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Blueprint for Opportunity

No. 16-A

Implementation Memo

TO: Governor Ritter
Members of the 66th Colorado General Assembly

FROM: The Bell Policy Center – Robin Baker, Senior Policy Analyst

DATE: January 9, 2007

**RE: Implementing Bell's Blueprint recommendation No. 16-A
to review Medicaid eligibility levels and reimbursement rates to providers**

In the 2006 Blueprint for Opportunity, the Bell Policy Center recommends:

Strengthen the health care safety net

The next governor and legislature should thoroughly review eligibility levels and reimbursement rates for Colorado's health care programs to ensure more families benefit from health programs as they work toward self-sufficiency. (See *Blueprint*, page 23)

This memorandum briefly discusses the issues surrounding this proposal, describes steps for implementing it, outlines some of the factors to consider and lists sources for additional information and resources.

If you are interested in pursuing this issue further, we are prepared to work with you. Please contact the author of this memo directly at (303) 297-0456 or baker@thebell.org, or Rich Jones, director of policy and research, at (303) 297-0456 or jones@thebell.org.

Overview of the issue

Medicaid is a federal-state partnership that gives states considerable flexibility, within federal guidelines, to create their own laws, regulations and plans to administer and deliver Medicaid services. The federal government contributes approximately \$1 for every \$1 of state Medicaid spending in Colorado.

The 50-50 match rate in Colorado is based on the overall health of Colorado's economy, and is the lowest match available. The Colorado legislature has made the state's Medicaid program one of the most conservative allowed under federal law. The Colorado Department of Health Care and Policy Financing (HCPF) administers the state's Medicaid program.

Medicaid plays a critical safety-net role during economic downturns. At the same time, Medicaid places enormous pressure on state budgets. In nearly every state, Medicaid is the second largest spending program following K-12 education.¹

In Colorado, current Medicaid spending exceeds 20 percent of the state's budget, and it is growing.

In an attempt to rein in Medicaid spending, Colorado, like other states, turned to a Medicaid managed care system in the mid 1990s.² Managed care plans are supposed to ensure that appropriate health care services are delivered in a cost-efficient manner. Under Medicaid managed care, states make fixed payments to managed care plans or health maintenance organizations (HMOs) to provide services for all recipients.



Research examining the impact of Medicaid managed care shows mixed results. On one hand, Medicaid managed care spending has grown at a slower pace than private coverage. For example, the Kaiser Commission notes that between 2000 and 2004, spending per Medicaid enrollee increased by an average annual rate of 5 percent for the aged and disabled and 6 percent for families. By comparison, per enrollee spending for private coverage increased by an average annual rate of 9.5 percent during the same period.³

On the other hand, some research⁴ suggests that Medicaid managed care does not produce savings to the overall system. Instead it increases cost shifting and creates barriers for beneficiaries who often have difficulty finding physicians willing to accept them as patients.

Under Colorado's Medicaid managed care, providers have consistently received reimbursements well below current market rates for their services. Below market rate reimbursements serve as economic disincentives for providers, who are forced to absorb the difference between what they are paid and actual costs of providing services. Colorado pediatricians, for example, report that they lose \$20 to \$30 per visit for every Medicaid patient they see.⁵ If, however, reimbursements were increased enough for pediatricians to at least "break even," 80 percent of those surveyed said they would accept new patients.⁶

Research by the University of Colorado School of Medicine found that children enrolled in Medicaid and those with no insurance at all had worse health outcomes than children with private insurance.⁷ According to this cost-estimate study, if Medicaid children would have received regular preventative and primary care in 2005, the state might have saved up to \$128 million in hospital charges and more in reduction of emergency department charges.⁸

Low Medicaid reimbursements don't save money — they shift the cost of providing care to others. For example, the Children's Hospital lost \$49 million in 2005 for serving other patients covered by Medicaid. To stay solvent, medical practices and hospitals must find other ways to pay for uncompensated care.

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Medicaid reimbursement calculations are set in state law and are very complex. For example, Colorado has more than 5,000 reimbursement codes for surgical procedures alone, and more than 18,000 total codes. The state's formula bases reimbursement rates on type of service, frequency of usage, age of clients, general health and so on.

In 2002, following a series of lawsuits over below-market provider reimbursements, the legislature passed HB02-1292. This bill requires the Department of Health Care and Policy Financing (HCPF) to recalculate the base funding for Medicaid reimbursements every three years.

