Schulte Consulting

Sarah Schulte, Principal
1881 9th Street, Suite 201A
Boulder, Colorado 80302
303 440 7481
sarahschulte@mindspring.com

Review of the Colorado HIFA Proposal

Prepared for Colorado Legislative Council

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Executive Summary

Colorado has experienced increasing difficulty financing its Medicaid program due to state budget pressures, rising health care costs, and increasing Medicaid caseloads. In response to these pressures, the Department of Health Care Policy and Financing (the Department) has developed a reform proposal that builds on the successes of Child Health Plan Plus (CHP+) to improve cost and quality in Medicaid. The resulting plan is Colorado Family Care, a program that relies on joint purchasing of managed care services for Medicaid and CHP+, and uses the resulting savings to cover additional low-income parents.

In July 2005, Schulte Consulting was hired by Colorado Legislative Council with a grant from Rose Community Foundation to describe and evaluate the major elements of the reform proposal, including its benefits and risks, relying on information provided by the Department as well as testimony given during public hearings in Denver, Greeley and Durango. The following are the findings and recommendations of the final report.

Conclusions

- **The Colorado Family Care program will increase access to medical care for children, parents and pregnant women.** Improvements to access include expanded coverage for low-income parents, 12 months of eligibility for parents and children, and assignment of a primary care physician to each enrollee.

- **Public testimony expressed support of the use of managed care to improve the cost and quality of care.** The Colorado Family Care program plans to improve HMO participation and stability by providing 12 month eligibility, actuarially sound rates, and competitive bidding.

- **Testimony emphasized the need for strong performance standards for HMO selection and adequate monitoring of HMO performance.** Individuals testified that weak standards and inadequate oversight of the program could worsen access to care in Medicaid and CHP+.

- **Physicians testified that the proposed increase in physician reimbursement may not increase the number of physicians who participate in the program**. Three provider groups stated that 100% of the Medicare fee schedule, not 80%, would be necessary to cover the costs of seeing patients and thereby induce more physicians to participate in the program.

- **Federally Qualified Health Centers[1] testified that the proposed decrease in their Medicaid reimbursement would negatively impact their ability to serve uninsured patients in their communities**. Providers, consumers, and local agencies at each public hearing opposed any reduction in Federally Qualified Health Center funding.

- **Implementing Colorado Family Care with a HIFA waiver requires accepting a per capita growth cap on federal funding, yet most elements of the new program could be implemented with state plan amendments that do not require a cap on federal funding.** Individuals who testified expressed concern that accepting a growth cap might later require reductions in benefits or provider reimbursements. The Department believes, however, that the state plan requirement to provide a choice of HMOs in urban areas would reduce its ability to meet the program's access, cost, and quality goals.

- **The amount of savings created through managed care enrollment will be revised in September, potentially affecting eligibility, benefits, and provider reimbursements under the new program.** Some providers and consumers expressed concern that the savings assumptions may not be reasonable. They also asked why only savings generated by enrolling children, and not also adults and pregnant women, were included in the waiver budget.

- **Consumers, providers, health plans, and county agencies testified that they had been given an inadequate amount of time to review the Colorado Family Care proposal and requested more involvement in the implementation of the program.** Despite two years of public input gathered by the Department, individuals including consumers, hospitals, physicians, health plans and local agencies testified that they felt they had not been given enough time to study the proposal and to provide comments to the Department and the legislature. Most expressed concern that inadequate engagement of constituent groups would threaten the success of the program.

Recommendations

The following recommendations address the issues identified by individuals who testified during the Denver, Greeley, and Pueblo hearings:

- **Implement Colorado Family Care using state plan amendments.** Testimony expressed the urgent need for Medicaid reform to improve

[1] Federally Qualified Health Centers are sometimes referred to as Community Health Centers

access, quality, and cost for low-income, uninsured individuals in the state. State plan amendments would allow Colorado to pursue a modified reform proposal without accepting new limitations on federal funding.

- **Closely monitor whether private physician and FQHC involvement in the program is sufficient to ensure access and quality of care.** Provider participation in the new program should carefully monitored to assure that the over 300,000 program enrollees have access to primary care. If provider participation is inadequate, changes to reimbursement, administration and provider support should be considered.

