AGENDA
FY 2007-08 Joint Budget Committee Hearing
Commission on Family Medicine

Tuesday -- December 19, 2006
9:00 a.m. to 10:00 a.m.

Tuesday -- December 19, 2006

Commission on Family Medicine
(9:00 a.m. to 9:05 a.m)

1. Introductions and Opening Comments from Commission Director

Performance Based Budgeting
(9:05 a.m. to 9:30 a.m.)

2. How do your performance measures influence department activities and budgeting?

3. To what extent do the performance outcomes reflect appropriation levels?

4. To what extent do you believe that appropriation levels in your budget could or should be tied to specific performance measure outcomes?

5. As a department director, how do you judge your department's performance? What key measures and targets do you use?

Residency Funding Questions
9:30 to 9:55

6. Please describe how the additional funding for the Commission will aid the state in recruiting and retaining family medicine physicians in Colorado.

7. Even though the General Assembly has increased funding for the nine remaining family residency programs during the last two years, most of the family medicine residency programs have reduced residency slots. Will additional funding allow more residency slots to be created or will the funding merely offset current cost increases for existing slots?

8. Does the Commission have success in retaining doctors in rural areas after their residencies are complete? What effect does this program have on cost of medicine in Colorado?

9. How many family medicine slots remain open in Colorado?

AGENDA
FY 2007-08 Joint Budget Committee Hearing
Commission on Family Medicine

Tuesday -- December 19, 2006
10:00 a.m. to 5:00 p.m.
&
Wednesday -- December 20, 2006
10:00 a.m. to 5:00 p.m.

Tuesday -- December 19, 2006

Department of Health Care Policy and Financing

(10:00 a.m. to 10:15 a.m)

1. Introductions and Opening Comments from Department Director

Performance Based Budgeting
(10:15 a.m. to 10:30 a.m.)

2. How do your performance measures influence department activities and budgeting?

3. To what extent do the performance outcomes reflect appropriation levels?

4. To what extent do you believe that appropriation levels in your budget could or should be tied to specific performance measure outcomes?

5. As a department director, how do you judge your department's performance? What key measures and targets do you use?

Break 10:30 to 10:40

Implementing Immigration Reform
(10:40 a.m. to 11:00 a.m.)

6. Provide a list of programs in your department that are subject to the provisions of H.B. 06S-1023 and the Budget Reconciliation Act of 2005?

7. How has your department implemented the provisions of H.B. 06S-1023 and the Budget Reconciliation Act of 2005? What problems have been encountered in implementing them? Please describe how the state and federal requirements are similar and different.

8. Provide an estimate of the costs your department will incur in FY 2006-07 to implement these laws. Are any additional costs anticipated in FY 2007-08? If so, please elaborate.

9. Provide a summary of anticipated savings in FY 2006-07 in your department as a result of not providing services to individuals who are in the country illegally. Are any additional savings anticipated in FY 2007-08? If so, please elaborate.

10. The Department's decision item #4 seems to indicate that the 3.0 FTE positions would be a permanent need. Once procedures and initial training of the counties and medical application sites is complete would these costs need to be continued?

11. Once a client has established citizenship or lawful presence, the counties will not have to verify these documentation upon redetermination or a new application. Does the Department anticipate that the costs to the counties will diminish overtime?

12. Please describe for the Committee other costs to the counties that may occur due to the need to store additional records.

13. Currently, the Department's monthly caseload reports show a declining trend in the low-income adult and children populations. These caseload were originally forecasted to increase due to eliminating the Medicaid asset test. Does the Department have any data or anecdotal evidence that would support that some of this decline is due to implementing the Budget Reform Act of 2005 or H.B. 06S-1023?

14. Please describe generally the challenges the Department and counties have experienced in implementing these laws. Please describe the procedures and policies the Department has adopted until system changes can be made to CBMS and MMIS.

Efficiencies / Footnote Report Questions / General Questions
(11:00 to 11:45)

15. Is the Department aware of any technology available or that could be developed to improve the identification of third party payers? Please describe how the Department currently identifies clients that may have access to other insurance?

