COLORADO GENERAL ASSEMBLY
JOINT BUDGET COMMITTEE

FY 2009-10 STAFF BUDGET BRIEFING

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

(Includes information related to the Executive Director's Office, Medical Services Premiums, Indigent Care Programs, Other Medical Programs, and the Commission on Family Medicine)

JBC Working Document - Subject to Change
Staff Recommendation Does Not Represent Committee Decision

Prepared By:
Melodie Beck, JBC Staff
December 3, 2008

For Further Information Contact:

Joint Budget Committee Staff
200 E. 14th Avenue, 3rd Floor
Denver, Colorado 80203
Telephone: (303) 866-2061
TDD: (303) 866-3472

FY 2009-10 BUDGET BRIEFING
STAFF PRESENTATION TO THE JOINT BUDGET COMMITTEE

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

(Executive Director's Office, Medical Services Premiums, Indigent Care Programs, Other Medical Programs and Commission on Family Medicine)

Table of Contents

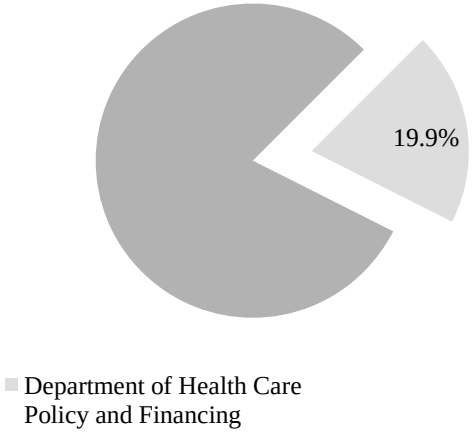
Strategic Health Care Issues

A Look Ahead

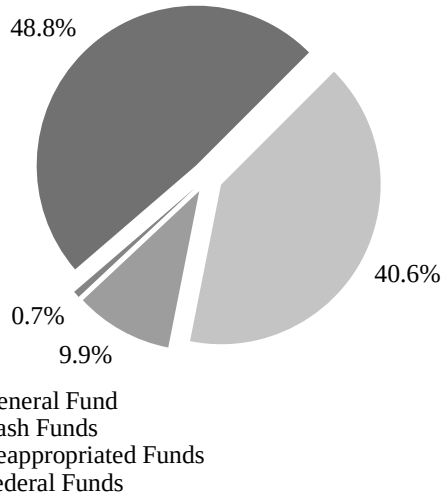
Appendices:

FY 2009-10 Budget Committee Staff Budget Briefing
Department of Health Care Policy and Financing
GRAPHIC OVERVIEW

Department's Share of Statewide General Fund FY 2008-09 Appropriation

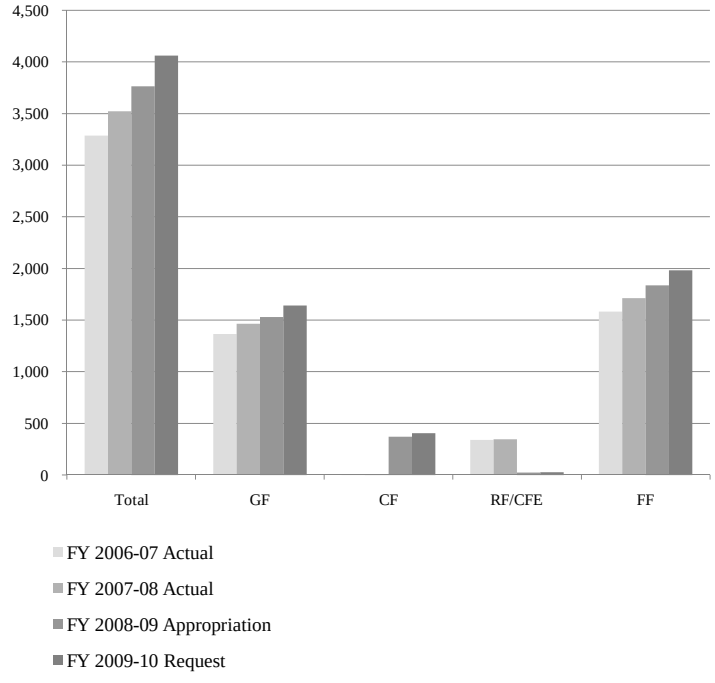


Department Funding Sources FY 2008-09 Appropriation

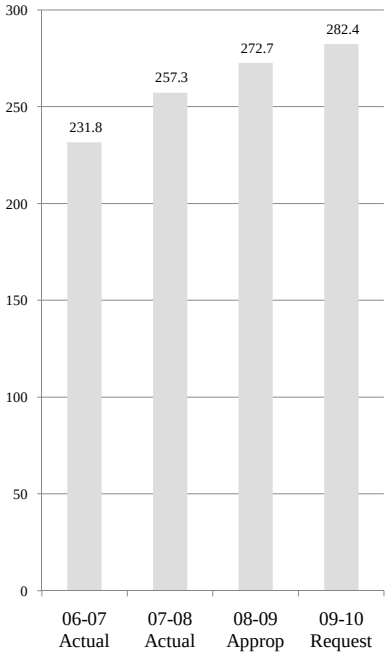


*Includes GF exempt from the 6.0% limit -- percentage subject to 6.0% limit is 20.2%

Budget History
(Millions of Dollars)



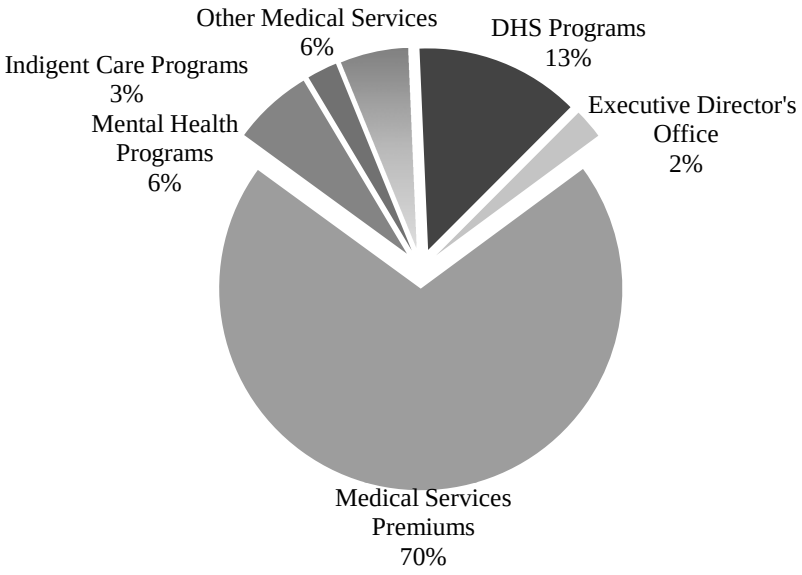
FTE History



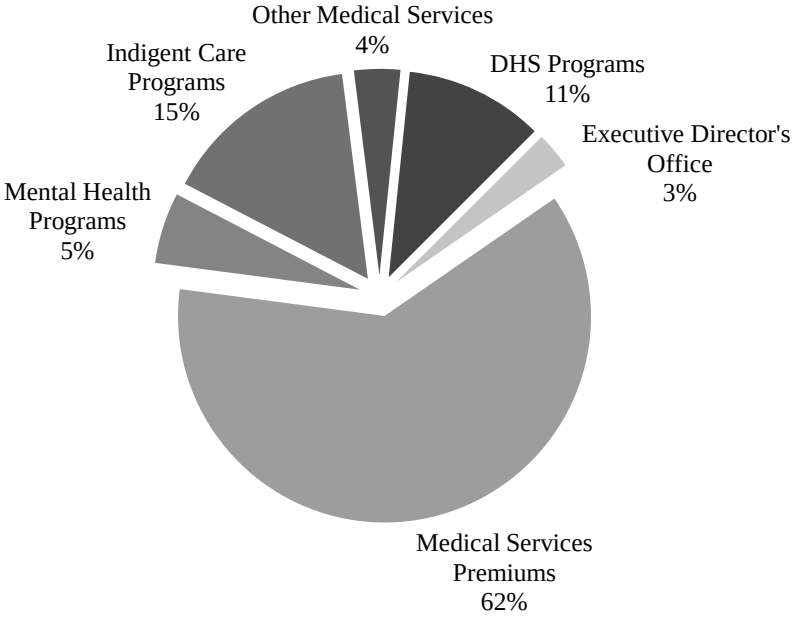
Unless otherwise noted, all charts are based on the FY 2008-09 appropriation.

FY 2009-10 Budget Committee Staff Budget Briefing
Department of Health Care Policy and Financing
GRAPHIC OVERVIEW

Distribution of General Fund by Division
FY 2008-09 Appropriation



Distribution of Total Funds by Division
FY 2008-09 Appropriation



FY 2009-10 Joint Budget Committee Staff Budget Briefing
Department of Health Care Policy and Financing

DEPARTMENT OVERVIEW

Key Responsibilities

- Administers the State's Medicaid program which provides health care services to a forecasted 381,390 low-income people in FY 2008-09 (based on current appropriation).
- Administers the Children's Basic Health Plan, a health insurance program for a forecasted 77,152 low-income children and approximately 1,697 adult pregnant women in FY 2008-09.
- Operates the Colorado Indigent Care Program to offset clinic and hospital provider costs for services to low-income and uninsured clients who are not Medicaid eligible. In FY 2006-07 (last year with data) this program served approximately 172,500 low-income individuals.
- Administers the Old Age Pension Health and Medical Fund which provides health care to a forecasted 5,389 elderly persons who do not qualify for Medicaid or Medicare in FY 2008-09.
- Administers the Primary Care Fund and the Comprehensive Primary and Preventive Care Grant Program.
- Acts as the single-state agency to receive Title XIX (Medicaid) funds from the federal government and therefore, passes these federal funds to other state agencies that have qualifying programs (mainly the Department of Human Services).

Factors Driving the Budget

Funding for the Department in FY 2008-09 consists of 40.6 percent General Fund, 48.8 percent federal funds, and 9.9 percent cash funds, and 0.7 percent reappropriated funds. Major sources for the cash funds and reappropriated funds include (1) the certification of expenditures from other government entities (mainly public hospitals, school districts, and regional centers) that qualify for matching federal funds from the Medicaid program; (2) the Health Care Expansion Fund; (3) the Primary Care Fund; (4) the Children's Basic Health Plan Trust Fund; (5) the Old Age Pension Health and Medical Care Fund and Supplemental Fund; (6) the Health Care Services Fund; (7) the Comprehensive Primary and Preventive Care Grants Fund; and (7) various other cash funds. Federal Funds are appropriated as matching funds to the Medicaid program (through Title XIX of the Social Security Administration Act) and as matching funds to the Children's Basic Health Plan programs (through Title XXI of the Social Security Administration Act). Some of the most important factors driving the budget are reviewed below.

Medical Services Premiums

The Medical Services Premiums section provides funding for the health care services of individuals qualifying for the Medicaid program. Health care services include both acute care services (such as

physician visits, prescription drugs, and hospital visits) and long-term care services (provided within nursing facilities and community settings). The Department contracts with health care providers through fee-for-service and health maintenance organization (HMO) arrangements in order to provide these services to eligible clients. Total costs for the program are driven by the number of clients, the costs of providing health care services, and utilization of health care services.

Medicaid Caseload Growth

The following factors affect the number of clients participating in the Medicaid program: (1) general population growth; (2) policy changes at the state and federal level regarding who is eligible for services; and (3) economic cycles. Since FY 2004-05, the Medicaid caseload has declined due to improving economic conditions and federal policy changes contained in the Federal Deficit Reduction Act of 2005. The current Medicaid caseload forecast is 381,390 clients in FY 2008-09. The following table shows the Medicaid caseload history by aid category from FY 2004-05 through the forecast period for FY 2008-09.

Medicaid Caseload	**FY 2004-05 Actual/1**	**FY 2005-06 Actual/1**	**FY 2006-07 Actual/1**	**FY 2007-08 Actual/1**	**FY 2008-09 Estimate/2**
Supplemental Security Income (SSI) Ages 65+	35,615	36,219	35,977	36,044	36,278
Supplemental. Security Income (SSI) Ages 60 - 64	6,103	6,048	6,042	6,116	6,216
Qualified Medicare Beneficiaries/Special Low-income Medicare Beneficiaries	9,572	11,012	12,818	14,130	15,068
Disabled	47,626	47,565	48,567	49,662	50,123
Categorically Eligible Adults	56,453	57,747	51,361	44,234	41,667
Expansion Low-Income Adults	0	0	4,974	8,627	9,629
Baby Care Adults	6,110	5,050	5,123	6,108	6,028
Breast and Cervical Cancer Treatment	86	188	230	270	301
Low-Income Children	220,592	213,600	206,170	201,800	193,484
Foster Children	15,669	16,311	16,601	17,014	18,858
Non-Citizens	4,976	5,959	5,214	4,044	3,738
Total Medicaid Caseload	402,802	399,699	393,077	388,049	381,390
Annual Percent Change	11.1%	-0.8%	-1.7%	-1.3%	-1.7%

/1 Beginning in FY 2008-09, the Department rebased caseload to reflect data through the last day of a month. The table above shows the actual caseload numbers before the rebase since this was the data that was used to develop the original FY 2008-09 estimate. In other tables in this document, the rebased caseload amount may be shown in past years. If this done, it will be noted on the table.

/2 This table includes the caseload estimates reflected in H.B. 08-1375 (General Appropriation Act) as well as caseload impact estimates for S.B. 07-2 and S.B. 08-99.

Medical Cost Increases

In addition to increased costs due to caseload growth, the Medicaid budget also grows as a result of higher medical costs and greater utilization of medical services. For FY 2008-09, the appropriation assumes a 3.4 percent increase in the average cost per client. The increase in the per capita costs results mainly from a caseload drop in the lower cost adult and children categories (changes in case mix) and from provider rate increases for long-term care and acute care providers. The following table shows the average medical costs per Medicaid client from FY 2004-05 through the forecast period for FY 2008-09.

	FY 2004-05 Actual	FY 2005-06 Actual	FY 2006-07 Actual	FY 2007-08 Actual	FY 2008-09 Appropriation
Medical Service Cost Per Capita	$4,700.29	$4,959.65	$5,211.29	$5,739.06	$5,936.79
Annual Percent Change	-7.5%	5.5%	5.1%	10.1%	3.4%

Medicaid Mental Health Capitation

Medicaid mental health community services throughout Colorado are delivered through a managed care or "capitated" program. Under capitation, the State pays a regional entity - a Behavioral Health Organization (BHO) - a contracted amount (per member per month) for each Medicaid client eligible for mental health services in the entity's geographic area. The BHO is then required to provide appropriate mental health services to all Medicaid-eligible persons needing such services.

The rate paid to each BHO is based on each class of Medicaid client eligible for mental health services (*e.g.*, children in foster care, low-income children, elderly, disabled) in each geographic region. Under the capitated mental health system, changes in rates paid, and changes in overall Medicaid eligibility and case-mix (mix of types of clients within the population) are important drivers in overall state appropriations for mental health services. Capitation represents the bulk of the funding for Medicaid mental health community programs.

The following table provides information on the recent expenditures and caseload for Medicaid mental health capitation. Please note, the Medicaid mental health caseload used was converted effective FY 2005-06 to mirror how Medicaid caseload is reported in other areas of the Department's budget. Specifically, the caseload beginning in FY 2005-06 does not include retroactivity adjustments.

	FY 2004-05 Actual	FY 2005-06 Actual	FY 2006-07 Actual	FY 2007-08 Actual	FY 2008-09 Appropriation
Medicaid Mental Health Capitation Funding	$164,540,442	$176,727,920	$184,640,568	$196,011,033	$207,799,886
Annual Dollar Change	$13,211,714	$12,187,478	$7,912,648	$11,370,465	$11,788,853
Annual Percent Change	8.1%	7.4%	4.5%	6.2%	6.0%

	FY 2004-05 Actual	FY 2005-06 Actual	FY 2006-07 Actual	FY 2007-08 Actual	FY 2008-09 Appropriation
Individuals Eligible for Medicaid Mental Health Services (Caseload)/1	388,254	382,734	375,046	369,875	362,584
Annual Caseload Change	5,520	(5,520)	(7,508)	(5,171)	(7,291)
Annual Percent Change	1.4%	-1.4%	-2.0%	-1.4%	-2.0%

/1 Not all Medicaid caseload aid categories are eligible for mental health services. The caseload reported in this table does not reflect the Qualified Low-Income Medicaid (QMB/SLMB) or non-citizen aid categories.

Indigent Care Program

The Safety Net Provider Payment, the Children's Hospital Clinic Based Indigent Care, and the Pediatric Speciality Hospital line items provide direct or indirect funding to hospitals and clinics that have uncompensated costs from treating approximately 172,500 under-insured or uninsured Coloradans through the Indigent Care Program. The Indigent Care Program is not an insurance program or an entitlement program. Because this is not an entitlement program, funding for this program is based on policy decisions at the state and federal level and is not directly dependent on the number of individuals served or the cost of the services provided. The majority of the funding for this program is from federal sources. State funds for the program come through General Fund appropriations and through certifying qualifying expenditures at public hospitals.

In FY 2004-05, funding for private hospitals participating in the program was cut by $6.2 million total funds. However, because the State received approval from the U.S. Centers for Medicare and Medicaid Services (CMS) to change the methodology by which the Upper Payment Limit (UPL) financing was calculated, the total fund appropriation for the program actually increased by $8.1 million associated with recouping prior year payments. In FY 2005-06, total funding for the program increased by $28.7 million. The increase was due to restoring the $6.2 million for private hospitals that was cut in the prior year, increasing funding for pediatric speciality hospitals by $5.5 million, and accessing an additional $17 million in available Medicare UPL funding. For FY 2006-07, an additional $9.9 million was expended for these programs due mainly to $15.0 million in available S.B. 06-44 funding offset by a decrease of $5.5 million in UPL financing. For FY 2007-08 a provider rate increase was included for the pediatric speciality hospital line item and federal matching funds were appropriated for the S.B. 06-44 funding for a total funding increase of $33.2 million. In FY 2008-09, the $3.2 million increase is related mainly to additional funding for the pediatric speciality hospital line item.

	FY 2004-05 Actual	FY 2005-06 Actual	FY 2006-07 Actual	FY 2007-08 Actual	FY 2008-09 Appropriation
Safety Net Provider Payments	$264,013,206	$287,296,074	$279,933,040	$296,188,630	$296,188,630
Children's Hospital Clinic Based Indigent Care	6,119,760	6,119,760	6,119,760	6,119,760	6,119,760

	FY 2004-05 Actual	FY 2005-06 Actual	FY 2006-07 Actual	FY 2007-08 Actual	FY 2008-09 Appropriation
Pediatric Speciality Hospital	0	5,452,134	7,732,072	8,439,487	12,865,212
S.B. 06-44 Funding Available for Service Expenditure	0	0	14,962,408	31,225,421	30,000,000
Total	**$270,132,966**	**$298,867,968**	**$308,747,280**	**$341,973,298**	**$345,173,602**
General Fund	12,492,364	18,362,593	19,500,662	19,701,662	21,701,662
Cash Fund Exempt/Cash Funds/ Reappropriated Funds	122,574,119	131,071,391	142,354,182	150,668,119	150,885,139
Federal Funds	135,066,483	149,433,984	146,892,436	171,603,517	172,586,801
Total funding percent change	3.07%	10.64%	3.31%	10.76%	0.94%

Comprehensive Primary Care Program

In November 2004, the voters passed Amendment 35 to the Colorado Constitution which increased the taxes on tobacco products in order to expand several health care programs. During the 2005 Legislative Session, the General Assembly passed H.B. 05-1262 to implement the provisions of Amendment 35. Specifically, H.B. 05-1262 created the Comprehensive Primary Care program. This program provides additional funding to qualifying providers with patient caseloads that are at least 50 percent uninsured, indigent, or enrolled in the Medicaid or Children's Basic Health Plan programs. For FY 2005-06, the amount of funding available for this program was $44.1 million. Funding in FY 2005-06 included tobacco tax revenues that were collected in both FY 2004-05 and FY 2005-06. In FY 2006-07, funding for this program decreased to $32.0 million. The decrease reflected solely the fact that the program had only twelve months of revenue in FY 2006-07 instead of the 18 months of revenue collections that were available in FY 2005-06. For FY 2007-08, funding for this program was $31.0 million and in FY 2008-09 funding is estimated at $31.3 million. There are no matching federal funds available for this program.

Children's Basic Health Plan

The Children's Basic Health Plan (CBHP) was implemented in 1997 to provide health care insurance to children from families with incomes at or below 185 percent of the federal poverty level (FPL). A 65 percent federal match is available for the program. Since its passage in 1997, a number of expansions to the program have occurred. In FY 2002-03, the program was expanded to include adult pregnant women up to 185 percent FPL. However, due to budget constraints in FY 2003-04, the adult prenatal program was suspended for the entire year and no new enrollment was accepted into the children's program beginning in November 2003. In FY 2004-05, the cap was lifted on the children's caseload and the adult prenatal program was reinstated.

In November 2004 the voters approved Amendment 35 to the Colorado Constitution, which increased the taxes on tobacco products in order to expand several health care programs. During the 2005 legislative session, the General Assembly passed H.B. 05-1262 to implement the provisions of Amendment 35. Among other changes, H.B. 05-1262 increased eligibility for the CBHP for both children and women up to 200 percent of the federal poverty level. During the 2007 legislative session, S.B. 07-97 expanded the program's eligibility to 205 percent FPL for FY 2007-08. During the 2008 legislative session, the program's eligibility was once again expanded to 225 percent FPL for children beginning in April 2009 and for pregnant women beginning in October 2009. The following table provides a five-year funding history for the CBHP medical and dental costs.

	FY 2004-05 Actual	FY 2005-06 Actual	FY 2006-07 Actual	FY 2007-08 Actual	FY 2008-09 Appropriation
Medical Services	$52,000,289	$65,919,891	$89,657,433	$104,684,790	$154,739,207
Dental Services	5,084,701	5,368,921	6,834,843	8,715,754	12,450,809
Total Service Costs	**$57,084,990**	**$71,288,812**	**$96,492,276**	**$113,400,544**	**$167,190,016**
Cash Fund Exempt/Cash Funds	20,059,529	25,305,261	33,923,185	39,874,379	58,778,331
Federal Funds	37,025,461	45,983,551	62,569,091	73,526,165	108,411,685
Total funding percent increase	-0.17%	24.88%	35.35%	17.52%	47.43%

The following table provides a five-year history of the caseload served by the Children's Basic Health Plan.

	FY 2004-05 Actual	FY 2005-06 Actual	FY 2006-07 Actual/1	FY 2007-08 Actual	FY 2008-09 Approp.
Children Caseload	41,101	44,177	47,047	57,795	77,152
Percent Change	-11.98%	7.48%	6.50%	22.85%	33.49%
Adult Pregnant Women Average Monthly Caseload	557	1,204	1,169	1,570	1,697
119	368.07%	116.14%	-2.88%	34.27%	8.09%

/1 Beginning in FY 2006-07, the caseload has been adjusted to remove retroactive caseload pursuant to the requirements of S.B. 07-131 which moved this program to a cash basis of accounting. The FY 2008-09 caseload includes the impact of S.B. 08-160.

Department of Human Services Medicaid-Funded Programs

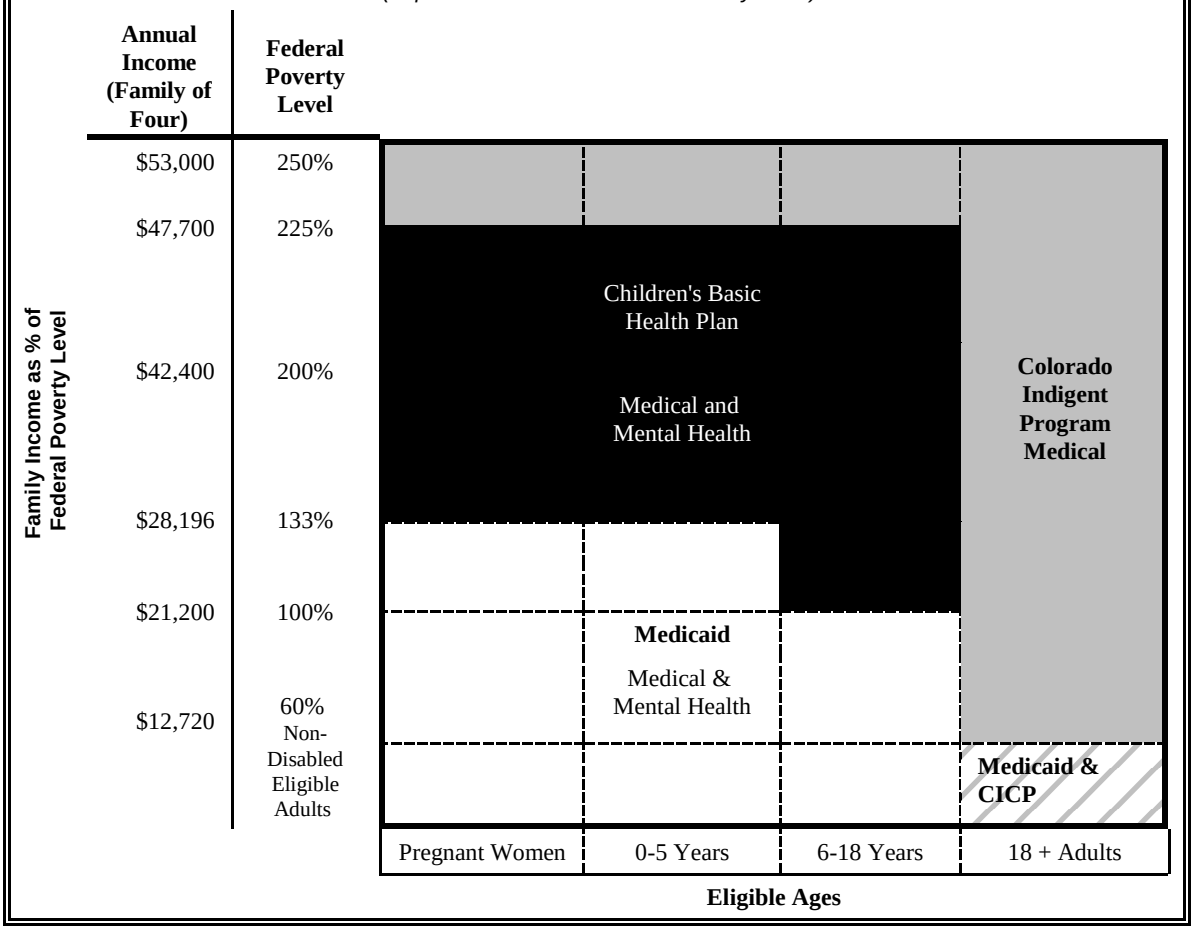
Many programs administered by the Department of Human Services (DHS) qualify for Medicaid funding. The federal government requires that one state agency receive all federal Medicaid funding. Therefore, the state and federal funding for all DHS programs that qualify for Medicaid funding is first appropriated in the Department of Health Care Policy and

Financing and then transferred to the Department of Human Services (as reappropriated funds). A five-year funding history for the DHS Medicaid-funded programs is provided in the table below.

	FY 2004-05 Actual	FY 2005-06 Actual	FY 2006-07 Actual	FY 2007-08 Actual	FY 2008-09 Approp.
Expenditures	$420,876,735	$446,257,606	$333,128,748	$351,308,449	$409,132,487
Annual percent change	-25.9%	6.0%	-25.4%	5.5%	16.5%

Figure 1 below summarizes the eligibility for the Medicaid, CBHP, and CICP programs for the populations based on federal poverty guidelines.

Figure 1. Department of Health Care Policy and Financing
Medicaid, Children's Basic Health Plan (CBHP), and Colorado Indigent Care Program (CICP)
Eligibility
(Populations based on Federal Poverty Level)



*In addition, Medicaid coverage is available to children and adults who qualify because of a disability up to 300% of the Social Security Income level -- which is approximately 240% of the federal poverty level and is not shown in the chart above.

FY 2009-10 Joint Budget Committee Staff Budget Briefing
Department of Department of Health Care Policy and Financing
(Executive Director's Office, Medical Services Premiums, Indigent Care Programs, Other Medical Services, and Commission on Family Medicine)

DECISION ITEM PRIORITY LIST

Decision Item	GF	CF	RF	FF	Total	FTE
1	80,080,442	24,911,912	130,695	107,498,749	212,621,798	0.0

Request for FY 2009-10 Medical Services Premiums (Base Caseload & Cost Forecast)

Medical Services Premiums. Estimated base increase to the medical services premiums line item based on the anticipated number of clients who will be served in FY 2009-10 and the cost of providing medical services to those clients. The Department currently projects an increase in caseload of 3.17 percent over their *revised* FY 2008-09 estimate. The Department is also projecting an increase in overall per-capita spending of 2.17 percent over their *revised* FY 2008-09 estimate. The overall total increase projected for the ***base*** changes to the medical service premiums is 9.2 percent over the ***current*** appropriation. This decision item is discussed in greater detail in Issue #3. *Statutory authority: Sections 25.5-4 et al, 25.5-5-et al, and 25.5-6 et al C.R.S. (2008).*

2	6,001,519	2,143,323	1,246	8,149,608	16,295,696	0.0

Request for FY 2009-10 Medicaid Mental Health Community Programs (Base Caseload & Cost Forecast)

Medicaid Mental Health Community Programs. Estimated base increase to the Medicaid Community Mental Health line items. The request is based on the anticipated growth in the Medicaid caseload described above as well as an increase in the overall weighted capitation rate change of 1.67 percent. This decision item is discussed in greater detail in the JBC Staff Briefing on Medicaid Mental Health presented on December 4, 2008. *Statutory authority: Sections 25.5-308, 25.5-5-408, and 25.5-5-411, C.R.S. (2008).*

3	4,270,540	(12,328,096)	4,595,239	(14,100,209)	(17,562,526)	0.0

Children's Basic Health Plan Medical Premium and Dental Costs (Base Caseload & Cost Forecast)

Indigent Care Programs. Estimated decrease from current FY 2008-09 appropriation based on forecasted caseload and cost-per-client estimates for the Children's Basic Health Plan. The current FY 2008-09 appropriation assumed a total enrollment of 77,152 children. However, the Department's FY 2009-10 caseload estimate is 71,598. This decision item is discussed in greater detail in Issue #3 of this briefing packet. *Statutory authority: Sections 25.5-8 et al, C.R.S. (2008).*

4	5,310,019	0	0	0	5,310,019	0.0

Medicare Modernization Act State Contribution Payment (Base Caseload & Cost Forecast)

Other Medical Programs. Estimated increase for the Medicare Modernization Act (MMA) State Contribution Payment based on projected caseload of dual eligible individuals and a projected increase in the per-client per-month rate paid by the State, per federal regulation. *Statutory authority: Section 25-5-4-105 and Section 25.5-5-503, C.R.S. (2008) and 42 CFR 423.910 (g).*

Decision Item	GF	CF	RF	FF	Total	FTE
5	3,591,238	0	0	3,936,894	7,528,132	2.8
Improved Eligibility and Enrollment Processing **Executive Director's Office.** The Department requests $7.5 million total funds and 2.8 FTE in FY 2008-09 to implement and administer an Eligibility Modernization Vendor model. Under the Eligibility Modernization Vendor model, a contractor would manage all eligibility and enrollment activities for Medicaid and the Children's Basic Health Plan and reduce the time to process and determine eligibility. The Department envisions that three critical systems would be implemented as part of the new business model: (1) an Electronic Document Management System; (2) Workflow Process Management System; and (3) Customer Contact Center. This decision item is discussed in greater detail in Issue #9 of this briefing document. *Statutory authority: Sections 25.5-1-104 (2) (4); Section 25.5-4-204 (1) (b); Section 25.5-4-206; and Section 25.5-5-101 (1), C.R.S. (2008).*						
6	899,050	8,954	0	1,489,705	2,397,709	1.8
Medicaid Value-Based Care Coordination Initiative **Executive Director's Office and Medical Services Premiums.** The Department requests $2.4 million total funds and 1.8 FTE to begin a statewide competitive procurement process to provide a coordinated health delivery system for Medicaid clients. Enrollment in the project will initially be limited to 60,000 clients until the Department could program efficacy could be demonstrated. The Department intends to regionally procure services from Accountable Care Organizations that would operate as Administrative Service Organization (ASOs) providing enhanced Primary Care Case Management services. The Department envisions that the ASO would also administer a comprehensive network of care coordination services. Care coordinators would be based in the community and help reinforce treatment plans, coordinate care between different providers, assist in care transitions between hospitals and community care, and serve as a client advocate in navigating between physical health, behavioral health, waiver services, and long-term care services as appropriate. This decision item is discussed in greater detail in Issue #8 of this briefing document. *Statutory authority: Sections 25.5-4-104 and Section 25.5-5-105, C.R.S. 92008).*						
7	0	0	0	0	0	0.0
(Decision Item Pulled)						
8	0	0	0	0	0	0.0
(Decision Item Pulled)						
9	0	0	0	0	0	0.0
(Decision Item Pulled)						
10	70,353	3,046	0	216,718	290,117	0.0
Annual Medicaid Management Information System Cost Adjustment						

Decision Item	GF	CF	RF	FF	Total	FTE
Executive Director's Office. The Department requests $290,117 total funds in order to fund the fixed-price portion of the Medicaid Management Information System (MMIS) contract. This amount represents the negotiated increase for the administrative functions performed by the Department's fiscal agent, Affiliated Computer Services, Inc. Beginning in March 2004, the MMIS contract was converted to a fixed-price contract. The MMIS fixed price contract covers: (1) All claims processing for the Department's medical programs including Medicaid, CBHP, and Old Age Pension Medical Program; (2) Most Pharmacy prior authorization reviews; (3) Orthodontia prior authorization reviews; and (4) Drug Rebate Analysis and Management System. Items not covered in the fixed price contract include postage costs and new legislation programming costs. As part of the fixed price contract, the Department negotiated annual cost-of-living adjustment (inflation) increases. The negotiated amount for FY 2009-10 is 1.35 percent and results in an increase of $290,117 total funds over the current FY 2008-09 appropriation. *Statutory authority: Section 25.5-4-204 (3), C.R.S. (2008) and Section 1903 (A) of the Social Security Act [42 U.S.C. 1396b].*						
11	110,667	0	0	110,667	221,334	0.0
Additional Leased Space for Standardization **Executive Director's Office.** The Department requests $221,334 total funds in FY 2009-10 for commercial lease space to provide work space for the Department's employees. The additional lease space is needed due to the remodeling of the Department 1570 Grant Street and for an anticipated increase of 12 employees (including employees requested in other decision items and employees funded through grants). The remodel of the offices at 1570 Grant Street will increase the size of work spaces from an average of 35 square feet to 63 square feet and will result in a net reduction of 20 workstations at the Grant Street location. The request will fund 3,600 square feet of office space plus the personal services and operating expenses associated with build out of the acquired space with cubicles, chairs, telecommunications, and information technology equipment.						
12	114,828	0	0	280,201	395,029	0.9
Enhance Medicaid Management Information System Effectiveness **Executive Director's Office.** The Department is requesting $395,029 total funds in FY 2009-10 and 0.9 FTE to design, develop, and implement policy changes and enhancements to the Medicaid Management Information System and reduce the backlog of customer service requests (CSRs). Most CSRs are initiated as a result of changes in federal or state law or to enhance system reporting requirements based on user requests. Because of the high volume of work and the fixed price contract, many CSRs remain open and unaddressed due to workload shortfalls. The Department's request would reduce the backlog of current CSRs by adding 2,625 in additional programming hours and 0.9 FTE to prioritize, oversee and test program changes. *Statutory authority: Section 25.5-4-204 (3), C.R.S. (2008) and Section 1903 (a) of the Social Security Act [42 U.S.C. 1396b] (a).*						
13	0	0	0	0	0	0.0
(Decision Item Pulled)						
14	64,933	0	0	64,933	129,866	0.0
Nursing Facility Audit Reprocurement						

Decision Item	GF	CF	RF	FF	Total	FTE
Executive Director's Office. The Department requests an additional $129,866 total funds in FY 2009-10 to increase the funding for audits of Medicaid nursing facilities for rate setting purposes. The Department is required to audit nursing facility costs for rate setting purposes. The current five-year audit contract expires on July 1, 2009. The Department will be reprocuring the contract this year. The Department anticipates that the new contract will require additional funding based on additional responsibilities required under the new rate setting methodology established under S.B. 08-1114. The increase in funding would increase the current contract of $1,097,500 per year to $1,227,366 per year (an 11.83 percent increase). The contract has not been increased since FY 2004-05. The contract will be a fixed price contract throughout the duration of the 5-year contract period. *Statutory authority: Section 25.5-6-202 (9) (c) (II), and Section 25.5-6-201 (2), C.R.S. (2008).*						
15	87,629	0	0	262,885	350,514	0.0
Provider Web Portal Reprocurement **Executive Director's Office.** The Department requests $350,514 in total funds in FY 2009-10 for the reprocurement of the web portal contract. Currently, the Department contracts with CGI Technology and Solutions (CGI), Inc. to operate and manage the Department's web portal. The web portal allows medical providers to submit electronic transactions to and from the Medicaid Management Information System (MMIS), Colorado Benefits Management System (CBMS), and Business Utilization System (BUS). Under the contract with CGI, the contractor provides: (1) maintenance and support of web internet applications; (2) web hosting costs and fees to support 500 concurrent users; and (3) manages change requests. The Department's contract with CGI expires on June 30, 2009. The Department anticipates that the reprocured contract will result in an additional $350,514 total funds as follows: (1)$179,654 to bring the current contract for web hosting service up to current market pricing; (2) $120,810 for additional application maintenance and help desk support; and (3) $50,050 for additional change request management. *Statutory authority: Section 25.5-4-105, C.R.S. (2008) and Section 1903 (a) of the Social Security Act [42 U.S.C. 1396b]*.						
16	11,410	3,722	0	17,586	32,718	0.0
School Based Medical Assistance Site Pilot Expansion **Executive Director's Office.** The Department requests an additional $32,718 in total funding in FY 2009-10 for school districts participating in the school-based medical assistance sites pilot project. The increase is requested in order to provide sufficient funding to the three participating school districts in order to renew their contracts beginning in FY 2009-10. The request also includes a technical correction to the source of the State's share of funding for children determined eligible for the Children's Basic Health Plan (funding changed from the Health Care Expansion Fund to the Children's Basic Health Plan Trust Fund). When the pilot began in FY 2007-08, 187 schools (in three districts) participated in the program at an average cost per school of approximately $1,215. In FY 2008-09, 27 additional schools with added and thus dropped the average cost per school to $1,062. The Department's request would restore the average cost per school to $1,215. *Statutory authority: Section 25.5-4-205.*						
17	0	0	0	0	0	0.0
School Health Services Program Auditor **Executive Director's Office and Other Medical Services.** The Department's request transfers $433,700 federal funds from the administrative costs for the School Health Services Program to the Department's line item for provider audits. The Department would use this funding to audit school districts for compliance with federal mandates and accurate cost certification. *Statutory authority: Section 25.5-5-318 (1) - (8) (a) C.R.S. (2008).*						
Total	**100,612,628**	**14,742,861**	**4,727,180**	**107,927,737**	**228,010,406**	**5.5**

FY 2009-10 Joint Budget Committee Staff Budget Briefing
Department of Health Care Policy and Financing
(Executive Director's Office, Medical Services Premiums, Indigent Care Programs, Other Medical Services, and Commission on Family Medicine)

BASE REDUCTION ITEM PRIORITY LIST

Base Reduction	GF	CF	RF	FF	Total	FTE
1	(207,348)	0	0	175,841	(31,507)	0.0

Pharmacy Technical and Pricing Efficiencies

Executive Director's Office and Medical Service Premiums. The Department's request includes a net reduction of $31,507 total funds ($207,348 General Fund) in FY 2009-10 as a result of the implementation of an automated prior authorization system and changes to the reimbursement rates of drugs using a state maximum allowable cost structure. Currently, providers are required to submit paperwork on every prior authorization requested either electronically, through the mail or through fax. Under the Department's proposal, the Department would higher a contractor to provide automated prior authorization services. The automated prior authorization system would screen pharmacy claims against client information from a medical and pharmacy database to determine if the client meets the prior authorization approval criteria at the point of sale. The Department's request assumes savings will result by removing a large majority of the administrative burden and will result in prescription drug savings in the Medical Services Premiums line item by allowing the Department to better monitor and control drug utilization. For more information on prescription drugs and cost saving estimates implemented over the past several years, see Issue #11 of this briefing packet. *Statutory authority: Section 25.5-4-401, C.R.S. (2008) and 42 CFR 447.205.*

2	(865,509)	0	0	(865,509)	(1,731,018)	0.9

Medicaid Program Efficiencies

Executive Director's Office and Medical Service Premiums. The Department's request includes a net reduction of $1,731,018 ($865,509 General Fund) in FY 2009-10 based on efficiency saving estimates from six Medicaid reforms. These six reforms include: (1) A Review of the Medicaid Benefits; (2) Improve Health Outcome Measurement Initiative; (3) Floride Varnish Benefit; (4) Hospital Back-Up Program Enhancements; (5) Oxygen Durable Medical Equipment Reform; and (6) Serious Reportable Events Initiative. The Hospital Back-Up Program Enhancements and Oxygen Durable Medical Equipment Reform initiatives are anticipated to result in cost savings. However, all measures are anticipated to result in better health outcomes for clients. For more information on this base reduction item, see Issue #13 of this briefing packet. *Statutory authority: Sections 25.5-4-104 and 25.5-5-101, C.R.S. (2008).*

Total	**(1,072,857)**	**0**	**0**	**(689,668)**	**(1,762,525)**	**0.9**

FY 2009-10 Joint Budget Committee Staff Budget Briefing
Department of Health Care Policy and Financing
(Executive Director's Office, Medical Services Premiums, Indigent Care Programs, Other Medical Services, and Commission on Family Medicine)

NON-PRIORITIZED ITEM LIST

Non-Prioritized Item List	GF	CF	RF	FF	Total	FTE
1	100,000	0	0	100,000	200,000	0.0
Commission on Family Medicine -- Expanding Access to Primary Care **Other Medical Services.** The Commission on Family Medicine requests an increase of $200,000 total funds in FY 2009-10 to provide approximately $22,200 in additional funding for each family medicine residency programs. The Commission believes that the increase in funding will expand access to primary care by augmenting the funding spent by hospitals for family medicine residency training programs. For more information on this decision item, please see Issue #14 of this briefing packet. *Statutory authority: Section 25-1-901, C.R.S. (2008).*						
2	4,500	500	0	9,000	14,000	0.0
Department of Regulatory Agencies Sunset Reviews **Executive Director's Office.** The Department requests an additional $14,000 total funds in FY 2009-10 in order to fund three sunset reviews conducted by the Department of Regulatory Agencies: (1) $3,000 for a review of the Telemedicine Pilot Program; (2) $6,000 for a review of the In-Home Support Services Program; and (3) 5,000 for the sunset review of the Teen Pregnancy and Dropout Prevention Program. Because these reviews are eligible to draw down federal Medicaid funding, these reviews must first be appropriated in the Department of Health Care Policy and Financing and then transferred to the Department of Regulatory Agencies. *Statutory authority: Section 24-34-104, C.R.S. (2008).*						
3	2,646,442	0	0	2,646,441	5,292,883	0.0
DHS - Community Funding for Individuals with Disabilities						
4	182,572	0	0	182,572	365,144	0.0
DHS - Child Welfare Caseload						
5	56,361	0	7,079	56,744	120,184	0.0
DHS - Postage Increase and Mail Equipment Upgrade						
6	751,751	0	0	751,751	1,503,502	0.0
DHS - Regional Centers - High Needs Clients						
7	43,936	0	0	43,936	87,872	0.0
DHS - Inflationary Increase for DHS Residential Programs						

Non-Prioritized Item List	GF	CF	RF	FF	Total	FTE
8	82,125	0	0	82,125	164,250	0.0
DHS - Direct Care Capital Outlay for Regional Centers, Mental Health Institutes, and Facilities Management and Facilities Management Operating Increase						
9	7,483	218	123	7,772	15,596	0.0
DPA - Mail Equipment Upgrade						
10	25	0	0	24	49	0.0
DPA - Ombuds Program Increase less Annualization of CSEAP Program Increase						
11	9,076	0	0	9,076	18,152	0.0
DPA - Office of Administrative Courts Staffing Adjustment						
12	2,250	66	37	2,337	4,690	0.0
DPA - Postage Increase						
13	513,124	0	0	513,123	1,026,247	0.0
DHS - High Risk Pregnant Women Program						
14	3,176	0	0	6,750	9,926	0.0
DPHE - Fleet Common Policy for Facility Survey and Certification						
15	1,944	0	0	1,944	3,888	0.0
DHS - Annual Fleet Vehicle Replacements						
16	30,031	0	0	30,031	60,062	0.0
DHS - Annual Fleet Vehicle Replacements						
17	46,894	0	0	46,891	93,785	0.0
DHS - State Fleet Variable Costs						
18	15,702	0	0	15,701	31,403	0.0
DHS - Budget Office Staffing						
Total	**4,497,392**	**784**	**7,239**	**4,506,218**	**9,011,633**	**0.0**

FY 2009-10 Joint Budget Committee Staff Budget Briefing
Department of Health Care Policy and Financing
(Executive Director's Office, Medical Services Premiums, Indigent Care Programs, Other Medical Services, and Commission on Family Medicine)

OVERVIEW OF NUMBERS PAGES

The following table summarizes the total change, in dollars and as a percentage, between the Department's FY 2008-09 appropriation and its FY 2009-10 request.

Table 1: Total Requested Change, FY 2008-09 to FY 2009-10 (millions of dollars)

Category	GF	CF	RF	FF	Total	FTE
FY 2008-09 Appropriation	$1,528.9	$372.8	$25.5	$1,836.8	$3,764.0	272.7
FY 2009-10 Request	1,641.9	406.3	28.3	1,982.3	4,058.8	282.4
Increase / (Decrease)	$113.0	$33.5	$2.8	$145.5	$294.8	9.7
Percentage Change	7.4%	9.0%	11.0%	7.9%	7.8%	3.6%

As shown in Table 1 above, the Department's FY 2009-10 budget request includes a total increase of $113.0 million (7.4 percent) in additional General Fund spending. The General Fund increases are mainly attributable to the following issues: (1) $86.1 million for caseload growth and cost increases for medical and mental health services for the Medicaid program; (2) $12.7 million for Medicaid funding related to decision and budget items in the programs administered by the Department of Human Services; (3) $5.3 million for caseload growth and cost increases for the Medicare Modernization Act (MMA) State Contribution Payment; (4) $4.3 million to back fill the Children's Basic Health Plan (CBHP) Trust Fund due to caseload growth and cost increases in the CBHP; and (5) $3.9 million for information technology contract projects mainly related to improving eligibility and enrollment processes.

Table 2 summarizes the changes requests contained in the Department's total FY 2009-10 budget request, as compared with the FY 2008-09 appropriation.

Table 2: Total Department Requested Changes, FY 2008-09 to FY 2009-10 (in millions)

Category	GF	CF	RF	FF	Total	FTE
Decision Items	$100.6	$14.7	$4.7	$107.9	$227.9	5.5
Base Reduction Items	(1.1)	0.0	0.0	(0.7)	(1.8)	0.9
Non-Prioritized Items	4.5	0.0	0.0	4.5	9.0	0.0
Technical/Base Changes	9.0	18.8	(1.9)	33.8	59.7	3.3
Total Changes	$113.0	$33.5	$2.8	$145.5	$294.8	9.7

The tables on the following pages summarizes the Department's FY 2009-10 budget request by division. For a breakdown of change requests by line item see the Department's number pages in Appendix A of this briefing packet.

Table 3: Requested Changes for Executive Director's Office, FY 2008-09 to FY 2009-10

Category	GF	CF	RF	FF	Total	FTE
Executive Director's Office Current Appropriation	**$36,693,562**	**$8,783,862**	**$1,790,768**	**$61,107,488**	**$108,375,680**	**272.7**
Annualize prior year budget actions and special legislation	(947,490)	(74,388)	(23,281)	(2,044,501)	(3,089,660)	3.3
Salary Survey	177,902	6,066	12,539	198,242	394,749	0.0
Employee Benefits Related Adjustments	115,796	8,490	15,945	132,428	272,659	0.0
Executive Director Office Base Request	**$36,039,770**	**$8,724,030**	**$1,795,971**	**$59,393,657**	**$105,953,428**	**276.0**
Improved Eligibility and Enrollment Process (DI #5)	3,591,238	0	0	3,936,894	7,528,132	2.8
Medicaid Value-Based Care Coordination Initiative (DI #6)	639,908	0	0	1,221,608	1,861,516	1.8
Annual MMIS Cost Adjustment (DI #10)	70,353	3,046	0	216,718	290,117	0.0
Additional Lease Space for Standardization (DI #11)	110,667	0	0	110,667	221,334	0.0
Enhance MMIS Effectiveness (DI #12)	114,828	0	0	280,201	395,029	0.9
Nursing Facility Audit Reprocurement (DI #14)	64,933	0	0	64,933	129,866	0.0
Provider Web Portal Reprocurement (DI #15)	87,629	0	0	262,885	350,514	0.0
School Based Medical Assistance Site Pilot Expansion (DI #16)	11,410	3,722	0	17,586	32,718	0.0
School Health Services Program Auditor (DI #17)	0	0	0	233,700	233,700	0.0
Pharmacy Technical and Pricing Efficiencies (BRI #1)	304,095	0	0	687,285	991,380	0.0
Medicaid Program Efficiencies (BRI #2)	317,463	0	0	317,464	634,927	0.9
Non-Prioritized Items (NP #2, #9 - #12, #14)	26,510	783	161	34,959	62,413	0.0
Executive Director's Office Total Request	**$41,378,804**	**$8,731,581**	**$1,796,132**	**$66,778,557**	**$118,685,074**	**282.4**
Total Change	**$4,685,242**	**($52,281)**	**$5,364**	**$5,671,069**	**$10,309,394**	**9.7**
Percent Change	**12.8%**	**-0.6%**	**0.3%**	**9.3%**	**9.5%**	**3.6%**

Table 4: Requested Changes for Medical Service Premiums, FY 2008-09 to FY 2009-10

Category	GF/GFE	CF	RF	FF	Total
Medical Services Premiums Current Appropriation	**$1,072,222,480**	**$85,281,324**	**$2,767,998**	**$1,161,825,797**	**$2,322,097,599**
Annualize prior year budget cost saving actions	(2,108,479)	0	0	(2,108,477)	(4,216,956)
Annualize prior year budget actions with caseload/cost impacts	4,122,371	0	0	4,122,371	8,244,742
Annualize prior year special legislation	(1,107,777)	9,936,145	0	8,828,369	17,656,737
Medical Services Premiums Base Request	**$1,073,128,595**	**$95,217,469**	**$2,767,998**	**$1,172,668,060**	**$2,343,782,122**
Medicaid Caseload and Cost Growth (DI #1)	80,080,442	24,911,912	130,695	107,498,749	212,621,798
Medical Services Premiums Base with Caseload Growth Request	**$1,153,209,037**	**$120,129,381**	**$2,898,693**	**$1,280,166,809**	**$2,556,403,920**
Medicaid Value-Based Care Coordination Initiative (DI #6)	259,142	8,954	0	268,097	536,193
Pharmacy Technical and Pricing Efficiencies (BRI #1)	(511,443)	0	0	(511,444)	(1,022,887)
Medicaid Program Efficiencies (BRI #2)	(1,182,972)	0	0	(1,182,973)	(2,365,945)
Non-Prioritized Items #3 -- DHS Community Funding for Individuals with Developmental Disabilities	46,283	0	0	46,282	92,565
Medical Services Premiums Total Request	**$1,151,820,047**	**$120,138,335**	**$2,898,693**	**$1,278,786,771**	**$2,553,643,846**
Total Change	**$79,597,567**	**$34,857,011**	**$130,695**	**$116,960,974**	**$231,546,247**
Percent Change	**7.4%**	**40.9%**	**4.7%**	**10.1%**	**10.0%**

Of the FY 2009-10 request for cash funds, $85,709,086 is from the Health Care Expansion Fund, $784,875 shall be from the Colorado Autism Treatment Fund; $1,046,828 is from the Breast and Cervical Cancer Treatment Fund; $16,828,504 shall be from the Nursing Facility Cash Fund; and $15,769,042 shall be certified public expenditures.

The FY 2009-10 request for reappropriated funds is a transfer from the Department of Public Health and Environment Prevention, Early Detection, and Treatment Fund (PEDT Fund) with $898,693 for the Breast and Cervical Cancer Treatment Program and $2,000,000 for disease management programs.

Table 5: Requested Changes for Medicaid Mental Health Community Programs, FY 2008-09 to FY 2009-10

Category	GF	CF	RF	FF	Total
Medicaid Mental Health Community Programs Current Appropriation	**$97,698,852**	**$6,976,195**	**$7,205**	**$104,702,904**	**$209,385,156**
Annualize prior year budget actions with caseload/cost impacts	315,848	0	0	315,848	631,696
Annualize prior year special legislation	7,595	530,974	0	538,568	1,077,137
Medicaid Mental Health Community Programs Base Request	**$98,022,295**	**$7,507,169**	**$7,205**	**$105,557,320**	**$211,093,989**
Medicaid Community Mental Health Programs (DI #2)	6,001,519	2,143,323	1,246	8,149,608	16,295,696
Medicaid Mental Health Community Programs Base with Caseload Growth Request	**$104,023,814**	**$9,650,492**	**$8,451**	**$113,706,928**	**$227,389,685**
Non-Prioritized Items #3 -- DHS Community Funding for Individuals with Developmental Disabilities	5,412	0	0	5,412	10,824
Medicaid Mental Health Community Programs Total Request	**$104,029,226**	**$9,650,492**	**$8,451**	**$113,712,340**	**$227,400,509**
Total Change	**$6,330,374**	**$2,674,297**	**$1,246**	**$9,009,436**	**$18,015,353**
Percent Change	**6.5%**	**38.3%**	**17.3%**	**8.6%**	**8.6%**

Of the FY 2009-10 request for cash funds, $9,579,111 is from the Health Care Expansion Fund, $61,502 shall be from the Colorado Autism Treatment Fund; and $9,879 from the Breast and Cervical Cancer Treatment Fund.