- **Create a Department organizational, staffing and information technology plan based on review of Medicaid programs that manage competitively-bid HMO programs.** Development and management of HMO premium rates, selection criteria, reporting requirements, and performance incentives will determine the ability of Colorado Family Care to meet its cost, access, and quality goals. The Department states that it plans to develop an implementation plan upon legislative approval of Colorado Family Care, building on internal strengths and the advice of national Medicaid managed care experts.

- **Create an implementation plan with consumer, provider, health plan, and local agency involvement.** Because these groups feel that they have been inadequately involved and are concerned about the implementation of the program, the Department may need a different public input strategy for the implementation phase of Colorado Family Care. Processes such as advisory committees and work groups that engage leaders in meaningful decisions will increase community confidence in the program, particularly in light of the Colorado Benefit Management System problems and the Medicaid HMO lawsuits.

Project Description

For the past several years, the Department of Health Care Policy and Financing (the Department) has relied on a Department-run provider network to provide services to most Medicaid enrollees. This Department-run network, or fee-for-service program, consistently experiences higher costs, poorer access and poorer quality of care compared to the Medicaid and CHP+ managed care programs.[2] In addition, the Medicaid and CHP+ programs have different benefit packages and different provider networks, leading to disruptions in care for children that move between the two programs.

Based on these experiences, the Department is proposing to create Colorado Family Care, a single managed care system to serve its Medicaid and CHP+ recipients. This new program would rely on managed care organizations to increase access and quality of care as well as create savings that would be used to expand coverage to additional low-income parents.

During the 2005 legislative session, Senate Bill 05-221 was passed, creating a review process whereby the Joint Health and Human Services Committee would hold hearings on the Department's reform proposal and vote to approve or reject the plan on August 31, 2005.

In July 2005, Schulte Consulting was hired by Legislative Council to describe, evaluate and make recommendations regarding the major elements of the Department's reform proposal, relying on information provided by the Department as well as testimony given during public hearings in Denver, Greeley and Durango.

Data Sources

The analysis presented in this report is based on the data collected in July and August of 2005, including:

- The Department's written submission to the Committee
- The Department's presentations at public hearings in Denver, Greeley, and Durango
- The Department's written responses to questions submitted by Legislative Council
- Meetings with the Department's staff and consultants

[2] HMOs report higher rates of childhood immunizations, well-child visits, and early prenatal care.

- Public testimony provided in Denver, Greeley, and Durango, including written testimony

- Follow-up interviews with individuals who testified at the public hearings

The analysis, conclusions and recommendations in this paper are based on analysis of the Department's written submissions and public testimony given at the three public hearings in Denver, Greeley, and Durango, with weight given to testimony that was repeated by multiple individuals and at multiple hearings. Time did not allow for all hearing testimony to be independently verified. This report attempts to distinguish conclusions and recommendations that are based solely on public testimony.

Analysis

The following analysis presents the major features of the new Colorado Family Care program, as well as the support and concern regarding the program given during testimony at hearings held in July and August of 2005. A copy of a presentation given by Schulte Consulting on August 9, 2005 summarizing the major changes in Colorado Medicaid and CHP+ created by Colorado Family Care is presented in Attachment A.

Eligibility

The Department's proposal:

All children, parents, and pregnant women currently served by the Medicaid and CHP+ programs would be enrolled in Colorado Family Care, including populations recently covered by the new tobacco tax. Because Colorado Family Care intends to use a managed care system similar to large employers, individuals with high medical needs such as the disabled, elderly, or foster care children would not be enrolled in the new program. Colorado Family Care would also provide 12 months of eligibility for parents and children. Twelve month eligibility is not provided by the current Medicaid program (pregnant women would retain their current eligibility that ends two months post-partum).

Colorado Family Care would also expand coverage to low-income parents from 60% of poverty up to 100% of poverty using both savings generated by use of managed care as well as tobacco tax funds. The Department is requesting the authority to cap parent enrollment for this population if cost of coverage exceeds available funds.

Public Testimony:

Health plans, providers, and consumers who testified in July and August strongly supported the expansion of coverage to additional low-income parents, as well as the provision of 12 month eligibility to children and parents enrolled in the program.

