AGENDA
FY 2008-09 Joint Budget Committee Hearing
Commission on Family Medicine

Friday -- December 14, 2007
10:00 a.m. to 11:00 a.m.

Friday -- December 14, 20076

Commission on Family Medicine
(10:00 a.m. to 10:15 a.m)

1. Introductions and Opening Comments from Commission Director

Goals and Performance of the Commission
(10:15 a.m. to 10:50 a.m.)

1. What are the Commission's principal goals and objectives? What are the metrics by which you measure success or failure?

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

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

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

5. Please identify the Commission's 3 most effective programs and your 3 least effective programs. Explain why you identified them as such. Explain how your most effective programs further the Commission's goals.

Closing Comments
(10:50-11:00 a.m.)

6. Closing comments from the Commission

AGENDA
FY 2008-09 Joint Budget Committee Hearing
Department of Health Care Policy and Financing

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

Thursday -- December 13, 2007

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

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

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

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

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

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

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

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

7. Please describe what impact the "Colorado Plan" has in determining the Department's goals and priorities for the next three years. Also, please briefly describe major accomplishments or setbacks associated with moving forward with the following four issues that are specifically mentioned in the Colorado Plan (some of these issues may also be discussed more specifically in other issues -- please just give a broad overview here).

    a) What is the Department's current assessment for the loss of Medicaid managed care? What it the status of initiatives or negotiations to attract new managed care

plans to the Medicaid market? Is the Department on target to adding one more plan in the Denver Metro area in FY 2007-08 (page N-10 of your strategic plan)?

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

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

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

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

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

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

A. General Budget Outlook

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

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

12. Does the Department have any concerns that economic conditions could worsen in the near future causing a greater increase to the Medicaid caseload forecast in FY 2008-09? How confident is the Department that caseload growth will remain below 1.0 percent for FY 2008-09?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Break (10:30 to 10:40)

Provider Rate Increase Issues

(10:40 to 11:00)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Indigent Care

CBHP
1:30 to 2:15

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

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

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

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

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

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

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

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

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

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

Uninsured Assistance Programs
(2:15 - 2:30)

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

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

Blue Ribbon Commission -- Health Care Reform
2:30 to 3:00

51. Does the Department support using the Lewin Group's estimate of the number of uninsured in Colorado? If not, why not?

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

53. What are the Department's cost estimates if ***all*** currently eligible children and adults were enrolled in Medicaid/CBHP?

54. How much does the Department estimate it would cost if Medicaid clients were provided one-year continuous eligibility.

55. How much would it cost to expand coverage for low-income adults on Medicaid to 100 percent of poverty?

56. How much does the Department estimate it would cost to expand Medicaid/CBHP to cover all uninsured legal residents of Colorado up to 205 percent of FPL (Please breakdown this estimate into Children, Parents of Eligible Children, Adults without Dependent Children).

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

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

Break (3:00 to 3:10)

Old Age Pension Program
(3:10 to 3:25)

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

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

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

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

61. Please explain why this program reverted $1.6 million in FY 2006-07. Please explain why the Department's budget request for FY 2008-09 does not request using any of the

available $2.4 million fund balance in the OAP Supplemental Medical Fund to increase provider rates for this program in FY 2008-09 (See page M-14 of the Department's request).

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

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

Break
(3:25 to 3:35)

Administrative/Other Issues
(3:35 to 4:50)

General Budget Issues

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

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

Caseload Reporting

a) Medicaid caseload by aid category (JBC gets this now);
b) Medicaid caseload enrolled in MCOs by aid category (JBC gets this now);
c) Medicaid caseload by aid category for each BHO (new);
d) Medicaid caseload enrolled in an HCBS waiver program (new);
e) Medicaid caseload qualified for Long-Term Care programs broken-out by HCBS, nursing homes, and PACE (new);
f) Medicaid caseload that are dual eligibles (new);
g) Children's Basic Health Plan by aid category (JBC gets this now);
h) Old Age Pension Medical Program caseload (new);

Expenditures

I) Medicaid Medical Services Premiums year-to-date expenditures by service category (get this now) and projected annual expenditures for the fiscal year (new);

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

k) Medicaid Mental Health Capitation year-to-date expenditures and projected annual expenditures for the fiscal year (new);

l) Children's Basic Health Plan monthly expenditures (JBC gets this now);

m) Medicare Modernization's Act State Contribution Payment monthly expenditures (new);

n) Old Age Pension Medical Program expenditures (new);

Other

o) Personal Services expenditure and filled and vacant positions (new);

p) Amount of third party recoveries (new); and

q) Monthly expenditures for all other Department line items (new).

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

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

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

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

Common Hearing Questions to all Departments

Costs and savings from complying with specific bills and orders

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

70. Provide an estimate of the costs your department will incur in FY 2007-08 in carrying out the provisions of H.B. 06S-1023. Provide an estimate of your department's savings in FY

2007-08 as a result of not providing services to individuals who are in the country illegally.

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

Closing Comments