16. The Department's footnote report seems to indicate that Medicare recoveries and commercial insurance recoveries are <u>*post-pay*</u> recoveries. Is it accurate to infer from this statement that Medicaid initially pays the claim and then attempts to recover from these providers? If so, how can the Department do this and still be in compliance with 42 CFR 433.139 (b) (1)? Please describe specifically how claims are paid for dual eligible clients where Medicare may be responsible for the cost before Medicaid?

16a. Please address how waiting for Medicare to reimburse a provider before Medicaid pays may impact a client's access to needed wheelchair equipment.

17. During last year's hearing, the Department indicated that it has been unable to quantify a direct impact to Medicaid expenditures or third party recoveries that can be attributable to a tort auto insurance system. Please provide an update on how auto insurance reform may have impacted the Department's ability to collect from post-payment recovery or from tort/casualty recovery.

17a. Does the Department have the necessary staff needed to do indemnity claims for Medicaid clients involved in car accidents.

18. Given the late start for the HMS contract, does the Department anticipate that there will be any cost savings in FY 2006-07 from this contract? What is a reasonable estimate of cost savings for FY 2007-08 from this contract?

19. FY 2005-06 third party recoveries resulted in recoveries of $24.7 million (of which half would be General Fund). This represents approximately 1.2 percent of the total expenditures for Medical Services Premiums. Would it be a fair performance target to set 1.0 percent of Medical Services Premiums as a third party recovery target?

20. Please describe the current status of the Autism Waiver program. Was the program implemented in October 2006? What information and outreach is the Department providing to clients that potentially could benefit from the services of this program?

20a. Why did it take so long for the Department to receive the autism waiver? How many children were impacted by the delay and therefore did not receive the early intervention services provided through this waiver?

21. Does the Department have any current cost information for the outpatient substance abuse benefit? What have been the costs for this program from July 1 through October 31, 2006?

22. Obesity and morbid obesity is becoming one of the leading public health concerns in this century. Given that the time frames in H.B. 05-1066 have expired and the bill can not be implemented without statutory changes, does the Department see any benefit from trying to institute a obesity pilot program or disease management program. If so, what type of program does the Department believe would be appropriate for the Medicaid clientele? Should a program focus on weight management programs, heart disease and/or diabetes control, or nutritional education? Because benefits from these programs take a long time to occur, would the program be better situated to the Adult Medicaid caseload rather than to the Family Medicaid caseload?

23. Please provide the Committee with an update on the consumer-directed care waiver process and program.

23a. Please explain why there was a year and half delay in implementing H.B. 05-1243.

24. Please explain the Department's rationale for not applying H.B. 06-1369 Footnote 40a to the individuals providing community long-term care services to clients who were enrolled in the Consumer Directed Attendant Support Services waiver program prior to the rate increase.

25. What is the Department's cost estimate for extending the Footnote 40a (H.B. 06-1369) rate increases to cover all services provided through the Consumer Directed Attendant Support Services waiver program? Could extending these rate increases be made retroactive to July 1, 2006? If not, could the rate increases begin by January 1, 2007 with supplemental funding?

26. The school districts are allowed to develop their own Local Service Plan to address the health needs of their school children. School districts use the federal reimbursement in a number of ways, including covering some medical costs for children who are uninsured or under insured. The Department of Education's annual report on the Medicaid Extended School Health Program indicates that in FY 2003-04, 2.37 percent of the federal reimbursement was spent on insurance outreach for the CHP+ and Medicaid programs. Does the Department have any information on how many children are enrolled into CHP+ and Medicaid due to efforts of school districts?

27. Does the Department have information on the amount of federal reimbursement funding used by the school districts to pay for direct medical or dental costs for children who are uninsured that is provided by a non-school provider (i.e. private physician, clinic, or dentist)?

28. What is the future of increasing federal reimbursement for additional Medicaid services in the S.B. 97-101 Public School Health Service Program?

29. Please provide additional information regarding the ability of the school districts to charge for non-emergency transportation. In FY 2003-04, the state changed the rules for non-emergency transportation to ensure that transportation services were only be charged for medically necessary travel. How does travel to and from school translate to medically necessary? In a related area, please provide information on any non-emergency transportation reimbursement to National Jewish Hospital for their private school. How does Medicaid funding for non-emergency transportation relate to a school districts responsibility to transport children to and from school?

