles (Net rebate) (= C * (1 + I))	$3,861,289
K. FY 05-06 Fee-for-Service Estimate (expenditures for January 1, 2006 – June 30, 2006) (= J * 0.5)	$1,930,644
L. FY 06-07 Fee-for-Service Estimate (expenditures for a full year) (= J * (1 + I))	$4,586,771

Row B drug rebate is based on rates in effect during the fourth quarter of calendar year 2004

Preliminary Estimate of Cost of Non-Part D Covered Drugs for HMO-Enrolled Dual Eligibles	
A. FY 04-05 Actual HMO Expenditure (November 15, 2005 Budget Request, page EN-2)	$162,090,246
B. Percentage of Non-Part D Fee-for-Service Prescription Drug Expenditure (Net Rebate)	1.2%
C. Estimated Percentage of HMO Rate for SSI clients Related to Prescription Drug Expenditure (Net Rebate)	52.1%
D. FY 04-05 Actual Non-Part D Prescription Drug Expenditures for Dual Eligibles (Net Rebate) (= A * B * C)	$976,757
E. FY 02-03 Total Prescription Drug Costs (Pre-rebate)	$201,539,446
F. FY 03-04 Total Prescription Drug Costs (Pre-rebate)	$265,797,673
G. FY 04-05 Total Prescription Drug Costs (Pre-rebate)	$280,930,899
H. Growth Rate for FY 02-03 to FY 03-04 (= F ÷ E)	31.88%
I. Growth Rate for FY 03-04 to FY 04-05 (= G ÷F)	5.69%
J. Average of Annual Growth Rates for Last Two Years (=(H+I)÷2)	18.79%
K. Estimated FY 05-06 Expenditure for Dual Eligibles (Net rebate) (= D * (1 + J))	$1,160,276
L. FY 05-06 HMO Estimate (Expenditures for January 1, 2006 – June 30, 2006) (= K * 0.5)	$580,138
M. FY 06-07 HMO Estimate (Expenditures for a Full Year) (= K * (1 + J))	$1,378,275

Row B is the FY 04-05 actual non-Part D prescription drug expenditure divided by FY 04-05 total prescription drug expenditure.
Row C is taken from an FY 05-06 weighted average HMO rate for SSI clients.

Estimate of Total Cost of Non-Part D Covered Drugs for All Dual Eligibles	
FY 05-06 Fee-for-Service Estimate	$1,930,644
FY 05-06 HMO Estimate	$580,138
Total FY 05-06 Estimate	**$2,510,782**
FY 06-07 Fee-for-Service Estimate	$4,586,771
FY 06-07 HMO Estimate	$1,378,275
Total FY 06-07 Estimate	**$5,965,046**

The top ten non-Part D drug classes in FY 04-05 for all fee-for-service dual eligibles are as follows:

Rank	Drug Therapeutic Class	Class Description	FY 04-05 Expenditures
1	Z2E	Immunomodulators	$1,198,421
2	H2F	Anti-anxiety Drugs	$819,872
3	C1D	Potassium Replacements	$724,381
4	H4B	Anti-convulsants	$327,731
5	H2E	Sedative-hypnotics	$132,451
6	C1B	Sodium/Saline Preparations	$84,916
7	W7K	Anti-sera	$64,583
8	D4K	Gastric Acid Secretion Reducers	$57,384
9	C6D	Vitamin D Preparations	$35,074
10	H3E	Analgesic/Antipyretics	$29,234

The Department is not aware of any non-Part D drugs currently provided under Colorado's formulary as outlined in the State Plan which would not receive federal financial participation.

30. Please provide the Committee with an update on the estimated prescription drug cost savings for transferring dual eligible clients to the MMA benefit. Past estimates have assumed only drug costs in the fee-for-service and Primary Care Physician Program. Is it possible to achieve additional savings for clients enrolled in Managed Care Organizations? If so, how much additional savings could be estimated? Please explain how the Department arrives at its FY 2006-07 drug savings estimate? Is this a post-rebate or pre-rebate amount?

RESPONSE:
The Department estimates FY 06-07 savings in the Medical Services Premiums appropriation for the first full year impact of implementing the Medicare Modernization Act to be $72,329,951 General Fund. This estimate does incorporate both fee-for-service and managed care prescription drug expenditures and does incorporate an anticipated drug rebate specific to Part D covered drugs of 25.4%. This estimate is summarized in Attachment 2 of the Department's November 15, 2005 Budget Request, Base Reduction Item #3, and is included as Attachment 5 in this binder.

31. Please provide the Committee with how many dual eligibles were enrolled on a monthly

basis from July 2005 through October 2005. Has all interface problems between CBMS and the Social Security Administration's BENDEX system been restored? Are client counts reported from CBMS accurate enough to base clawback payment estimates?

RESPONSE:
The first table below provides all full benefit dual eligibles by month for the four-month period beginning July 2005 through October 2005. Please note that these monthly caseload figures are slightly higher than the September 2005 caseload (45,623) used in the Department's November 15, 2005 Budget Request in Base Reduction Item #3, Attachment 2, which is included as Attachment 5 in this binder. The reason for this discrepancy is due to the actual impact of restoring the BENDEX interface with the Social Security Administration. This table does not include partial dual eligibles, such as Qualified Medicare Beneficiaries and Special Low Income Beneficiaries.

	July 2005	August 2005	September 2005	October 2005
Number of Full Benefit Dual Eligibles	49,466	49,625	49,702	49,574

The number of all dual eligibles, including Qualified Medicare Beneficiaries and Special Low Income Beneficiaries, by month beginning July 2005, is below.

	July 2005	August 2005	September 2005	October 2005
Number of All Dual Eligibles	56,659	56,853	56,976	56,889

The federal government has specific files that are required for their use in the clawback payment calculation. The federal government will approve our methodology for the calculation of the clawback and the data that we use. Therefore, yes, the counts are adequate for calculation of the clawback.

All interface problems between CBMS and the Social Security Administration have recently been fixed. The full interface update ran during the weekend of December 3, 2005. CBMS processed the BENDEX files and the annual December updates that weekend, which synchronized all the clients with current Social Security Administration (SSA) data. CBMS will continue to receive bi-weekly updates from the SSA. The Department has informed Electronic Data Services that we need approximately one month from the run date to ensure that the cycle ran accurately. Department staff will be assessing the interface into January.

32. The Department's request for the FY 2006-07 clawback payment does not grow the dual eligible caseload estimate. However, the Department's base budget for premiums assumes a caseload increase based on implementing the MMA? Because the clawback payment is based on monthly dual eligible enrollment, won't it also increase if there is an increase in caseload?

RESPONSE:
Dual eligible clients are predominately Supplemental Security Income Adults 65 and Older and Supplemental Security Income Disabled Individuals. Historically, both of these populations are extremely stable populations, and comprise roughly 94% of the full benefit dual eligible caseload.

While implementation of the Medicare Modernization Act of 2003 is anticipated to increase Medicaid caseload due to the "woodwork effect," this increased caseload is not anticipated to be entirely comprised of full benefit dual eligibles. Exhibit B (page EB-2) in the Department's November 15, 2005 Budget Request estimates that total caseload will increase by 9,240 clients; however, only 1,940 Supplemental Security Income Adults 65 and Older clients are anticipated to be full benefit dual eligibles. The remaining 7,300 Qualified Medicare Beneficiaries / Special Low-Income Medicare Beneficiaries clients will not be full benefit dual eligibles, and will therefore not increase the State's clawback.

The Department's long standing clawback estimating spreadsheet has never adjusted for caseload in the out year, even for growth not related to the woodwork effect. It was on October 20, 2005 upon receiving the supporting documentation from the Centers for Medicare and Medicaid Services that the Department became aware that the clawback should be adjusted for caseload as well as the National Health Expenditure inflator. We agree with staff that it would not be unreasonable to apply a 4.28% caseload growth factor to the Supplemental Security Income Adults 65 and Older to account for this growth in the clawback (Exhibit E, page EB-1).

33. Please discuss the Department's estimates for the clawback payment. Please inform the Department of all negotiations with CMS to reduce the clawback payment amount based on the state moving to cash accounting in 2003. What is the Department's estimate for how much more Colorado is paying because CMS will not allow an exception based on Colorado's unique experience of not counting all drug rebates in 2003 due to the cash accounting transition?

RESPONSE:
In all of the estimates that the Department has presented for the clawback, the Department attempted to follow the federal requirements as closely as possible. In fact, the estimated savings and the estimated clawback do not use the same calculations because the Department projects savings for its Budget differently than the Centers for Medicare and Medicaid Services requires for the clawback.

On October 1, 2004, after receiving the draft rules from the Centers for Medicare and Medicaid Services (CMS) on August 3, 2004, the Department submitted comments in writing. On page 12 of those comments, the Department expressed concerns about how CMS was handling the rebate.

On January 11, 2005, the Department attended the Centers for Medicare and Medicaid Services conference on the Medicare Modernization Act for federal Region VIII states. There was an opportunity to present questions and concerns to the Centers for Medicare and Medicaid Services Central Office officials, and Colorado stated that the calculation of the clawback should be

reconsidered for Colorado due to unusual problems with the rebate. The CMS Central Office acknowledged that states may not benefit from the way the calculation was designed, but there was no flexibility allowed by law.

At an April 26-27, 2005 national conference in Chicago funded by the Centers for Medicare and Medicaid Services, at which the Department was present, Dr. Mark McClellan, Administrator for the Centers for Medicare and Medicaid Services, announced that CMS was willing to hear from states about problems in the clawback calculation. He stated that the Centers for Medicare and Medicaid Services "will work with states to make the clawback correct." Regional CMS staff approached the Department as well, and stated that CMS was willing to reconsider the clawback calculation and the Department was encouraged to pursue it.

On July 1, 2005, the Department submitted a written letter to the Director of Finance Systems and Budget at the CMS Central Office. We expressed our issues in detail in that letter. A teleconference was held on July 25, 2005 with at least five CMS officials to discuss our letter. We were told unconditionally that no reconsideration of our clawback calculation would occur. The Department requested a written response during the teleconference call. A written response was never received.