The FY 2009-10 request for reappropriated funds is a transfer from the Department of Public Health and Environment Prevention, Early Detection, and Treatment Fund (PEDT Fund) for the Breast and Cervical Cancer Treatment Program.

Table 5: Requested Changes for Indigent Care Programs, FY 2008-09 to FY 2009-10

Category	GF/GFE	CF	RF	FF	Total
Indigent Care Programs Current Appropriation	**$37,196,662**	**$238,412,149**	**$15,525,328**	**$287,537,703**	**$578,671,842**
Annualize prior year budget actions with caseload/cost impacts	0	3,485,705	0	6,396,200	9,881,905
Annualize prior year special legislation	0	4,929,077	62,093	9,038,614	14,029,784
Indigent Care Programs Base Request	**$37,196,662**	**$246,826,931**	**$15,587,421**	**$302,972,517**	**$602,583,531**
Children's Basic Health Plan Premium and Dental Benefit Costs (DI #3)	4,270,540	(12,328,096)	4,595,238	(14,100,209)	(17,562,527)
Indigent Care Programs Base with Caseload Growth Request	**$41,467,202**	**$234,498,835**	**$20,182,659**	**$288,872,308**	**$585,021,004**
No Other Policy Issues	0	0	0	0	0
Indigent Care Programs Total Request	**$41,467,202**	**$234,498,835**	**$20,182,659**	**$288,872,308**	**$585,021,004**
Total Change	**$4,270,540**	**($3,913,314)**	**$4,657,331**	**$1,334,605**	**$6,349,162**
Percent Change	**11.5%**	**-1.6%**	**30.0%**	**0.5%**	**1.1%**

Of the FY 2009-10 request for cash funds, $135,003,533 is from certified funds from public hospitals, $23,599,826 9,579,111 is from the Health Care Expansion Fund, $30,883,339 is from the Children's Basic Health Plan Trust Fund, $2,875,007 is from the Supplemental Tobacco Litigation Settlement Money Account in the Children's Basic Health Plan Trust Fund Supplemental Account, $481,664 is from the Colorado Immunization Fund, $417,119 is from enrollment fees from the Children's Basic Health Plan, $495,000 is from the Tobacco Tax Cash Fund, $386,606 is from the Supplemental Tobacco Litigation Settlement Money Account in the Pediatric Speciality Hospital Fund, $2,602,848 is from local government provider fees, and $6,459,236 is from the Comprehensive Primary and Preventive Care Fund.

Of the FY 2009-10 request for reappropriated funds, $4,687,659 is from the Children's Basic Health Plan Trust Fund, $495,000 is transfer from the Pediatric Speciality Hospital Fund, and $15,000,000 is from the Health Care Services Fund.

Table 6: Requested Changes for Other Medical Services, FY 2008-09 to FY 2009-10

Category	GF	CF	RF	FF	Total
Other Medical Services Current Appropriation	**$83,443,350**	**$31,692,000**	**$3,980,000**	**$17,192,781**	**$136,308,131**
Remove One-Time Funding for Old Age Pension Medical Program	0	0	(2,088,232)	0	(2,088,232)
Annualize prior year special legislation	2,902	0	0	2,901	5,803
Other Medical Services Base Request	**$83,446,252**	**$31,692,000**	**$1,891,768**	**$17,195,682**	**$134,225,702**
Medicare Modernization Act State Contribution Payment (DI #4)	5,310,019	0	0	0	5,310,019
Other Medical Services with Caseload Growth Request	**$88,756,271**	**$31,692,000**	**$1,891,768**	**$17,195,682**	**$139,535,721**
School Health Services Program Auditor (DI #17)	0	0	0	(233,700)	(233,700)
Commission on Family Medicine - Expanding Access to Primary Care	100,000	0	0	100,000	200,000
Other Medical Services Total Request	**$88,856,271**	**$31,692,000**	**$1,891,768**	**$17,061,982**	**$139,502,021**
Total Change	**$5,412,921**	**$0**	**($2,088,232)**	**($130,799)**	**$3,193,890**
Percent Change	**6.5%**	**0.0%**	**-52.5%**	**-0.8%**	**2.3%**

Of the FY 2009-10 request for cash funds, $135,003,533 is from certified funds from public hospitals, $23,599,826 9,579,111 is from the Health Care Expansion Fund, $30,883,339 is from the Children's Basic Health Plan Trust Fund, $2,875,007 is from the Supplemental Tobacco Litigation Settlement Money Account in the Children's Basic Health Plan Trust Fund Supplemental Account, $481,664 is from the Colorado Immunization Fund, $417,119 is from enrollment fees from the Children's Basic Health Plan, $495,000 is from the Tobacco Tax Cash Fund, $386,606 is from the Supplemental Tobacco Litigation Settlement Money Account in the Pediatric Speciality Hospital Fund, $2,602,848 is from local government provider fees, and $6,459,236 is from the Comprehensive Primary and Preventive Care Fund.

Of the FY 2009-10 request for reappropriated funds, $4,687,659 is from the Children's Basic Health Plan Trust Fund, $495,000 is transfer from the Pediatric Speciality Hospital Fund, and $15,000,000 is from the Health Care Services Fund.

Table 7: Requested Changes for Department of Human Services, Medicaid-Funded Programs, FY 2008-09 to FY 2009-10

Category	GF	CF	RF	FF	Total
DHS Medicaid-Funded Programs Current Appropriation	**$201,601,008**	**$1,609,689**	**$1,460,341**	**$204,465,449**	**$409,136,487**
Annualize prior year budget actions	8,362,617	(4,374)	41,858	8,251,502	16,651,603
Annualize prior year special legislation	21,920	(12,148)	0	12,396	22,168
DHS Medicaid-Funded Programs Base Request	**$209,985,545**	**$1,593,167**	**$1,502,199**	**$212,729,347**	**$425,810,258**
Non-Prioritized Items #3-8, #13, and #15-18	4,319,187	0	7,079	4,319,565	8,645,831
DHS Medicaid-Funded Programs Total Request	**$214,304,732**	**$1,593,167**	**$1,509,278**	**$217,048,912**	**$434,456,089**
Total Change	**$12,703,724**	**($16,522)**	**$48,937**	**$12,583,463**	**$25,319,602**
Percent Change	**6.3%**	**-1.0%**	**3.4%**	**6.2%**	**6.2%**

Of the FY 2009-10 request for cash funds, $9,968 is from the Children's Basic Health Plan Trust Fund, $1,000,000 is from certified funds from local governments, and $583,199 is from the Health Care Expansion Fund.

Of the FY 2009-10 request for reappropriated funds, $1,019,627 is from Regional Center Fees, $44,367 is from the Old Age Pension Fund, $435,861 is from the Children's Basic Health Plan Trust Fund and $618 is from the Health Care Expansion Fund.

FY 2009-10 Joint Budget Committee Staff Budget Briefing
Department of Health Care Policy and Financing
(Executive Director's Office, Medical Services Premiums, Indigent Care Programs, Other Medical Services, and Commission on Family Medicine)

BRIEFING ISSUE

ISSUE: Framework for Department of Health Care Policy and Financing Budget Request

The inverse relationship between Medicaid growth and the state's ability to pay for the program during economic downturns may once again present a budget challenge to the State.

SUMMARY:

- ❑ There is an inverse relationship between Medicaid growth and the state's ability to pay for the program during economic downturns. Medicaid caseloads grow at the same time State revenues decline.

- ❑ During the last budget downturn, Colorado was able to use accounting changes and aid from the federal government to balance the Medicaid budget growth within the State budget requirements. These options will be limited this time around.

- ❑ Nationally, states appropriated spending growth of 5.8 percent for Medicaid in FY 2008-09. Similarly, Colorado's Medical Services Premiums line item was appropriated at 5.6 percent growth in FY 2008-09 over the FY 2007-08 appropriation. According to the Kaiser Foundation's Annual Survey of States, approximately two third of all Medicaid directors have indicated that Medicaid budget shortfalls are likely in FY 2008-09.

RECOMMENDATION:

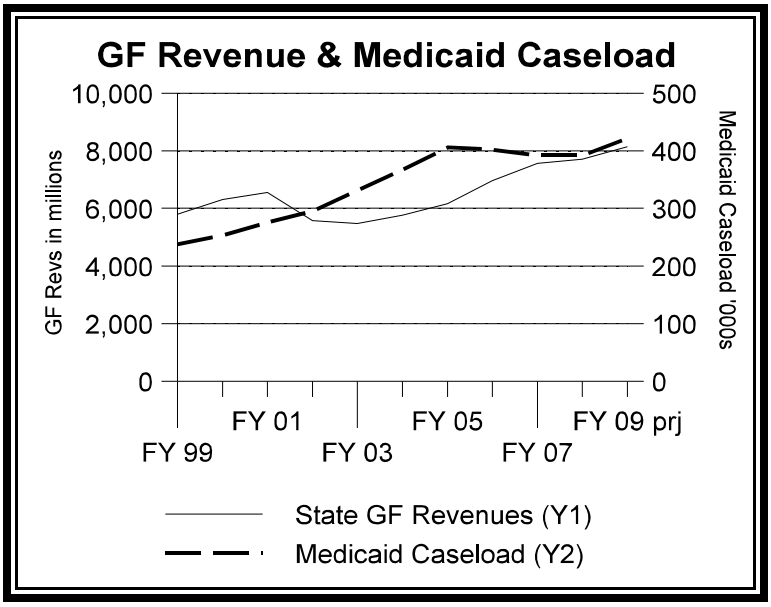
Preserving funding for current Medicaid program requirements should take precedent over any issue that expands Medicaid caseload or benefits during this time of economic uncertainty.

DISCUSSION:

Medicaid Funding and the Economy

During most economic downturns, unemployment rises and puts upward pressure on Medicaid enrollment and therefore Medicaid spending. At the same time, State revenues decline as income taxes and sales taxes reflect the contraction of the business cycle. This inverse relationship has always been a budget challenge for all states to manage during economic downturns. In Colorado,

the budget challenge of Medicaid entitlement growth can be especially daunting due to the reduced budget flexibility that Colorado has under its expenditure and TABOR limits.



In FY 2000-01, the start of the last economic downturn, the Department of Health Care Policy and Financing's (Department) percent of the state's General Fund appropriations was 18.8 percent. By the height of the economic downturn in FY 2003-04, the Department's General Fund appropriations had risen to 22.0 percent of all General Fund appropriations. This increase resulted from faster General Fund growth in the Medicaid program compared to rest of State government. After peaking at a new historic high in FY 2004-05, Medicaid caseload declined during FY 2005-06 through FY 2007-08. During this recovery period, the Department's percentage of the General Fund stabilized and declined to the current FY 2008-09 appropriated level of 19.9 percent of total General Fund appropriations (including amounts exempt from the 6.0% limit).

Table 1: HCPF General Fund Appropriations Compared to Statewide General Fund Appropriations

	HCPF GF Appropriations	HCPF GF Growth	Statewide GF Appropriations	Statewide GF App. Growth	% of GF Approp.	% of GF Growth
FY 2000-01	1,015.0	n/a	5,401.0	n/a	18.8%	n/a
FY 2001-02	1,082.3	67.3	5,605.5	204.5	19.3%	32.9%
FY 2002-03	1,043.8	(38.5)	5,551.2	(54.3)	18.8%	70.9%
FY 2003-04	1,240.3	196.5	5,635.7	84.5	22.0%	232.5%
FY 2004-05	1,280.8	40.5	5,840.9	205.2	21.9%	19.7%
FY 2005-06	1,365.8	85.0	6,291.3	450.4	21.7%	18.9%
FY 2006-07	1,379.9	14.1	6,818.6	527.3	20.2%	2.7%
FY 2007-08 current app.	1,458.7	78.8	7,233.2	414.6	20.2%	19.0%
FY 2008-09 current app.	1,528.9	70.2	7,675.9	442.7	19.9%	15.9%

*Source: JBC Staff Ten Year History of Final and Current Appropriations -- Not Based on Actual Expenditures

In FY 2007-08, the Department had a $25.7 million General Fund over-expenditure. For FY 2008-09, the Department's current budget request indicates a General Fund shortfall of $31.4 million. The Department's FY 2009-10 General Fund request is $81.6 million (5.2 percent) higher than their revised FY 2008-09 estimate and $113.0 million (7.4 percent) higher than the current FY 2008-09 appropriation. For the most part, the Department's FY 2009-10 requested increases are attributable to caseload growth and costs associated with current benefits. The Department has contained costs by excluding discretionary spending issues such as non-mandatory provider increases or benefit enhancements. However, if the economic situation continues to worsen and caseloads continue to grow, these measures may not be enough to contain costs under Colorado's budget limits.

Budget Actions Taken During the Last Budget Downturn

During the last economic downturn, FY 2000-01 through FY 2003-04, a variety of budgetary actions were used to manage the growth in the Medicaid program. The most significant items were:

1) In FY 2002-03, the State moved to cash accounting for the Medicaid program. This accounting change allowed the State to write-off a one-time savings of approximately $54.0 million General Fund to the MSP line item (the original fiscal note estimate was $70 million for the MSP line item but this amount did not materialize due to compounding impacts from other budget cuts).

2) In FY 2002-03, the Department shut down the MMIS system and rolled over $23.0 million in General Fund expenditures into FY 2003-04.

3) In May 2003, the Congress passed the Federal Job and Growth Tax Relief Reconciliation Act of 2003 which increased the Federal Medical Assistance Percentage (FMAP) for each state by 2.95% from April 2003 to June 2004. This provided an additional $16.2 million federal revenues for the Medicaid program in FY 2002-03 and $71.2 million federal revenues in FY 2003-04.

4) Medicare Upper Payment Limit (UPL) refinancing was maximized where available.

5) Provider rate increases were suspended or provider rates were decreased.

If the State were to find itself in a similar situation as in FY 2002-03 and FY 2003-04, most of the budget actions listed above would not be available this time around for the following reasons:

✓ The State can not move to cash accounting twice.

✓ Over the last several years, the State has maximized its ability to refinance using the Medicare UPL limits.

✓ A Congress economic package with an FMAP percentage increase is not guaranteed. In September 2008, the House of Representatives passed a bill that included an FMAP increase.

However, this bill failed in the Senate. The National Governor's Association, National Council of State Legislatures, and other Medicaid lobbying groups continue to support an FMAP change. However, at the time this issue was written, Congress has not acted to increase the FMAP. Staff will keep the Committee apprised if this situation changes.

Additionally, cutting the Medicaid program is also difficult for the following policy reasons:

✓ Ultimately, Medicaid provides direct aid to individuals that promotes their health and welfare.

✓ Reductions to the Medicaid program results in a corresponding loss of federal funds.

✓ In most cases, Medicaid pays the lowest provider rates of any health insurance program. Further cuts to rates will erode the provider network willing to serve the Medicaid population and may result in limited access to care.

✓ The eligibility expansions in recent years has used the Amendment 35 tobacco taxes. Cutting these expansion populations do not translate into immediate General Fund savings.

National Outlook for the Medicaid Program

For FY 2008-09, state legislatures adopted Medicaid appropriations that averaged 5.8 percent above total expenditures for FY 2007-08. Colorado's initial FY 2008-09 appropriation for the Medical Services Premiums (MSP) line item was 5.6 percent above the FY 2007-08 appropriation. However, in Colorado the current FY 2008-09 MSP appropriation is only 4.4 percent higher than the FY 2007-08 MSP actual expenditure. According to the Kaiser Commission on Medicaid and the Uninsured Annual State Survey, Medicaid directors in several states have indicated that mid-year budget adjustments may be necessary for FY 2008-09. Following are a few examples of budget actions taken or projected in neighboring states.

Utah: In a special session in September 2008, the Utah Legislature cut their Department of Health (State Medicaid Agency) by $31.8 million total funds ($9.7 million GF and $22.1 FF). The reductions enacted included:

$5.4 million GF in Medicaid provider rate reductions;
$3.0 million GF in reductions to Medicaid programs and benefits;
$0.6 million GF for department efficiencies and Medicaid reductions; and
$0.6 million GF for administrative reductions and efficiencies.

Arizona*:* As part of their FY 2009-10 budget request, AHCCCS (State Medicaid Agency) is currently forecasting $209.8 million total fund budget shortfall for their Medicaid program in FY 2008-09. Of this amount, $82.7 million is General Fund.

Kansas: The state currently faces a $136 million budget deficit in FY 2008-09 statewide (not just in Medicaid). Governor Sebelius asked most government agencies (excluding K-12) to prepare 2 percent budget cuts for FY 2008-09 and 5 percent cuts for FY 2009-10.

At the federal level, Medicaid also presents budget issues. An October 2008 Centers for Medicare and Medicaid Services (CMS) Actuary Report for the Medicaid Program included these observations:

2007 Medicaid Expenditures and Enrollment

✓ Total national Medicaid expenditures in 2007 were $333.2 billion; $190.6 billion or 57 percent represented Federal spending and $142.6 billion or 43 represented State spending.

✓ Estimated average Medicaid enrollment was 49.1 million people in 2007. At some point during the year 61.9 million people, or about one of every five persons in the U.S. were enrolled in Medicaid.

10-Year Medicaid Projections

✓ National expenditures for Medicaid outlays are projected to increase 7.3 percent in 2008. Over the next 10 years, expenditures are projected to increase at average annual rate of 7.9 percent.

Medicaid in Context of U.S. Health Spending

✓ Total Medicaid outlays represent 14.8 percent of all U.S. health care spending in 2006.

✓ Medicaid is the largest source of general revenue spending on health care for both the Federal government and the States (please note Medicare is not general revenue spending).

✓ Medicaid accounted for 7.0 percent of the entire Federal spending in 2007 and is projected to account for 8.4 percent by 2013.

✓ Total health care spending represents about 16 percent for the Gross National Product (GNP) and Medicaid spending represents is approximately 3 percent of GNP.

FY 2009-10 Joint Budget Committee Staff Budget Briefing
Department of Health Care Policy and Financing
(Executive Director's Office, Medical Services Premiums, Indigent Care Programs, Other Medical Services, and Commission on Family Medicine)

BRIEFING ISSUE

ISSUE: Accuracy of the FY 2007-08 Final (March 2008) Medicaid Forecast

The *final* FY 2007-08 appropriation for the Medicaid Medical Services Premiums (MSP) line item was under forecasted by $23.1 million General Fund, a 2.27 percent forecast error. The Medicaid Mental Health Capitation Program (MH) line items was under forecasted by $2.3 million General Fund, a 2.56 percent forecast error.

SUMMARY:

- Because of the entitlement nature of the Medicaid program, the Medicaid line items are provided with ***unlimited*** over-expenditure authority as long as the over-expenditure are consistent with the statutory provisions of the Medicaid program. A Medicaid over-expenditure is not counted against the six percent appropriation limit in the year it occurs and builds the appropriation base for the following fiscal year by the amount of the over-expenditure plus six percent.
- In FY 2007-08, the Department had General Fund over-expenditures of $25.7 million. The majority of these General Fund over-expenditures were for the Medical Services Premiums (MSP) line item ($23.1 million). The remaining over-expenditures were in the Medical Mental Health Capitation (MH) program ($2.3 million) and in the high-risk pregnant women substance abuse program administered by the Department of Human Services ($0.3 million).
- The forecast error was mainly attributed to higher than anticipated Medicaid caseload growth in the second half of FY 2007-08 and higher than anticipated expenditures for acute care services.
- A portion of the General Fund over-expenditure error was also related to miscalculating the cash fund splits for the MSP and MH programs as well as the Department not accounting appropriately for the passage of H.B. 08-1373.

RECOMMENDATION:

1. The FY 2007-08 over-expenditure in the Medical Service Premiums line item is mainly due to forecast error and not because of mismanagement of the appropriation. Therefore, staff recommends that the JBC approve a *FY 2007-08* General Fund supplemental for this line item in order to lift the current restriction on the FY 2008-09 appropriation. The JBC can

take formal action on this recommendation during the January supplemental presentation for the Department.

2. Staff recommends that the Joint Budget Committee also lift the FY 2008-09 appropriation restriction on the Mental Health Capitation program line item due to the FY 2007-08 over-expenditure. Again, this over-expenditure was due to forecast error. The JBC can take formal action on this recommendation during the January supplemental presentation for the Department.

DISCUSSION:

Medicaid Over-expenditure Authority

In order to close the state books each fiscal year, the State Controller may authorize departments to over-expend their appropriations within certain limits if approved by the Governor (Section 24-75-109, C.R.S.). Because of the entitlement nature of the Medicaid program, the Medicaid line items are provided with ***unlimited*** over-expenditure authority as long as the over-expenditure are consistent with the statutory provisions of the Medicaid program. Therefore, most of HCPF's line items are allowed unlimited over-expenditure authority.

Whenever an over-expenditure occurs, the State Controller is instructed to"*restrict, in an amount equal to said over-expenditure, the corresponding items or items of appropriation that are made in the general appropriation act for the fiscal year following the fiscal year for which the overexpenditure that is allowed occurs*." The restriction on the current year appropriation is lifted if the General Assembly approves a supplemental for the prior year over-expenditure during the next Legislative Session. This restriction allows the JBC to review the reasons for over-expenditures and to decide if the over-expenditure could have been avoided with better management of the appropriation or if the over-expenditure occurred as a result of an unforeseen event or forecast error.

The statute also provides that an appropriation for an over-expenditure in the Medicaid program not be counted against the six percent appropriation limit for the General Fund (Section 24-75-109 (5), C.R.S.). Typically, when an over-expenditure in the Medicaid program occurs, the General Assembly passes an "after the fiscal year end close supplemental" for the previous year in order to lift the restriction against the current year appropriation. The "after the fiscal year end close supplemental" is not counted against the previous year's six percent limit (since the appropriation is provided after the books are closed). However, the current year's six percent limit (in this case FY 2008-09) is adjusted upward by the amount of the over-expenditure plus six percent.

Department FY 2007-08 General Fund Over-expenditure

For FY 2007-08, HCPF had line items where the General Fund was over-expended and other line items where General Fund reverted. Table 1 on the following page shows the General Fund over-expenditures and reversions summarized at the Department's division level.

Table 1: Department Over-Expenditures and Reversions -- General Fund Only				
Division	**Over-expenditure (under-forecasted)**	**Reversion (over-forecasted)**	**Net Total**	**% of Final Spending Authority**
Executive Director's Office	$0	$666,521	$666,521	2.03%
Medical Services Premiums	($23,119,872)	$0	($23,119,872)	-2.27%
Mental Health Programs	($2,347,326)	$124,768	($2,222,558)	-2.40%
Indigent Care Programs[/1]	$0	$8,315	$8,315	0.02%
Other Medical Services	$0	$30	$30	0.00%
DHS-Administered Programs	($253,217)	$5,661,363	$5,408,146	3.00%
Total HCPF	($25,720,415)	$6,460,997	($19,259,418)	-1.33%
Rollforward Authority			$271,968	
Total Net Spending over Total Appropriations (Controller's Report)			($18,987,450)	

Medical Services Premiums Over-expenditure

The final FY 2007-08 spending authority for the Medical Services Premiums line item (MSP) was $2,199,430,739. The final FY 2007-08 expenditures for the MSP line item was $2,237,284,805. The result was an over-expenditure of $37,854,066 (1.72 percent) total funds. Table 2 shows the final FY 2007-08 spending authority and expenditures by fund source.

Table 2: FY 2007-08 Final Expenditures				
	GF & GFE	**CF and CFE**	**Federal Funds**	**Total Funds**
Original FY 2007-08 Appropriation	$996,321,500	$76,039,624	$1,075,497,784	$2,147,858,908
2008 Session Adjustments (all bills)	$22,863,127	$1,736,565	$26,501,640	$51,101,332
1331 June Emergency Supplemental	$0	$466,523	$0	$466,523
Accounting Adjustment	$1,988	$0	$1,988	$3,976
Total Spending Authority	$1,019,186,615	$78,242,712	$1,102,001,412	$2,199,430,739
FY 2007-08 Final Expenditures	$1,042,306,487	$72,252,413	$1,122,725,905	$2,237,284,805
Difference (- reversion/ + overexpenditure)	$23,119,872	($5,990,299)	$20,724,493	$37,854,066

Table 2: FY 2007-08 Final Expenditures				
	GF & GFE	CF and CFE	Federal Funds	Total Funds
% Difference from final appropriation	2.27%	(7.66)%	1.88%	1.72%
% Difference from original appropriation	(4.62)%	4.98%	(4.39)%	(4.16)%

As Table 2 above shows, the original FY 2007-08 General Fund appropriation was 4.62 percent lower than the FY 2007-08 General Fund actual and the final General Fund appropriation was 2.27 percent lower than the actual FY 2007-08 expenditure. ***Staff would note that these forecast errors resulted in the highest General Fund over-expenditure error since FY 2002-03*** (the actual over-expenditure in FY 2002-03 was lower but would have been higher if the Department had not rolled-over expenditures into FY 2003-04).

In their letter to the Controller explaining the over-expenditure, the Department estimated that $15.3 million of the over-expenditure was related to caseload growth and the remaining $22.5 million was related to higher than anticipated costs. Staff estimates that $17.1 million was related to higher than anticipated caseload and approximately $22.2 million was related to higher than anticipated costs. This amount was reduced by $3.5 million for slightly lower than anticipated UPL financing and for rollforward authority for the disease management program. Table 3 breaks down the reason for the forecast errors based on caseload and cost-per-client estimates.

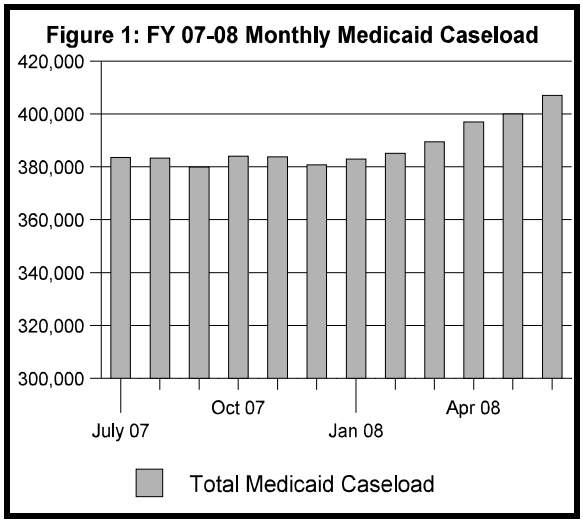
Table 3: Analysis of FY 2007-08 Over-expenditure Based on Caseload and Cost Growth						
Aid Category	Caseload Difference (Actual - Final Est.)	Net Cost Per Client Difference (Final Est-Actual)	Cost Associated with Higher Caseload Estimate	Cost Associated with Higher Cost Estimate	Compounding Effect	Total Costs
SSI 65+	273	($388.03)	$5,438,826	($13,887,553)	($105,932)	($8,554,659)
SSI 60-64	18	$358.33	$288,828	$2,185,088	$6,450	$2,480,366
SSI Disabled	97	$370.96	$1,238,249	$18,386,478	$35,983	$19,660,710
Low-Income Adults	262	($42.82)	$1,135,679	($1,883,137)	($11,220)	($758,678)
Expansion Low-Income Adults	60	$61.56	$128,585	$527,412	$3,694	$659,691
Baby Care Adults	213	($188.68)	$1,911,070	($1,112,246)	($40,188)	$758,636
Children	3,300	$87.30	$5,657,261	$17,327,942	$288,072	$23,273,275
Foster Children	74	$102.00	$271,178	$1,727,919	$7,548	$2,006,645
Breast and Cervical Cancer Treatment Patients	(1)	$1,378.11	($24,935)	$373,467	($1,378)	$347,154
Partial Dual eligibles	44	$17.61	$58,255	$248,072	$775	$307,102

Table 3: Analysis of FY 2007-08 Over-expenditure Based on Caseload and Cost Growth						
Aid Category	**Caseload Difference (Actual - Final Est.)**	**Net Cost Per Client Difference (Final Est-Actual)**	**Cost Associated with Higher Caseload Estimate**	**Cost Associated with Higher Cost Estimate**	**Compounding Effect**	**Total Costs**
Non-citizens (emergency care)	72	$49.19	$951,358	$195,385	$3,541	$1,150,284
Total	4,412	n/a	$17,054,354	$24,088,827	$187,345	$41,330,526
Change to UPL Estimate (Denver Health Outstantioning costs included above--UPL only)						($1,664,860)
Deduct roll-forward authority for the disease management programs + accounting adjustment						($1,811,600)
Total Overexpenditure						$37,854,066

As Table 3 shows, approximately 45.2 percent ($17.1 million / $37.8 million) of the final forecast error related to higher than projected caseload growth and 54.8 percent relate to higher than projected service costs net of accounting adjustments.

Forecast Caseload Errors

At the time the final caseload was projected, the original caseload forecast appeared consistent with the data through the first seven months of the fiscal year. However, caseload in the second half of the fiscal year exceeded the caseload projection for each of the aid categories. This is the first time in five years that the final caseload forecast under estimated all but one aid category (the one exception was the breast and cervical cancer treatment program). While all but one aid category was under estimated, most of the caseload forecast error was in the low-income adults and children aid categories. The charts below shows the monthly caseload growth for FY 2007-08.



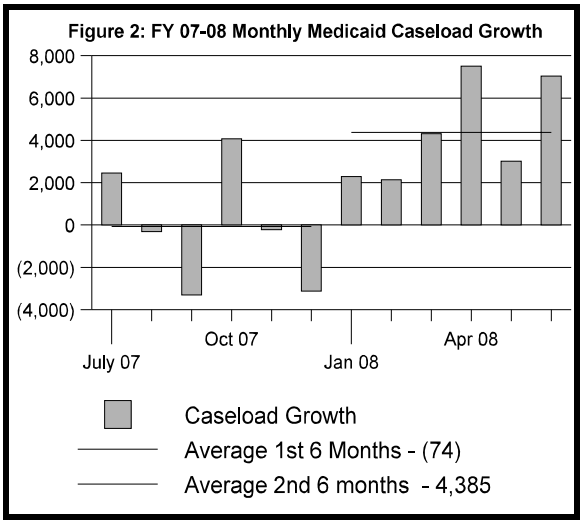


Table 4 below compares the FY 2007-08 caseload forecast with the FY 2007-08 actual caseload by aid category.

Table 4: FY 2007-08 Caseload by Aid Category

	Final Caseload Forecast	Actual Caseload	Difference	% Difference
SSI 65+	35,790	36,063	273	0.76%
SSI 60-64	6,098	6,116	18	0.30%
SSI Disabled	49,565	49,662	97	0.20%
Low-Income Adults	43,972	44,234	262	0.60%
Expansion Low-Income Adults	8,567	8,627	60	0.70%
Baby Care Adults	5,895	6,108	213	3.61%
Children	198,500	201,800	3,300	1.66%
Foster Children	16,940	17,014	74	0.44%
Breast and Cervical Cancer Treatment Patients	271	270	(1)	(0.37)%
Medicare QMB/SLMB/QI	14,086	14,130	44	0.31%
Non-citizens (emergency care)	3,972	4,044	72	1.81%
Total	383,656	388,068	4,412	1.15%

*Forecast Cost Error*s

In FY 2007-08, acute care services (physician, inpatient hospital, pharmacy, durable medical equipment, etc.) were underforecasted by $49.9 million and community long-term care services were underforecasted by $5.1 million. These forecast errors were offset by $17.1 million in over forecasted costs for nursing facilities, insurance programs (mainly Medicare premium assistance), administrative programs, and other adjustments. Table 5 below compares the FY 2007-08 estimated costs for the major service costs with the actual expenditures in those areas.

Table 5: FY 2007-08 MSP Costs By Service Area

	Final Cost Estimate	Actual Cost	Difference	% Difference
Acute Care Cost	$1,286,139,754	$1,336,004,287	$49,864,533	3.88%
Community Long-Term Costs	236,641,585	241,742,015	5,100,430	2.16%

Table 5: FY 2007-08 MSP Costs By Service Area				
	Final Cost Estimate	**Actual Cost**	**Difference**	**% Difference**
Nursing Facilities & PACE	546,064,657	538,222,989	(7,841,668)	(1.44)%
Insurance Programs	87,058,398	83,370,893	(3,687,505)	(4.24)%
Administrative Services	29,802,563	27,697,298	(2,105,265)	(7.06)%
Total Medical Costs	$2,185,706,957	$2,227,037,482	$41,330,525	1.89%
Other Cost Adjustments	13,723,783	10,247,323	(3,476,460)	(25.33)%
Total MSP Line Item	$2,199,430,740	$2,237,284,805	$37,854,065	1.72%

Acute Care Services: The underforecast is related to both caseload increases and higher than anticipated costs. It can be expected that whenever children and low-income adult caseloads are under forecasted that there would be higher acute care services costs (the majority of the costs for these populations are acute care services). However, the over-expenditure in this area cannot be explained away by increased caseload only. The acute care costs, regardless of caseload, were higher than anticipated. For example, the children's per capita cost was $87.30 (5.1 percent) higher than anticipated resulting in approximately $17.5 million in higher expenditures. In recent years, the General Assembly has provided targeted rate increases to improve primary care physician rates. This may have resulted in better access to care and thus higher utilization that may not have been picked up in past trend data (which is what is used to develop acute care cost estimates).

Community Care Services: Again the under forecast is reflective of both higher caseload and costs. The majority of the these costs are in the elderly and disabled aid categories. In the Governor's letter explaining the over-expenditure, the Department indicated that increased usage of these services may coincide with rate increases that have been provided in recent years.

Nursing Facility and PACE: Most of the over forecast for this service forecast related to nursing home expenses. In the final supplemental recommendation, staff over estimated the nursing home costs based on the first six months of expenditures in FY 2007-08. Because the elderly (SSI 65+) use most of the nursing home services, over estimating the costs for nursing homes led to over estimating the per capita expenditures for the SSI 65+ aid category as seen on Table 3.

Insurance Programs: The majority of the service costs for these category are for Medicare premium payments for qualifying Medicaid clients. These costs impact the elderly, disabled, and partial dual eligible aid categories. The forecast error is related to the case mix of clients (clients receive different benefits based on income level) as well as the number clients (the Medicare premiums are generally known by March of each fiscal year).

Administrative Services: This aid category includes the costs for the single-entry point agencies, administrative services organizations (ASOs) administrative fees and disease management programs. Each of these services were over estimated. For the most part, staff had recommended the Department's estimates for this service category in the final supplemental.

Forecast Error Related to Fund Split Issues

The Medical Services Premiums has a variety of fund sources. Table 6 below shows the forecast error for each of the fund sources in the Medical Services Premiums line item.

Table 6: FY 2007-08 Medical Services Premiums Expenditures by Fund Source

	JBC Staff Final Rec.	Enacted Expenditure Authority	Actual	Difference (Actual - Enacted)	Difference (Actual - JBC Staff Rec.)
General Fund	$697,837,163	$691,686,615	$714,806,487	$23,119,872	$16,969,324
General Fund Exempt	$327,500,000	$327,500,000	$327,500,000	$0	$0
Nursing Facility Cash Fund	$466,523	$466,523	$466,522	($1)	($1)
Autism Fund	$430,000	$430,000	$345,093	($84,907)	($84,907)
Breast and Cervical Cancer Treatment Fund	$1,638,694	$1,638,694	$620,236	($1,018,458)	($1,018,458)
Health Care Expansion Fund	$55,525,077	$61,442,613	$56,072,285	($5,370,328)	$547,208
Gifts, Grants, and Donations	$126,870	$126,870	$65,000	($61,870)	($61,870)
Certified Funds	$13,412,247	$13,412,247	$13,412,247	$0	$0
Transfer from DPHE	$725,764	$725,764	$725,764	$0	$0
Federal Funds	$1,102,234,424	$1,102,001,412	$1,122,725,905	$20,724,493	$20,491,481
Total Funds	$2,199,896,762	$2,199,430,738	$2,236,739,539	$37,308,801	$36,842,777
Accounting Adjustment*	$0	$0	$545,265	$545,265	$545,265
Total w/ Acct Adj	$2,199,896,762	$2,199,430,738	$2,237,284,804	$37,854,066	$37,388,042

Staff would note two items related to the fund splits:

1. Last year the Committee approved the OSPB comeback related to funding splits between the Health Care Expansion Funding and the General Fund. The issue related to a new methodology that the Department was using to calculate the impact of the asset test removal. Staff had recommended a lower impact for removing the asset test and therefore, had recommended a lower appropriation from Health Care Expansion Fund and a higher General Fund appropriation. OSPB believed that more MSP costs could be assigned to the Health Care Expansion Fund and recommended lowering the General Fund amount and increasing the Health Care Expansion Fund. However, the Department ended up reverting $5.3 million from the Health Care Expansion Fund due to lower costs being assigned from the removal of the asset test than what the Department had calculated (coincidentally the reverted amount is very similar to the OSPB comeback amount) and overexpending the General Fund by about $5.2 million more due to the fund split issue.

2. Last year the JBC sponsored H.B. 08-1373 to allow the Breast and Cervical Cancer Treatment (BCCT) Fund to pay 100% of the state match. This bill effectively reduced the General Fund by $1.2 million and increased the BCCT Fund by $1.2 million. However, due to an accounting error, the Department paid the *state match* for the BCCT Program based on the percentages in law prior to the passage of H.B. 08-1373 (25% BCCT Fund and 75% General Fund). Therefore, the Department reverted $1.0 million from the BCCT Fund and overexpended $1.0 million from the General Fund.

Because revenues were sufficient in FY 2007-08 to pay for the General Fund overexpenditure, the issues above were not catastrophic. ***In fact, due to Colorado's unique budgeting laws, the higher General Fund over-expenditure in FY 2007-08 may actually help the State adjust for the FY 2008-09 supplementals*** (the MSP FY 2008-09 supplemental need is discussed in Issue #4). As discussed earlier, the General Fund over-expenditure builds the expenditure limit base for FY 2008-09.

Medicaid Mental Health Capitation Program Over-expenditure

The final FY 2007-08 appropriation for the Medicaid Mental Health Capitation Program line item (MH) was $194,231,112. The final FY 2007-08 expenditures for the MH line item were $196,011,033. Thus, there was a total fund over-expenditure of $1,779,920 (0.92 percent) from the MH line item appropriation at the end of the fiscal year. Table 7 shows the final FY 2007-08 appropriations and expenditures by fund source for the MH program.

Table 7: FY 2007-08 Final Expenditures -- Medicaid Mental Health Capitation

	GF & GFE	CF and CFE	Federal Funds	Total Funds
Original FY 2007-08 Appropriation	$91,836,416	$6,829,511	$98,478,117	$197,144,044
2008 Session Adjustments (all bills)	($11,591)	($1,304,070)	($1,597,270)	($2,912,931)

Table 7: FY 2007-08 Final Expenditures -- Medicaid Mental Health Capitation				
	GF & GFE	**CF and CFE**	**Federal Funds**	**Total Funds**
FY 2007-08 Final Appropriation	$91,824,825	$5,525,441	$96,880,847	$194,231,113
FY 2007-08 Final Expenditures	$94,172,151	$4,311,729	$97,527,153	$196,011,033
Difference (- reversion/ + overexpenditure)	$2,347,326	($1,213,712)	$646,306	$1,779,920
% Difference from final appropriation	2.56%	(21.97)%	0.67%	0.92%
% Difference from original appropriation	(2.54)%	36.87%	0.97%	0.57%

Most of the over-expenditure in the MH program can be attributed to the increase in Medicaid caseload above the final forecast. Table 8 below shows the over-expenditure caused by caseload growth and cost increases.

Table 8 Analysis of FY 2007-08 Over-expenditure for MH Program Based on Caseload and Cost Growth*

Aid Category	Caseload Difference (Final Est - Actual)	Net Cost Per Client Difference (Final Est- Actual)	Cost Associated with Higher Caseload Estimate	Cost Associated with Higher Cost Estimate	Compounding Effect	Total Costs
SSI 65+	273	$0.35	$43,701	$12,584	$96	$56,381
Disabled	115	($1.99)	$170,570	($110,522)	($228)	$59,820
Adults	535	($2.43)	$133,072	($141,962)	($1,300)	($10,190)
Children	3,300	$0.35	$613,139	$70,075	$1,165	$684,379
Foster Children	74	$44.15	$237,928	$747,903	$3,267	$989,098
Breast and Cervical Cancer Treatment Patients	(1)	$2.41	($220)	$654	($2)	$432
Total Medicaid Caseload Eligible for MH Services	4,296	n/a	$1,198,190	$578,732	$2,998	$1,779,920

*Includes all cost adjustments (recoupment and the one-time funding for a federal disallowance) based on original caseloads (not the rebased caseload).

As the table shows, $1.2 million of the FY 2007-08 over-expenditure was related to the increase in caseload. However, another $578,732 was related to per capita costs being higher than estimated. The majority of this cost was related to foster children blended per capita actual being higher than the amount estimated.

Similar to the Medical Services Premiums line item, the General Fund over-expenditure was higher due to reversion of funds from the Health Care Expansion Fund program. Most of the reversion from the Health Care Expansion Fund (the majority of the CF/CFE fund reversion) was due to a lower amount of caseload being assigned due to the removal of the asset test than what was appropriated.

High Risk Pregnant Women Program Over-expenditure

The High Risk Pregnant Women Program is a substance abuse program administered by the Department of Human Services. However, the women who are served on this program are Medicaid eligible. Therefore, the program's funding is appropriated in the Department of Health Care Policy and Financing and then is transferred to the Department of Human Services. The Committee has already voted to lift the FY 2008-09 restriction on this program due to the FY 2007-08 over-expenditure as a 1331 Supplemental Action in September. This issue is discussed in JBC staff briefing for the Department of Human Services.

FY 2009-10 Joint Budget Committee Staff Budget Briefing
Department of Health Care Policy and Financing
Executive Director's Office, Medical Services Premiums, Indigent Care Programs, Other Medical Services, and Commission on Family Medicine

BRIEFING ISSUE

ISSUE: The Medicaid statutory over-expenditure authority expires on July 1, 2009.

Without over-expenditure authority in the Medicaid program, the General Assembly will have less budget flexibility or will run the risk of annual Special Sessions in June to balance the budget.

SUMMARY:

- ❑ Specific to this Department, the repeal of Section 24-75-109 would impact the over-expenditure authority in the Medicaid Program and in the Children's Basic Health Plan. [This issue will discuss only the impacts related to the Department of Health Care Policy and Financing -- not the statewide impacts of the repeal of Section 24-75-109].

- ❑ Every 1.0 percent forecast error in the Medical Services Premiums line item swings $10.4 million in General Fund.

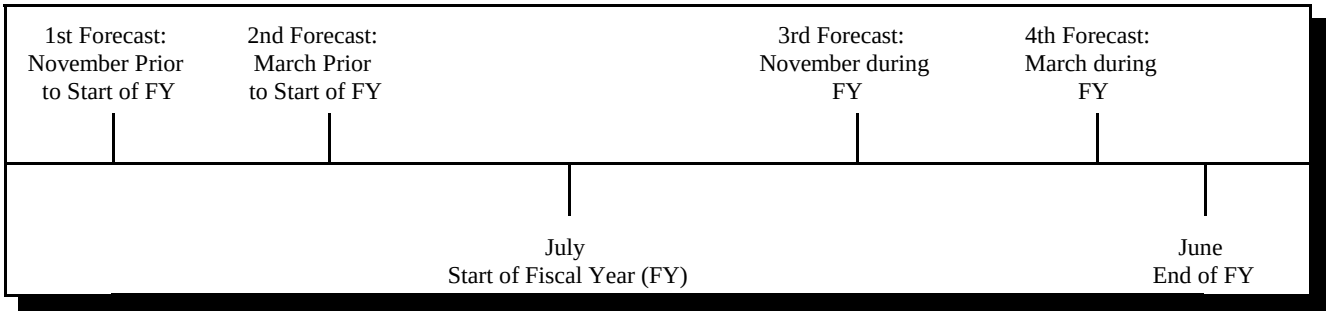
RECOMMENDATION:

At a minimum, staff recommends that the Committee sponsor legislation to extend the unlimited over-expenditure authority for the Medicaid program and to also extend the limited over-expenditure authority for the Children's Basic Health Plan Program.

DISCUSSION:

Summary of major legislative history: Section 24-75-109 was first enacted in 1987. In the original bill, the Medicaid program was provided with unlimited expenditure authority. In 1989, Section 24-75-109 was amended to provide that "*the limitation on general fund appropriations and the requirement for a general fund reserve contained in section 24-75-201.1 shall not apply to overexpenditures from the general fund for medicaid programs...*". In 2004, the JBC Committee sponsored H.B. 04-1411 which extended the repeal date from July 1, 2004 to July 1, 2009. In 2008, S.B. 08-022 amended Section 24-75-109 to provide over-expenditure authority of Children's Basic Health Plan (CBHP) outside the over-expenditure limit provided for the rest of state government [prior to S.B. 08-022, the CBHP's over-expenditure authority was within the $1.0 million overexpenditure authority that applies to most of state government]. Senate Bill 08-022 caps the General Fund over-expenditure authority for the CBHP program at $250,000.

Impact on Medicaid program if Section 24-75-109 is repealed*:** As an entitlement program, the Medicaid program must provide services to all who qualify for the program. Therefore, expenditures for the program can not be capped to stay within an appropriation limit if additional service costs or caseload costs occur. Therefore, when the General Assembly establishes the budget for the Medicaid program each year, the General Assembly relies on forecasts. ***All forecasts are wrong -- the Medicaid program never spends exactly what is appropriated. In order to provide the most accurate estimate possible, Medicaid expenditures for a fiscal year are forecasted several times before and during a fiscal year as shown in the time line below.



The forecast for the final estimated appropriation usually occurs in March of the fiscal year and reflects approximately six to seven months of actual expenditure and caseload data. However, even with this much information known, over-expenditures still occur. Table 1 below shows the amount of over-expenditures or reversions for the Medical Services Premiums line item (the bulk of the Medicaid program) for the last five years.

Table 1: Accuracy of General Fund and Total Fund Expenditures
Medical Services Premiums

Total Medicaid Medical Expenditures	**FY 2003-04[1]**	**FY 2004-05**	**FY 2005-06**	**FY 2006-07**	**FY 2007-08**
Original Total Fund Estimate	$1,844,485,672	$1,934,644,559	$2,178,221,370	$2,111,287,559	$2,147,858,908
Original General Fund Estimate	$864,399,617	$936,641,159	$1,042,362,634	$996,821,857	$996,321,500
Final Total Fund Estimate/1	$1,854,919,776	$1,966,958,051	$1,999,646,558	$2,057,801,212	$2,199,430,739
Final General Fund Estimate/1	$846,564,816	$957,699,084	$976,750,574	$974,636,899	$1,019,186,615
Actual Total Fund	**$1,868,658,515**	**$1,920,474,771**	**$1,996,264,308**	**$2,061,396,808**	**$2,237,284,805**
Actual General Fund	**$855,002,797**	**$935,078,890**	**$976,206,452**	**$976,477,714**	**$1,042,306,487**
% Actual GF Different from Original Estimate (Negative means reversion, positive indicates over-expenditure)	(1.09)%	(0.17)%	(6.35)%	(2.04)%	4.62%

Table 1: Accuracy of General Fund and Total Fund Expenditures
Medical Services Premiums

Total Medicaid Medical Expenditures	FY 2003-04[1]	FY 2004-05	FY 2005-06	FY 2006-07	FY 2007-08
% Actual GF Different from Final Estimate (negative means reversion, positive over-expenditure)	1.00%	(2.36)%	(0.06)%	0.19%	2.27%

[/1] Adjusts the final estimate to include the impact of the Federal Job and Growth Tax Relief Reconciliation Act of 2003 which contained a provision to temporarily increase Colorado's Federal Match Rate (FMAP) from 50 percent to 52.95 percent from April 2003 through June 2004. The 2003-04 appropriation was not adjusted to reflect the impact of the FMAP increase in order not to impact the future 6.0 percent limit on appropriations. However, for the purposes of the analysis contained in the table above, staff has adjusted the final estimate by the FMAP increase in order to reflect the accuracy of the forecast. Also it is important to note that in FY 2003-04, negative supplementals were enacted in order to curtail the growth in Medicaid spending because of dropping state revenues. The changes in FY 2003-04 also reflect the move to cash accounting for this line item. Therefore, the change from the original appropriation to the final appropriation reflected different circumstances within the total state budget, not just the Medicaid forecast.

As Table 1 shows, the final General Fund estimate for the Medical Services Premiums has ranged from being overestimated by 2.36 percent in FY 2004-05 to being underestimated by 2.27% in FY 2007-08. While the final estimate has been fairly accurate over the years (97.64 to 99.94 percent), a one percent error drives approximately a $10.4 million General Fund error.

If the unlimited over-expenditure authority for the Medicaid program expires, then the Joint Budget Committee would have the following options to balance the state's books at the end of the fiscal year:

1) Build "wiggle room" into the final Medicaid forecast. Basically over-estimate the Medical Services Premiums budget slightly to ensure that over-expenditures do not occur. This means that other state programs or priorities could not be appropriated this funding under the 6.0 percent appropriation limit. If the funding reverted, it would go to the two third/one third transfer on any year that the statutory reserve was fully funded.

2) Pass emergency 1331 supplementals in May/June. To avoid an over-expenditure the JBC could pass emergency supplementals. However, if the Medicaid over-expenditure was very high, there would not be a lot of room to cut from other programs at the end of the fiscal year since most funding has been spent by this time. Also, if major year cuts were necessary, the entire General Assembly may want to be involved in the decisions and a Special Session might be necessary.

Neither of these options are optimal. Therefore, staff recommends that the unlimited over-expenditure authority for the Medicaid program be extended just as it has been during every repeal review since Section 24-75-109 was enacted. Staff also recommends that the CBHP over-expenditure be extended.

FY 2009-10 Joint Budget Committee Staff Budget Briefing
Department of Health Care Policy and Financing
(Executive Director's Office, Medical Services Premiums, Indigent Care Programs, Other Medical Services, and Commission on Family Medicine)

BRIEFING ISSUE

ISSUE: Preliminary budget outlook for the Medicaid Medical Services Premiums line item.

The Department currently forecasts a FY 2008-09 total fund supplemental for the Medical Services Premiums Line Item of $103.3 million ($30.3 million General Fund). The Department currently forecasts a FY 2009-10 total fund increase of $231.5 million ($79.6 million General Fund) over the current FY 2008-09 appropriation.

SUMMARY:

- The Department's budget request shows a ***preliminary*** FY 2008-09 Medical Services Premiums line item supplemental need of $103.3 million total funds (4.5 percent). Of this amount, $30.3 million is from the General Fund (a 2.8 percent increase to General Fund).

- The Department's FY 2009-10 budget request for Medical Services Premiums line item is $231.5 million total funds higher than the current FY 2008-09 appropriation (10.0 percent increase). Of this amount, $79.6 million is from the General Fund (a 7.4 percent increase).

RECOMMENDATION:

Staff recommends that the Committee discuss the Department's request for the Medical Service Premiums line item at their hearing.

DISCUSSION:

FY 2008-09 Medical Services Premiums -- Preliminary Supplemental Calculations

In order to calculate their FY 2009-10 request for the Medical Services Premiums (MSP) line item, the Department provides a new expenditure estimate for FY 2008-09 in their November budget request. While this estimate of current year expenditures is not the Department's final supplemental request, it is an early indicator of what the Department's supplemental request may be in February 2009. For FY 2008-09, the Department is currently forecasting that $2.4 billion will be necessary to meet the obligations for the MSP line item. The Department's forecast indicates that the current appropriation of $2.3 billion is under funded by approximately $103.3 million (4.5 percent increase). Of this amount, $30.3 million is General Fund (a 2.8 percent increase).

Because the Department anticipates that the current year appropriation is under funded, the Department's FY 2009-10 MSP line item request is $231.5 million total funds (10%) higher than the current FY 2008-09 appropriation. However, the Department's request is only $128.2 million (5.3%) higher than the Department's revised estimate for FY 2008-09. Table 1 below summarizes the Department's FY 2008-09 expenditure estimate and FY 2009-10 budget request.

