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Participant: Equal Employment Opportunity Commission and U. S. Department of Justice  
Americans With Disabilities Act Training and Implementation Network  
Local Affiliate: Disability and Business Technical Assistance Center  
Member: Colorado Advisory Council For Persons With Disabilities  
Assistant Chief/Incident Commander: Golden Gate Fire Department

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March 7, 2003

Senator Dave Owen, Chairman  
Joint Budget Committee  
Colorado Senate  
Denver, Colorado

I am writing as a concerned citizen, who is a Medicaid client and has done substantial amounts of advocacy for other clients over the past 17years. I am disappointed that the Department has not appeared open to the attached suggestions that would result in significant savings to the Medicaid Program. I am bringing these suggestions to you, in hope that you will give them serious consideration. As you know, few are more motivated than I to use these precious resources as efficiently as possible.

I am interested in working with you and anyone else interested to develop cooperative solutions. I become concerned when legitimate concerns are dismissed when Medicaid clients bring them. We are the most invested in the system, and know how the system actually works, despite what the "official policy" dictates. We see waste and want to eliminate it. It is hurtful to get an attitude of "After all, you are just a bunch of dumb recipients trying to screw the system."

I have been doing this work for 17 years. I cannot help but wonder if the lack on communication is related to the explosion in costs. My personal experience is that the reluctance of the Departments to work cooperatively with recipients towards the effective resolution of problems is worse than ever. I can figure out that the "pot" is not bottomless and that we do need to contain the budget, but it gets frustrating (and is unconscionable) that the Dept. is willing to make cuts that hurt clients but will not entertain improving efficiencies that were "not invented here". All to frequently, I have seen the Dept. manipulate the Fiscal Note process by inflating the costs of changes/programs they do not want so the legislature will not pursue the proposal.

Finally, I have also included a few possible solutions to related issues, such as health coverage for college kids, in the reform of "affordable" health insurance, no-fault auto coverage, etc.

I have spent quite a bit of my time researching this information and trying to condense it for your review, I do hope you will take the time to review it. I think you will find it worth your time.

Please feel free to call on me if I may be of further assistance or answer any questions.

Most sincerely,



## **DETAIL OF MEDICAID WASTE ISSUES THE DEPARTMENT DOES NOT WANT TO HEAR**

(See letter of 6/2/01 to HCP&F ED providing some of this info, and no reply.)

**PROBLEM NUMBER ONE:** Bureaucratic culture of obstruction.

First and foremost is the attitude and culture within the bureaucracy, which is obstructive, punitive and demeaning. This problem became much more prevalent under the predecessor of the current Executive Director. An overall attitude from the staff of ‘how can we make it work in the most efficient way possible’ would save significant dollars. Some staff will not answer their phone and always use voice mail to screen all calls. They will not return calls to anyone trying to resolve a problem. Staff does not treat clients or the public as ‘valued customers’ but with distrust and hostility. This eliminates any incentive clients may have to try to save the program money; to the contrary, as we know from workers comp, they drive costs. They alienate advocates who try to work with them to smooth the way for their clients, which would result in an easier and reduced workload for staff.

**EXAMPLE:** HCPF will pay \$200 for a taxi but not \$25 (or anything) for parking as ‘the rule states [they] do not pay for services when the client is not in the vehicle’. This is a misapplication of the rule, when read in context it clearly was intended to cover a transportation provider who drops off a client and travels back empty. They will pay \$200 for taxis on out-state/cross-state travel for medical care but will not pay \$30 for a rental car because ‘the rules do not allow for it’ (nor do they prohibit it). This is a problem with either out of state care when the client needs to go to the airport, or a case where a client may be hospitalized for several days.