On December 29, 2005, the Department's Executive Director sent a letter to Dr. Mark McClellan, Administrator, Centers for Medicare and Medicaid Services. This letter again emphasized the need for a review of our rebate contribution and expressed our understanding of a reconsideration offered by CMS. Executive Director Steve Tool intends to follow-up by telephone later in the month.

To answer the Committee's question about what the clawback might be if the fourth quarter of rebate was included, the Department analyzed the rebate history from an accounting perspective. The analysis ended up to be more complicated than expected. The following table contains actual drug expenditures and drug rebates for calendar years 2002, 2003, and 2004, as reported on the Centers for Medicare and Medicaid Services CMS 64 reports. Therefore, expenditures will vary from what is reported in the Department's budget documents due to using federal rules in quarterly reporting. For this analysis (defense of higher rebates to CMS), this is the best source of data. Calendar year 2003 was the basis used by the Centers for Medicare and Medicaid Services for determining the states' clawback percentages.

Total Drug Expenditures and Rebates for All Fee-for-Service Medicaid Clients			
Calendar Year	Total Drug Expenditures	Total Drug Rebates	Rebate as a Percent of Total Expenditures
2002	$192,561,595	$39,691,555	20.6%
2003	$236,549,670	$34,131,984	14.4%
2004	$363,753,914	$80,317,391	31.8%

Detail by quarter for these calendar years is shown in the table below. The change to cash accounting for Medical Services Premiums occurred at the end of FY 02-03. The impact of this change can be seen in drug expenditures and rebates for the quarter ending June 30, 2003.

Total Fee-for-Service Drug Expenditures and Rebates by Quarter			
Quarter Ending	Total Drug Expenditures	Total Drug Rebates	Rebate as a percent of Total Expenditures
03/31/2002	$43,623,833	$9,633,712	22.1%
06/30/2002	$47,892,072	$10,103,581	21.1%
09/30/2002	$49,882,218	$10,463,508	21.0%
12/31/2002	$51,163,472	$9,490,754	18.5%
03/31/2003	$56,346,579	$11,614,821	20.6%
06/30/2003	$49,411,077	$428,045	0.9%
09/30/2003	$69,376,379	$10,913,308	16.0%
12/31/2003	$62,415,635	$11,175,810	17.9%
03/31/2004	$67,644,016	$14,812,281	21.9%
06/30/2004	$67,300,729	$16,756,107	24.9%
09/30/2004	$66,756,842	$17,520,508	26.2%
12/31/2004*	$51,052,327	$31,228,495	61.2%

*This quarter had some erroneous reporting which was reversed in the CMS 64 report to the Centers for Medicare and Medicaid Services for the quarter ending March 31, 2005.

If the quarters ending June 30, 2002 and December 31, 2004 are removed, the remaining quarterly average for this three-year period is 21.02%. The Department believes that this is historically a more reasonable estimate for the actual drug rebate. Assuming 21.02% for a drug rebate percentage, the Department would estimate the first full year of clawback in FY 06-07 to be $70,324,730 (see Attachment 6). This is $5,263,605 less than the $75,588,335 estimated clawback amount contained in the Department's November 15, 2005 FY 06-07 Budget Request, in Base Reduction Item #3.

34. Please describe any outreach services that the Department is offering for seniors applying for "extra help" under the MMA to enroll in Medicaid. Does the Department have any real or antidotal data at this time on how much the Medicaid caseload has increased due to the MMA?

RESPONSE:
The Department is not doing any outreach to seniors per se on the low-income subsidy. Medicare and the Social Security Administration have been the lead on this and have actually provided an extensive amount of information. A Colorado Coordinating Committee has been set up and is coordinated by CMS that includes CMS, Medicaid, Agencies on Aging, Senior Health Insurance Assistance Program (SHIP) of the Colorado Division of Insurance, the Governor's Office, Denver Regional Council of Government, American Association of Retired Persons, and others. This Committee helps ensure that all involved agencies know what each other is doing and clients are receiving up to date information. The Department's focus on low-income subsidy has been in speaking and training counties, including sending two agency letters on July 15, 2005. Also, the call center described in question #28 is available to answer basic questions if clients have them. Clearly, the Social Security Administration has taken the lead on this and has provided excellent resources to facilitate information sharing and make the application process as easy as possible.

The Department agrees with Joint Budget Committee staff that the woodwork affect caseload may not be as high as estimated using the federal Centers for Medicare and Medicaid Services (CMS) information. The Department is not aware that caseload has been significantly increased at this time due to preparation for the new prescription drug benefit.

To remind the Committee, the basic event causing the increase in caseload is the fact that the low-income subsidy (which is extra help for premiums, deductibles, and the donut hole) has been extensively advertised by the Social Security Administration. The states have been informed that as the Social Security Administration approves clients for low income subsidy, CMS will notify the clients that they may be eligible for Medicaid programs and that they should apply at their county offices. However, we do not know if these notices have been sent by CMS yet. Since the new prescription drug program has not started, we are not surprised that caseload would not be affected very much in the first half of the year. In addition, we know that no low-income subsidy applications have been processed by the counties to date; they have all been processed by the Social Security Administration. Fewer than expected clients are accessing the program through their county eligibility site, preventing easy screening for Medicaid at the county location.

2:30 PM – 3:00 PM – Managed Care

35. Because the MCO rates are based off of the claims experience in the FFS and PCP programs, what steps does the Department take to verify that the rates are reasonable based on the actual costs born by each contractor? Besides receiving the certification letter from the contractors, does the Department audit the plans based on actual encounter and cost data obtained from the contractor that the rate was reasonable?

RESPONSE:
In conformance with federal and state statute and regulation, the Department takes several steps to determine that rates are reasonable based on the claims and cost in fee-for-service and primary care physician programs, but does not directly verify or measure the actual costs borne by each contractor. As noted in the question, the Department requires the contractor to actuarially certify that the capitation payments are sufficient to assure the financial stability of the managed care health plan in its delivery of services to the Medicaid recipients covered in the contract, as required under C.R.S. 26-4-119(k) (2005). It is the responsibility of the actuaries employed by managed care health plans to look at the actual historic cost borne by the specific managed care health plan during the independent certification process. The Department does not audit the plans to determine that the rates are reasonable based on the actual costs borne by each contractor.

36. Does the Department anticipate that additional MCOs would be willing to enter the Colorado Medicaid. program in FY 2006-07? Please show a chart of the enrollment in the MCO program compared to the Fee for Service and PCCP program for the last five years.

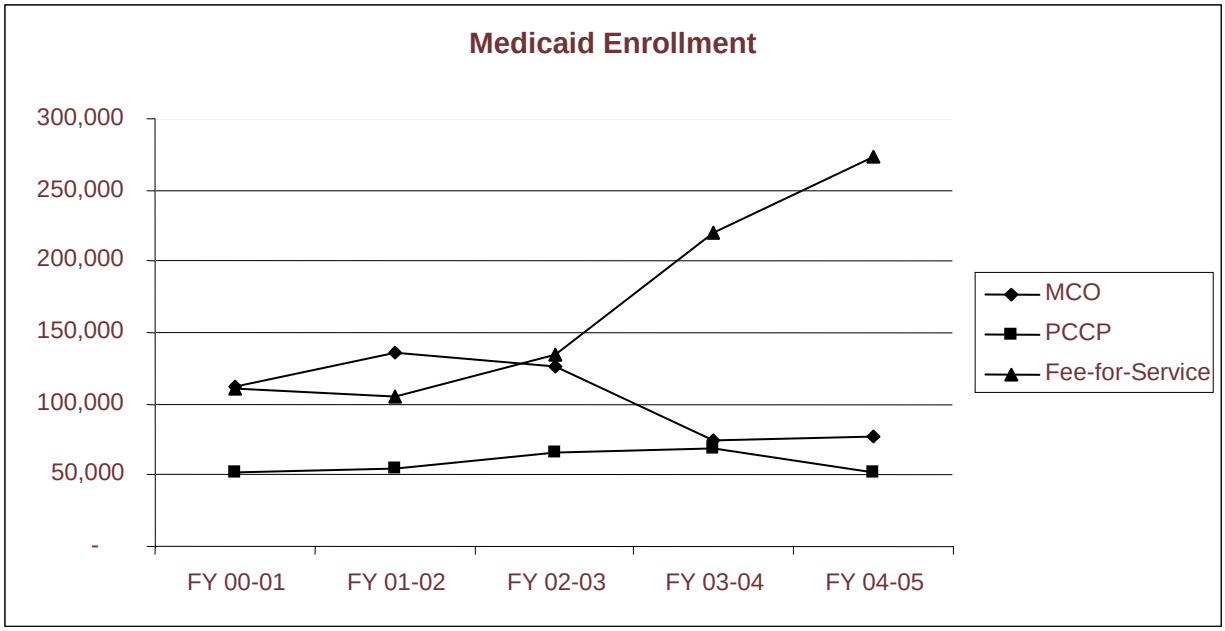
RESPONSE:
The Department has not been approached by any managed care organizations expressing an interest in entering the Medicaid program in FY 06-07. However, the Department is pursuing

default enrollment for the greater Denver metropolitan area into managed care plans for FY 06-07. If this is implemented, it will generate increased managed care enrollments that would be attractive to managed care organizations.

Below is a chart showing the enrollments in the managed care organization, fee-for-service, and the Primary Care Physician Program for the last five years.

Membership Category	FY 00-01	FY 01-02	FY 02-03	FY 03-04	FY 04-05
Administrative Service Organizations	N/A	N/A	N/A	12,380	15,860
Managed Care Organizations	112,824	135,518	126,669	74,439	77,354
Primary Care Physicians Program	52,214	54,086	65,475	68,557	51,669
Unassigned Fee-for-Service	110,361	105,809	135,251	207,155	257,919
Total Medicaid Caseload	**275,399**	**295,413**	**327,395**	**362,531**	**402,802**

Sources:
FY 06-07 Budget Request, Volume II, Strategic Plan, page L-77
Administrative service organization, health maintenance organization, and Primary Care Physician Program enrollment numbers are from the Managed Care Report. FY 04-05 total Medicaid count comes from the averages for twelve months of this fiscal year as reported to the Joint Budget Committee and Office of State Planning and Budgeting on July 18, 2005. Caseload numbers are an average of the fiscal year's caseload for each month, without retroactivity.
Notes:
1) Fee-for-Service enrollment is derived by the total enrollment minus enrollment in the administrative organization, health maintenance organization, and the Primary Care Physician Program.