Table 1: FY 2008-09 Estimate & FY 2009-10 Budget Request

Funds	**Current** *FY 2008-09* Appropriation	Department's **Estimated** *FY 2008-09* Expenditure	**Difference Possible Supplemental Amount**	**Department's** *FY 2009-10* **Budget Request**	*FY 2009-10* Increase Compared to Current FY 2008-09 Appropriation	*FY 2009-10* Increase Compared to Estimated FY 2008-09 Expenditure
GF/GFE	$1,072,222,480	$1,102,486,011	**$30,263,531**	$1,151,820,047	$79,597,567	$49,334,036
CF	85,281,324	105,634,733	**20,353,409**	120,138,335	34,857,011	14,503,602
RF	2,767,998	2,809,192	**41,194**	2,898,693	130,695	89,501
FF	1,161,825,797	1,214,507,758	**52,681,961**	1,278,786,771	116,960,974	64,279,013
Total	$2,322,097,599	$2,425,437,694	**$103,340,095**	$2,553,643,846	$231,546,247	$128,206,152
Percent (Decrease) / Increase			**4.45%**	n/a	9.97%	5.29%

The supplemental adjustments indicated in Table 1 are the Department's *base* forecast for FY 2008-09. ***The base supplemental request does not include any adjustments associated with policy changes -- it is strictly a caseload and cost trend forecast***. Thus, Table 1 does not represent the total supplemental request that the Department may submit in January 2009. For example, in July 2008 the Audit Committee was apprised that the Department had erroneously over drawn federal funds by $4.7 million from FY 2004-05 through FY 2006-07 due to an accounting error in the partial dual eligible program. This amount will need to be reimbursed to the Centers for Medicare and Medicaid Services. However, this $4.7 million General Fund impact is not included in Table 1 above (it is not related to caseload or cost projections). The Department will submit this issue as a stand alone supplemental issue in January 2009. Thus, the supplemental request submitted in January/February 2009 will most likely be higher than the amount shown in Table 1.

Updated FY 2008-09 Caseload and Cost-Per-Client Estimates

The $103.3 million supplemental request shown in Table 1 above represents the Department's current FY 2008-09 estimate for medical services costs for the Medicaid caseload. This calculation is based on the Department's current forecast that the average monthly Medicaid caseload will be 421,651 clients during FY 2008-09 (specific caseload estimates by aid category are shown in Table 5 latter in this issue). This is an increase of 40,261 clients (10.6 percent) from the current FY 2008-

09 appropriated Medicaid caseload of 381,390 clients. The Department's caseload projection has the following major components:

✓ *Rebased the Medicaid monthly caseload reports*. Beginning in July 2008, the Department changed the monthly Medicaid caseload reports to include data through the last day of the month. Previously, the Medicaid monthly caseload report was run on the Friday before the last Tuesday of every month and did not include eligibility changes that occurred from that date to the last day of any given month. The caseload "rebase" created a slight increase to reported caseload over the previous methodology. (When caseloads are growing, not reporting data through the end of month slightly undercounts caseload).

✓ *Reflects current caseload trends.* The new FY 2008-09 caseload forecast reflects the higher than anticipated caseload in FY 2007-08 and continues to project strong caseload growth in FY 2008-09 based mainly on the current economic conditions. Other factors that impact caseload projections include population growth, in-state migration, length of stay on Medicaid, and aging of the population.

The Department's forecast also reflects updated cost estimates. The cost estimates are a function of both caseload increases and estimates of per-client costs based on recent trend data. Table 2 below shows the projected costs increases for each service category.

Table 2: FY 2008-09 Service Forecast

	Current FY 2008-09 Appropriation	Dept. FY 2008-09 Estimate --Nov 08	Difference	% Difference
Acute Care Cost	$1,357,120,561	$1,453,999,248	$96,878,687	7.14%
Community Long-Term Costs	251,120,985	259,515,815	8,394,830	3.34%
Nursing Facilities & PACE	570,666,065	565,412,808	(5,253,257)	(0.92)%
Insurance Programs	95,491,972	96,235,687	743,715	0.78%
Service Management	33,543,854	33,663,735	119,881	0.36%
Total Medical Costs	$2,307,943,437	$2,408,827,293	$100,883,856	4.37%
Other Cost Adjustments	14,154,162	16,610,401	2,456,239	17.35%
Total MSP Line Item	$2,322,097,599	$2,425,437,694	$103,340,095	4.45%

The Department's FY 2008-09 Supplemental request also adjusts the funding sources for the Medical Service Premiums line item. Table 3 shows the Department's revised estimates for fund splits.

Table 3: FY 2008-09 Medical Services Premiums Expenditures by Fund Source

	Current FY 2008-09 Approp.	Department's Revised FY 2008-08 Est. (Nov 1, 2008)	Difference (Est - Approp)
General Fund	$703,222,480	$733,486,011	$30,263,531
General Fund Exempt	$369,000,000	$369,000,000	$0
Autism Fund	$233,043	$784,875	$551,832
Breast and Cervical Cancer Treatment Fund	$1,800,529	$1,903,980	$103,451
Health Care Expansion Fund	$69,405,126	$77,887,758	$8,482,632
Nursing Facility Provider Fees*	$0	$9,907,870	$9,907,870
Certified Funds	$13,842,626	$15,150,250	$1,307,624
Transfer from DPHE	$2,767,998	$2,809,192	$41,194
Federal Funds	$1,161,825,797	$1,214,507,758	$52,681,961
Total Funds	$2,322,097,599	$2,425,437,694	$103,340,095

*Because the appropriation for H.B. 08-1114 is conditional based on waiver approval by CMS by April 1, 2009, the current FY 2008-09 appropriation does not include the impact of H.B. 08-1114 at this time. The Department's request assumes that CMS will approve the waiver and has included the appropriation.

Staff would note the following about the financing of the Department's FY 2008-09 supplemental estimate:

1. The Department includes a $4.0 million decrease to the General Fund due to provisions in H.B. 08-1114 which limit the growth of the General Fund for nursing facilities (and an increase of $4.0 million to the Nursing Facility Provider Fee Cash Fund). However, this General Fund cap is contingent on the CMS approving the nursing facility provider fee waiver. If CMS does not approve the waiver by April 1, 2009, this refinancing will not be available. The Committee may not know if this a viable refinance until the Conference Committee on the Long Bill in April 2009.

2. The Department refinances all of the State match costs of legal immigrants onto the Health Care Expansion Fund. This increases the costs assigned to the Health Care Expansion Fund from the current $6.2 million to $14.1 million. This allows the Department to cost shift $7.9 million from the General Fund to the Health Care Expansion Fund.

Without these two fund shifts, the Department's General Fund supplemental request would be approximately $40.0 million compared to the $30.2 million requested.

FY 2009-10 Department Budget Request

For FY 2009-10, the Department anticipates that Medical Service Premiums expenditures will increase by $231.5 million total funds over the current FY 2008-09 appropriation. This is a total fund increase of 9.97 percent over the current FY 2008-09 appropriation. Table 4 below summarizes the Department's FY 2009-10 request.

Table 4: Medical Service Premiums FY 2008-09 Budget Request

Item	Total Funds	GF & GFE	Cash Funds	Reapprop. Funds	Federal Funds
Current FY 2008-09 Appropriation	**$2,322,097,599**	**$1,072,222,480**	**$85,281,324**	**$2,767,998**	**$1,161,825,797**
Department's Estimated Increases for FY 2009-10 (Nov 1, 2008 Request)					
Annualize prior year budget adjustments & legislation	$21,684,523	$906,115	$9,936,145	$0	$10,842,263
Base caseload growth & cost-per-client (DI #1)	$212,621,798	$80,080,442	$24,911,912	$130,695	$107,498,749
Other Decision Items or Base Reductions (DI #6, BRI #1 & #2, and NPI #3)	(2,760,074)	(1,388,990)	8,954	0	(1,380,038)
Department's FY2009-10 Budget Request	**$2,553,643,846**	**$1,151,820,047**	**$120,138,335**	**$2,898,693**	**$1,278,786,771**
Increase above current FY 2007-08 appropriation	**$231,546,247**	**$79,597,567**	**$34,857,011**	**$130,695**	**$116,960,974**
Percent Increase	**9.97%**	**7.42%**	**40.87%**	**4.72%**	**10.07%**

*Greater detail on Decision Items and Base Reduction Items is shown on page 19 of this packet.

The majority of the Department's FY 2009-10 budget request relates to two issues:

1. H.B. 08-1114 -- This bill increases nursing home rates conditional on federal approval of a nursing home provider fee waiver. The estimated impact for this bill in FY 2009-10 is $16.3 million total funds. Of this amount, $10.3 million is cash funds and $8.1 million is federal funds. These fund increases are offset by a General Fund decrease of $2.1 million.

2. Base Forecast (Decision Item #1) -- The base forecast for FY 2009-10 assumes an increase of $212.6 million over the current FY 2008-09 appropriation. Again, the base forecast represents the Department's estimate for medical services costs for the eligible Medicaid caseload without any policy changes.

Following is a brief description of the Department's FY 2009-10 base request (i.e. Decision Item #1 plus the prior year budget action annualization impacts).

FY 2009-10 Caseload Projection

The Department is currently forecasting total Medicaid caseload of 435,038 clients for FY 2009-10. This caseload estimate represents 3.17% growth from the Department's revised FY 2008-09 estimate. Table 5 below shows the Department's current caseload projection by aid category.

Table 5: Total Medicaid Caseload -- Department's November 2008 Forecast

	FY 2007-08 Actual*	FY 2008-09 Current App. Estimate	FY 2008-09 November HCPF Forecast	% Change FY 2008-09 Forecast Compared to FY 2007-08 Actual	FY 2009-10 November HCPF Forecast	%Change FY 2008-09 Forecast Compared to FY 2007-08 Forecast
SSI 65+	36,063	36,278	37,155	3.03%	37,478	0.87%
SSI 60-64	6,116	6,216	6,257	2.31%	6,330	1.17%
Partial Dual Eligibles	14,130	15,068	15,202	7.59%	16,097	5.89%
SSI Disabled	49,662	50,123	50,582	1.85%	51,057	0.94%
Low-Income Adults	44,234	41,667	45,161	2.10%	46,444	2.84%
Expansion Low-Income Adults	8,627	9,629	11,950	38.52%	13,260	10.96%
Baby-Care Adults	6,108	6,028	7,353	20.38%	7,566	2.90%
Breast & Cervical Cancer Program	270	301	285	5.56%	303	6.32%
Eligible Children	201,800	193,484	225,209	11.60%	233,082	3.50%
Foster Care Children	17,014	18,858	17,968	5.61%	18,682	3.97%
Non-Citizens	4,044	3,738	4,529	11.99%	4,739	4.64%
Total	**388,068**	**381,390**	**421,651**	**8.65%**	**435,038**	**3.17%**

*shows actual reported caseload not adjusted for the rebase.

A few observations about the Department's caseload forecast:

- ✓ The FY 2009-10 caseload is fairly moderate when compared to the FY 2008-09 revised caseload growth rate (a 3.17% growth rate instead of 8.65%).[1]

- ✓ During the last economic downturn, the low-income adults and children categories experienced double digit growth rates for three years.

- ✓ The aid category with the highest growth rate is the low-income adults. This is to be anticipated since this caseload is still in the "ramp-up" phase. Additionally, this aid category is directly impacted by economic downturns.

- ✓ Partial Dual Eligibles continue to grow at a higher rate than most aid categories. This group reflects low-income Medicare beneficiaries who qualify for Medicare premium assistance under the Medicaid program. After Medicare Part D was enacted, the Partial Dual Eligible caseload experienced double digit growth rates for three years. It was anticipated that as seniors applied for Medicare Part D they would realize that they were eligible for Medicare premium assistance. While the growth rate for this aid category is still relatively high, the forecast is moderate compared the most recent three years.

The Department's Specific Cost - Per -Client Projections for FY 2008-09 & FY 2009-10

After forecasting the Medicaid enrollment, the next step in developing the ***base*** cost estimates for the MSP line item is forecasting the average cost-per-client for each of the caseload aid categories. The average cost-per-client is estimated by looking at past trends in each aid categories expenditures for acute care services, community long-term care services, institutional long term care services, supplemental insurance costs, and costs for administrative services. The Department then adjusts these forecasted trends for any special circumstances that are not part of the historical data (i.e. new policy initiatives enacted during the prior year). Table 6 summarizes the Department's Medicaid medical service cost estimates by service area for FY 2008-09 and FY 2009-10.

Table 6: Department November Forecast by Service Category

	FY 2007-08 Actual	FY 2008-09 Cur. App.	FY 2008-09 Dept. Estimate	% Change to Cur. App.	FY 2009-10 Estimate	% Change to Dept. Est.
Acute Care Services	$1,336,004,287	$1,357,120,561	$1,453,999,248	7.14%	$1,527,556,326	5.06%
Community Long-Term Care	$241,742,015	$251,120,985	$259,515,815	3.34%	$269,603,995	3.89%

[1]Please note that the FY 2007-08 is the actual reported caseload. The Department's estimate of the FY 2007-08 caseload under the rebase methodology is 391,962. Compared against an rebased FY 2007-08 caseload, the Department's growth rate for FY 2008-09 is only 7.57% instead of 8.65%.

Table 6: Department November Forecast by Service Category						
	FY 2007-08 Actual	FY 2008-09 Cur. App.	FY 2008-09 Dept. Estimate	% Change to Cur. App.	FY 2009-10 Estimate	% Change to Dept. Est.
Institutional Long-Term Care	$538,222,989	$570,666,065	$565,412,808	(0.92)%	$604,700,067	6.95%
Supplemental Insurance	$83,370,893	$95,491,972	$96,235,687	0.78%	$102,155,514	6.15%
Administrative Services	$27,697,298	$33,543,854	$33,663,735	0.36%	$35,158,825	4.44%
TOTAL	$2,227,037,482	$2,307,943,437	$2,408,827,293	4.37%	$2,539,174,727	5.41%
Increase from current FY 2008-09 App.			**$100,883,856**	**4.37%**	**$231,231,290**	**4.63%**
Bottom Line Financing	**$10,247,323**	**$14,154,162**	**$16,610,401**	**17.35%**	**$17,229,193**	**3.73%**
TOTAL BASE with Bottom Line Financing	**$2,237,284,805**	**$2,322,097,599**	**$2,425,437,694**	**4.45%**	**$2,556,403,920**	**5.40%**

For FY 2009-10, the Department is forecasting overall growth to the base MSP line item of 5.40 percent when compared to their revised FY 2008-09 estimate. Table 7 below shows staff's estimate of how much of the FY 2009-10 request is being driven by caseload increases and how much by health care cost increases (due to health cost inflation and utilization).

Table 7: Analysis of FY 2009-10 Cost Drivers When Compared to Revised FY 2008-09 Request						
Aid Category	Caseload Difference	Net Cost Per Client Difference	Cost Associated with Higher Caseload Estimate	Cost Associated with Higher Cost Estimate	Compounding Effect	Total Costs
SSI 65+	323	$978.86	$6,504,261	$36,369,673	$316,173	$43,190,107
SSI 60-64	73	$550.26	$1,240,152	$3,442,952	$40,169	$4,723,273
SSI Disabled	475	$415.03	$6,464,867	$20,992,977	$197,139	$27,654,983
Low-Income Adults	1,283	$136.63	$5,700,737	$6,170,493	$175,300	$12,046,530
Expansion Low-Income Adults	1,310	$180.39	$3,246,546	$2,155,669	$236,312	$5,638,527
Baby Care Adults	213	$331.89	$1,636,862	$2,440,402	$70,693	$4,147,957

Table 7: Analysis of FY 2009-10 Cost Drivers When Compared to Revised FY 2008-09 Request

Aid Category	Caseload Difference	Net Cost Per Client Difference	Cost Associated with Higher Caseload Estimate	Cost Associated with Higher Cost Estimate	Compounding Effect	Total Costs
Children	7,873	$24.03	$14,612,586	$5,410,904	$189,158	$20,212,648
Foster Children	714	$343.80	$2,969,684	$6,177,383	$245,473	$9,392,540
Breast and Cervical Cancer Treatment Patients	18	$1,010.95	$491,334	$288,122	$18,197	$797,653
Partial Dual eligibles	895	$49.21	$1,273,519	$748,029	$44,039	$2,065,587
Non-citizens (emergency care)	210	($456.73)	$2,642,086	($2,068,543)	($95,914)	$477,629
Total	13,387	n/a	$46,782,634	$82,128,061	$1,436,739	$130,347,434
Change in Bottom of the Line Financing						$618,792
Total FY 2009-10 MSP Base Increase over Revised FY 2008-09 Estimate						$130,966,226

A few observations:

✓ In the low-income adults aid categories, the overall cost impacts associated with caseload growth and increased per-client cost increases are similar.

✓ In the low-income children's aid category, the majority of the costs are associated with caseload growth. Because caseload growth in this category is healthy, the cost-per-client impact benefits from a larger risk pool (i.e. the case mix of healthy clients compared to sick clients tends to lower the overall cost).

✓ In the disabled, elderly, and foster children categories, the costs associated with higher medical costs are higher than the costs associated with caseload. These aid categories have caseload growth that is based more on demographic growth and is not impacted as much by economic downturns. The clients in these aid categories usually have greater health needs due to their age, disabilities, or at-risk status. Because elderly usually qualify for Medicare for their acute care needs, the majority of their cost increases reflect higher long-term care costs. The disability aid categories also reflect higher costs due to long-term care services as well as higher use of acute care services. Foster children reflect higher costs due to greater utilization of acute care services due to their health issues surrounding issues of neglect and abuse.

Table 8 shows the fund splits for the Department's FY 2009-10 base MSP line item request.

Table 8: FY 2009-10 Medical Services Premiums Expenditures by Fund Source

	Department's Revised FY 2008-08 Est. (Nov 1, 2008)	Department's FY 2009-10 Est. (Nov 1, 2008)	Difference (Est - Approp)
General Fund	$733,486,011	$784,209,037	$50,723,026
General Fund Exempt	$369,000,000	$369,000,000	$0
Autism Fund	$784,875	$784,875	$0
Breast and Cervical Cancer Treatment Fund	$1,903,980	$1,046,828	($857,152)
Health Care Expansion Fund	$77,887,758	$85,700,132	$7,812,374
Nursing Facility Provider Fees*	$9,907,870	$16,828,504	$6,920,634
Certified Funds	$15,150,250	$15,769,042	$618,792
Transfer from DPHE	$2,809,192	$2,898,693	$89,501
Federal Funds	$1,214,507,758	$1,280,166,809	$65,659,051
Total Funds	$2,425,437,694	$2,556,403,920	$130,966,226

Similar to staff's comments regarding the FY 2008-09, staff is concerned about two fund split issues for the FY 2009-10. In FY 2009-10, there is a $8.7 million decrease to the General Fund based on the provision in H.B. 08-1114 that limits the growth of General Fund expenditures to 3.0 percent annually. This provision is effective only if CMS approves the Nursing Home Provider Fee Waiver. Staff anticipates that discussion on the waiver will be continuing during the time that the Committee is doing figure setting.

In addition, the Department's FY 2009-10 request moves all of the state match costs for the optional legal immigrants to the Health Care Expansion Fund. Therefore, this action lowers the General Fund appropriation by about $7.9 million and increases the Health Care Expansion Fund appropriation by $7.9 million.

FY 2009-10 Joint Budget Committee Staff Budget Briefing
Department of Health Care Policy and Financing
Executive Director's Office, Medical Services Premiums, Indigent Care Programs, Other Medical Services, and Commission on Family Medicine

BRIEFING ISSUE

ISSUE: The Medicaid Modernization Act State Contribution Payment Forecast

The Department's FY 2009-10 budget requests indicates the Medicare Modernization Act (MMA) State Contribution will be $86.5 million. This is a $5.3 million General Fund increase over the current FY 2008-09 appropriation.

SUMMARY:

- ❏ The Department forecasts an increase of 6.5 percent for the MMA State Contribution Payment in FY 2009-10.

- ❏ Based on more current information from the Centers for Medicare and Medicaid Services (CMS), staff estimates that the MMA State Contribution Payment may need approximately a $1.0 million General Fund supplemental in FY 2008-09. For FY 2009-10, staff estimates that the payment could be as high as $88.9 million.

DISCUSSION:

Prior to the passage of the Medicare Part D benefit in the Medicare Modernization Act (MMA), the states paid the prescription drug costs for dual eligible clients (i.e. those clients eligible for both Medicare and Medicaid). With the passage of Medicare Part D, all Medicare clients had to receive their prescription drug benefits from the Medicare program (for drugs covered under Part D). However, the MMA required that states continue to contribute to the costs of this program in what is known as the MMA State Contribution Payment. The MMA State Contribution Payment is calculated each year as follows:

Base Amount: The MMA law requires that the net weighted average monthly per capita expenditure for the dual eligible's in the year 2003 is the state's base maintenance effort amount.

Yearly Obligation: The base amount is increased by a health expenditure factor (e.g. the per capita expenditure will be adjusted annually for national prescription care cost growth). This per capita cost will then be multiplied by the number of dual eligibles for the month (e.g. caseload x cost). The maintenance of effort will then be multiplied by the state contribution percentage. Initially, states were responsible for 90 percent of the costs. This percentage will phase-down to 75 percent of the costs by 2015. For FY 2009-10, the phase-down factor is 85.00 percent from July to December 2009 and 83.33

percent from January to June 2010. Table 1 on the next page shows the calculations for the Department's FY 2009-10 request.

Table 1: Department Calculation Assumptions for MMA State Contribution Payment for FY 2009-10			
	FY 2008-09 App.	**FY 2009-10 Dept. Req.**	**Difference**
Payments from July through December of Fiscal Year			
Monthly Per Capita Cost multiplied by the Phase down	$120.03	$124.98	$4.95
Average Monthly Enrollment (1st Seven Months of FY) for Dual Eligibles	55,091	56,347	1,256
Total payments for the first seven months of Fiscal year	**$46,588,158**	**$49,295,635**	**$2,707,477**
Payments from January through June of Fiscal Year			
Per Capita Cost multiplied by the Phase down	$125.16	$130.77	$5.61
Average Monthly Enrollment (Last Five Months of FY) for Dual Eligibles	55,237	56,847	1,610
Total payments for the last five months of Fiscal Year	**$34,567,037**	**$37,169,579**	**$2,602,542**
TOTAL MMA State Contribution Payment Estimate	$81,155,195	$86,465,214	**$5,310,019**

In October, the Centers for Medicare and Medicaid Services (CMS) forwarded information that the 2009 per capita estimate would be $128.62. Unfortunately, this information was forwarded too late to be included in the Department's November 1, 2008 request. With this new 2009 per capita rate, staff estimates that the MMA payment will increase by approximately $1.0 million for FY 2008-09 to $82.1 million. For FY 2009-10, staff estimates this rate will increase the MMA payment to $88.9 million, rather than the $86.5 million included in the Department's request. These calculations are shown in Table 2 below.

Table 2: Calculation Assumptions for MMA State Contribution Payment for FY 2009-10 Based on New CMS Information			
	FY 2008-09 App.	**FY 2009-10 Staff Est.**	**Difference**
Payments from July through December of Fiscal Year			
Monthly Per Capita Cost multiplied by the Phase down	$120.03	$128.62	$8.59
Average Monthly Enrollment (1st Seven Months of FY) for Dual Eligibles	55,091	56,347	1,256
Total payments for the first seven months of Fiscal year	**$46,588,158**	**$50,731,458**	**$4,143,300**
Payments from January through June of Fiscal Year			
Per Capita Cost multiplied by the Phase down	$128.62	$134.28	$5.66
Average Monthly Enrollment (Last Five Months of FY) for Dual Eligibles	55,237	56,847	1,610
Total payments for the last five months of Fiscal Year	**$35,522,915**	**$38,166,871**	**$2,643,956**
TOTAL MMA State Contribution Payment Estimate	$82,111,073	$88,898,329	**$6,787,256**

A Few Observations About the MMA Payment

✓ ***The MMA Payment Is Not Included in the Department's Over-expenditure Authority*:** As a Medicare payment, this appropriation is not included in the over-expenditure authority for the Medicaid program (in Section 24-75-109). This is despite the fact that this program is based on a Medicaid caseload and mandated per capita costs from the federal government (i.e. the state has no control over the costs for this program). Therefore, if an over-expenditure for this program occurs, the over-expenditure is counted against the $1.0 million over-expenditure for all of State government. If the Committee decides to carry legislation to extend the over-expenditure authority in Section 24-75-109, the Committee may want to consider whether a separate over-expenditure authority should be provided to the MMA Payment similar to what the General Assembly passed last year for the Children's Basic Health Plan.

✓ ***The Department's Initiatives to Control Prescription Drug Costs Don't Impact the MMA Payment:*** The State has no control over the amount of the MMA payment. The inflationary factors used for the payment are national figures and do not relate directly to the costs of the Colorado dual eligibles (the original base year of 2003 did but thereafter, the per capita cost has been inflated by national costs that are not necessary representative of the costs for Colorado dual eligibles).

✓ ***The MMA Payment Should Be Considered in State Bail-Out Discussions:*** In the long-term it would be more advantageous to the states if Congress eliminated the MMA payment rather than provided a temporary FMAP change.

FY 2009-10 Joint Budget Committee Staff Budget Briefing
Department of Health Care Policy and Financing
Executive Director's Office, Medical Services Premiums, Indigent Care Programs, and Other Medical Services, including the Commission on Family Medicine

BRIEFING ISSUE

ISSUE: Children's Basic Health Plan Budget Outlook

The Department is currently forecasting an increase of $6.3 million total funds for the Children's Basic Health Plan (CBHP) for ***base*** caseload and cost-per-client increases in FY 2009-10 above the current FY 2008-08 appropriation. Of this amount, $4.3 million is from the General Fund.

SUMMARY:

- ❑ In FY 2007-08, the CBHP premiums line item reverted $4.2 million total funds (3.8 percent) of the final appropriation. The final children's caseload was 1,120 children (1.9 percent) lower than the final caseload forecast. The final adult prenatal caseload was 10 women higher (0.6 percent) than the final caseload forecast.
- ❑ The Department's FY 2009-10 budget request for the CBHP program is $6.3 million total funds higher than the current FY 2008-09 appropriation. The majority of this increase, $4.3 million, is a General Fund appropriation into the CBHP Trust Fund to ensure solvency in FY 2009-10.

RECOMMENDATION:

1. Staff recommends that the Committee amend Section 24-22-115, C.R.S. to allow $4,960,871 in the unused balance in the Health Care Supplemental Appropriations and Overexpenditures Account in the Tobacco Litigation Settlement Cash Fund to be transferred to the CBHP Trust Fund or to be used for supplemental appropriations for the Colorado Benefits Management System for FY 2009-10.

2. Staff recommends that the Department present at their budget hearing how the $1.4 million in additional outreach and marketing activities has been disbursed. As part of this presentation, the Department should address the corrective action plans they plan to implement in order to address the State's Auditor's recommendation regarding the effectiveness of their current marketing and outreach activities. Specifically, the Department should address how the Department is collecting and analyzing data regarding how clients find out about the CBHP program and on how to determine the effectiveness of any one marketing or outreach strategy.

3. Staff recommends the discontinuation of appropriating enrollment fees into the CBHP Trust Funds. Current statute allows for these fees to be deposited into the CBHP Trust Funds (Section 25.5-8-105 (7), C.R.S.). As a general rule, revenues should not be appropriated into funds -- they are deposited or transferred. This recommendation will eliminate the need to reappropriate these

funds into the program lines. This recommendation should also reduce some confusion regarding necessary appropriations for fiscal note purposes.

DISCUSSION

Background

The State Children's Health Insurance Program (SCHIP) was enacted by Congress in 1997 as Title XXI of the Social Security Act. In Colorado, SCHIP was enacted as the Children's Basic Health Plan (CBHP). The CBHP program receives a 65 percent federal match and currently covers children up to 205 percent of the federal poverty level (FPL) with a required expansion up to 225 percent FPL beginning in April 2009. In addition to covering children, the CBHP also has an adult pregnant woman program that provides prenatal care for women up to 205 percent FPL with a required expansion to 225 percent FPL beginning October 2009. Current law allows the General Assembly to fund children and pregnant women up to 250 FPL if funding becomes available.

There are four program appropriation line items for the CBHP program.

- ✓ ***CBHP Trust Fund****:* This line item is for any appropriated contributions into the CBHP Trust Fund.

- ✓ ***CBHP Plan Administration*****:** This line item funds the private contracts for administrative services associated with the operation of the CBHP programs. Most of these costs are for eligibility determination and enrollment costs. The line item also funds outreach and client education. This line item does not contain the Department's internal administrative costs. These costs are found in various line items in the Executive Director's Office, including but not limited to personal services and operating expenses.

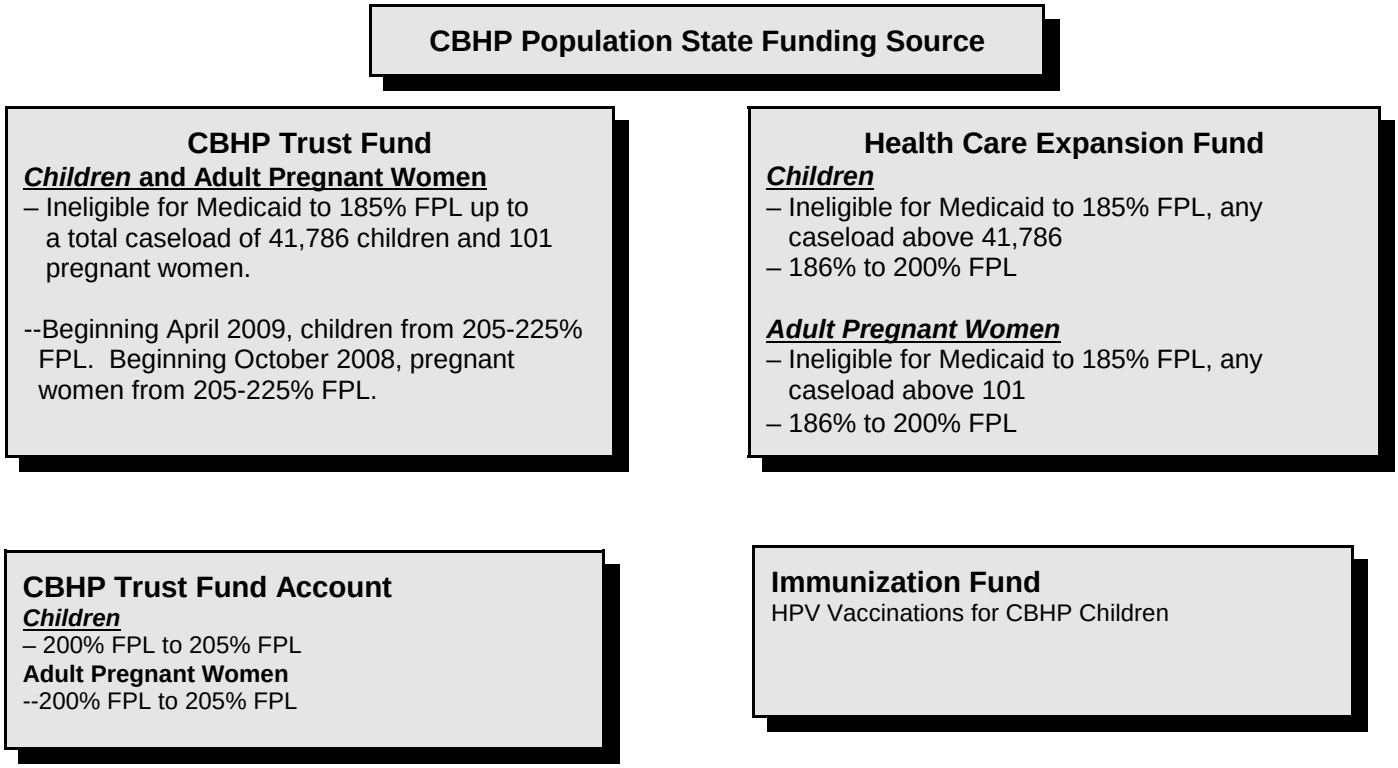
- ✓ ***CBHP Premium Costs:*** This line item contains the medical benefit costs for both the children and adult pregnant women caseloads.

- ✓ ***CBHP Dental Benefit Costs:*** This item contains the dental benefit costs for the children's caseload.

Funding for the CBHP Program

The State match for the program is provided from four sources: (1) the CBHP Trust Fund (Fund); (2) the Supplemental Tobacco Litigation Settlement Moneys Account of the CBHP Trust Fund (Account); (3) the Health Care Expansion Fund; and (4) the Colorado immunization program. The revenue sources for the CBHP Trust Fund include 24 percent of the funding received annually from the Master Tobacco Settlement Agreement up to $30.0 million, any General Fund appropriations into the Fund, interest and investment earnings, and enrollment fees charged to program participants. The revenue sources for the CBHP Trust Fund Account include 5.0 percent of Tobacco Master Settlement Agreement that was not

previously allocated before S.B. 07-097 to other programs and other transfers specified in statute from the Innovative Health Program Grant Fund. Any expended funds and interest earnings from this account must be swept at the end of each fiscal year into the Short-Term Innovative Health Program Grant Fund. The revenue sources for the Health Care Expansion Fund include 46 percent of the revenues collected from the increase to the Tobacco taxes approved by the voters in November 2004 and any interest and investment earnings to the fund. The State Constitution limits the use of this fund to certain eligibility caseloads within the Medicaid and CBHP programs.



FY 2007-08 Reversion

Table 1 below summarizes the CBHP program line reversions for FY 2007-08.

Table1: FY 2007-08 CBHP Program Line Items Reversions*

Item	Total Funds	Cash Funds	Cash Fund Exempt	Federal Funds
FY 2007-08 Appropriation CBHP Administration	$5,541,590	$0	$2,474,735	$3,066,855
Actual Expenditures	$5,514,804	$0	$2,466,584	$3,048,220
(Reversion)/Over-expenditure	($26,786)	$0	($8,151)	($18,635)

Table1: FY 2007-08 CBHP Program Line Items Reversions*				
Item	**Total Funds**	**Cash Funds**	**Cash Fund Exempt**	**Federal Funds**
FY 2007-08 Appropriation CBHP Premiums	$108,872,971	$1,479	$38,292,856	$70,578,636
Actual Expenditures	$104,684,790	$0	$36,823,865	$67,860,925
(Reversion)/Over-expenditure	($4,188,181)	($1,479)	($1,468,991)	($2,717,711)
FY 2007-08 Appropriation CBHP Dental	$8,976,385	$0	$3,141,735	$5,834,650
Actual Expenditures	$8,715,754	$0	$3,050,514	$5,665,240
(Reversion)/Over-expenditure	($260,631)	$0	($91,221)	($169,410)

The reversion in the CBHP program line items can be explained by both lower than forecasted caseload for the children's population and lower per capita costs than forecasted. Table 2 below shows the reasons for the forecast error.

Table 2: CBHP FY 2007-08 Forecast Error -- Premiums Only						
Aid Category	**Caseload Difference (Actual - Final Est.)**	**Net Cost Per Client Difference (Final Est-Actual)**	**Cost Associated with Caseload Estimate**	**Cost Associated with Lower Cost Estimate**	**Compounding Effect**	**Total Costs**
Children	(1,120)	($15.19)	($1,715,903)	($894,651)	$17,008	($2,593,546)
Adult Pregnant Women	10	($1,091.68)	$119,307	($1,703,024)	($10,917)	($1,594,634)
Total	(1,110)	($1,106.87)	($1,596,596)	($2,597,675)	$6,091	($4,188,180)

*figures are based are actuals and show the lower impact for cash accounting.

From July 2007 through January 2008, the CBHP children's caseload was averaging 1,060 client per month increase in the traditional eligibility category (up to 185% FPL). However, in February 2008 this trend reversed. From February to June 2008, the caseload averaged a 93 decrease per month. This helps explain why the children's caseload was over-forecasted.

The lower CBHP per capita costs for the program result from: (1) as a fairly new, small, and expanding caseload, the prenatal program's costs are still difficult to predict; (2) the children's lower children caseload may have changed the ratio between the HMO and the State's managed network; and (3) adjustments due to special bills were not as high as anticipated.

Staff Comment: In January 2008, the Department issued final rules related to the Deficit Reduction Act of 2005. The new Department rules require citizenship and identification requirements for children in the CBHP program. Thus, the children who were made eligible for the CBHP program rather than Medicaid due to lack of DRA documentation will now be required to present such identification for either

program. While the Department states they do not know the magnitude of the caseload declines anticipated from this policy change, the Department stated that they anticipated caseload to decline for at least one year from the date of implementation as all children complete redeterminations. This decline is anticipated to be mitigated somewhat by the CBHP marketing efforts.

FY 2009-10 CBHP Program Request

Table 3 shows the reasons for the anticipated increases in the CBHP program line items for FY 2009-10.

Table 3: CBHP Program Line Items FY 2009-10 Request Detail*

Item	Total Funds	GF / GFE	Cash Funds	Reapprop. Funds	Federal Funds
Current FY 2008-09 Appropriation	$174,548,651	$0	$62,170,269	$30,328	$112,348,054
Department's Estimated Changes from FY 2008-09 Approp. (Nov 1, 2008 Request)					
CBHP ***BASE*** Caseload and Per-Capita Cost increases for medical and dental benefits	2,082,548	0	(3,919,138)	4,657,331	1,344,355
CBHP External Administration	(15,000)		(5,250)	0	(9,750)
CBHP Trust Fund Solvency	4,281,614	4,270,540	11,074	0	0
Department's FY 2009-10 request (Nov 1, 2008)	**$180,897,813**	**$4,270,540**	**$58,256,955**	**$4,687,659**	**$113,682,659**
(Decrease)/Increase from current FY 2008-09 appropriation	$6,349,162	$4,270,540	($3,913,314)	$4,657,331	$1,334,605

* Includes changes to CBHP Trust Fund, CBHP Administration, CBHP Premium Costs, and CBHP Dental Benefit Costs. Does not include costs in the EDO Division.

CBHP BASE Caseload and Per-Capita Cost increases for medical and dental benefits: This issue represents the Department's base costs for the CBHP medical and dental program including annualizing prior year legislation, anticipated caseload growth and cost increases as follows:

- ✓ The current FY 2008-09 appropriation assumed a children's caseload of 77,152. The Department now estimates that the children's caseload will be 66,757 in FY 2008-09. The FY 2009-10 children's caseload is forecasted at 71,598.

- ✓ The current FY 2008-09 appropriation assumed a prenatal caseload of 2,021. The Department's revised estimates for FY 2008-09 assumes a prenatal caseload of 1,847. The FY 2009-10 prenatal caseload is forecasted at 2,363.

- ✓ The per capita costs for the children's medical program was budgeted at $1,672.36 in FY 2008-09. The Department's new per capita estimate for FY 2008-09 is estimated at $1,635.35. The Department's FY 2009-10 children's per capita estimate is forecasted at $1,775.92 (an increase of 8.6 percent from the Department's revised estimate).

- ✓ The per capita costs for the children's dental program was budgeted at $161.38 in FY 2008-09. The Department's new estimate is $160.09. For FY 2009-10, the Department estimates a per capita dental cost of $169.79 per child.

- ✓ The per capita medical cost for the adult pregnant women were budgeted at $12,723.22 in FY 2008-09. The Department now anticipates this cost to be $12,015.85. For FY 2009-10, the Department estimates a per capita cost of $12,680.33 per woman (an increase of 5.5 percent from the Department's revised estimates.).

CBHP External Administration: The Department's FY 2008-09 request reflects a technical adjustment to the CBHP External Administration line item in order to remove one-time costs from implementing S.B. S.B. 08-160.

CBHP Trust Fund Solvency: As stated earlier, the majority of the CBHP Trust Fund revenues come from transferring 24 percent of the total amount of money that the State receives annually from the Tobacco Master Settlement Agreement (Section 25.5-8-105, C.R.S.). The CBHP Trust Fund also receives revenue from the enrollment fee charged to clients and interest earnings. If necessary, the CBHP Trust Fund may also receive General Fund appropriations in order to maintain a positive fund balance. The CBHP Trust Fund is able to retain it's fund balance and interest earnings and its funding is prohibited from being transferred to the General Fund unless otherwise authorized by the General Assembly through legislation. Table 4 shows the impact of the Department's caseload and cost estimates on the CBHP Trust Fund.

Table 4: CBHP Trust Fund Anticipated Revenues and Expenditure Needs

	FY 2006-07 Actual	FY 2007-08 Actual	FY 2008-09 Dept. Estimate	FY 2009-10 Dept. Request
Beginning Balance	$4,411,882	$7,776,123	$9,231,076	$5,463,581
General App.	11,243,215	5,564,404	0	0
Tobacco Settlement Transfer	19,214,822	22,851,718	26,128,545	26,686,343
Other Revenue	610,607	910,096	928,612	941,579
HCE Fund State Match Earnings	9,557,980	15,005,337	20,737,073	23,599,826
Supplemental Tobacco Tax Revenue	0	480,157	1,989,214	1,989,214
Colorado Immunization fund	0	90,795	409,846	481,664
Federal Match Earnings	65,616,702	76,574,384	97,899,817	115,503,428
SUBTOTAL REVENUE	**$110,655,208**	**$129,253,014**	**$157,324,183**	**$174,665,635**
State Match for Trust Caseload	$27,704,403	$27,871,265	$30,824,652	$37,437,205
State Match for Expansion Caseload	9,557,980	15,005,337	20,737,073	23,599,826

Table 4: CBHP Trust Fund Anticipated Revenues and Expenditure Needs				
	FY 2006-07 Actual	FY 2007-08 Actual	FY 2008-09 Dept. Estimate	FY 2009-10 Dept. Request
Supplemental Tobacco Tax Account & Immunization Fund	0	570,952	2,399,060	2,470,878
Federal Match	65,616,702	76,574,384	97,899,817	115,503,428
SUBTOTAL EXPENDITURES	**$102,879,085**	**$120,021,938**	**$151,860,602**	**$179,011,337**
REMAINING BALANCE	**$7,776,123**	**$9,231,076**	**$5,463,581**	**($4,345,702)**

The difference between this deficit shown in this table and the Department's request is a deduction of $75,161 due to interest earnings on the General Fund appropriation.

Health Care Supplemental Appropriations and Over-expenditure Account in the Tobacco Litigation Settlement Cash Fund

House Bill 07-1359 established a Health Care Supplemental Appropriations and Over-expenditure Account in the Tobacco Litigation Settlement Cash Fund. Of the amount in this Account, $6.2 million was set aside to fund any over-expenditures or supplemental appropriation in the CBHP program that occurred in FY 2006-07 or FY 2007-08. Moneys in the Account can also be used for the Colorado Benefits Management System in FY 2006-07, FY 2007-08, and FY 2008-09.

Of the $6.2 million in the Account, the Committee appropriated $1.2 million in FY 2006-07 for CBHP program supplemental. The Committee approved using the remaining $5.0 million for the FY 2007-08 supplemental. However, due to a staff error, the FY 2007-08 supplemental referenced the CBHP Trust Fund instead of the Account. Therefore, this $5.0 million remains in the account and can be used for CBMS.

If the correction action for CBMS does not need this funding, staff recommends a law change that would allow this $5.0 million or a portion thereof to be transferred from the Account into the CBHP Trust Fund. If this funding is not used by FY 2008-09 for the CBMS project, then it will revert to all of the other programs that receiving funding from the tobacco litigation settlement cash fund (the CBHP Trust Fund would get 24% of the reversion or approximately $1.25 million).

A Few Observations From the State Audit Report

As part of their performance audit of the CBHP program in June 2008, the State Auditor had these findings regarding CBHP program penetration, marketing and outreach, and eligibility determinations (please note staff has not included all findings, just significant ones related to this issue):

1. The Auditor noted that there were serious problems with the Department's methodology for estimating the number of children eligible for CBHP and for estimating the penetration rate. Because of these problems, the Department lacks meaningful data to demonstrate whether the program has been successful in enrolling eligible children into CBHP. Based on the Auditor's recommendations, the Department has agreed to contract the Colorado Health Institute (CHI) to develop a methodology of estimating the number of uninsured eligible children for the CBHP program by county. The Department began their corrective action on this audit finding in October 2008.

2. The Auditor's evaluation of the Department's oversight of the Maximus' marketing and outreach contract found that the Department has not evaluated the extent to which Maximus is meeting its contract requirements to increase the number of individuals enrolled in the program. As a result, it is difficult for the Department to ensure that the investment in marketing and outreach has been cost-effective, as required by statute. The Auditor noted that while the Department believes Maximus' marketing and outreach efforts have been successful (i.e. the Department attributed the increase of about 13,000 children in CBHP between 2006 to 2007 to "extensive marketing and outreach"), the Department currently has no mechanism to prove these assertions.

   In FY 2008-09, the General Assembly provided an additional $1.4 million for additional outreach and marketing efforts. The Department estimated that 8,000 children would be enrolled due this marketing effort (although the JBC only approved an increase of 5,358 due to different assumptions used by staff). Currently, the October 2008 caseload is approximately 300 children lower than the caseload report in January 2008 and July 2008 (although October's caseload is higher than the amount reported in August and September 2008).

   Staff recommends that as part of the Department's budget hearing presentation, the Department address the corrective action plans they are implementing in order to address the State's Auditor's recommendation regarding the effectiveness of their current marketing and outreach activities and data collection.

3. The State Auditor also found that the Department provided inadequate oversight for proper handling and recording of enrollment fees. Under CBHP rules, families whose incomes exceed150 percent of the federal poverty level pay an annual fee of $25 for one child or $35 for two or more children before their children can be enrolled in CBHP. Families can pay their enrollment fees by: (1) mailing payments to a designated bank lockbox; (2) mailing payments to ACS (the Department administration contractor); or (3) being in payments in person to the ACS office. The Auditor found that neither ACS nor the Department has adequate controls in place to ensure that all enrollment fees are deposited and properly recorded in CBMS.

   Staff brings this issue to the Committee's attention because as higher income populations are added to the CBHP program, it may be prudent to discuss whether greater premium sharing should be required from these families (for example, state employees at the same poverty levels as CBHP parents pay approximately $154.12 a month to add children to their insurance under the

Kaiser HMO option compared to the annual $35 fee for a family with two or more children on the CBHP program). If the Department is not adequately accounting for current enrollment fees it could be difficult to implement greater cost sharing options if the General Assembly were to look into these options.

Staff also recommends that the practice of "appropriating" enrollment fees be eliminated in this year's Long Bill. Current statute allows these enrollment fees to be deposited into the CBHP Trust Fund. Therefore, appropriating these fees is an "informational-only" appropriation that is unnecessary. Because enrollment fees are not matched with federal dollars, the Department will always need to provide information in their budget request regarding on how much revenue is anticipated to be collected from enrollment fees. In addition, appropriating the enrollment fees into the CBHP Trust Fund results in a double counting true expenditure authority because when these fees are expended in the program line items, they are appropriated as "re-appropriated funds".

FY 2009-10 Joint Budget Committee Staff Budget Briefing
Department of Health Care Policy and Financing
(Executive Director's Office, Medical Services Premiums, Indigent Care Programs, Other Medical Services, and Commission on Family Medicine)

BRIEFING ISSUE

ISSUE: Federal Reauthorization of the State Children's Health Insurance Plan (SCHIP)

Congress must reauthorization the SCHIP by April 1, 2009 or the program expires.

SUMMARY:

- ❑ The Balanced Budget Act of 1997, which established SCHIP, required that the SCHIP program be reauthorized after a 10 year period -- September 2007. After several months of debate between Congress and the President Bush, the only bill signed in 2007 was an extension of the SCHIP program to March 31, 2009.

- ❑ According to Joy Wilson, the NCSL Health Care Lobbyist, it is possible for Congress to meet the March 31, 2009 deadline if they pass something similar to the Children's Health Insurance Program Reauthorization Act of 2007.

- ❑ During the Presidential campaign, President-Elect Obama proposed mandatory health insurance for all children. The reauthorization of the SCHIP program will provide the new administration with its first opportunity to impact health care reform.

DISCUSSION:

Background: The Balanced Budget Act of 1997, which established SCHIP, required that the SCHIP program be reauthorized after a 10-year period. The original expiration date for the program was September 30, 2007. During 2007, Congress passed two versions of the Children's Health Insurance Program Reauthorization Act of 2007 (HR 976 and HR 3963) to expand and extend SCHIP. Both bills were vetoed by President Bush. In December 2007, Congress passed S 2499 which extended SCHIP through **March 31, 2009.** This extension fell short of the SCHIP reauthorization efforts which would have significantly increased SCHIP funding. Issues around the income eligibility limit for children, crowd-out impacts, and treatment of immigrants, parents and childless adults as well as tobacco tax financing were the key stumbling blocks between Congress and President Bush. Thus, only the extension of the program to March 31, 2009 was agreed upon in 2007. Without further action from Congress, the SCHIP program will expire on April 1, 2009.

Current Debate Regarding Reauthorization: Staff assumes that the majority of the work on a new SCHIP reauthorization bill will occur after the new Congress and President are seated. Due to the short-time frame between January 20th and March 31, 2009, a likely scenario is that Congress will introduce

a bill with provisions similar to the last version of the 2007 SCHIP Reauthorization Bill (H.R. 3963). Table 1 below summarizes the major provisions that were contained in H.R. 3963.

Table 1: Provisions in Children's Health Insurance Program Reauthorization Act of 2007 (H.R. 3963)		
	Current Law	**Provisions in H.R. 3963**
Federal SCHIP Appropriations	Original law specified the amount of federal appropriations available through FFY 2007. The extension bill authorized federal appropriations through FFY 2008.	Contained specific federal appropriations for a five year period.
Allotment of federal SCHIP funds to states	Current allotments are based on the number of children who are low income and are uninsured. States have up to 3 years to spend their annual allotments.	Based primarily on actual and projected spending plus inflation for population growth and health care costs. Continency fund for spending in excess of allotments. States allowed 2 years to spend annual allotment.
Financing	General Fund	61 cent increase in per pack cigarette tax. $35 billion increase over 5 years.
Optional State Plan Amendment to cover adult pregnant women	Current, states can cover pregnant women ages 19 and older through a wavier provision.	Would allow states to cover adult pregnant women as a state plan option instead of as a waiver. Expands medical coverage to beyond prenatal, delivery, and post-partum care. ***Staff Comment:*** Colorado covers pregnant women through a waiver.
Non-pregnant adults	Section 1115 waivers allowed coverage for some childless adults.	Prohibits new 1115 demonstration waivers to cover childless adults. Allows a one-year transition period for the sic states with such waivers to move these populations to Medicaid.
Parents of Enrolled Children	Section 1115 waivers allowed coverage of parents.	No new waivers. Move to cap funds for parents on the program.
Children	Original legislation assumed 200% of FPL but income disregards have allowed some states to cover children up to 350% FPL.	No SCHIP coverage > 300% FPL (exception for NJ). ***Staff Comment:*** Colorado has the option to cover up to 250% FPL if funding is provided.
Crowd-out	42 C.R.R. 457.805 provides that States must have "reasonable procedures" to prevent substitution of public SCHIP coverage for private coverage.	All states must implement best practice on crowd-out provisions. ***Staff Comment***: In Colorado, children can not enroll in CBHP for 3 months if they had previous insurance coverage except in cases of loss coverage or unemployment.

Table 1: Provisions in Children's Health Insurance Program Reauthorization Act of 2007 (H.R. 3963)		
	Current Law	**Provisions in H.R. 3963**
Dental Services	Does not require dental benefits.	Requires dental benefits. ***Staff Comment***: Colorado already provides a dental benefit.
Mental Health Services	Does not require mental health benefits.	Mental health parity required if states offer mental health services. ***Staff Comment***: In Colorado S.B. 08-160 required the CBHP mental health services be equivalent to the benefits provided under Medicaid.

When asked about SCHIP Reauthorization, Joy Wilson, the NCSL health care lobbyist in Washington D.C., had the following comments:

> "*I think the outcome of reauthorization will depend on whether Congress builds on what was already agreed to in The Children's Health Insurance Program Reauthorization Act of 2007 or whether they start over again. Congress had a consensus [on H.R. 3963] ... so that seems like a reasonable place to start.*
>
> *However, there are some people who would like to start over and do some more things [to the program], though that will certainly slow the process down. If you draft legislation from scratch, all of the things people did and did not want in the bill are back on the table. The likelihood of working all that out between January and April is very unlikely. On the other hand, given that there is a general consensus on the previously enacted piece of legislation, then a reauthorization by April 1, might be possible.*
>
> *If reauthorization does not occur, then I assume Congress will extend the program for a few months in order to [allow more time for negotiations]. But for the states, that's not a good outcome. First, states will not know what the federal contribution towards their programs will be. And, secondly, many states will be out of session when the reauthorization occurs and, as a result, be unable to make needed budgetary changes.*"

Due to the timing of Colorado's legislation session and the time line for SCHIP Reauthorization, it will be difficult to react to any major changes passed by Congress during this budget cycle. The Committee will most likely be finalizing the Long Bill before or during the negotiations on the SCHIP Reauthorization Bill. Staff will keep the Committee apprised of any details in the SCHIP Reauthorization debate as she is made aware of the proposed changes or bills.

Mandatory Health Insurance Coverage for All Children: During the Presidential election, President-Elect Obama developed a health care proposal that would require mandatory health insurance coverage for all children. If this provision becomes part of the SCHIP Reauthorization Bill, there could be

significant costs to Colorado. Last year, the Lewin Group's analysis of Colorado's uninsured population estimated that approximately 70,125 of uninsured children are eligible for either Medicaid or the CBHP program.[2] If health insurance becomes mandatory for children and penalties are imposed for non-compliance (such as withholding tax refunds or imposing fees, etc.) more of these children would enroll in the public programs that they qualify for. At an average per-capita cost of $1,880.06 per Medicaid child and $1,775.92 for CBHP children, the cost for insuring eligible but not enrolled children could be as high as $124.5 million (of which the state match could range from $43.6 million to $62.3 million).

Because of the current economic conditions facing the federal government and states, staff does not believe that a mandatory insurance provision for children will be added to the SCHIP Reauthorization bill -- at least not initially. However, staff wanted to make sure that the Committee was aware of the potential state impact if such a provision is added.

A Quick Note About Crowd-Out: Last year the CBHP program's eligibility was expanded to 225% FPL for children beginning March 2009 and for pregnant women beginning October 2009. At the time this proposal was discussed the Department provided estimates regarding the number of clients that were potentially eligible (based on the 2007 Lewin Group estimates). Table 2 shows the caseload assumptions for the potentially eligible clients (as presented in the Department's February 2008 Budget Amendment).