Even with adjustments to the state's rate-setting methodology, Colorado's Medicaid program has long struggled with rigid state spending limits, lawsuits and recession-driven budget cuts. With the passage of Amendment 35 in 2004 (raising the tobacco tax) and Referendum C in 2005, the state was able to put back some of the millions of dollars cut from Medicaid services during the recession, but the state's Medicaid program remains troubled.

We recommend that Medicaid eligibility be reviewed and that reimbursements be increased, and we believe these recommendations go hand in hand. Expanding eligibility to more low-income families and children is critical. If, however, providers cannot afford to see Medicaid patients because the reimbursements are substantially below market rates, then expansion policies will not be effective.

Therefore, we recommend that the glaring problem of insufficient Medicaid provider reimbursements be addressed first. Once this problem is attended to, the state will be in a better position to review and expand eligibility so that more low-income Coloradans have access to affordable, quality health care.

Implementation steps

There are several steps the governor and the legislature should consider when reviewing Medicaid eligibility and rate-setting. Each should be judged against the ideal outcome of providing sufficient reimbursement payments that ensure that patients are seen and quality services are provided.

- **The legislature and the Joint Budget Committee should fully consider HCPF’s suggestions for adjusting the current Medicaid rate-setting formula** as set forth in CRS 25.5-5-408. This new rate-setting method was presented to the Joint Budget Committee during the department’s hearing on Dec. 19, 2006.
- **Medicaid eligibility should be fully reviewed and expanded.** Before this can occur, it is important to carefully assess the current Medicaid system, including reimbursement rates, before increasing eligibility. The current system may not have the capacity to provide care for an increased number of enrollees. A continuous funding stream needs to be identified to properly expand these reimbursement rates.

Colorado has several health research and advocacy organizations. Three groups in particular have studied, researched and suggested strategies for addressing Colorado’s Medicaid eligibility and reimbursement issue: the [Colorado Coalition for the Medically Underserved](#), the [Colorado Health Institute](#) and the [Colorado Children’s Healthcare Access Program](#). We recommend that the governor, the legislature and HCPF consider the information and solutions from these groups concerning Medicaid and the capacity of public insurance to provide care to an increased number of enrollees.

- **The governor should direct the Department of Health Care and Policy Financing to appoint a chief medical officer.** This would ensure ongoing oversight of the adequacy and effectiveness of Medicaid reimbursements, as well as Medicaid and CHP+ eligibility expansion and health outcome measures. The legislature should specify qualifications and duties of the chief medical officer using similar guidelines and language as set forth in CRS 25-1-105. Responsibilities should include, but not be limited to, developing transparent health outcome measures, determining provider clinical standards for participation, developing consistent Medicaid and CHP+ definitions and eligibility categories and establishing information systems to better measure and improve the effectiveness care and efficient use of the health care dollar.



Factors to consider

Initially, changing the Medicaid managed care rate-setting formula could result in a high fiscal note. However, research suggests the long-term benefits would lower costs as more providers become willing to accept Medicaid patients and provide ongoing medical care.⁹

In response to the state's budget crisis, the Department of Health Care and Policy Financing (HCPF) sought ways to cut its budget. Between 2001 and 2004, HCPF reduced Medicaid reimbursement rates, eliminated services and implemented other cost saving measures to reduce its budget by nearly \$60 million. At the same time the department was reducing provider rates, Medicaid enrollment grew by 23 percent.¹⁰

While the state's economic recovery and slower caseload growth have helped to restore some of the cuts, HCPF funding has not been fully restored. The lack of revenue makes it difficult for the department to restore services and increase provider reimbursements. *Because changes in reimbursement rates must be backed by long-term funding sources, Referendum C money cannot be used because it is not an ongoing funding source.*

In addition, the federal Centers for Medicare and Medicaid Services (CMS) has increased state accountability for Medicaid managed care. CMS requires state Medicaid managed care payment cap to be actuarially sound, meaning payments must be sufficient to cover the reasonable cost of services. Under the current Colorado statute, rate-setting methods artificially cap reimbursements and limit HCPF from making federally required adjustments.