**SOLUTION:** There should be overall instruction, perhaps in the form of a footnote, which empowers and directs the staff to make reasonable modifications to policy when it will result in a cost savings and offer equivalent services. Federal law already recognizes the need for states to make such changes with the language in the Americans with Disabilities Act.<sup>1</sup>

**PROBLEM:** Decisions on approval for services are made without regard to the long-term consequences.

**EXAMPLE:** a client with private health ins. gets rare cancer in leg, which requires extensive out of state treatment (chemo, radiation, extensive specialized surgery) to save limb and life. The client quickly becomes eligible for Medicaid via both SSI and HCBS due to the severity and immediacy of the effects. In this case, the prognosis was dependent upon treatment. Permanent and severe disability was a possibility, as was a cure. Through advocacy efforts I was able to maintain the private health insurance through the Health Insurance Buy In option where the Department will pay the premium to retain primary coverage if cost effective. In these situations Colorado Medicaid is the secondary payer and fills the gaps. These gaps are generally services that are necessary to the very ill or disabled, but not to the general public therefore they are not covered by traditional insurance. The Health insurer (HMO) approves out of state treatment and makes arrangements. Medicaid fights ‘filling the gaps’ The gaps in this case were approximately \$5,000. However, a prosthetic limb would be \$20,000 with only \$2,000 covered by health insurance. Another example has to do with the way they do prior authorization. Clients may wait weeks or months for approval for a wheelchair cushion. I had problems getting a cushion that has prevented me from getting pressure sores that cost \$200. Lack of appropriate seating can cause a sore in anywhere from one day to one week. Sores usually require hospitalization, and sometimes surgery, with extensive nursing care following.

**SOLUTION:** Involve consumers, the Department, The JBC and a representative of the CBMS project to determine areas where the Department may be acting ‘penny wise and pound foolish’ and redirect existing technological resources to develop more appropriate and more timely cost/benefit analysis.

**PROBLEM: MANGEMENT OF THE HEALTH INSURANCE BUY IN PROGRAM.** The poor management actually encourages clients to terminate their health insurance as soon as they are approved for Medicaid. This has caused people to lose coverage that would have been primary in very expensive situations. The problems include:

1) Collection of health insurance information. It is collected at application at the County. There is no accountability to insure that the County is timely in notification to the state. This also delays possible collections for covered benefits by the state. The state has refused to give the application out, and some

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<sup>1</sup> Title II of the American’s with Disabilities Act directs state and local government to modify policies, practices and procedures when necessary to insure the most integrated setting regarding services to persons with disabilities.

counties do not even know the program exists. The state refuses to accept the information from clients, advocates, providers or any source other than counties or select state staff. Should a client understand the complexities of this program, and have the physical and psychological ability to be persistent, the State refuses to reimburse the client. Clients (already poor enough to qualify for Medicaid) pay for premiums paid or any expenses, co-pays, deductibles, etc., in any month prior to the month the “State” (HIBI Officer) receives notice from the County. Clients who do this do this with the belief that they will be reimbursed. The few clients that can afford to do this do so by borrowing money either from family, a bank or a credit card. They usually pay interest, and can find themselves in serious credit problems quickly. In several different situations the state has refused to reimburse, even though the rules allow for up to 90 days backdating and reimbursement, from application. In one case, solely due to the advocates efforts, it still took 3 months to get HIBI approved and client is still fighting for any reimbursement, it saved the state over \$200,000 that the health insurer paid for. The state seemed to do everything they could to cause the health insurance to lapse; including failing to pay the premiums timely on multiple occasions, many months AFTER they had approved HIBI inclusion.

2) Once the information gets to the state, they then frequently take so long to get going that the coverage has lapsed for non-payment if the client cannot afford the premiums.

3) If and when HIBI buy-in actually occurs, the client and providers must go through all the hoops of the health insurer. Despite legislation passed in 2001 to prevent these problems clients have to get written denials before Medicaid can pay. The concept is good—get the private insurance to pay. The effect of how this is managed is that insurance companies just write denials because they know Medicaid will pay. Many of these services are the type that one cannot wait to receive. This includes treatments for acute medical conditions, home health care, wheelchair repair, etc. The SOLUTION for this specific problem is to. **Implement “pay-and-chase”**, where the client gets what they need and the Medicaid chases the health insurer if approval from the insurer is not immediately forthcoming. This would also reduce denials from health insurers if they know that someone who understands health ins. issues (the State) will be looking at their denials and collecting from them if the insurer denies benefits improperly.