Table 2: Potential Estimated Caseload Impact (Whole Universe of Expected Caseload)*

	Children 205% FPL to 225% FPL	Pregnant Women 205% FPL to 225% FPL
Estimated 2007 Uninsured Between 205% FPL to 225% FPL	5,649	329
Estimated 2007 Crowd-Out (group who will drop private insurance to join CBHP)	3,520	524
Total number of clients estimated eligible	9,169	853
% of potential eligibles uninsured	61.61%	38.57%
% of potential eligibles already insured	38.39%	61.43%

*This table does not show the caseload impacts in S.B. 08-160. Those caseload impacts are based on the gradual enrollment of the caseload. This table shows the estimated potentially eligible clients (not necessary those that enroll).

As the table shows, as income eligibility limits increase, the potential for additional clients opting out of private coverage increases. Almost 38 percent of the potential eligible children clients and 61.4 percent of adult pregnant women clients are anticipated to drop private insurance in favor of public insurance under the Children's Basic Health Plan.

[2]Characteristics of the Uninsured in Colorado, Draft, Lewin Group, July 12, 2007, p. 10. This analysis was performed for the 208 Commission on Health Care Reform. In modeling the different proposals, the Lewin Group used an uninsured number of 791,800. Of this amount, they estimated 10.82 were eligible for Medicaid or CBHP.

FY 2009-10 Joint Budget Committee Staff Budget Briefing
Department of Health Care Policy and Financing
(Executive Director's Office, Medical Services Premiums, Indigent Care Programs, Other Medical Services, and Commission on Family Medicine)

BRIEFING ISSUE

ISSUE: Solvency of the Health Care Expansion Fund

Beginning in FY 2011-12 the Health Care Expansion (HCE) Fund will experience deficit spending. Without an additional State match funding source, the State will need to either eliminate expansion health care populations currently funded with the HCE Fund or absorb a portion of these population's costs into the General Fund. Absorbing these populations into the General Fund will be difficult due to the annual six percent expenditure cap on General Fund appropriations.

SUMMARY:

- ❑ In FY 2007-08, non-interest revenue earnings in the Health Care Expansion (HCE) Fund were $75.0 million. Interest earning were $6.5 million. Expenditures from the HCE Fund were $76.4 million. The balance forward was $5.1 million.

- ❑ According to the Department's budget request, a total of $24.2 million in fund balance will be spent to support HCE Fund programs in FY 2008-09. In FY 2009-10 the Department's budget request indicates that an additional $37.8 million in HCE Fund balance will be spent down.

- ❑ By FY 2011-12 all of the available HCE Fund balance will have been spent and the HCE Fund programs will have a budget deficit of $37.1 million. Because the HCE Fund is used for expansion Medicaid or CBHP caseloads, either caseload eligibility will need to be changed or the another State funding source will be needed.

- ❑ Despite the looming fund deficit, the Department has refinanced additional costs onto the HCE Fund.

RECOMMENDATION:

1. During figure setting, staff will *not* recommend any additional refinancing from the HCE Fund than what is already required under past calculation methodologies with the exception of the asset test change adopted by the Committee during Figure Setting in March 2008.

2. The General Assembly must develop a permanent funding solution for these HCE Fund expansion populations. If a new revenue source is needed, then the revenue proposal must be available by the November 2010 ballot in order to avoid the HCE Fund deficit in FY 2011-12.

3. The Committee should discuss with the Department the long-term strategic plan for managing the costs of the expansion Medicaid and CHBP within existing resources or within new resources. If new resources are needed, what will be the source?

DISCUSSION:

The HCE Fund receives 46 percent of the total tobacco taxes collected pursuant Article X, Section 21 of the Colorado Constitution (Amendment 35). The HCE Fund can be used for three purposes: (1) expand enrollment in CBHP above FY 2003-04 enrollment; (2) add parents of enrolled children; and (3) expand eligibility of low income adults and children in either CBHP or Medicaid. The General Assembly has passed H.B. 05-1086, H.B. 05-1262, S.B. 07-2, and S.B. 08-99 to expand Medicaid and CBHP in order to use these funds.

During the first three years after Amendment 35 passed, total revenues into the HCE Fund exceeded expenditures. This was mainly due to the lag time from passing legislation to allocate the funds and when caseloads began to materialize from the legislative changes. *In FY 2007-08 expenditures from the HCE Fund exceeded non-interest revenues for the first time. However, due to the interest earnings in the HCE Fund, the fund balance grew by $5,068,485.*

Based on the Department's projections for FY 2008-09, the HCE Fund revenues will be $83.4 million and expenditures will be $107.6 million. Therefore, in order to pay the program costs the HCE Fund balance will be spent down by $24.2 million. In FY 2009-10, the Department forecasts that the HCE Fund revenues will be $82.2 million while expenditures from the HCE Fund will increase to $120.0 million. Thus, another $37.8 million in HCE Fund balance will be needed.

By FY 2011-12 all of the HCE Fund balance reserve will be expended and the funding shortfall for the HCE Fund programs will be $37.1 million based on the Department's forecasts. By FY 2012-13 the funding shortfall grows to $72.2 million. Absorbing these costs, as well as normal growth in the traditional Medicaid and CBHP programs (remember nationally Medicaid spending is anticipated to grow by approximately 7.9 percent during these years), will be a budget challenge. It is unlikely that the General Fund could easily absorb this cost without some relief.

Currently, the following populations or programs are eligible to be funded by the HCE Fund.

1. *Optional Legal Immigrants*: This population was added by H.B. 05-1083. In the past, the portion of the HCE Fund used for this population was $6.2 million (based on S.B. 03-176 savings for eliminating optional caseload). This amount has been held constant since FY 2004-05. However, the Department has managed to track costs for these clients through CBMS and the MMIS systems. In FY 2008-09 the Department estimates that the state match for optional legal immigrants will be $14.1 million. In FY 2009-10 the Department estimates the state match for optional legal immigrants will be $15.0 million. As stated in earlier issues, the Department requests FY 2008-09 and FY 2009-10 that all of the state match for optional legal immigrants be funded with the HCE Fund.

2. *Expansion Low-Income Adults*: These are low-income adults with income between approximately 34% and 60% of the federal poverty level (FPL). The Department estimates that the state match from the HCE Fund for this population is $14.8 million and $17.6 million in FY 2008-09 and FY 2009-10, respectively.

3. *Expansion Foster Care*: This expansion population was added last year in S.B. 07-2 and S.B. 08-99 and includes young adults from the ages of 19 to 21 that were in the foster care system prior to emancipation. The Department estimates that the state match from the HCE Fund for this population is $3.0 million in FY 2008-09 and $5.0 million in FY 2009-10.

4. *New Waiver slots for Children's HCBS Waiver:* This caseload expanded the waiver slots for the Children's HCBS Waiver. The Department estimates that the state match from the HCE Fund for this population is $10.0 million in FY 2008-09 and $10.3 million in FY 2009-10.

5. *New Waiver slots for Children's Extensive Support Waiver*: This caseload expanded the waiver slots for the Childrens Extensive Support Waiver. The Department estimates that the state match from the HCE Fund for this population is $1.6 million in FY 2008-09 and $1.7 million in FY 2009-10.

6. *Presumptive Eligibility for Pregnant Women*: The additional state match costs from the HCE Fund for presumptively eligible pregnant women is $1.9 million in FY 2008-09 and $2.0 million in FY 2009-10.

7. *Medicaid Asset Test - Adult and Children Expansion*: The state match costs from the HCE Fund for removing the Medicaid asset test is $32.4 million in FY 2008-09 and $34.1 million in FY 2009-10.

8. *Children's Basic Health Plan*: The HCE Fund eligible populations in the CBHP are estimated to have state match costs of $20.2 million in FY 2008-09 and $23.1 million in FY 2009-10.

If the Committee decides the policy should be to fund these populations from the General Fund once the HCE Fund balance has been exhausted, it may be prudent to gradually begin the cost shift now so that impact could be phased in over several years. For example, some of the smaller population costs, such as presumptive eligibility for pregnant women, expanded foster care, and legal immigrants could be shifted over to the General Fund in FY 2009-10. Of course, this options assumes that the FY 2009-10 General Fund revenues and appropriation needs would allow this refinance (which probably isn't likely).

If the Committee decides the policy should be to explore other funding sources to augment the HCE Fund, the Committee may want to consider amending the Constitution to eliminate the funding stream into the Primary Care Fund and placing this revenue into the HCE Fund. The Primary Care Fund receives approximately $31.3 million in Amendment 35 Tobacco Revenues annually. These revenues are distributed to providers who provide health care to the uninsured. This funding is not matched federal funds. If redistributed to the HCE Fund, this money would receive a 50 percent match for Medicaid

clients and a 65 percent match for CBHP clients. However, there are lot of issues that would need to be considered before moving forward with this option: (1) it would only temporarily solve the HCE Fund balance problem; and (2) it would eliminate funding that goes to help care for clients who are uninsured but not eligible for Medicaid and CBHP (such as non-disabled adults without children).

Table 1 below summarizes the Department's projections for the HCE Fund.

Table 1: Health Care Expansion Fund Outlook

	FY 2008-09	FY 2009-10	FY 2010-11	FY 2011-12	FY 2012-13
HCE Reserve Fund Balance	$135,721,615	$111,499,130	$73,689,947	$24,037,438	$0
Tobacco Tax Revenues	$76,600,000	$76,200,000	$76,400,000	$75,400,000	$75,008,166
Interest Earnings	$6,794,292	$6,006,372	$4,802,878	$3,181,998	$2,400,261
Total Revenues	$83,394,292	$82,206,372	$81,202,878	$78,581,998	$77,408,427
Program Expenditures	$107,616,777	$120,015,555	$130,855,387	$139,721,678	$149,613,997
Rev-Expenditure	($24,222,485)	($37,809,183)	($49,652,509)	($61,139,680)	($72,205,570)
Remaining HCE Reserve	$111,499,130	$73,689,947	$24,037,438	($37,102,242)	($72,205,570)

*This analysis is based on the Department's Budget Request.

FY 2009-10 Joint Budget Committee Staff Budget Briefing
Department of Health Care Policy and Financing
Executive Director's Office, Medical Services Premiums, Indigent Care Programs, Other Medical Services, and Commission on Family Medicine

BRIEFING ISSUE

ISSUE: Service Delivery and Outcomes

The Department requests $2.4 million total funds and 1.8 FTE in FY 2009-10 to develop and procure a medical delivery system that would coordinate the care and services for all Medicaid clients, regardless of age or health status. The Department anticipates that the coordinated care system will result in cost savings in future years as primary care access improves the health status of Medicaid clients.

SUMMARY:

- ❑ The Department proposes to regionally procure services from Accountable Care Organizations that would operate as Administrative Services Organizations providing enhanced Primary Care Case Management Services. This proposal builds on the concept of providing a "medical home" for all Medicaid clients. Initially, the procurement would be limited to 60,000 participants until the efficacy of the program could be demonstrated.

- ❑ The Department's proposal is a reversal of a long-standing managed care policy to advance capitation contracting. The Department has suspended efforts to expand risk-based managed care (although existing managed care contracts will remain in place). Under this model, the Department assumes all risk as well as pays a monthly management fee on a per-member per-month basis of $20.00 for care coordination.

- ❑ In addition to the Department's ASO proposal, the Department has implemented medical home initiatives for children, disease management programs, and the Colorado Regional Integrated Care Collaborative Initiative (CRICC) to improve health outcomes and control costs within the Medicaid program.

RECOMMENDATION:

1. Staff recommends that the Department present their Accountable Care Organizations proposal to the Committee at their budget hearing.

2. Staff recommends that the Department provide an update to the Committee on the three cost containment initiatives that the Department has implemented during the last two years: (1) Disease Management Programs; (2) Colorado Regional Integrated Care Collaborative Initiative; and (3) Medical Homes.

DISCUSSION:

Managed Care Background:

Currently, the Department has the following managed care arrangements in the Medical Services Premiums line item:

a) *Managed Care At-risk Capitation:* Denver Health, as Denver Health Medicaid Choice, has a risk-based capitation contract with the Department. This is a "traditional" managed care type contract where the provider is paid a capitation fee and must managed the costs of their caseload within their per member per month (PMPM) reimbursement.

b) *Program for All-Inclusive Care of the Elderly At-risk Capitation:* Currently, the Department contracts with Total Long Term Care to provide managed long-term care services for qualified Medicaid beneficiaries. This program is an at-risk capitated model that manages benefits for both the Medicaid and Medicare programs.

c) *Targeted Managed Care*: Last year, the Department entered into a contract with Colorado Access to operate the "Colorado Regional Integrated Care Collaborative Initiative (CRICC). The goal of this program is to better manage the care and costs of a subset of the highest-need, highest cost beneficiaries. The program is currently targeting 500 clients for enrollment and intervention.

d) *Prepaid Inpatient Health Plan*: Currently, the administrative service agreement (ASO) that the State has with Rocky Mountain HMO operates as a PIHP agreement under federal rules. Rocky Mountain HMO manages Medicaid clients but they are not paid a capitation rate. Rather the Department pays an administrative fee to Rocky Mountian HMO to open their provider network to Medicaid clients under their fee schedules. The State assumes the risk for these clients.

e) *Primary Care Physician Program:* Currently, the Department has a Primary Care Physician Program. This is a managed care choice where a client selects a primary care physician and must make all of their medical appointments through their chosen doctor (with some exceptions).

f) *Targeted Disease Management Programs*: The Department has six current disease management programs to target client with specific diseases.

Currently, the at-risk capitation arrangements serve approximately 40,343 clients and the Primary Care Physician Programs serves approximately 23,374 clients (9.6 percent and 5.6 percent of the Medicaid caseload, respectively).

Department's Proposal For Accountable Care Organizations

Building on their experience with Rocky Mountain HMO and the Behaviour Health Organizations (both of these arrangements are recognized as PIHP arrangements under federal rules), the Department proposes to divide the state into five health care regions. The Department would then undertake a statewide competitive bid process for physical health services that emphasizes the importance of increasing the availability and services of medical homes for all clients. The contractors, called Accountable Care Organizations (ACOs), would primarily be responsible for establishing a coordinated care delivery system for all clients. The Department also envisions that the ACO would coordinate care between different providers, assist in care transitions between hospitals and community care, and serve as a client advocate in navigating between physical health, behavioral health, wavier services, and long-term care. In addition, the Department anticipates that ACO contracts would also be performance based with guarantees established around health outcomes.

Under the Department's proposal, the ACO would receive a $20.00 per member per month management fee for care coordination. Of this amount, $16.00 would go directly to the ACO for administrative duties; and $4.00 would be placed into an escrow account to fund pay-for-performance incentives. With the increased coordination and emphasis on primary care, the Department anticipates that there would be immediate savings to the Medicaid program. Although not part of their current proposal, the Department is also considering a "shared outcomes" model whereby a percentage of net savings would be paid to providers to monetarily incent desired outcomes. The Department estimates that between 20 percent and 50 percent of the savings would be targeted for shared savings. Because no saving payments could be made until FY 2010-11, the Department would submit new budget estimates if and when they decide that incentive saving payments are feasible.

Initially, the Department plans to pilot this program to 60,000 clients. The Department would implement passive enrollment to ensure clients are enrolled in the program. The Department anticipates that they will eventually be able to save at least 12 percent of current per capita costs, although savings would start lower and increase over time. Therefore, in the first year, the Department anticipates only 8 percent savings. These savings would not be enough to cover the administrative fees the first year so there is a net cost increase during the first year of implementation.

The Department bases its costs estimates on experience from other states, most notably North Carolina. North Carolina has operated a Community Care Program since the early 1990s. The most recent study from Mercer indicates that their program has cost savings of approximately 17 percent from a traditional fee-for-service program.

Funding Summary:

With an initial investment of $2.4 million total funds in FY 2009-10, the Department estimates that the Medicaid program will have $4.4 million in savings by FY 2010-11 with possible greater savings as the program matures and more caseload is added. Table 1 on the following page summarizes the Department's estimated costs and savings for the ACO proposal.

Table 1: ACO Proposal FY 2009-10 and FY 2010-11					
Cost by Function Area	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**FTE**
Personal Services	$201,440	$100,720	$0	$100,720	1.8
Operating Expenses	$17,584	$8,792	$0	$8,792	0.0
Actuarial Services	$125,000	$62,500	$0	$62,500	0.0
Medicaid Management System	$1,058,400	$264,600	$0	$793,800	0.0
Enrollment Broker	$354,092	$177,046	$0	$177,046	0.0
External Quality Review	$105,000	$26,250	$0	$78,750	0.0
Medical Services Premiums (provider reimbursements)	$536,193	$259,142	$8,954	$268,097	0.0
Total FY 2009-10 COSTS	**$2,397,709**	**$899,050**	**$8,954**	**$1,489,705**	**1.8**
Personal Services	$327,409	$163,704	$0	$163,705	3.0
Operating Expenses	$2,850	$1,425	$0	$1,425	0.0
Actuarial Services	$125,000	$62,500	$0	$62,500	0.0
Medicaid Management System	$0	$0	$0	$0	0.0
Enrollment Broker	$567,170	$283,585	$0	$283,585	0.0
External Quality Review	$604,780	$151,195	$0	$453,585	0.0
Medical Services Premiums (provider reimbursements)	($5,989,463)	($2,929,431)	($65,300)	($2,994,732)	0.0
Total FY 2010-11 Costs/Savings	**($4,362,254)**	**($2,267,022)**	**($65,300)**	**($2,029,932)**	**3.0**

✓ ***Personal Services:*** As part of this initiative, the Department is requesting funding for 0.8 FTE in FY 2009-10 to provide contract management for the ASOs. These FTE annualize to 2.0 FTE in FY 2010-11. The Department also requests 1.0 FTE in both FY 2009-10 and FY 2010-11 to direct the Center for Improving Value in Health Care (CIVHC). Lastly, the personal services costs reflect contract for ombudsman services to ensure that clients have fair access and representation once they are enrolled in an ACO.

✓ ***Operating Expenses:*** These are the expenses associated with the FTE request.

✓ ***Medicaid Management System:*** These costs are associated with the system changes necessary to implement the proposal including: (1) changes to allow passive enrollment in counties other than Denver; (2) payment of the monthly administrative fees; and (3) data sharing with the ASOs.

✓ ***Enrollment Broker/External Quality Review:*** Per federal rule, Medicaid clients enrolled in managed care arrangements must be informed of their choices. The FY 2009-10 and FY 2010-11 costs for the enrollment broker reflect increase to the contract for producing and mailing this

information to the Medicaid clients involved in the project. In addition, the Department will need to increase funding for their External Quality Review Contract in order to conduct HEDIS audits and calculatons; perform site reviews; and perform encounter data audits.

✓ ***Medical Services Premiums:*** The Department's estimates for the MSP line item include the impacts of three administrative fees: (1) $20 administrative fee for Primary Care Case Management (PCCM); (2) $28.00 administrative fee to prepaid inpatient health plans (an increase of $3 from the current rate of $25.00); and (3) $20.00 administrative fee for Colorado Regional Intregated Care Collaborative. These cost increases are offset by estimated savings to medical costs based on eliminating improper emergency room use and unnecessary tests and therapies. The Department assumes that they can save 8.0 percent on the per capita costs of the clients enrolled in the program in FY 2009-10 and 10.0 percent on per capita costs in FY 2010-11. Table 2 below shows the Department's estimates for the Medical Services Premiums.

Table 2: Medical Services Premiums Costs and Savings from ASO Proposal

	FY 2009-10	FY 2010-11
PCCM Monthly Management Fee	$1,729,080	$14,296,260
Increase to PIHP Administration	$433,137	$433,137
CRICC Monthly Management Fees	$360,000	$360,000
Savings	($1,986,024)	($21,078,860)
Total Medical Services Premiums	$536,193	($5,989,463)

Besides the ACO proposal, the Department has a number of current strategies and programs for improving the health status of Medicaid clients while containing costs. These initiatives are discussed below.

The Center for Improving Value in Health Care

In February 2008, Governor Ritter issued Executive Order D 005 08 Establishing the Center for Improving Value in Health Care (CIVHC) "to develop a structured, well-coordinated approach to improving quality, containing costs, and protecting consumers in health care." As part of the Department's decision item on care delivery, the Department requests 1.0 FTE position to direct the activites of CIVHC. These activities include:

✓ creating a health care quality committee of relevant state departments, health care stakeholder organizations and individuals;

✓ establishing priorities, developing strategies, coordinating existing efforts and implementing strategies to improve health ccare quality and manage the growth of health care costs;

✓ researching quality forums or councils in other states, including best practices;

✓ identifying strategies for tying qualtiy measurement to rate setting methodologies.

The Department has received a grant from the Caring for Colorado Foundation to hire a director for CIVHC through the end of FY 2008-09. The Department anticipates that the director will continue with the project for the foreseeable furture, and therefore, requests funding on a permanent basis.

Disease Management Programs

Currently, the Department has six specific disease management programs. Last year, the Committee sponsored S.B. 08-118 to transfer $2.0 million annually from the Prevenition, Early Detection, and Treatment Fund to the for these disease management programs. This money is matched with $2.0 million in federal funds. The six disease management programs that the Department is operating include:

- ✓ Asthma (552 participants);
- ✓ Congestive Heart Failure (117 participants);
- ✓ Chronic Obstructive Pulmonary Disease (195 participants);
- ✓ Telehealth Pilot Program for Chronic Disease (157 participants);
- ✓ High Risk Obstetrics (1,469 participants); and
- ✓ Weight Management (1,000 participants).

With the exception of the Asthma program, most of the programs are just completing their first year and reports analyzing the initial results of the programs are not yet available. However, a 2007 evaluation of the Asthma program showed the following:

- ✓ 38.9% decrease in Emergency Room Utilization for clients in enrolled in the program;
- ✓ 46.8% reduction in patients with >=1 inpatient admit
- ✓ 57.4% reduction in patients with >=2 inpatient admits

Medical Homes

During the 2007 Session, the General Assembly passed S.B. 07-130, which required that the Department develop systems and standards to maximize the number of Medicaid children enrolled with a medical home. Last year, provider rates were increased for standard procedures up to 90 percent of the Medicare rate. In addition, the Department received funding to begin a pilot program with the goal of enrolling 124 providers and 10,000 children while providing pay for performance to physicians. The Department has exceeded this goal and currently has 160 providers (more than 70 percent of the pediatricians are part of the program) and 25,000 children in the program.

Providers enrolled as medical homes are responsible for ensuring healht maintenance and preventative care, health education, acute and chronic illness care and coordination of specialists, and therapies, provider participation in hospital care; and, twenty-four hour telephone care for all clients enrolled. The Department believes that the medical home concept will be fully integrated in their new ACO model.

FY 2009-10 Joint Budget Committee Staff Budget Briefing
Department of Health Care Policy and Financing
(Executive Director's Office, Medical Services Premiums, Indigent Care Programs, Other Medical Services, and Commission on Family Medicine)

BRIEFING ISSUE

ISSUE: Eligibility and Enrollment Processing

The Department requests $7.5 million total funds in FY 2009-10 in order to redesign and modernize the eligibility and enrollment process for the Department's medical programs. The amount of funding needed in FY 2010-11 for this multi-year project is $14.8 million total funds.

SUMMARY:

- ❏ In March 2008, the Committee approved an appropriation of $614,400 total funds for the Department to contract for a study to determine best practices for determining eligibility and to prepare a request for proposals (RFP) for an Eligibility Modernization Vendor (last Session this project was called the Centralized Eligibility Vendor). The Department contracted with Public Knowledge to conduct the study and the report is due to be released on November 28, 2008.

- ❏ Since June 5, 2008, the Department has been meeting with stakeholder groups to solicit input regarding the Eligibility Modernization Project.

- ❏ The Eligibility Modernization Project is a multi-year IT and business systems review project. Relatively speaking, it is a major investment of resources at a time when economic resources may not be available to fund the Department's growing caseloads.

RECOMMENDATION:

Staff recommends that the Department present the outcome of the "Best Practices Study" that was performed by Public Knowledge to the Committee at their hearing.

Staff recommends that the Department discuss the results of the recent PERM (payment error rate measurement project) as well as recent state audit findings regarding erroneous payments for ineligible clients and how the Eligibility Modernization Project may reduce these errors.

DISCUSSION:

Background: Currently, Medicaid and Children's Basic Health Plan eligibility determinations are performed by counties, contracted medical assistance sites, and school districts (pilot project). Eligibility is performed by an eligibility technician entering a client's application into the Colorado Benefit Management System. The eligibility technicians also verify the applicant's submitted information (such

as wage data, child support, etc). In FY 2008-09, approximately $26.2 million is appropriated for eligibility determination functions in the Department's EDO Division and another $3.9 million is in the CBHP Administration line item in the Indigent Care Division. Of this amount, $4.8 million is from local funds that the counties provide that draw a federal match. Thus, the $7.5 million total fund decision item for FY 2009-10 represents approximately 25.0 percent of the current funding that is spent on Medicaid and CBHP eligibility determinations.

Best Practice Study: As part of the Governor's "Building Block to Health Care Reform", the Department submitted a budget amendment in February 2008 to centralize eligibility determinations. Last Session, the Committee approved $614,400 total funds ($460,800 in FY 2007-08 and $153,600 in FY 2008-09) for the Department to contract for a "best practice study" and to prepare an RFP for an Eligibility Modernization Vendor. In May 2008, Public Knowledge was awarded the contract to conduct the "best practice study". The scope of work included in the contract with Public Knowledge included:

✓ Performing a "best practice study" for administering eligibility and enrollment functions including a review of existing delivery models, client enrollment access points, application intake, ongoing case maintenance, fraud and abuse monitoring, and recoveries;

✓ Conducting a comprehensive business process analysis, with accompanying cost benefit and return on investment analysis; and

✓ Assisting with developing the RFP for the Eligibility Modernization Vendor.

At the time the Department submitted their November budget request, the "best practice study" was not yet complete. Therefore, most the Department's estimates for the Eligibility Modernization Vendor contract are based on their February 2008 Budget Amendment assumptions. The Department anticipates receiving the "best practice study" on November 28, 2008 and will adjust their budget request based on the outcomes and recommendations from the study.

Stakeholder Input: Beginning in June 2008, the Department has been conducting stakeholder meetings to receive input regarding the Eligibility Modernization Project. The Department's budget request indicates that the stakeholder meetings have been instrumental for developing the following guiding principles for the project:

✓ Clients should receive their eligibility status timely and accurately.

✓ Clients should receive their benefits timely and accurately.

✓ Clients deserve predictability and consistency of results throughout Colorado.

✓ Government programs should be run efficiently and effectively.

- ✓ Eligibility processes should be streamlined and simplified in order to increase enrollment and retention. Technology should be used to further this objective.

- ✓ Clients should have a variety of self-service options available to learn about, apply for, enroll in, and retain health insurance coverage including the option for face-to-face guidance.

- ✓ Document management should meet minimum standards across the state.

- ✓ Clients deserve to be treated with dignity and respect.

- ✓ Clients should have the option of applying for public health insurance programs when they are applying for other human services programs.

Staff would note that some of the principles presented above change the original view of the project presented in the February 2008 Budget Amendment. Staff originally understood the project to eliminate most county responsibilities for eligibility determinations. The Department's budget request now indicates that the Department anticipates that county social services departments will continue to have a role in the eligibility and enrollment process. However, until the best practices for administering eligibility have been identified, the exact level of participation in the eligibility and enrollment process is indeterminate.

Costs for the Eligibility Modernization Project: Currently, the General Assembly has invested $614,400 total funds ($460,800 in FY 2007-08 and $153,600 in FY 2008-09). The first phase of the project was to develop a "best practice study" and to write an RFP. The next phase of the project, which will begin in FY 2009-10, is to higher a vendor to develop the necessary systems for a modernized eligibility system.

Table 1 below shows the Department's estimated cost components for FY 2009-10 and FY 2010-11.

Table 1: Eligibility Modernization Project Costs for FY 2009-10 and FY 2010-11

	Total Funds	General Fund	Cash Funds	Federal Funds	FTE
FY 2009-10					
Personal Services	$174,304	$83,070	$0	$91,234	2.8
Operating Expense	$18,534	$8,830	$0	$9,704	0.0
Professional Services and Special Contracts	$100,000	$47,854	$0	$52,146	0.0
Centralized Eligibility Vendor Contract Project	$7,741,136	$3,704,405	$0	$4,036,731	0.0
County Administration	($505,842)	($252,921)	$0	($252,921)	0.0
Total FY 2009-10	$7,528,132	$3,591,238	$0	$3,936,894	2.8
FY 2010-11					
Personal Services	$190,150	$90,622	$0	$99,528	3.0

Table 1: Eligibility Modernization Project Costs for FY 2009-10 and FY 2010-11					
	Total Funds	**General Fund**	**Cash Funds**	**Federal Funds**	**FTE**
Operating Expense	$2,850	$1,359	$0	$1,491	0.0
Centralized Eligibility Vendor Contract Project	$22,572,998	$10,801,970	$0	$11,771,028	0.0
County Administration	($4,046,742)	($2,023,371)	$0	($2,023,371)	0.0
CBHP Administration	($3,919,590)	$0	($1,371,857)	($2,547,733)	0.0
Total FY 20010-11	$14,799,666	$8,870,580	($1,371,857)	$7,300,943	3.0
Total 2-year	$22,327,798	$12,461,818	($1,371,857)	$11,237,837	3.0

Under the Department's proposed project time line, the Eligibility Modernization Vendor would begin performing Medicaid eligibility (although this may change to CBHP eligibility) for one county beginning in January 1, 2010. The Department's proposal assumes that the Eligibility Modernization Vendor would be performing eligibility for all counties by July 1, 2012.

In FY 2009-10, the Eligibility Modernization Vendor costs include:

- ✓ $1.0 million for start-up;
- ✓ $0.7 million for electronic document management;
- ✓ $1.75 million for customer contact center;
- ✓ $3.59 million for Medicaid eligibility and enrollment personnel;
- ✓ $0.7 million for administrative costs.

In FY 2009-10 the Department also requests $100,000 total funds for a contractor to access the impact to other programs administered by the County Departments and Department of Human Services.

Systems and Responsibilities of the Eligibility Modernization Vendor: Under the Eligibility Modernization Vendor contract the following systems would be developed:

- ✓ ***Electronic Document Management System:*** This is a computer system used to track and store electronic documents and/or images of paper documents. The vendor would provide a central repository for all documents related to Medicaid and CBHP applications.

- ✓ ***Workflow Process Management System:*** This is an electronic document system that routes documents through the business process as each increment of work is completed within a Que. Once applications are imaged, the applications and related documents would be routed to the appropriate work queues for follow-up and completion.

✓ ***Customer Contact Center:*** The Eligibility Modernization Vendor would also provide a customer contact center. The Department anticipates that the Customer Contact Center would utilize software, which will be linked to the Electronic Document Management System. Please note that calls not relating to eligibility and enrollment would be screened and forwarded to the Department's current Customer Service Section.

✓ ***Virtual Application Gateway:*** Additionally, the Department anticipates that the Vendor would develop a Virtual Application Gateway. This gateway would be similar to the presumptive eligibility determination system developed in the Colorado Benefits Management System. The Virtual Application Gateway would be primarily used by hospitals, community health centers and other health care providers to assist clients in electronically applying for Medicaid and CBHP coverage.

A Quick Observation About Eligibility Determination Process Now: During the State Auditor's review of the CBHP program, the Auditor found a 10 percent eligibility error rate for the CBHP program based on a sample they reviewed (21 out of 203 reviewed). The CBHP cost for these 21 clients was a total of $48,300 due to the eligibility errors determined. Some of the clients had multiple eligibility errors. Reasons for the eligibility errors that the Auditor identified included:

Applicants enrolled erroneously in CBHP

- ✓ one applicant's family income exceeded CBHP income limit (CBMS error);
- ✓ one applicant was ineligible due to having private insurance (eligibility worker error);
- ✓ three applicants were children of state employees (eligibility worker error);
- ✓ eleven applicants had family incomes low enough to qualify for Medicaid instead of CBHP (seven were eligibility worker error and four appeared to be CBMS error);
- ✓ one applicant met the requirements of CHP+ Work program but was denied enrollment (eligibility worker error);
- ✓ nine applicants had missing documentation supporting their eligibility determination (four had missing family income documentation and five applicants met the Medicaid requirements but the application had missing pages or required signatures).

The State Auditor's findings are somewhat similar to the national findings for payment error rates for the Medicaid and SCHIP programs. In November 2008, CMS released their estimate of improper payments for the Medicare, Medicaid and SCHIP. According to the CMS data, the Medicaid composite payment error rate is 10.5 percent and the SCHIP rate is 14.7 percent rate. The majority of Medicaid and SCHIP errors were due to providers not submitting adequate documents for the claims paid. However, other errors are due to services provided under Medicaid or SCHIP to beneficiaries who were not eligible for either program or who were not eligible for the services received. At the time this issue was written, staff did not have the Colorado data from the PERM study. However, the Department should have the Colorado data by the time of their hearing.

Staff uses the findings from the State Auditor report and national PERM study to emphasize that problems with the current eligibility system determinations results in additional costs to the State. There

is a possibility that modernizing and investing in the work processes surrounding eligibility could be beneficial to the State budget if erroneous eligibility determinations are reduced.

Staff Concerns: Initially, the Eligibility Modernization Project will result in additional costs to the State. Staff believes that it could be several years, if ever, for this investment to result in efficiencies or effectiveness savings. In addition, staff is not totally convinced that the customer service gains will be immediate (initially staff believes there would be a lot of consumer confusion about where to call or go for assistance). Staff continues to have budgetary concerns about the project for the following reasons:

1) The Department's proposal in unclear on how administrative cost will be lessened in the long run. The counties will still need to perform Medicaid eligibility for clients that apply for Food Stamps and TANF. The Department's proposal now has a vision that there should be "no wrong door" and that "face to face" help should be available to clients. Therefore, staff believes that the counties and the Eligibility Modernization Vendor will both perform Medicaid and CBHP eligibility. Even if most of the eligibility is performed by the vendor, as long as the counties process other welfare or health benefits, they will still field questions about Medicaid and CBHP. The counties will continue to have administrative costs even with the best case scenario. Therefore, staff anticipates that there will be some duplication of effort.

2) Processing applications faster may have an initial increase to the State budget. Currently, for clients who are *not already* using health care services, the current processes inefficiencies delay some health care costs. Staff anticipates that once the Eligibility Modernization Vendor is fully implemented there would be a one-time cost due to expenses being moved forward due to a shortening of the application and approval process. (This is a one-time concern. The state budgets on a fiscal year basis not a forever basis -- if budgeted on a forever basis this would not be a concern). This impact will also be lessened due to the Department's phased-in approach for the project.

3) Improving eligibility determinations should help the State enroll and retain those children and families who are eligible but not enrolled in Medicaid and CBHP. As stated in an earlier issue, if all children eligible for Medicaid and CBHP were enrolled the cost could be as high as $124.5 million. If the end goal of making eligibility processes faster and easier for families is to eliminate the barriers that exist to enrolling these children, then State must first find a sustainable and growing revenue source to pay for this new initiative.

4) Health care benefits will be fragmented away from other social benefits. Clients who go through the Eligibility Modernization Vendor will not have their eligibility checked for other public benefit programs. Thus, health care could be segmented out from nutrition, housing, child care, welfare, and other needs for the most at-risk low-income clients (although most of these clients would still go through the counties for social services help).

FY 2009-10 Joint Budget Committee Staff Budget Briefing
Department of Health Care Policy and Financing
(Executive Director's Office, Medical Services Premiums, Indigent Care Programs, Other Medical Services, and Commission on Family Medicine)

BRIEFING ISSUE

ISSUE: Medicaid Prescription Drug Initiatives

The Department seeks funding for two new prescription drug initiatives that should result in cost savings of $31,507 in FY 2009-10 and $1.1 million in FY 2010-11. The Department also forecasts $3.8 million in additional savings from prescription drug initiatives enacted last year.

SUMMARY:

- ❏ In FY 2009-10, the Department requests $750,000 total funds to automate prior authorization for prescription drugs. This administrative costs is offset by $737,764 total funds in prescription drug savings. In FY 2010-11, prescription drug savings are anticipated to increase to $1.6 million total funds.

- ❏ In FY 2009-10, the Department requests $225,000 for a State Maximum Allowable Cost Contractor. This administrative costs is offset by $285,123 total funds in prescription drug savings. In FY 2010-11, the administrative costs are anticipated to increase to $300,000 total funds while prescription drug savings are anticipated to increase $510,806 total funds.

- ❏ The Department's FY 2009-10 request indicates a total decrease of $3.8 million total funds from prescription drug savings related to the preferred drug list, pharmacy pricing, mail order prescription drugs, and drug rebates for physician and hospital administered drugs.

RECOMMENDATION:

1. Staff recommends that the Department present the costs savings related to the different prescription drug initiatives implemented over the last several years at their budget hearing.

2. Staff recommends rescinding last year's budget action to increase pharmacy dispensing fees for retail pharmacies to $5.60.

DISCUSSION:

Prescription drugs remain one of the top five expenditures in the Medical Services Premiums line item despite the passage of the Medicare Modernization Act of 2003.

✓ **FY 1995-96**: Prescription drug costs were $64.9 million or 10.5 percent of acute care spending.

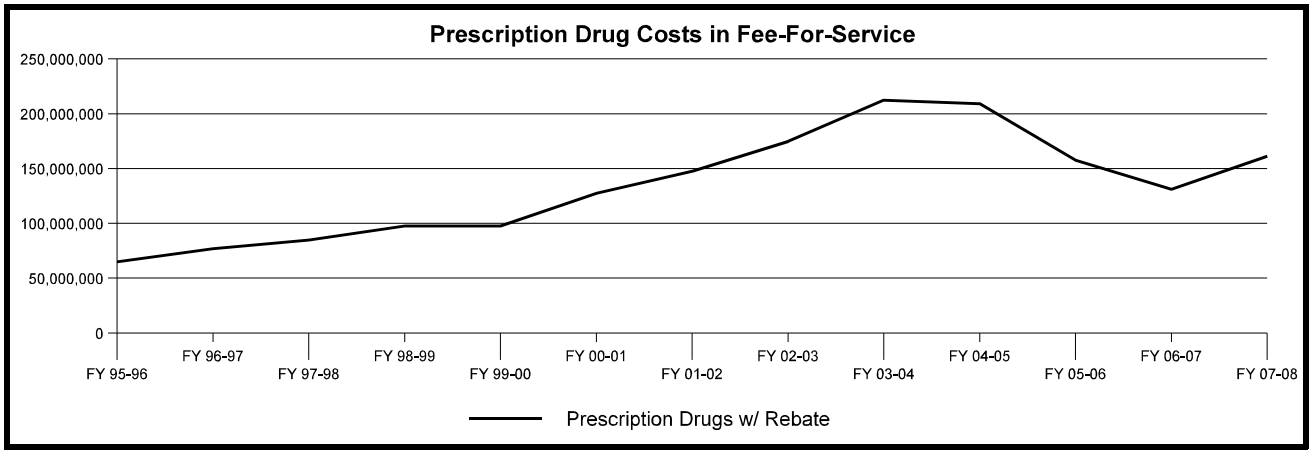
✓ **FY 2004-05**: Prescription drug costs were $209.3 million or 17.6 percent of acute care spending.

✓ **FY 2005-06**: Prescription drug costs were $147.9 million or 13.0 percent of acute care spending (1/2 year impact of Medicare Modernization Act of 2003).

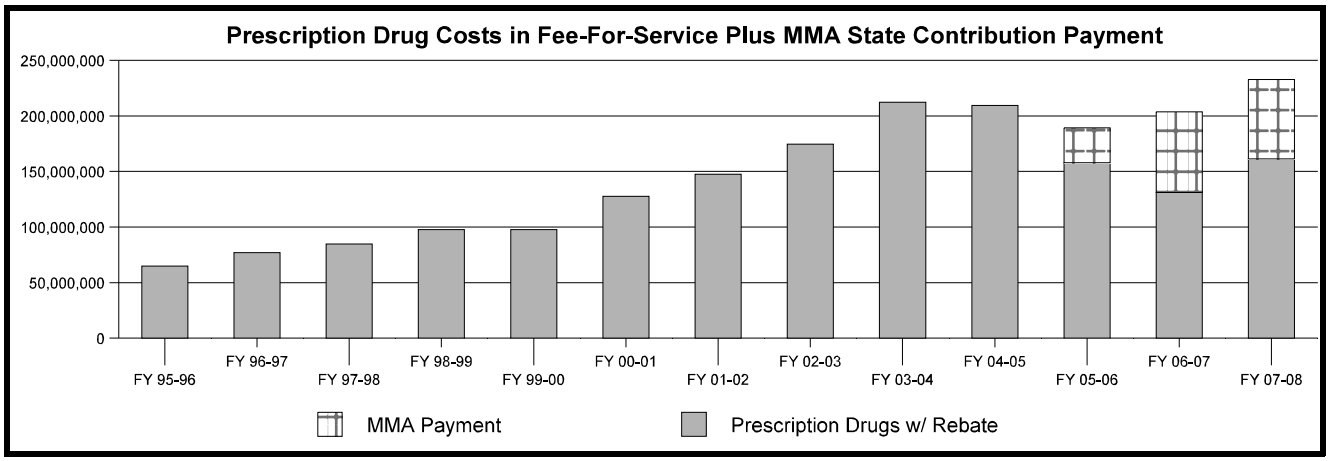
✓ **FY 2006-07:** Prescription drug costs were $131.2 million or 10.9 million of acute care spending (full year impact of Medicare Modernization Act of 2003).

✓ **FY 2007-08**: Prescription drug costs were $161.4 million or 12.1 percent of acute care costs.

The graph below shows the costs of prescription drug costs in the Medical Services Premiums line item.



The graph below shows the cost or prescriptions drugs in the MSP line item plus the amount of the Medicare Modernization Act (MMA) State Contribution Payment.



Both of the charts on the preceding page indicate that prescription drug costs are rising again for the Medicaid program. This should be expected due to increasing caseload and drug costs. However, without proper controls and oversight, the Medicaid prescription drug benefit will present even a greater budget challenge. To address this concern, the Department has proposed two new initiatives in their FY 2009-10 budget request. These initiatives attempt to control both the demand for higher cost drugs and the price of drugs as discussed below.

Automated Prior Authorizations

Current Process: Currently, the Department has prior authorization requirements for certain drug classes. The number of drugs anticipated to require a prior authorization will continue to grow as more drug classes are added to the Department's preferred drug list. The current process for handling prior authorizations is cumbersome for the providers and the Department's contractor. Every time a prior authorization is requested, the provider must submit a form. While some forms for certain drug classes can be submitted electronically, other forms must be faxed to the contractor. Additionally, pharmacists in long-term-care pharmacies and infusion pharmacies must obtain a signature from someone authorized to prescribe before they submit prior authorization forms.

Once the forms are submitted to the contractor (Affiliated Computer Systems), each prior authorization is individually reviewed for approval. The Department anticipates as the preferred drug list adds more classes, ACS will need to handle additional prior authorizations. This will drive greater administrative costs for the MMIS contract and may slow down the approval process (which can take up to 24 hours).

Automated Process: In order to avoid future administrative costs and to improve customer service, the Department proposes that the prior authorization process be automated. An automated prior authorization system screens pharmacy claims against client information from the medical and pharmacy database and determines if a client meets the prior authorization approval criteria. This process takes seconds and can occur at the point of sale. Some drugs classes would retain the current process with a written form. However, the Department that most drugs could be prior authorized through the automated system.

Estimated Costs: The Department estimates that in FY 2009-10, the automated prior authorization process would result in savings of $737,764 total funds to the Medical Services Premiums line item. The Department anticipates that these savings will result from putting 12 drug classes on prior authorization lists. These savings are anticipated to grow to $1.6 million total funds. These savings are in addition to the Department's savings estimates for the preferred drug list. These savings are offset by the costs to the automated prior authorization contract of $750,000 total funds in both fiscal years. The contractor is anticipated to have $375,000 in development costs in the first year and then monthly management costs of $62,500 thereafter.

State Maximum Allowable Costs

Current Process: The Department currently determines pharmacy reimbursement rates based on the lowest rate as determined by four different pricing methodologies.

a. The Federal Upper Payment Limit (UPL) for prescription drugs is calculated as 150 percent of the Average Wholesale Price (AWP) of the least costly therapeutic equivalent in a multiple-source drug group. The Federal UPL is published every 6 months and is only used for drugs for which three generic equivalents are available. Approximately 36 percent of all pharmacy claims are subject to the Federal UPL.

b. Average Wholesale Price is calculated on a national basis as the average price at which wholesalers of prescription drugs sell to pharmacies, and is adjusted downward before use by the Department by 13.5 percent for brand name drugs and 35 percent for generic drugs to arrive at the price (the exception is that rural pharmacies receive AWP - 12 percent for all drug classes). approximately 33 percent of all pharmacy claims are subject to this methodology.

c. Usual and Customary Charge is defined as the prevailing price charged by a pharmacy to final consumers of a drug. Approximately 23 percent of all pharmacy claims were paid using this pricing methodology.

d. Direct Price is represents a manufacturer's published category or list price for a drug product to non-wholesalers. Approximately 8 percent of pharmacy claims were paid using this pricing methodology.

Proposed Process: The Department proposes adding one more methodology to the four mentioned above to determine pharmacy reimbursement. The Department proposes a State Maximum Allowable Cost (MAC) reimbursement methodology. Under the MAC methodology, the reimbursement would be determined as the average acquisition cost plus 18 percent. The markup would serve to both ensure that pharmacies are not reimbursed below acquisition costs and to create incentives for greater pharmacy participation. The Department would use the lowest of the five pricing methodologies. However, in the case that the lowest pricing methodology would fall below acquisition costs, the Department would then use the MAC rate to ensure that pharmacies are not underpaid for a drug.

Additional savings are anticipating from moving to a MAC program because: (1) more drug classes can be covered under this methodology than are under the federal UPL, and (2) the reimbursement rates may fall under the federal UPL for certain drugs.

Currently 45 states have MAC programs.

Estimated Costs: The Department estimates that in FY 2009-10, the MAC program would result in savings of $285,123 total funds to the Medical Services Premiums line item. In FY 2010-11, these savings are anticipated to grow to $510,806 total funds. These savings are offset by the costs to the implement

the MAC of $225,000 in FY 2009-10 and $300,000 in FY 2010-11. The administrative costs reflect a monthly contract amount of $25,000 (based on the state of Indiana's experience). The first reflects only 9 months of operation while in the 2nd year the costs are fully annualized.

Status of Deficit Reduction Act (DRA) Average Manufacture Price(AMP) Rule Change.

On July 15, 2008, Congress passed the Medicare Improvements for Patients and Providers Act of 2008 which placed a moratorium on implementing the DRA rule for AMP pharmacy pricing until October 1, 2009. Last year during figure setting the Committee approved staff's recommended savings of $1.0 million total funds in the Medical Services Premiums line item based on assumed implementation of the DRA AMP Rule by April 2009. The Committee also approved $1.0 million total funds to increase pharmacy dispensing fees from $4.00 to $5.60 beginning in April 2009. Based on the moratorium on the DRA AMP Rule, staff recommends that the there be no increase to the pharmacy dispensing fee. In addition, the Department has indicated that the CMS would require a study justifying the increase in dispensing fees before the state plan amendment would be approved. It is unlikely that the CMS would approve the dispensing fee increase by April 2009 anyway. Therefore, during figure setting this year, staff will recommend that this issue be eliminated from the calculations for the FY 2008-09 budget and from the FY 2009-10 budget calculations.

Other Prescription Drug Issues Contained in the Department's FY 2009-10 Budget Request

The Department's budget request reflects cost savings for these on-going pharmacy initiatives as follows.

1. **Preferred Drug List (PDL):** The Department anticipates that there will be savings of $644,362 total funds resulting from the PDL. As of November 3, 2008, the Department has implemented seven drug classes on the PDL including: proton pump inhibitors, sedative-hypnotics, statins, antihistamines, antihypertensives, opiods, and attention deficit hyperactivity disorder drugs. The Department is currently reviewing other drug classes and anticipates that 11 classes will be added by or during FY 2009-10.

   Currently, the Department has decided that the following drug classes will not be included on the PDL prior to December 31, 2009: atypical and typical antipsychotics (excluding immunosuppressants and anticonvulsants); drugs used for the treatment of HIV/AIDS; drugs used for the treatment of hemophilia; and drugs used for the treatment of cancer.

2. **340 B Pharmacy Pilot Program:** The Department anticipates savings of $858,583 total funds resulting from the 340 B Pharmacy Pilot Program. A 340 B pharmacy is a federally administered program that allows covered entities to provide low-priced outpatient prescription drugs to their patients. The pilot program tries to encourage, when possible, clients to purchase drugs through a 340 B pharmacy in order to receive the pricing discounts received by 340 B pharmacies.

3. **S.B. 08-090:** The Department's budget request reflects the annualized cost savings of $199,480 total funds for implementing S.B. 08-090. Senate Bill 08-090 made the following two changes regarding mail-order prescription drugs for the Medicaid program: it allows Medicaid clients to use a mail-order pharmacy if they have third-party insurance and require maintenance medications, and it authorizes a mail-order pharmacy to bill Medicaid for the difference between the Medicaid co-payment and a third-party insurer's co-payment or deductible.

4. **Drug Rebates for Physician and Hospital-Administered Drugs:** The Department's budget request reflects a savings of $2.1 million total funds for additional drug rebates received from physician and hospital administered drugs. As a result of the DRA 2005, the Department is now able to collect drug rebates on drugs administered directly by physicians and hospitals. Previously, the Department was unable to invoice these rebates due to the lack of information provided in the billing of these claims. The new federal regulations in place require physicians and hospitals to provide national drug code information.

Staff recommends that the Committee discuss with the Department at their hearing the past cost savings calculated from prior drug initiatives including but not limited to the PDL, prior authorizations, and drug utilization and review programs.

FY 2009-10 Joint Budget Committee Staff Budget Briefing
Department of Health Care Policy and Financing
(Executive Director's Office, Medical Services Premiums, Indigent Care Programs, Other Medical Services, and Commission on Family Medicine)

BRIEFING ISSUE

ISSUE: Medicaid Long-Term Care

Expenditures for community and institutional long-term care services were approximately $780 million in FY 2007-08. The Department estimates that cost will rise to $824.9 million (5.8 percent increase) in FY 2008-09 and to $874.3 million (6.0 percent increase) in FY 2009-10.

SUMMARY:

- ❏ The State Plan Amendment and Provider Fee Demonstration Waiver for nursing home reimbursement was sent to the Centers for Medicare and Medicaid Services on September 30, 2008. Currently, the Department believes that the waiver will be implemented in April 2009, according to the original assumptions for H.B. 08-1114.

- ❏ The Department's budget request does not include any community provider rate increases for FY 2009-10.

- ❏ Beginning in April 2008, the Department has convened a standing Long-Term Care Advisory Committee to provide input on identifying strategies and policy directions for meeting the future long-term care program needs.

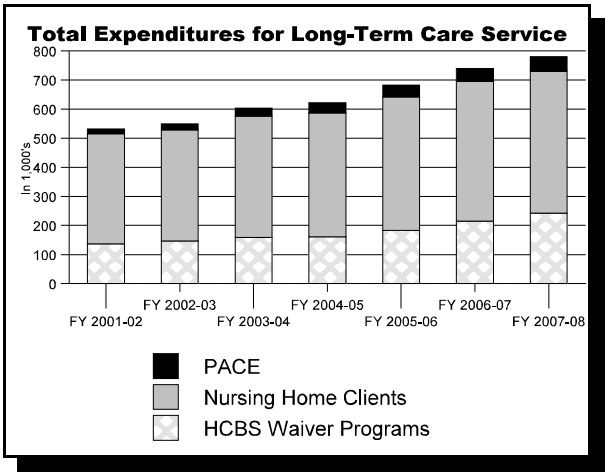
DISCUSSION:

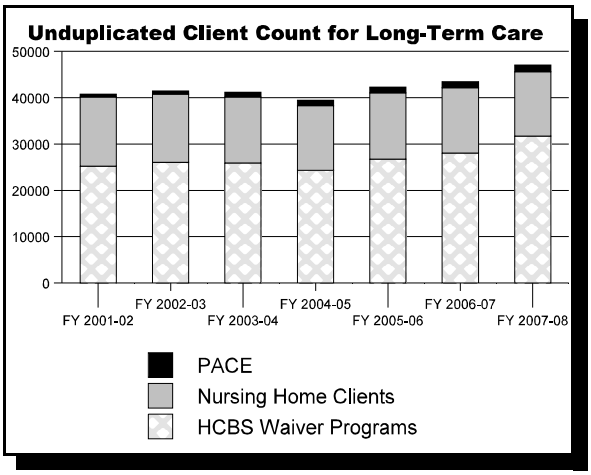
Background

Long-term care services (community long-term care waivers, class I & II nursing facilities, and the PACE program) were 35.0 percent of total Medical Service Premium service costs in FY 2007-08. While long-term care services represent only about one third of all Medical Service Premium costs, they are one of the fastest growing cost drivers. Since FY 2001-02, expenditures have climbed from $531.3 million to $780.0 million in FY 2007-08 (an increase of $248.7 million or 46.8 percent in seven years). To put this in perspective, during the same time period acute care services increased from $952.2 million in FY 2001-02 to $1.3 billion in FY 2007-08 (an increase of $383.8 million or 40.0 percent).

In FY 2007-08, the costs for long-term care services were approximately 62.7 percent from nursing facility care, 31.0 percent from home and community-based waiver services (HCBS), and 6.3 percent for the Program for All-Inclusive Care for the Elderly (PACE) program. Conversely, in FY 2007-08 the

number of clients served were approximately 67.2 percent (31,683 unduplicated clients) in HCBS waivers, 29.5 percent in nursing facility settings (13,907) and 3.2 percent (1,501) in PACE.