Without adjustments to the Medicaid rate-setting method, the state is at risk for additional lawsuits for inadequate payments. The state is also at risk for losing federal dollars and losing managed care organizations that cover medical services for Medicaid patients and physicians willing to treat Medicaid patients.¹¹

Information and resources

☎ The Colorado Department of Health Care and Policy and Financing
www.chcpf.state.co.us, (303) 866-5624

The Children's Hospital of Denver
Dr. James K. Todd, Departments of
Epidemiology, Clinical Microbiology, and
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Colorado Coalition for the Medically
Underserved

Molly Markert, executive director

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(303) 832-7727

☎ Catterall, G., Chimento, L., Sethi, R. &
Maughan, B. (2006). [Rate Setting and Actuarial
Soundness in Medicaid Managed Care](#), The
Lewin Group, prepared for the Association for
Community Affiliated Plans & Medicaid Health
Plans of America.

Colorado Access press release, July 18, 2006,
Colorado's Largest Medicaid Managed Care
Organization Elects to Not Renew Medicaid
Physical Health Contract.

☎ [https://www.coaccess.com/public/access
HealthPlan.jsp](https://www.coaccess.com/public/accessHealthPlan.jsp)

☎ Felt-Lisk, S., Dodge, R. & McHugh, M.
(2001). [Trends in health plans serving
Medicaid—2000 data update](#). Prepared by
Mathematica Policy Research, Inc. for Kaiser
Commission on Medicaid and the Uninsured.

Medicaid Managed Care: Access and Quality
Requirements Specific to Low-Income and Other
Special Needs Enrollees. General Accountability
Office, 2004, 05-44R.

☎ <http://www.gao.gov/new.items/d0544r.pdf>

☎ Gold, A., Fox, D. A. (2001). Colorado Office of
the State Auditor, [Historical HMO and Fee for
Service Costs Review and Analysis](#). Reden and
Anders, Ltd., Consultants & Actuaries, Denver.

⌘ Sparer, M.S. & Brown, L. D. (2000). [Uneasy Alliances: Managed Care Plans Formed By Safety-Net Providers](#). Will Medicaid managed care be a nail in the coffin or a healthy stimulus for safety-net providers and plans? *Health Affairs*, July/August 2000, pgs. 23-35.

⌘ Summer, L. & Mann, C. (2006). [Instability of Public Health Insurance Coverage for Children and Their Families: Causes, Consequences, and Remedies](#). Georgetown University Health Policy Institute and The Commonwealth Fund.

End notes

¹ Smith, V., Ramesh, R., Gifford, K., Ellis, E., Rudowitz, R. & O'Malley, M. (2004). [The Continuing Medicaid Budget Challenge: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2004 and 2005](#), Results from a 50-State Survey. Kaiser Commission on Medicaid and the Uninsured.

² The Balanced Budget Act of 1997 gave states the authority to require certain Medicaid beneficiaries to enroll in managed care plans. The act also required the establishment of consumer protections for Medicaid managed care enrollees in access to and quality of care.

³ Kaiser Commission on Medicaid Facts (2006). "Medicaid enrollment and spending trends." Kaiser Family Foundation <http://www.kff.org/medicaid/upload/7523.pdf> See also Kaiser Commission on Medicaid Facts (2001). [Medicaid and managed care: Key Facts](#), Kaiser Family Foundation.

⁴ Todd, J., Armon, C., Griggs, A., Poole, S. & Berman, S. (2006). "Increased rates of morbidity, mortality, and charges for hospitalized children with public or no health insurance as compared with children with private insurance in Colorado and the United States." *Pediatrics*, August 2006, 118: 577-585.

⁵ Berman, S., Armon, C. & Todd, J. (2005). [Impact of a Decline in Colorado Medicaid Managed Care Enrollment on Access and Quality of Preventive Primary Care Services](#). *Pediatrics*, December 2005; 116: 1474 - 1479.

⁶ Berman, S., Armon, C. & Todd, J. (2004). "Access to primary care physicians and preventative primary care services for Colorado children enrolled in Medicaid," *State of Health of Colorado's Children*, VII(4). Department of Epidemiology, The Children's Hospital of Denver. ⌘ www.thechildrenshospital.org/pdf/childrens_outcomes804.pdf

⁷ Todd, et.al., *Pediatrics*, August 2006, end note No. 4.

⁸ Berman, et.al., *State of Health of Colorado's Children*, 2004, end note No. 6.

⁹ Todd, et.al., *Pediatrics*, August 2006, and Kaiser Commission on Medicaid Facts (2006).

¹⁰ Colorado Department of Health Care and Policy Financing (2006). FY 07-08 Budget Request, Medicaid Caseload Forecast, Exhibit B (p. EB-1). ⌘ www.chcpf.state.co.us/HCPF/Budget/07-08Requests/Exhibit%20B.b

¹¹ 42 CFR, 438.6 (c).