

Health Care — Medicaid, Children's Health Insurance Program, Indigent Care, and Mental Health

Department of Health Care Policy and Financing

Department Overview. The Department of Health Care Policy and Financing (DHCPF) helps pay medical and long-term care expenses for low-income and vulnerable populations. To assist with these costs the Department receives significant federal matching funds, but must adhere to federal rules regarding program eligibility, benefits, and other features, as a condition of accepting the federal money. The major programs administered by the DHCPF include:

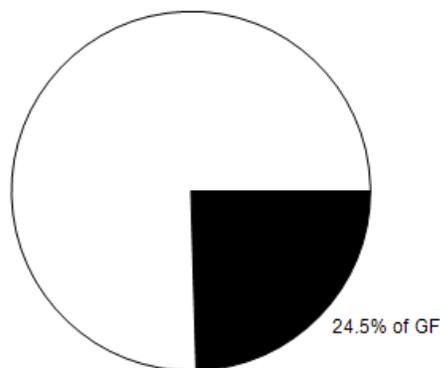
- **Medicaid** – serves people with low incomes and people needing long-term care;
- **Children's Basic Health Plan** – provides a low-cost insurance option for children and pregnant women with incomes slightly higher than the Medicaid eligibility criteria;
- **Colorado Indigent Care Program** – defrays a portion of the costs to providers of uncompensated and under-compensated care for people with low incomes, if the provider agrees to program requirements for discounting charges to patients on a sliding scale based on income; and
- **Old Age Pension Health and Medical Program** – serves elderly people with low incomes who qualify for a state pension but do not qualify for Medicaid or Medicare.

The DHCPF also performs functions related to improving the health care delivery system, including advising the General Assembly and the Governor on health care issues, distributing tobacco tax funds through the Primary Care and Preventive Care Grant Program, financing Public School Health Services, and housing the Commission on Family Medicine Residency Training Programs.

General Factors Driving the Budget

Total funding to the DHCPF in FY 2012-13 is about \$5.5 billion, of which 49.8 percent is federal funds, 33.4 percent is General Fund, 16.6 percent is cash funds, and 0.1 percent is reappropriated funds. As shown in Figure 1, the DHCPF receives about one-quarter of all state General Fund. The major sources of cash funds include: (1) hospital and nursing facility provider fees; (2) tobacco taxes and tobacco settlement funds; (3) local government funds (certified public expenditures); (4) recoveries and recoupments; and (5) sales taxes diverted to the Old Age Pension Health and Medical Care Fund. Federal Funds are appropriated as matching funds to the Medicaid program (through Title XIX of the Social Security Administration Act) and as matching funds to the Children's Basic Health Plan programs (through Title XXI of the Social Security Administration Act). A description of the major health care program and the factors driving the DHCPF budget are discussed below.

Figure 1
Percent of General Fund Appropriated to the
Department of Health Care Policy and Financing

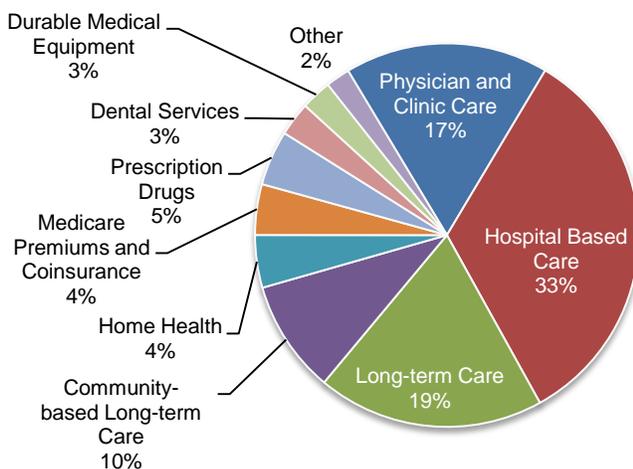


Medicaid

Medicaid provides health care to people with low incomes and people needing long-term care. Generally, the federal government pays 50.0 percent of the cost of the Medicaid program and state funds must provide the remaining 50.0 percent as a match, although the rate can change over time, and there are exceptions for specific services and populations that receive a higher federal contribution. Medicaid expenditures are usually discussed and budgeted in four distinct chunks: (1) Medical Service Premiums; (2) Mental Health Community Programs; (3) the Indigent Care Program; and (4) programs administered by other departments.

