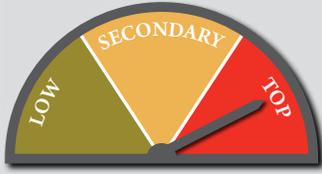


# MEDICAID

## PRIORITY



## OVERVIEW

The material describes the scope and size of the health care programs run by the State government. It is the second time this chapter has appeared in a Citizen's Budget.

## RECOMMENDATIONS

- Revise the commitment to Medicaid managed care now that it has been proven to be more costly than the alternative it replaced
- Reform the long-deferred modifications in out-of-pocket charges for people already benefitting from the government health care programs
- Amend the growth in administrative overhead and change the bureaucracy's objectives which favor reliance on Medicaid

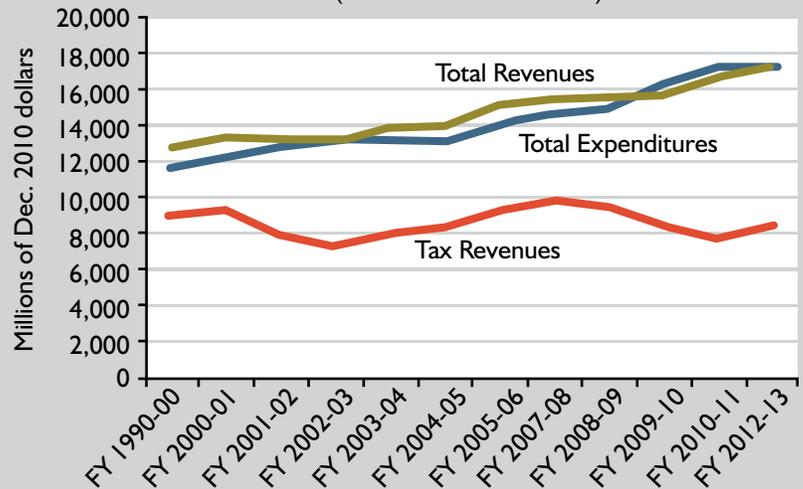
The Patient Protection and Affordable Care Act (PPACA) of 2010 offers large subsidies for the purchase of health insurance to people who are not eligible for Medicaid. If the Colorado legislature takes advantage of PPACA by pruning the current Colorado Medicaid program, it could make current Medicaid clients better off by making them eligible to purchase heavily subsidized commercial health coverage. Also, it could possibly cure Colorado's structural budget imbalance by simultaneously reducing Medicaid and child health insurance program spending.

If it works as advertised, the federally subsidized commercial health coverage offered through the PPACA health benefits exchange will provide better health coverage for the basically healthy adults and children who make up the largest part of the Colorado Medicaid caseload. But people are eligible for subsidized coverage through PPACA only if they are ineligible for Medicaid. In order to allow people to receive the full benefit of PPACA, the state's Medicaid program should be cut

back rather than expanded.

Commercial coverage likely will benefit the majority of Medicaid beneficiaries because it has historically provided better access to care than Medicaid. Commercial policies have reimbursed at significantly higher rates, making it easier to find a physician and to arrange for timely care.<sup>1</sup> A number of recent papers in the medical literature report that Medicaid coverage is an independent predictor for increased mortality, extended hospital stays, and higher costs, even after adjusting for known risks. In some cases, Medicaid patients have worse outcomes than uninsured patients.<sup>2</sup> Although the extent to which the actions of patients in the Medicaid program

**Figure I**  
**Colorado Inflation-Adjusted Tax Revenues and Expenditures**  
(December 2010 dollars)



contribute to these differences remains unknown, mainstream academic studies of health disparities generally assume that different patient populations behave similarly.

If state officials expand Medicaid in order to take advantage of near term funding in the PPACA, they prevent people from taking advantage of its commercial coverage subsidies. They also will worsen Colorado's existing structural budget imbalance over the next decade. Contrary to popular impression, the state must pay administrative costs for the Medicaid expansion and commit matching

funds beginning in 2017. Current growth in the Medicaid budget imperils the state's ability to fund schools, roads, and other core functions of state government. Medicaid expansion means there will be less money for these activities.