Due to people living longer and aging of the baby boomer population, caseload and costs for long-term care services are anticipated to increase dramatically during the next few decades.

Department's FY 2008-09 and FY 2010-11 Request

Nursing Facility Care: Class 1 nursing facility costs result essentially from multiplying the rate determined for each facility based on the statutory formula by the average daily census in nursing facilities offset by any estate or income trust recoveries. Prior to the passage of H.B. 08-1114, the statutory reimbursement methodology was facility specific, based on the facility's actual costs adjusted for resident acuity. Because the system was cost-based, statutory caps on reimbursement were established in order to contain costs and to narrow the range of rates paid. House Bill 08-1114 changed the methodology for nursing home reimbursement as follows:

- ✓ eliminated the 8% Health Care and 6% Administrative and General cap on cost increases; general services;
- ✓ established an Administrative and General price set based on 105% of the medical cost for all facilities;
- ✓ established per diem rates for direct and indirect care, capital assets, and performance quality;
- ✓ provided an additional per diem payment for clients with severe mental health conditions or cognitive dementia; and
- ✓ added reimbursement for speech therapy services.

In addition, under H.B. 08-1114 nursing homes will be charge a quality assurance fee. The fees will be used to increase the payments to nursing facilities for Medicaid clients based on the new reimbursement system. The fee can also be used for administrative costs associated with charging the fee and to limit

the growth of General Fund appropriations to nursing facilities to 3.0 percent annually. The new nursing facility reimbursement methodology is conditional upon the federal approval of the fee.

The anticipated increase to nursing home reimbursements due to the passage of H.B. 08-1114, is $11.9 million in FY 2008-09 and $15.4 million in FY 2009-10. Additionally, the Department estimates that the General Fund will be offset by nursing facility fees by approximately $4.0 million FY 2008-09 and by $8.7 million in FY 2009-10 due to the 3.0 percent cap on General Fund Expenditures.

The original implementation plan for H.B. 08-1114 assumed waiver approval by April 2009. The Department submitted the waiver on September 30, 2008 and currently anticipates that the original implementation plan will be met.

Table 1 below summarizes the Department's request for Class 1 Nursing Facilities.

Table 1: Class 1 Nursing Facility Estimates for FY 2008-09 and FY 2009-10

	FY 2008-09	FY 2009-10
Estimated Per Diem Allowable Medicaid Rate (average rate)	$179.18	$187.34
Deduct Estimated Patient Per Diem Payment	($30.82)	($31.98)
Estimated Medicaid reimbursement per day	$148.36	$155.36
Estimated Patient Days	3,355,212	3,323,690
Estimated Costs (Patient Days multiplied by reimbursement rate)	$497,779,252	$516,368,478
Deduct Expenditures Estimated to by payed after Fiscal Year	($36,088,996)	($37,436,715)
Add Expenditures Paid for Prior Fiscal Year	$33,870,607	$36,088,996
Adjustments for Hospital Back-up, Estate Recovery & Audit	($2,252,340)	($2,835,590)
Current Methodology Reimbursement Estimate	$493,308,524	$512,185,170
Adjustment for H.B. 08-1114 impact to reimbursement	$11,854,320	$15,397,478
Estimated Payments for Class I Nursing Facilities	$505,162,844	$527,582,648
Estimated Payments for Class II Nursing Facilities*	$2,261,792	$2,288,255
TOTAL NURSING FACILITY COSTS	**$507,424,636**	**$529,870,903**

*Good Shepherd Lutheran operates as a class II facility and serves between 16 to 20 clients. This facility serves developmentally disabled client and operates more like a group home than a nursing facility.

Community Care

The Department forecasts that Home-and Community-Based Services (HCBS) waivers will be $259.5 million in FY 2008-09, an increase of 7.35 percent over the FY 2007-08 actual. For FY 2009-10, the Department is forecasting that HCBS waiver will be $269.6 million, a 3.89 percent increase. The Department's forecast is based on a trend analysis with a few adjustments for recent policy changes

(including pediatric hospice waiver, consumer directed care, and impact from more clients enrolling in PACE).

The Department's request for FY 2009-10 does not include any provider rate increases. While nursing facilities rates are based on a statutory formula and increase each year, Home and Community-Based Rates are only increased if the Committee and General Assembly appropriate additional funding for the rate increases (i.e. usually as part of the adopted common policy for all community providers). For example, in FY 2008-09 a 1.5 percent rate increase was provided.

PACE

The Department forecasts that the Program for All-Inclusive Care for the Elderly (PACE) program will be $58.0 million in FY 2008-09, an increase of 17.34 percent over the FY 2007-08 actual. For FY 2009-10, the Department is forecasting that the costs for the PACE program will be $74.8 million, a 29.04 percent increase. Reasons for the increase include:

✓ The PACE program includes nursing facility care and therefore, are impacted by the increase in the nursing home rates;

✓ Rates for the PACE program were increased to 100 percent of the fee-for-service rates in H.B. 08-1374 (a Committee sponsored bill);

✓ New PACE providers are being added to the program. A new provider began serving clients in Montrose and Delta counties in September 2008. In January 2009, the Department anticipates adding another provider to El Paso county. For purposes of calculating the budget impact, the Department assumed that an average monthly caseload of 34 clients would result from these new providers in FY 2008-09. However, by FY 2009-10, an average monthly caseload of 241 clients is forecasted from these new sites.

Strategic Planning for the Meeting the Future Demand for Long-Term Care

Starting in April 2008, the Department convened a standing Long-Term Care Advisory Committee to provide input on future policy direction for long-term care services. The Advisory Committee has identified four topic areas for future focus:

- ✓ eligibility reform;
- ✓ integrated & coordinated care; and
- ✓ building capacity and infrastructure.

Eligibility reform includes looking at issues related to expedited enrollment and are discussed in the Department's Eligibility Modernization Project. The Department has also been discussing with the stakeholder's the possibility of piloting of medical assistance sites within the Single Entry Point system.

The integrated and coordinated care workgroup is discussing how long-term care services and supports are integrates with physical health and behavioral health in order to improve health outcomes. Two managed care models, PACE and the Colorado Regional Integrated Care Collaborative (CRICC) are being looked at as possible managed care strategies.

The Building Capacity and Infrastructure workgroups are focusing on understanding where current provider system gaps exists and the strategies needed to ensure adequate services will be available to meet the increasing demands for the system.

FY 2009-10 Joint Budget Committee Staff Budget Briefing
Department of Health Care Policy and Financing
Executive Director's Office, Medical Services Premiums, Indigent Care Programs, Other Medical Services, and Commission on Family Medicine

BRIEFING ISSUE

ISSUE: Medicaid Reform Initiatives

The Department's FY 2009-10 budget requests includes a total fund reduction of $1.7 million resulting from six Medicaid reform initiatives: (1) Medicaid Benefit Package Reform; (2) Health Outcomes Measurement Initiative; (3) Fluoride Varnish Benefit; (4) Hospital Back Up Program Enhancements; (5) Oxygen Durable Medical Equipment Reform; and (6) Serious Reportable Events Initiative.

SUMMARY:

- ❏ The Department's FY 2009-10 budget requests reflects a net total fund savings of $1.7 million due to six Medicaid reform initiatives. The Department anticipates that these initiatives will result in savings of $2.5 million total funds in FY 2010-11.

- ❏ Four of the initiatives (Medicaid Benefit Package Reform; Health Outcomes Measurement Initiative; Fluoride Varnish and Serious Reportable Events), have initial benefit or administrative costs before any savings are anticipated to occur. The FY 2009-10 costs for these four initiatives is $607,646 total funds.

- ❏ The Department estimates that two of the initiatives (Hospital Back Up Program Enhancements and Oxygen Related Durable Medical Equipment) have immediate cost savings. The FY 2009-10 cost savings for these two initiatives is estimated at $2.3 million total funds.

RECOMMENDATION:

1. Staff recommends that the Department present their Medicaid reform initiatives to the Committee at their budget hearing.

2. The Committee should be cautious in accepting first year cost savings estimates for reforms that require building provider capacity or require state plan amendments regarding the scope and duration of services and reimbursement rate changes.

3. As part of any reform package, the Department should implement a research verification tool to measure cost savings netted against administrative costs.

DISCUSSION:

As part of their FY 2009-10 budget request, the Department has identified savings of $1.7 million total funds from six Medicaid reform initiatives. The Department anticipates that the costs savings from these initiatives will grow to $2.5 million in FY 2010-11. In addition, the Department believes that these initiatives will help improve the health outcomes for Medicaid clients by ensuring proper benefit packages and services. Following is a brief discussion of each initiative.

Medicaid Benefit Package Reform

The Department requests an increase of $300,000 total funds in both FY 2009-10 and FY 2010-11 to conduct a comprehensive review of the current fee-for-service benefit package offered under the Medicaid plan. The goals of this review are as follows:

- ✓ Establish a process for endorsing best medical practices and benefit determinations;
- ✓ Establish a process for consideration and endorsement of new procedure and equipment;
- ✓ Defining and/or refining the amount, duration, and scope of the mandatory and optional State Plan services provided;
- ✓ Defining a systematic process for consideration of requests to exceed amount, duration, scope, and frequency limitations when medically necessary;
- ✓ Establishing a process to use for outreach to stakeholders seeking input on benefit definition and limitations; and
- ✓ Exploring the feasibility of consolidating the prior authorization review process for mandatory and optional services into one reviewing agency.

Health Outcomes Measurement Initiative

The Department is requesting $141,964 total funds in FY 2009-10 to implement a process to survey the health and functional outcomes of Medicaid clients. The Department currently administers surveys to clients through the Consumer Assessment of Health Plans Survey (CAHPS). This survey measures client satisfaction with their health plan and plan providers. However, this survey does not measure self-reported functional health status.

In addition to the CAHPS, the Department also collects data from the Health Plan Employer Data Information Set (HEDIS). This data collection allows the Department to measure certain clinical data that is taken from claim data and/or medical reviews. For example, this data allows the Department to determine how many clients are receiving immunizations.

In addition to these two measures, the Department would like to implement a survey-based evaluation model for clients to self-report their health status information. Through this survey, clients would be asked to rate different aspects of their daily functioning such as: physical functioning, bodily pain, general health, vitality, social functioning, emotional functioning, and mental health. The Department believes that this survey would assist them in determining if a clients' health is improving or declining while

receiving Medicaid services. The survey results could help the Department target future initiatives related to health and disease management programs.

Fluoride Varnish

The Department requests $146,182 total funds in FY 2009-10 in order to initiate a fluoride varnish benefit for Medicaid children up to the age of six. Fluoride varnish is a topical agency containing a high concentration of fluoride in a resin or synthetic base and is painted directly onto teeth. The Department cited studies that demonstrate that children receiving 3 to 4 fluoride varnish treatments over a 2 year period showed a statistically significant decrease in cavities. In FY 2009-10, the Department anticipates that 4,016 clients will receive the benefit at a cost of $36.40 per client. The Department anticipates that both dentists and primary care providers will be able to provide the treatment.

Hospital Back Up Program Enhancements

As part of their Medicaid Reform initiative, the Department request an increase of $100,000 total funds for administrative costs associated with increasing access to the Hospital Back-Up Program. These administrative costs are offset by a total estimated savings of $1,937,867 in FY 2009-10.

The Hospital Back-Up Program has existed since 1987 and admits patients whose conditions require around-the-clock oversight and treatment for rehabilitation and chronic conditions. Given the complexity of the care required by these patients, discharge to a nursing home or into the community is not appropriate. However, without a hospital back-up program the patient would remain in higher cost inpatient bed. Currently, the hospital back-up program has about 30 bed available and cost approximately $5.2 million in FY 2007-08. The program is currently at capacity. When the Department surveyed hospitals, the Department was able to identify that about 30 more clients could benefit from an adult hospital back-up program. In addition, the Department believes that another 30 beds could be filled for a pediatric hospital back-up program.

As a result of the increased demand for Hospital Back-Up Beds, the Department proposes a change in the rate structures to provide an incentive for more providers to enter the program. The Department proposes offering reimbursement rates based on the federal guidelines set forth under the Prospective Payment System (PPS) for skilled nursing facilities. The Department also proposes supplementing the PPS rate with a quality incentive Medicaid add-on based on the type of facility. Accredited beds associated with a hospital would receive a 15 percent incentive payment and accredited beds associated with stand alone facilities would receive an additional 10 percent incentive payment. The ***average*** of the new rates that would be paid is $369.73 for the adult back-up program (compared to the average $1,216.09 per day outlier reimbursement rate). For the Prediatric Hospital back-up program, the Deparment proposes a fixed per day rate of $650.00 (compared to the average $1,439.72 per day outlier reimbursement rate).

Oxygen Durable Medical Equipment Administrator

As part of their reform package, the Department requests in FY 2009-10 $73,463 and 1.0 FTE for an Oxygen Durable Medical Equipment Administrator. These administrative costs are anticipated to be offset by total fund savings of $574,260 in FY 2009-10.

While the Department has a contractor to perform prospective and retrospective reviews for durable medical equipment, the current contract does not cover reviews for oxygen durable medical equipment claims. For the last three fiscal years, oxygen related expenditures were the highest expenditure category for the durable medical equipment benefit service category. The Department has identified four possible ways to contain costs for oxygen supplies and equipment:

- ✓ Create an oxygen prior authorization request or oxygen certificate of medical necessity and require the form for all oxygen patients;
- ✓ Establish gate-keeping provisions that require documentation of hypxemia levels along with retesting after 90 days;
- ✓ Combine select oxygen procedure codes and reimburse providers for a complete oxygen system rather than a base oxygen unit and several accessories; and
- ✓ Rent-to-own alternatives for high-cost oxygen equipment.

By implementing these alternatives, the Department anticipates that they would be able to save approximately 2.0 percent of costs for oxygen durable equipment costs. On an estimated base of $28.7 million a 2.0 percent reduction equates to $574,260 in total fund savings in FY 2009-10.

Serious Reportable Events Initiative

Serious reportable events are identified as avoidable errors that occur during hospitalization. National momentum is currently building around ending payment for these events as a way to improve patient safety. The Department requests $19,500 for administrative costs associated with performing manual review and adjustments to claims paid for serious reportable events. While the Department anticipates that there will be eventual cost savings from this initiative, the amount is indeterminate. The Department's Medicaid Management Information System currently lacks an indicator which identifies claims processed for these events.

Staff Observations

The total administrative costs associated with the Department's six initiatives in FY 2009-10 is $781,109 total funds and 0.9 FTE. These costs are offset by estimated savings of $2,512,127 total funds in FY 2009-10. Table 1 on the following page summarizes the costs and savings for these initiatives.

Table 1: Medicaid Reform Initiatives Cost Savings				
	Total Funds	**General Fund**	**Federal Funds**	**FTE**
Medicaid Benefit Reform -- administrative costs	$300,000	$150,000	$150,000	0.0
Health Outcomes Survey -- administrative costs	$141,964	$70,982	$70,982	0.0
Fluoride Varnish -- benefit cost	$146,182	$73,091	$73,091	0.0
Hospital Back-up Program Enhancements -- administrative costs	$100,000	$50,000	$50,000	0.0
Oxygen Durable Medical Equipment -- administrative costs	$73,463	$36,731	$36,732	0.9
Serious Reportable Events -- administrative costs	$19,500	$9,750	$9,750	0.0
Total Administrative Costs	$781,109	$390,554	$390,555	0.9
Hospital Back-up Program -- Cost Savings	($1,937,867)	($968,933)	($968,934)	0.0
Oxygen Durable Medical Equipment -- Cost Savings	($574,260)	($287,130)	($287,130)	0.0
Total Cost Savings	($2,512,127)	($1,256,063)	($1,256,064)	0.0
Total Reform Savings (cost savings - administrative costs)	($1,731,018)	($865,509)	($865,509)	0.9

The two initiatives above with cost savings in FY 2009-10 require adding additional provider capacity, implementing rates subject to state plan amendment, and researching and analyzing ways to restructure the oxygen benefit. Staff has some concern on whether cost savings for these proposals will be realized in the first year.

For example, the Department has not fully justified the oxygen durable medical equipment savings estimated in their request. In their request, the Department states, " *this FTE (related to the Oxygen initiative) will spend approximately two years analyzing and implementing alternative oxygen related processes. This will include researching options, communicating with the [CMS] regarding federal guidelines, compiling cost savings estimates, conducting stakeholder meetings to solicit feed back .....*". Also according to the Department's request, "*System development costs or modifications may be required for the [MMIS] ....The Department may submit an additional budget action if system modifications are determined to be necessary to implement portions of this Request*.". However, the savings request is based on a cost reduction of 2.0 percent to all oxygen related expenditures. While this may be a modest savings estimate, the timing of any savings during a year when research, rules, and meeting with stakeholder's is occurring raises staff concerns. Staff does not have concerns about the appropriateness of these Medicaid reform or about their long-term benefits to the Medicaid program. Staff concerns are solely regarding whether it is appropriate to reduce appropriations by the amount of assumed cost savings before those cost savings can be demonstrated.

Lastly, in all requests (or legislation) that result in estimated reductions to the Medical Services Premiums line item, staff would recommend a provision to require a follow-up analysis on whether the cost savings occurred and how to measure the impact.

FY 2009-10 Joint Budget Committee Staff Budget Briefing
Department of Health Care Policy and Financing
(Executive Director's Office, Medical Services Premiums, Indigent Care Programs, Other Medical Services, and Commission on Family Medicine)

BRIEFING ISSUE

ISSUE: Adequacy of Family Medicine Medical Training Funding

The Commission on Family Medicine requests an increase of $200,000 total funds ($100,000 General Fund) to help suport expanding access to primary care by increasing the capacity of Colorado's family medicine residency training.

SUMMARY:

- In FY 2001-02, the Commission's total funds budget was $2,364,545 total funds. The Commission's FY 2009-10 total fund appropriation request is $2,373,558 total funds. This request will restore funding back to the original levels before the budget cuts during the last economic downturn.

DISCUSSION:

Background: The Commission on Family Medicine distributes funding for the support of nine family medicine residency programs at hospitals throughout the State and assists in the recruitment of residents to these programs. Funding for the Commission is contained solely in the Department of Health Care Policy and Financing in two line items: (1) Other Medical Services; Commission on Family Medicine Residency Training Programs; and (2) Other Medical Services; State University Teaching Hospitals, University of Colorado Hospital Authority.

Budget Request: In FY 2001-02, the Commission had a total funds budget of $2,364,545. During the budget reduction years, the Commission's budget was reduced by approximately 33.3 percent to a funding low in FY 2004-05 of $1,576,501. Beginning in FY 2006-07, the Committee has gradually been approving increases for the Commission. The Commission's FY 2009-10 budget request for $2,373,558 total funds restores the Commission's funding to just above the FY 2001-02 level.

The Commission's request will increase funding to each residency program from $241,506 to $263,728 ($22,222 per residency program). The increase in funding will offset some of the costs of training residencies. Staff would note that Commission's funding provides only a fraction of the funding necessary to maintain residency programs. The majority of funding for the residency programs come from the Medical Edcuation program funded by the federal government. However, the state funding helps the hospitals mitigate some of the operating losses that the residency programs have been experiencing.

FY 2009-10 Joint Budget Committee Staff Budget Briefing
Department of Health Care Policy and Financing
(Executive Director's Office, Medical Services Premiums, Indigent Care Programs, Other Medical Services, and Commission on Family Medicine)

BRIEFING ISSUE

ISSUE: Centennial Cares Choice Program

As required by S.B. 08-217, the Department released a request for information (RFI) on October 8, 2008 to health insurance carriers and other interested parties to gather information about what benefits could be offered to currently uninsured populations. The responses for the RFI are due on December 2, 2008.

SUMMARY:

- ❑ Last Session, the General Assembly passed S.B. 08-217. This bill required the Department of Health Care Policy and Financing, in coordination with the Division of Insurance and a panel of experts, to prepare a request for information from health insurance carriers and other interested parties. Carriers were requested to provide information regarding the design of a new health insurance product, known as a value benefit plan (VBP), to be offered in the individual market.

- ❑ The Department released the RFI on October 8, 2008. The responses from the RFI are due on December 2, 2008. Based on the responses from the RFI, the bill requires the Department to provide the House and Senate Health and Human Services Committee with a preliminary report by December 15, 2008, and a final report with legislative recommendations by March 1, 2009.

RECOMMENDATION:

Staff recommends that the Department present their preliminary findings to the Committee during their budget hearing on December 17, 2008.

DISCUSSION:

Senate Bill 08-217, commonly called the Centennial Care Choice bill, established a process for the Department, inconjunction with the Division of Insurance, to gather information from health insurance carriers about what benefits could be offered in a "Value Benefit Plan" to cover more of the uninsured population in Colorado.

At a minimum, proposals for VBPs must be based on the following:

- ✓ the lowest level of benefits allowed in the state's individual health insurance market, including primary and preventive care and participation in wellness programs;

- ✓ the use of health information technology, telemedicine, and internet-based health care education materials and tools;

- ✓ encouragement of pay-for-performance systems for reimbursing health care providers and other innovative or collaborative efforts within communities including community health centers, hospice providers, and other safety net providers;

- ✓ rate setting based on age and geographic location of the policyholder with optional coverage choices for consumers;

- ✓ premium payment through a state-paid premium subsidy if appropriate; and

- ✓ protection of the existing small group and individual markets and the CoverColorado program.

In October 2008, the Department released a request for information (RFI) to solicit information from insurance carriers regarding how a VBP could be designed and operated. Consistent with the provisions in the S.B. 08-217, the interested parties were told to consider the following assumptions in their responses:

- ✓ all Coloradans will be required to obtain health coverage;

- ✓ a VBP will be the minimum benefits package available in the individual market;

- ✓ a premium subsidy program to assist low-income individuals and families will be created;

- ✓ Medicaid will be expanded to include adults with income up to 100 percent of the federal poverty level; and

- ✓ a dedicated source of revenue will be available.

Responses from the RFI are due on December 2, 2008. Based on the responses from the RFI, the bill requires the Department to provide the House and Senate Health and Human Services Committee with a preliminary report by December 15, 2008, and a final report with legislative recommendations by March 1, 2009. Staff recommends that the Department present their preliminary findings to the Joint Budget Committee during their budget hearing on December 17, 2008.

FY 2009-10 Joint Budget Committee Staf Budget Briefing
Department of Health Care Policy and Financing
Appendix A: Number Pages Summary
Source: November 1st Submittal

	FY 2008-09 Appropriation	FY 2008-09 Estimate	Difference Est. - App	FY 2009-10 Request	Difference rom FY 08-09 Ap	% Difference	Difference rom FY 08-09 Est	% Difference
Executive Director's	**108,375,680**	**108,379,680**	**4,000**	**118,685,074**	**10,309,394**	**9.5%**	**10,305,394**	**9.5%**
FTE	**272.7**	**272.7**	**0.0**	**282.40**	**9.7**	**3.6%**	**9.7**	**3.6%**
General Fund	36,693,562	36,695,562	2,000	41,378,804	4,685,242	12.8%	4,683,242	12.8%
Cash Funds	8,783,862	8,783,862	0	8,731,581	(52,281)	-0.6%	(52,281)	-0.6%
Reappropriated Funds	1,790,768	1,790,768	0	1,796,132	5,364	0.3%	5,364	0.3%
Federal Funds	61,107,488	61,109,488	2,000	66,778,557	5,671,069	9.3%	5,669,069	9.3%
Medical Services Premiums	**2,322,097,599**	**2,425,437,694**	**103,340,095**	**2,553,643,846**	**231,546,247**	**10.0%**	**128,206,152**	**5.3%**
General Fund & GFE	1,072,222,480	1,102,486,011	30,263,531	1,151,820,047	79,597,567	7.4%	49,334,036	4.5%
Cash Funds	85,281,324	105,634,733	20,353,409	120,138,335	34,857,011	40.9%	14,503,602	13.7%
Reappropriated Funds	2,767,998	2,809,192	41,194	2,898,693	130,695	4.7%	89,501	3.2%
Federal Funds	1,161,825,797	1,214,507,758	52,681,961	1,278,786,771	116,960,974	10.1%	64,279,013	5.3%
Medicaid Mental Health	**209,385,156**	**213,499,512**	**4,114,356**	**227,400,509**	**18,015,353**	**8.6%**	**13,900,997**	**6.5%**
General Fund	97,698,852	98,816,799	1,117,947	104,029,226	6,330,374	6.5%	5,212,427	5.3%
Cash Funds	6,976,195	7,914,409	938,214	9,650,492	2,674,297	38.3%	1,736,083	21.9%
Reappropriated Funds	7,205	7,648	443	8,451	1,246	17.3%	803	10.5%
Federal Funds	104,702,904	106,760,656	2,057,752	113,712,340	9,009,436	8.6%	6,951,684	6.5%
Indigent Care Program	**578,671,842**	**578,671,842**	**0**	**585,021,004**	**6,349,162**	**1.1%**	**6,349,162**	**1.1%**
General Fund & GFE	37,196,662	37,196,662	0	41,467,202	4,270,540	11.5%	4,270,540	11.5%
Cash Funds	238,412,149	238,412,149	0	234,498,835	(3,913,314)	-1.6%	(3,913,314)	-1.6%
Reappropriated Funds	15,525,328	15,525,328	0	20,182,659	4,657,331	30.0%	4,657,331	30.0%
Federal Funds	287,537,703	287,537,703	0	288,872,308	1,334,605	0.5%	1,334,605	0.5%
Other Medical Services	**136,308,131**	**136,308,131**	**0**	**139,502,021**	**3,193,890**	**2.3%**	**3,193,890**	**2.3%**
General Fund	83,443,350	83,443,350	0	88,856,271	5,412,921	6.5%	5,412,921	6.5%
Cash Funds	31,692,000	31,692,000	0	31,692,000	0	0.0%	0	0.0%
Reappropriated Funds	3,980,000	3,980,000	0	1,891,768	(2,088,232)	-52.5%	(2,088,232)	-52.5%
Federal Funds	17,192,781	17,192,781	0	17,061,982	(130,799)	-0.8%	(130,799)	-0.8%
DHS Programs	**409,136,487**	**409,132,487**	**(4,000)**	**434,456,089**	**25,319,602**	**6.2%**	**25,323,602**	**6.2%**
General Fund	201,601,008	201,599,008	(2,000)	214,304,732	12,703,724	6.3%	12,705,724	6.3%
Cash Funds	1,609,689	1,609,689	0	1,593,167	(16,522)	-1.0%	(16,522)	-1.0%
Reappropriated Funds	1,460,341	1,460,341	0	1,509,278	48,937	3.4%	48,937	3.4%
Federal Funds	204,465,449	204,463,449	(2,000)	217,048,912	12,583,463	6.2%	12,585,463	6.2%
DEPARTMENT TOTAL	**3,763,974,895**	**3,871,429,346**	**107,454,451**	**4,058,708,543**	**294,733,648**	**7.8%**	**187,279,197**	**4.8%**
FTE	**272.70**	**272.70**	**0.0**	**282.4**	**9.7**	3.6%	**9.7**	3.6%
General Fund & GFE	1,528,855,914	1,560,237,392	31,381,478	1,641,856,282	113,000,368	7.4%	81,618,890	5.2%
Cash Funds	372,755,219	394,046,842	21,291,623	406,304,410	33,549,191	9.0%	12,257,568	3.1%
Reappropriated Funds	25,531,640	25,573,277	41,637	28,286,981	2,755,341	10.8%	2,713,704	10.6%
Federal Funds	1,836,832,122	1,891,571,835	54,739,713	1,982,260,870	145,428,748	7.9%	90,689,035	4.8%

FY 2009-10 Joint Budget Committee Staff Budget Briefing
Department of Health Care Policy and Financing
Appendix A: Number Pages

	FY 2006-07 Actual	FY 2007-08 Actual	FY 2008-09 Appropriation	FY 2009-10 Request	Change Req. #	% Change from App.

Department of Health Care Policy and Financing
Executive Director: Joan Henneberry

(Primary Functions: Administration of Medicaid, the Colorado Indigent Care Program, S.B. 00-71 Comprehensive Primary and Preventative Care Grant Program, Old Age Pension Health and Medical Fund Services, and the Children's Basic Health Plan).

---

(1) Executive Director's Office/1

(Primary Functions: Provides all of the administrative, audit and oversight functions for the Department. This Division contains 7 Subdivisions.)

Adminstration
(Primary Functions: Contains all of the personal services costs, operating costs, and centrally appropriated costs for the Department)

Personal Services/1	**15,260,951**	**20,382,113**	**19,015,961**	**20,525,566**	DI #5, 6, 11, 12
FTE	231.8	243.8	271.7	282.4	BRI #2
General Fund	6,054,845	8,021,372	7,876,614	8,385,216	IBC #s: 8.01, 8.02, 8.03, 8.04, 8.05
Cash Funds	0	0	731,501	786,800	8.06, 8.51, 9.51, 9.81, 10.01, 10.02
CFE/Reappropriated Funds	399,006	2,328,843	1,557,401	1,564,984	10.03, 10.12, 10.15
Federal Funds	8,807,100	10,031,898	8,850,445	9,788,566	
Health, Life, and Dental/2	**748,309**	**0**	**1,278,471**	**1,414,691**	IBC #8.01 & 10.16
General Fund	334,784	0	578,598	640,247	
Cash Funds	0	0	28,315	31,332	
CFE/Reappropriated Funds	24,355	0	35,213	38,965	
Federal Funds	389,170	0	636,345	704,147	
Short-term Disability/2	**15,110**	**0**	**22,871**	**22,360**	IBC #8.01 & 10.17
General Fund	6,286	0	9,538	9,324	
Cash Funds	0	0	818	800	
CFE/Reappropriated Funds	401	0	1,795	1,755	
Federal Funds	8,423	0	10,720	10,481	

FY 2009-10 Joint Budget Committee Staff Budget Briefing
Department of Health Care Policy and Financing
Appendix A: Number Pages

	FY 2006-07 Actual	FY 2007-08 Actual	FY 2008-09 Appropriation	FY 2009-10 Request	Change Req. #	% Change from App.
Equalization						
Disbursement/2	**93,197**	**0**	**279,035**	**344,000**	IBC #8.01 & 10.18	
General Fund	41,256	0	114,941	141,702		
Cash Fund	0	0	10,057	12,398		
CFE/Reappropriated Funds	2,092	0	22,096	27,240		
Federal Funds	49,849	0	131,941	162,660		
S.B. 06-235 Supplemental						
AED/2	**0**	**0**	**128,887**	**215,000**	IBC #8.01 &10.19	
General Fund	0	0	51,968	86,689		
Cash Fund	0	0	4,714	7,864		
CFE/Reappropriated Funds	0	0	10,358	17,278		
Federal Funds	0	0	61,847	103,169		
Salary Survey and						
Senior Executive Service/2	**459,483**	**0**	**676,435**	**394,749**	IBC #10.01 & 10.20	
General Fund	198,893	0	304,849	177,902		
Cash Funds	0	0	10,395	6,066		
CFE/Reappropriated Funds	11,087	0	21,487	12,539		
Federal Funds	249,503	0	339,704	198,242		
Performance-based Pay Awards/2	**0**	**0**	**251,236**	**0**	IBC #10.02 & 10.21	
General Fund	0	0	112,340	0		
Cash Funds	0	0	4,417	0		
CFE/Reappropriated	0	0	9,131	0		
Federal Funds	0	0	125,348	0		
Worker's Compensation	**25,760**	**25,363**	**32,346**	**32,395**	NP #10	
General Fund	12,880	12,682	16,173	16,198		
Federal Funds	12,880	12,681	16,173	16,197		

FY 2009-10 Joint Budget Committee Staff Budget Briefing
Department of Health Care Policy and Financing
Appendix A: Number Pages

	FY 2006-07 Actual	FY 2007-08 Actual	FY 2008-09 Appropriation	FY 2009-10 Request	Change Req. #	% Change from App.
Operating Expenses	**1,242,074**	**980,465**	**1,825,072**	**1,893,483**	DI # 5, 6, 11, & 12;	
General Fund	609,487	469,925	878,741	916,225	BRI #2; NP #9 & 12;	
Cash Funds	0	0	23,307	19,505	IBC #8.01, 8.03, 8.05, 8.06, 8.07	
CFE/Reappropriated Funds	8,151	24,209	13,377	13,461	8.51, 8.52, 9.81, 9.82, & 9.83	
Federal Funds	624,436	486,331	909,647	944,292		
Legal and Third Party Recovery						
Legal Services	**763,821**	**739,856**	**982,984**	**982,984**	IBC #9.51	
General Fund	318,913	307,656	399,045	399,044		
Cash Funds	62,998	61,932	87,378	87,378		
Federal Funds	381,910	370,030	496,561	496,562		
Administrative Law Judge Services	**380,930**	**438,975**	**469,789**	**487,941**	NP #11	
General Fund	190,465	219,488	234,895	243,971		
Federal Funds	190,465	219,487	234,894	243,970		
Computer Systems Costs	**0**	**15,973**	**135,103**	**135,103**		
General Fund	0	4,650	65,883	65,883		
CFE/Reappropriated Funds	0	3,337	3,337	3,337		
Federal Funds	0	7,986	65,883	65,883		
Payment to Risk Management and						
Property Funds	**101,810**	**60,484**	**71,989**	**71,989**		
General Fund	50,905	30,242	35,995	35,995		
Federal Funds	50,905	30,242	35,994	35,994		
Leased Space	**166,899**	**248,164**	**394,236**	**477,036**	DI #11	
General Fund	77,950	118,582	191,619	233,019		
Cash Funds	0	0	5,500	5,500		
CFE/Reappropriated Funds	5,500	5,500	0	0		
Federal Funds	83,449	124,082	197,117	238,517		

FY 2009-10 Joint Budget Committee Staff Budget Briefing
Department of Health Care Policy and Financing
Appendix A: Number Pages

	FY 2006-07 Actual	FY 2007-08 Actual	FY 2008-09 Appropriation	FY 2009-10 Request	Change Req. #	% Change from App.
Capitol Complex Leased Space	**344,022**	**397,238**	**395,208**	**395,208**		
General Fund	172,011	198,619	197,604	197,604		
Federal Funds	172,011	198,619	197,604	197,604		
General Professional Services and Special Projects	**0**	**0**	**2,443,584**	**3,267,298**	DI #5 & 6; BRI # 1 & 2	
General Fund	0	0	1,099,292	1,384,003	IBC # 7.01, 7.35, 7.36, 8.02,	
Cash Funds	0	0	62,500	0		
Federal Funds	0	0	1,281,792	1,883,295	8.04 & 8.08	
Appropriation for H.B. 08-1114	**0**	**0**	**239,936**	**0**	IBC #9.81	
FTE	0	0	1.0	0		
General Fund	0	0	119,968	0		
Federal Funds	0	0	119,968	0		
						Request vs. Appropriation
SUBTOTAL -- Executive Director's Office, General Administration						
Total Funds	**19,602,366**	**23,288,631**	**28,643,143**	**30,659,803**		**7.04%**
FTE	231.8	243.8	272.7	282.4		3.56%
General Fund	8,068,675	9,383,216	12,288,063	12,933,022		5.25%
Cash Funds	62,998	61,932	968,902	957,643		-1.16%
CFE/Reappropriated Funds	450,592	2,362,127	1,674,195	1,679,559		0.32%
Federal Funds	11,020,101	11,481,356	13,711,983	15,089,579		10.05%

/2 Due to a change in OSPB budget instructions, FY 2007-08 actuals for these line items are shown in the FY 2007-08 actuals for personal services line item.

	FY 2006-07 Actual	FY 2007-08 Actual	FY 2008-09 Appropriation	FY 2009-10 Request	Change Req. #	% Change from App.
(B) Transfers to Other Departments						
(Primary Functions: Contains administrative costs that are transferred to other Departments that administer programs eligible for Medicaid funding).						
Transfer to the Department of Public Health and Environment for Facility Survey and Certification	**4,006,727**	**4,052,138**	**4,932,027**	**5,142,190**	NP #14	
General Fund	1,015,448	1,040,488	1,300,605	1,555,030	IBC #10.38	
Federal Funds	2,991,279	3,011,650	3,631,422	3,587,160		
Transfer to the Department of Regulatory Agencies for Nurse Aide Certification	**308,766**	**325,343**	**325,343**	**339,343**	NP #2	
General Fund	0	148,020	148,020	152,520		
Cash Funds	0	0	0	500		
CFE/Reappropriated Funds	154,383	14,652	14,652	14,652		
Federal Funds	154,383	162,671	162,671	171,671		
Transfer to the Department of Regulatory Agencies for In-Home Support Review	**5,986**	**4,000**	**0**	**0**		
General Fund	2,993	2,000	0	0		
Federal Funds	2,993	2,000	0	0		
Transfer to the Department of Education for Public School Health Services Administration	**200,000**	**335,430**	**407,747**	**207,747**	DI #17	
Federal Funds	200,000	335,430	407,747	207,747		
Transfer to Department of Human Services for Related Adminstration	**74,564**	**88,973**	**0**	**0**		
General Fund	37,282	44,487	0	0		
Federal Funds	37,282	44,486	0	0		

	FY 2006-07 Actual	FY 2007-08 Actual	FY 2008-09 Appropriation	FY 2009-10 Request	Change Req. #	% Change from App. Request vs. Appropriation
SUBTOTAL -- Executive Director's Office, Transfers to Other Departments						
Total Funds	**4,596,043**	**4,805,884**	**5,665,117**	**5,689,280**		**0.43%**
General Fund	1,055,723	1,234,995	1,448,625	1,707,550		17.87%
Cash Funds	0	0	0	500		#DIV/0!
CFE/Reappropriated Funds	154,383	14,652	14,652	14,652		0.00%
Federal Funds	3,385,937	3,556,237	4,201,840	3,966,578		-5.60%

(C) Information Technology Contracts and Projects

(Primary Functions: Contains funding the Medicaid Management Information System, Web Portal, and special IT projects).

Information Technology Contracts	**28,721,593**	**21,912,172**	**24,094,147**	**25,535,610**	DI #6, 10, 12, 15
General Fund	6,566,567	5,178,565	5,499,078	5,891,761	BRI #1
Cash Funds	0	0	1,881,903	1,836,659	IBC #7.02, 7.37, 8.05, &
CFE/Reappropriated Funds	607,584	690,794	100,328	100,328	8.53
Federal Funds	21,547,442	16,042,813	16,612,838	17,706,862	
Fraud Detection Software Contract	**0**	**0**	**1,000,000**	**250,000**	IBC #8.05
General Fund	0	0	100,000	62,500	
Federal Funds	0	0	900,000	187,500	
Colorado Benefits Management System Medical Assistance Project	**0**	**0**	**5,300,000**	**5,050,000**	IBC #8.08
General Fund	0	0	2,536,236	2,416,602	
Federal Funds	0	0	2,763,764	2,633,398	

	FY 2006-07 Actual	FY 2007-08 Actual	FY 2008-09 Appropriation	FY 2009-10 Request	Change Req. #	% Change from App.
Centralized Eligibility Vendor Contract Project	**0**	**0**	**153,600**	**7,741,136**	DI #5	
General Fund	0	0	73,503	3,704,405	IBC #8.08	
Federal Funds	0	0	80,097	4,036,731		
						Request vs. Appropriation
SUBTOTAL -- Executive Director's Office, Information Technology Contracts and Projects						
Total Funds	**28,721,593**	**21,912,172**	**30,547,747**	**38,576,746**		**26.28%**
General Fund	6,566,567	5,178,565	8,208,817	12,075,268		47.10%
Cash Funds	0	0	1,881,903	1,836,659		-2.40%
CFE/Reappropriated Funds	607,584	690,794	100,328	100,328		0.00%
Federal Funds	21,547,442	16,042,813	20,356,699	24,564,491		20.67%

(D) Eligibility Determinations and Client Services

(Primary Functions: Contains funding to determine client eligibility and to provide information services to clients about their health benefits).

Medical Identification Cards	**92,592**	**98,730**	**120,000**	**120,000**	
General Fund	35,314	39,683	48,444	48,444	
Cash Funds	0	0	10,759	10,759	
CFE/Reappropriated Funds	11,716	10,479	1,593	1,593	
Federal Funds	45,562	48,568	59,204	59,204	
Contracts for Special Eligibility Determinations	**2,053,143**	**2,251,335**	**2,410,994**	**2,443,712**	DI #16
General Fund	801,701	873,075	913,610	925,020	
Cash Funds	0	0	30,854	34,576	
Federal Funds	1,246,442	1,347,524	1,466,530	1,484,116	

FY 2009-10 Joint Budget Committee Staff Budget Briefing
Department of Health Care Policy and Financing
Appendix A: Number Pages

	FY 2006-07 Actual	FY 2007-08 Actual	FY 2008-09 Appropriation	FY 2009-10 Request	Change Req. #	% Change from App.
County Administration	**24,003,023**	**31,449,101**	**27,203,133**	**26,697,291**	DI #5	
General Fund	7,216,315	9,475,266	8,248,943	7,996,022	IBC #9.52	
Cash Funds	0	0	5,452,981	5,452,981		
CFE/Reappropriated Funds	4,881,494	6,249,284	0	0		
Federal Funds	11,905,214	15,724,551	13,501,209	13,248,288		
Administrative Case Management	**2,861,494**	**3,714,209**	**2,917,528**	**2,917,528**		
General Fund	1,430,747	1,857,105	1,458,764	1,458,764		
Federal Funds	1,430,747	1,857,104	1,458,764	1,458,764		
Customer Outreach	**3,305,059**	**3,410,364**	**3,790,283**	**3,927,093**	DI #6	
General Fund	1,633,622	1,671,668	1,861,628	1,930,033	IBC #8.08	
Cash Funds	0	0	33,514	33,514		
CFE/Reappropriated Funds	18,908	33,514	0	0		
Federal Funds	1,652,529	1,705,182	1,895,141	1,963,546		
Non-Emergency Transportation	**7,583,761**	**0**	**0**	**0**		
General Fund	3,791,881	0	0	0		
Federal Funds	3,791,880	0	0	0		
						Request vs. Appropriation
SUBTOTAL -- Executive Director's Office, Eligibility Determinations and Client Services						
Total Funds	**39,899,072**	**40,923,739**	**36,441,938**	**36,105,624**		**-0.92%**
General Fund	14,909,580	13,916,797	12,531,389	12,358,283		-1.38%
Cash Funds	0	0	5,528,108	5,531,830		0.07%
CFE/Reappropriated Funds	4,917,118	6,324,013	1,593	1,593		0.00%
Federal Funds	20,072,374	20,682,929	18,380,848	18,213,918		-0.91%

	FY 2006-07 Actual	FY 2007-08 Actual	FY 2008-09 Appropriation	FY 2009-10 Request	Change Req. #	% Change from App.
(E) Utilization and Quality Review Contracts						
(Primary Functions: Contains contract funding to review the utilization and qualify of services provided in the acute, mental health, and long-term care programs.)						
Professional Service Contracts	**4,547,268**	**4,505,599**	**4,669,035**	**4,681,355**	DI #6	
General Fund	1,113,360	1,301,011	1,362,318	1,385,398	BRI #2	
Cash Funds	0	0	54,949	54,949	IBC #8.03	
CFE/Reappropriated Funds	55,674	55,674	0	0		
Federal Funds	3,378,234	3,148,914	3,251,768	3,241,008		
						Request vs. Appropriation
SUBTOTAL -- Executive Director's Office, Utilization and Quality Review Contracts						
Total Funds	**4,547,268**	**4,505,599**	**4,669,035**	**4,681,355**		**0.26%**
General Fund	1,113,360	1,301,011	1,362,318	1,385,398		1.69%
Cash Funds	0	0	54,949	54,949		0.00%
CFE/Reappropriated Funds	55,674	55,674	0	0		n/a
Federal Funds	3,378,234	3,148,914	3,251,768	3,241,008		-0.33%
(F) Provider Audits and Services						
(Primary Functions: Contains contract funding to audit nursing homes, federally-qualified health centers, hospitals, and other providers).						
Professional Audit Contracts	**1,805,459**	**1,662,241**	**1,708,700**	**2,272,266**	DI #14 & 17	
General Fund	902,730	831,121	854,350	919,283		
Federal Funds	902,729	831,120	854,350	1,352,983		
Primary Care Provider Rate Task Force and Study	**53,075**	**351**	**0**	**0**		
General Fund	26,538	176	0	0		
Federal Funds	26,537	175	0	0		

	FY 2006-07 Actual	FY 2007-08 Actual	FY 2008-09 Appropriation	FY 2009-10 Request	Change Req. #	% Change from App.
Prepaid Inpatient Health Plans						
Feasability Study	**0**	**70,015**	**0**	**0**		
CFE/Reappropriated Funds	0	35,008	0	0		
Federal Funds	0	35,007	0	0		
						Request vs. Appropriation
SUBTOTAL -- Executive Director's Office, Provider Audits and Services						
Total Funds	**1,858,534**	**1,732,607**	**1,708,700**	**2,272,266**		**32.98%**
General Fund	929,268	831,297	854,350	919,283		7.60%
CFE/Reappropriated Funds	0	35,008	0	0		n/a
Federal Funds	929,266	866,302	854,350	1,352,983		58.36%

(G) Recoveries and Recoupment Contract Costs

(Primary Functions: Contains contract costs associated with recovery eligible Medicaid expenses.)

Estate Recovery	**432,784**	**405,872**	**700,000**	**700,000**		
Cash Funds	216,392	202,936	350,000	350,000		
Federal Funds	216,392	202,936	350,000	350,000		
Payment Error Rate Measurement						
Project Contract	**0**	**441,365**	**0**	**0**		
General Fund	0	110,340	0	0		
CFE/Reappropriated Funds	0	77,240	0	0		
Federal Funds	0	253,785	0	0		

	FY 2006-07 Actual	FY 2007-08 Actual	FY 2008-09 Appropriation	FY 2009-10 Request	Change Req. #	% Change from App.
						Request vs. Appropriation
SUBTOTAL -- Executive Director's Office, Recoveries and Recoupment Contract Costs						
Total Funds	**432,784**	**847,237**	**700,000**	**700,000**		**0.00%**
General Fund	0	110,340	0	0		n/a
Cash Funds	216,392	202,936	350,000	350,000		0.00%
CFE/Reappropriated Funds	0	77,240	0	0		n/a
Federal Funds	216,392	456,721	350,000	350,000		0.00%
						Request vs. Appropriation
SUBTOTAL -- Executive Director's Office						
Total Funds	**99,657,660**	**98,015,869**	**108,375,680**	**118,685,074**		**9.51%**
FTE	231.8	243.8	272.7	282.4		3.56%
General Fund	32,643,173	31,956,221	36,693,562	41,378,804		12.77%
Cash Funds	279,390	264,868	8,783,862	8,731,581		-0.60%
Cash Funds Exempt	6,185,351	9,559,508	1,790,768	1,796,132		0.30%
Federal Funds	60,549,746	56,235,272	61,107,488	66,778,557		9.28%

1/ In FY 2008-09, the Department's Executive Director's Office approrpiation structure was changed. In order to provide better historical comparisons, staff has shown all actual expenses in the corresponding line item in the new structure rather than in the old appropriation structure.

(2) Medical Service Premiums

(Provides acute care medical and long-term care services to individuals eligible for Medicaid).

Services for Supplemental Security					
Income Adults 65 and Older (SSI 65+)	**$681,708,325**	**$707,710,893**	**$753,313,732**	**$796,751,251**	DI #1
Medicaid Clients	35,977	36,063	36,278	37,478	IBC #s: 8.03, 8.05, 8.06, 8.08, 8.09, 8.10
Cost per Client	$18,948.45	$19,624.29	$20,765.03	$21,259.17	8.51, 8.54, 8.55, 8.56, 8.57, 8.58 & 8.59

FY 2009-10 Joint Budget Committee Staff Budget Briefing
Department of Health Care Policy and Financing
Appendix A: Number Pages

	FY 2006-07 Actual	FY 2007-08 Actual	FY 2008-09 Appropriation	FY 2009-10 Request	Change Req. #	% Change from App.
Services for Supplemental Security Income Adults 60 to 64 (SSI 60 - 64)	**$89,709,160**	**$100,790,470**	**$102,872,209**	**$111,772,855**	DI #1	
Medicaid Clients	6,042	6,116	6,216	6,330	IBC #s: 8.03, 8.05, 8.06, 8.08, 8.09, 8.10	
Cost per Client	$14,847.59	$16,479.80	$16,549.58	$17,657.64	8.51, 8.54, 8.55, 8.56, 8.57, 8.58 & 8.59	
Services for Qualified Medicare Beneficiaries (QMBs) and Special Low-Income Medicare Beneficiaries (SLIMBs)	**$17,132,545**	**$19,043,849**	**$20,961,632**	**$23,857,694**	DI #1	
Medicaid Clients	12,818	14,130	15,068	16,097	IBC #s: 8.03, 8.05, 8.06, 8.08, 8.09, 8.10	
Cost per Client	$1,336.60	$1,347.76	$1,391.14	$1,482.12	8.51, 8.54, 8.55, 8.56, 8.57, 8.58 & 8.59	
Services for Supplemental Security Income Disabled Individuals	**$568,932,898**	**$655,382,139**	**$650,591,218**	**$720,947,416**	DI #1	
Medicaid Clients	48,567	49,662	50,123	51,057	IBC #s: 8.03, 8.05, 8.06, 8.08, 8.09, 8.10	
Cost per Client	$11,714.39	$13,196.85	$12,979.89	$14,120.44	8.51, 8.54, 8.55, 8.56, 8.57, 8.58 & 8.59	
Services for Categorically Eligible Low-Income Adults	**$200,074,498**	**$190,718,130**	**$194,943,274**	**$214,153,111**	DI #1	
Medicaid Clients	51,361	44,234	41,667	46,444	IBC #s: 8.03, 8.05, 8.06, 8.08, 8.09, 8.10	
Cost per Client	$3,895.46	$4,311.57	$4,678.60	$4,611.00	8.51, 8.54, 8.55, 8.56, 8.57, 8.58 & 8.59	
Services for Expansion Low-Income Adults	**$7,406,101**	**$19,107,069**	**$25,684,646**	**$35,493,173**	DI #1	
Medicaid Clients	4,974	8,627	9,629	13,260	IBC #s: 8.03, 8.05, 8.06, 8.08, 8.09, 8.10	
Cost per Client	$1,488.96	$2,214.80	$2,667.43	$2,676.71	8.51, 8.54, 8.55, 8.56, 8.57, 8.58 & 8.59	
Services for Baby Care Program Adults	**$47,989,940**	**$53,898,593**	**$59,621,904**	**$61,065,839**	DI #1	
Medicaid Clients	5,123	6,108	7,127	7,566	IBC #s: 8.03, 8.05, 8.06, 8.08, 8.09, 8.10	
Cost per Client	$9,367.55	$8,824.26	$8,365.64	$8,071.09	8.51, 8.54, 8.55, 8.56, 8.57, 8.58 & 8.59	

FY 2009-10 Joint Budget Committee Staff Budget Briefing
Department of Health Care Policy and Financing
Appendix A: Number Pages

	FY 2006-07 Actual	FY 2007-08 Actual	FY 2008-09 Appropriation	FY 2009-10 Request	Change Req. #	% Change from App.
Services for Breast and Cervical Cancer Treatment Clients	**$5,750,514**	**$7,135,052**	**$7,343,967**	**$8,635,303**	DI #1	
Medicaid Clients	230	270	301	303	IBC #s: 8.03, 8.05, 8.06, 8.08, 8.09, 8.10	
Cost per Client	$25,002.23	$26,426.12	$24,398.56	$28,499.35	8.51, 8.54, 8.55, 8.56, 8.57, 8.58 & 8.59	
Services for Categorically Eligible Children	**$332,386,215**	**$365,238,989**	**$380,381,117**	**$441,182,481**	DI #1	
Medicaid Clients	206,170	201,800	193,484	233,082	IBC #s: 8.03, 8.05, 8.06, 8.08, 8.09, 8.10	
Cost per Client	$1,612.19	$1,809.91	$1,965.96	$1,892.82	8.51, 8.54, 8.55, 8.56, 8.57, 8.58 & 8.59	
Services for Categorically Eligible Foster Children	**$53,963,402**	**$64,379,260**	**$70,122,718**	**$84,696,238**	DI #1	
Medicaid Clients	16,601	17,014	18,657	18,682	IBC #s: 8.03, 8.05, 8.06, 8.08, 8.09, 8.10	
Cost per Client	$3,250.61	$3,783.90	$3,758.52	$4,533.57	8.51, 8.54, 8.55, 8.56, 8.57, 8.58 & 8.59	
Services for Non-Citizens	**$56,343,210**	**$53,880,361**	**$56,261,182**	**$57,848,559**	DI #1	
Medicaid Clients	5,214	4,044	3,738	4,739	IBC #s: 8.03, 8.05, 8.06, 8.08, 8.09, 8.10	
Cost per Client	$10,806.14	$13,323.53	$15,051.15	$12,206.91	8.51, 8.54, 8.55, 8.56, 8.57, 8.58 & 8.59	
excluding DI #1 which is included in the caseload/ cost-per-client detail above	$0	$0	**$0**	**($2,760,074)**	DI #6, BRI # 1 & 2, NPI #3	

	FY 2006-07 Actual	FY 2007-08 Actual	FY 2008-09 Appropriation	FY 2009-10 Request	Change Req. #	% Change from App. Request vs. Appropriation
SUBTOTAL -- Medical Services Premiums/3	**2,061,396,808**	**2,237,284,805**	**2,322,097,599**	**2,553,643,846**		**9.97%**
General Fund	633,377,714	714,806,487	703,222,480	782,820,047		11.32%
General Fund Exempt	343,100,000	327,500,000	369,000,000	369,000,000		0.00%
Cash Funds	0	466,522	85,281,324	120,138,335		40.87%
CFE/Reappropriated Funds	48,860,206	71,785,891	2,767,998	2,898,693		4.72%
Federal Funds	1,036,058,888	1,122,725,905	1,161,825,797	1,278,786,771		10.07%

/3 The General Fund and General Fund Exempt percent change for FY 2009-10 is 7.4%.

