STATE OF COLORADO

DEPARTMENT OF HEALTH CARE POLICY & FINANCING

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Bill Owens
Governor

Stephen C. Tool
Executive Director

November 1, 2006

The Honorable Bernie Buescher, Chairman
Joint Budget Committee
200 East 14th Avenue, Third Floor
Denver, CO 80203

Dear Representative Buescher:

Enclosed please find a report to the Joint Budget Committee concerning the Old Age Pension State Medical Program in response to Footnote 33 of the Long Bill, H.B. 06-1385.

Questions regarding the Old Age Pension State Medical Program and this report can be addressed to Greg Tanner, Manager, Safety Net Financing Section. His telephone number is 303-866-5177.

Sincerely,

Stephen C. Tool
Executive Director

ST:cln

Enclosure(s)

Cc: Senator Abel Tapia, Vice-Chairman, Joint Budget Committee
Senator Moe Keller, Joint Budget Committee
Senator Dave Owen, Joint Budget Committee
Representative Jack Pommer, Joint Budget Committee
Representative Dale Hall, Joint Budget Committee
Senator Joan Fitz-Gerald, President of the Senate
Senator Ken Gordon, Senate Majority Leader
Senator Andy McElhany, Senate Minority Leader
Representative Andrew Romanoff, Speaker of the House
Representative Alice Madden, House Majority Leader
Representative Mike May, House Minority Leader
John Ziegler, JBC Staff Director
Melodie Beck, JBC Analyst
Henry Sobanet, Director, Office of State Planning and Budgeting
Luke Huwar, Budget Analyst, OSPB
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COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

OPERATIONS AND FINANCE OFFICE
FINANCE DIVISION
SAFETY NET FINANCING SECTION

REPORT TO THE JOINT BUDGET COMMITTEE

ON

OLD AGE PENSION STATE MEDICAL PROGRAM

NOVEMBER 1, 2006

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EXECUTIVE SUMMARY

Pursuant to SB 03-022, on July 1, 2003, the Department of Health Care Policy and Financing became responsible for the administration of the Old Age Pension (OAP) State Medical Program. The OAP Health and Medical Care Fund was established through Article XXIV of the Colorado Constitution and 25.5-2-101 C.R.S. (2006) to provide a health and medical care program to persons who qualify to receive old age pensions but who are not eligible for Medicaid, and who are not patients in an institution for tuberculosis or mental diseases. This program is 100% State-funded and is not an entitlement. The FY 06-07 Long Bill, House Bill 06-1385, line item named "Services for 5,989 Old Age Pension State Medical Program clients at an average cost of $2,381.48," provides necessary medical services under the program, within the constraints that expenditures shall not exceed appropriations by the General Assembly. The FY 06-07 appropriation for the Old Age Pension State Medical Program is $14,262,663.

The eligibility qualifications for the OAP State Medical Program must match those as set for Old Age Pension financial assistance as the two programs are directly linked under the Colorado Constitution. Eligibility for the OAP State Medical Program and Medicaid differ on three criteria related to age, financial resources and residency status. Individuals aged 60 and over are eligible for OAP State Medical Program if they are a Colorado resident, uninsured (including Medicaid), a U.S. Citizen or legal immigrant, have a monthly income less than $628 (76.9% of the federal poverty level), and less than $2,000 in available resources. For this program, the average monthly caseload in FY 04-05 grew by 505 eligibles or 11.85% over the previous year and then increased by another 310 eligibles or 6.50% in FY 05-06. Current expectations are that the average monthly caseload will increase to 5,542 in FY 06-07.