Since the end of the recession in June 2009, Colorado's economy has made a slow recovery. State tax revenues have begun to climb back to historically normal levels. Unfortunately, even normal tax revenues are not sufficient to support the current size of state government. As California, Illinois, and New York have shown, it is unlikely Colorado can increase state tax revenues enough to close the gap. Many of the state's residents and businesses are mobile, and in recent years Colorado's business

tax climate has begun to deteriorate relative to other states. According to the Tax Foundation, Colorado now ranks a middling 18th in the quality of its business tax climate. In its region, it is behind Wyoming, Washington, Utah, Texas, Nevada, Montana, and South Dakota.<sup>3</sup> The Tax Foundation also reports that Colorado's combined state and local sales tax rates are the 15th highest in the country. At a per capita average of \$816, the state's individual income tax is already more lucrative than that in 31 other states.<sup>4</sup>

Many of Colorado's residents and businesses were attracted to the state by its reasonable tax and regulatory climates. If these climates deteriorate, taxpayers will depart for other, more hospitable, states.

*Current growth in the Medicaid budget imperils the state's ability to fund schools, roads, and other core functions of state government. Medicaid expansion means there will be less money for these activities.*

## **HOW REALISTIC ARE CLAIMS THAT ALL MEDICAID EXPANSION COSTS WILL BE BORNE BY THE FEDERAL GOVERNMENT?**

Advocates for Medicaid expansion often ignore the large uncertainties associated with the subsidies that PPACA promises. First, it is entirely possible that unintended consequences from PPACA's other effects on Colorado Medicaid will add significantly to the state expenditures. No money then will be left to expand Medicaid eligibility, regardless of its apparent low cost. The federal government currently promises to pay 100 percent of the cost of additional enrollees who result from expanding Medicaid to cover everyone with an income of less than 133 percent of the federal poverty level. However, this level of coverage lasts for only three years. The match rate floats down beginning in 2017, stabilizing at 90 percent in 2020. Due to income set-asides included in the law, the operative coverage extends to those with incomes up to 138 percent of the poverty level, a slightly larger population than those with incomes of 133 percent.

If the federal government changes the matching rate to the blended rate already proposed by the Obama administration, state costs will increase significantly. Colorado Medicaid spending would increase by \$376.7 million from 2014 to 2019 and by \$684.1 million from 2014 to 2022. Because the 100 percent federal match does not cover new administrative costs, Medicaid expansion will add to state expenses. Edmund F. Haislmaier

*Advocates for Medicaid expansion often ignore the large uncertainties associated with the subsidies that PPACA promises.*

and Drew Gonshorowski of the Heritage Foundation estimate that “Nationally, on average, every additional \$100 of state Medicaid spending generates about \$5.50 in new administrative costs, of which states pay around \$2.48.”<sup>5</sup> They also caution that federal matching rates can be changed by legislation, and that reducing the federal matching rate for Medicaid expansion has already been proposed in the Obama administration’s FY 2013 budget.

*Colorado’s decision to set up a state-run health benefits exchange rather than to let the federal government foot the bill may impose additional costs.*

Colorado’s decision to set up a state-run health benefits exchange rather than to let the federal government foot the bill may impose additional costs. Colorado’s Health Benefits Exchange must begin

supporting itself by January 1, 2015. The Massachusetts Commonwealth Connector Authority is its closest real world example. The Connector Authority supports itself by charging Massachusetts Medicaid for performing Medicaid enrollment. If the Colorado health benefits exchange plans to charge for Medicaid enrollment services, then State Medicaid costs are likely to increase. They also will increase if CIVHC, the 501(c)3 organization that manages Colorado’s All Payer Claims Database, begins charging Colorado for its data services.

Estimates of the effect of PPACA Medicaid expansion vary widely. However, virtually all existing estimates agree that Medicaid expansion adds to state costs. In 2010, Legislative Council estimated that PPACA would extend Colorado Medicaid from covering almost everyone with household incomes up to 100 percent of the Federal Poverty Level (FPL) to covering every-

one with incomes up to 133 percent of the FPL. It estimated that Colorado could cover an additional 35,600 people at no cost in FY 2012-14. By FY 2019-20, 144,500 additional people would be covered at an additional annual cost of \$66.4 million.<sup>6</sup>

Because PPACA makes such sweeping changes, precise estimates of annual changes in existing state Medicaid expenditures are little better than guesses. Those who do produce estimates typically quote changes for a range of years, usually before and after the PPACA 100 percent matching ends, or as a single period. Using data from the Congressional Budget Office’s March 2012 baseline for Medicaid spending, Haislmaier and Gonshorowski estimate that expanding Medicaid to 138 percent of the Federal Poverty Level under PPACA conditions will add \$53 million to the Colorado state budget from 2014 to 2019, an average of slightly more than \$10 million a year. From 2014 to 2022, it will add \$155.5 million to the Colorado state budget, or an average of roughly \$50 million a year due to the decline in the federal match decline.