37. Does the Colorado MCO program actually help to contain costs? What are the advantages of having an MCO program?

RESPONSE:
Whether or not the Colorado Medicaid health maintenance organization program actually saves the State money compared to fee-for-service has been a matter of debate for several years. The primary reason for suspicion is the multiple lawsuits that plagued the State after several HMOs sued for higher rates over several years. The following table reflects the approximate costs of settlements and costs related to those lawsuits:

HMO Rates Litigation and Administrative Settlements

HMO	FY 02-03	FY 03-04	FY 04-05	Total
Rocky Mountain Health Plans	$21,220,064	$0	$14,972,000	$36,192,064
Community Health Plan of the Rockies	$0	$16,500,000	$0	$16,500,000
Kaiser	$0	$10,500,000	$0	$10,500,000
Colorado Access	$0	$14,618,331	$0	$14,618,331
Total	$21,220,064	$41,618,331	$14,972,000	$77,810,395

- Administrative payment correction issues are only counted when the issues are rolled up into the settlement (e.g. RMHP FY 04-05) or when the issues were part of litigation that was settled (e.g. CHPR, FY 03-04)
- Does not count ongoing administrative payment correction issues, such as recoupments for ineligible clients, or the correction for institutional rates.
- Does not include administrative costs for litigation, totaling $783,184 in FY 02-03 and $259,346 in FY 03-04. Totals can be found in the Department's November 1, 2004 Budget Request, page D.1-32.

In addition, after the passage of SB 97-005, the Department was required to submit a "Savings Report" estimating the savings from managed care. This report was based on a number of assumptions and the idea of savings was subject to some criticism. In fact, the Joint Budget Committee staff reported in the Briefing of December 14, 1998, " . . . [HMO] managed care savings are sharply lower than originally anticipated . . ." Again, in the staff Briefing of December 14, 1999, "[s]taff's calculations show that since FY 1996-97, the state has not saved money by enrolling additional clients into Medicaid managed care." "In fact, the state has instead lost money by spending an additional $8,850,345 more cumulatively since that time. . ."

More recently, Karen Reinertson advised the Committee at the Department's December 16 and 17, 2003 Hearing that "the Department does not believe that the original goals of cost containment and greater access to care for clients can be achieved with the health maintenance organization program the Department had structured." The Department explained that as HMO enrollment declines, the Department has seen an increase in physician and drug claims but the fee-for-service budget does not seem to be increasing at a rate that would indicate the Department is paying more than would have been paid under capitation. At that Hearing, the Department also presented an analysis that concluded that the Medicaid population left in health maintenance organizations tends to be healthier than those found in fee-for-service. Since the Medicaid capitation rates are calculated on the fee-for-service population, they are, therefore, higher. Risk adjustment takes care of some of this discrepancy, but the Department does not have the capability to risk adjust all populations. In general, the health maintenance organization rates have increased more than fee-for-service provider rates.

FY 04-05 and FY 05-06 have seen a reduction in managed care enrollment, and health maintenance organizations are complaining that they need critical mass. The Department is proceeding slowly due to the issues of the past, and we want to make sure that we learn from experience.

It is important to note that the Medicaid health maintenance organizations do not receive an administrative component in their rate, and their rate is based off of fee-for-service experience. Health maintenance organizations in the Children's Basic Health Plan have rates based on actuarial analysis of the health maintenance organization's cost. The Children's Basic Health Plan has experienced more success by using the health maintenance organization plans than Medicaid has when looking at the entire historical picture.

The managed care organization programs are not panaceas, but properly structured and with enough volume for the health plans, offer the opportunity to provide comprehensive access to health care services with medical management at a fixed cost to the state. The Department has been researching various strategies through the Colorado Family Care proposal. Through a competitive request for proposals process, Colorado could potentially obtain a better value for its health care dollars by contracting with a limited number of health plans that demonstrate an ability and long-term commitment to meet the special needs of low-income children and families enrolled in Medicaid and the Children's Basic Health Plan. A key component of any purchasing strategy would need to include contractual health plan performance standards and incentives to expand access to timely primary care and reduce preventable emergency room visits and hospitalizations for Medicaid and the Children's Basic Health Plan members. In addition, any future program would include quantifiable annual quality improvement goals.

38. Please compare how capitation rates are set in the Medicaid MCO program with how capitation rates are set in the Medicaid Mental Health Program and the Children's Basic Health Plan.

RESPONSE:
Since all three sets of capitation rates are based upon historical experience, adjustments are made to account for the expected difference in cost between the historical period and the future period in which the rates are effective. The precise methodologies vary somewhat; but either, utilization and cost trends are built using historical data, or external cost indices are used in each methodology. Lastly, legislation that affects benefits, provider rates, or utilization is incorporated into each of the three sets of capitation rates, as applicable.

The methodologies used to determine these different sets of capitation rates are all designed to calculate an actuarially sound estimate of future costs of each risk contractor. The fundamental dissimilarity between the rate setting methodologies is the data used in the calculation for each of the three sets of rates.

The Children's Basic Health Plan is required by C.R.S. 26-19-110 (7) to:

> "make capitation payment to managed care plans based on a defined scope of services at an agreed upon rate. The Department shall only use market rate bids that do not

discriminate and are adequate to assure quality, network sufficiency, and long-term competitiveness of the Children's Basic Health Plan managed care market. The Department shall retain a qualified actuary to establish a lower limit for such bids."

The independent actuary contracted by the Department for the Children's Basic Health Plan develops the rates based on detailed medical, pharmacy, and mental health claims data from the participating managed care organizations as well as the State's self-funded managed care network. The actuary has access to claims data for the managed care organizations going back to FY 02-03 and the State's self-funded managed care network since the inception of the program.

For example, Medicaid health maintenance organization capitation rates rely on historical fee-for-service data. This data is actuarially credible, as the Medicaid fee-for-service population is a close analogue to the Medicaid managed care population. Encounter data is used to adjust for known differences between the acuity level of the fee-for-service population and the population covered in each of the managed care organizations.

The precise future cost and experience of the risk contractors cannot be known but it can be projected. To make the best-cost estimate possible, the Department must use the most credible data available, and must adjust that data in such a way that it most closely matches the expectation of future cost and experience.

Comprehensive, recent fee-for-service data is not available in the Medicaid mental health program. Encounter data is available, but does not contain the prices paid by the participating managed care plans. Encounter data is considered credible in capitated rate setting, although its accuracy is less than for fully processed fee-for-service claims. The Department uses financial statements to impute pricing for the encounter data, and uses the resulting cost calculation for a small, but increasing portion of the rate. The remainder of the rate is based on historical rate experience, trended forward.

3:00 PM – 3:30 PM – Provider Rates and Medicaid Reform

39. The Department's FY 2005-06 budget request includes a 3.0 percent provider rate increase for inpatient hospitals, primary care physicians, and home health and home and community-based providers. Please explain why these service categories were included and why other service categories that have received rate decreases in the past were not included. Specifically, address why lab and x-ray, durable medical equipment, pharmacy, private duty nursing, emergency transportation and count transportation rates were not addressed in the Department's budget request. Please provide a chart of various potential rate increases and what it would cost to increase rates for these services.

RESPONSE:
The Department and the Governor's Office know that many providers have not received consistent increases during recent years and most have received reductions. However, as the Joint Budget Committee is aware, it is not feasible to restore every rate cut in one year. By requesting a rate increase for the providers identified, primary care (which in the long run

reduces emergency care and inpatient care) was still emphasized while addressing the multiple reductions that hospitals received. The Department and the Governor's Office were following the direction set by the Joint Budget Committee of last year's rate increase. The Department and the Governor's Office would like to work with the Joint Budget Committee on a plan to restore reimbursement rates to an adequate level in all service categories over the next five years. The 3.0% rate increase request will at least restore some of the cuts from the previous years. The Department could provide the committee with a plan sometime in February 2006.

40. Would the Department consider providing rate increases to target certain deficiencies rather than across the board rate increases. For example, according the Department's footnote reports, the Department could increase inpatient hospital rates up to 100 percent of the Medicare rate and physician rates up to 80 percent of the Medicare rate and still provide a provider rate increase for home and community-based service provides. Does the Department have any goals or suggestions on how Medicaid rates could be increased in order to improve the efficiency and effectiveness of delivery Medicaid services to clients? (include a discussion about inequities of rates for certain services).

RESPONSE:
A full discussion of Medicaid rate inequities across all service types would require extensive analysis, a process that would be very staff and time intensive and was not feasible for completion by this Hearing date. Certainly the Department would consider implementing budgeted provider rate increases that are targeted to certain deficiencies, as has in fact been the case in recent years. It is the Department's observation that these historical budgeted increases do not always align with health care access incentives. For example, perhaps it would be more appropriate to fund primary care more fully than inpatient hospital care. In our responses to questions 3 and 4 the Department provided details on suggested reimbursement rate increases for several provider categories. Any additional suggestions on how reimbursement rates could be increased are in the context of the need for Medicaid health care system delivery reform through an initiative like the Streamlining Bill.

41. Please provide information on the current trends for physicians willing to take Medicaid clients.

RESPONSE:
Overall, the trend shows an increase in the number of physician providers willing to take Medicaid clients. Currently, there are 25,815 enrolled physicians who are Medicaid providers. In 2001, the number of physicians enrolled as Medicaid providers totaled 18,274. This represents an increase of 7,541 physicians or 29% increase in physicians willing to serve Medicaid clients. This increase has occurred even though the Department has been reducing this number through its physician re-enrollment efforts that have eliminated those providers lacking board certifications for practice specialties, having sanctions restricting practicing in federally funded programs, and failing to meet credentialing requirements.