Because of increasing caseload, expenditure reduction actions have been necessary when expenditures under the OAP State Medical Program were expected to exceed the available spending authority. When HB 05-1262 (the tobacco tax) was enacted, providing additional funding to the program, the Medical Services Board approved the Department's recommended changes to provider reimbursement to increase client access to medical care under the program. Unfortunately, caseload growth exceeded the Department's expectations and rate reductions were necessary again in May 2006 to keep the program within the appropriated spending authority for the fiscal year. The rate reductions enacted in May 2006 reversed back to their prior levels as of July 1, 2006 to allow the Department time to analyze program changes necessary to stay within the appropriated spending authority for FY 06-07. Based on the forecast provided to the Medical Services Board at their August 2006 meeting, program expenditures were expected to exceed the program's FY 06-07 spending authority by $9.9 million if the July 1, 2006 rates were maintained.

As caseload is expected to continue to grow, the total expenditures under the program at 100% of the Medicaid rate in FY 07-08 are forecasted to reach $40.2 million, which would exceed the Department's requested appropriation of $13.1 million by $27.1 million. Forecasting the OAP State Medical Program expenditures for FY 07-08 is difficult and changes in caseload will require the Department to revise the figures provided above. At this time, the Department cannot provide a reliable forecast of program expenditures beyond FY 07-08.

INTRODUCTION

This report is presented to the Joint Budget Committee (JBC) of the Colorado General Assembly in response to footnote 33 of House Bill 06-1385:

> *Department of Health Care Policy and Financing, Other Medical Services, Services for 5,989 Old Age Pension State Medical Program clients at an average cost of $2,381.48 -- The Department is requested to submit a report by November 1, 2006, recommending changes to the benefit structure or eligibility criteria for the Old Age Pension State Medical Program in order to stay within the appropriation limit of $13,286,483 for FY 2007-08. The report should include the most recent five-year expenditure history for the different medical services categories used by this population. In addition, the report should include a five-year forecast for the caseload and costs of this program if benefits are not reduced.*

The Governor vetoed footnote 33 stating:

> *I vetoed a similar footnote last year. This footnote is in violation of the Colorado Constitution, Article III and possibly Article V, Section 32, because it interferes with the ability of the executive branch to administer the appropriation and may constitute substantive legislation that cannot be included in the general appropriations bill.*

PROGRAM OVERVIEW

Pursuant to SB 03-022, on July 1, 2003, the Department of Health Care Policy and Financing became responsible for the administration of the Old Age Pension (OAP) State Medical Program. The OAP Health and Medical Care Fund was established through Article XXIV of the Colorado Constitution and 25.5-2-101 C.R.S. (2006) to provide a health and medical care program to persons who qualify to receive old age pensions but who are not eligible for Medicaid, and who are not patients in an institution for tuberculosis or mental diseases. This program is 100% State-funded and is not an entitlement. HB 02-1276 established the Supplemental OAP Health and Medical Care Fund, which has provided additional resources since July 1, 2002. HB 05-1262 (the tobacco tax) which allocates 3% of the tobacco revenue generated through Amendment 35 to the Cash Fund for Health Related Purposes, increased funding to the Supplemental OAP Health and Medical Care Fund. HB 05-1262 also provides that 50% of the Cash Fund for Health Related Purposes be annually appropriated by the General Assembly to the Supplemental Old Age Pension Health and Medical Fund.

The appropriations clause for HB 05-1262 increased funding to the Supplemental Old Age Pension Health and Medical Fund by $943,500 in FY 04-05 and by $2,538,000 in FY 05-06. However, the bill's appropriation clause did not increase the spending authority within the OAP State Medical Program line item, thereby not making this funding available for distribution to providers. Therefore, on January 3, 2006, the Department submitted Supplemental S-4 entitled

"Request to Fund the Old Age Pension State Medical Program" to utilize this additional tobacco tax revenue. This request was approved by the Joint Budget Committee on January 20, 2006 and was passed in the Department's Supplemental Bill, HB 06-1217. In addition, the Department submitted an Emergency 1331 entitled "Prevent Old Age Pension State Medical Program Overexpenditure" June 20, 2006 which requested an additional $1,140,484 in FY 05-06 from the existing fund balance of Supplemental Old Age Pension Health and Medical Care Fund. The request was approved by the Joint Budget Committee, to bring the final FY 05-06 spending authority to $14,426,967.