Medical Service Premiums. Medical Service Premiums pay for physical health and long-term care services. Expenditures for Medical Service Premiums are driven by the number of clients, the amount of services each client uses, and the cost per unit of service. Figure 2 below shows typical expenditures by service category for Medical Service Premiums.

Figure 2
Medical Service Premiums FY 2011-12



Enrollment and Eligibility. Medicaid enrollment has increased significantly in recent years because of increases in the state population, economic conditions that impact the number of people who meet the income eligibility criteria, and policy changes at the state and federal level regarding eligibility. Figure 3 below shows the actual and forecasted Medicaid population. The "CO Population Trendline" shows the trajectory if Medicaid enrollment had grown at the same rate as Colorado's population since June 1996. The "Unemployment Rate" graphed on the right axis shows the relationship of Colorado's unemployment rate to Medicaid enrollment. Historically, changes in Medicaid enrollment have lagged changes in Colorado's unemployment rate.

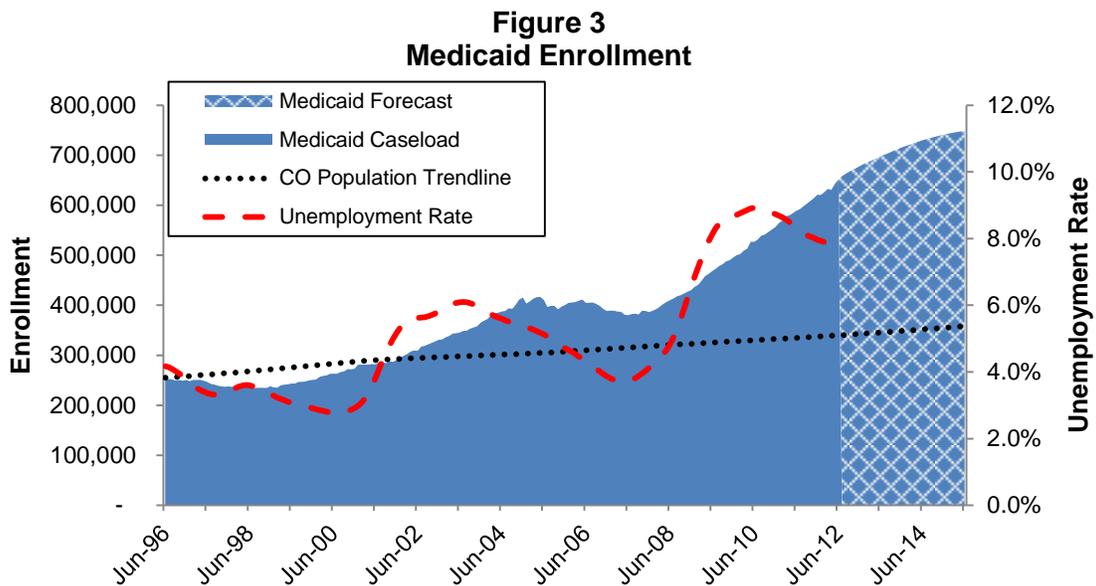


Figure 4 summarizes current eligibility criteria for Medicaid and other state-financed health care programs.¹ Colorado's Medicaid eligibility criteria are at or near the minimums required by federal law, except for certain populations where the state match is financed with a Hospital Provider Fee instead of General Fund. Table 1 provides an example of the income levels associated with different percentages of the federal poverty level.