Note that while there has been an increase in providers there has also been an increase in Medicaid caseload. Medicaid enrollment has increased from 275,399 in 2001 to 402,802 in

2005. This is an addition of 127,403 enrollees or 46% increased enrollment over the five-year period.

Similar to other Medicaid programs across the nation, the Colorado Medicaid program is experiencing a shortage of some specialist physicians. During the same timeframe (2001-2005), the number of physicians serving as primary care physicians in the Primary Care Physician Program (PCPP) has decreased from 1,721 to the current enrollment of 1,122 physicians. As of November 2005, 769 or 69% of these physicians are open to accepting new Medicaid clients. The remaining 31% continue to see their existing Medicaid clients but will not accept new Medicaid clients. The enrollment of Medicaid recipients in the PCPP for this period decreased slightly from 52,214 to 51,669 enrollees.

Some providers cite poor reimbursement levels, burdensome administrative requirements, and poor client compliance as reasons why they do not wish to be enrolled Medicaid providers.

42. Please discuss whether the current rates for home health and home-and-community based services are adequate. Please give a status report on implementing the recommendations in Footnote 50a.

RESPONSE:
For background purposes, Footnote 50a of House Bill 00-1451 directed the Department to work with long term care clients and providers, legislators, and advocates to examine issues of rate disparity and shortfalls within the long term care continuum. The long term care services examined were adult day services, alternative care facilities, home health services, nursing facility, personal care and homemaker services, private duty nursing, and the single entry point agency system. The task force found that the Medicaid rate of reimbursement for several long term care services fell short of the cost to provide care.

The Footnote 50a report recommended rate increases for home health and home and community based services (HCBS) providers. Three services were targeted to receive significant short-term rate increases. The recommendations were to increase alternative care facility rates by 12.5%, home health aide rates by 3%, and personal care/homemaker rates by 11.6% rate. Other services were recommended to receive a 1% inflationary increase. The recommendation was that these rate increases were to occur every year for three years. These increases were implemented for FY 01-02. The economic recession of 2001 intervened and the additional rate increases were not appropriated for FY 02-03 and FY 03-04.

Home and community based services were held harmless in the FY 02-03 Medicaid budget reductions although home health and private duty nursing services rates were reduced by 5% for three months. For FY 05-06 a 2% rate increase was appropriated and implemented for home health, private duty nursing, and home and community based services.

In the years since the Footnote 50a findings, the reimbursement rates for home health and home and community based services have fallen further behind the cost to provide care. Medicaid rates for these services average 56.7% of the current market rates and 62.8% of Medicare rates for similarly titled services. When making such comparisons it should be noted that the long

term care services funded by Medicaid differ from the skilled services funded by Medicare and private pay market dynamics and that some Medicaid-funded services have no Medicare or market equivalents.

42a. What has been the impact of not keeping up with COLAs for hospitals? Have the costs been shifted or are hospitals just absorbing the impacts.

RESPONSE:
Based on legislation from the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), Medicare hospital rate increases are set to the hospital market basket update. Since FY 02-03, the average hospital market basket percentage equaled 3.5% and is a reasonable estimate on the inflationary increase that will be applied to Medicare rates in future years.

Hospitals do not receive any inflationary increase for Medicaid purposes without a budget action. Since Medicare increases inpatient hospital rates every year by an inflationary factor, and Medicaid rates are based on Medicare rates, hospitals are reimbursed a smaller percentage of Medicare's rates every year. For FY 06-07 it is anticipated that Medicaid inpatient hospital rates will fall below 90% of the Medicare rate since Medicare's rates are receiving an inflationary increase of 3.7% in FY 05-06.

The Department does not have an analysis regarding whether hospitals have absorbed the impact of the rate cuts or if there is any cost shifting to other payers.

42b. What has been the impact of going to a tort auto insurance system on hospitals, other providers and Medicaid?

RESPONSE:
The Department has not been able to quantify a direct impact to Medicaid expenditures that can be attributed to going to a tort auto insurance system. The Department has always recovered costs for Medicaid services from third party insurance payers, including auto insurance. From FY 03-04 to FY 04-05 there has been a $705,562 (32.6%) increase in the Department's tort and casualty recoveries but it would require in depth medical record review and comparison to court records to conclude the source of the recovery. Pursuant to §26-4-403, C.R.S. (2005) personal injury claims cannot be settled until the Department's lien to recover medical care costs has been satisfied.

Anecdotally, the Department has heard that some hospital providers have experienced a decrease in motor vehicle accident medical cases being covered by insurance.

42c. How much would it cost restore the targeted rate reduction that was taken from hospitals during the recession?

RESPONSE:
See response for questions 3 and 4.

42d. Does CICP reimburse hospitals for their actual costs? If not, what percentage of their actual costs are covered by CICP?

RESPONSE:
See response for questions 3 and 4.

43. Please update the Committee on the Department's drug utilization efforts.

RESPONSE:
Detail of the Department's drug utilization efforts were submitted to the Joint Budget Committee in the Pharmacy Utilization Plant FY 04-05, dated December 1, 2005. The Department has continued to pursue a reduction in pharmaceutical expenditures as outlined in SB 03-294 and SB 03-011 using the Pharmacy Utilization Plan. The Department has implemented several utilization mechanisms to control costs while allowing access to medications for clients who need them. Such mechanisms include limits per federal or manufacturer guidelines and prior authorizations on certain drugs. The Department is also considering other utilization mechanisms to determine if they would result in any reduction in expenditure.

The Drug Utilization Review (DUR) Board established by the Department continues to review drug utilization issues and make recommendations to the Department to optimize appropriate prescription drug use. The DUR Board findings are used by the Department to review identified drugs and to achieve expenditure reduction in pharmaceuticals.

The Department has also contracted with the Business Research Division (BRD) of the Leeds School of Business at the University of Colorado to assist the Department with more in-depth analysis of various drug utilization issues. The BRD contract with the Department includes studies and reports on drug utilization practices, effectiveness of antipsychotic drug medications and treatments, and identifies historical patterns of incorrect treatment. Through these activities, the BRD monitors treatment patterns to check consistency with the client's health status and provider's prescribing habits and educated providers on potential problems when necessary.

In addition, the Department continues to contract with Health Information Designs, Inc. The Department recently acquired RxExplorer, a tool for facilitating the optimum use of drugs so that the benefits to the patient are maximized while costs are minimized. Further, Thomson Micromedex continues to provide online reference services that offer a wide range of clinical databases including reference information about drugs, acute care, and alternative medicines.

44. Please describe the Department's efforts to automatic the drug rebate collection system. Please discuss with the Committee the recent findings from the U.S. Department of Health and Human Services Inspector's Office that the Department owes CMS $1.9 million in drug rebates that were improperly assigned to the Old Age Pension program. Please describe the difficulties associated with charging rebates for prescription drugs used in the Managed Care Program.

RESPONSE:
A) The Department's November 15, 2005 Budget Request, BRI-4, includes a proposal to implement a fully automated drug rebate collection system. Prior to submitting its request, the Department contacted other states that have implemented automated systems and collected information about their use. Additionally, the Department consulted a vendor and obtained detailed information on the operation of that vendor's drug rebate collection system. While the Department awaits a decision on its budget request, we have automated the calculation of interest on unpaid balances owed the state. This interim measure is labor intensive and requires manual data entry for amounts owed by each of the participating manufacturers who have an unpaid balance.

B) The Department has reviewed the final Office of the Inspector General (OIG) report submitted to the Department on November 17, 2005. The Department does not agree that the amount of $1,880,565 specified by the OIG as improperly assigned to the Old Age Pension (OAP) Health and Medical Program should be refunded to the Centers for Medicare and Medicaid Services (CMS). To address inconsistencies in the report, the Department presented a solution to identify the actual amount associated with the state funded program and adjust the CMS 64 accordingly. The Department produced several estimates of these amounts, under the direction of the OIG, which were omitted from the final audit report. The Department will have the actual amount completed by January 31, 2006.

In addition, the Department had started work on obtaining Medicaid family planning drug rebate amounts prior to the inception of the OIG audit (October 27, 2004). Making the necessary adjustments related to Medicaid family planning will reduce the amount of rebate to be refunded. This offset was not presented in the OIG's report.

The Department concurs that rebates for OAP Health and Medical Program were based on estimates. The Department did not have the specific utilization data related to OAP Health and Medical Program invoices and agrees that some amount was invoiced under the Medicaid drug rebate. The Department began a process to separate the OAP Health and Medical Program invoices from the Medicaid invoices in July 2004. The ability to separate the invoices is now complete and the Department is pursuing a state only drug rebate program. Using these corrected invoices, the Department can make the necessary adjustments to the CMS 64, which we believe will be less than the amount reported by the OIG.

The OIG also stated that Colorado must adjust all the drug manufacturers' Medicaid drug rebate invoices that it billed in error. The OIG said that until Colorado can document to CMS that specific steps have been taken, Colorado should refund drug rebate collections. The Department believes it would be inappropriate for CMS to require adjustments to the CMS-64s now and borrow from the Old Age Pension State and Medical Program. CMS should also not mandate how we handle rebates for a non-federally funded program. The Department requests that CMS support any action with the applicable regulations that would authorize such an action. As stated in our response to the audit report, the Department will work with the CMS Region VIII office to make the necessary adjustments related to the OAP Health and Medical Program and Medicaid family planning drug rebate amounts.

C) Federal constraints (42 U.S.C 1396 r-8 (j)) explicitly exempt prescription drugs provided by managed care programs from the federal rebate program. The Department has confirmed its interpretation of this federal prohibition with the Centers for Medicare and Medicaid Services.

45. What is the Department's position on the reforms before Congress on changing the pricing for prescription drugs from an AWP model to a AMP model?

RESPONSE:
The U.S. House of Representatives passed the conference committee report on the 2006 Budget Reconciliation Bill by a vote of 212-206 on December 19. The Senate passed the conference committee report by a vote of 51-50 with the vice-president breaking the tie. Because there were minor changes made to the legislation in the Senate, it now must go back to the House for concurrence. That vote for concurrence in the House should take place during the week of January 30, 2006.