More recently, Urban Institute researchers have estimated that Medicaid expansion will increase Colorado Medicaid spending by \$581 million from 2013 to 2022, with most of the increase probably occurring after the federal matching rate declines.<sup>7</sup> This estimate includes savings of \$277 million based on the estimated decline in the uninsured as a result of the expansion and a reduction in uncompensated care.

Uncompensated care savings of this magnitude are unlikely to materialize. Similar claims were made in Massachusetts and yet, as Haislmaier reports, there was no reduction in payments for uncompensated care even with virtually universal coverage because “safety-net hospitals successfully lobbied to continue receiving over \$200 million in supplemental payments from state taxpayers.”<sup>8</sup>

In fact, Medicaid expansion is more likely to expand uncompensated care costs. Medicaid is itself a source of uncompensated care because it reimburses at rates far below both the list price quoted by hospitals and the negotiated rates paid by private commercial insurance. If most of the expansion population in need of medical care is already covered either by Medicaid via programs for the

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acutely ill and disabled or by private coverage, it is possible that the uninsured generate less uncompensated care uncovered than they would if they were enrolled in Medicaid.

In general, there is no particular reason to believe that covering the uninsured reduces costs. The uninsured tend to be healthier than those who sign up for coverage. They also pay for about half of their own health care, which gives them an incentive to minimize their health care use. Existing evidence suggests that changing status from being uninsured to being covered by Medicaid increases individual health care utilization, and thus the uncompensated care generated by Medicaid, by an estimated 25 percent.<sup>9</sup>

It is also important to remember that a surprisingly high proportion of people in the lowest income groups already have private coverage. Using 2000 data, Pauly and Bundorf estimated that 36 percent of people with incomes below 150 percent of the poverty level had private health insurance.<sup>10</sup> Among people with incomes below the poverty level, 28.5 percent had purchased private insurance. If able-bodied people who work minimal hours to get health insurance are offered “free” Medicaid coverage, they may stop working, drop their private coverage, and increase both uncompensated care costs and Medicaid program costs. In 2007, economists Jonathan Gruber and Kosali Simon found that crowd-out rates for the federal Children’s Health Insurance Program approached 60 percent.<sup>11</sup> In 2012, Antwi et al. found that PPACA’s requirement that family coverage be extended to “children” up to age 26 reduced work-hours by roughly 5 percent. It also reduced the prevalence of full-time work.<sup>12</sup>

**EVEN IF MEDICAID IS NOT EXPANDED, SPENDING ON THE EXISTING MEDICAID PROGRAM WILL INCREASE DUE TO PPACA PROVISIONS**

Figure 2 describes Colorado’s existing health subsidy programs. In general, able-bodied adults aged 19 to 65 are not eligible for Med-

icaid. Those with medical needs are helped by the Colorado Indigent Care Program which aids in the purchase of medical care from participating providers.

Under PPACA, people who are not

**Table 1. Maximum Out-of-Pocket Premium Payments Under PPACA, If Currently Implemented for the 48 contiguous states and the District of Columbia**