¹ Note that eligibility for some of the programs is based on standards other than the federal poverty guidelines, such as eligibility for federal Supplemental Security Income (SSI), and these alternate standards have been converted to a percentage of the federal poverty guidelines for these charts. Also, note that the treatment of assets, the income of relatives, and other elements of the eligibility calculation can vary significantly between eligibility categories.

Figure 4

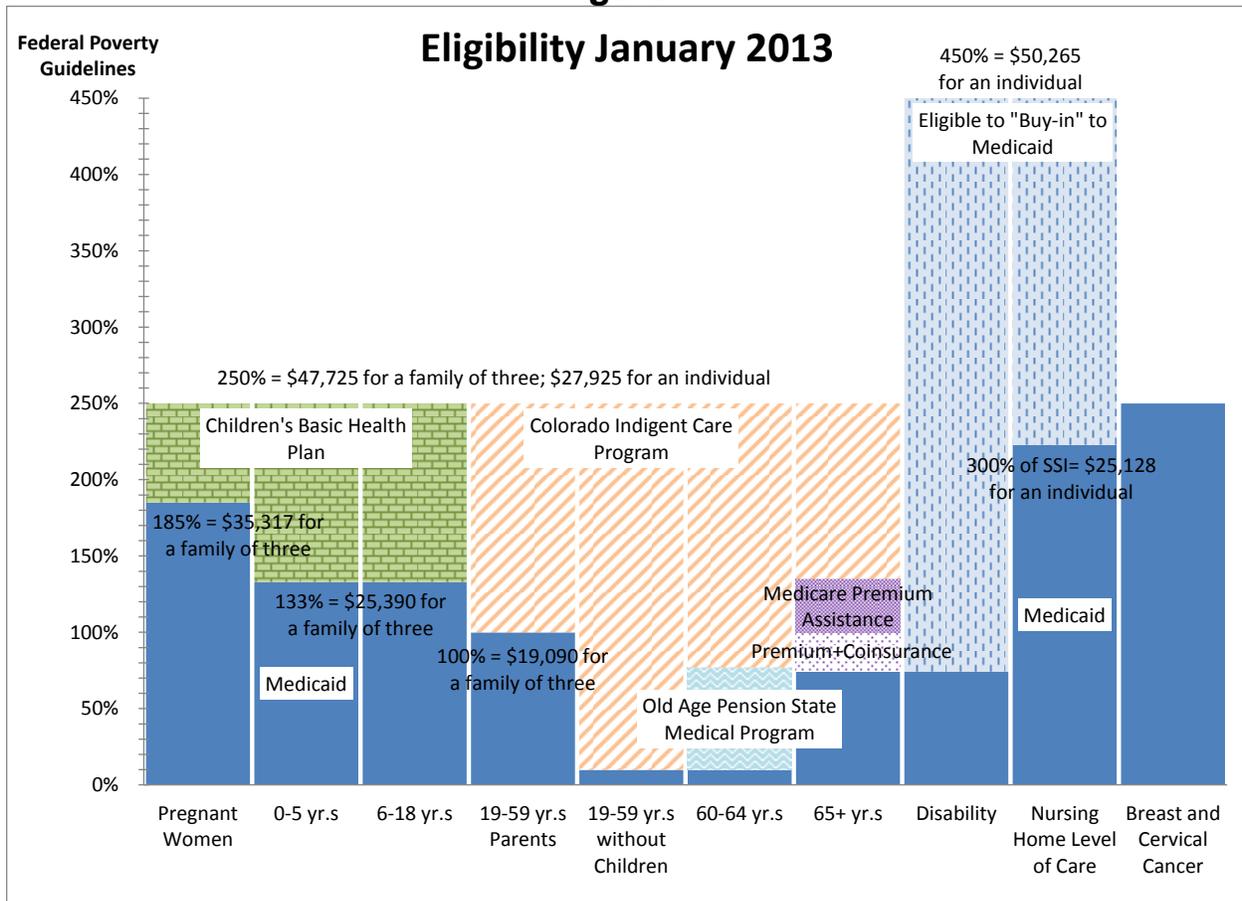
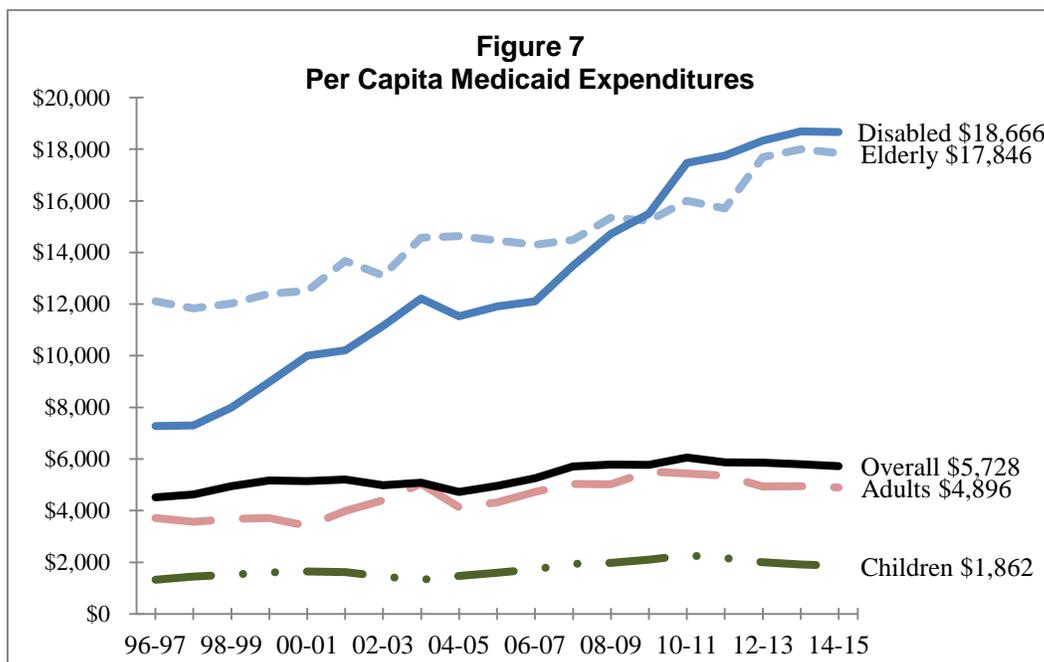
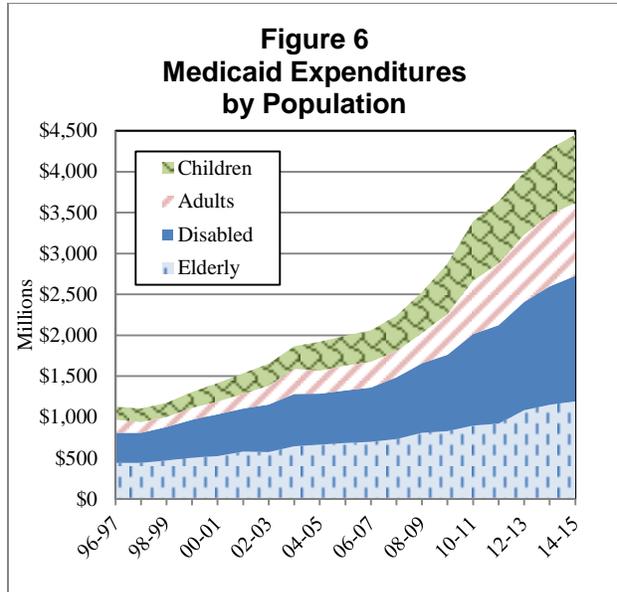
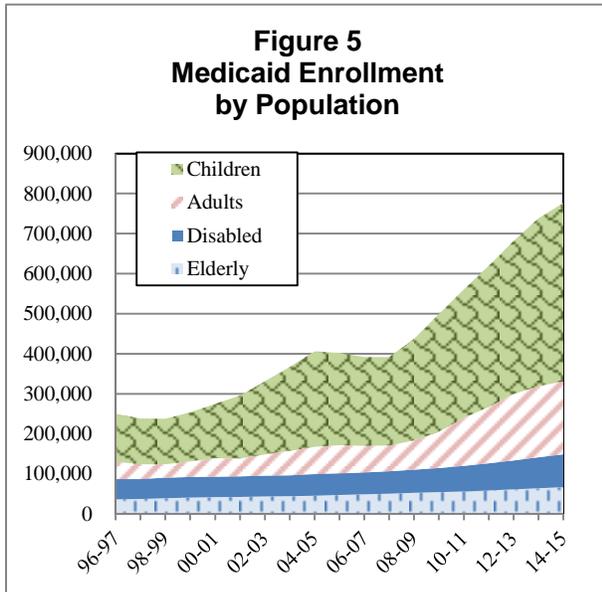