30. It is staff's understanding that as of 2005, the Office of Inspector General has finalized audits of this program in eleven different states. Thus far, its audit work has shown that Federal Medicaid funds were claimed for (1) services that were not approved in the state plan; (2) services that were not sufficiently documented to ensure that services prescribed in the students' individualized educational plans (IEP) were delivered; (3) services that were not authorized or were in excess of the quantity authorized in the IEP; (4) transportation services when there was no authorized Medicaid service on the same day; (5) services rendered by health care providers that did not have the qualifications

required by Medicaid regulations; (6) services provided free to other students; and (7) students who were absent. OIG's audit work in this area continues. Please describe any input that the Department has received from CMS or the OIG regarding Colorado's school based program. Please describe the oversight activities that the Department performs to ensure that only federally accepted services are billed to Medicaid.

Lunch Break

Medical Services Premiums
(1:30 to 5:00)

A. Current Outlook of Medicaid Services Premiums Budget Expenditures

31. Please describe what the Department believes to be the current strengths and weaknesses in the Department's forecasting methodologies for the Medical Services Premiums line item? How does the Department's forecasting methodologies and accuracy compare to forecasting models and accuracy in other states? Does the Department believe that more accurate forecasts could be developed if other methodologies were used? If so, how much funding would be necessary to help develop and test new methodologies for the Medical Services Premiums line item?

32. If a FY 2006-07 supplemental is needed for the Medical Services Premiums line item, does the Executive have suggestions on how to avoid being over the 6.0 percent appropriations limit?

33. The Department's current FY 2007-08 appropriation indicates a General Fund increase to the Medical Services Premiums line item of $55.9 million. This is 5.61 percent increase over the current FY 2006-07 appropriation. If Decision Item #10 is excluded from the request (since it is a transfer of funds to another division and does not represent a true decrease), the General Fund increase for the Medical Services Premiums line item is $66.6 million or a 6.7 percent increase over the current FY 2006-07 appropriation. Whenever, the Medical Services Premiums line item grows by more than 6.0 percent, this affects the amount of funding that other State programs can grow under the 6.0 percent appropriations limit. Does the Executive have a long-term strategy on how to reduce or maintain the growth in the Medical Services Premiums line item to within 6.0 percent growth?

33a. How much of the Department's Medicaid request is being driven by federal mandates and how much the request is being driven by state law and Department rule?

B. Factor's Driving the Medicaid Budget

34. What is the status of the system changes for being able to identify optional legal immigrants? It is staff's understanding that CBMS has been modified in order to identify legal immigrants in the "Family Medicaid" categories. However, staff understands that the Department has encountered problems with modifying CBMS to identify legal immigrants in the "Adult Medicaid" categories. Please explain the difficulties that have occurred and update the Committee on the current status of the effort to identify optional legal immigrants. Currently the Department's budget request continues to grow both the caseload and expenditure costs for this eligibility group without hard data to back up the growth rates. Would it be a more conservative approach to maintain the original optional legal immigrant cost estimates until final system changes could verify both caseload and costs for this population?

35. Because separate aid categories were not created for adults and children who become Medicaid eligible due to the elimination of the Medicaid asset test, population growth attributable to this change is not tracked in the monthly reports. Has the Department been able to identify how many new clients have become eligible for Medicaid due to change in the asset test? Has the Department been able to match how many children have left the Children's Basic Health Plan and been enrolled in Medicaid due to the elimination of the Medicaid asset test? Please provide a break-out of the caseload by aid category that have been added thus far in FY 2006-07 due to elimination of the asset test. If the Department is unable to do so, please explain why.

36. The Department's budget request indicates that parents of eligible children in the CBHP and Medicaid became eligible for Medicaid beginning July 1, 2006. Although this population has its own aid category and can be tracked separately from all other Medicaid clients, the monthly reports do not yet show this enrollment (as of the October 2006 report). Please provide the Committee with monthly enrollment for this population as of July 2006 and explain any trends that the Department sees in enrolling this population up to the original appropriation projections.