Benefits

The Department's Proposal:

The Colorado Family Care proposal redesigns Medicaid and CHP+ benefits, creating two new benefit packages called Core and Core Plus. The Core benefit package would be provided to all parents, pregnant women and children enrolled in Colorado Family Care. This benefit package is modeled on the current CHP+ benefit package and mirrors a commercial HMO benefit package. The Core benefit package both expands and reduces covered benefits for parents and pregnant women in Medicaid. It creates new limits on outpatient mental health visits, physical and speech therapy visits and durable medical equipment, while covering new services, primarily hearing aids and eyeglasses.

Children enrolled in CFC would also receive the Core Plus benefit package that covers expanded mental health, physical and speech therapy, durable medical equipment, and dental health benefits not covered by the Core package. According to the Department, Core and Core Plus together represent the current child Medicaid benefit package. Core Plus benefits are new covered services for CHP+ children. The following table shows the new benefits packages, what services they cover, and who will receive them.

Services and Populations Covered by Core and Core Plus

Core	CHP+ benefit package	Parents, pregnant women and children
Core Plus	Services covered for Medicaid children outside of Core	Children only

Public Testimony:

Some individuals who testified at the hearings praised the development of a consistent benefits package. Other consumers and providers, however, expressed concern that reducing mental health and durable medical equipment benefits would prevent low-income high-need individuals from receiving needed services.

Managed Care Organizations

The cornerstone of the Colorado Family Care program is the use of a single set of managed care organizations to provide health care services to Medicaid and CHP+ eligibles. Most Medicaid enrollees today receive services through a Department-administered provider network ("fee-for-service"). Relative to Medicaid HMO enrollees, patients served by this system are less likely to have a primary care provider, are more likely to use an emergency room, are less likely to receive preventive care, and have higher costs. In addition, because Medicaid and CHP+ are administered separately and have somewhat different provider networks and benefits, children who move between the two programs can experience disruptions in services.

The Department's Proposal:

To address these problems, the Department proposes to use a combined managed care purchasing strategy for the Medicaid and CHP+ programs, similar to that used by large employers in Colorado including:

- Combination of eligible populations into a single program to increase purchasing power
- Contracts with managed care organizations to deliver all health care benefits
- Competitive selection of managed care organizations
- Actuarially sound premium rates
- Use of performance standards and incentives in managed care contracts

The Department's purchasing strategy has both an urban and a rural competent. The Department intends to competitively select one or two HMOs in urban areas of the state, where 85% of Medicaid and CHP+ recipients live. In the remaining rural areas, the Department will contract with a single managed care organization to administer a non-HMO plan for Colorado Family Care enrollees.

The Department testified that managed care services will reduce Medicaid child costs by 4% and increase access to care by assigning a primary care provider to each enrollee. The Department further believes that this new method of purchasing managed care services will increase managed care organization participation and stability, primarily by assuring an adequate number of members for each participating HMO and by using actuarially-sound rates. Health plans have stated that their participation in the program will be based on the adequacy of reimbursement rates and enrollment volume, as well as implementation timeframes.

Public Testimony:

Citizens who testified at the hearings in Denver, Greeley, and Durango expressed both support and concerns for this new model of care. Provider organizations and consumer groups testified that they support the use of managed care organizations, citing the potential for improved access and quality of care for Medicaid and CHP+ recipients. These groups and others, however, also expressed concern that weak oversight of the new managed care program could lead to poor access and quality. Suggestions to ensure managed care performance included requiring licensure and accreditation of HMOs, evaluating bids on the number of contracted providers in an HMO's network, and assuring adequate Department staff and resources to implement a strong managed care monitoring program. One suggestion included studying Medicaid programs in other states that have experience competitively selecting and managing HMOs to ensure that the Department has the right staff and resources to implement Colorado Family Care successfully.

Consumers also expressed concern about the lack of detail regarding provision of Core Plus services by HMOs and the potential for barriers to receiving these needed services for high-need children.

Physician Reimbursement and Participation

Providers stated at the public hearings that both publicly-funded clinics and private physicians are needed to serve Medicaid and CHP+ patients, and that the lack of participation by either public clinics or private physicians in the new program would threaten access to care.

Private physicians

Department's Proposal:

The most common reasons given by providers for not accepting Medicaid patients include low reimbursement and administrative burden. Under the Colorado Family Care plan, the Department intends to increase physician fees from 62% to 80% of the Medicare fee schedule. This increase in fees, combined with streamlined administration of the Medicaid and CHP+ programs, is intended to ensure an adequate network of private physicians for the over 300,000 enrollees who would be served by this program.