Table 1
The 2012 Poverty Guidelines for the
48 Contiguous States and the District of Columbia

Family Size	Percent of poverty guideline									
	10%	75%	75%	100%	133%	185%	225%	250%	400%	450%
	AWDC	SSI	OAP		ACA	Pregnant	300% SSI	CHP+	Tax Credits	Buy-in
1	\$1,117	\$8,376	\$8,388	\$11,170	\$14,856	\$20,665	\$25,128	\$27,925	\$44,680	\$50,265
2	\$1,513	\$11,345	\$11,362	15,130	\$20,123	\$27,991	\$34,036	\$37,825	\$60,520	\$68,085
3	\$1,909	\$14,315	\$14,335	19,090	\$25,390	\$35,317	\$42,945	\$47,725	\$76,360	\$85,905
4	\$2,305	\$17,284	\$17,309	23,050	\$30,657	\$42,643	\$51,853	\$57,625	\$92,200	\$103,725
5	\$2,701	\$20,254	\$20,283	27,010	\$35,923	\$49,969	\$60,762	\$67,525	\$108,040	\$121,545
6	\$3,097	\$23,223	\$23,257	30,970	\$41,190	\$57,295	\$69,670	\$77,425	\$123,880	\$139,365
7	\$3,493	\$26,193	\$26,230	34,930	\$46,457	\$64,621	\$78,578	\$87,325	\$139,720	\$157,185
8	\$3,889	\$29,162	\$29,204	38,890	\$51,724	\$71,947	\$87,487	\$97,225	\$155,560	\$175,005

Medical Costs and Utilization. In addition to increased costs from caseload growth, the Medicaid budget also grows as a result of higher medical costs and greater utilization of medical services. Costs for the elderly and people with disabilities have risen faster relative to the enrolled population than expenditures for children and adults. Figures 5 and 6 compare the total enrollment and costs by population. In recent years, the overall per capita cost for Medicaid has decreased slightly as the growth in program caseload has mainly been for lower cost clients (children and their parents) rather than higher cost clients (the elderly and disabled). Per capita expenditures are influenced by case mix, utilization of services, and the price of those services. In addition, recent provider rate reductions have also lowered the per capita costs per client. Figure 7 shows the trends in per capita costs by population.



Mental Health Community Programs. Medicaid mental health community services throughout Colorado are delivered through a managed care or "capitated" program. Under capitation, the State pays a regional entity - a Behavioral Health Organization (BHO) - a contracted amount (per member per month) for each Medicaid client eligible for mental health services in the entity's geographic area. The BHO is then required to provide appropriate mental health services to all Medicaid-eligible persons needing such services.