4) HIBI has a policy of not allowing a Medicare dual eligible client to participate. The state already pays the Medicare premium for Medicare clients. However, with more young disabled there are people that have Medicare and also have private insurance through a spouse or former employer. Because neither private insurance nor the basic Medicare packages cover long-term care, people may also receive Medicaid via one of the long-term care programs. The number of people with this option is small, but these are likely the most expensive clients. Drugs alone would be substantial. Even if there was a \$2,000 limit on medical equipment, couple that with Medicare and you have paid for half of a new motorized wheelchair. Moreover, keeping this policy in place is sure to sabotage the potential success of the Medicaid Buy In Program that will allow people with disabilities to become employed. It is the same population that is effected, and this is the population we need to make TWIIA work. SOLUTION: Footnote requiring the Department to stop automatically excluding Medicare recipients from HIBI participation. (This would not be a guarantee that all Medicare clients would get HIBI –it would simply allow for the cost effectiveness test to be applied.)

5) The Department applies a cost effectiveness formula when deciding eligibility for HIBI. The concept of a cost effectiveness formula is a good one; as in many cases primary health insurance costs far exceed any anticipated benefits. However, the way the formula is designed and applied discounts any disability or chronic health issues. Given that the disabled/elderly are the most likely to have private insurance and the most costly to serve, it is ironic that the HIBI formula is geared towards the TANF population. Several people in the disability community have made concrete suggestions for change and have been rebuffed at every turn. SOLUTION: Mandate through a footnote that the Department convene a work group of knowledgeable volunteers and whatever appropriate experts to modify the formula and develop a decision making tree that can be applied in each individual circumstance. This is a relatively small program, but one that saves money.

**PROBLEM:** The State is unwilling to try to resolve issues/disputes informally. When a problem cannot be resolved informally, the client is forced to go the Administrative Law Judge. The ALJ is an essential component to assure due process and to resolve legitimate disputes. However, the State regularly misuses the denial/hearing process. Disputes are frequently caused because staff does not know the rules. They make decisions that are wrong, makes up the rules as they go along. I have seen them fight tooth and nail to prove that they are right. Again, rather than working cooperatively to resolve a problem and giving honest examination to a challenge, some staff become very offended if their error is pointed out to them. They also clearly believe the

“rules” do not apply to them and they can do whatever they like. One staff person admitted under oath she did not know parts of her job (and she has been with the Dept. for more than a decade) and whole sections of regulations that she is responsible for administering. There are some “urban legends” where staff believes something is true and it is told so many times, to so many people it becomes their reality. The federal government recently audited the state over some HCBS programs. Despite federal requirements for there to be a need for services at least once a month, many people on staff believed that the requirement was 90 days. This could have cost the state staggering dollars in repayments, risking the entire HCBS program.

EXAMPLES: I spent 5 days at hearing, with between nine and twelve State and County employees. This was not event counting the ALJ and support staff at \$104/hr, the ALH preparation and decision writing and follow up appeals. The dispute was over \$5,000, part of which they admitted they should have paid (and still have not). The Rocky Mtn. HMO litigation shows that interest and penalties add up. They regularly deny requests for Prior Authorizations only to approve it a week before the hearing. The ALJ must go through the process of a decision even if the case is withdrawn. There are sometimes excessive review and PAR requirements. Renewals of PAR paperwork for clients with an incurable medical condition that remain financially eligible makes no sense.

About 18 months (?) ago I sent a request to the Department for a copy of the regulations (Vol. 8, CCR) on disk. Instead of telling me where they could be found or sending me an order form, it was given to the Department’s AG who was ready to try to defend an “open records” lawsuit rather than fulfill the request. It was only due to someone from another agency then providing me a copy of the order form that resolved the issue. WHAT WASTE!!!

SOLUTION: Unfortunately you cannot legislate common sense. However, a directive from the JBC to the Department to work with interested parties and seriously consider their solutions could not hurt. I know there is a workload issue, and the Department should not have to do research for special interest groups that profit off of Medicaid. These groups have contract lobbyists. Recipients, however, most invested in the program and without paid contract lobbyists, seem to be last on the list.

PROBLEM: Delays in eligibility determination and mis-interpretation of the Medicaid rules results in increased Medicaid costs. It can take months to approve client for eligibility, client then incurs medical expenses that are not covered under Medicaid’s fee schedule, and if the client pays it, under federal case law Medicaid must reimburse client 100%. State has refused to reimburse as required and now has litigation pending over that issue. Also causes exacerbation of condition if client cannot access medical care while awaiting approval, increasing costs of mitigation and cure.

They require PAR’s be renewed annually, even for certain medications or supplies that the client has used for years, sometimes decades.