37. Please describe for the Committee any other ongoing issues with tracking and allocating funds for the Amendment 35 populations. Please discuss with the Committee if the Department will need any additional funding in FY 2006-07 for system changes in order to track the Expansion population. Initially last year the JBC voted to provide the Department with some additional funding for system changes but the funding was left out of the final appropriation bills. Has the Department been able to fund the necessary system changes within existing resources?

38. What impact, if any, does the Department anticipate from the passage of Amendment 42 (raising the minimum wage) on the number of clients eligible for Medicaid. Please discuss specifically the possible impacts to the low-income children and adult categories with special emphasis on how it may change the number of parents eligible at or below

60 percent of FPL. In the Department's opinion, will the passage of Amendment 42 result in more uninsured because of loss of Medicaid eligibility?

	34% FPL	60% FPL	100% FPL	133% FPL
Family of 1	$3,332	$5,880	$9,800	$13,034
Family of 2	$4,488	$7,920	$13,200	$17,556
Family of 3	$5,644	$9,960	$16,600	$22,078
Family of 4	$6,800	$12,000	$20,000	$26,600
Annual Salary for worker earning old minimum wage of $5.51 working 2,080 hours a year				$11,461
Annual Salary for worker earning new minimum wage of $6.85 working 2,080 hours a year				$14,248

39. Objective 1.1 in the Department's strategic plan is "to maximize the opportunity to preserve health care services through the purchase of services in the most cost-effective manner possible". Please describe for the Committee the Department's current and recent past initiatives to improve the cost-effectiveness of Medicaid medical services.

40. Please describe the difficulties that would be associated with developing caseload numbers (rather than client counts) for individuals eligible for the different long-term care waiver and institutional care counts? Would it be possible for the Department to submit a "long-term care" caseload with their monthly reports? What would be the costs of developing such a report?

41. In FY 2004-05, there was a 6.1 percent decrease in the number of clients served by the Home and Community Based Service Programs (L-112 of the Department's Strategic Plan). However, in FY 2005-06 there was an increase 9.9 percent increase over the FY 2004-05 count. Does the Department have an explanation on why these years had such dramatic changes in client counts numbers (previous year changes were much more stable)?

42. The Department's request indicates that additional PACE sites may be approved during FY 2006-07. Please describe the current status of these applications.

C. Adequacy of Medicaid Rates

43. Last year the General Assembly attempted to move most of the home and community-based service provider rates to within 80 percent of their comparable Medicare rate. The Department’s rate plan does not contain any FY 2007-08 rate increases for these providers. Will these provider rates stay within 80 percent of the Medicare rate without a COLA increase in FY 2007-08? Is 80 percent of the Medicare rate an acceptable goal to

try to maintain? What impact, if any, does the Department anticipate from the increase in the minimum wage on home health agencies and home and community based services providers?

44. When does the Department anticipate the final report for the acute care provider rate disparity study? Please describe the specific rate issues the Department hopes the address in the study that have not been addressed by the Department's current decision item on provider rates.

44a. Please explain the Department's rationale for increasing the provider rates for the top 25 physician codes rather than providing an across the board 3.25 percent rate increase.

45. Please describe the reasons why there was a sharp increase in the non-emergency transportation need from FY 2004-05 to FY 2005-06. Please describe the estimated supplemental that the Department will be submitting on this issue for FY 2006-07? Given the fact that the State is within $2.0 to $3.0 million of the 6.0 percent limit for FY 2006-07, does the Department have any strategies on how this supplemental can be implemented without exceeding the 6.0 percent limit? Does the Department believe that the current rules and regulations for non-emergency transportation is meeting the needs of the Medicaid clients?

46. Staying within 90 percent of the Medicare rate for inpatient hospitals will continue to drive costs in the future. Given the constraints of a 6.0 percent limit, does the Department believe that this is a reasonable goal that the State can maintain into the future? Does this goal create an unrealistic expectation that this level of reimbursement can be maintained?