Public Testimony:

Three provider organizations testified or provided information that suggests that the new physician reimbursement level of 80% of the Medicare fee schedule will be inadequate to

bring more physicians into the program[3]. Provider organizations suggested that reimbursement would have to be increased from current Medicaid and CHP+ levels (62% and 80% of Medicare, respectively) to 100% of the Medicare fee schedule. This level of reimbursement would cover physician costs and, according to provider groups, bring new physicians into the program.

Federally Qualified Heath Centers

The Department's Proposal:

The Colorado Family Care plan proposes to pay Federally Qualified Health Centers (FQHCs) the same rate as private physicians.

Public Testimony:

Colorado Community Health Network, the FQHC association, stated in an interview that the new reimbursement would represent a 40% cut in reimbursement for FQHCs, who currently receive cost-based reimbursement for serving Medicaid patients (Colorado Community Health Network, 2005). Local providers and agencies at each hearing testified that they would not support the program if it reduced payments to their local FQHCs, thereby reducing FQHC capacity to serve low-income uninsured patients in their communities.

Employer Premium Assistance

The Department's Proposal:

Colorado Family Care will include a pilot program for individuals who are interested in receiving a subsidy to enroll in their employer's health plan in lieu of enrolling in the Colorado Family Care program. The Department is currently working with two employers and two health plans that are interested in participating in this pilot program.

The Department testified that while the employer premiums assistance concept is appealing, other states' experience suggests that these programs can have low enrollment and high administrative costs. The Department is therefore planning to test the concept in a pilot program with interested health plans and employers.

Public Testimony:

No public testimony was given regarding the Employer Premium Assistance Pilot.

[3] Two data sources report that , despite 30% higher physician reimbursement levels in CHP+ compared to Medicaid, Medicaid and CHP+ have a similar number of participating providers (Colorado Department of Public Health and Environment, 2004; Colorado Medical Society, 2005).

Federal Funding/Budget Neutrality

The Department's Proposal:

To secure continued federal funding of the Colorado Medicaid and CHP+ programs, Colorado must seek permission from the federal government to make the changes to eligibility, benefits, and managed care envisioned in the Colorado Family Care proposal. The Department is requesting authority from the Joint Health and Human Services Committee to submit a Health Insurance Flexibility and Accountability (HIFA) wavier to the federal government for implementation of Colorado Family Care. HIFA waivers allow states to use federal Medicaid and State Children's Health Insurance Program funds in ways not otherwise allowed by federal law. In its Colorado Family Care concept paper, the Department names six elements of its program that require a waiver of federal laws, including addition of new preventive services for Medicaid parents, mandatory managed care enrollment for Native Americans, and implementation of an employer premium assistance program.

In exchange for the increased flexibility provided through HIFA waivers, states must accept a cap on federal funding to ensure that the new program is "budget neutral." The Department has proposed an 8.4% per capita annual growth rate over the five year waiver program. Since state fiscal year 01-02, per capita growth rates for children have ranged between -12% and +4% in the Medicaid program, and between +4% and +12% in the CHP+ program.

The cap proposed by the Department is a cap in per person expenditures; it is not a cap on the total program budget. This means that an increase in program enrollment will not reduce federal funds; however, increases in per person costs above the anticipated growth rate would reduce federal funding.

The Department believes the 8.4% per capita annual growth cap to be more than adequate, yet it recognizes the potential risk in such a per capita cap. The Department stated in its July 26, 2005 submission that "there is an advantage to minimizing the scope of what is subject to the budget neutrality provisions of the waiver."

Public Testimony:

Providers and consumers at the public hearings testified that they were concerned that the cap puts the program at risk, and several asked if benefits would be cut or provider reimbursements reduced if the growth cap were exceeded. In response to these concerns, several legislators and citizens have asked if the Colorado Family Care program could be implemented without a HIFA waiver and its related budget neutrality requirements. State plan amendments, for example, allow states to make changes to their Medicaid and CHP+ programs that comply with current federal law. State plan amendments do not have a budget neutrality requirement.