They refuse to work with anyone outside the agency to get clients best services at lowest costs. Staff will not even entertain alternatives to their rigid conceptions, even if it will result in a better outcome for the client and save money for the taxpayers. Every time I have tried to save Medicaid money, I would encounter hostility and paranoia, and they would try to twist my suggestions in a manner designed to either shift the cost to the client, or to deny it.

PROBLEMS: Lack of Supervision of County and other entities that are administering state programs : State refuses to supervise and oversee the County DSS. Until recently they would not even acknowledge they are the State’s agent. The situation is further complicated by HCP&F contracting with DHS who contracts with the counties to do all of the front line work and no one holds anyone down the line accountable and constantly tries to pass the buck. The concept of “single entry point” is great, but in action has not worked. The Department “contracts” with multiple entities in the delivery of services but only seems to demand performance and accountability if they believe it will result in a cost savings.

The idea of a “single entry point” is a good one, but unfortunately it does not function as intended. Clients still have to hunt for appropriate referrals and programs, apply multiple times and multiple locations for various programs and deal with numerous people, many of whom ask the same questions, do the same things, etc. We have three entries into long term community based care, and several more avenues to receive nursing facility services. Despite clear directives from the JBC, the Department never began doing continued stay reviews on nursing facility clients. Many clients are sent to facilities from hospitals. Facility staff, with a financial interest, does the paperwork and the “utilization review contractor” CFMC reviews. The review consists of looking at

the paperwork, but never seeing a client to know if the paper is at all accurate. Yet a quadriplegic in the community is relentlessly scrutinized to make sure that his or her paralysis is not cured.

The administration and application of the rules are forcing people into nursing homes, at 3-5 times the cost of home care, all in the name of ensuring that no one gets home care who doesn't REALLY need it. A nursing home admission can be done in less than 24 hours. At best HCBS will take a few weeks, but I have had HCBS cases take 7 months from application to commencement of services. SOLUTION: Have a true single point of entry to determine long term care eligibility for all Medicaid clients, regardless of type of service being requested or type of disability.

PROBLEM: Case Management is a joke. In one case, the client had as many as 9 case managers, all being paid and all the case management was done by the volunteer advocate. We could be getting a higher match rate if this were used more effectively. Proper care management can be time consuming, but can teach clients to be more independent and reduce hospitalizations and emergency room use. Effective case management requires creativity, working with referrals other than publicly funded programs and understanding both the philosophy and practical applications of Independent Living.

They will not pay for/approve "well care", even for persons with chronic conditions or fragile health. SOLUTION: Redirect case management dollars to effective entities. Develop real measurable outcomes and tie reimbursement to these outcomes. Provide vouchers for case management and allow clients to choose the entity (SEP, CCB, ILC, etc). The worse providers will go away based on attrition.

We also need to look at creating a program to actively target Medicaid recipients with unhealthy habits (smoking, overweight, etc.) and offer (and encourage) effective "treatment" (smoking cessation, weight loss, proper diet, etc.) and we need to look at "alternative" medicine (chiropractic, osteopathy, acupuncture, etc.). Clearly, western Medicine does not have a "lock" on effective treatments and we are now seeing more and more recognition of that (look at the hospital in Longmont who offers several different disciplines).

Finally, I want to outline a number of miscellaneous areas of waste and solutions to end the waste:

- 1) We mail out tens of thousands of Medicaid cards every month to all current Medicaid recipients. Instead we should be programming the providers credit card readers to read the encoded info on the back of the Colorado drivers license or ID and go to a paperless system. The client would present their DL/ID card at the provider who would swipe the card, have instant online verification of eligibility and then be able to bill electronically when done and have direct deposit for payment. This would also prevent clients from selling or loaning their Medicaid cards and allow rapid detection of patterns of provider fraud. This would also remove a significant portion of the administrative burden (paperwork) put on providers and allow them to learn of billing problems timely (instead of months later, with no explanation of what the problem is or why the bill was rejected). This will result in more providers willing to participate in the system, spreading the costs across a much larger base, reducing overall health care costs, particularly for specialty care. We already have the Quest system as a starting place.
- 2) Providers should also be required to send copies of all billings to the clients. The State needs to offer training to clients on how to review a billing for accuracy and should offer a percentage (as a reward) to any client who detects improper billings and saves the State money. Medicare and private insurance companies send statements. This can help detect human error as well as deliberate fraud.
- 3) The Primary Care Physician Program (PCPP) needs to be rebuilt and expanded. As we have "put all our eggs in the HMO basket" and have very few doctors left in PCPP. The Dept has done as much harm to PCPP as possible. Now, in some parts of the state we have no options, or more importantly, competition. We need to make a real effort to lure docs back in, make it easy for them to participate, bill, etc., we need to let them add patients they want, not make them do "open enrollment" and take anyone that comes through the door. We need to treat them as they are valued, not criminals. We need to increase the monthly per patient case management payment, particularly for those with higher needs,
- 4) Telemedicine: We could start allowing docs to bill for "tele-medicine" when it can reduce the need for an office visit. Finally, even if we cannot raise the rate, the Department should be directed to reduce the hassle factor. We could establish a lower cost rate for telemedicine, so the doctor is paid, but less than for a full office visit. This is essentially an expansion of the "Ask a Nurse" program, but allowing patients to ask their own doc, who they are much more likely to trust, than someone they may perceive as having a vested interest in them not going for medical care. Many people will deal with most issues by phone if they can, but I have clients' docs

tell me that if they deal with it by phone they cannot get paid so they require an office visit In some cases, paying a doctor a case rate for combined calls and visits to resolve a specific problem may be more cost effective and produce better quality.

5) The Medicaid Managed Care Ombudsman program is another waste. It was a great idea and had the potential to be a very effective resource in efficiently resolving problems, but has done nothing.

SOLUTION; HIRE, as full time paid consultant, a person with a long history of true advocacy, who operates with true autonomy, who's job is to look for ways to improve health care delivery, save on costs of delivery of care, truly advocate for clients, and who is given the authority to tell State and County staff "YOU WILL" in implementing solutions.

6) All aspects of the Deinstitutionalization Project needs to be expanded, adequately funded and staffed with real advocates. It is shameful (and quite costly) that we have a single person in an institutional setting that has the capacity to live in the community. We need to shift our bias from institutional placement to community supports. It is too bad that this program does not do more as this program USED to be a stand out for consumer involvement and participation. We need fast track to be statewide and we need to fully utilize the ILC's within and beyond the current Nursing Facilities Transition grant.

7) Supporting unpaid family caregivers (and enabling them to continue):

We need to actively provide respite care to families caring for Medicaid eligible individuals and offer adequate supports. The current policy of the Dept. is that respite can only be provided if the client is placed in a nursing home (at significantly greater costs). Without respite, the family is much more likely to burn out which frequently results in an institutional placement, at much greater long-term costs than community based care.

Family caregivers do not need a lot, but often do need some help. Even without institutional care, once the family member becomes ill or burnt out, the entire burden of care is thrust on the state regardless of the setting.

8) Deregulate home care. We need to lift the limitations on using family members. We know that people will most frequently receive better care from a family member than a paid attendant, but most people cannot take the income hit to stay home without some kind of income replacement. It will be cheaper for many folks if we allowed payment to family members directly and cut out the agency. We could set up a system that would pay family caregivers only when they are sacrificing a needed income or in cases where we can prove cost effectiveness.

We also need to seriously address the problems in home care of who can do what. There are many needs a client has that we will only pay a nurse or other professional to do. We allow unpaid family members with no training to do these tasks, but do not allow home health aides to perform even some of the simpler tasks, even under the supervision of a professional.

The self-directed attendant care program needs to get up and running NOW and be expanded to full status and statewide. We need to lift the restrictions on only paying "certified Medicaid Providers" and should be willing to pay anyone who passes a background check, is willing to obtain the appropriate education (PCP class, etc., and make that education available to them) if they are willing to work for what Medicaid can pay (and this should apply to as many other "areas" of Medicaid as it can reasonable be expanded to). The excessive amount of restrictions is a major barrier to solving this problem. We also need to require agencies to work with clients (of the agencies) to identify viable candidates and hire them, to provide services when needed, not just during "bankers hours" as is the case in many parts of the state. I have one agency in particular that I have worked with several times on "rural" cases where with the clients help, we developed the supports the client needed from folks in the local area, who were then put on the agency's payroll. It has worked well.