46a. In setting rate policy for different providers, does the Department prioritize rates based on certain goals that the Department wants to achieve (e.g. such as increasing immunization rates, the number of providers willing to accept Medicaid clients, or eliminating disparities that evolved over the years for certain providers). Please describe the results that the Department believes will be achieved with the current rate plan.

46b. Are there efforts by the Department to try to adjust hospital rates to encourage additional providers in the Medicaid program (this question relates to the difficulty of accessing services at Denver Health for clients outside of the metro-area)?

46c. When Medicaid rates increases, does that lessen the hospital cost shifts to private insurance or Medicare? If so, does the Department have any information on how increasing Medicaid rates reducing the cost shifts and how much the cost shift is reduced by hospital?

46d. Please provide the Committee with the list of hospitals that the Medicaid program reimbursed in FY 2005-06 for Medicaid services by the total amount of expenditures at each hospital.

D. Long-Term Care Reform

47. Please describe for the Committee any RFP's the Department has issued for pilot programs recommended by the Advisory Committee on Long Term Care or that may address some of the issues raised by the Advisory Committee. Specifically, address the status of the RFP's for pilot programs for alternative housing options, integrated primary care and long-term care pilot programs, expediting financial eligibility determinations, and selective contracting for geographic service areas.

48. What are the Department's five top priorities for improving the efficiency and effectiveness for the Medicaid Long-Term Care System? What challenges and opportunities does the Department see in the next five to ten years for long-term care delivery?

49. Please discuss the recommendations from the Advisory Committee report that the Department believes should be implemented as soon as possible. What are the possible fiscal impacts from these recommendations.

49a. Does the Department have any suggestions on how the state can create incentives for hospitals and nursing homes to tie into electronic records?

50. Please provide the Committee with a fiscal analysis on how much eliminating the 8.0 percent cap on health care costs for nursing home reimbursement would cost in FY 2007-08.

51. From the Department's perspective, what are the advantageous and disadvantageous of a pricing or prospective-pay model for nursing homes.

52. From the Department's perspective, what are the advantageous and disadvantageous of a quality add-ons incentives for nursing home rates.

52a. When nursing home clients spend down into Medicaid eligibility, is Medicaid required to continue to reimburse the facility at the same rate the client paid before spending down into Medicaid eligibility?

53. What future fiscal impact does the Department anticipate from increasing the look back period from three years to five years and changing the penalty time frame (impact will not be felt until 2009 but how large of impact does the Department anticipate)?

54. Please provide the Department's perspective on the Long-Term Care Partnership program? What could be the potential fiscal impact of implementing such a program in Colorado?

55. Is there any way that the State can qualify for the enhanced federal match for programs that help place more individuals in community-based service programs rather than in nursing facility care? Is the Department applying for any demonstration programs?

55a. Please provide the Committee with information on how the Colorado's use of community long-term care services compares with other states. Also describe for the Committee why some counties have a higher percentage of clients in community care settings when compared to institutional settings than do other counties.

E. Managed Care -- Department's Perspective

56. Please describe for the Committee the advantageous and disadvantageous of entering into more PIHP agreements.

57. Does the Department believe that there is any state benefit to having a traditional capitation MCO program in the Medicaid Medical program? In the Department's opinion, what should the goals of a MCO program be?

58. What steps (statutory changes, rate adjustment, policy directives) does the Department believe are necessary for a viable MCO program to be reestablished in the Colorado Medical Medicaid program?

59. Why has managed care struggled in the Colorado Medical Medicaid program but has been somewhat more successful in the Children's Basic Health Plan?

60. Which populations ought to be served in a Medical Medicaid MCO program? Should the program be statewide or limited to certain geographic areas or populations?

61. If competition between plans is encouraged, how would the Department ensure a significant risk pool for participating providers? Should adjustments be made to rates if a providers risk pool is declining?

61a. Briefly describe for the Committee the process of rebasing the capitation rates for each aid category and major reason for the drop in the capitation rates for Denver Health and Colorado Access.

<u>Wednesday -- December 20, 2006</u>

Department of Health Care Policy and Financing

F. Prescription Drugs -- Before and After MMA
(10:30 a.m. to 11:00)

62. Please update the Committee about ongoing issues with implementing the MMA. Please discuss any problems that dual eligible clients have experienced or are experiencing as they sign up for Medicare Part D plans? Does the Department believe that most dual eligible clients are now able to access their drug benefit through Medicare and have understanding of how the program works? What assistance is the Department still providing to dual eligible clients regarding the Medicare Part D program?