In addition to the ongoing funding from tobacco tax revenue, the Joint Budget Committee[1] increased the spending authority for FY 06-07 by $976,180. This additional funding is comprised of the $943,500 in tobacco tax revenue that can be attributed to FY 04-05, plus $32,680 from the prior year tobacco tax revenue exceeding revenue projections provided by the Legislative Council. As a result of these changes, the final FY 06-07 appropriation for the Old Age Pension State Medical Program is $14,262,663.

Because of increasing caseload, expenditure reduction actions have been necessary when expenditures under the OAP State Medical Program were expected to exceed the available spending authority. The following actions, detailed in Table 1 and summarized in Table 2, have been taken since FY 99-00 to adjust expenditures under the program:

Table 1

Year	Actions To Reduce Actual Expenditures to Remain Within Total Available Spending Authority
FY 99-00 Actual	Effective October 1, 1999, inpatient rates for all hospitals statewide were reduced to 80% of the Medicaid rate.
FY 00-01 Actual	Continuation of the 20% reduction of inpatient hospital rates for all hospitals implemented on October 1, 1999.
FY 01-02 Actual	Effective February 1, 2002, inpatient hospital coverage and medical transportation services were eliminated for the remainder of FY 01-02. In addition, all provider payments, such as payments for practitioner, and outpatient services were reduced by 20% and the maximum client copayment was increased from $100 a year to $300.
FY 02-03 Actual	Effective July 1, 2002, most providers in the Old Age Pension State Medical Program were reimbursed at 82% of the Medicaid rate. The two exceptions to this reimbursement rate were pharmacists who were paid at the Medicaid reimbursement rate, and inpatient hospitals that were reimbursed at 68% of the Medicaid rate.

[1] March 13, 2006 Figure Setting, page 209

Year	Actions To Reduce Actual Expenditures to Remain Within Total Available Spending Authority
FY 03-04 Actual	Effective January 1, 2004 inpatient hospital services were suspended for Old Age Pension State Medical Program clients. In addition, all provider reimbursement rates for outpatient practitioner/physician, emergency dental, laboratory, medical supply, home health, and emergency transportation services were decreased from 82% to 50% of the Medicaid rate. Pharmacists were paid at the Medicaid reimbursement rate.
FY 04-05 Actual	Effective October 15, 2004, the reimbursement rate for physician and practitioner, emergency transportation, medical supplies, hospice, and home health care services were restored to 82% of the Medicaid rate. In addition, the inpatient hospital benefit was restored and services were limited to only those inpatient services available under the Colorado Indigent Care Program. The reimbursement rate for inpatient benefits was set at 10% of the Medicaid reimbursement rate.
FY 05-06 Actual	Because of increased funding made available under HB 06-1262, effective July 15, 2005, the reimbursement rate was increased from 82% of the Medicaid rate to 100% of the Medicaid rate for the following expenditure categories: practitioner/ physician, medical supplies, home health care and emergency transportation services. Additionally, the reimbursement rate was increased from 50% of the Medicaid rate to 100% of the Medicaid rate for dental and independent laboratory claims. Finally, outpatient claims reimbursement was increased from 50% to 62% of the Medicaid rate. The reimbursement rate for inpatient benefits remained at 10% of the Medicaid reimbursement rate. Effective from May 1, 2006 to June 30, 2006, the reimbursement rate was decreased from 100% of the Medicaid rate to 53% of the Medicaid rate for the following expenditure categories: dental, medical supplies, home health care, emergency transportation, and independent laboratory claims. Additionally, the reimbursement rate was decreased from 100% of the Medicaid rate to 70% of the Medicaid rate for practitioner/ physician services. Finally, outpatient claims reimbursement was decreased from 62% to 53% of the Medicaid rate. In addition, the Department submitted an Emergency 1331 entitled “Prevent Old Age Pension State Medical Program Overexpenditure” on June 20, 2006 which requested an additional $1,140,484 in FY 05-06 from the existing fund balance of Supplemental Old Age Pension Health and Medical Care Fund.