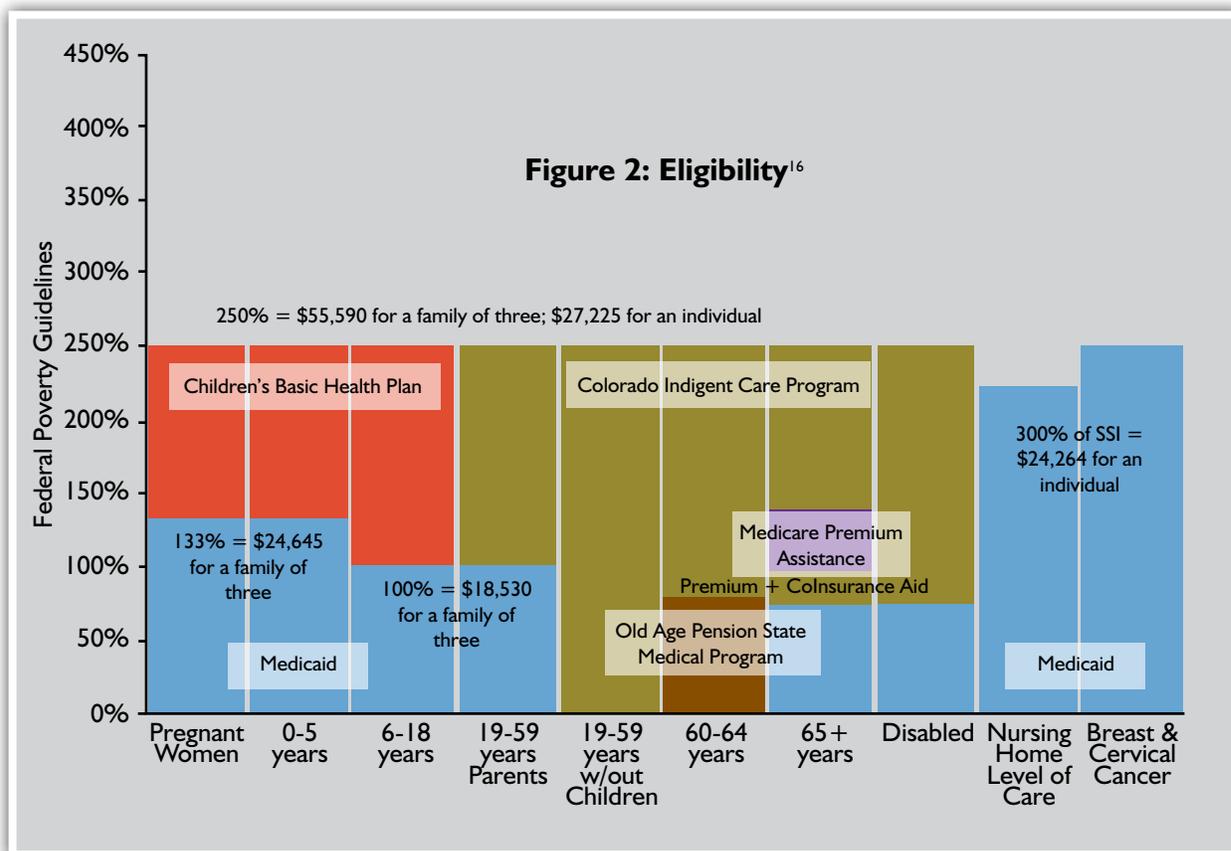
Federal Poverty Line (FPL)	Max. Premium as a % of Income (2014)	Max. Annual Premium (current), by Family Size			
		1	2	3	4
100%	2.0%	\$217	\$291	\$366	\$441
133.00%	2.0%	\$288	\$388	\$487	\$587
133.01%	3.0%	\$487	\$656	\$824	\$992
150%	4.0%	\$650	\$874	\$1,099	\$1,323
200%	6.3%	\$1,365	\$1,836	\$2,307	\$2,778
250%	8.05%	\$2,130	\$2,932	\$3,685	\$4,438
300%	9.5%	\$3,087	\$4,152	\$5,218	\$6,284
350%	9.5%	\$3,601	\$4,845	\$6,088	\$7,332
400%	9.5%	\$4,115	\$5,537	\$6,958	\$8,379

Sources: CRS computations based on “Annual Update of the HHS Poverty Guidelines,” 74 *Federal Register* 4200, January 23, 2009, <http://aspe.hhs.gov/poverty/09fedreg.pdf>, and PPACA, for the second least expensive silver plan available to eligible individuals. If individuals choose more expensive plans, they would be responsible for additional premiums.

Source: Hinda Chaikind et al. April 15, 2010. Private Health Insurance Provisions in PPACA (P.L. 111-148). R40942, Congressional Research Service. [http://assets.opencrs.com/rpts/R40942\\_20100415.pdf](http://assets.opencrs.com/rpts/R40942_20100415.pdf), accessed November 13, 2012.

enrolled in Medicaid, Medicare, or another acceptable health coverage plans as of January 1, 2014, will be required either to become insured or to pay a penalty. For those who meet certain income requirements, generous subsidies for purchasing health coverage are available. The subsidies, and the maximum annual premiums required, are shown in table #1 [maximum out-of-pocket premium payments].

Those persons who do not buy coverage will be penalized. By 2016 and beyond,



the penalty is \$695 per adult and \$347.50 per child, up to \$2,085 for a family or 2.5 percent of family income, whichever is greater.<sup>13</sup> Some experts believe that the

finer, coupled with greater outreach, will encourage people who are already eligible for Medicaid but not enrolled to sign up. Estimates from the Census Bureau and others suggest that these people make up 20 to 30 percent of the uninsured population.<sup>14</sup> The 100 percent federal matching rate will not apply to

newly enrolled people who already would have been eligible for Colorado's existing Medicaid program.

Other experts believe that the penalty is unenforceable as long as taxpayers never overpay their taxes.<sup>15</sup> Coupled with the high cost of purchasing PPACA's high cost

coverage and the statute's guaranteed issue requirement, which makes it possible to wait to get coverage until one is sick enough to need it, the inability to enforce the penalty could encourage people to remain uninsured and dependent on state safety-net programs.