The following table presents each element of the Colorado Family Care program for which the Department has stated it will need a HIFA waiver. For each item, the table presents which could be implemented with a state plan amendment and, for those that cannot be implemented with an amendment, what program changes would need to be made to implement with a state plan amendment.

[4][5][6]FA versus State Plan Amendment implementation of Colorado Family Care

Cover pregnant women up to 200% of poverty	Yes.	Use existing HIFA waiver to cover this population.
Require all Medicaid children, parents and pregnant women to enroll in an managed care plan	No.	No change. This can be implemented with a state plan amendment.
Provide only one plan choice in urban areas, if necessary	Yes.	Offer a choice of at least two plans in urban areas.
Require Native American Medicaid eligibles to enroll in managed care	Yes.	Do not require Native Americans to enroll.
Provide new preventive hearing and eye services to parents	Yes.	Do not provide new preventive hearing and eye services.
Add Core Plus benefits to CHP+ covered services	No.	No change. This can be implemented with a state plan amendment.
Provide pilot program to purchase employer coverage	Yes.	Do not provide pilot program to purchase employer coverage .
Cap parent enrollment if state funds are inadequate to cover all parents up to 100% of poverty	Yes.	Do not cap enrollment on parent enrollment.
Three month federal approval process	Yes.	Nine month federal approval process

[4] This list of program changes that require a waiver is presented in "Colorado Family Care Concept Paper," Department of Health Care Policy and Financing, July 1, 2005

[5] A separate HIFA waiver could be pursued to implement an employer buy-in program for Colorado Family Care.

[6] It is not clear whether or not CMS will allow the state to cap parent enrollment with a HIFA waiver.

As the table shows, several changes would have to be made to implement Colorado Family Care using state plan amendments:

- The Department would have to contract with at least two managed care organizations in each urban area.
- American Indian eligibles could not be required to enroll in a managed care plan. American Indians represent less than 1% of the proposed enrollment of Colorado Family Care.
- Parents could not be given new preventive benefits, unless these benefits were given to all Medicaid eligibles.
- The employer premium assistance program, as envisioned in the Colorado Family Care plan, could not be implemented with a state plan amendment, but could be pursued through a separate HIFA waiver.
- There could not be a cap on parent enrollment between 60% and 100% of poverty, although a new poverty level for parents could be chosen.
- The timeframe for federal approval would be nine months, instead of the three months.

Savings from Managed Care

The Department's Proposal:

Under the Colorado Family Care program, savings created by enrolling Medicaid eligibles in managed care would be used to improve eligibility, benefits and service delivery in Medicaid and CHP+. Specifically, managed care savings would fund coverage of low-income parents between 60% and 100% of poverty, new benefits for CHP+ children, and increased physician reimbursement.

The draft HIFA waiver budget developed by the Department indicates that managed care enrollment will save the program 4% per Medicaid child. These savings are produced by:

- Volume purchasing
- Increased enrollment in HMOs
- Contracted management of the state's non-HMO provider network.

The Department has hired an actuarial firm to produce new premium estimates, using new price and utilization assumptions, and in September, the Department will revise its

savings estimates.

Public Testimony:

While consumers, providers and health plans testified that they supported the use of managed care, some also expressed concern that the Department's savings assumptions may not be reasonable and that actual savings could be less that predicted. In addition to concerns about the reliability of the managed care savings estimates, consumers asked why only savings for Medicaid children are calculated in the program budget. While enrolling Medicaid children into HMOs will create program savings, presumably enrolling Medicaid parents and pregnant women into HMOs will produce savings as well. It is unclear whether the savings generated by these populations would be used to fund coverage expansions and other program improvements, or would be returned to the state's general fund.

Public Input

The Department's Proposal:

Beginning in 2003, the Department began a public input process that included public meetings, meetings with community groups such as provider organizations and health plans, and a website with program information and reports. In addition, the Department has maintained an email address and phone number for public comments on the Colorado Family Care Plan. The Department has made changes based on feedback received through this process such as changes to the medical necessity definition. The Department plans to continue this public input process through implementation, including release of the draft HMO Request for Proposals document for comment and development of ad hoc committees on specific issues.