The Department has not fully analyzed the reforms contained in the legislation, but the shift from using average wholesale price (AWP) to average manufacturer's price (AMP) is recommended. Department staff will participate in a conference call with Medicaid Directors from around the country today to review provisions contained in the bill. There is widespread acceptance that AWP is inflated and does not reflect a valid benchmark for pricing. We do believe that AMP would more directly reflect the actual price of drugs.

46. What is the Department's position on changing the look back period for asset transfers and moving the start of the penalty period for asset transfers to the date of application for Medicaid. Does the Department have an estimate of the financial cost to the Colorado Medicaid program due to asset transfers.

RESPONSE:
The Medicaid program must be administered in accordance with federal and state laws and regulations. Our current rules for asset transfers are based on federal law (42 USC 1396p(c) (1) (A)) and specify a look back period of 36 months prior to the date of Medicaid application. The penalty period begins in the month in which the transfer occurred.

At this time, the look-back period is three years. If Congress passes the legislation mentioned in question #45 and it is signed into law, it would change the start date for the penalty period of ineligibility to the date of application for Medicaid. Presuming this bill becomes law, the Department would be required to change its transfer without fair consideration rules to remain in compliance with federal law. No State Plan Amendment would be required.

It is not possible to estimate the financial cost to the Colorado Medicaid program due to asset transfers. The county departments of social services account for asset transfers when making Medicaid eligibility determinations, but no data on the value of transferred assets are maintained. Transferred assets may cause a period of ineligibility as a result of application of the transfer without fair consideration rules, but this period of ineligibility would not necessarily offset the additional Medicaid expenditures that would be required.

The Department believes that changing the look back period for asset transfers and changing the start date for calculating the penalty period for transfers would not necessarily help to reduce the prevalence of asset transfers as a form of Medicaid planning. In the short term, such a change would likely result in a shift in the types of strategies used for transferring assets to attain Medicaid eligibility, as well as increase the number of appeals of transfer without fair consideration decisions.

47. Does the Department have any estimates of how many people in institutional care could be in community-care? Describe the Department's efforts to ensure that clients are served in the least-restrictive care environment.

RESPONSE:
The Department was awarded a federal Nursing Facility Transitions (NFT) grant from 2001-2004. The federally funded grant provided funds to help clients transition from a nursing facility to a community-based residence by providing a transition coordinator to assist in finding and securing housing, utility deposits, furnishings and grocery staples. In FY 02-03, 93 individuals successfully transitioned from a nursing facility to the community using NFT grant funds. These 93 individuals were 0.63% of the total 14,807 Medicaid nursing facility residents for FY 02-03. Applying the 0.63% to the FY 04-05 Medicaid nursing facility population, 92 clients may be appropriate for community care assuming they qualify for the Home and Community Based Services waiver program.

To ensure clients are served in the least restrictive care environment, the Department requires all Single Entry Point case managers to inform initial clients seeking services of their right to choose between a nursing facility and community living. The Single Entry Point case managers also assess clients living in nursing facilities each year using the ULTC 100.2. During the assessment in the nursing facility, the Single Entry Point case manager determines if the client can be safely served in the community and informs the client of his or her right to choose between a nursing facility and community living.

The following table shows the percent of institutional level of care clients receiving services in the community through the Home and Community Based Services waivers.

Fiscal Year	Nursing Facilities Clients	HCBS Waiver Clients	Total Population of Institutional Level of Care Clients	Percent Served in Community
FY 01-02	15,125	25,504	40,629	63%
FY 02-03	14,807	26,289	41,096	64%
FY 03-04	14,397	25,995	40,392	64%
FY 04-05	14,545	25,595	40,140	64%

*Unduplicated client count is based on fiscal year date of service with 6-month payment runout from service claims.
Sources: HCBS client count from the Centers for Medicare and Medicaid Services 372 lag reports.
Class I Nursing Facility client count from BOA for fiscal year dates of service with 6-month payment runout from service claims.
Due to the way Medicaid Caseload is calculated on a cash accounting basis and without retroactivity, the numbers below cannot be considered a subset of Medicaid caseload.
Figures are not calculated on a cash basis to ensure comparability from year-to-year. Year-to-year comparability would be skewed because each year would have a different amount of runout.

The Department is implementing a new benefit in the Home Community Based Services for the Elderly, Blind and Disabled (HCBS-EBD) waiver called Community Transition Services (CTS). CTS will allow reimbursement for the services previously funded under the NFT grant. These services will enable clients who qualify for HCBS-EBD to transition from a nursing facility to the community by providing a person to assist the client with coordinating all aspects of the transition and providing funds to cover many of the one-time costs associated with transitioning to the community. Authority for the benefit was given to the Department in HB 04-1219. The Department expects implementation of the Community Transition Services benefit May 2006.

48. Please update the Committee on the pieces of the "Colorado Family Care" proposal that can go forward through state plan amendments rather than through a waiver proposal. What is the current status of the proposal?

RESPONSE:
To date, the Department has not pursued an analysis of the components of the Colorado Family Care program other than the waiver proposal presented to the joint health care committees of the General Assembly this summer. The Department expects a bill to be submitted to the General Assembly allowing for implementation of Colorado Family Care. The Department is working with the sponsors at this time.

49. Please discuss with the Committee the Department's plans to enter into a contingency-based contract to evaluate the accuracy of DRG billing. How will this project differ from the Payment Error Rate Measurement project?

RESPONSE:
On October 28, 2005, the Department sent to the Joint Budget Committee a letter requesting approval to promulgate a fraud and abuse Request for Proposals (RFP) focusing on hospital Diagnosis Related Group (DRG) payments. The Department believes that intense post payment review of DRG payments will be beneficial to the Department for the following reasons:

- Inpatient hospital payments account for a significant portion of Medicaid expenditures.
- Currently, the acute care utilization management contractor reviews approximately 11% of hospital stays.
- Comprehensive evaluation of coding accuracy for the more than 500 DRG categories and over 13,000 International Classification of Disease diagnosis codes performed by certified coding specialists will minimize and correct coding errors. This level of expertise does not exist at the Department.
- Contingency based contracting with a contractor who can provide coding specialists to perform this type of review allows for a more cost effective approach with less risk to the Department compared to traditional contracting.

There are several differences between this project and the Payment Error Rate Measurement Project (PERM). Foremost, a federal contractor selected by CMS will conduct PERM reviews once every three years. Another significant difference is that the sample of claims reviewed in PERM will be a stratified sample of all provider types; therefore, only a fraction of the total

number of inpatient hospital claims will be evaluated. The proposed RFP focusing on hospital DRG payments would allow for a systematic and thorough approach to reviewing the majority of DRG payments and not the small random sample that will be selected every three years for the PERM project. In addition, the PERM evaluation includes an eligibility confirmation that is not part of the proposed RFP.

The Department awaits response from the Committee providing approval of this project.

50. Does the Department have any other recommendations on how to control the costs of the Medicaid program?

RESPONSE:
There are fundamentally three factors that drive Medicaid expenditures: the number of people eligible, the services covered and utilized, and the rates paid to providers. In recent years, each of these factors has, in turn, been the focus of attention with limited results. These limited results provide the backdrop for the Department's interest in reforming the Medicaid program. When the Department does identify a specific proposal to control costs it submits a Base Reduction Item.

3:30 PM – 4:40 PM – Children's Basic Health Plan and Medicare Pay and Chase

51. Please update the Committee on the Department plans to provide a continuum of care as 30 percent of the CHBP children caseload is transferred from CBHP to Medicaid. Please discuss the status of the discussion that the Department has had with CMS on allowing these children to continue to access the CBHP network until July 1, 2006. Please discuss the necessity of the provider network stabilization funding to prepare the system for the large drop in caseload.

RESPONSE:
See response on question 22.

52. Given an improving economy and the return of marketing efforts for the CBHP program, has the Department received an increase in applications for the program? Please discuss with the Committee the Department's marketing efforts.

RESPONSE:
After the General Assembly appropriated funds for marketing, state procurement protocol was followed and a Request for Proposals for marketing the Children's Basic Health Plan was published in August 2005. Maximus, Inc. won the bid and the contract is in the process of being executed.

The major components of the marketing plan are:

- Regional outreach coordinators
- Television and radio advertising
- Outdoor advertising

Application volume has been stable for the Children's Basic Health Plan for the last five months. These data are based on applications received by the enrollment contractor, ACS, and do not reflect applications received by the counties.

Month FY 05-06	Application volume
July	2,075
August	2,229
September	2,571
October	2,227
November	2,068

53. Are all issues related to capturing the CBHP caseload in the CBMS system resolved?

RESPONSE:
Issues with caseload reporting were discussed under Question #6. One issue specific to the Children's Basic Health Plan (CBHP) most recently being addressed is missing HMO enrollments (this does not affect Medicaid). There are also known issues between the Colorado Benefits Management System and the Medicaid Management Information System that are preventing some enrollment spans from being loaded into the Medicaid Management Information System (MMIS). All of these issues have a relatively small impact on caseload but continue to be actively addressed. As system corrections are implemented, it is possible to see a higher fluctuation in caseload reporting than typical.

The estimated impact of these systems issues is that the caseload data reported from the MMIS contains approximately 99% of current enrollment spans for clients at any given time. Comparisons with CBMS as of December 29, 2005 reveal that 20 CBHP clients did not move to the MMIS, and 87 CBHP clients do not have State IDs. That puts the percentage at over 99% accurate [107 / 43,788) = 99.8%].

54. Please give the reasons why the CBHP children's HMO rate is 20.7 percent lower than the rate for children served in the self-insured network. In addition, the AFDC-C rate for children served by Colorado Access in the Denver metro region is only $63.83. Please provide an apple to apples comparison of the Medicaid HMO rate to the CBHP HMO rate.39. Please compare rates for Department's managed care programs (Medicaid and CBHP) with rates for the Medicaid and CBHP fee-for-service program and for private insurance.