If that happens, safety-net program costs could increase, and the state will need to budget extra safety-net funding.

In addition to extra safety-net funding, the state will need to cover the Medicaid costs of people who are currently eligible for Medicaid and CHP+, have not yet signed up, but will sign up when the coverage mandate takes effect on January 1, 2014. In 2009, the Colorado Health Institute revised its estimates of the number of Colorado children who were eligible for Medicaid and CHP+ but not enrolled. An estimated 47,603 children up to the age of 18 were eligible for Medicaid but not enrolled, almost 20 percent of the existing caseload.<sup>17</sup> The number of children eligible but not enrolled in CHP+ was 30,625, 40 percent of the caseload. If just half of the 78,228 children enroll and the state pays \$1,000 per child, the average per capita Medicaid rate

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for a healthy child in FY 2010-11, the additional cost to the state would be \$39 million a year.

Colorado already covers parents with incomes below 60 percent of the poverty level. The Hospital Provider Fee, passed in 2009, instituted a provider tax on hospital bills. Its proceeds may be used to expand eligibility to adults up to 100 percent of the federal poverty guidelines (\$11,170 for one person, \$15,130 for two people in 2012), children in CHP+, and, with an unspecified “premium,” pregnant women up to 250 percent of the federal poverty guideline (\$37,825 for a two people, \$57,625 for a family of four). A person earning the Colorado hourly minimum wage of \$7.64 who works the standard 2,080 hours a year would earn \$15,891 before payroll taxes.

As eligibility expands up the income scale, program enrollments become more expensive simply because there are more people in higher income categories. The American Community Survey estimates roughly 47,000 Colorado families with incomes below \$10,000. They are eligible for a number of programs that provide housing, transportation, and food subsidies that are not counted as money income. For comparison, more than 86,000 families have incomes between \$15,000 and \$24,999, while 155,960 families have incomes between \$35,000 and \$49,999.

Higher Medicaid caseloads could also result if employers respond to PPACA incentives by ending employer-provided health plans. To encourage employers to offer health insurance, PPACA fines businesses with more than 50 employees. The fines are \$2,000 for the 31st employee and every employee thereafter if any employee applies for health insurance at a state exchange. The cost of the fine is below

the current cost of providing an employee with PPACA-dictated health coverage, even without the accompanying administrative costs. The wording of the statute suggests that employers in states in which the federal government runs the exchange are not subject to such fines, yet another reason for allowing the federal government to fund a state’s health benefits exchange.

Offering coverage also puts employers at risk for a potential \$3,000 penalty per employee. The penalty applies if an employer offers

coverage but fails to meet the PPACA affordability test. The test is based on employee household income, data that employers typically do not have. No one knows how employers will react, but at least one large firm is experimenting with limiting employee work hours to the maximum at which it can eliminate health coverage without paying any fines.<sup>18</sup> By altering the income of low-wage workers, an employer flight from health coverage likely will increase both Medicaid caseloads and Colorado’s Medicaid expenditures.

## **THE STATE SHOULD BEGIN INVESTIGATING POSSIBLE COST SAVINGS FROM MOVING PEOPLE FROM MEDICAID TO FEDERALLY SUBSIDIZED COMMERCIAL PLANS WHEN THE PPACA MAINTENANCE OF EFFORT REQUIREMENTS EXPIRE IN JANUARY 2014**

The long-term question posed by the PPACA health insurance subsidies is the extent to which Colorado can save money and better serve its citizens by cutting back its Medicaid program. Given the low reimbursement rates for Medicaid and the difficulty of accessing care, state officials should give serious consideration to freeing people from the Medicaid program. They could do so by concentrating state efforts on those who need benefits not provided by the commercial insurance products offered through the federally-qualified health

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benefits exchange. State officials should also consider legislation that aligns the premiums charged for state coverage programs with the payments required under PPACA. People are not eligible for federal health coverage subsidies as long as they are eligible for state Medicaid programs. As the Urban Institute researchers point out, “it is possible that states could achieve additional savings through maintenance of effort reductions. For example, states could discontinue Medicaid eligibility currently provided through Section 1931 and 1115 waivers and move those adults to federally subsidized coverage in the exchange.” States also could eliminate Medicaid eligibility for adults “between 100% and 138% of the FPL and mov[e] them into federally subsidized coverage in the exchange.”<sup>19</sup>

*In addition to having more easily accessible networks, commercial policies may also do a better job of controlling health expenditures than Medicaid does.*

In addition to having more easily accessible networks, commercial policies may also do a better job of controlling health expenditures than Medicaid does.