(3) Medicaid Mental Health Community Programs

(Primary Functions: Mental health programs for Medicaid eligible clients.)

Mental Health Capitation for Medicaid Clients	**184,640,568**	**196,011,033**	**207,799,886**	**225,919,437**	DI #2, NP #3
General Fund	89,832,730	94,172,151	96,906,217	103,288,690	IBC #8.09, 8.54 & 8.58
Cash Funds	0	0	6,976,195	9,650,492	
CFE/Reappropriated Funds	2,481,026	4,311,729	7,205	8,451	
Federal Funds	92,326,812	97,527,153	103,910,269	112,971,804	
Medicaid Mental Health Fee for Service Payments	**1,367,867**	**1,335,736**	**1,585,270**	**1,481,072**	DI #2
General Fund	683,934	667,868	792,635	740,536	
Federal Funds	683,933	667,868	792,635	740,536	
Medicaid Anti-Psychotic Pharmaceuticals	**34,294,729**	**0**	**0**	**0**	
CFE/Reappropriated Funds	34,294,729	0	0	0	

	FY 2006-07 Actual	FY 2007-08 Actual	FY 2008-09 Appropriation	FY 2009-10 Request	Change Req. #	% Change from App.
						Request vs. Appropriation
SUBTOTAL -- Medicaid Mental Health Community Programs	**220,303,164**	**197,346,769**	**209,385,156**	**227,400,509**		**8.60%**
General Fund	90,516,664	94,840,019	97,698,852	104,029,226		6.48%
Cash Funds	0	0	6,976,195	9,650,492		n/a
CFE/Reappropriated Funds	36,775,755	4,311,729	7,205	8,451		17.29%
Federal Funds	93,010,745	98,195,021	104,702,904	113,712,340		8.60%

(4) Indigent Care Program

(Primary functions: Provides assistance to hospitals and clinics serving a disproportionate share of uninsured or underinsured populations, provides health insurance to qualifying children and pregnant women who are ineligible for Medicaid, and provides grants to providers to improve access to primary and preventive care for the indigent population.

Safety Net Provider Payments	**279,933,040**	**296,188,630**	**296,188,630**	**296,188,630**
General Fund	13,090,782	13,090,782	13,090,782	13,090,782
Cash Funds	0	0	135,003,533	135,003,533
CFE/Reappropriated Funds	126,875,738	135,003,533	0	0
Federal Funds	139,966,520	148,094,315	148,094,315	148,094,315
Colorado Health Care Services Fund	**0**	**15,000,000**	**15,000,000**	**15,000,000**
General Fund	0	15,000,000	15,000,000	15,000,000
The Children's Hospital, Clinic Based Indigent Care	**16,180,483**	**26,291,760**	**26,291,760**	**26,291,760**
General Fund	3,059,880	3,059,880	3,059,880	3,059,880
CFE/Reappropriated Funds	10,060,723	10,086,000	10,086,000	10,086,000
Federal Funds	3,059,880	13,145,880	13,145,880	13,145,880

FY 2009-10 Joint Budget Committee Staff Budget Briefing
Department of Health Care Policy and Financing
Appendix A: Number Pages

	FY 2006-07 Actual	FY 2007-08 Actual	FY 2008-09 Appropriation	FY 2009-10 Request	Change Req. #	% Change from App.
Health Care Services Fund Programs	**4,901,685**	**11,053,421**	**9,828,000**	**9,828,000**		
CFE/Reappropriated Funds	4,901,685	4,914,000	4,914,000	4,914,000		
Federal Funds	0	6,139,421	4,914,000	4,914,000		
Pediatric Speciality Hospital	**7,732,072**	**8,439,487**	**12,865,212**	**12,865,212**		
General Fund	3,350,000	3,551,000	5,551,000	5,551,000		
Cash Funds	0	0	386,606	386,606		
CFE/Reappropriated Funds	516,036	664,586	495,000	495,000		
Federal Funds	3,866,036	4,223,901	6,432,606	6,432,606		
Appropriation to Pediatric Speciality Hospital	**516,036**	**490,885**	**495,000**	**495,000**		
General Fund Exempt	516,036	490,885	495,000	495,000		
Tobacco Tax Fund to General Fund	**1,032,072**	**490,885**	**495,000**	**495,000**		
Cash Funds	0	0	495,000	495,000		
Primary Care Fund	**31,980,929**	**30,967,650**	**31,294,657**	**31,294,657**		
Cash Funds	0	0	31,294,657	31,294,657		
CFE/Reappropriated Funds	31,980,929	30,967,650	0	0		
Inpatient Provider Fee	**0**	**2,112,929**	**2,154,322**	**2,154,322**		
Cash Funds	0	0	1,077,161	1,077,161		
CFE/Reappropriated Funds	0	2,112,929	0	0		
Federal Funds	0	2,112,929	1,077,161	1,077,161		
Outpatient Provider Fee	**0**	**2,992,746**	**3,051,374**	**3,051,374**		
Cash Funds	0	0	1,525,687	1,525,687		
CFE/Reappropriated Funds	0	2,992,746	0	0		
Federal Funds	0	2,992,746	1,525,687	1,525,687		

FY 2009-10 Joint Budget Committee Staff Budget Briefing
Department of Health Care Policy and Financing
Appendix A: Number Pages

	FY 2006-07 Actual	FY 2007-08 Actual	FY 2008-09 Appropriation	FY 2009-10 Request	Change Req. #	% Change from App.
Children's Basic Health Plan Trust	**11,475,351**	**6,671,262**	**406,045**	**4,687,659**	DI #3	
General Fund	11,243,215	4,736,447	0	4,270,540	IBC #8.08, 8.08 & 8.53	
Cash Funds	232,136	283,367	406,045	417,119		
CFE/Reappropriated Funds	0	1,651,448	0	0		
Children's Basic Health Plan Administration	**5,507,031**	**5,514,804**	**6,952,590**	**6,937,590**	IBC #8.08	
Cash Funds	0	0	3,016,221	3,010,971		
CFE/Reappropriated Funds	2,459,420	2,466,584	0	0		
Federal Funds	3,047,611	3,048,220	3,936,369	3,926,619		
Children's Basic Health Plan Premium Costs (Children & Pregnant Adults)	**89,657,433**	**104,684,790**	**154,739,207**	**157,115,940**	DI #3	
Cash Funds	0	0	54,390,220	50,574,047	IBC #8.08, 8.09, 8.11, 8.53 & 8.60	
CFE/Reappropriated Funds	31,530,990	36,823,865	30,328	4,687,659		
Federal Funds	58,126,443	67,860,925	100,318,659	101,854,234		
Children's Basic Health Plan Dental Costs	**6,834,843**	**8,715,754**	**12,450,809**	**12,156,624**	DI #3	
Cash Funds	0	0	4,357,783	4,254,818	IBC #8.08, 8.09, & 8.53	
CFE/Reappropriated Funds	2,392,195	3,050,514	0	0		
Federal Funds	4,442,648	5,665,240	8,093,026	7,901,806		
Comprehensive Primary and Preventive Care Fund Grants	**2,310,510**	**5,586,419**	**6,459,236**	**6,459,236**		
Cash Funds	0	0	6,459,236	6,459,236		
CFE/Reappropriated Funds	2,310,510	4,130,465	0	0		
Federal Funds	0	1,455,954	0	0		

	FY 2006-07 Actual	FY 2007-08 Actual	FY 2008-09 Appropriation	FY 2009-10 Request	Change Req. #	% Change from App.
						Request vs. Appropriation
SUBTOTAL -- Indigent Care Program	**458,061,485**	**530,307,097**	**578,671,842**	**585,021,004**		**1.10%**
General Fund	30,743,877	39,438,109	36,701,662	40,972,202		11.64%
General Fund Exempt	516,036	490,885	495,000	495,000		n/a
Cash Funds	232,136	283,367	238,412,149	234,498,835		-1.64%
CFE/Reappropriated Funds	214,060,298	235,355,205	15,525,328	20,182,659		30.00%
Federal Funds	212,509,138	254,739,531	287,537,703	288,872,308		0.46%

(5) Other Medical Services

(This division provides funding for state-only medical programs including the Old-Age Pension Medical Program, MMA State Contribution, Colorado Cares Contract Costs. The division also funds 6 special purposes Medicaid programs.)

Old Age Pension State Medical Program	**12,578,662**	**9,956,951**	**15,311,715**	**13,223,483**	IBC #7.03
Cash Funds	0	0	12,836,715	12,836,715	
CFE/Reappropriated Funds	12,578,662	9,956,951	2,475,000	386,768	
Tobacco Tax Transfer from General Fund to the Old Age Pension State Medical Progr	**2,580,179**	**0**	**2,475,000**	**2,475,000**	
Cash Funds	0	0	2,475,000	2,475,000	
Commission on Family Medicine Residency Training Programs	**1,703,558**	**1,868,307**	**1,932,052**	**2,109,830**	NP #1
General Fund	851,779	934,153	966,026	1,054,915	
Federal Funds	851,779	934,154	966,026	1,054,915	

FY 2009-10 Joint Budget Committee Staff Budget Briefing
Department of Health Care Policy and Financing
Appendix A: Number Pages

	FY 2006-07 Actual	FY 2007-08 Actual	FY 2008-09 Appropriation	FY 2009-10 Request	Change Req. #	% Change from App.
Enhanced Prenatal Care Training and Technical Assistance	**102,155**	**108,942**	**117,411**	**117,411**		
General Fund	51,078	54,471	58,706	58,706		
Federal Funds	51,077	54,471	58,705	58,705		
Nurse Home Visitor Program	**2,621,943**	**2,736,784**	**3,010,000**	**3,010,000**		
CFE/Reappropriated Funds	1,310,972	1,368,392	1,505,000	1,505,000		
Federal Funds	1,310,971	1,368,392	1,505,000	1,505,000		
Public School Health Services	**21,049,585**	**19,774,430**	**27,501,534**	**27,267,834**	DI #17	
Cash Funds	0	0	14,101,907	14,101,907		
CFE/Reappropriated Funds	10,472,200	9,866,585	0	0		
Federal Funds	10,577,385	(572,356)	13,399,627	13,165,927		
Medicare Modernization Act State Contribution Payment	**72,494,301**	**71,350,801**	**81,155,195**	**86,465,214**	DI #4	
General Fund	72,494,301	71,350,801	81,155,195	86,465,214		
Colorado Cares Rx Program Contract Costs	**0**	**0**	**2,278,378**	**2,278,378**		
Cash Funds	0	0	2,278,378	2,278,378		
State University Teaching Hospitals Denver Health and Hospital Authority	**0**	**410,000**	**1,829,008**	**1,831,714**		
General Fund	0	205,000	914,504	915,857		
Federal Funds	0	205,000	914,504	915,857		
State University Teaching Hospitals University of Colorado Hospital Authority	**0**	**95,251**	**697,838**	**723,157**		
General Fund	0	47,626	348,919	361,579		
Federal Funds	0	47,625	348,919	361,578		

	FY 2006-07 Actual	FY 2007-08 Actual	FY 2008-09 Appropriation	FY 2009-10 Request	Change Req. #	% Change from App.
						Request vs. Appropriation
SUBTOTAL -- Other Medical Programs	**113,130,383**	**106,301,466**	**136,308,131**	**139,502,021**		**2.34%**
General Fund	73,397,158	83,072,252	83,443,350	88,856,271		6.49%
Cash Funds	0	0	31,692,000	31,692,000		n/a
CFE/Reappropriated Funds	26,942,013	21,191,928	3,980,000	1,891,768		-52.47%
Federal Funds	12,791,212	2,037,286	17,192,781	17,061,982		-0.76%

(6) Department of Human Services Medicaid

(Primary functions: This division reflects the Medicaid funding utilized by the Department of Human Services. The Medicaid dollars appropriated to the DHS are first appropriated in this division, then transferred as Reappriated Funds into the program lines in the Department of Human Services. The line items in this division are discussed in other staff briefings. This division is shown here only to show the overall total funds request for the Department of Health Care Policy and Financing.)

						Request vs. Appropriation
SUBTOTAL -- DHS Medicaid Programs	**333,128,748**	**351,308,449**	**409,136,487**	**434,456,089**		**6.19%**
General Fund	159,238,552	172,182,852	201,601,008	214,304,732		6.30%
Cash Funds	0	0	1,609,689	1,593,167		n/a
Cash Funds Exempt	6,931,705	2,614,171	1,460,341	1,509,278		3.35%
Federal Funds	166,958,491	176,511,426	204,465,449	217,048,912		6.15%

FY 2009-10 Joint Budget Committee Staff Budget Briefing
Department of Health Care Policy and Financing
Appendix A: Number Pages

	FY 2006-07 Actual	FY 2007-08 Actual	FY 2008-09 Appropriation		FY 2009-10 Request	Change Req. #	% Change from App.
							Request vs. Appropriation
TOTAL -- Department of Health Care Policy and Financing (with DHS programs)	**3,285,678,248**	**3,520,564,455**	**3,763,974,895**	**/1**	**4,058,708,543**		**7.83%**
FTE	**231.80**	**243.80**	**272.70**		**282.40**		3.56%
General Fund	1,019,917,138	1,136,295,940	1,159,360,914		1,272,361,282		9.75%
General Fund Exempt	343,616,036	327,990,885	369,495,000		369,495,000		0.00%
Cash Funds	511,526	1,014,757	372,755,219		406,304,410		9.00%
Cash Funds Exempt	339,755,328	344,818,432	25,531,640		28,286,981		10.79%
Federal Funds	1,581,878,220	1,710,444,441	1,836,832,122		1,982,260,870		7.92%

/1 Represents current appropriation. Does not include any supplemental adjustments.

Note: The General Fund and General Fund Exempt percent change together equals 7.4%.

							Request vs. Appropriation
TOTAL -- Department of Health Care Policy and Financing (w/o DHS Division)	**2,952,549,500**	**3,169,256,006**	**3,354,838,408**		**3,624,252,454**		**8.03%**
FTE	**231.80**	**243.80**	**272.70**		282.40		3.56%
General Fund	860,678,586	964,113,088	957,759,906		1,058,056,550		10.47%
General Fund Exempt	343,616,036	327,990,885	369,495,000		369,495,000		0.00%
Cash Funds	511,526	1,014,757	371,145,530		404,711,243		9.04%
Cash Funds Exempt	332,823,623	342,204,261	24,071,299		26,777,703		11.24%
Federal Funds	1,414,919,729	1,533,933,015	1,632,366,673		1,765,211,958		8.14%

Note: The General Fund and General Fund Exempt percent change together equals 7.56% (this excludes the DHS Medicaid Funded programs)

FY 2009-10 Joint Budget Committee Staff Budget Briefing
Department of Health Care Policy and Financing

APPENDIX B: SUMMARY OF MAJOR LEGISLATION

- **S.B. 08-2 (Boyd, Soper) Family Caregiver Developmentally Disabled:** Specifies that the Department of Human Services may purchase services and supports for persons with developmental disabilities from a family care giver in the family home if it is determined that this provides services in the least restrictive environment. Provides the following appropriations for FY 2008-09: $17,132 General Fund and $17,132 federal funds to the Department of Health Care Policy and Financing; and $34,264 reappropriated funds (transferred from the Department of Health Care Policy and Financing) and 0.5 FTE to the Department of Human Services. Also reduces the FY 2008-09 Long Bill appropriation for the Controlled Maintenance Trust Fund by $17,132 General Fund.

- **S.B. 08-6 (Boyd, Solano) Suspend Medicaid for Confined Persons:** Specifies that persons who are eligible for Medicaid just prior to their confinement in a jail, juvenile commitment facility, a Department of Corrections facility, or a Department of Human Services facility shall have their Medicaid benefits suspended, rather than terminated, during the period of their confinement. Also clarifies that juveniles retain Medicaid eligibility when held in a facility operated by or under contract with the Division of Youth Corrections or Department of Human Services if care within that facility qualifies for federal financial participation. Provides the following appropriations for FY 2008-09: $118,703 General Fund, $5,142 cash funds, $487 reappropriated funds (transferred from the Department of Human Services), and $268,255 federal funds to the Department of Health Care Policy and Financing; and $42,546 General Fund, $21,754 cash funds, $94,092 reappropriated funds (transferred from the Department of Health Care Policy and Financing) and $112,688 federal funds to the Department of Human Services. Also reduces the FY 2008-09 Long Bill appropriation for the Controlled Maintenance Trust Fund by $161,249 General Fund.

- **S.B. 08-7 (Windels, Stafford) Jail Inmate Application Assistance:** Creates the Inmate Assistance Demonstration Grant Program to provide grants to counties for the purpose of assisting inmates in county jails to access health care, housing, and employment benefits. Connects inmates with appropriate public benefits, including mental health treatment. Appropriates $279,000 General Fund to the Department of Human Services and a total of $2,000 (including $1,000 General Fund and $1,000 federal funds) to the Department of Health Care Policy and Financing for the implementation of the act in FY 2008-09. Also reduces the FY 2008-09 Long Bill appropriation for the Controlled Maintenance Trust Fund by $279,000 General Fund.

- **S.B. 08-57 (Kester, Marshall) Insurance Coverage for Hearing Aids for Minors:** Requires health insurance coverage for medically appropriate hearing aids for minor children

whose hearing loss is verified by a physician or audiologist. Appropriates $54,300 (including $19,000 cash funds and $35,300 federal funds) to the Department of Health Care Policy and Financing for the implementation of the act in FY 2008-09.

- **S.B. 08-90 (Hagedorn, McGihon) Mail Order Rx under Medicaid:** Allows Medicaid clients to use a mail-order pharmacy if they have third-party insurance and require maintenance medications; and authorizes a mail-order pharmacy to bill Medicaid for the difference between the Medicaid co-payment and a third-party insurer's co-payment or deductible. The bill reduces the Department of Health Care Policy and Financing's FY 2008-09 appropriation for Medical Services Premiums by $279,272 total funds (including $139,636 General Fund and $139,636 federal funds).

- **S.B. 08-99 (Sandoval, Stafford) Extending Foster Care Eligibility**: Expands Medicaid eligibility to young adults, under age 21, for whom the state made subsidized adoption or foster care payments immediately prior to the client turning age 18. These young adults were not eligible for Title IV-E federal funds while in foster care, but received state benefits. The bill appropriates $1,428,800 total funds (including $714,400 cash funds and $714,400 federal funds) to the Department of Health Care Policy and Financing in FY 2008-09.

- **S.B. 08-118 (Keller, Buescher) Money Transfer for Medicaid Programs:** Provides that for FY 2008-09 through FY 2012-13, the Department of Public Health and Environment shall transfer $2.0 million in funding from the Prevention, Early Detection, and Treatment Fund to the Department of Health Care Policy and Financing for Medicaid disease management programs. This funding is matched by $2.0 million in federal funds.

- **S.B. 08-131 (Buescher, Morse) Increase for Supplemental Old Age Pension Medical Fund:** For all fiscal years, beginning with FY 2009-10, the bill increases funding to the Supplemental Old Age Pension (OAP) Health and Medical Care Fund by $2,100,000. The total diversion to the fund increases from $750,000 to $2,850,000 annually.

- **S.B. 08-155 (Cadman, Kerr A) Centralized IT Management:** Consolidates the responsibility for information technology (IT) oversight of most of the state's executive branch in the Governor's Office of Information Technology (OIT) by transferring several IT functions and staff positions from various state agencies to OIT. Transfers 1.5 FTE from the Department of Health Care Policy and Financing to OIT in FY 2008-09. For more information on this bill, please see the Recent Legislation section for the Governor's Office.

- **S.B. 08-160 (Hagedorn, McGihon) Children's Health Care:** Expands eligibility in the Children's Basic Health Plan (CBHP) from 205 percent to 225 percent of federal poverty level (FPL) for children (beginning in March 2009) and for pregnant women (beginning in October 2009). Also allows the Department of Health Care Policy and Financing to increase CBHP eligibility to 250 percent of FPL if appropriations become available to fund the program at this level. The bill also increases the CBHP mental health benefit for children

to be as comprehensive as the mental health benefit in the Medicaid program. Provides the following appropriations for FY 2008-09: $2,245,037 cash funds, $30,328 reappropriated funds (transferred from the CBHP Trust Fund), and $4,096,796 federal funds to the Department of Health Care Policy and Financing; and $21,776 cash funds, $31,866 reappropriated funds (transferred from the Department of Health Care Policy and Financing) and $38,164 federal funds to the Department of Human Services.

- ❑ **S.B. 08-161 (Boyd, Merrifield) Income Verificiation for Medicaid and Children's Basic Health Plan Eligibility:** Requires the Department of Health Care Policy and Financing to establish rules for Medicaid and the Children's Basic Health Plan (CBHP) to verify applicant income through records of the Department of Labor and Employment (DOLE). Allows applicants to provide other forms of income verification if it is more recent than information available through the DOLE. In addition, requires the Advisory Committee on Covering All Children in Colorado to investigate the feasibility of combining Medicaid and the CBHP. Provides the following appropriations for FY 2008-09: $13,474 cash funds and $13,162 federal funds to the Department of Health Care Policy and Financing; and $3,791 cash funds, $5,554 reappropriated funds (transferred from the Department of Health Care Policy and Financing) and $6,655 federal funds to the Department of Human Services.

- ❑ **S.B. 08-217 (Hagedorn, McGihon) Centennial Care Choices Program:** Requires the Department of Health Care Policy and Financing, in coordination with the Division of Insurance and a panel of experts, to prepare a request for information from health insurance carriers and other interested parties. Carriers are requested to provide information regarding the design of a new health insurance product, known as a value benefit plan, to be offered in the individual market. After information is received, the Department, in collaboration with the division and the panel of experts, must acquire actuarial projections, research potential cost savings, and analyze the information provided by the carriers. Provides the following appropriations for FY 2008-09: $128,700 General Fund, $62,500 cash funds, and $191,200 federal funds to the Department of Health Care Policy and Financing; and $29,500 cash funds to the Department of Regulatory Agencies. Also reduces the FY 2008-09 Long Bill appropriation for the Controlled Maintenance Trust Fund by $128,700 General Fund.

- ❑ **S.B. 08-230 (Morse, Buescher) Hospitals to Levy Sales Tax:** Authorizes specified governmental hospital care providers, subject to voter approval, to levy and collect a sales tax within certain geographic areas. Establishes a definition of "state university teaching hospital" and authorizes the General Assembly to appropriate moneys annually to state university teaching hospitals for services provided under the state's Medicaid program. Provides direct appropriations to Denver Health Hospital and University Hospital for graduate medical education programs by transferring current funding for these activities contained in the Medical Services Premiums and Commission on Family Medicine line items in FY 2007-08 and FY 2008-09. The net impact of the funding transfer is zero in both years.

❑ **H.B. 08-1046 (Stafford, Windels) Offenders Apply for Public Benefits:** For juveniles in a juvenile commitment facility and certain individuals committed to a Department of Human Services facility, requires appropriate personnel in each facility to provide assistance in applying for Medicaid, Children's Basic Health Plan benefits, Supplemental Security Income, or Social Security Disability Insurance at least 120 days prior to release from commitment, or as soon as practicable for those juveniles committed for less than 120 days. Appropriates $11,941 General Fund, $6,106 cash funds, $26,408 reappropriated funds (transferred from the Department of Health Care Policy and Financing), and $31,626 federal funds to the Department of Human Services in FY 2008-09. Appropriates $13,371 General Fund, $1,580 cash funds, and $13,457 federal funds to the Department of Health Care Policy and Financing in FY 2008-09. Also reduces the FY 2008-09 Long Bill appropriation for the Controlled Maintenance Trust Fund by $25,312 General Fund. For more information on H.B. 08-1046, see the "Recent Legislation" section at the end of the Department of Human Services.

❑ **H.B. 08-1072 (Soper, Williams) Medicaid Buy-In for Disabled Persons**: Establishes a Medicaid Buy-in Program for people with disabilities who earn too much to qualify for Medicaid and for those whose medical condition improves while participating in the program. Requires the Department of Health Care Policy and Financing (DHCPF) to submit an amendment to the State's Medical Assistance Plan, and request any necessary waivers to expand eligibility under Medicaid to implement the Medicaid Buy-in Program. Requires qualifying individuals to pay a medical premium based on a sliding payment schedule in order to participate in the program. The bill appropriates $55,000 total funds (including $27,500 general fund and $27,500 federal funds) to the Department of Health Care Policy and Financing in FY 2008-09.

❑ **H.B. 08-1114 (White, Isgar) Reimbursement of Nursing Facilities Under Medicaid**: Establishes a new methodology for reimbursing nursing facilities under the Medicaid program by establishing: (1) a reimbursement schedule for administrative and general services; (2) per diem rates for direct and indirect care, capital assets, and performance quality; (3) an additional per diem payment for clients with severe mental health conditions or cognitive dementia; and (4) reimbursement for speech therapy services. In addition, requires the Department of Health Care Policy and Financing to charge and collect a quality assurance fee from nursing facilities, with certain exceptions. Fees are intended to allow for increased payments to Medicaid nursing facilities based on the new reimbursement system. The fee can be used for administrative costs related to assessing the fee and to limit growth of General Fund expenditures to 3.0 percent annually. The new nursing facility rate method is conditional upon the federal approval of the fee. Contains two appropriations clauses based on whether or not the federal waiver for the quality assurance fee is approved. If the waiver *is not* approved, appropriates $239,936 total funds (including $119,968 General Fund and $119,968 federal funds) and 1.0 FTE to the Department of Health Care Policy and Financing in FY 2008-09 and reduces the FY 2008-09 Long Bill appropriation for the Controlled Maintenance Trust Fund by $119,968 General Fund. If the waiver *is* approved,

appropriates $12,109,242 total funds (including $6,054,621 cash funds and $6,054,621 federal funds) and 1.3 FTE to the Department of Health Care Policy and Financing in FY 2008-09.

- **H.B. 08-1250 (Pommer, Johnson) County Contingency Fund**: Restructures funding of the County Administration group of line items. Replaces the County Contingency Fund with a new County Tax Base Relief Fund. Replaces the formulas used to determine the amount of assistance for which counties with high social services costs relative to their property tax base will be eligible. Appropriates $3,400,000 total funds (including $1,000,000 General Fund, $700,000 cash funds, and $1,700,000 federal funds) to the Department of Health Care Policy and Financing for County Administration in FY 2008-09. For more information on H.B. 08-1250 and impact to the Department of Human Services, see the "Recent Legislation" section at the end of the Department of Human Services.

- **H.B. 08-1285 (Buescher, Keller) Supplemental Appropriation for Health Care Policy and Financing:** Supplemental appropriation to the Department of Health Care Policy and Financing to modify the FY 2007-08 appropriations included in the FY 2007-08 Long Bill (S.B. 07-239). Also modifies appropriations for FY 2006-07.

- **H.B. 08-1373 (Buescher, Keller) Breast and Cervical Cancer Treatment and Prevention Fund Extention:** Extends the repeal date for the Breast and Cervical Cancer Treatment and Prevention Fund (BCCTP Fund) until FY 2013-14 and allows the BCCTP Fund to fund all of the state match for the Breast and Cervical Cancer Treatment Program in both FY 2007-08 and FY 2008-09. From FY 2009-10 through FY 2013-14, 50 percent of the state match for the Breast and Cervical Cancer Treatment Program will be paid from the BCCTP Fund and 50 percent will be paid from the General Fund. Reduces General Fund appropriations by $1,239,310 and $1,817,420 in FY 2007-08 and FY 2008-09, respectively. Increases appropriations from the BCCTP Fund by $1,239,310 and $1,817,420 in FY 2007-08 and FY 2008-09, respectively.

- **H.B. 08-1374 (Pommer, Johnson) Program for All-inclusive Care for the Elderly - Repal Cap on Rates:** Raises the rate cap on the Program for All Inclusive Care for the Elderly (PACE) from 95 percent of fee-for-service rates to up to 100 percent of fee-for-service rates. Appropriates $3.1 million total funds to the Department of Health Care Policy and Financing for FY 2008-09 for the additional expenses for the PACE program associated with increasing the rate cap. These costs are split equally between the General Fund and federal funds.

- **H.B. 08-1375 (Buescher, Keller) Long Bill Appropriation Act:** General Appropriations Act for FY 2007-08. Also includes supplemental adjustments to modify appropriations to the Department of Health Care Policy included in the FY 2007-08 Long Bill (S.B. 07-239) and in the FY 2006-07 Long Bill (H.B. 06-1385).

- ❑ **H.B. 08-1407 (Romanoff, Gordon) Insurance Benefit Program:** Prohibits the unreasonable delay or denial of payment of a claim for benefits owed by an insurance company, and provides remedies for claimants, including a new cause of action. The bill reduces the Department of Health Care Policy and Financing's FY 2008-09 appropriation for Medical Services Premiums by $277,780 total funds (including $138,890 General Fund and $138,890 federal funds).

- ❑ **H.B. 08-1409 (Pommer, Johnson) Medicaid Payment Recovery:** Authorizes the Department of Health Care Policy and Financing to take all reasonable measures to determine the legal liability of third parties to pay for services provided to Medicaid clients and to pursue claims against liable parties. Reduces the Department of Health Care Policy and Financing's FY 2008-09 appropriation for Medical Services Premiums by $300,000 total funds (including $150,000 General Fund and $150,000 federal funds).

FY 2009-10 Joint Budget Committee Staff Budget Briefing
Department of Health Care Policy and Financing

APPENDIX C: UPDATE OF FY 2008-09 LONG BILL FOOTNOTES AND REQUESTS FOR INFORMATION

Long Bill Footnotes

8 **Department of Health Care Policy and Financing, Executive Director's Office, General Administration, General Professional Services and Special Projects** -- It is the intent of the General Assembly that $150,000 of the appropriation be used to conduct a study of the adequacy of the rates paid to the Program for All Inclusive Care to the Elderly (PACE). The Department is requested to work with Centers of Medicare and Medicaid Services and the provider community in developing the criteria for assessing the frailty of PACE clients compared to the frailty of other Long-term Care clients being served in nursing homes and the home- and- community based programs. The Department is requested to submit the results of the study to the Joint Budget Committee no later than September 30, 2009.

Comment: *The Governor vetoed this footnote but directed the Department to comply to the extent possible. The Governor vetoed the footnote because the footnote requested that a portion of the appropriation be used for a specific study and reported on by a date certain. In the Governor's opinion the footnote went beyond simply expressing legislative intent and therefore, violated the separation of powers in Article III of the Colorado Constitution by administering the appropriation.*

The report requested for by this footnote is not until September 30, 2009. The Governor's veto letter indicated that report would be completed by December 1, 2008. At the time of this writing, staff had not received a copy of the report.

9 **Department of Health Care Policy and Financing, Medical Services Premiums** -- The calculations for this line item include $5,322,778 total funds for a 1.5 percent reimbursement rate increase for home and community based long term care providers, home health, and private duty nursing beginning July 1, 2008.

Comment: This footnote documents assumptions and calculations included in the FY 2008-09 appropriation for the Medical Services Premiums line item. The Department implemented the proposed rate increases as indicated in the footnote.

10 **Department of Health Care Policy and Financing, Medical Services Premiums** -- The calculations for this line item include $4,679,688 total funds for a 1.5 percent reimbursement rate increase for inpatient hospital rates beginning July 1, 2008.

Comment: This footnote documents assumptions and calculations included in the FY 2008-09 appropriation for the Medical Services Premiums line item. The Department implemented the proposed rate increases as indicated in the footnote.

11 **Department of Health Care Policy and Financing, Medical Services Premiums** -- The calculations for this line item include $1,000,000 total funds to increase pharmacy dispensing fees to $5.60 beginning April 1, 2009.

Comment: This footnote documented assumptions and calculations that were included in the FY 2008-09 appropriation for the Medical Services Premiums line item. The rate increase for this line item has not yet occurred. Staff recommends that this budget action be rescinded due to Court and Congressional action related to a moratorium on Average Manufacture Pricing through FY 2008-09.

12 **Department of Health Care Policy and Financing, Medical Services Premiums** -- The calculations for this line item include $24,718,783 total funds rate increases for acute care providers as adopted by the Joint Budget Committee on March 11, 2008.

Comment: This footnote documents the assumptions and calculations included in the FY 2008-09 appropriation for the Medical Services Premiums line item. It is staff's understanding that the Department implemented the proposed rate increases as indicated in the footnote.

13 **Department of Health Care Policy and Financing, Medical Services Premiums** -- It is the intent of the General Assembly that expenditures for these services should be recorded only against the bill group total for Medical Services Premiums.

Comment: This footnote reflects the legislative intent for the Division of Medical Services Premiums to have flexibility in spending the Medical Services Premium line item. The detail by aid category is provided for tracking and policy-making purposes only and does not restrict the Department's ability to move funding from one aid category to another based on actual expenditure patterns.

14 **Department of Health Care Policy and Financing, Indigent Care Program, Children's Basic Health Plan Premium Costs** -- This appropriation assumes the following: (1) a total children's caseload of 70,044 at an average per capita cost of $1,626.07 per year, and (2) a total adult prenatal caseload of 2,021 at an average per capita cost of $12,723.22 per year.

Comment: This footnote indicates assumptions used to calculate the FY 2008-09 Long Bill appropriation for the Children's Basic Health Plan medical costs.

15 **Department of Health Care Policy and Financing, Indigent Care Program, Children's Basic Health Plan Dental Costs** -- This appropriation assumes an average cost of $161.38 per child per year.

Comment: This footnote indicates assumptions used to calculate the FY 2008-09 Long Bill appropriation for the Children's Basic Health Plan dental costs.

16 **Department of Health Care Policy and Financing, Department of Human Services - Medicaid-Funded Programs, Executive Director's Office - Medicaid Funding** -- The appropriation in this Health Care Policy and Financing line item corresponds to the Medicaid funding in the Department of Human Services, Executive Director's Office, General Administration. As such, the appropriation contains amounts that correspond to centralized appropriation amounts in the Department of Human Services. Consistent with the head notes to the Long Bill, the Department of Human Services is authorized to transfer the centralized appropriations to other line item appropriations to the Department of Human Services. In order to aid budget reconciliation between the Department of Health Care Policy and Financing and the Department of Human Services, the Department of Health Care Policy and Financing is hereby authorized to make line item transfers out of this appropriation to other Department of Human Services Medicaid-funded programs appropriation in this section (5) in amounts equal to the centralized appropriation transfers made by the Department of Human Services for Medicaid-funded programs in the Department of Human Services.

Comment: This footnote is included in the Long Bill to allow some flexibility in the transfer of funds in the Department of Human Services Medicaid-funded programs in order to reconcile to centralized appropriating transfers made in the Department of Human Services.

Requests for Information

1 **All Departments, Totals** - Every department is requested to submit to the Joint Budget Committee information on the number of additional federal and cash funds FTE associated with any federal grants or private donations that are applied for or received during FY 2008-09. The information should include the number of FTE, the associated costs (such as workers' compensation, health and life benefits, need for additional space, etc.) that are related to the additional FTE, the direct and indirect matching requirements associated with the federal grant or donated funds, the duration of the grant, and a brief description of the program and its goals and objectives.

Comment: As the Committee is aware, approximately 48.8 percent of the Department's appropriated funds are from federal monies distributed accordingly to Title XIX (Medicaid) and Title XXI (State Children's Health Insurance Plans) of the U.S. Social Security Act. Because these federal funds are matching funds to the state's costs for these programs, these federal funds are appropriated and reported in the Department's annual budget as well as any

FTE associated with them. However, any additional federal funds that the Department receives from the federal government through grants are not reported in the Department's annual budget submission.

6 **Department of Health Care Policy and Financing, Executive Director's Office; and Department of Human Services, Services for People with Disabilities** – The Departments are requested to develop a plan with respect to how the State will limit any inappropriate proliferation of intermediate care facilities for the mentally retarded (ICFs/MR) in the community and how it will manage any growth in the number of such facilities to ensure that state and federal funding for persons with developmental disabilities is used efficiently. The Departments are requested to submit such a plan, including any recommendations for statutory changes, by October 1, 2008.

Comment: Please see the JBC staff briefing for the Department of Human Services, Services for People with Disabilities for comment on this request.

19 **Department of Health Care Policy and Financing, Executive Director's Office** -- The Department is requested to submit monthly Medicaid expenditure and caseload reports on the Medical Services Premiums and mental health capitation line items to the Joint Budget Committee, by the fifteenth or first business day following the fifteenth of each month. The Department is requested to include in the report the managed care organization caseload by aid category. The Department is also requested to provide caseload and expenditure data for the Children's Basic Health Plan within the monthly report.

Comment: The Department complies with this request. Monthly expenditure and caseload reports for the Medicaid and Children's Basic Health Plan are delivered to the JBC and are posted on the Department's website. This information is used by staff to track monthly caseload and expenditure as well as forecast trends.

20 **Department of Health Care Policy and Financing, Medical Services Premiums** -- The Department is requested to submit a report on the managed care organizations' capitation rates for each population and the estimated blended rate for each aid category in effect for FY 2008-09 to the Joint Budget Committee by July 25, 2008. The Department is requested to include in the report a copy of each managed care organization's certification that the reimbursement rates are sufficient to assure the financial stability of the managed care organization with respect to delivery of services to the Medicaid recipients covered in their contract pursuant to Section 25.5-5-403 (1) (l), C.R.S.

Comment: The Department submitted the requested to information. This information is used by staff to track annual increases to rates for managed care organizations and behavior health organizations.

21 **Department of Health Care Policy and Financing, Medical Services Premiums** -- The Department is requested to provide a report to the Joint Budget Committee by August 1, 2008 on the status of the rules adopted by the Medical Services Board regarding all changes to reimbursement rates that have been enacted for FY 2008-09.

Comment: The Department complied with the request for information and submitted the report. The Department applied the following the funded rate increases:

Provider Class	Rate Increase	Appropriated Funding
Physician - Evaluation & Management	24.25% increase on average	$11,750,000
Dental	25% increase	$11,880,289
Substance Abuse	23-63%	$750,000
Radiology	17.7%	$2,250,000
Vision	33.45	$500,000
Medical Home Incentive	n/a	$3,305,400
Inpatient Hospital	91.5% of Medicare	$4,679,688
Community Providers	1.5% rate increase	$5,322,778
Total Rate Increases Enacted (Fee-for-Service Only)		$40,438,155

22 **Department of Health Care Policy and Financing, Medical Services Premiums**-- The Department is requested to submit a report to the Joint Budget Committee on January 2, 2009 regarding potential savings to the Medical Services Premiums line item based on implementing the Deficit Reduction Act of 2005 average manufacture price upper payment limits for pharmacy reimbursement.

Comment: The Department submitted this report early. On December 19, 2007, a court injunction was issued to block the Centers for Medicare and Medicaid Services (CMS) from implementing this rule. Currently, this injunction remains in place. Additionally, on July 15, 2008, the U.S. Congress implemented a moratorium on the publication of AMP data until October 1, 2009. Because the AMP rule can not be implemented until at least October 2009, there are no savings anticipated in FY 2008-09 from implementing this rule.

23 **Department of Health Care Policy and Financing, Indigent Care Program, Safety Net Provider Payments** -- The Department is requested to submit a report by February 1, 2009, to the Joint Budget Committee, estimating the disbursement to each hospital from the Safety Net Provider Payment line item for FY 2007-08.

Comment: The Department submits this report every February to the Committee. This information is used to tract disbursements to providers from the Indigent Care Program.

24 **Department of Health Care Policy and Financing, Other Medical Services, S.B. 97-101 Public School Health Services** -- The Department is requested to submit a report by November 1 of each year to the Joint Budget Committee on the services that receive reimbursement from the federal government under S.B. 97-101 public school health service program. The report should include information on the type of services, how those services meet the definition of medical necessity, and the total amount of federal dollars that was distributed to each school under the program. The report should also include information on how many children were served by the program.

Comment: The Department submitted the requested report. In FY 2007-08, 109 School Health Services Program Providers received Medicaid reimbursement totaling $9.4 million. Since its inception in 1997, through FY 2007-08, the School Health Services Program has allowed the State to reimburse providers more than $83.0 million in Medicaid funds. As the original expenditures of the medical service were incurred by a public entity using local tax dollars or General Fund appropriated to educational institutions, the Medicaid reimbursement is federal funds. The federal funds are made available to deliver new and expanded primary and preventative health services to Colorado's public school children identified and specified under the providers' Local Service Plan. The Local Service Plan written by the district descries the type and costs of services to be provided with the funds.

25 **Department of Health Care Policy and Financing, Medical Services Premiums** -- The Department is requested to submit a report to the Joint Budget Committee by February 15, 2009 regarding the implementation of the Medical Home program. The Department is requested to report how many children have been assigned to a Medical Home, the number of providers participating in the program, and an estimate of the costs for the incentive payments.

Comment: The Governor directed the Department to comply with this request for information. Staff anticipates that this report will be submitted with the Department's final budget amendments for their FY 2009-10 request.

26 **Department of Health Care Policy and Financing, Medicaid Mental Health Community Programs, Mental Health Capitation Payments** -- The Department is requested to provide recommendations to the Joint Budget Committee by November 1, 2008 on whether greater budget accuracy would be achieved if caseload and capitation payments were estimated and tracked for each Regional Behavioral Center. In developing their recommendations, the Department will note any additional administrative costs associated with changing systems to track caseload data in this manner and to compile and report on the data.

Comment: Please see staff's briefing on Medicaid Mental Health presented on December 4, 2008 for comment on this issue.

27 **Department of Health Care Policy and Financing, Medicaid Mental Health Community Programs** -- The Department is requested to report in their annual budget submission the amount of expenditures for each year for anti-psychotic pharmaceuticals.

Comment: Please see staff's briefing on Medicaid Mental Health presented on December 4, 2008 for comment on this issue.

28 **Department of Health Care Policy and Financing, Other Medical Services, Public School Health Services** -- The Department is requested to report to the Joint Budget Committee on November 1, 2008 regarding the impact that the Centers of Medicare and Medicaid Services rule 2287-F has had on the ability to claim federal reimbursement for Medicaid services provided by school districts.

Comment: The Department complied with request and submitted the report. Currently, no impact is anticipated from the implementation of this rule. The Medicare, Medicaid and SCHIP Extension Act of 2007, imposed a six-month moratorium on CMS rule 2287-F that was set to expire on June 30, 2008. On June 30, 2008, President Bush signed the supplemental appropriations act into law (H.R. 2642, P.L. 110-252). Section 7001 of that supplemental appropriations act placed a moratorium on six Medicaid regulations, including CMS 2287-F, which prevents the Secretary of Health and Human Services from taking any action to enforce or implement these regulations until April 1, 2009.

29 **Department of Health Care Policy and Financing, Other Medical Services, Colorado Cares Rx Program Contract Costs** -- The Department is requested to submit a report to the Joint Budget Committee on November 1, 2008 providing information on the number of clients that have signed up for this program. The report should also contain updated expenditures for the program and revenue estimates for the Colorado Cares Rx Program Fund.

Comment: The Department submitted the required report. From March 2008 through September 2008, a total of 40 individuals have signed up for this program.

A Summary of the Colorado Medicaid Program

COLORADO MEDICAID PROGRAM OVERVIEW

The Medicaid program is now the second largest source of health care insurance in the United States -- after employer-based coverage. As a "safety-net" health insurance program for the poor, disabled, and elderly, Medicaid provides essential medical and medically related services to the most vulnerable and at-risk populations in society. In FY 2008-09 Colorado anticipates serving 381,390 Medicaid clients on a monthly basis (non-retroactive caseload). This equates to approximately 1 out every 12 persons in Colorado. Specifically, the Colorado Medicaid program provides health insurance coverage for approximately 1 out of 3 births, 1 out of 6 children, and 6 out of 10 persons in nursing home care.

Federally, the Medicaid program was enacted in the same legislation that created the Medicare program -- the Social Security Act Amendments of 1965 (P.L. 89-97). Medicare was enacted as Title XVIII and Medicaid was enacted as Title XIX of that Act. Therefore, Medicare programs are sometimes referred to as Title XVIII programs and Medicaid programs are sometimes referred to as Title XIX programs.

Medicare and Medicaid Differences

Medicare was enacted as a comprehensive acute health insurance program for the elderly. Medicare does not provide long-term care (i.e. extended nursing home stays). Medicare is not a means tested program -- all *eligible* individuals 65 and older qualify for Medicare. Medicare is solely a federal program funded by a dedicated tax (part of the FICA tax rate) and with its own trust fund.

In contrast, Medicaid is a health insurance plan for the poor that provides both acute care and long-term care coverage. Medicaid is means tested -- an individual must meet certain income criteria and asset tests in order to qualify. When Medicaid was first enacted, eligibility was tied specifically to the Aid to Families with Dependent Children (AFDC) program. Therefore, the program covered mainly low income children and women. In the early 1970s, Medicaid was amended to also cover disabled adults and elderly who were eligible for Supplemental Security Income (SSI) under the Social Security Act. Many of the elderly covered by Medicaid are "dual eligible." The "dual eligible" elderly qualify for both Medicare and Medicaid coverage. In the late 1980s and early 1990s the federal government expanded Medicaid coverage to include a greater number of the uninsured children, pregnant women, and elderly. When federal welfare reform passed in 1996, Medicaid was no longer specifically tied to welfare populations and states were *allowed* greater flexibility on developing expanded eligibility for Medicaid programs.

Lastly, unlike Medicare, Medicaid is funded and administered jointly by the federal government and states. Medicaid at both the federal and state level relies on general taxation (i.e. there is no Medicaid trust fund from dedicated tax revenues -- it is a General Fund program at both the federal and state level).

Technically, Medicaid is an optional state program.

States are not required to have Medicaid programs. However, if a state does not participate in the Medicaid program, the state loses the federal matching money. The federal match (FMAP) is based on a state's per capita income compared with the national average. By law, the FMAP can not be lower than 50 percent or higher than 83 percent. The FMAP for Colorado is approximately 50 percent while Mississippi receives an FMAP of approximately 76 percent.

If a state opts to participate in Medicaid, then the state must abide by the federally mandated rules and conditions of the program. Currently, all 50 states, the District of Columbia, and the five U.S. territories have Medicaid programs. Because the federal law allows each state and territory to establish their own eligibility standards, benefit package, and rate structures within the federal guidelines, there is wide variation amongst the 56 Medicaid programs.

Medicaid Populations and Services

Colorado enacted a Medicaid program in FY 1968-69. Medicaid is an entitlement program. Therefore, any person meeting the eligibility requirements must be added to the program and receive all eligible covered services. For the most part, the Colorado Medicaid program is a basic program providing mainly the federally required services for federally required populations. In the few instances where Colorado has optional services or populations, most other states also cover those services or populations. In addition, most of Colorado's optional services and populations are covered in order to avoid other costs or because they are considered essential to medical care. A good example is prescription drugs. In the late 1960s when the Medicare and Medicaid programs were enacted, most private health insurance did not offer prescription drug coverage. Therefore, Medicare did not include prescription drug coverage and the federal government labeled prescription drug coverage as an "optional" service in the Medicaid program. However, over the last 30 years, advances in prescription drugs have allowed patients to have better health outcomes and to avoid expensive inpatient or therapy treatments. Therefore, prescription drug coverage has become an important benefit under most private insurance plans and all states have elected to cover prescription drugs under Medicaid. Since January 2006, Medicare has also added a prescription drug benefit.

Mandatory Populations

The federal guidelines ***require*** that the following populations be eligible for Medicaid:

All children who are under age 6 and below 133 percent of the Federal Poverty Level (FPL) and children ages 6 through 18 who are below 100 percent FPL and meet other eligibility requirements. These children are referred to in the Long Bill and in the charts in this document as "categorically eligible low-income children and baby care program children" or as "children". For FY 2008-09, this caseload is forecasted at 193,484 or 50.7 percent of the total forecasted Medicaid caseload.

All children who are recipients of foster care and adoption assistance under Title IV-E of the Social Security Act. These children are referred to in the Long Bill and in the charts in this documents as "foster children." For FY 2008-09, this caseload is forecasted at 18,858 or 4.9 percent of the total forecasted Medicaid caseload.

Adults who meet the eligibility requirements that were in place under the AFDC program in 1996. These adults are generally the parents of eligible children and are mainly women. The current federal poverty level (FPL) for this category is approximately 40 percent. These adults are referred to in the Long Bill and in this document as "categorically eligible low-income adults" or "adults". For FY 2008-09, this population is forecasted at 41,667or 10.9 percent of the Medicaid caseload.

Pregnant women at or below 133 percent of the poverty level. These women are referred to in the Long Bill and in this document as "baby care program adults" or "BCPA". For FY 2008-09, this population is forecasted at 6,028 or 1.6 percent of the total caseload.

Supplemental Security Income (SSI) eligible persons: States are generally required to provide Medicaid to recipients of SSI payments. SSI is a federal program to provide cash assistance to individuals who meet certain income levels and who are either blind, disabled, or aged. States, however, may use more restrictive eligibility standards for Medicaid than those used for the SSI program if those eligibility standards were in place before 1972. Colorado covers SSI eligible individuals and extends coverage to individuals with incomes up to 300 percent of the SSI limit. Colorado also allows individuals to establish income trusts so that the client can qualify for the 300 percent level. In the Long Bill and the charts in this document, this population is divided into three different groups:

- ✓ *SSI 65 +:* This group includes individuals 65 and older who are eligible for SSI and have incomes less than 300 percent of the SSI payment. For FY 2008-09, this population is forecasted at 36,278 or 9.5 percent of the total caseload.

- ✓ *SSI 60-64:* This group includes individuals 60 to 64 years of age who are eligible for SSI and have incomes less than 300 percent of the SSI payment. For FY 2008-09, this population is forecasted at 6,216 or 1.6 percent of the Medicaid caseload.

- ✓ *SSI Disabled:* This group includes *children and adults* to age 60 who are eligible for SSI because of a physical disability or blindness and have incomes less than 300 percent of the SSI payment. For FY 2008-09, this population is forecasted at 50,123 or 13.1 percent of the total caseload.

Qualified Medicare Beneficiaries and Special Low-Income Medicare Beneficiaries (QMBs and SLMBs): All Medicare beneficiaries with incomes below the poverty level receive Medicaid assistance for payment of Medicare premiums, deductibles and cost sharing. These individuals are called QMBs. Medicare beneficiaries with income levels slightly higher than poverty receive Medicaid assistance for payment of Medicare premiums. These individuals are called SLMBs. In

the Long Bill and the charts in this document, these two groups are combined as QMBs/SLMBs. For FY 2008-09, this population is forecasted at 15,068 or 4.0 percent of the total caseload.

Emergency Services for Non-citizens: States are required to pay for emergency health care services for any non-citizen (documented or undocumented) who would be eligible for Medicaid coverage if they were a citizen. In the Long Bill and the charts in this document, these individuals are called "Non-citizens." For FY 2008-09, this population is forecasted at 3,738 or 1.0 percent of the total caseload.

Optional Populations

Federal law allows states to offer Medicaid coverage to the additional populations.

Colorado has elected to serve the following optional populations:

300%ers: These clients are individuals who make *up to* 300% of the SSI payment level and are in need of long-term care services either through institutional care or in community settings. *Colorado has elected to serve this population up to the maximum of 300% SSI and also allows for an income trust provision*. In the Long Bill and charts in this document these individuals are included in the SSI populations. Currently, for budget and appropriation purposes, these individuals are not tracked separately from the federally mandatory SSI populations.

Medicaid Buy-In: These individuals are eligible to "buy-into" Medicaid coverage. To be eligible for this program, the individual must have been previously eligible for Medicaid under an SSI category but because of new employment income or improved medical condition is no longer eligible. This program is sometimes referred to as "Ticket to Work Program." The state statute enacting this program requires the program to be budget-neutral. Currently, the Department has not implemented this program.

Children in the HCBS Waiver Program (sometimes called the Katie Beckett waiver) and other HCBS Waiver Programs for Children : These children are ineligible for Medicaid because of their family's income but would be eligible for Medicaid because of their disabilities and risk for institutional care. In the Long Bill and charts in this document, these children are included in the SSI Disabled caseload. Currently, these individuals are not tracked separately in the Long Bill from the federally mandated SSI populations. These programs can be and are capped.

Non IV-E Foster Care: These are foster children who are ineligible for Medicaid through Title IV-E of the Social Security Act. In the Long Bill and charts in this document, these individuals are included in the Foster Care children populations. Currently for budget and appropriation purposes, these individuals are not tracked separately from the federally mandated Title IV-E Foster Care population.

Young Adults Aging Out of Foster Care: These are young adult under age 21 who previously were covered under the Medicaid program due to their status as foster children. Currently, this population is not tracked separately from the foster care child caseload.

Breast and Cervical Cancer Treatment Patients: These clients are women who have been screened by the U.S. Department of Health, are diagnosed with breast or cervical cancer, meet certain income guidelines, and have no insurance coverage. In the Long Bill and charts in this document, this population is referred to as "Breast and Cervical Cancer Treatment Patients (BCCTP) clients". These clients receive an enhanced match rate from the Federal government of 65 percent. This population was added in 2001. For FY 2008-09 this population is forecasted at 301 individuals.

Optional Legal Immigrants: When federal welfare reform was passed in 1996, the federal legislation allowed states to serve certain "optional" legal immigrants. This population is not tracked separately in the Long Bill. Individuals eligible under this classification appear in the aid categories that they would belong in if they were citizens.