RESPONSE:
CBHP HMO vs. the CBHP self-insurance network
The health maintenance organization (HMO) rate in the Children's Basic Health Plan (CBHP) has traditionally been lower than the rate for the State's self-funded managed care network. The reason the rate is higher in the State's self-funded managed care network is because this network provides care for all members in their pre-health maintenance organization enrollment period. A pre-health maintenance organization enrollment period is the span of time from a member's original enrollment until the member is enrolled in a Children's Basic Health Plan (CBHP)

participating health maintenance organization. It is important to note that the original enrollment date is the date the application is received at a processing site. Several factors increase the costs during the pre-health maintenance organization (HMO) enrollment period. Health care costs are higher during this period of time because member's care is not provided through their "medical home" or Primary Care Provider (PCP). There is pent-up demand for services when members initially become eligible for the program that increases costs for the State's self-funded managed care network. In fact, out-of-network providers provide many of the services received during the pre-health maintenance organization's enrollment period.

The State's self-funded managed care network also covers members in areas of the state where no health maintenance organization (HMO) is available. The costs in these geographic areas tend to be higher than those where health maintenance organizations are available.

Medicaid HMO vs. CBHP HMO

The following is a comparison of the total Medicaid HMO costs to the CBHP HMO cost.

Medicaid HMO rates and the Children's Basic Health Plan rates are not directly comparable for the following reasons:

- The Medicaid HMO rates are based on 95% of the direct health care cost of providing those same services to an actuarially equivalent Colorado Medicaid population group. Furthermore, Medicaid fee for service (the basis of HMO rates) provider reimbursement is on average lower than provider reimbursement in the Children's Basic Health Plan.

- Although actuarially certified HMO rate ranges do include administrative costs, per State statute, C.R.S. 26-4-119 (1) (b) (2005), the Medicaid HMO rates do not include an adjustment for administrative costs, while the Children's Basic Health plan rates do. For FY 05-06 the Children's Basic Health Plan administrative cost adjustment for HMOs was 7.4% of claims cost.

- The Medicaid HMO rates are based on the claims experience of unmanaged fee-for-service Medicaid clients while the Children's Basic Health Plan rates are based on the claims experience of all clients who are enrolled in the Children's Basic Health Plan.

Most importantly, the two populations have different demographics as far as age and income distribution that affects the overall average rates and would skew any comparison of the two.

Medicaid HMO costs

The AFDC-C rate of $63.83 is for children ages 1-18 in the Denver Metro area enrolled in Colorado Access. Newborns enrolled in Colorado Access are paid at a rate of $302.53 per member per month. The $63.83 for children ages 1-18 does not include mental health services that are paid under a separate capitation payment to the Behavioral Health Organizations (BHOs). For FY 05-06 the BHO rate for children for the Denver metro area ranges from $10.00

to $17.84. Therefore the total cost for HMO clients ages 1 to 18 is between $73.83 and $81.67 per member per month.

Children's Basic Health Plan HMO Costs

The Children's Basic Health Plan rates include mental health services, but do not utilize the same rate cells by age band. The FY 05-06 Children's Basic Health Plan HMO rate for children ages 2 through 6 is $73.11. The average rate for children ages 7-18 is $103.06. The average cost per child in the Children's Basic Health Plan for FY 05-06 based on the age and income distribution projected for that time period is $101.44 per member per month.

Managed Care vs. Fee for Service vs. Private Insurance

The Department was unable to find an informative pricing range for a comparable private group insurance package where the group consisted of children. Generally private insurance is packaged for families rather than for individual children.

55. Please explain why women in the CBHP prenatal program could not be added to the capitation rates for women served in the Medicaid HMO programs. For example, couldn't the Department contract with Colorado Access and Denver Health to provider prenatal services to both Medicaid and CBHP women. Please explain why the delivery rates for the CBHP prenatal program estimated at a higher rate than the delivery rates for the Colorado Access and Denver Health HMO programs?

RESPONSE:
If the Department combines only the Medicaid and Children's Basic Health Plan prenatal women, the continuity of care for the child and the mother would be compromised. The mother would receive services through a Medicaid delivery system while the newborn, Children's Basic Health Plan eligible, would receive services through a different delivery system.

The two programs' delivery rates are similar. The Children's Basic Health Plan delivery rate for FY 05-06 is $4,346.15. The Medicaid FY 05-06 delivery rate for Colorado Access is $4,108.16. The Medicaid FY 05-06 delivery rate for Denver Health is $4,440.10. Although the Children's Basic Health Plan prenatal rate is similar to the Medicaid rates, Medicaid has a larger pool of enrollees to spread the risk among the population that helps smooth out drastic year-to-year fluctuations in the rate. The Children's Basic Health Plan does not have enough members to achieve this.

56. Please provide the Committee with information on what month of pregnancy women enrolled into the CBHP prenatal care program in FY 2004-05.

RESPONSE:
At this time, the system cannot report this information and because presumptive eligibility places women in the program who sometimes do not deliver, the number of months pregnant at entry cannot reasonably be calculated.

57. How does the CBHP per member per month cost for dental costs compare to the monthly costs per child on the Medicaid program?

RESPONSE:
The FY 04-05 Children's Basic Health Plan appropriated per member per month rate for dental services was $11.31. The calculated per capita dental cost for Medicaid Eligible Children in FY 04-05 was $11.06 (November 15, 2005 FY 06-07 Budget Request: Exhibit M, page EM-2, $29,302,343 divided by Eligible Children caseload for FY 04-05, Exhibit B, at 220,592, then divided by 12).

These monthly dental amounts are not comparable. The Children's Basic Health Plan is structured on a preventive commercial model using pre-paid capitation rates with a $500 per year benefit maximum. The Children's Basic Health Plan contracts with a vendor to provide a defined benefit package with a fixed monthly rate per enrollee. The Children's Basic Health Plan dental program has a statewide defined network of over 1,047 dentists (85% of all licensed dentists in the State).

Medicaid tends to have lower reimbursement rates than the Children's Basic Health Plan and Medicaid clients are able to receive unlimited dental benefits through Early and Periodic Screening, Diagnosis and Treatment services. Medicaid pays dental care on a fee-for-service basis for any willing provider. Medicaid's cash based accounting creates additional differences when making a dental cost comparison with the accrual-based system of the Children's Basic Health Plan.

58. How satisfied is the Department with the CBHP administrator contract? When will this contract be rebid?

RESPONSE:
Performance of the Children's Basic Health Plan administrative contractor has improved and is now at a level that the Department feels is adequate. There is no longer a backlog of cases that are out of timely processing compliance.

The following table reports the actual success of the Children's Basic Health Plan administrative contractor in meeting performance standards around application processing:

Performance Standards	July 2005	August 2005	September 2005	October 2005	November 2005
95% of all applications shall be approved, denied or pended and notification sent to applicants within 45 days from the date of the receipt of the application.	97%	99%	97%	99%	99%
100% of applications shall be approved or denied and notifications sent to applicants within 45 days from the date of the receipt of the application.	99%	99%	99%	99%	(not yet available)

Note: These standards are for the contractor only, and do not apply to counties processing Children's Basic Health Plan applications.

The administrative contractor was initially awarded the contract in July 2003 for one year with the option for renewal for up to three additional one-year periods. This contract will end on July 1, 2007 and will have to be rebid prior to that date.

59. Does the Department have the statutory authority to pay the costs for wheelchairs for dual eligible clients and then bill Medicare later. If not, please describe the statutory changes that would be necessary for the Department to continue this process.

RESPONSE:
The Department does not have explicit state statutory authority or federal waiver approval to pay the costs for wheelchairs for dual eligible clients and then bill Medicare later. States are required to "cost avoid" with the exception of certain statutory exclusions or with an approved waiver to "pay and recover" from CMS. Colorado does not have an approved waiver to "pay and recover" or "pay and chase." The Department must comply with the cost avoidance requirements of 42 CFR 433.139 (b) (1), and reject claims that may be payable by a third party. It is only after a claim to a third party is denied that the Department may pay the claim.

Medicaid is the payer of last resort; therefore, when an individual is entitled to Medicare and eligible for Medicaid, Medicare, like any other third party, is the primary payer. Providers are required to bill Medicare, as the third party insurer, before submitting claims to Medicaid, unless it is evident that there is no Medicare eligibility or benefit coverage.

Several years ago the Department did pay wheelchair claims before those claims were submitted to Medicare for payment under the authority of a temporary verbal agreement between Medicaid and Medicare. This verbal agreement was made in order to safeguard the interests of dual eligible wheelchair clients and providers because Medicare was taking an excessive amount of time to pay. Investigation of this issue over the summer by the Department confirms that the majority of providers are currently billing Medicare first before submitting claims to Medicaid.

60. Please provide the Committee with the last five years of costs for providing wheelchairs, wheelchair components, and wheelchair repairs to dual eligible clients (broken out by

fiscal year). Please provide the Committee with information on how much the Department has recovered from Medicare for these claims.

RESPONSE:
The tables below detail the total reimbursement from Medicaid to providers for dual eligible wheelchair claims. The total third party liability payments are payments other parties have contributed to the claim. Those may be the result of Medicare paying before the bill was forwarded to Medicaid, or reflect recoveries.

Data from the previous four fiscal years shows an upward trend in third party liability payments. This may indicate that providers are correctly billing Medicare as the primary payer for wheelchairs.