Their relative freedom from the political process allows them to structure their policies in ways that give patients the incentive to use health care wisely. In contrast, Medicaid’s structure encourages patients to use health care as if it is free. Although Colorado health policy circles were recently surprised by a report showing that Medicaid patients use emergency rooms for routine care simply because they are more convenient than appointments at Medicaid clinics,<sup>20</sup> firms offering commercial coverage have long adjusted incentives to control this kind of behavior. In 1993, for example, Northern California Kaiser Permanente experimented with an emergency department copayment of \$25 to \$35. It

reported a 15 percent reduction in inappropriate utilization with no detectable adverse effects on health.<sup>21</sup>

Revamping the Colorado’s Child Health Plan (CHP+) to give more children in their own federally subsidized coverage plans would improve coverage for children. PPACA coverage is more extensive than previous commercial products, and the federal government pays all costs of the insurance subsidy through the exchange.

## **THE STATE SHOULD REVISIT INCREASING CHP+ ENROLLMENT FEES**

State officials should note that the federally acceptable affordable premium rates for PPACA are far above the \$35 annual premium that Colorado charges families for CHP+ membership. The state could save millions on this program simply by bringing its premiums in line with the means-tested premiums for federally subsidized commercial policies. Last year’s effort to raise CHP+ premiums to a reasonable level failed when Governor Hickenlooper vetoed the bill, fearing it might increase the number of uninsured.

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With the passage of PPACA and its measures to prevent people from being uninsured, these concerns have considerably less force. The Department of Health Care Policy and Financing’s proposed alternate solution was to increase copays for a variety of services by a few dollars. This proposal adds unnecessary complexity to the system and makes it impossible for low-income people to know how much they will have to pay in advance should they become ill. Purchasing behavior in the individual market suggests consumers prefer policies that make their financial exposure clear so that they know exactly how much they might have to pay.

In view of PPACA’s determination of affordability, last year’s legislation to increase CHP+ premiums should be reintroduced, and last year’s veto should be reconsidered. PPACA annual premiums for commercial coverage for people at 100 percent of the Federal Poverty Level (\$11,170 in 2012 monetary income) are limited to \$217 for a single person. They increase by about \$75 for each additional person.

Federal poverty level income refers only to cash income. It understates the living standards of families eligible for various benefits programs because it does not take into account subsidies from programs like those that provide means-tested assistance for food, housing, transportation, childcare, or heat. According to the 2010 Consumer Expenditure Survey, people in spending groups with under \$10,000 a year in pretax money income spent about \$1,000 on entertainment, \$1,000 on food away from home, and more than \$2,000 on private vehicle transportation.

## **THE STATE SHOULD REPEAL THE LEGISLATION THAT ESTABLISHED THE COLORADO HEALTH BENEFIT EXCHANGE**

PPACA gives states the option of setting up health benefits exchanges. As of mid-December 2012, 26 states have decided their citizens are better off if the federal government runs the exchange. The first reason states have taken this approach is that exchanges are proving to be more expensive to set up and operate than was foreseen. The software required is technically demanding, and little

information has been released about the status of the federal data hubs into which states will connect. Ohio declined because it estimated \$43 million in annual costs for a state-run exchange and only \$1.6 million a year to participate in a federally-run exchange.<sup>22</sup>

The second reason for reversing the decision to operate a state health benefits exchange is that it may substantially reduce the cost of complying with PPACA. States have little freedom to operate exchanges as they see fit. In early September, for example, the Colorado Department of Insurance correctly decided the state lacked the expertise to operate the reinsurance and risk adjustment

function of the Colorado exchange. It ceded the function to the federal government. The Colorado exchange thus is likely to use the Centers for Medicare and Medicaid Services risk adjustment pricing model. Evidence suggests the federal model underestimates the cost of taking care of people who are seriously ill, sets payments for them too low, and therefore encourages plans to discriminate against them. If the state exchange uses the federal pricing method, it might as well let the federal government operate the exchange.

*The second reason for reversing the decision to operate a state health benefits exchange is that it may substantially reduce the cost of complying with PPACA.*

No state funding would be required, and the federal government has announced that fees will be limited to a 3.5 percent fee for policies sold through the exchange.

Third, opting out of a state exchange may protect state businesses from the \$2,000 per employee fines for not offering a health plan. Alert state officials understand that having a job is more important than having employer-provided health insurance and that the fines operate as an employment tax. As a result, they have moved to protect their citizens from a job-killing tax.