Public Testimony:

Testimony on the public input process focused on the timeframe given for review of the Department's proposal submitted to the Joint Health and Human Services Committee. Concern was expressed by consumers, providers, health plans, and local agencies that they had been given inadequate time to review and provide comment on the 160-page Colorado Family Care proposal. Constituents in the Denver area had seven calendar days to review the plan before the Denver hearing. One local social services department testified that the Department had not notified county agencies regarding the hearings. Providers and consumers testified that they feared that an inadequate timeframe for stakeholder review and comment could threaten the successful implementation of the program.

Department Capacity

The Department's Proposal:

SB 05-221 did not direct the Department to submit information regarding implementation of the Colorado Family Care program, and the Department plans to develop a plan upon state legislative approval of the program. In response to questions raised in public testimony and interviews regarding implementation issues, the Department states that it plans an implementation approach that builds on both existing internal strengths, such as contract management and data analysis, as well as advice from national Medicaid purchasing experts on management and program issues.

Public Testimony:

Health plans and providers stated in public testimony and interviews that they were concerned about the Department's capacity to implement the program. Issues such as state and federal budget pressures, premium and fee schedule adequacy, implementation timeframe, HMO selection criteria and evaluation, and program oversight were cited as potential barriers to HMO and provider participation. Concerns were further elevated by negative recent Medicaid experiences with the Colorado Benefit Management System and the Medicaid HMO lawsuits.

Summary of Program Issues

The following list summarizes the impact of Colorado Family Care on cost, access, quality, and funding in the Medicaid and CHP+ programs based on review of the Department's plan and public testimony presented in Denver, Greeley and Durango. This list concludes with a summary of implementation issues raised during public testimony.

Cost

- Reduces costs for Medicaid children due to managed care enrollment
- Increases cost for CHP+ children due to provision of new Core Plus benefits.

Access

- Increases access for 6,000 new low-income parents who receive Medicaid coverage in the first year of the program, subject to available state funding
- Increases access for Medicaid enrollees who receive 12 months of eligibility
- Increases access through assignment of enrollees to a primary care physician
- Decreases access through reduced FQHC capacity to serve Medicaid and uninsured patients as testified by FQHCs

Quality

- Increases quality for managed care enrollees due to increased preventive care and chronic care management

Funding

- Reduced federal funding could occur if the per capita cost growth cap is exceeded
- A revised savings estimate will be available in September. The estimate of savings available for increased coverage, benefits and physician reimbursement may be increased or decreased at that time.

Implementation Issues

- The Department plans to develop an implementation plan upon legislative approval of Colorado Family Care.
- Managed care plans will participate only if reimbursement rates, enrollment volume, and implementation timeframes are adequate (Baillit Health Purchasing, 2005).
- Testimony emphasized the need for strong performance standards for HMO selection and adequate monitoring of health plan performance to assure improvements in access and quality.
- Through public testimony and interviews, multiple providers and health plans stated that the Department needs adequate capacity--staffing, information technology and funding--to ensure that it is able to successfully manage Colorado Family Care.
- Consumers, providers and health plans testified that they need to be involved in the design and implementation of the program to ensure program goals are met.

Conclusions

The public hearings held in Denver, Greeley, and Durango revealed support for the core concepts of the Colorado Family Care program particularly for increased access to care through expanded eligibility and improved quality of care through managed care delivery of health care services. Concerns expressed during the hearings mainly addressed budget and implementation issues. The following conclusions describe the benefits and risks identified through review of the Colorado Family Care proposal and public testimony.

The Colorado Family Care program will increase access to medical care for children, parents and pregnant women. The Colorado Family Care proposal has several strategies for increasing access to care including expansion of Medicaid eligibility for parents up to 100% of poverty, provision of 12 months of eligibility for program enrollees, and assignment of a primary care physician to each enrollee. In addition, Medicaid and CHP+ will contract with the same managed care organizations, eliminating disruptions in care for children who move between the two programs. These elements of the program were widely supported by individuals who testified at the public hearings as successful strategies to improve access to care.

The Colorado Family Care program relies on enrollment of parents and children in managed care organizations to reduce cost and increase quality. The success of this strategy depends on strong performance standards for evaluating health plan bid proposals and program management that closely monitors health plan performance. Individuals who testified at the public hearings stated that while they were supportive of the use of managed care to increase access and reduce costs, they worried that low premium rates, lack of licensure and accreditation requirements, and weak oversight of the program could lead to deterioration in current levels of access and quality. The Department states that it plans to develop an implementation plan that builds on the Department's existing strengths and the advice of national Medicaid managed care experts.