The CDAS pilot has just started and there are already issues arising. The "fiscal intermediary" is an out of state company that does not clearly understand Colorado Medicaid regs or our work comp system (as they will be the employer of record). While the program is designed so that a client is given a set allotment to go buy their services in the manner they see as best for them, the Dept. has increased the difficulty of finding and retaining good people. While they will allow clients to pay a decent wage, the health insurance offered is inadequate, and there CANNOT be any sick or vacation pay (they would get that at McDonalds). We have enough problems getting people to do this work for low pay and seem to making it harder to find and retain anyone who may be worthwhile. There is also the concern that clients who opt to pay a decent wage and do with less hours will then get their allotment cut because they have shown they can do with less hours, and some client somewhere found someone to do their care for less, not even considering that the higher paid person may be more effective and deliver higher quality, in less time.

9) Medications: There is something wrong when I can order medication on the internet for 40% less than the

pharmacies can buy it for (but Medicaid would never reimburse the client for them). The department has not seriously pursued “bulk buying” of medications, even those that are heavily utilized.

Now the Dept. is talking about doing a “medication review” on individuals who have high utilization. It will save us money if they are doing a true polypharmacopia review to assure that the client is not taking a potentially harmful combination of drugs, not still taking a medication that is no longer needed, etc. Unfortunately, I predict the department will use this to build another/bigger bureaucracy that will have a focus of depriving clients of necessary medications, second guessing doctors determinations as to what is medically necessary and in the end increasing acute care costs and client suffering, exacerbating illnesses/impairments, etc.

They have imposed the formulary in a manner to deny, not save costs. I used to take a medication that cost (wholesale) \$10 per 100. When my pharmacist found an appropriate, cost effective alternative, at a (wholesale) cost of \$5 per thousand, Medicaid refused it on the basis that it was not on their formulary and would not consider adding it or making an exception. They further require annual prior authorization on all over the counter drugs when prescribed by the doctor. This results in the docs prescribing a drug that requires a prescription instead of a possibly effective over the counter alternative.

10) Return to work efforts: HB 01-1271 is a good starting place for “return to work Medicaid buy-in” but we must be very careful to implement it properly. The failures of Ticket to Work, projects WIN and DWIN are glowing examples of how to come up with a program that does not work. Put PWD’s and their advocates in charge of decision making in the development of the program and the drafting of the regulations (to be referred to the Med. Svc’s Board) and we might just come out with a program that can work. If someone who is already on Medicaid contributes a dollar to his or her care, it is a dollar we saved. If we don’t have a punitive approach to those that want to work (and contribute) we might get some of them to.

We also should seriously study implementation of a Medicaid “spend down” program, where one could “spend down” their income on needed/necessary medical care and when they cross a predetermined threshold, Medicaid would then kick in. This would help prevent individuals from making themselves destitute to qualify for Medicaid, which increases the time they will spend on the program and the difficulties in leaving the program. Also, this, in conjunction with an effective return to work program/rules would result in more people trying to return to the workforce who otherwise may never be able to earn enough to pay for all of their own care, but I would rather they contribute a dollar (and put 2 in their pocket) than not contribute anything. We must move away from this “all or nothing” system that traps people who cannot get health care through other means. People do not choose to live in poverty and be on Medicaid, far to frequently they are left without any other options, and then stay because they cannot get health care elsewhere.

11) Lack of appropriate review to assure appropriate Durable Medical Equipment is provided. There was a proposal put forward a few years ago by the Health Care Committee of the Governor’s Advisory Council for Person’s with Disabilities (Barry Sanger was Committee Chair) whereby we would create an entity that would do the evaluations, design and ordering of DME to paid for by Medicaid, rehab, Medically Needy Fund, etc., who would be required to have experts in various disciplines, (ortho, neuro, OT, PT, bio-mechanics, ergonomics, etc.) to assure that people with disabilities get appropriate, proper DME,. 50% of all manual wheelchair users will develop upper-body impairment from an improperly fit wheelchair and will one day need a powerchair at 5 times the cost, as a result.

12) There is no “recycling” of expensive DME. Medicaid should retain title to any DME of any real value (wheelchairs, feeding pumps, respirators, etc.) and when the recipient no longer needs it for whatever reason (change in condition, death, etc.) Medicaid would recover it, have it refurbished and put it in a “pool” for future clients. When a client needed a “new” piece of DME we would look in the “pool” to see if there was something that was appropriate, or that could be modified cost efficiently, to meet the clients needs, if not, then we would buy new. We could contract with one or more Independent Living Centers to operate the refurbishment program and also have them use it to train recipients to become DME technicians with the long term goals of teaching these “trainees” a trade and then having them strategically located around the state. This would enable us to not only save \$\$ on the purchase of DME, but would significantly improve access to repairs and make that field more competitive.