Year	Actions To Reduce Actual Expenditures to Remain Within Total Available Spending Authority
FY 06-07 Projected	The rate reductions enacted in May 2006 reversed back to their prior levels as of July 1, 2006 to allow the Department time to analyze program changes necessary to stay within the appropriated spending authority for FY 06-07. Effective September 1, 2006, the reimbursement rate was decreased from 100% of the Medicaid rate to 40% of the Medicaid rate for the following expenditure categories: dental, medical supplies, home health care, emergency transportation, and independent laboratory claims. Additionally, the reimbursement rate was decreased from 100% of the Medicaid rate to 40% of the Medicaid rate for practitioner/ physician services. Finally, outpatient claims reimbursement was decreased from 62% to 40% of the Medicaid rate. On November 1, 2006, pharmacists will be paid at 70% of the Medicaid reimbursement rate.

Table 2 summaries Table 1, by listing the percent of Medicaid reimbursement paid under OAP State Medical Program by service type. Because of increasing caseload, expenditure reduction actions have been necessary when expenditures under the OAP State Medical Program were expected to exceed the available spending authority and the dates in Table 2 note when additional action was implemented. When HB 05-1262 was enacted, the Medical Services Board approved the Department's recommended changes to provider reimbursement to increase client access to medical care under the program. Unfortunately, caseload growth exceeded the Department's expectations and rate reductions were necessary again in May 2006 to keep the program within the appropriated spending authority.

Table 2
Percent of Medicaid Reimbursement Paid by OAP State Medical Program

Service Type	7/1/02	1/1/04	10/15/04	7/15/05
Inpatient Hospital	68%	0%	10%	10%
Outpatient Services	82%	50%	50%	62%
Practitioner/Physician	82%	50%	82%	100%
Emergency Dental	82%	50%	50%	100%
Laboratory and X-ray	82%	50%	50%	100%
Medical Supply	82%	50%	50%	100%
Home Health	82%	50%	82%	100%
Emergency Transportation	82%	50%	82%	100%
Pharmacy	100%	100%	100%	100%

Table 2 (continued)
Percent of Medicaid Reimbursement Paid by OAP State Medical Program

Service Type	5/1/06	7/1/06	9/1/06	11/1/06
Inpatient Hospital	10%	10%	10%	10%
Outpatient Services	53%	62%	40%	40%
Practitioner/Physician	70%	100%	40%	40%
Emergency Dental	53%	100%	40%	40%
Laboratory and X-ray	53%	100%	40%	40%
Medical Supply	53%	100%	40%	40%
Home Health	53%	100%	40%	40%
Emergency Transportation	53%	100%	40%	40%
Pharmacy	100%	100%	100%	70%

ELIGIBILITY OVERVIEW

Eligibility for the OAP State Medical Program and Medicaid differ on three criteria related to age, financial resources and residency status. Individuals aged 60 and over are eligible for the OAP State Medical Program if they are a Colorado resident, uninsured (including Medicaid), a U.S. Citizen or legal immigrant, have a monthly income of less than $628 (76.9% of the federal poverty level), and less than $2,000 in available resources. To be eligible for Medicaid, individuals aged 60 to 64 must meet the social security disability criteria, while this requirement does not apply to individuals aged 65 and over. The eligibility criteria for the OAP State Medical Program and Medicaid both have a $2,000 resource limit, but Medicaid includes the cash surrender value of life insurance policies within that resource limit, while the OAP State Medical Program exempts the cash surrender value of life insurance policy up to $50,000. Regarding residency, legal immigrants can qualify for full Medicaid only after they have been in the United State for at least five years, while legal immigrants can qualify for the OAP State Medical Program regardless of how long they have been in the country. In summary, those on the OAP State Medical Program are low-income individuals aged 60 to 65 who do not meet the social security disability criteria; those aged 65 and over who may have a life insurance policy with a cash surrender value over the Medicaid resource limit; or legal immigrants who have not been in the country for at least five years.