The rate paid to each BHO is based on each class of Medicaid client eligible for mental health services (e.g., children in foster care, low-income children, elderly, disabled) in each geographic region. Under the capitated mental health system, changes in rates paid, and changes in overall Medicaid eligibility and case-mix (mix of types of clients within the population) are important drivers in overall state appropriations for mental health services. Capitation represents the bulk of the funding for Medicaid mental health community programs.

Table 2 provides information on the recent expenditures and caseload for Medicaid mental health capitation.

Table 2
Medicaid Mental Health Capitation Funding

	FY 2009-10 Actual	FY 2010-11 Actual	FY 2011-12 Actual	FY 2012-13 Appropriation	FY 2013-14 Request ³
Capitation Funding ¹	\$226,620,818	\$249,352,665	\$273,376,614	\$312,580,712	\$347,855,029
Annual Dollar Change	\$10,759,881	\$22,731,847	\$24,023,949	\$39,204,098	\$35,274,317
Annual Dollar % Change	5.0%	10.0%	9.6%	14.3%	11.3%
Caseload ²	479,185	540,456	598,322	664,441	712,810
Annual Caseload Change	61,435	61,271	57,866	66,119	48,369
Annual Caseload % Change	14.7%	12.8%	10.7%	11.1%	7.3%

1) Does not include the fee-for-service payments.

2) Not all Medicaid caseload aid categories are eligible for mental health services. The caseload reported in this table does not reflect the Partial Dual Eligible or non-citizen aid categories.

3) Does not include the request to add the substance use disorder benefit to the capitation program.

Indigent Care Program. The Indigent Care Program distributes Medicaid funds to hospitals and clinics that have uncompensated costs from treating uninsured or underinsured Coloradans. Unlike the rest of Medicaid, this is not an insurance program or an entitlement. Funding for this program is based on policy decisions at the state and federal levels and is not directly dependent on the number of individuals served or the cost of the services provided. The majority of the funding is from federal sources. State funds for the program come from certifying public expenditures at hospitals, the Hospital Provider Fee, and a small General Fund appropriation.

Programs Administered by Other Departments. The DHCPF transfers Medicaid money to the Department of Human Services for long-term care services to people with disabilities, mental health services provided to people in youth corrections, child welfare services, the mental health institutes, and Medicaid's share of the Colorado Benefits Management System, as well as to the Department of Public Health and Environment to pay for the regulation of long-term care settings. The money is first appropriated to the DHCPF and then transferred to the administering departments to comply with federal regulations that one state agency receive all federal Medicaid funding. Table 3 below provides size of transfers of Medicaid funds to other departments.

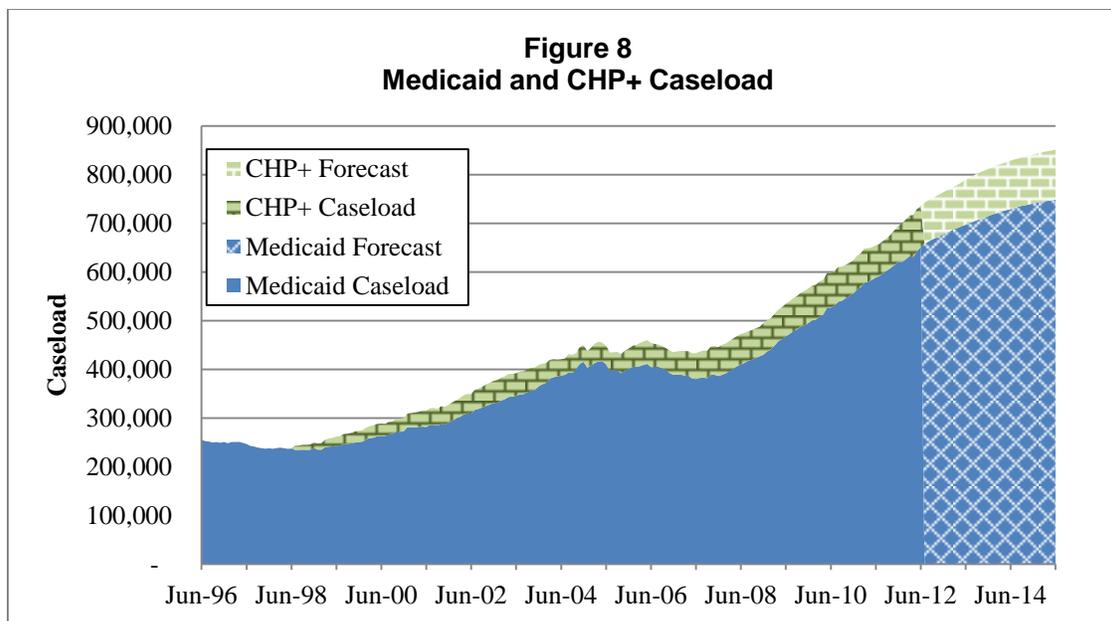
**Table 3
Medicaid-Funded Programs Administered by Other Departments**