At this point I will address a few financial issues that affect the Medicaid Program:

1) Workers compensation and auto insurance: A 1991 study revealed that the taxpayers paid \$5.5 million dollars for medical care for injured workers who were waiting for benefits and we were recovering less than

50%. I do not know what the current stats are but would bet they have not improved much. For starters we should actively offer the recipient some reward for seeking recovery for Medicaid. Next seek legislative approval for a penalty to be imposed on comp carriers of treble damages to Medicaid if it is found they wrongfully denied benefits and Medicaid had to pay.

We need to statutorily require that restitution and all costs of collection (without statute of limitations) be ordered in any sentence issued to an uninsured driver who has an accident that results in injury paid for by Medicaid. While it may not mean anything today, if we turn them over to a collection agency someday we will likely get something.

2) Health Insurance Reform: The “overhaul” of the health insurance industry to allow Low-cost premiums is already clearly driving Medicaid enrollments, particularly for persons with high needs. An individual is diagnosed with cancer a week after his employer changed to a low cost policy. The new policy has no mandated benefits and a \$5,000 deductible and a \$17,000 lifetime cap. He expended everything he had buying necessary, lifesaving treatment and now has qualified for Medicaid. The elimination of “minimum coverages/mandates” will only benefit the health insurance industry, at the taxpayer’s expense. It will drive not only the number of Medicaid enrollments, but also the average cost per enrollee. This will result in Medicaid becoming the “catastrophic health coverage” program, and if we are going to do that, we need to recognize and acknowledge that is our intent and adequately fund the program. The proposed elimination of Personal Injury Protection (no-fault) in auto insurance will likely have the same effect.

One possible solution for the issues of costs and numbers of insured for health care would be to “merge” coverage’s. A few years ago there was several legislative proposals for “24-hour coverage” which proposed allowing employers to opt-out of the workers comp system and purchasing 24-hour a day, on and off the job health, life and disability coverage (with minimum standards comparable to the current system) that were vigorously opposed by the insurance industry. A small unofficial demonstration project showed that it was not only feasible, but produced a savings for many small employers, particularly those who offer health insurance to their employees. In the mid -90’s, cost analysis of the worker’s comp system revealed that we spend approximately \$150 MILLION per year just “allocating the costs of an injury”. We know that when an injury or illness occurs, someone must pay for it, whether it be the individual (through medical costs, suffering, lost wages, etc.), the employer (through work comp, health and disability insurances, lost productivity, etc.), auto insurance carrier (if motor vehicle related), the taxpayers (through Medicaid, lost tax revenues and productivity, etc.) or all of us (through increased insurance rates, increased cost of medical care due to uncompensated care/bad debt, reduced access to medical care, increased Medicaid budget, etc.). We need to find ways to “merge” as much of work comp, health, life, disability, auto (medical and lost wages), homeowners (medical and lost wages), personal and commercial liability (medical and lost wages), etc. insurances. We need to reduce what is spent on administration of these numerous coverage’s, and the fight about who is going to pay.

Also, on the issue of coverage, in Colorado, for a child to attend an institution of higher education (college), they must have health insurance or purchase it from the school (which usually only provides services at the student health clinics) for about \$1,500/yr. For kids coming from economically disadvantaged (poor) households, this can require they spend scarce scholarship or student loan dollars to buy the coverage, as if they receive Medicaid, they are terminated on their 19<sup>th</sup> birthday. We know one of the most effective ways to “break the cycle of poverty” is through education of the next generation and therefore need to reduce or minimize the barriers to higher education for poor kids. I would suggest, as we returned tens of millions of dollars in Children’s Health Plan dollars to the feds, that instead we get approval to use those dollars as follows; for any child who attends an institution of higher education as a full-time student and maintains satisfactory progress, AND except for age otherwise meets all Medicaid eligibility requirements (or is on Medicaid on their 19<sup>th</sup> birthday), we require the student to buy the school health coverage, have the student pay whatever the “state share” of the cost would be and have CHP (federal) dollars pay the balance. This would leverage the “local match dollars” against federal dollars, allow us to spend more of the federal allotment, increase the number of “insured” in our state, fix our cost exposures for medical care for these kids, substantially reduce a barrier for these kids to go to college, and it would not cost the state any dollars. As this particular population is highly prone to injuries and usually do not have insurance, this may also be a way to encourage and promote both health coverage and continuing education.