The eligibility qualifications for the OAP State Medical Program must match those as set for Old Age Pension financial assistance as the two programs are directly linked under the Colorado Constitution. Eligibility qualifications to receive Old Age Pension financial assistance are determined by statute and regulations established by the Department of Human Services. Eligibility qualifications for Medicaid are established by State statute, federal regulations and State regulations. To reduce the number of those eligible for the OAP State Medical Program would require a reduction in those eligible for Old Age Pension financial assistance or an expansion of the Medicaid entitlement. Both methods are outside the authority of the OAP State Medical Program regulations. In addition, the Colorado Constitution specifies that the OAP State Medical Program be used for U.S. citizens, but recent federal case law prohibits states from

limiting access to such State programs by immigration status. Consequently, limiting the caseload to only U.S. citizens is outside the authority of the program, and in this case, the Colorado Constitution.

Since those eligible for OAP State Medical Program are not eligible for Medicaid, they can also qualify for discounted healthcare services under the Colorado Indigent Care Program (CICP). The CICP promotes access to health care services for low-income individuals by helping to defray provider costs of furnishing uncompensated care and by limiting the amount that low-income patients must pay. To the extent of available appropriations, the program serves persons with income and assets at or below 250% of the federal poverty level who are not eligible for Medicaid or the Children's Basic Health Plan. The CICP is not an insurance plan under State law, because it does not provide individuals with a policy that defines a list of benefits to which they are entitled; rather, the program is a financing mechanism through which the State reimburses participating providers for a portion of costs incurred in treating eligible individuals. In turn, providers must adhere to State-established limits for amounts charged to eligible individuals.

CASELOAD

The table below delineates the caseload history for the OAP State Medical Program since FY 95-96. The program's caseload has fluctuated over the years, but has risen steadily since FY 02-03. For informational purposes, the Department has forecasted caseload for FY 06-07 and FY 07-08 based on the average annual growth from FY 04-05 to FY 05-06. Despite the outcome of caseload forecasts, the Department will manage expenditures to the appropriation in accordance with statutory and constitutional expectations. Table 3 demonstrates that from FY 95-96 to FY 05-06, the average caseload increased 61.1%.

Table 3

Year	Average Caseload	Percent Change
FY 95-96 Actual	3,150	3.08%
FY 96-97 Actual	3,152	0.06%
FY 97-98 Actual	3,215	2.00%
FY 98-99 Actual	3,150	-2.02%
FY 99-00 Actual	3,066	-2.67%
FY 00-01 Actual	3,212	4.76%
FY 01-02 Actual	3,782	17.75%
FY 02-03 Actual	3,794	0.33%
FY 03-04 Actual	4,261	12.31%
FY 04-05 Actual	4,766	11.85%
FY 05-06 Actual	5,076	6.50%
FY 06-07 Projected(1)	5,542	9.18%
FY 07-08 Projected(1)	6,051	9.18%
(1) Department's November 1, 2006 Budget Request. Average annual grow from FY 04-05 to FY 05-06, 9.18%=(11.85%+6.50%)/2		

EXPENDITURE HISTORY

Table 4 illustrates the available Medicaid Management Information System (MMIS) expenditure history for the different medical services categories, by claim type, for the program. The expenditures do not include payables or any offsets from rebates from pharmaceutical manufactures (drug rebates) that effect expenditures outside of the MMIS.