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## **OTHER BUDGET CONSIDERATIONS**

### **Medicaid Managed Care Increases Costs. Stop Forcing People Into It**

Rather than pay for health needs on an as-needed basis, the Department of Health Care Policy and Financing has responded to a decade of federal pressure to enroll people in managed care programs. Managed care programs require state taxpayers to pay managed care providers a specific amount per client regardless of whether that person ever visits the doctor. The Department admits managed care is more expensive, in part because managerial overhead seems to be higher.<sup>23</sup>

A 2012 synthesis report from the Robert Wood Johnson Foundation reviews the literature on Medicaid managed care and finds that claims of lower costs and

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better access are not well supported. In fact, like the State of Colorado, a number of researchers have found that managed care increases costs.<sup>24</sup> Failed managed care projects cost money. In 2006, the University of Colorado Hospital Authority wrote off \$600,000 in principal when Colorado Access failed.<sup>25</sup> There is no particular reason to believe the new Accountable Care Organizations, which the state is using federal money to set up, will fare better. State officials should explore the possibility that moving away from managed care now will save taxpayers money in the long run despite the fact the move would agitate the special interests currently profiting from the Medicaid managed care movement.

### **ESTABLISH ADEQUATE RESERVES TO ACCOUNT FOR THE STRESS THAT MEDICARE REIMBURSEMENT CUTS WILL IMPOSE ON THE INCOMES OF STATE-OWNED HOSPITALS**

The Medicare reimbursement cuts present another important budgetary consideration because they are likely to increase uncompensated care costs at state hospitals. PPACA penalizes Medicare providers for economy-wide productivity improvements, whether or not they take place in health care. The 2012 Medicare Trustees Report calculates that these cuts will “result in negative total facility margins for an estimated 15 percent of hospitals, skilled nursing facilities, and home health agencies.”<sup>26</sup>

The University of Colorado Hospital Authority’s primary revenue source is patient service revenue. The Authority recently entered into an agreement to combine with Memorial Health System in Colorado Springs and Poudre Valley Health Care to create the University of Colorado Health System. At present, the University of Colorado Hospital Authority receives roughly 25 percent of its revenues from Medicare and 10 percent of its revenues from Medicaid. After adjusting for differences between the hospital’s billing rates and Medicare and Medicaid reimbursements, its net patient-service revenue from the Medicare and Medicaid programs was \$251.9 million in FY 2010-11. It received Disproportionate Share Payments equal to \$52.3 million.<sup>27</sup> State funding for indigent patients was approximately \$20 million in 1999 and 2000, and \$34.2 million in FY 2009-10.

PPACA’s Medicare cuts are likely to affect the Hospital Authority’s balance sheet, which may require increased subsidies from state taxpayers. In addition, the future of the Disproportionate Share Payment program is uncertain. PPACA cuts federal disproportionate share payments by \$18.1 billion and Medicaid disproportionate share spending by \$22.1 billion over the years 2014-2020.

### **ENCOURAGE THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING TO MOVE AWAY FROM PERFORMANCE GOALS THAT ENCOURAGE IT TO MAXIMIZE MEDICAID AND CHP+ CASELOAD TOWARDS PERFORMANCE GOALS THAT MEASURE ACTUAL PROGRAM COST AND QUALITY**

The Department of Health Care Policy and Financing suffers from managerial weaknesses that reduce its ability to control Medicaid spending. The Department also has weaknesses in its accounting and program controls. Of the 11 Material Weaknesses identified by the State Auditor in the accounting and program controls throughout state government, HCPF had seven.<sup>28</sup>

Under Colorado statute, unlimited over-budget expenditures are allowed for the Medicaid program, provided the program can take money from state cash funds to cover its spending. Total over-ex-

*PPACA’s Medicare cuts are likely to affect the Hospital Authority’s balance sheet, which may require increased subsidies from state taxpayers.*

penditures for the Medicaid program were roughly \$42.6 million. At the end of FY 2010-11, the Department of Health Care Policy and Financing was more than \$6.1 million in the red, as shown by the State's General Fund Surplus Schedule. In part, this is a carry-over from poor fiscal management in FY 2009-10. In order to meet departmental budget targets that year, state officials authorized cooking the books. The Department made vendors who already had done work for Medicaid to wait an additional two weeks to be paid. The \$28.1 million in payments were added to this year's budget.