Additional Low-Income Adults: With the passage of Amendment 35 to Colorado Constitution, the General Assembly has elected to serve additional low-income adults who have children enrolled in Medicaid. Beginning July 1, 2006, Colorado began serving parents of children enrolled in Medicaid up to 60 percent of the federal poverty level. For FY 2008-09, this population is forecasted at 9,629 individuals or 2.5 percent of the Medicaid caseload.

Low-Income Adults and Children with Family Assets That Exceed the Federal Allowance: With the passage of Amendment 35, Colorado eliminated the asset test for the Family Medicaid program. Previously, Medicaid clients could not have assets totally more than $2,000 dollars (some assets such as housing and transportation were excluded). The caseload for this optional program is not tracked separately but fall in the low-income adults and children categories.

The following list shows the federal optional populations that Colorado has elected not to serve:

Poverty-related groups: States may choose to cover certain higher-income pregnant women and children defined than the mandatory populations. For example, when Title XXI (Children's Basic Health Plan) was enacted, the federal legislation allowed states to expand their pregnant women and children populations in Medicaid up to 185 percent FPL instead of enacting a CBHP plan. If the state elected to add these populations into the Medicaid program, the state received the enhanced federal match for them. However, the population would become part of the "entitlement" program -- i.e. all eligibles that present must be enrolled. Therefore, the population could not be capped. Colorado elected to establish a CBHP program instead of expand Medicaid coverage.

Medically Needy: States may choose to cover individuals who do not meet the financial standards for program benefits but fit into one of the categorical groups and have income and resources with special "medically needy" limits established by the state. Individuals with income and resources

above the "medically needy" standards may qualify by "spending down" -- i.e. incurring medical bills that reduce their income and/or resources to the necessary levels.

Mandatory Services

The Medicaid benefit package is defined by each state based on broad federal guidelines. As stated earlier, there is much variety between the different Medicaid programs regarding not only which services are covered, but also the amount of care provided within specific service categories (i.e. amount, duration, and scope of services).

Each state Medicaid program must cover the "mandatory services" identified in federal law. Following is the list of mandatory services:

- ✓ Inpatient hospital services;
- ✓ Outpatient hospital services;
- ✓ Rural health clinic and Federally Qualified Health Center (FQHC) services;
- ✓ Laboratory and X-ray services;
- ✓ Nurse practitioners' services;
- ✓ Nursing facility (NF) services and home health services for individuals age 21+;
- ✓ Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) for individuals under age 21;
- ✓ Family planning services and supplies;
- ✓ Physicians' services and medical and surgical services of a dentist;
- ✓ Nurse-Midwife services.

In addition to covering "mandated services" states have the discretion to cover additional services -- i.e., "optional services." State may choose among the optional services allowed by federal law. The following is a list of the optional services Colorado has elected to provide.

- ✓ Podiatrists
- ✓ Optometrists
- ✓ Psychologist
- ✓ Nurse anesthetists
- ✓ Private duty nursing
- ✓ Clinic services
- ✓ Mandatory Dental services
- ✓ Physical therapy
- ✓ Occupational therapy
- ✓ Speech, hearing and language disorders
- ✓ Prescribed drugs
- ✓ Prosthetic devices
- ✓ Eyeglasses
- ✓ Diagnostic services

- ✓ Screening services
- ✓ Preventative services
- ✓ Rehabilitative services
- ✓ Intermediate Care Facilities/Mentally-Retarded services
- ✓ Inpatient psychiatric services for under age 21
- ✓ Nursing facility services for under age 21
- ✓ Emergency hospital services
- ✓ Personal care services
- ✓ Transportation services
- ✓ Case management services
- ✓ Hospice care services
- ✓ Respiratory care services
- ✓ Inpatient and NF services for 65+ in institutions for mental disease

Waiver Programs

- ✓ HCBS for Elderly Blind and Disabled
- ✓ HCBS for Developmentally Disabled
- ✓ HCBS for AIDS patients
- ✓ HCBS for Mental Illness
- ✓ HCBS for Brain Injury
- ✓ HCBS for Children (three different waiver programs)
- ✓ Program for the All-Inclusive Care of the Elderly

Following is the list of optional services that Colorado does not offer:

- ✓ Chiropractors services
- ✓ Medical social workers
- ✓ Optional dental
- ✓ Eyeglasses (except if necessary after surgery)
- ✓ Christian Science Nurses
- ✓ Christian Science Sanatoriums
- ✓ TB-related Services

Based on FY 2005-06 appropriations (the last time this study was done), the Department of Health Care Policy and Financing estimates that $817.7 million total funds of the Medicaid premiums budget was spent on optional services. Of the optional service expenditures, $402.9 million or 49.3 percent was spent on SSI clients with incomes up to 300 percent of the SSI benefit. These clients are elderly or disabled clients at-risk of institutional care. Other optional services, such as the HCBS waiver programs, provide less costly services that allow individuals to stay within community settings instead of institutional care settings such as nursing homes. Generally, because community settings are less expensive than nursing home settings, these programs were enacted to save the state money.

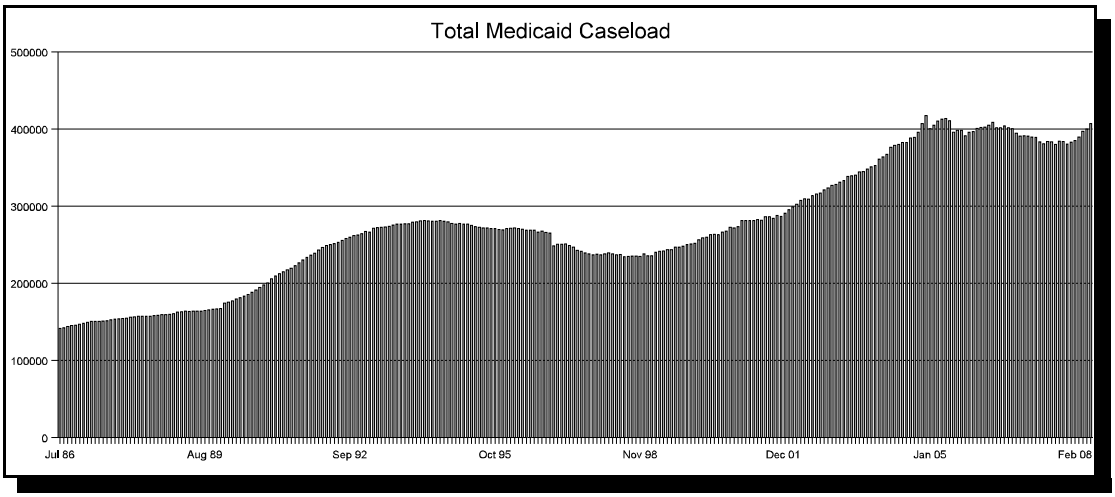
Medicaid Service Premiums Expenditures

Nationally, from the inception of the Medicaid program in the mid 1960s through the late 1980s, Medicaid expenditures grew at a rate that was comparable to national health spending. However, since the late 1980s, Medicaid spending growth has outpaced national health spending. Nationally, Medicaid expenditures have almost tripled since 1989.

In Colorado, Medicaid medical services premiums expenditures (that part of the Medicaid budget related to medical expenses only) have increased from $662.9 million in FY 1991-92 to $2,227.0 million in FY 2007-08, or a 336.4 percent increase. The major factors contributing to the increase in Medicaid spending include: (1) caseload growth, and (2) medical cost growth due to price and utilization of services.

Caseload Growth

From FY 1995-96 to FY 2007-08, Colorado's Medicaid population grew from 254,083 to 391,962. This represented an increase of 54.3 percent. Some of the growth in Colorado's Medicaid program results purely from increases in Colorado's overall population (which increased by more than 30 percent in the 1990s). However, growth in the Medicaid caseload cannot be solely attributed to general population growth. Rather, growth in the Medicaid caseload is also affected by policy changes made at both the federal and state level and economic cycles. The chart below shows the monthly Medicaid caseload for FY 1986-87 through FY 2003-04.



The chart shows that there was a major increase in caseload in the early 1990s that coincided with major policy changes and an economic recession. The caseload then leveled off during the mid-1990s. This reflects the impact of major policy changes and the improved economic situation. Then again in the late 1990s through the early 2000s, caseload began to increase again. Until it began to level off again in 2006. However, beginning in January 2008, the Medicaid caseload has begun to increase again reflecting the current economic downturn.

Following are the major factors that drove caseload growth in the early 1990s (note some changes occurred in the late 1980s but impact was not seen until the 1990s):

1988 Congress requires states to cover pregnant women and infants up to 100 percent FPL and Qualified Medicare Beneficiary (QMBs) are added.

1989 Congress requires states to cover pregnant women and children under age 6 to 133 percent of FPL.

1990 Phased-in coverage ages 6 through 18 under 100 percent FPL is established (last age cohort was phased-in during FY 2002-03). Specified Low-Income Medicare (SLIMBs) are added.

1991-1993 Nation experiences a war with Iraq and an economic recession.

Following are the major factors that resulted in a leveling off and drop in the Medicaid caseload during the mid-1990s:

1994-1999 Nation experiences robust economic growth during the technology boom of the late 1980s and 1990s.

1996 Welfare Reform -- the Aid to Families with Dependent Children (AFDC) entitlement program is replaced by the Temporary Assistance for Needy Families (TANF); enrollment/termination of Medicaid is no longer automatic with receipt/loss of welfare cash assistance.

Following are the major factors that resulted in the increase in the Medicaid caseload during the late 1990s and early 2000s:

1997 Congress passes the Children's Health Insurance Program (CHIP) and Colorado enacts its Children's Basic Health Plan (CBHP -- see CBHP section). In order for children to be eligible for CBHP, they first must be screened for Medicaid eligibility.

1999-2002 TATUM lawsuit -- When Welfare Reform was enacted several Medicaid clients had their Medicaid benefits erroneously discontinued. The resulting lawsuit add the appropriate clients back into the program.

2001-2005 Technology boom collapses, nation falls into economic recession, September 11th terrorist attacks and war with Iraq. Continued growth due to longer length of stay on program and eligibility benefit freeze that took place with the implementation of CBMS.

2006-2007 Slight decline in caseload due to economic recovery.

2008 Caseload begins to grow again as the nation begins to experience another economic downturn including major failure of the banking industry.

Fiscal Year	Caseload	# Change	% Change
FY 1995-96	254,083		
FY 1996-97	250,098	(3,985)	(1.6)%
FY 1997-98	238,594	(11,504)	(4.6)%
FY 1998-99	237,598	(996)	(0.4)%
FY 1999-00	253,254	15,656	6.6%
FY 2000-01	275,399	22,145	8.7%
FY 2001-02	295,413	20,014	7.3%
FY 2002-03	331,800	36,387	12.3%
FY 2003-04	367,559	35,759	10.8%
FY 2004-05	406,074	38,515	10.5%
FY 2005-06	402,218	(3,856)	(1.0)%
FY 2006-07	392,228	(9,990)	(2.5)%
FY 2007-08	391,962	(266)	(0.1)%

*based on the Department's restated caseload (may not match other charts the contain the original caseload estimate).

Medical Cost Growth, Utilization of Services, and Acuity Mix

Another factor that contributes to the cost of Medicaid is the increase cost of medical services and supplies. Medicaid reimbursement structures are complicated and are based on a variety of factors depending on the service. For example, nursing home rates reimbursement are determined by applying a statutory formula. This formula includes increases due to rising costs. Other Medicaid services (such as hospital reimbursement, pharmacy, durable medical equipment) are established by Department rule and may or may not be linked to inflationary increases. In some of these cases, the reimbursement is tied to a percentage of the Medicare reimbursement rate (which may be adjusted for inflation). In addition, the General Assembly enacts policy initiatives that affect reimbursement rates for providers.

However, price of medical services is not the only factor affecting Medicaid health care costs. Health care costs are also affected by how many services clients utilize and the medical risk factors associated with the clients served. For example, new Medicaid clients often have "pent-up" medical needs because of a lack of health insurance in the past and will use more services than the general population. Additionally, costs may be driven upwards for Medicaid due to the acuity level of the clients served. For example, serving large numbers of clients with diabetes or biological-based mental illnesses will increase overall medical costs for the program.

The cost drivers related to medical inflation, acuity mix, and utilization of services are captured in the Long Bill and the charts in this document as cost-per-client.

Cost per Client

In FY 1995-96, the average cost per Medicaid client was approximately $3,901.23. In FY 2007-08, the average cost per Medicaid client was approximately $5,681.77. This represents an increase in cost-per-client services of 45.6 percent.

Following is the history of growth in client costs for the Medical Services Premiums line item from FY 1995-96 through FY 2007-08.

Fiscal Year	Cost Per Client	$ Change	% Change
FY 1995-96	$3,901.23		
FY 1996-97	$4,509.91	$608.68	15.6%
FY 1997-98	$4,631.18	$121.27	2.7%
FY 1998-99	$4,950.52	$319.34	6.9%
FY 1999-00	$5,166.43	$215.91	4.4%
FY 2000-01	$5,143.57	($22.86)	(0.4)%
FY 2001-02	$5,202.22	$58.65	1.1%
FY 2002-03	$4,977.91	($224.31)	(4.3)%
FY 2003-04	$5,010.73	$32.82	0.7%
FY 2004-05	$4,662.42	($348.31)	(7.0)%
FY 2005-06	$4,928.66	$266.24	5.7%
FY 2006-07	$5,222.57	$293.91	6.0%
FY 2007-08	$5,681.77	$459.20	8.8%

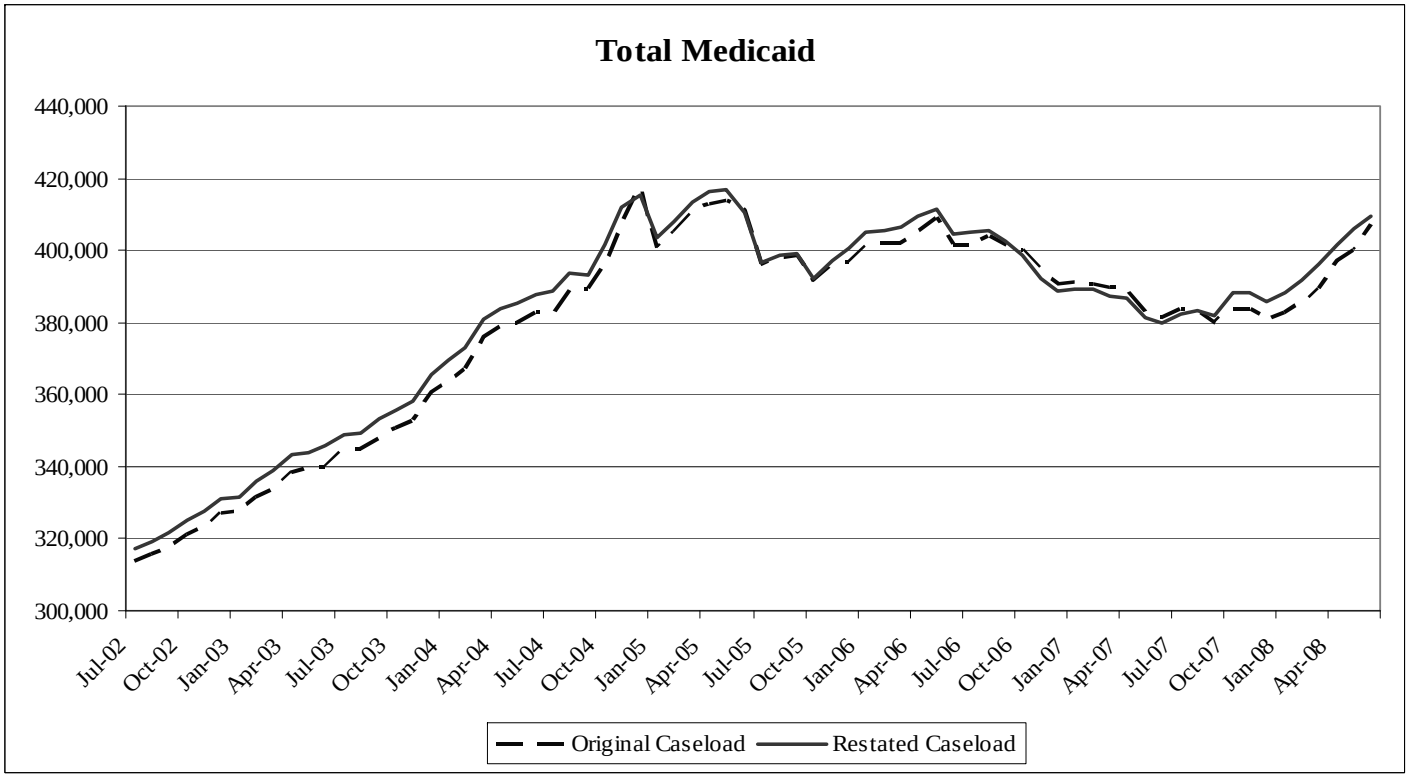
*based on the Department's restated caseload (may not match other charts the contain the original caseload estimate).

It is important to note that the cost-per-client numbers do not include bottom of the line refinancings (i.e. refinancing up to the Medicare Upper Payment Limit, savings from moving to cash accounting, and provider fees from nursing homes have been taken out of the numbers).

Following is a history of total fund costs for the Medicaid Services Premiums line item.

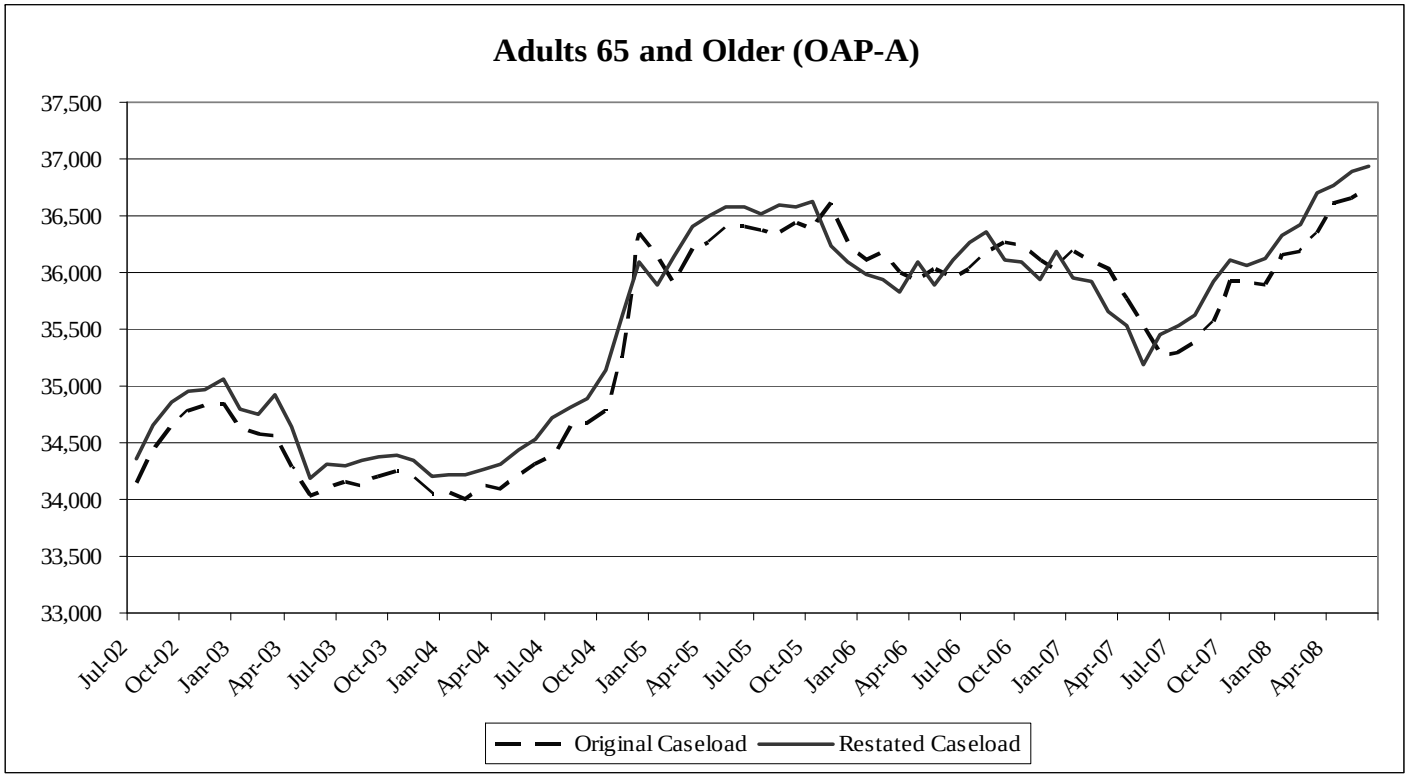
Fiscal Year	Cost Per Client	$ Change	% Change
FY 1995-96	$991,235,479		
FY 1996-97	$1,127,919,788	$136,684,309	13.8%
FY 1997-98	$1,104,970,992	($22,948,796)	(2.0)%
FY 1998-99	$1,176,233,410	$71,262,418	6.4%
FY 1999-00	$1,308,420,100	$132,186,690	11.2%
FY 2000-01	$1,416,535,408	$108,115,308	8.3%
FY 2001-02	$1,536,804,691	$120,269,283	8.5%
FY 2002-03	$1,651,670,874	$114,866,183	7.5%
FY 2003-04	$1,841,738,922	$190,068,048	11.5%
FY 2004-05	$1,893,285,567	$51,546,645	2.8%
FY 2005-06	$1,982,396,076	$89,110,509	4.7%
FY 2006-07	$2,048,437,415	$66,041,339	3.3%
FY 2007-08	$2,227,037,481	$178,600,066	8.7%

Total Medicaid



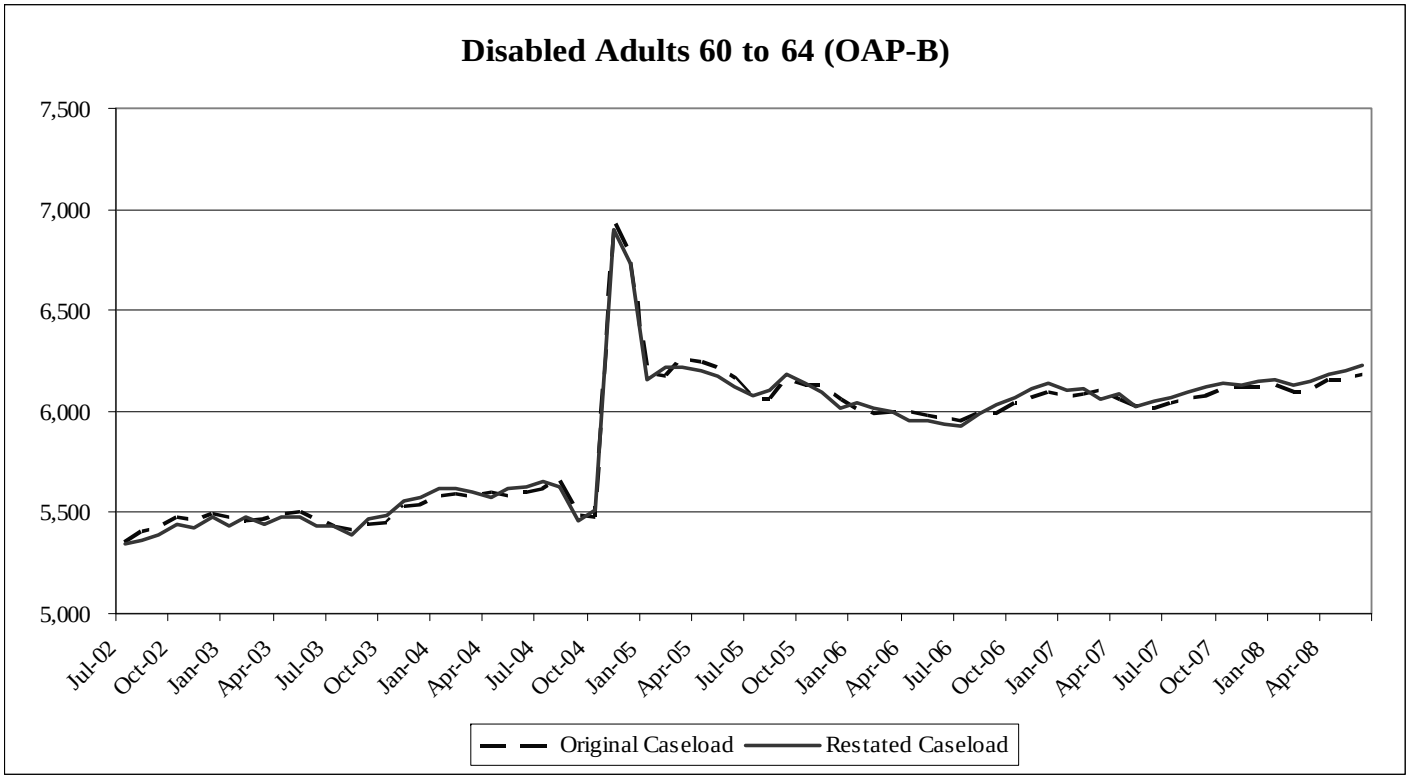
Total Medicaid					
	Original Caseload	Original Growth Rate	Restated Caseload	Restated Growth Rate	Difference
FY 02-03	327,395	10.83%	331,800		1.35%
FY 03-04	362,531	10.73%	367,559	10.78%	1.39%
FY 04-05	402,802	11.11%	406,023	10.46%	0.80%
FY 05-06	399,705	-0.77%	402,218	-0.94%	0.63%
FY 06-07	393,077	-1.66%	392,228	-2.48%	-0.22%
FY 07-08	388,068	-1.27%	391,962	-0.07%	1.00%

Adults 65 and Older



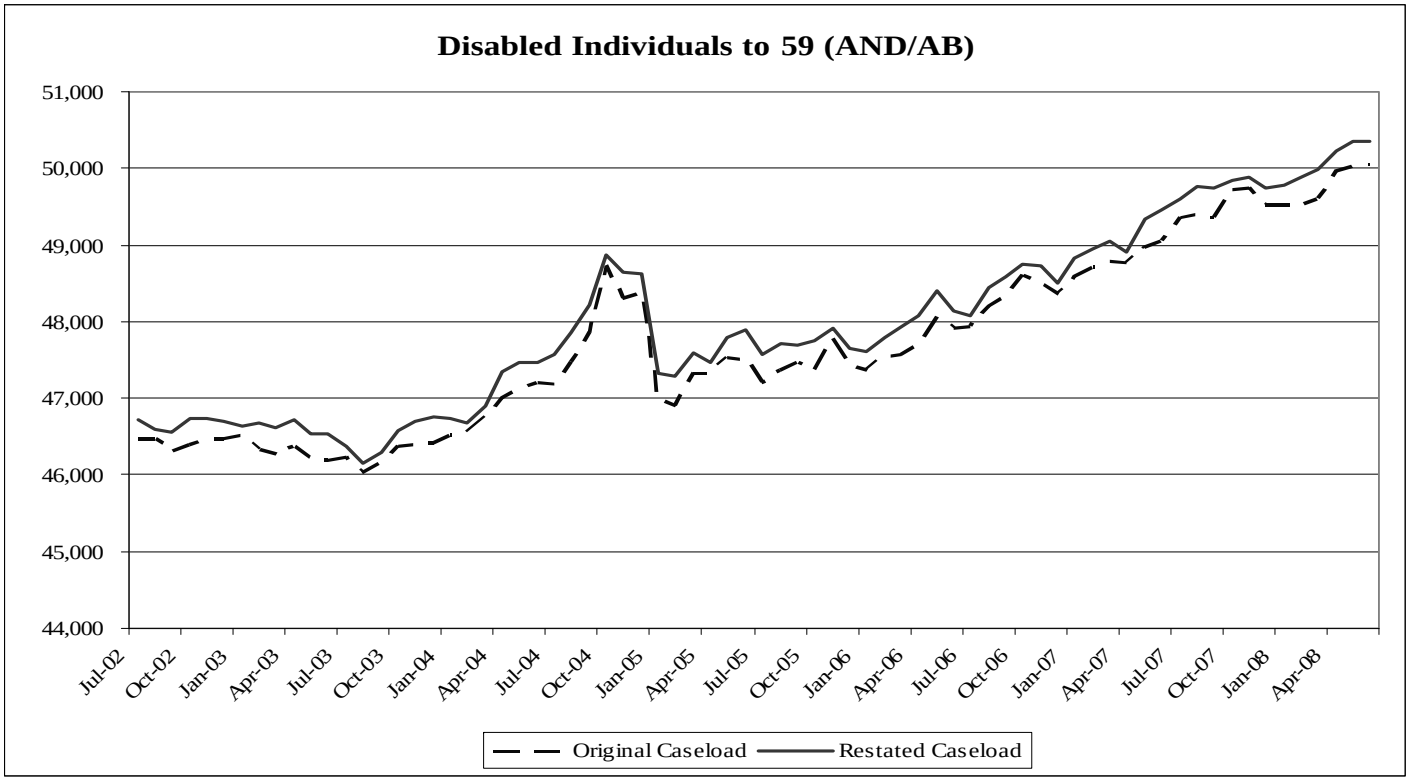
Adults 65 and Older (OAP-A)					
	Original Caseload	Original Growth Rate	Restated Caseload	Restated Growth Rate	Difference
FY 02-03	34,485	1.68%	34,704		0.64%
FY 03-04	34,149	-0.97%	34,329	-1.08%	0.53%
FY 04-05	35,615	4.29%	35,780	4.23%	0.46%
FY 05-06	36,219	1.70%	36,207	1.19%	-0.03%
FY 06-07	35,977	-0.67%	35,888	-0.88%	-0.25%
FY 07-08	36,063	0.24%	36,284	1.10%	0.61%

Disabled Adults 60 to 64



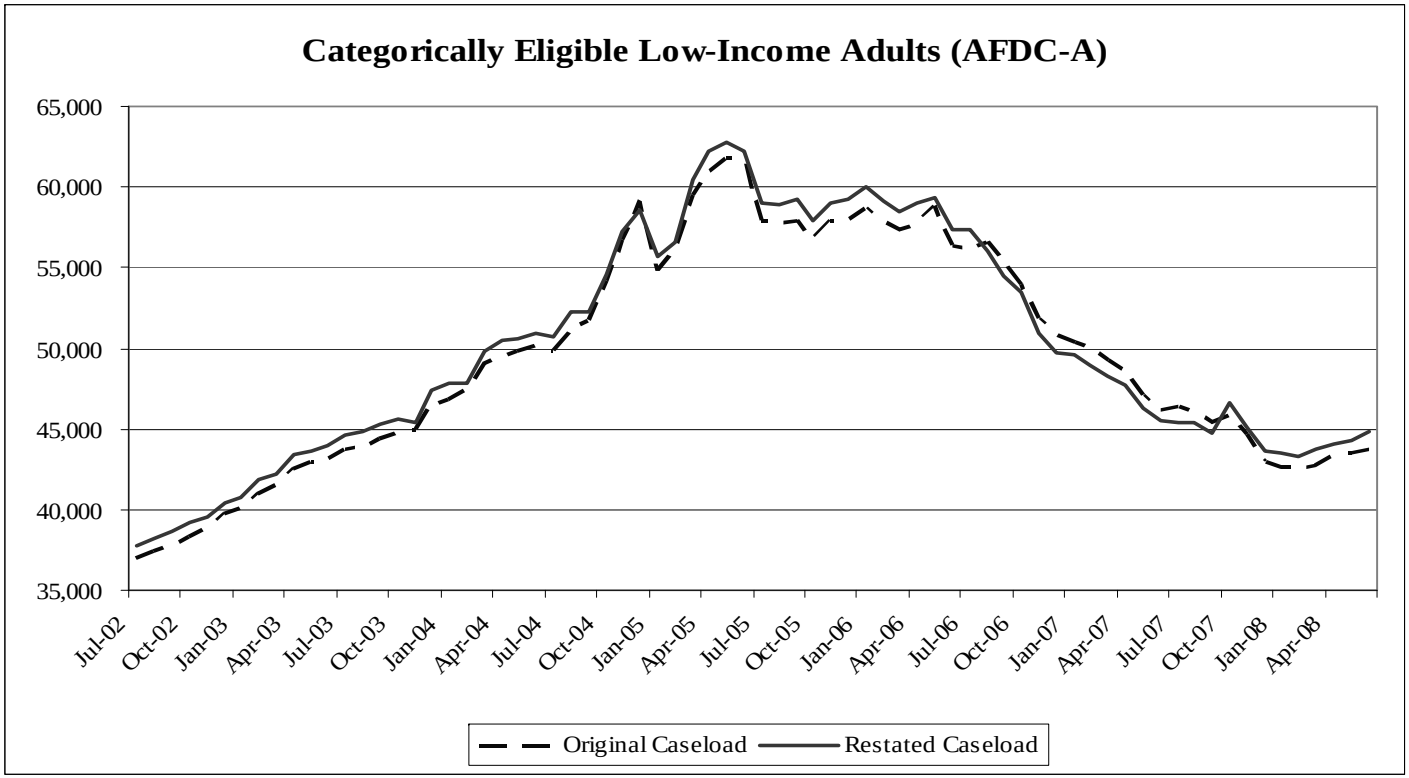
Disabled Adults 60 to 64 (OAP-B)					
	Original Caseload	Original Growth Rate	Restated Caseload	Restated Growth Rate	Difference
FY 02-03	5,456	5.25%	5,431		-0.46%
FY 03-04	5,528	1.32%	5,548	2.15%	0.36%
FY 04-05	6,103	10.40%	6,082	9.63%	-0.34%
FY 05-06	6,048	-0.90%	6,042	-0.66%	-0.10%
FY 06-07	6,042	-0.10%	6,059	0.28%	0.28%
FY 07-08	6,116	1.22%	6,146	1.44%	0.49%

Disabled Individuals to 59



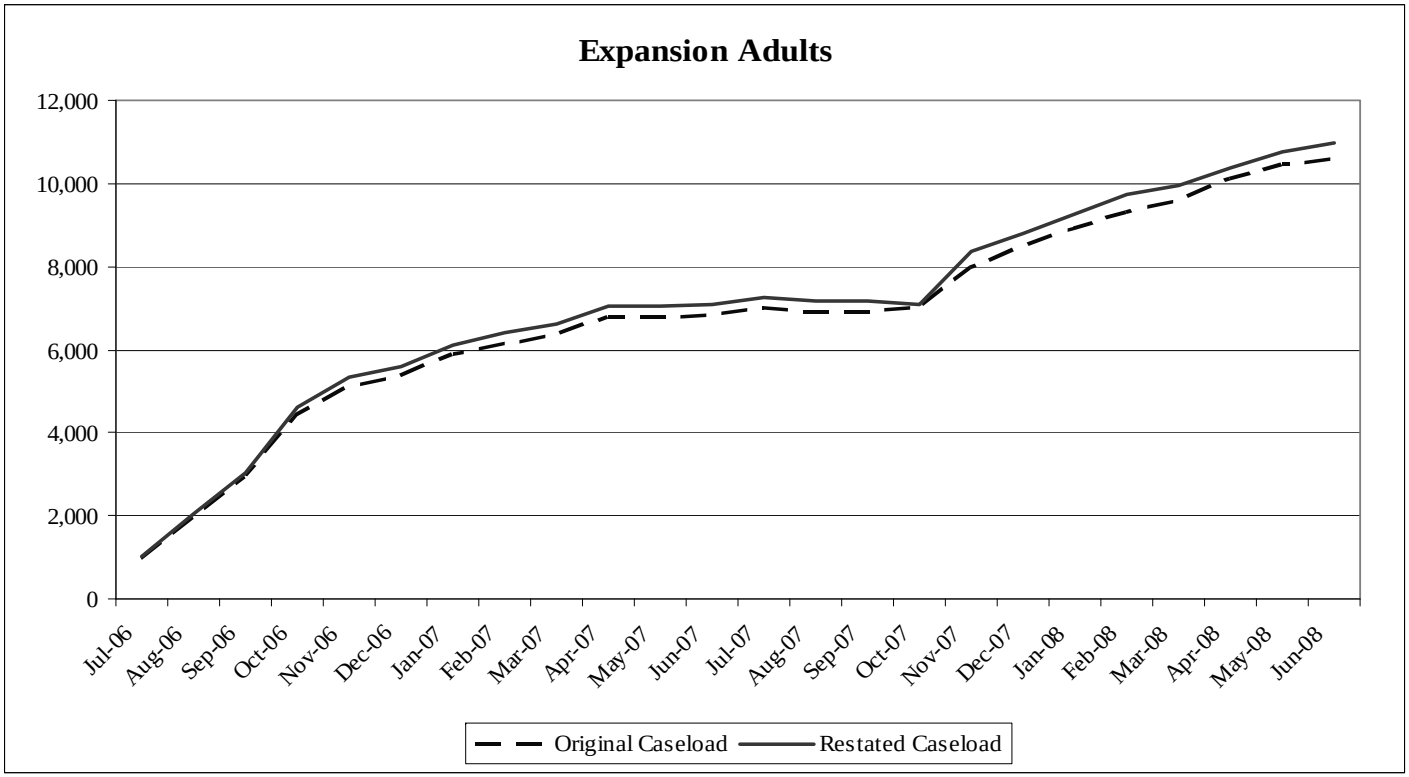
Disabled Individuals to 59 (AND/AB)					
	Original Caseload	Original Growth Rate	Restated Caseload	Restated Growth Rate	Difference
FY 02-03	46,378	0.06%	46,647		0.58%
FY 03-04	46,565	0.40%	46,789	0.30%	0.48%
FY 04-05	47,626	2.28%	47,929	2.44%	0.64%
FY 05-06	47,565	-0.13%	47,855	-0.15%	0.61%
FY 06-07	48,567	2.11%	48,799	1.97%	0.48%
FY 07-08	49,662	2.25%	49,933	2.32%	0.55%

Categorically Eligible Low-Income Adults



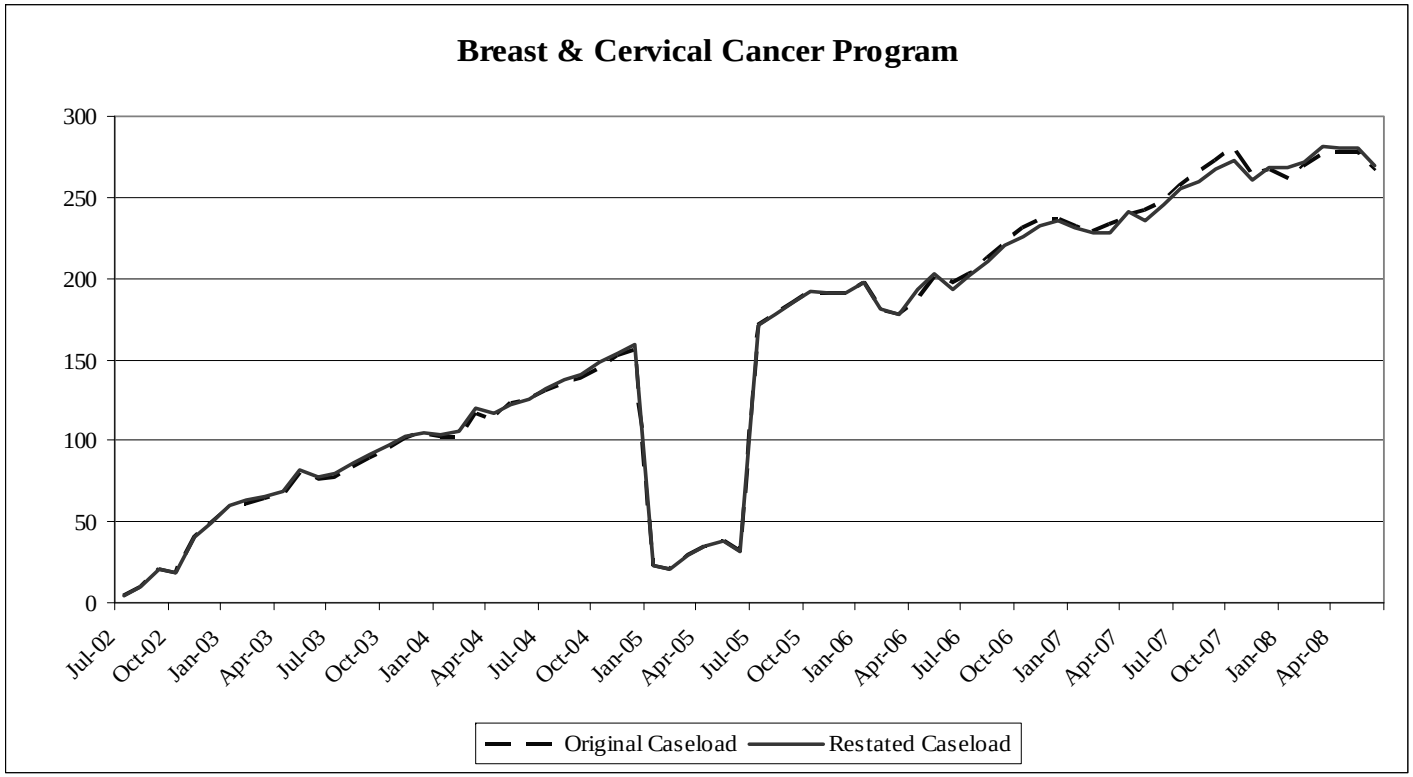
Categorically Eligible Low-Income Adults (AFDC-A)					
	Original Caseload	Original Growth Rate	Restated Caseload	Restated Growth Rate	Difference
FY 02-03	40,021	20.01%	40,798		1.94%
FY 03-04	46,756	16.83%	47,562	16.58%	1.72%
FY 04-05	56,453	20.74%	57,140	20.14%	1.22%
FY 05-06	57,754	2.30%	58,885	3.05%	1.96%
FY 06-07	51,361	-11.07%	50,687	-13.92%	-1.31%
FY 07-08	44,234	-13.88%	44,555	-12.10%	0.73%

Expansion Adults



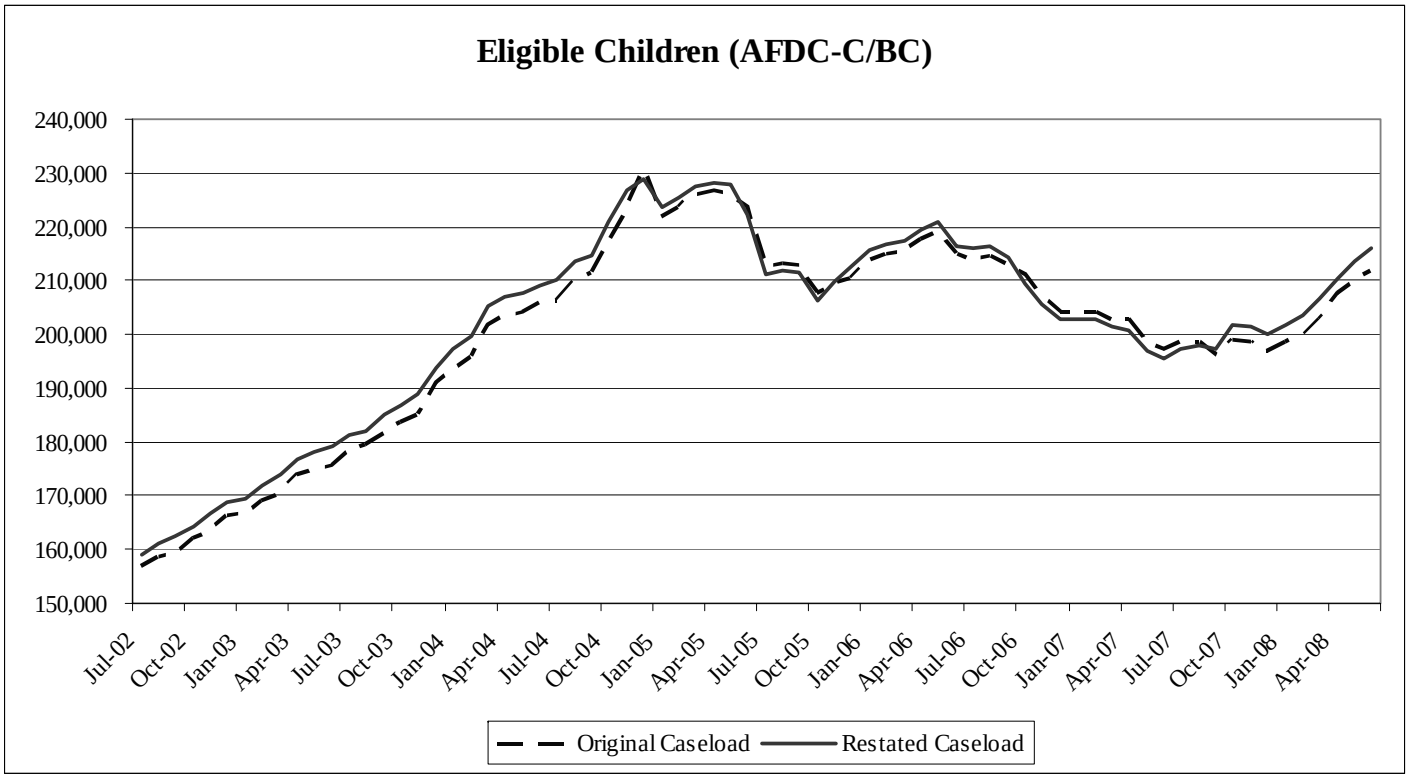
Expansion Adults					
	Original Caseload	Original Growth Rate	Restated Caseload	Restated Growth Rate	Difference
FY 06-07	4,974		5,162		3.78%
FY 07-08	8,627	73.44%	8,918	72.76%	3.37%

Breast and Cervical Cancer Program



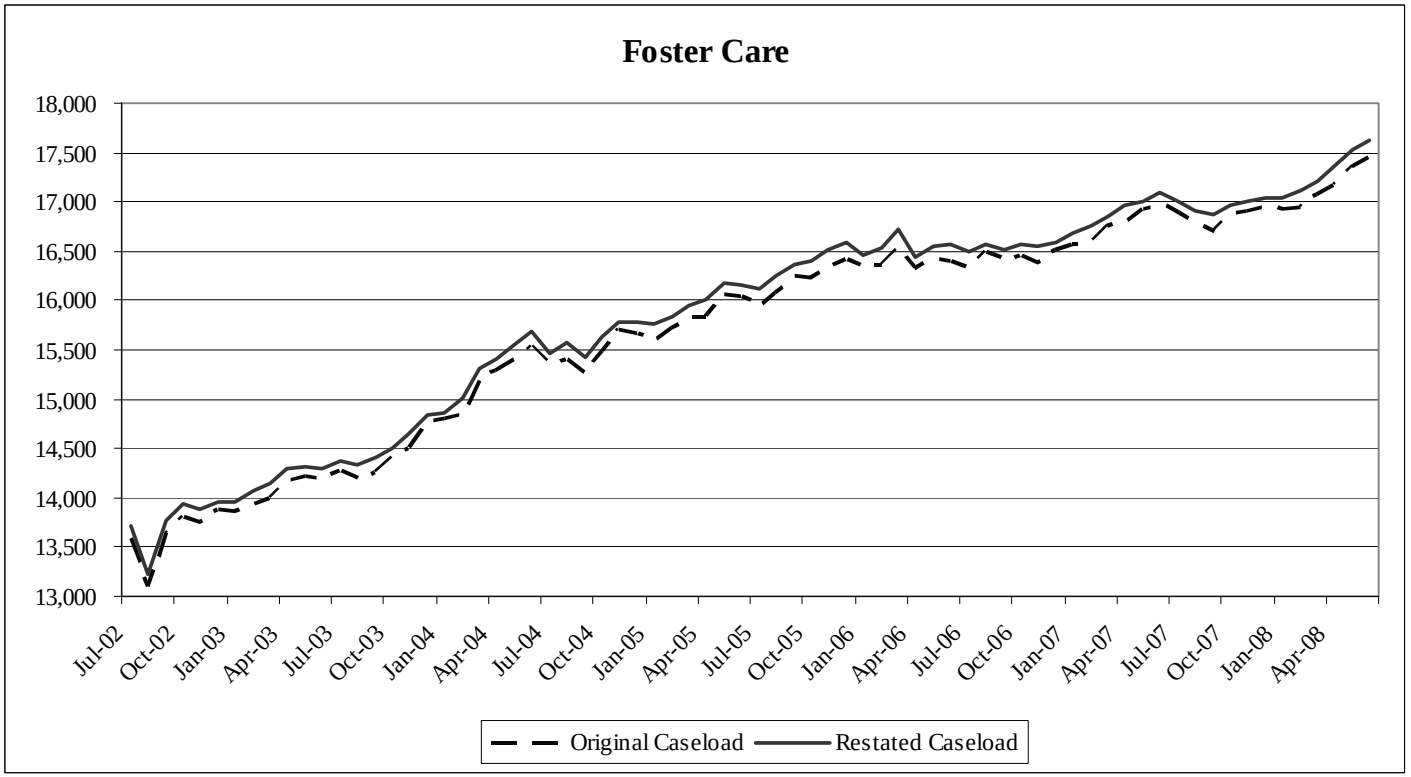
Breast & Cervical Cancer Program					
	Original Caseload	Original Growth Rate	Restated Caseload	Restated Growth Rate	Difference
FY 02-03	46		47		2.17%
FY 03-04	103	123.91%	105	123.40%	1.94%
FY 04-05	86	-16.50%	87	-17.14%	1.16%
FY 05-06	188	118.60%	188	116.09%	0.00%
FY 06-07	230	22.34%	228	21.28%	-0.87%
FY 07-08	270	17.39%	270	18.42%	0.00%

Eligible Children



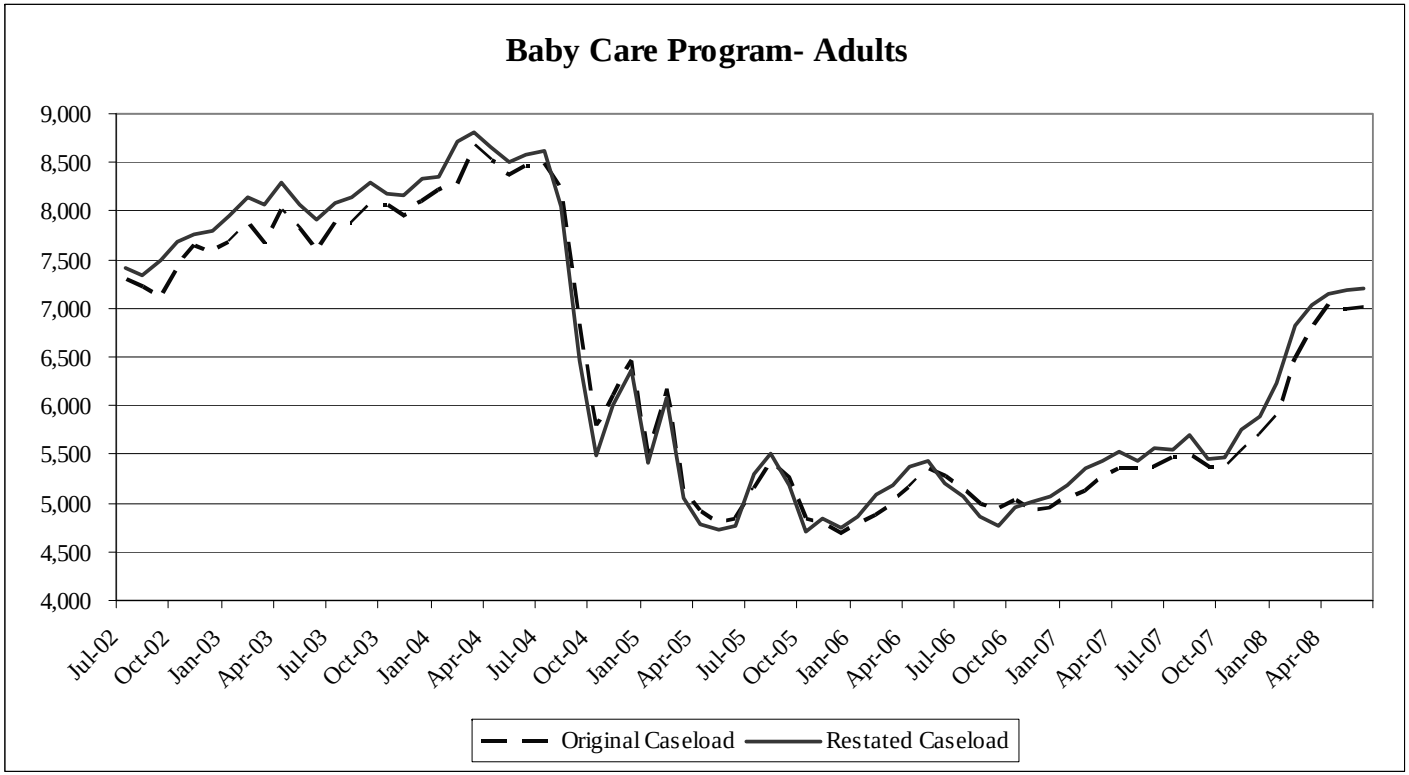
Eligible Children (AFDC-C/BC)					
	Original Caseload	Original Growth Rate	Restated Caseload	Restated Growth Rate	Difference
FY 02-03	166,537	15.72%	169,311		1.67%
FY 03-04	192,048	15.32%	195,279	15.34%	1.68%
FY 04-05	220,592	14.86%	222,472	13.93%	0.85%
FY 05-06	213,600	-3.17%	214,158	-3.74%	0.26%
FY 06-07	206,170	-3.48%	205,390	-4.09%	-0.38%
FY 07-08	201,800	-2.12%	204,022	-0.67%	1.10%