63. In addition to the costs for the clawback payment, what other costs does the Department estimate for the Medicare Part D program for FY 2007-08?

64. Nationally, the Congressional Budget Office forecasts that the change in pricing methodology will save the Medicaid program $3.8 billion from FY 2006 through FY 2010. However, the Department's budget request currently does not contain any cost saving estimates for prescription drugs due to the DRA. Please explain the possible impact the DRA will have on Colorado Medicaid prescription drug reimbursement or the difficulties in estimating the potential impact.

65. It is staff's understanding that the DRA also modified the definition of Medicaid "best price" to include the lowest price for authorized generics. Recently, a major U.S. retailer began promoting a program to offer $4.00 generic prescription drugs in Colorado. Please provide the Committee with information on the amount of sales volume that the Department currently does with this retailer for the affected drugs. Does the Department believe that there will be a potential cost savings in prescription drugs due to this policy change?

66. What are the potential savings or costs for developing a preferred drug list for the Medicaid FFS program?

67. What are the disadvantageous or advantageous to joining one of the three-existing multi-state purchasing pools?

68. According to the Department's current strategic plan, the Department estimates savings of between $100,000 to $500,000 for FY 2007-08 by identifying opportunities for cost avoidance within the drug program and providing a prescriber education program. Please describe the status of these projects for the Committee.

69. Please update the Committee on the total cost savings in the prescription drug program from implementing S.B. 03-294 and S.B. 03-011.

Children's Basic Health Plan
(11:30 to 12:00 and 1:30 to 1:45)

70. Current caseload reports seem to indicate that the decrease in the CBHP due to implementing the asset test has not been as high as originally forecasted. Does the Department have any data on how many CBHP children, year-to-date, have moved into the Medicaid program?

71. Please discuss the difficulties of using accrual accounting for budgeting the CBHP instead of cash accounting as is used in the Medicaid program? If the Department was allowed to use the cash basis of accounting, would that approve caseload forecasting for the CBHP program? What would be the impact to the per capita costs?

72. Over the last several years, the overall per capita costs for the Medicaid populations has decreased as the population increased. This was partly responsible for the large drop to Colorado Access's rates for children when the rate was rebased against the fee-for-service. However in the CBHP program, even though caseload is expanding, there does not seem to be the same lower cost resulting from an expanded risk pool. Does the Department have an explanation for this phenomenon?

73. Please describe the use of encounter data in the development of the actuary rate's for the CBHP program. Could this be a model on how to set MCO Medicaid rates in the future?

74. Does the Department have an explanation on why the case mix between the self-insured network and the MCOs changed from the original FY 2006-07 assumption?

75. Does the Department have any data on how many families have children enrolled in both the CBHP and Medicaid program based on their age and income (i.e. for a family under 133% FPL, their 4 year old would be in Medicaid but their 7 year would qualify for CBHP).

76. Please describe the issues that the Department believes should be addressed as Congress re-authorizes the SCHIP program.

The Uninsured
(2:00 p.m. to 3:00 p.m.)

A. Amendment 35 Implementation update

77. Please discuss the drawbacks or advantages of increasing the eligibility for parents from 60 percent FPL to 75 percent FPL. According to the Department's estimates, when would the Health Care Expansion Fund fail to meet its reserve requirement if this eligibility change was made?

78. Please briefly update the Committee on implementation of all H.B. 05-1262 Medicaid and CBHP expansion programs.

B. Covering more of the Uninsured within Existing Programs

79. Please discuss the impact that the funding increase for CBHP marketing program has had on enrollment in CBHP? Please update the Committee on the current implementation of the pilot programs to increase the enrollment of children into the Medicaid and CBHP programs through school eligibility sites.

80. Please discuss the potential fiscal impact if all children and adults currently eligible for Medicaid and CBHP were enrolled in the programs? What does the Department estimate the current penetration rates are for both programs?