The proposed increase in physician reimbursement to 80% of the Medicare fee schedule may be too small to increase physician participation. Three provider organizations testified that 80% of the Medicare fee schedule, while a significant improvement in reimbursement, is still less than the cost of treating Medicaid patients, and that 100% of the Medicare fee schedule would be needed to bring new physicians into the program.

Federally Qualified Health Centers testified that the proposed reduction in their reimbursement would impact their ability to serve Medicaid and uninsured patients in their communities. Federally Qualified Health Centers stated that the proposed reimbursement level for FQHCs would represent a 40% reduction in the cost-based reimbursement that they currently receive to treat Medicaid patients. They further stated

that Medicaid represented 36% of FQHC revenue in 2004. Providers, consumers, and local agencies at each public hearing opposed any reduction in funding to FQHCs.

Implementing Colorado Family Care with a Health Insurance Flexibility and Accountability (HIFA) waiver requires accepting a per capita growth cap on federal funding, yet most elements of the new program could be implemented with state plan amendments that do not require a cap on federal funding. Public testimony often addressed whether or not it is prudent to accept a cap on federal funding, and whether benefits and provider reimbursements would be reduced if growth caps were exceeded. The Department believes that state plan requirement to provide a choice of HMOs in urban areas would reduce its ability to meet the program's access, cost, and quality goals.

The extent of savings created through managed care enrollment may be revised in September, when the Department completes its revised actuarial analysis of the program. Health plans and consumers testified that they were unsure of the Department's assumptions regarding program savings, and wondered if savings would be adequate to fund expansions in access and quality outlined under the program. The Department has hired an actuarial firm to produce new premium rates for the Colorado Family Care program, using new utilization and pricing assumptions. This new report, which will be available in September, will result in a new estimate of program savings.

Consumers, providers, health plans, and county agencies testified that they had been given an inadequate amount of time to review the Colorado Family Care proposal and feared that they would not be adequately involved in the implementation of the program. Although public and stakeholder meetings were held by the Department in the two years preceding the Department's submission to the Joint Health and Human Services Committee, consumers, hospitals, physicians, health plans and local agencies testified that they felt they had not been given enough time to study the proposal and to provide comments to the Department and the legislature. Most expressed concern that inadequate engagement of constituent groups would threaten the success of the program.

Recommendations

The following recommendations address the issues identified by individuals who testified during the Denver, Greeley, and Pueblo hearings:

Implement Colorado Family Care using state plan amendments. Testimony expressed the urgent need for Medicaid reform to improve access, quality, and cost for low-income, uninsured individuals in the state. State plan amendments would allow Colorado to pursue a modified reform proposal without accepting new limitations on federal funding.

Closely monitor whether private physician and FQHC involvement in the program is sufficient to ensure access and quality of care. Private physicians testified that reimbursement levels and administrative burden in the new program would largely determine whether or not they would participate in the new program. Federally Qualified Health Centers stated that reduced reimbursement levels would negatively impact their ability to serve uninsured and Medicaid patients in their communities. Provider participation in the new program, therefore, should be carefully monitored to assure that the over 300,000 program enrollees have access to primary care. If provider participation is inadequate, changes to reimbursement, administration and provider support should be considered.

Create a Department organizational, staffing and information technology plan based on review of Medicaid programs that manage competitively-bid HMO programs. Multiple providers and health plans stated that the Department needs adequate capacity--staffing, information technology and funding--to ensure that it is able to successfully manage Colorado Family Care. Development and management of HMO premium rates, selection criteria, reporting requirements, and performance incentives will determine the ability of Colorado Family Care to meet its cost, access, and quality goals. The Department states that it plans to develop an implementation plan upon legislative approval of Colorado Family Care, building on internal strengths and the advice of national Medicaid managed care experts.

Create an implementation plan with consumer, provider, health plan, and local agency involvement. Because these groups feel that they have been inadequately involved and are concerned about the implementation of the program, the Department may need a different public input strategy for the implementation phase of Colorado Family Care. Processes such as advisory committees and work groups that engage leaders in meaningful decisions will increase community confidence in the program, particularly in light of the Colorado Benefit Management System problems and the Medicaid HMO lawsuits.

Attachment A