Program	FY 2010-11 Actual	FY 2011-12 Actual	FY 2012-13 Appropriation	FY 2013-14 Request
Department of Human Services				
Services for People with Disabilities	\$397,375,911	\$383,811,656	\$392,574,009	\$416,545,638
IT/Maintenance/Admin.	20,230,844	20,225,719	41,841,374	32,484,228
Child Welfare	12,324,356	11,085,184	14,426,342	14,640,741
Mental Health Institutes	6,350,043	6,432,434	7,827,548	7,859,288
Youth Corrections	2,602,242	1,506,706	1,632,783	1,656,589
Department of Public Health and Environment				
Regulation of long-term care facilities	4,707,033	4,671,998	5,205,465	5,372,914
TOTAL	\$443,590,429	\$427,733,697	\$463,507,521	\$478,559,398

Children's Basic Health Plan¹

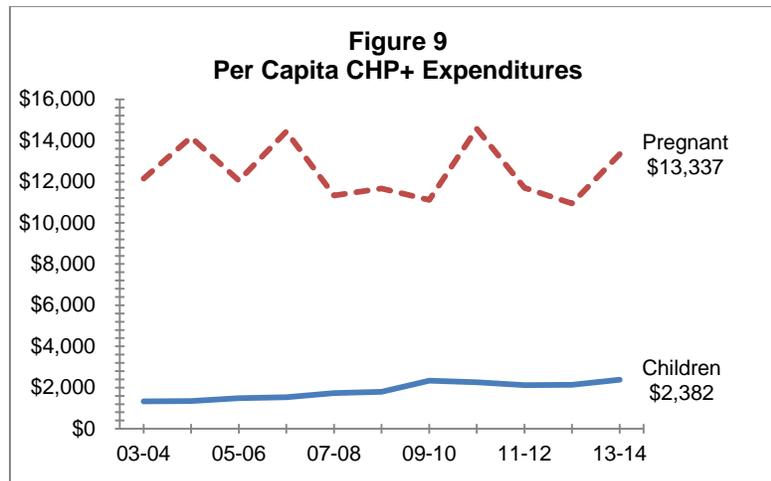
The Children's Basic Health Plan (CHP+) compliments the Medicaid program, providing low-cost health insurance for children and pregnant women in families with slightly more income than Medicaid eligibility criteria allows. Annual membership premiums are variable based on income, with an example being \$75 to enroll one child in a family earning 205 percent of the federal poverty guidelines, and coinsurance costs are similarly nominal. Federal funds pay 65 percent of the program costs not covered by member contributions and state funds pay the remaining 35 percent as a match. CHP+ typically receives approximately \$28 million in revenue from the tobacco master settlement agreement and the remaining state match comes from the General Fund.

Enrollment in CHP+ is highly changeable, in part because eligibility for the program is sandwiched between an upper income limit and a lower income limit below which an applicant is eligible for Medicaid and not eligible for CHP+. In addition, the program has experienced frequent adjustments to state and federal eligibility criteria and to administrative procedures for handling eligibility determinations that have impacted enrollment. Figure 8 below shows CHP+ enrollment in relation to Medicaid.