Total Reimbursements from Medicaid to Providers for Dual Eligible Wheelchair Claims

Procedure Code Category	FY 01-02	FY 02-03	FY 03-04	FY 04-05
Wheelchair	$1,250,939	$1,432,475	$1,321,780	$890,832
Support Systems	$100,929	$191,766	$188,626	$122,350
Wheelchair accessories	$843,452	$948,239	$1,118,708	$805,483
Wheelchair replacement parts, attachments and labor*	$584,546	$750,048	$783,456	$865,206
Total	$2,779,866	$3,322,530	$3,412,569	$2,683,871

*Reimbursements – included in the numbers above but not necessarily wheelchair related

Total Payments from Liable Third Parties

Procedure Code Category	FY 01-02	FY 02-03	FY 03-04	FY 04-05
Wheelchair	$30,506	$76,705	$71,318	$119,923
Support Systems	$271	$3,325	$3,732	$5,492
Wheelchair Accessories**	$20,239	$13,537	$3,206	$45,095
Wheelchair replacements parts, attachments and labor**	$20,995	$20,995	$32,045	$22,039
Total	$72,011	$114,562	$120,301	$192,549

**TPL Payments – included in the numbers above but not necessarily wheelchair related

Data Analysis Notes:
(1) Wheelchair-related procedure codes identified via the annual DME Provider Bulletins (2000-2005).
(2) Some procedure codes, such as the E1340 repair code, also relate to other DME areas. These include X2975, A9999, E1399, X2115, K0462, and E1340.
It is not possible to identify which of these expenditures is definitely wheelchair related and which are not so the amounts contributed by these codes are also reported separately. For example, in FY 02-03 $750,048 in reimbursements were made for "Wheelchair replacement parts, attachments and labor". Of that amount $403,736 in reimbursements may or may not be wheelchair related.
(3) Dual eligibles defined as TPL codes 01 – 26 as reported on the claims.
(4) Claims categorized into fiscal years by date of payments.
(5) Procedure codes categorized into the four groups reported by the coding in the DME Provider Bulletins (e.g. E1037 categorized as Chair), if more than one category applied for different bulletins, the most recent bulletin's category was used.
(6) Data pulled from BOA 12/16/2005

61. Would it be possible for the State to recoup payments from Medicare for any pass

claims that were not submitted? Please describe any resources that the Department would need to pursue Medicare reimbursement for wheelchair claims?

RESPONSE:
There is a federal two year time limit on States to claim federal financial participation so the Department could only go back 24 months from the current quarter to bill Medicare for any claims that had not been submitted. It would not be possible for the State to recoup payments from Medicare for any claims older than two years. For claims that are within the two year time frame, it would be both costly and difficult to recoup payments from Medicare.

A federal waiver to "pay and recover" or "pay and chase" wheelchair claims for dual eligible clients can not be implemented retroactively. That leaves only two other options. One option would require the Department retract all previous payments, require the providers to bill Medicare directly, and then only pay those claims that were denied by Medicare. This option would be financially detrimental to the provider community. The other option would require the Department to enroll as a provider with Medicare's Durable Medical Equipment Regional Contractor (DMERC). Any request for enrollment by the Department would need to be approved by the Division of Medicare Operations at the Centers for Medicare and Medicaid Services.

In combination with the Department enrolling with DMERC, it would be necessary to identify which specific claims were for dual eligible clients of those claims that were billed as Medicaid only. This would be a labor-intensive activity and any potential reimbursement the Department could expect would be minimal. In general Medicare does not authorize the more expensive wheelchairs that we authorize for Medicaid only clients.

62. Please inform the Committee of the amount of third party recoveries the Department received in FY 2002-03, FY 2003-04, and FY 2004-05? What were the sources of the third party recoveries?

RESPONSE:

Recovery Type	FY 02-03	FY 03-04	FY 04-05	Total
Estate Recoveries*	$3,878,211	$4,281,906	$4,918,434	$13,078,551
Tort/Casualty*	$2,896,459	$2,114,750	$3,072,422	$8,083,631
Trusts/Recoveries	$877,556	$1,449,835	$1,766,756	$4,094,147
Post Pay Recoveries*	$5,854,567	$11,512,388	$7,881,430	$25,248,385
Total	$13,506,793	$19,358,879	$17,639,042	$50,504,714

* The contractor's contingency fee has been removed from the recovery amounts.

The Department provides recoveries annually in its program crosswalks. FY 02-03 can be found on page 63 in the FY 04-05 Budget Request, volume 2; FY 03-04 can be found on page 53 in the FY 05-06 Budget Request, volume 2; FY 04-05 can be found on page 49 in the FY 06-07 Budget Request, volume 2. The following describes the four recovery types listed above.

Estate Recovery

The Estate Recovery program, operated by a contractor under supervision of State staff, recovers funds from estates and places Tax Equity and Financial Responsibility Act of 1992 liens on real property held by Medicaid clients in nursing facilities. This program is a federally mandated program that requires the State to recover the cost of benefits paid on behalf of a Medicaid client from their estate. The Contractor places liens on property owned by the Medicaid client if it has been determined that this individual is unlikely to return home from a nursing facility. In addition, upon the death of certain Medicaid clients, the contractor files a claim against the estate of this client for the Medicaid benefits paid on their behalf.

Tort/Casualty Recovery

The Medicaid program attempts to recover payments made by third parties who are liable as insurers in the case of auto, accident, homeowner's policies, worker's compensation, or through tort litigation. The Department seeks recovery from statutory liens it has on Medicaid client settlements.

In addition, a contractor works with the Department staff, on a contingency fee basis, to pursue tort recoveries previously unknown to the Department, as well as assume the responsibility for the non-reported Worker's Compensation cases that are listed on a quarterly report.

Trust Recovery

Income and disability qualifying trusts provide a mechanism for individuals, whose incomes and/or assets would otherwise make them ineligible, to qualify for Medicaid. For income trusts, the client's income, minus a small personal needs amount, is placed in a trust. Disability trusts are created from settlement agreements that provide an income source for the client for non-Medicaid services. The Medicaid program pays for a client's medical care and is the beneficiary of the trust monies when the trust closes.

Post Pay Recoveries

Third party liability post-pay recovery utilizes a contractor to recover the cost of benefits paid on behalf of a Medicaid client where a third party was liable for these payments. This post-pay recovery contract encompasses several separate and distinct recovery programs. The Contractor administers the following post-pay recovery projects under this contract including the following:

- Medicare recoveries
- Commercial insurance recoveries
- Provider retractions
- Cost avoidance

The State, through its fiscal agent, retracts the value of Medicaid-paid claims if a third party is later identified as a primary payer. These recoveries, known as credits or retractions, are

collected from providers when other health coverage is discovered subsequent to payment by the Medicaid program.

63. Please describe the process the Department uses in determining whether seeking recovery of reimbursement from third party payors is cost effective.

RESPONSE:
Third party liability post-pay recovery utilizes a contractor to recover the cost of benefits paid on behalf of a Medicaid client where a third party was liable for these payments. The contractor is paid a contingency fee based on the amount actually collected. These recoveries, known as credits or retractions, are collected from providers when other health coverage is discovered subsequent to payment by the Medicaid program. The recoveries of claims, from providers or third party liability carriers, are not pursued when the claim value is less than $10.00.

Third party liability tort and casualty attempt to recover payments made by third parties who are liable as insurers in the case of auto, accident, homeowner's policies, worker's compensation, or through tort litigation. The Department does not seek recovery from statutory liens for recovery cases under $300.

4:30 PM – 5:00 PM – MMIS Reprocurement and Closing Comments

64. Please explain why the Department was unable to hire the consultant during FY 2004-05, even though the Committee gave the Department the authority to do so in June 2004? Why did it take the Department over a year to hire the consultant? Why did the Department revert over 98 percent of the supplemental funding that was provided by the General Assembly to begin this reprocurement process in FY 2004-05?

RESPONSE:
With the intended production of Colorado Benefit Management System (CBMS) in December 2003, the Department had every intention to hire the MMIS Reprocurement consultant effective June 2004. Even with the revised CBMS production dates of April and then June 2004, the Department stayed the course in its intent to hire by the end of FY 03-04. The Department acknowledges that resource overload and changing priorities caused a delay in a timely procurement of the consultant. The Department has adjusted its focus and is committed to proceed in a timelier manner.

65. Please update the Committee on CMS's response to the Department's request to extend the reprocurement deadline or delay the penalties for missing the deadline? Please discuss the Department's calculations for the impact to the state if CMS does not extend the reprocurement deadline or delay the penalties for missing the reprocurement deadline?

RESPONSE:
In response to the Department's letter dated September 5, 2005, the Centers for Medicare and Medicaid Services' Regional Office has requested information regarding the costs associated with extending the current fiscal agent contract through July 2007. The Department provided the

required information on November 23, 2005, and is awaiting the Centers for Medicare and Medicaid Services response. CMS has indicated they are recommending a one year extension to the CMS Central Office who will make the final decision. Calculations of the impact for delay are provided in the Department's November 15, 2005 Budget Request, DI-6. It is possible that further delays could lead to reduced federal financial participation.

66. Please discuss the current status of the reprocurement process. Has CMS approved the consultant contract?

RESPONSE:
The Centers for Medicare and Medicaid Services approved the Advanced Planning Document and enhanced federal financial participation for the procurement process on November 2, 2004. The Department posted the Request for Proposals on September 16, 2005, the notice of intent of award on November 18, 2005, and formally awarded the contract on December 1, 2005 to the selected procurement consultant. The contract for the consultant (Public Knowledge, LLC) is currently in the clearance process within the Department. The Governor's Office of Innovation and Technology and the Centers for Medicare and Medicaid Services have both been provided copies of the contract for required pre-approval. Once the contract has been executed Public Knowledge will begin work.

67. The Department's original schedule for the MMIS reprocurement allowed the consultant up to seven months to develop the RFP for the MMIS contract. The Department's revised schedule will only allow the consultant approximately four months to develop the RFP. Given the complexities involved, is this time frame realistic? Please explain why the time frame can be shortened for issuing the RFP? Will the RFP be complete enough to ensure accurate responses from vendors?

RESPONSE:
We believe that Public Knowledge will be able to develop a Request for Proposals in the four-month timeframe. The Public Knowledge staff assigned to the Colorado account has recent experience developing MMIS fiscal agent reprocurement Request for Proposals for several of the surrounding states. The Public Knowledge team has contacted those states and obtained copies of their Request for Proposals to aid them in developing the Colorado Request for Proposals. This information will serve as a template and should therefore help to facilitate the publication within the planned time frame. Secondly, the Public Knowledge team is quite familiar with the existing Colorado MMIS and fiscal agent operations. The Public Knowledge team provided quality assurance for the Department on the Health Insurance Portability and Accountability Act of 1996 implementation, beginning in 2002. The Department originally anticipated that a large amount of time would be necessary to analyze and document the requirements of major system enhancements and is aware that unexpected developments may cause delay. By reducing the number of enhancements expected by a new fiscal agent, the Department is expecting to save some time from original estimates.