Table 4

Claim Type	FY 01-02		FY 02-03		FY 03-04	
Capitation	$5,169,607	1, 2*	$539,410	3**, 7***	$532	7
Pharmacy	$1,937,756	1	$2,733,597	1	$3,770,625	1
Inpatient	$1,497,258	2, 7*	$3,145,714	4	$1,837,778	4, 7+
Outpatient	$973,886	1, 2*	$2,188,053	3**	$2,663,412	3, 5+
Practitioner/Physician	$1,009,673	1, 2*	$1,652,958	3**	$1,934,985	3, 5+
Dental	$77,617	1, 2*	$79,824	3**	$79,076	3, 5+
Laboratory	$69,346	1, 2*	$100,505	3**	$129,481	3, 5+
Medical Supply	$224,017	1, 2*	$326,677	3**	$406,486	3, 5+
Home Health	$102,058	1, 2*	$177,295	3**	$209,499	3, 5+
Transportation	$56,707	1, 7*	$39,061	3**	$59,043	3, 5+
Medicare Crossover	$17,172	1	$45,374	1	$95,016	1
Total	**$11,135,097**		**$11,028,468**		**$11,185,933**	

Claim Type	FY 04-05		FY 05-06	
Capitation	$4,654	7	$4,857	7
Pharmacy	$4,452,055	1	$5,436,909	1
Inpatient	$344,719	7, 6++	$580,515	6
Outpatient	$2,012,159	5	$2,985,902	5, 8+++, 9/
Practitioner/Physician	$2,174,861	5, 3++	$4,193,613	3, 1+++, 10/
Dental	$44,943	5	$60,538	5, 1+++ ,9/
Laboratory	$109,479	5	$203,174	5, 1+++, 9/
Medical Supply	$477,553	5	$878,582	9, 1+++, 9/
Home Health	$306,756	5, 3++	$530,883	5, 1+++, 9/
Transportation	$37,986	5, 3++	$58,142	5, 1+++, 9/
Medicare Crossover	$106,124	1	$96,062	1
Total	**$10,071,289**		**$15,029,177**	

Notes

1	OAP rate = 100% of Medicaid	*	Rate change effective February 1, 2002
2	OAP rate = 80% of Medicaid	**	Rate change effective July 1, 2002
3	OAP rate = 82% of Medicaid	***	Change effective August 30, 2002
4	OAP rate = 68% of Medicaid	+	Rate change effective January 1, 2004
5	OAP rate = 50% of Medicaid	++	Rate change effective October 15, 2004
6	OAP rate = 10% of Medicaid	+++	Rate change effective July 15, 2005
7	OAP rate = 0, benefit suspended	/	Rate change effective May 1, 2006
8	OAP rate = 62% of Medicaid		
9	OAP rate = 53% of Medicaid		
10	OAP rate = 70% of Medicaid		

PROGRAM EXPENDITURE FORECAST

Based on the forecast provided to the Medical Services Board at their August 2006 meeting, program expenditures were expected to exceed the program's FY 06-07 spending authority by $9.9 million if the July 1, 2006 rates were maintained. The September 1, 2006 and November 1, 2006 provider rate reductions are expected to allow the Department to stay within the appropriation for the OAP State Medical Program in FY 06-07. For the program to increase all provider rates to equal the Medicaid rate the Department forecasts that an additional $7.9 million would be necessary. Added together, an additional $17.8 million would be necessary to fund the OAP State Medical Program at 100% of the rate paid under Medicaid for FY 06-07 as total expenditures in FY 06-07 are predicted to reach $31.0 million. The estimates reported in this paragraph use a model developed at the beginning the State fiscal year and assume that the rates are effective July 1, 2006. As caseload is expected to continue to grow, the total expenditures under the program at 100% of the Medicaid rate in FY 07-08 are forecasted to reach $40.2 million, which would exceed the Department's requested appropriation of $13.1 million by $27.1 million. Forecasting the OAP State Medical Program expenditures for FY 07-08 is difficult and significant changes in caseload growth will require the Department to revise the figures provided above. At this time, the Department cannot provide a reliable forecast of program expenditures beyond FY 07-08.

An analysis of changes to the benefit structure and the feasibility for the Old Age Pension State Medical Program to become an insurance premium sharing program rather than a traditional fee-for-service program were addressed in the Department's response to footnote 42 of HB 04-1422, submitted to the Joint Budget Committee on November 1, 2004.