81. Please update the Committee on the grant awards for the Primary Care Program since its implementation (how much funding has been provided to which clinics)?

82. In the Department's opinion, could the Medicaid or CBHP program be modified to cover more of the uninsured without additional state funding requirements? Which uninsured populations and which providers would win or lose if a portion of the current funding provided for indigent care (namely the S.B. 06-44 & Primary Care Program) was restructured to expand eligibility in Medicaid and CBHP (granted there would be statutory and Constitutional changes necessary to do this)?

83. Given the growing caseload and costs of the program, would the OAP Medical Program be better as a primary care and pharmacy benefit program only?

84. When does the Department anticipate having a recommendation ready on a redesign of the OAP Medical program?

85. Please discuss the type of changes that the Department believes could be made to the OAP Medical Program and still stay within the requirements of the State Constitution to provide medical services to OAP clients (i.e. could the Medical Program be designed as an insurance subsidy program, could it be a pharmacy benefit only program, could it be a primary care program only).

Administrative Issue
(3:00 to 4:00)

B. Staffing Issues

86. Please provide an explanation on why the Department will not require additional funding if 12.8 more FTE positions are added. Please provide a comparison of how the Department's staffing level compares to the Medicaid agency in the following states: Oregon, Utah, Arizona, New Mexico, Nebraska, Kansas, and Washington.

87. Please discuss the staffing improvements that have occurred over the last year that have helped to reduce turnover and increased overall productivity.

87a. Does the Department believe there would be any benefit from hiring a medical doctor as a "medical director" to oversee quality assurance programs for the Medicaid program?

88. How many vacancies does the Department current have?

89. It is the JBC's understanding that the Department has conducted special staff training seminars related motivation, ethics, sexual harassment, and creating a productive work environment. Where did the money for these meetings come from? What company provided this training for the Department?

C. Summary of Recommended JBC Legislation

90. Has there been any incidents were a dual eligible client has disenrolled in their Medicare Part D and tried to receive Medicaid prescription drug coverage.

91. Please discuss the ramifications of what will happen to Medicaid clients who are on their birthday become eligible for Medicare but have not had the opportunity to enroll in a plan. Would there be a gap in coverage for these individuals if the statute is changed from "enrolled" to "eligible".

92. If the move to cash accounting was enacted in FY 2006-07 for the CBHP and OAP Medical program, how much savings does the Department anticipate? What would be the administrative costs associated with changing the accounting methodologies for these programs?

93. If CBHP and the OAP Medical program was moved to cash accounting, why not also move the MMA State Contribution Payment to cash accounting? What would be the estimated FY 2006-07 savings for moving the MMA State Contribution Payment to cash accounting?

D. County Administration Issues and CBMS (questions from the DHS briefing)

94. Why is the administration amount for the counties flat?

95. Has the department chosen a vendor for the workload study as yet? What was the process for choosing a vendor?

96. Is the Department of Human Services the key department for the CBMS system? Where should the Office of CBMS be located in the future?

97. What are the sources of funds other than General Funds used for CBMS?

E. Proposal to Eliminate "Cash Funds Exempt" in the Long Bill

98. ***Background.*** Joint Budget Committee staff has proposed eliminating the current "Cash Funds Exempt" column in the Long Bill and replacing it with a new column entitled "Transfers" effective with the **FY 2008-09 Long Bill.** The Joint Budget Committee has not formally voted on this issue. For details of the proposed change, please read the Joint Budget Committee staff memo from November 15, 2006, entitled "Proposed Long Bill Format Change." To help departments understand the new format, our staff has prepared an example of the Department of Revenue FY 2006-07 Long Bill in the proposed new format. This memo, and the example from the Department of Revenue, can be downloaded from the JBC web page at the following Internet address:

    http://www.state.co.us/gov_dir/leg_dir/jbc/PLBFC11-15-06.pdf

    Question. Please provide the Joint Budget Committee with a summary of any potential concerns that your department may have regarding the proposed change to the Long Bill format. Please highlight potential issues such as: implementation challenges, workload issues, and other related concerns.

Closing Comments
(4:00 - 4:30 p.m.)

Director's Closing Comments