68. If a new contractor is selected, is it reasonable to assume that the transition to a new contractor can be complete by July 2007?

RESPONSE:
The Department expects that it will take 11-12 months to perform the transition of the MMIS and fiscal agent operations. CMS states it also believes this should be appropriate. When the bidding vendors respond to the State's Request for Proposals, the Department will have a better handle on the timeline the vendors feel will be appropriate. There are always risks and unforeseen events that could impact any project. The Department is aware of several federal regulations that will need to be handled in parallel, as well as several State regulations and programs that must be implemented between now and July 2007. We have underscored the importance of a transition by the July 2007 deadline to Public Knowledge. They have given us their assurance that they will assist us in achieving this goal.

69. Please describe any ongoing problems between the current MMIS and CBMS.

RESPONSE:
As discussed in question number 6, the Department is working with the Office of CBMS and Electronic Data Systems to improve data integrity in CBMS so that the interfaces can deliver accurate, quality data to MMIS.

70. Does the Department have adequate staff resources to ensure that the Medicaid program is managed effectively and efficiently?

RESPONSE:
In a January 23, 2001 Budget Request Amendment (page 147, #1A, "Request for 10.0 FTE for workload associated with Department administration), the Department responded to a general Joint Budget Committee (JBC) concern about the staffing in the Department. In fact, the issues of staffing raised at the December 19, 2005 Health Care Policy and Financing Joint Budget Committee Briefing sounded very similar to those raised by the Committee at the Department's December 20 and 21, 2000 Hearing. In the Budget Request Amendment, the Department requested 10.0 FTE to address general staffing needs related to the increasing workload of the Department. The Joint Budget Committee approved this request (FY 01-02 Appropriations report, page 98).

But shortly after, as part of its 4% Reductions in FY 02-03, SB 03-203 reduced $340,754 from Personal Services and 5.70 FTE (Joint Budget Committee Staff Supplemental Briefing, January 17, 2003, page 3). This was similar to reductions all Departments experienced in the budget crisis. Nonetheless, the action reversed the relief that was granted in FY 01-02.

Although the second largest Department in terms of total funds at $3.4 billion appropriated in FY 05-06 (Governor Bill Owens' letter to the Joint Budget Committee, November 15, 2005), the Department is fourth from last in FTE (FY 05-06 JBC Appropriations Report, page 22), using just 0.44% of its FY 05-06 appropriation for Personal Services. We believe that the reason staffing is mentioned rather frequently for the Department is for two basic reasons. The first is the growth that is seen in this budget does not nearly mark to increases in staffing. Over time, the strain on programs and support functions such as accounting, budget, customer service, and information technology increases as clients increase, providers increase, programs increase, federal scrutiny increases, dollars increase, and calls increase. However, staffing adjustments for

this volume are not routinely considered. The second reason is that because a budget of this size drives much attention from the Joint Budget Committee staff, the strain on the Department's Budget staff is apparent. This strain, however, is much more related to the schedule of deliverables required October through January than the staffing levels. Indeed, with the extension of the main Budget deliverable on November 15 this year, the Department lost two of its three weeks to prepare Supplemental Requests. The schedule that is set up creates tremendously competing demands. In fact, despite staff comments, the Department's Budget Director Positions have been very stable in the last 15 years, but this has not reduced the work required during this peak time.

The Department does agree that, at a minimum, the restoration of the 5.7 FTE would assist the Department in applying additional resources in some key areas. In addition, the Department is working to better use its vacancy savings to ensure that all the current resources are appropriated are used to their maximum, even when turnover increases the number of positions that are open at some point during the year.

The Department believes that the most significant staffing resource issue is directly related to staff turnover. The Department has experienced the retirement of several long-tenured staff and has found it difficult to compete with an improved economy in retaining promising young talent and recruiting new hires. The Department's programs are complex and serve as an excellent training ground for the health care industry, and successful candidates for mid and higher level positions are typically internal candidates due to their knowledge and experience. This creates an ongoing cycle of vacancies that are currently more challenging to fill.

71. Please state the Department's position for cutting the funding for the safety net provider payment program and the pediatric speciality hospital line item.

RESPONSE:
The Department values the ongoing funding for indigent care, including private hospitals and The Children's Hospital. The funding issues are to be presented to the Joint Budget Committee later this month as a Stand Alone Budget Amendment.

72. Staff Issue: State Funding for Early Intervention Services for Children with Disabilities Please respond to the staff recommendation that the JBC sponsor legislation to improve the provision of early intervention services for newborns and toddlers under the age of 3. Does the Department of Health Care Policy and Financing support the proposal?

RESPONSE:
The Department feels that adequate research would need to be performed to identify possible options to improve the provision of services prior to drafting a legislative proposal. The Department supports the appropriate provision of early intervention services to newborns and toddlers under the age of three to the extent that those services are medically necessary and meet all the Centers for Medicare and Medicaid Services requirements for being considered medical assistance under the Medicaid program.

73. Staff Issue: Developmental Disability Services: Self-determination and Waiver Issues Provide an overview, from the HCPF perspective, of the current discussions with the federal Centers for Medicare and Medicaid Services (CMS) about Colorado's compliance with federal Medicaid waiver requirements for the developmental disability home- and community-based waivers.

RESPONSE:
The Department received federal approval for the renewal of the Home and Community Based Services waiver for Adults with Developmental Disabilities (HCBS – DD) on September 24, 2004 with an effective date of July 1, 2004. Prior to granting that waiver approval, an audit was conducted by the Centers for Medicare and Medicaid Services in early 2004 with the final audit report issued in April 2004. The audit included concerns over the health and welfare of waiver participants, qualified providers, and financial accountability. Final waiver renewal approval was contingent upon having all concerns addressed and corrected.

On November 30, 2005 CMS sent a letter to the Department asking for confirmation that all concerns found in the audit and the waiver renewal conditions had been addressed. This request is not unusual and the response is due to CMS on January 9, 2006. Federal officials met with staff from both the Department of Health Care Policy and Financing and the Department of Human Services on December 16, 2005 to identify areas of concern and get a sense of which issues have been corrected and which issues remain outstanding. The Department is working with the Department of Human Services to submit the January 9, 2006 response.

Issues that remain outstanding center on financial accountability, which includes unbundling of rates, assuring Medicaid is the payer of last resort, and wait list management. Federal staff expressed a willingness to continue working collaboratively with the Departments so long as they were honest about issues remaining and could commit to a timely resolution of those issues. The Departments will present a plan of correction and the timelines for implementation in the January 9, 2006 response.

74. What are the implications for changes to the current developmental disability waiver programs? To what extent do you anticipate that changes pursued by CMS will move the State away from Colorado's current system, which offers considerable local flexibility in developing and managing care for people with developmental disabilities?

RESPONSE:
It would be naïve to assume that greater accountability for Medicaid funds will not result in changes to the current developmental disability waiver programs. The financial accountability is a key issue for federal staff. It is the Department's current understanding that Community Centered Boards (CCBs) are given a fixed amount of money allocated to clients in their service area and that direct service providers are reimbursed by the CCBs. This funding mechanism potentially allows for these funds allocated to the CCBs to be presented as "claims" for federal match even if care to be "reimbursed" at the claimed amount has not yet been rendered to a Medicaid eligible client. The Department's understanding has been reinforced by the challenges in getting mandated federal reports on actual services provided and client numbers for the waivers for developmental disabilities.

The most straight forward manner to address the federal financial accountability concerns would be to have providers of waiver services bill claims directly, rather than having the Community Centered Boards bill on their behalf. Such direct billing will continue to allow local flexibility in developing and managing care because the CCBs would remain the case management agency that develops the individual's plan of care, calculates cost containment figures, assures their clients are receiving the services needed and is involved in provider quality assurances. The local flexibility that would be lost is financial.

If there is a need for particular Medicaid reimbursement rates to be reflective of individual client service intensity, rates may be set to accommodate that need. As an example, the Residential Habilitation reimbursement rate could have up to three levels that would correspond to the level of intensity of supervision a client needs.

An additional benefit of direct billing is that the Medicaid claims processing system (MMIS) could be used to ensure that Medicaid funds are only spent after all third party resources have been exhausted. The Department's Medicaid data shows that 55% of clients on Developmentally Disabled waivers have a third party payer source. Other states use such offsets to allow a greater number of clients to be served, thereby decreasing the waiver waiting lists.

75. Do the Departments of Human Services and Health Care Policy and Financing have a plan for dealing with CMS on this issue?

RESPONSE:
The Department will continue to work collaboratively with the Department of Human Services and the Centers for Medicare and Medicaid Services to appropriately address all concerns to ensure continued federal financial participation.

76. Please respond to concerns raised in the JBC staff issue on apparent mis-communication between the Department of Human Services and Health Care Policy and Financing regarding the implications of HB 05-1243 for the Department of Human Services' self-determination initiative.

RESPONSE:
The Department had been provided with a draft of the Department of Human Services' self-determination initiative during 2004. Late in 2004 the Department met with members of various stakeholder organizations prior to the introduction of HB 05-1243 at stakeholder request. During those meetings stakeholders indicated a strong interest in making sure that waiver programs for persons with developmental disabilities not be excluded from any legislative initiative to authorize an expansion of consumer direction in Medicaid. Based upon the draft document and conversations with stakeholders the Department concluded that the consumer direction to be authorized under HB 05-1243 was complementary to the self-determination initiative and represented the most independent end of the self-determination continuum.

The Department communicated this conclusion to Department of Human Services' staff and members of stakeholder organizations, including the Community Centered Boards, family members and advocates on numerous occasions prior to, during and after the 2005 legislative

session. The Department worked with those stakeholders to address concerns. The Department will continue to work with all stakeholders on each waiver program amendment to add consumer direction as a benefit is submitted for federal approval.

77. Closing Comments.