¹ What's in a name? The Children's Basic Health Plan (CBHP) is the state statutory name for Colorado's version of the federal Children's Health Insurance Program (CHIP), which was formerly called the State Children's Health Insurance Program (SCHIP). The federal program was recently renewed in the Children's Health Insurance Program Reauthorization Act (CHIPRA). From the beginning the DPCPF has marketed the state program as the Child Health Plan *Plus* (CHP+), based on feedback from advocates that this name would promote enrollment, reduce potential stigma associated with receiving public assistance, and differentiate the program from Medicaid. Thus, legislators may see or hear the program referred to as CBHP, CHIP, SCHIP, CHIPRA, or CHP+, but NOT Dr. Dynasaur, which is the name of the program in Vermont.

Figure 9 below shows per capita expenditures for CHP+. Note that the total number of pregnant women enrolled is relatively small, contributing to the annual variability in per capita expenditures.



Affordable Care Act

The federal Patient Protection and Affordable Care Act and amendments to the law in the Health Care and Education Reconciliation act of 2010, known collectively as the Affordable Care Act (ACA), contain five major provisions with ramifications for Colorado's publicly funded health care:

- Expand Medicaid coverage to former foster children between the ages of 21 and 26 and to people with incomes up to 133.0 percent of the federal poverty guidelines for all people under the age of 65, effective January 2014;
- Require states to maintain at least the eligibility criteria in effect during March 2010 through (1) January 2014 for adults on Medicaid, and (2) September 2019 for children on Medicaid or the Children's Health Insurance Program;
- Provide enhanced federal match rates for primary care services and for newly eligible Medicaid populations;
- Require individuals above federal tax filing income thresholds to obtain minimum essential health care coverage or pay a tax penalty; and
- Provide tax credits to individuals below 400 percent of the federal poverty guidelines for purchasing insurance through a health exchange, and to small employers for offering qualified health plans.

Although the ACA calls for Medicaid eligibility expansions, a recent Supreme Court ruling found that states cannot be denied participation in the Medicaid program for choosing not to implement the expansions.

The Medicaid eligibility expansions called for by the ACA are eligible for an enhanced federal match rate. Colorado has already partially implemented some of the required expansions with financing from the Hospital Provider Fee. The DHCPF's budget request assumes these partially implemented expansions are also eligible for the enhanced match rate, whether or not the state decides to implement the remainder of the eligibility expansions.

Table 4
Enhanced Federal Match
Rate for Newly Eligible Populations

Year	Rate
2014 - 2016	100.0%
2017	95.0%
2018	94.0%
2019	93.0%
2020+	90.0%

The ACA also made numerous changes to private insurance regulations, including:

- Limiting the ability of private insurers to deny coverage based on pre-existing conditions or lifetime or annual benefit maximums;
- Requiring private insurers to cover children up to age 26;
- Limiting co-insurance charges;
- Requiring that at least 85% of premiums be used to pay claims (80% in small group markets);
- Requiring standardized reporting of benefits to facilitate comparison shopping;
- Establishing appeals procedures for claims; and
- Redistributing funds among insurers if an insurer's actuarial risk of enrollees is less or more than the average risk of all enrollees of all plans in the state.

Legislative Staff Contacts

Joint Budget Committee Staff

Eric Kurtz – Medical Service Premiums (303-866-4952)

Kevin Niemand – Mental Health Community Programs (303-866-4958)

Legislative Council Staff

Bill Zepernick – Fiscal Notes (303-866-4777)

Kerry White – Fiscal Notes (303-866-3469)

Office of Legislative Legal Services

Brita Darling – (303-866-2241)

Debbie Haskins – (303-866-2313)

Jerry Barry – (303-866-4341)