3) Another problem is the State’s implementation of the “Medicaid Qualifying Trust” provisions of OBRA 93. Congress figured out that people were spending down or giving assets away (usually to family members and hoping they would be available later) to qualify for benefits. While Colorado had “gifting” penalties, they may

not apply if one qualifies for SSI, which has no such provisions. So in 1993 Congress changed the statutes that applied to these trusts to allow a potential recipient to take ANY assets (before one could only put certain limited assets into one of these trusts, e.g.; a disability claim settlement, a “Zebly” payment, etc.) and give them to a family member to be placed in trust for the person’s benefit. If that trust met certain requirements (not revocable, out of the recipient’s reach, etc.) and had a provision that put Medicaid in line right behind the recipient to recover up the full amount paid by Medicaid, upon the recipient’s death. This way we at least increase the chance of recovering something. When Colorado implemented this, the regulations were drawn in a way that is just as limiting, if not more so, than the pre-93 standards. As a result, we still have the “gifting” issues and I have also seen State and County employees attempt to use these provisions inappropriately, in one case to try to separate an HCBS client from their home.

4)The reform of the Medicaid Mental Health delivery system has not only been a failure, but has caused exorbitant costs. The current MHASA system, as designed, does not have any incentive for the provider to treat anyone, to the contrary, it creates great dis-incentive by paying them whether they treat anyone or not, which needs to be changed. Further, there should be a heavy penalty if they fail to treat a client who then harms themselves or others as a result of lack of treatment. In a recent case, the local MHASA refused to treat a client after he had made 3 suicide attempts (all requiring hospitalizations at much greater cost) and ignored 5 of 6 separate diagnoses in order to justify it. The result of this kind of actions is driving those clients to the criminal justice system at a vastly higher cost, as is evidenced by the current request of Dept. of Corrections for funding to build a treatment facility for mentally ill convicts. With another client, an honors student who had a “mental breakdown”, it took the MHASA weeks just to provide options for psychiatric evaluation after their own psychologist recommended it, and the one psychiatrist offered turned out to not be qualified. It took more than a month just to get a referral to an appropriate, qualified provider.

5) Regarding the recent judgment in favor of Rocky Mtn. HMO, has anyone asked what the Risk Management Fund’s participation/exposure is here? Given the required cuts in the budget, any portion of the judgment or litigation costs that can be attributed to Risk Mgmt. Fund, should be.

We need to change the attitude and culture from the County intake and caseworkers all the way to the State Departmental ED office to “how do we deliver necessary benefits to those who are in need, in the most timely and efficient manner, in partnership with them”. I do acknowledge that there are some employees at the State and Counties that do “get it”, but they are, unfortunately, the minority (and what I mean by “get it” is that almost no one would be putting themselves in the position necessary to be “eligible” if they had any other options, trapping themselves in poverty and a very meager existence without much of a way out). We have to kill the attitude that these people are trying to cheat the system and rip it off for anything they can, and that they are “beneath us”.

We need to make it clear that any employee who is not prepared to do their job, with an appropriate attitude and demeanor, should start looking for another! Remember, we who live in the program know where there is \$\$ to be saved. In the current environment we are greatly discouraged for even trying to give input and are frequently penalized for doing so. I have had the experience of being treated badly, put off, ignored and jerked around by NUMEROUS State and County employee, in numerous cases.

We need more consumer involvement and a mandate the Dept. incorporate consumer input or provide valid justification to a legislative committee as why they did not.

The single greatest step to “fixing” the program would be to require anyone involved in the funding stream, from Congress and the Legislature all the way down to the front line employees at the county level be enrolled in the program and the premiums being paid currently for their health coverage go to Medicaid. That insight would be extremely valuable. I understand that this is not going to happen, but implore you to remember that those of us living in the program know where the problems are and have good ideas to fix those problems. Please feel free to call or email me at any time.