The Department sometimes appears to have difficulty distinguishing between reducing expenditures and reducing health care costs. Reducing expenditures means less spending, a goal that can be

achieved by reducing costs or by denying people needed health care. Reducing health care costs means reducing how much it costs suppliers to do business. States reduce costs by reducing regulatory overhead, eliminating unnecessary taxes, and generally reducing the cost of doing business. One way to reduce the cost of producing health care in Colorado would be to let private physicians and hospitals operate under the same malpractice standards as those enjoyed by physicians and hospitals that work for the state. Another way to reduce health care

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costs would be to eliminate the Hospital Provider Fee. The fee increases expenses for people who pay for their own health care, in order to subsidize Medicaid expansions.

The Department apparently believes it can reduce already low Medicaid reimbursement rates without affecting the quality of health care offered to people covered by the Medicaid program. This belief has been encouraged by researchers in the Dartmouth Atlas Project. A growing body of academic evidence suggests the Project incorrectly concludes that arbitrary reimbursement reductions harm health care quality, and that at current levels higher spending improves patient outcomes.<sup>29</sup>

The Department's most recent budget documents unrealistically state that it will save money with reimbursement cuts while simultaneously improving access for Medicaid clients. Given that the

Department receives almost 58 percent of its appropriated budget from the federal government,<sup>30</sup> and the federal government has long promoted Medicaid managed care, it is not surprising that the Department wants to put clients into yet another federally supported, but untested, managed care organization. The Department apparently has no plans to develop measures to show whether these organizations are reducing costs by denying members necessary care or by expanding wait times and the difficulty of getting services.

The bureaucratic sprawl is becoming too big for even interested parties to provide effective advice and oversight for rule making. State officials should consider reducing the number of committees empowered to affect state health care policy.

Julie Reiskin of the Colorado Cross Disabilities Commission writes that her group has to keep track of the following committees just to follow Department changes to programs for the disabled:

- Community Living Advisory Group
- Community First Choice Implementation Council
- Long Term Care Advisory Committee (a main committee and four subcommittees)
- Dual Eligible Advisory Committee
- Accountable Care Advisory Committee (each Regional Care Coordination Organization has between one and four committees)
- Medical Services Board
- Human Services Board

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- HB 1294 implementation committee (about regulatory reform, which is adding regulations at a rapid rate)
- HB 1281 advisory committee (about payment reform)
- CDASS Advisory (called Participant Directed Programs Policy Collaborative)
- Benefits Collaborative with a new committee for each benefit (PT/OT, home health, and medical necessity in general)
- Medical Advisory Committee
- Rule Review Meetings
- Eligibility Reform Committees.

The Department's FY 2013-14 strategic plan, reinforces the notion that it is more interested in increasing enrollment in government coverage programs than in ensuring the people who are enrolled have the ability to get the kind of health care they need. The Department's goals are as follows:

- Enroll more people in Medicaid by expanding the program using money from a fee/tax on sick people's hospital bills.
- Improving selected health outcomes. (Unfortunately, the measures chosen are inappropriate in that they ignore the needs of the severely ill and disabled. For example, the FY 2013-14 health quality improvement goals consist of increasing the percentage of enrolled children who have a "dental service" from 49 percent in FY 2010-11 to 59 percent in FY 2017-18, and increasing annual depression screenings for adolescent depression.<sup>31</sup>)
- Contain health expenditures by

putting the Medicaid population into untested Accountable Care Collaboratives, limiting hospital readmissions within 30 days of discharge, and reducing reimbursements to nursing homes.

- Increase the fraction of Medicaid patients in managed care, which increases expenditures. Figure out how to get people who provide medical services to participate in Medicaid despite its low reimbursements.

In budget documents, the Department unrealistically proposes to contain Medicaid costs by containing what it calls the 10 Medicaid cost drivers. Six of the 10 are the result of labor and delivery, and of routine physician visits by children. One of the six was uncomplicated vaginal delivery. State Joint Budget Committee staff tentatively asked whether, in view of this goal, the Department plans to reduce vaginal deliveries by reducing the number of births.<sup>32</sup>

A more reasonable set of goals would measure progress towards reducing the Medicaid caseload by moving people from Medicaid to federally-subsidized private insurance policies. They would measure the Department's progress towards setting up Cash & Counseling type incentive programs that give Medicaid clients a budget and an incentive to spend it wisely. They would include measures for waiting time and inappropriate denial of care. And because real accountability requires real choice, they would measure the state's progress towards assuring that people covered by Medicaid have a choice of private providers—thanks to reasonable levels of payment, providing meaningful choice between private care and Medicaid managed care.

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*And because real accountability requires real choice, they would measure the state's progress towards assuring that people covered by Medicaid have a choice of private providers—thanks to reasonable levels of payment, providing meaningful choice between private care and Medicaid managed care.*

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## ENDNOTES

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