Foster Care



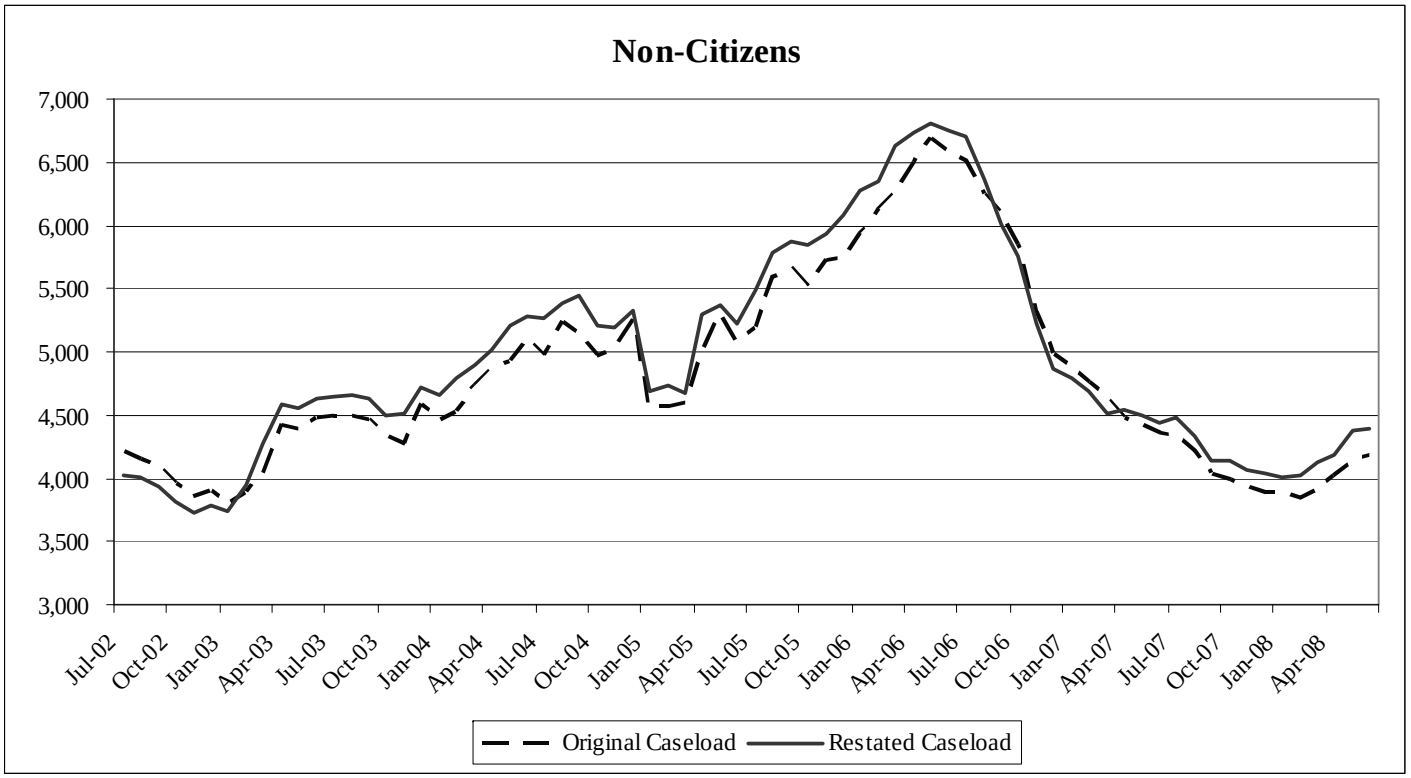
Foster Care					
	Original Caseload	Original Growth Rate	Restated Caseload	Restated Growth Rate	Difference
FY 02-03	13,843	5.50%	13,967		0.90%
FY 03-04	14,790	6.84%	14,914	6.78%	0.84%
FY 04-05	15,669	5.94%	15,795	5.91%	0.80%
FY 05-06	16,311	4.10%	16,460	4.21%	0.91%
FY 06-07	16,601	1.78%	16,724	1.60%	0.74%
FY 07-08	17,014	2.49%	17,141	2.49%	0.75%

Baby Care Adults



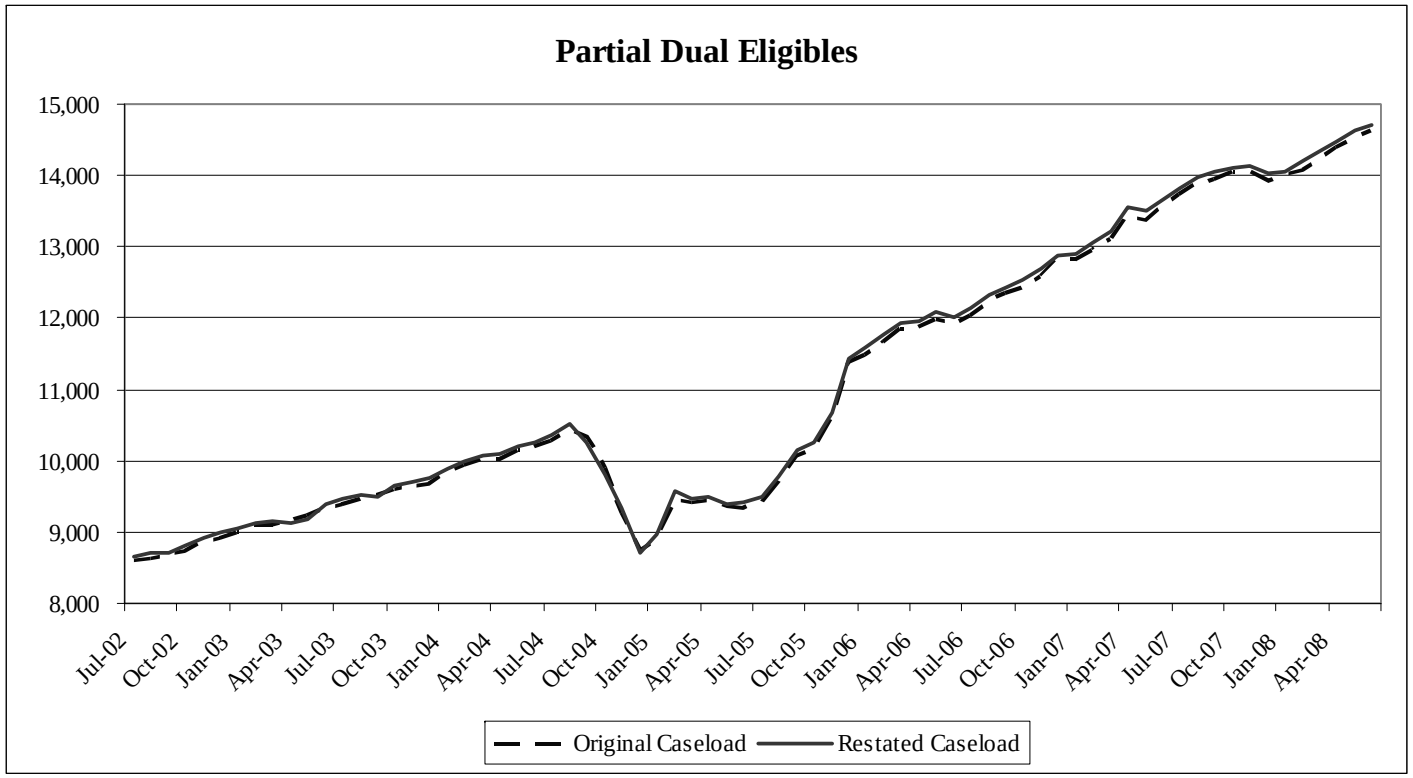
Baby Care Program- Adults					
	Original Caseload	Original Growth Rate	Restated Caseload	Restated Growth Rate	Difference
FY 02-03	7,579	6.28%	7,823		3.22%
FY 03-04	8,203	8.23%	8,398	7.35%	2.38%
FY 04-05	6,110	-25.52%	5,984	-28.74%	-2.06%
FY 05-06	5,050	-17.35%	5,119	-14.46%	1.37%
FY 06-07	5,123	1.45%	5,182	1.23%	1.15%
FY 07-08	6,108	19.23%	6,288	21.34%	2.95%

Non-Citizens



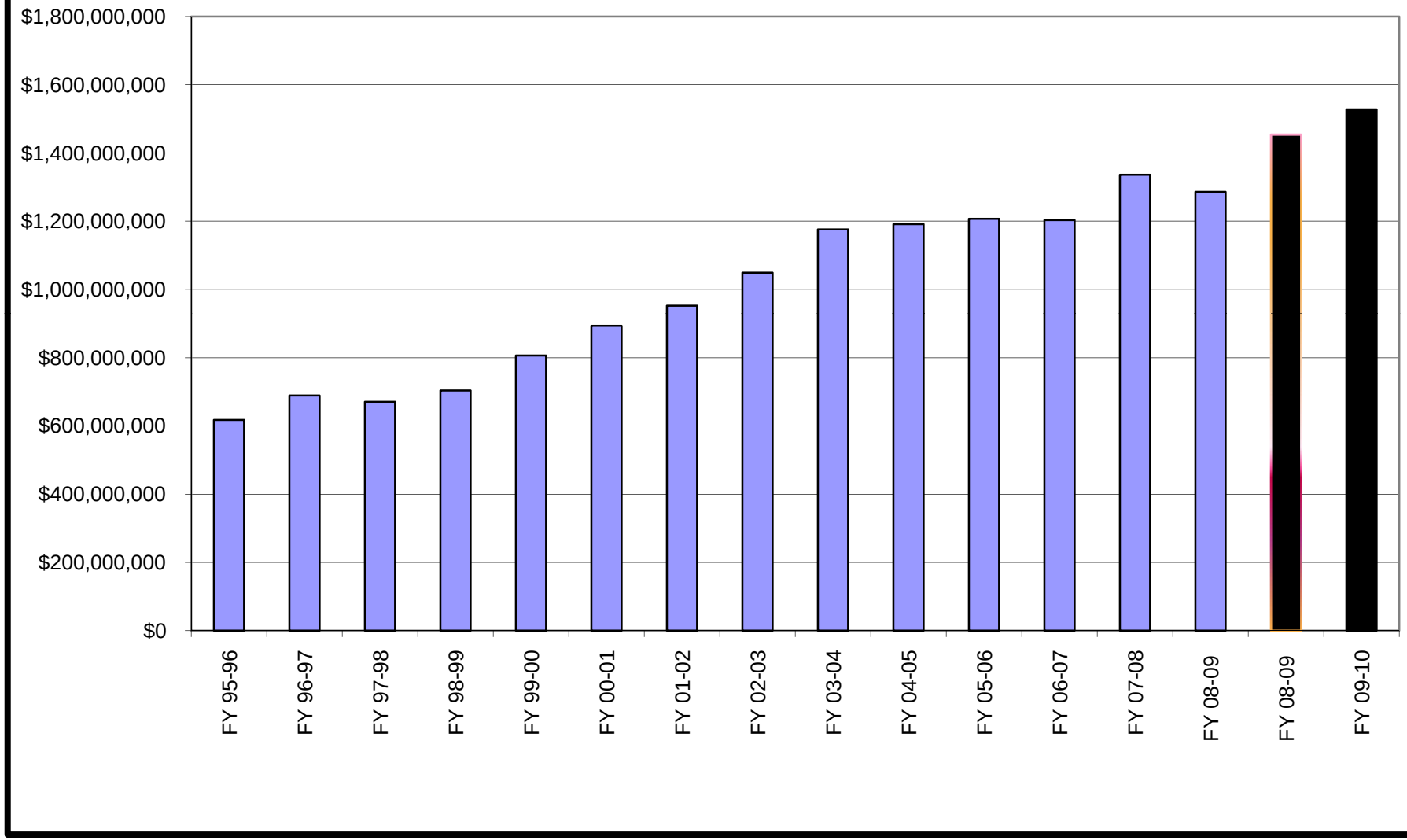
Non-Citizens					
	Original Caseload	Original Growth Rate	Restated Caseload	Restated Growth Rate	Difference
FY 02-03	4,101	1.81%	4,084		-0.41%
FY 03-04	4,604	12.27%	4,793	17.36%	4.11%
FY 04-05	4,976	8.08%	5,150	7.45%	3.50%
FY 05-06	5,959	19.75%	6,212	20.62%	4.25%
FY 06-07	5,214	-12.50%	5,201	-16.27%	-0.25%
FY 07-08	4,044	-22.44%	4,191	-19.42%	3.64%

Partial Dual Eligibles

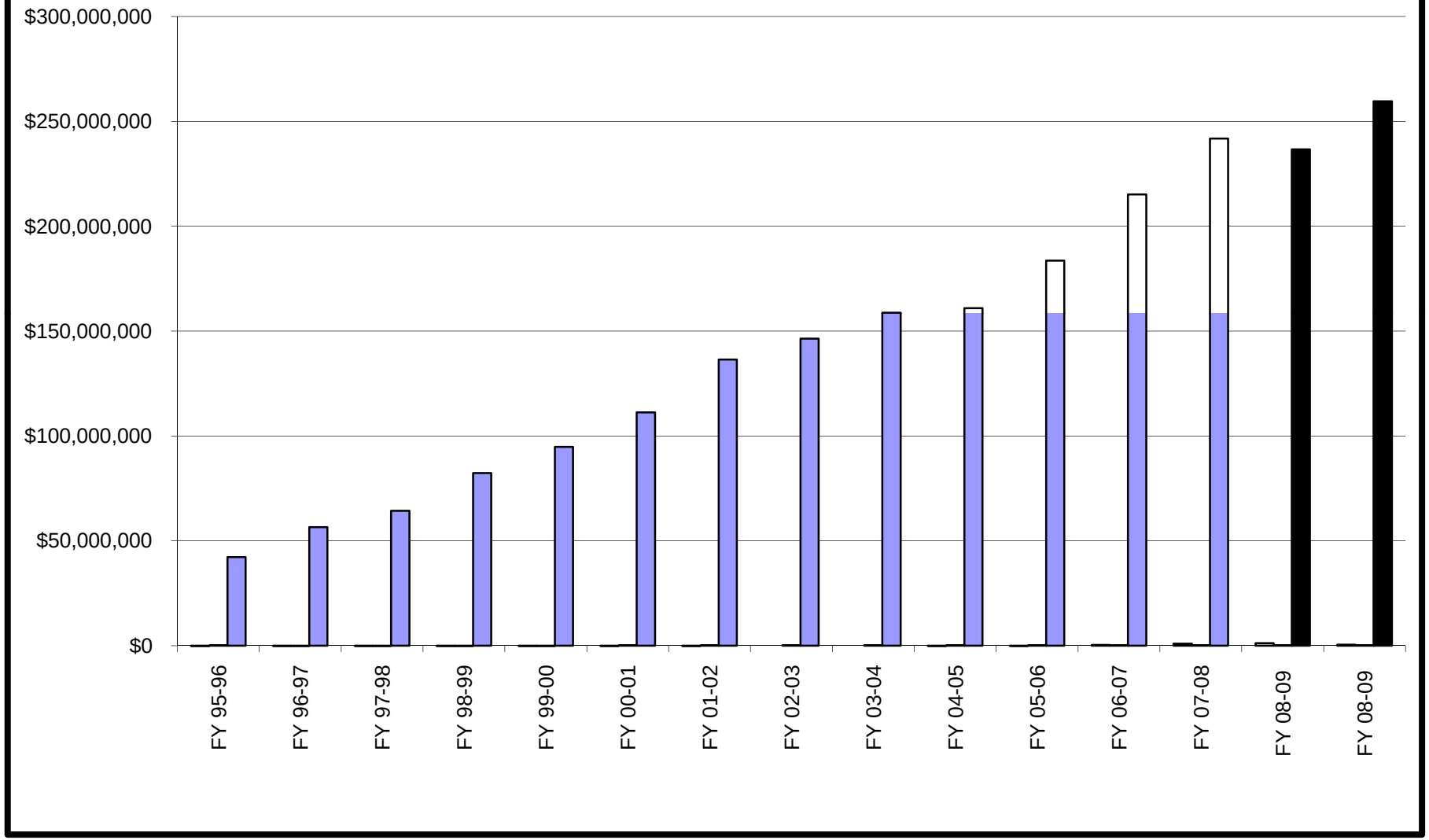


Partial Dual Eligibles					
	Original Caseload	Original Growth Rate	Restated Caseload	Restated Growth Rate	Difference
FY 02-03	8,949	6.18%	8,988		0.44%
FY 03-04	9,787	9.36%	9,842	9.50%	0.56%
FY 04-05	9,572	-2.20%	9,605	-2.41%	0.34%
FY 05-06	11,012	15.04%	11,092	15.48%	0.73%
FY 06-07	12,818	16.40%	12,908	16.37%	0.70%
FY 07-08	14,130	10.24%	14,214	10.12%	0.59%

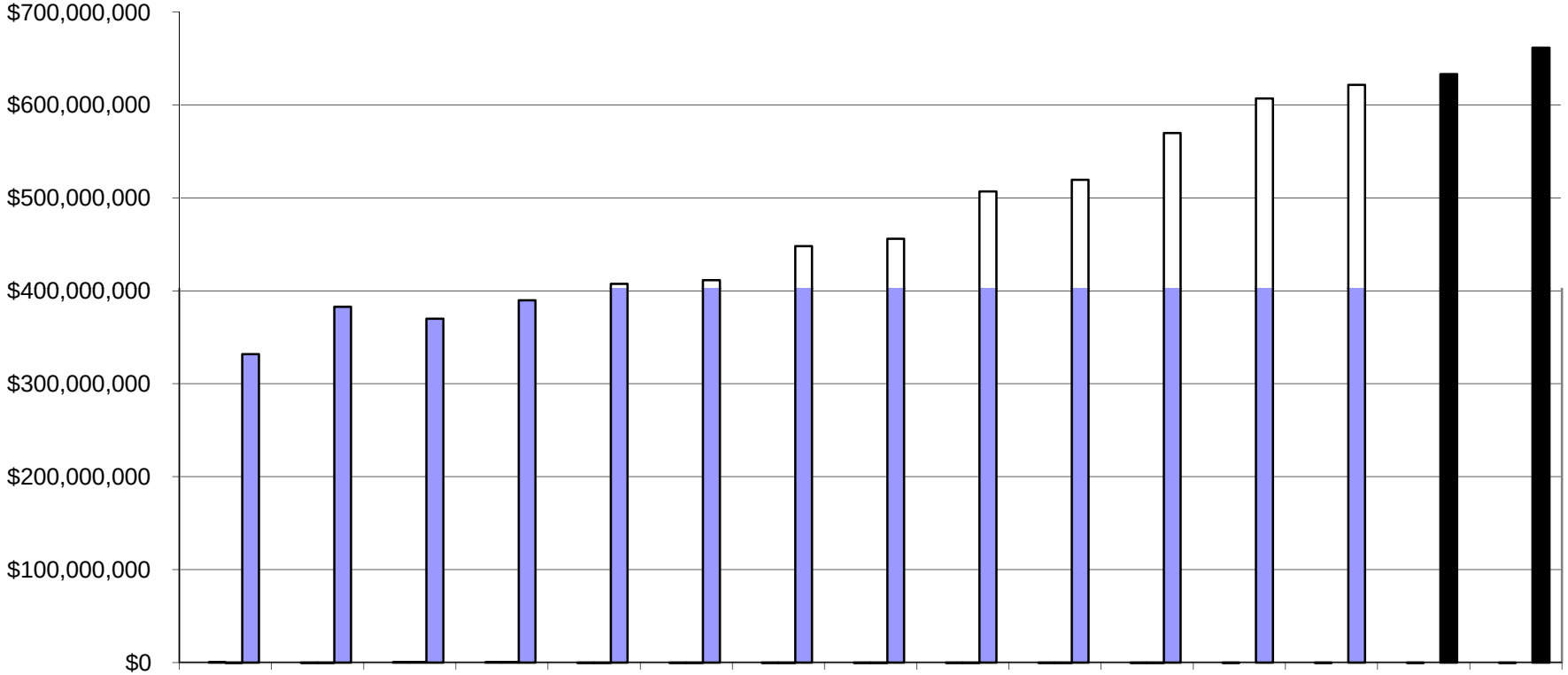
Acute Care Services Expenditure History

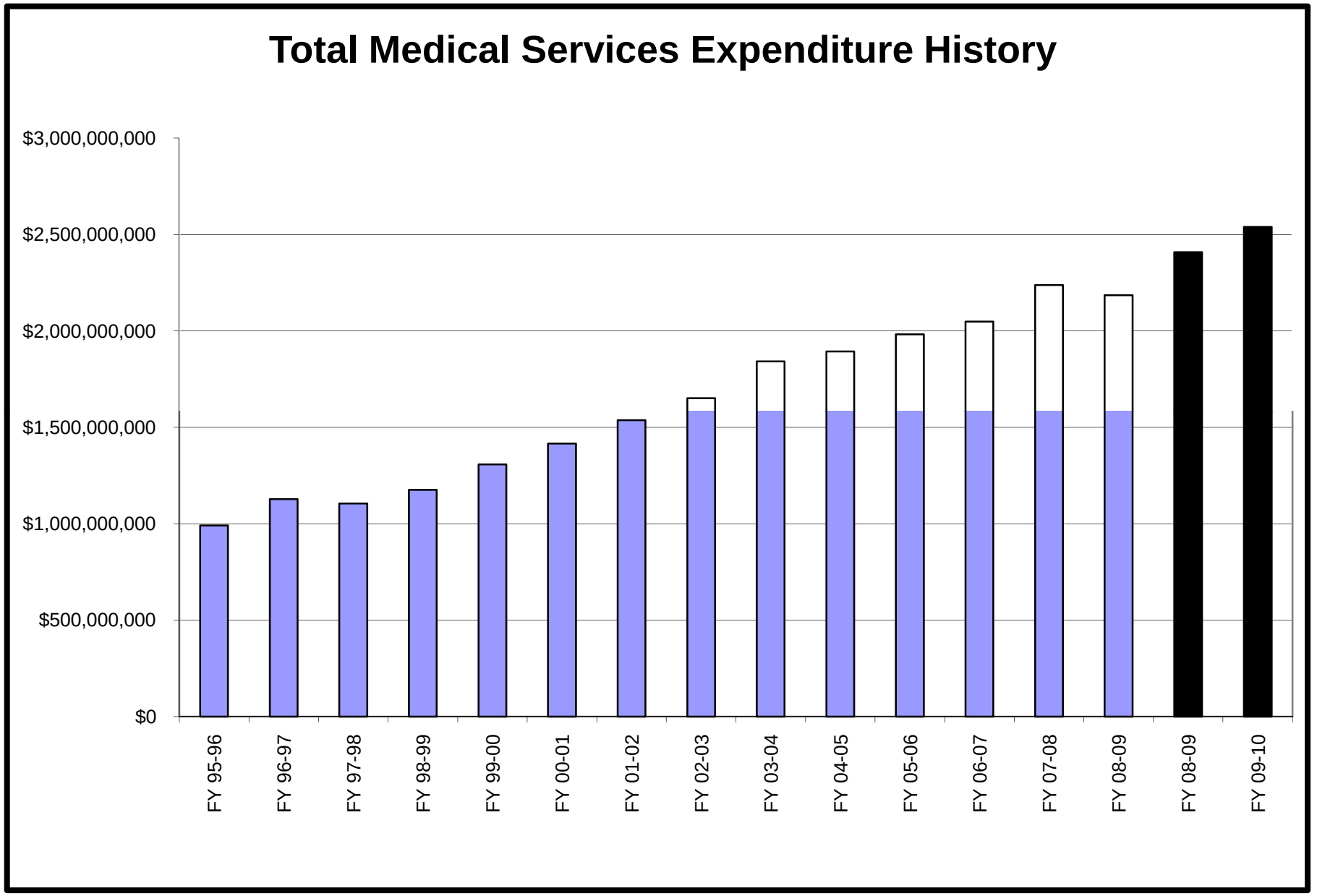


Community Based Long-Term Care Expenditure History



Institution Long-Term Care & Insurance Expenditure History




Total Medical Services Expenditure History
$3,000,000,000
$2,500,000,000
$2,000,000,000
$1,500,000,000
$1,000,000,000
$500,000,000
$0
FY 95-96
FY 96-97
FY 97-98
FY 98-99
FY 99-00
FY 00-01
FY 01-02
FY 02-03
FY 03-04
FY 04-05
FY 05-06
FY 06-07
FY 07-08
FY 08-09
FY 08-09
FY 09-10

Caseload and Cost Histroy -- JBC Document

Total Caseload and Cost History by Aid Category

		SSI 65	SSI 60-64	QMB/SLIMB	SSI Disabled	Low Income Adults	BC Adults	BCCTP	Exp. Adults	Eligible Children	Foster Care	Non-Citizens	Total
Medicaid Caseload													
FY 95-96		31,321	4,261	3,937	44,736	36,690	7,223	0	0	113,439	8,376	4,100	254,083
FY 96-97		32,080	4,429	4,316	46,090	33,250	5,476	0	0	110,586	9,261	4,610	250,098
FY 97-98		32,664	4,496	4,560	46,003	27,179	4,295	0	0	103,912	10,453	5,032	238,594
FY 98-99		33,007	4,909	6,104	46,310	22,852	5,017	0	0	102,074	11,526	5,799	237,598
FY 99-00		33,135	5,092	7,597	46,386	23,515	6,174	0	0	109,816	12,474	9,065	253,254
FY 00-01		33,649	5,157	8,157	46,046	27,081	6,561	0	0	123,221	13,076	12,451	275,399
FY 01-02		33,916	5,184	8,428	46,349	33,347	7,131	0	0	143,909	13,121	4,028	295,413
FY 02-03	original history	34,485	5,456	8,949	46,378	40,021	7,579	46	0	166,537	13,843	4,101	327,395
FY 03-04	original history	34,149	5,528	9,787	46,565	46,754	8,203	103	0	192,048	14,790	4,604	362,531
FY 04-05	original history	35,615	6,103	9,572	47,626	56,453	6,110	86	0	220,592	15,669	4,976	402,802
FY 05-06	original history	36,219	6,048	11,012	47,565	57,754	5,050	188	0	213,600	16,311	5,959	399,705
FY 06-07	original history	35,977	6,042	12,818	48,567	51,361	5,123	230	4,974	206,170	16,601	5,214	393,077
FY 07-08	original history	36,044	6,116	14,130	49,662	44,234	6,108	270	8,627	201,800	17,014	4,044	388,049
FY 08-09	Cur App.	36,278	6,216	15,068	50,123	41,667	6,028	301	9,629	193,484	18,858	3,738	381,390
FY 08-09	Dept Forecast	37,155	6,257	15,202	50,582	45,161	7,353	285	11,950	225,209	17,968	4,529	421,651
FY 09-10	Dept Forecat	37,478	6,330	16,097	51,057	46,444	7,566	303	13,260	233,082	18,682	4,739	435,038

Caseload and Cost Histroy -- JBC Document

Total Caseload and Cost History by Aid Category

Acute Care Services

		SSI 65	SSI 60-64	QMB/SLIMB	SSI Disabled	Low Income Adults	BC Adults	BCCTP	Exp. Adults	Eligible Children	Foster Care	Non-Citizens	Total
FY 95-96		$65,490,832	$20,813,888	$1,498,645	$215,076,923	$95,568,690	$42,767,829	$0	$0	$142,105,656	$20,002,990	$13,792,970	$617,118,423
FY 96-97		$86,555,911	$23,425,875	$1,768,008	$258,031,934	$105,465,599	$37,543,774	$0	$0	$136,318,983	$21,784,915	$17,851,756	$688,746,755
FY 97-98		$90,855,859	$24,711,381	$1,405,971	$258,958,421	$82,369,107	$28,942,845	$0	$0	$142,788,816	$22,102,057	$18,549,901	$670,684,358
FY 98-99		$99,611,066	$31,780,339	$1,429,623	$275,661,117	$71,396,513	$31,462,780	$0	$0	$149,529,580	$22,448,268	$20,732,564	$704,051,850
FY 99-00		$109,773,578	$36,614,227	$1,899,206	$316,945,087	$80,784,239	$33,518,472	$0	$0	$169,546,536	$27,431,418	$29,667,057	$806,179,820
FY 00-01		$126,369,794	$38,727,163	$2,302,841	$345,853,758	$88,491,965	$31,496,405	$0	$0	$192,833,114	$30,660,294	$36,924,837	$893,660,171
FY 01-02		$131,835,670	$37,856,289	$2,145,037	$349,368,303	$104,039,520	$33,937,796	$0	$0	$220,491,735	$33,156,728	$39,367,016	$952,198,094
FY 02-03		$127,969,752	$39,813,094	$1,897,397	$385,226,750	$139,553,510	$42,510,204	$1,428,780	$0	$227,550,173	$34,701,970	$48,724,102	$1,049,375,732
FY 03-04		$135,135,551	$46,255,115	$2,089,094	$414,667,649	$182,959,373	$63,256,861	$2,668,858	$0	$231,893,695	$41,981,745	$55,128,970	$1,176,036,911
FY 04-05		$144,236,013	$46,693,685	$1,893,876	$397,728,916	$183,416,905	$38,545,344	$2,490,150	$0	$289,270,930	$42,142,755	$44,696,253	$1,191,114,827
FY 05-06		$119,353,131	$45,562,871	$2,068,100	$395,096,174	$194,256,325	$39,291,425	$6,809,762	$0	$304,607,787	$44,535,020	$55,307,090	$1,206,887,685
FY 06-07		$83,069,760	$44,002,744	$2,845,609	$382,381,966	$197,984,589	$47,585,089	$5,712,309	$7,353,407	$327,049,562	$49,389,806	$55,988,997	$1,203,363,838
FY 07-08		$91,090,497	$50,360,206	$3,330,605	$449,938,999	$188,767,403	$53,476,246	$7,089,560	$18,945,426	$360,437,875	$58,933,895	$53,633,575	$1,336,004,287
FY 08-09	Cur App.	$84,621,888	$49,402,642	$3,057,108	$436,083,148	$189,261,673	$52,701,784	$6,743,169	$18,358,869	$336,271,614	$57,154,571	$52,483,288	$1,286,139,754
FY 08-09	Dept Forecast	$96,986,194	$53,024,073	$3,779,874	$468,413,709	$199,004,489	$56,204,713	$7,751,918	$29,518,147	$413,551,843	$68,783,238	$56,981,050	$1,453,999,248
FY 09-10	Dept Forecat	$99,988,933	$54,558,947	$4,246,893	$485,063,100	$211,008,135	$60,343,397	$8,549,571	$35,125,026	$433,662,525	$77,551,117	$57,458,682	$1,527,556,326

Community Based Long-Term Care

FY 95-96		$23,914,044	$2,421,317	$28,593	$15,693,871	$169,696	$0	$0	$0	$13,802	$2,051	$0	$42,243,374
FY 96-97		$33,196,634	$2,819,452	$17,406	$19,888,727	$7,414	$0	$0	$0	$132,517	$444,840	$0	$56,506,990
FY 97-98		$37,156,766	$3,246,682	$21,537	$23,055,275	$15,700	$14,436	$0	$0	$135,551	$649,676	$0	$64,295,623
FY 98-99		$46,152,127	$4,563,159	$47,186	$30,523,406	$47,389	$68	$0	$0	$79,498	$871,837	$0	$82,284,670
FY 99-00		$59,932,681	$5,511,069	$115	$29,301,508	$29,479	$0	$0	$0	$21,258	$21,723	$0	$94,817,833
FY 00-01		$61,569,418	$9,013,673	$217	$39,811,298	$163,996	$0	$0	$0	$679,864	$43,938	$0	$111,282,404
FY 01-02		$85,928,541	$7,399,415	$44	$42,961,368	$84,265	$0	$0	$0	$21,694	$36,905	$0	$136,432,232
FY 02-03		$78,719,107	$7,549,034	$0	$56,806,389	$70,931	$109	$0	$0	$389,329	$2,854,975	$0	$146,389,874
FY 03-04		$85,726,658	$8,298,496	$1	$61,272,991	$167,620	$0	$0	$0	$213,385	$3,044,165	$0	$158,723,316
FY 04-05		$86,505,276	$8,689,937	$224	$61,264,884	$126,591	$2,461	$0	$0	$689,933	$3,665,603	$0	$160,944,909
FY 05-06		$95,295,727	$12,130,404	$41,208	$71,302,410	$150,551	$0	$0	$0	$529,206	$4,121,260	$0	$183,570,766
FY 06-07		$112,939,443	$14,106,731	$395,653	$82,896,656	$88,469	$0	$0	$5,134	$704,094	$3,990,308	$0	$215,126,488
FY 07-08		$124,223,596	$16,355,186	$920,663	$94,673,894	$113,310	$0	$0	$8,054	$590,675	$4,856,637	$0	$241,742,015
FY 08-09	Cur app.	$122,825,124	$15,710,032	$1,235,622	$91,401,268	$137,033	$0	$0	$0	$771,105	$4,561,401	$0	$236,641,585
FY 08-09	Dept Forecast	$131,324,044	$17,409,994	$497,202	$104,125,871	$115,301	$0	$0	$10,798	$554,847	$5,477,758	$0	$259,515,815
FY 09-10	Dept Forecast	$135,166,214	$17,901,977	$394,859	$109,381,623	$118,432	$0	$0	$11,934	$529,096	$6,099,860	$0	$269,603,995

Caseload and Cost Histroy -- JBC Document

Total Caseload and Cost History by Aid Category

		SSI 65	SSI 60-64	QMB/SLIMB	SSI Disabled	Low Income Adults	BC Adults	BCCTP	Exp. Adults	Eligible Children	Foster Care	Non-Citizens	Total
Long Term Care and Insurance													
FY 95-96		$265,378,874	$10,954,225	$4,496,634	$48,395,635	$895,294	*$333,694*	$0	$0	$1,136,055	$179,036	*$104,233*	$331,873,680
FY 96-97		$314,390,400	$10,909,968	$4,778,071	$52,329,969	$110,037	*$5,162*	$0	$0	$18,773	$121,330	*$2,331*	$382,666,041
FY 97-98		$301,838,995	$10,146,682	$4,743,369	$50,362,296	$886,773	*$275,566*	$0	$0	$1,328,171	$229,016	*$180,144*	$369,991,012
FY 98-99		$316,477,042	$11,814,875	$4,743,222	$53,765,594	$785,668	*$328,015*	$0	$0	$1,516,010	$250,598	*$215,866*	$389,896,890
FY 99-00		$332,816,267	$12,277,622	$5,069,564	$57,069,162	$90,884	*$12,253*	$0	$0	$48,750	$29,080	*$8,866*	$407,422,448
FY 00-01		$331,336,749	$12,824,839	$5,523,571	$61,708,777	$102,744	*$7,417*	$0	$0	$41,469	$41,752	*$5,514*	$411,592,832
FY 01-02		$357,382,766	$15,509,568	$5,972,427	$69,135,778	$104,381	*$9,031*	$0	$0	$43,497	$11,168	*$5,747*	$448,174,363
FY 02-03		$362,124,520	$16,815,129	$6,037,874	$70,719,059	$121,987	$11,580	$0	$0	$55,287	$9,301	*$10,530*	$455,905,267
FY 03-04		$398,213,039	$20,698,583	$7,379,512	$80,411,131	$147,275	$17,982	$0	$0	$85,666	$14,361	*$11,145*	$506,978,694
FY 04-05		$404,700,124	$24,095,846	$9,029,704	$81,341,062	$202,034	$15,329	$0	$0	$73,026	$12,242	*$9,501*	$519,478,868
FY 05-06		$444,232,144	$27,813,673	$11,243,514	$86,190,316	$150,982	$13,231	$0	$0	$64,840	$10,566	*$8,200*	$569,727,466
FY 06-07		$466,369,276	$29,974,318	$13,749,798	$96,639,946	$148,220	$3,133	$0	$0	$9,795	$651	*$0*	$606,895,137
FY 07-08		$477,728,345	$31,702,410	$14,585,646	$97,405,044	$152,125	$2,208			$16,916	$1,188	$0	$621,593,882
FY 08-09	Cur app.	$486,944,368	$31,352,984	$14,315,091	$100,339,477	$154,731	$3,785	$0	$0	$11,833	$786	$0	$633,123,055
FY 08-09	Dept Forecast	$507,072,884	$33,649,296	$17,222,526	$103,508,681	$172,572	$2,450	$0	$0	$18,768	$1,318	*$0*	$661,648,495
FY 09-10	Dept Forecast	$542,960,720	$36,203,556	$18,915,995	$108,566,525	$185,015	$2,584	$0	$0	$19,796	$1,390	*$0*	$706,855,581
Service Management													
FY 04-05		$15,149,728	$1,042,839	$788	$4,685,739	$170,842	$24,807	$421	$0	$572,844	$90,444	*$8,512*	$21,746,964
FY 05-06		$14,047,680	$977,580	$10,538	$3,204,518	$669,383	$91,107	$637	$0	$2,993,587	$215,129	*$0*	$22,210,159
FY 06-07		$15,044,147	$1,061,392	$33,778	$3,437,617	$595,410	$100,020	$2,053	$1,000	$2,533,150	$243,385	*$0*	$23,051,952
FY 07-08		$11,426,962	$1,911,023	$119,709	$10,362,388	$811,755	$173,270	$12,812	$66,075	$2,520,637	$292,667	*$0*	$27,697,298
FY 08-09	Cur app.	$18,632,679	$1,382,802	$41,701	$4,895,723	$1,049,834	$185,311	$14,257	$995	$3,238,276	$360,984	$0	$29,802,563
FY 08-09	Dept Forecast	$12,808,221	$2,212,913	$131,715	$12,385,260	$1,370,908	$299,158	$27,533	$86,491	$3,870,972	$470,564	*$0*	$33,663,735
FY 09-10	Dept Forecast	$13,265,583	$2,355,068	$139,157	$13,077,256	$1,398,218	$308,297	$27,533	$117,002	$3,997,661	$473,050	$0	$35,158,825

Caseload and Cost Histroy -- JBC Document

Total Caseload and Cost History by Aid Category

Total Expenditures (DOES NOT INCLUDE BOTTOM OF THE LINE FINANCING -- ONLY SERVICE COSTS)

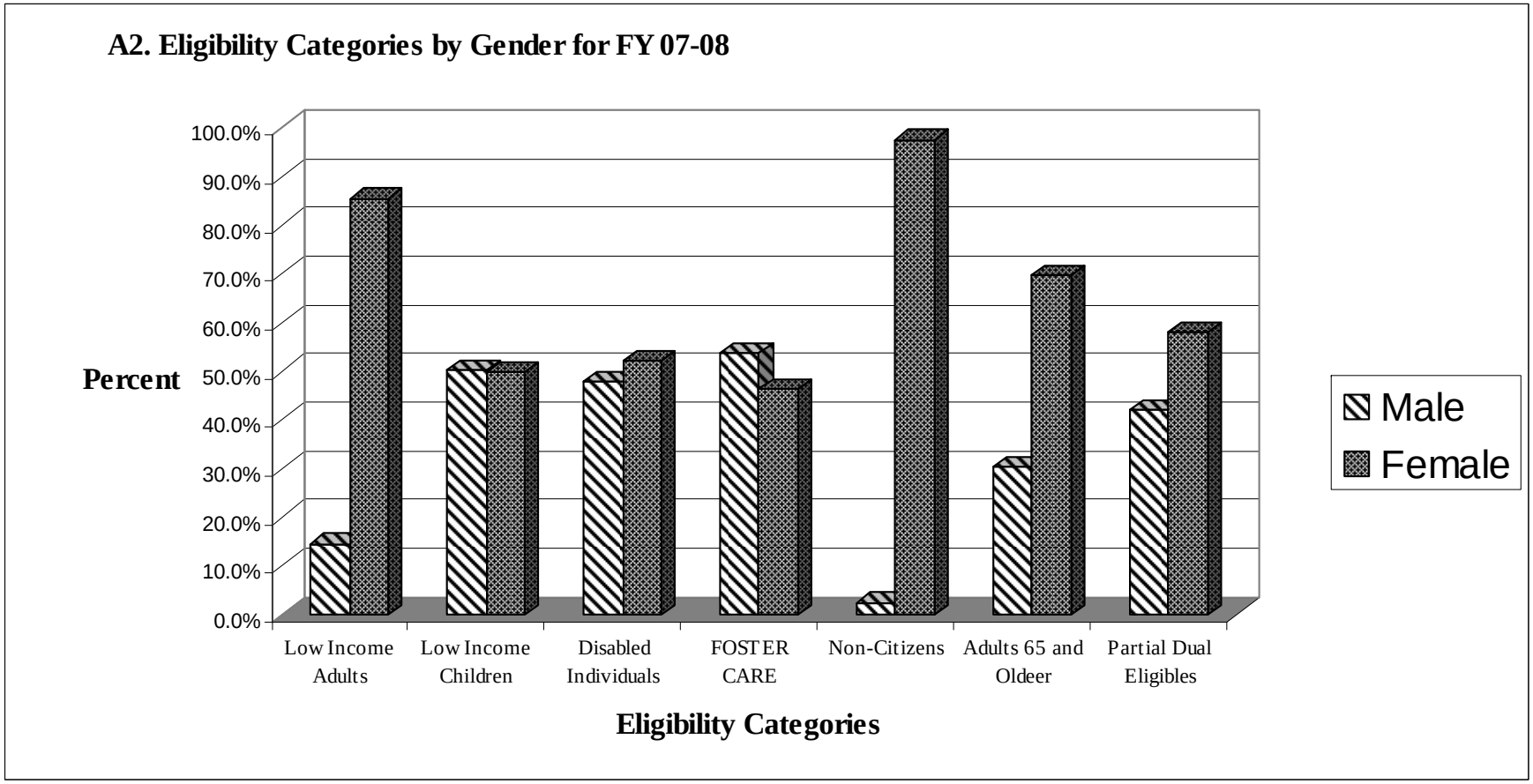
		SSI 65	SSI 60-64	QMB/SLIMB	SSI Disabled	Low Income Adults	BC Adults	BCCTP	Exp. Adults	Eligible Children	Foster Care	Non-Citizens	Total
FY 95-96		$354,783,750	$34,189,430	$6,023,872	$279,166,429	$96,633,680	$43,101,523	$0	$0	$143,255,513	$20,184,077	$13,897,203	$991,235,477
FY 96-97		$434,142,945	$37,155,295	$6,563,485	$330,250,630	$105,583,050	$37,548,936	$0	$0	$136,470,273	$22,351,085	$17,854,087	$1,127,919,786
FY 97-98		$429,851,620	$38,104,745	$6,170,877	$332,375,992	$83,271,580	$29,232,847	$0	$0	$144,252,538	$22,980,749	$18,730,045	$1,104,970,993
FY 98-99		$462,240,235	$48,158,373	$6,220,031	$359,950,117	$72,229,570	$31,790,863	$0	$0	$151,125,088	$23,570,703	$20,948,430	$1,176,233,410
FY 99-00		$502,522,526	$54,402,918	$6,968,885	$403,315,757	$80,904,602	$33,530,725	$0	$0	$169,616,544	$27,482,221	$29,675,923	$1,308,420,101
FY 00-01		$519,275,961	$60,565,675	$7,826,629	$447,373,833	$88,758,705	$31,503,822	$0	$0	$193,554,447	$30,745,984	$36,930,351	$1,416,535,407
FY 01-02		$575,146,977	$60,765,272	$8,117,508	$461,465,449	$104,228,166	$33,946,827	$0	$0	$220,556,926	$33,204,801	$39,372,763	$1,536,804,689
FY 02-03		$568,813,379	$64,177,257	$7,935,271	$512,752,198	$139,746,428	$42,521,893	$1,428,780	$0	$227,994,789	$37,566,246	$48,734,632	$1,651,670,873
FY 03-04		$619,075,248	$75,252,194	$9,468,607	$556,351,771	$183,274,268	$63,274,843	$2,668,858	$0	$232,192,746	$45,040,271	$55,140,115	$1,841,738,921
FY 04-05		$650,591,141	$80,522,307	$10,924,592	$545,020,601	$183,916,372	$38,587,941	$2,490,571	$0	$290,606,733	$45,911,044	$44,714,266	$1,893,285,568
FY 05-06		$672,928,682	$86,484,528	$13,363,360	$555,793,418	$195,227,241	$39,395,763	$6,810,399	$0	$308,195,420	$48,881,975	$55,315,290	$1,982,396,076
FY 06-07		$677,422,626	$89,145,185	$17,024,838	$565,356,185	$198,816,688	$47,688,242	$5,714,362	$7,359,541	$330,296,601	$53,624,150	$55,988,997	$2,048,437,415
FY 07-08		$713,685,423	$99,979,399	$18,686,068	$655,314,758	$189,847,199	$53,653,301	$7,102,372	$19,019,555	$363,561,020	$64,083,985	$53,633,575	$2,238,566,655
FY 08-09	Current App	$713,024,059	$97,848,459	$18,649,521	$632,719,616	$190,603,272	$52,890,881	$6,757,426	$18,359,864	$340,292,829	$62,077,742	$52,483,288	$2,185,706,956
FY 08-09	Depart Forecast	$748,191,343	$106,296,276	$21,631,317	$688,433,521	$200,663,270	$56,506,321	$7,779,451	$29,615,436	$417,996,430	$74,732,878	$56,981,050	$2,408,827,293
FY 09-10	Depart Forecast	$791,381,450	$111,019,548	$23,696,904	$716,088,504	$212,709,800	$60,654,278	$8,577,104	$35,253,962	$438,209,078	$84,125,417	$57,458,682	$2,539,174,727

Cost Per Client (without bottom line financing -- service costs only)

FY 95-96		$11,327.34	$8,023.80	$1,530.07	$6,240.31	$2,633.79	$5,967.26	$0.00	$0.00	$1,262.84	$2,409.75	$3,389.56	$3,901.23
FY 96-97		$13,533.13	$8,389.09	$1,520.73	$7,165.34	$3,175.43	$6,857.00	$0.00	$0.00	$1,234.06	$2,413.46	$3,872.90	$4,509.91
FY 97-98		$13,159.80	$8,475.25	$1,353.26	$7,225.09	$3,063.82	$6,806.25	$0.00	$0.00	$1,388.22	$2,198.48	$3,722.19	$4,631.18
FY 98-99		$14,004.31	$9,810.22	$1,019.01	$7,772.62	$3,160.75	$6,336.63	$0.00	$0.00	$1,480.54	$2,045.00	$3,612.42	$4,950.52
FY 99-00		$15,165.91	$10,684.00	$917.32	$8,694.77	$3,440.55	$5,430.96	$0.00	$0.00	$1,544.55	$2,203.16	$3,273.68	$5,166.43
FY 00-01		$15,432.14	$11,744.36	$959.50	$9,715.80	$3,277.53	$4,801.68	$0.00	$0.00	$1,570.79	$2,351.33	$2,966.06	$5,143.57
FY 01-02		$16,957.98	$11,721.70	$963.16	$9,956.32	$3,125.56	$4,760.46	$0.00	$0.00	$1,532.61	$2,530.66	$9,774.77	$5,202.22
FY 02-03		$16,494.52	$11,762.69	$886.72	$11,055.94	$3,491.83	$5,610.49	$31,060.43	$0.00	$1,369.03	$2,713.74	$11,883.60	$5,044.89
FY 03-04		$18,128.65	$13,612.91	$967.47	$11,947.85	$3,919.97	$7,713.62	$25,911.24	$0.00	$1,209.03	$3,045.32	$11,976.57	$5,080.22
FY 04-05		$18,267.34	$13,193.89	$1,141.31	$11,443.76	$3,257.87	$6,315.54	$28,960.13	$0.00	$1,317.39	$2,930.06	$8,985.99	$4,700.29
FY 05-06		$18,579.44	$14,299.69	$1,213.53	$11,684.92	$3,380.32	$7,801.14	$36,225.53	$0.00	$1,442.86	$2,996.87	$9,282.65	$4,959.65
FY 06-07		$18,829.33	$14,754.25	$1,328.20	$11,640.75	$3,870.97	$9,308.66	$24,845.05	$1,479.60	$1,602.06	$3,230.18	$10,738.20	$5,211.29
FY 07-08		$19,800.39	$16,347.19	$1,322.44	$13,195.50	$4,291.88	$8,784.10	$26,305.08	$2,204.65	$1,801.59	$3,766.54	$13,262.51	$5,768.77
FY 08-09	Current App.	$19,654.45	$15,741.39	$1,237.69	$12,623.34	$4,574.44	$8,774.20	$22,449.92	$1,906.73	$1,758.76	$3,291.85	$14,040.47	$5,730.90
FY 08-09		$20,137.03	$16,988.38	$1,422.93	$13,610.25	$4,443.29	$7,684.80	$27,296.32	$2,478.28	$1,856.04	$4,159.22	$12,581.38	$5,712.85
FY 09-10		$21,115.89	$17,538.63	$1,472.13	$14,025.28	$4,579.92	$8,016.69	$28,307.27	$2,658.67	$1,880.06	$4,503.02	$12,124.64	$5,836.67

A Few Characteristics of the Medicaid Caseload and Expenditures

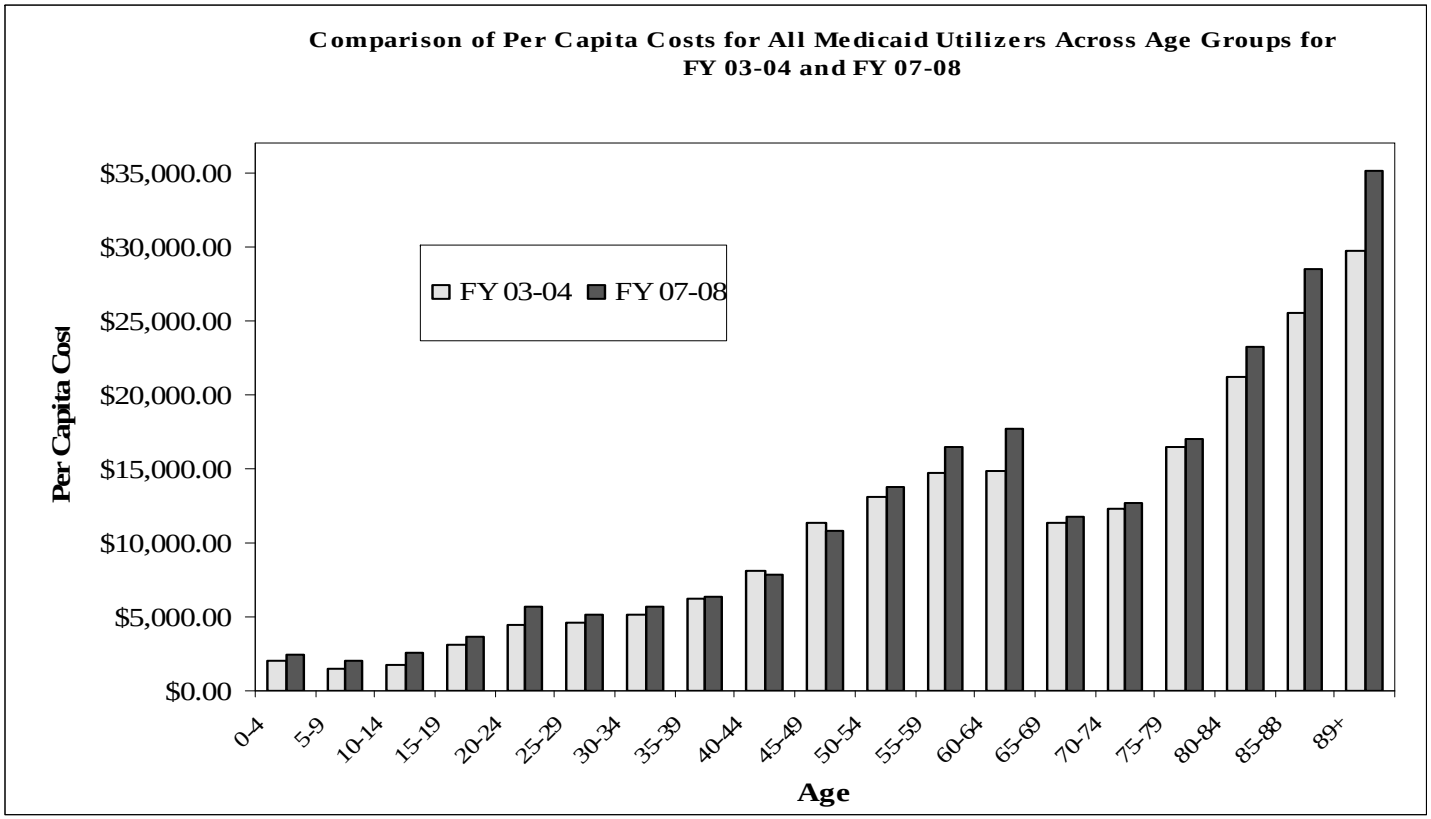
Eligibility Category by Gender



Source: Department's Budget request

A Few Characteristics of the Medicaid Caseload and Expenditures

Expenditures Per Capita By Age



Source: Department's Budget Request.

A Few Characteristics of the Medicaid Caseload and Expenditures

Medicaid Enrollment by Type of Managed Care Provider

The following table shows the breakdown by client count for FY 2002-03 through FY 2006-07 for clients enrolled in health maintenance organizations, prepaid inpatient health plan, Primary Care Physician Program, and unassigned fee-for-service. Health maintenance organizations, prepaid inpatient health plan and Primary Care Physician Program enrollment figures were subtracted from total caseload numbers (without retroactivity) to calculate the fee-for-service enrollment figures, and as a result may cause the fee-for-service counts to be underrepresented.

Average Medicaid Enrollment for FY 2002-03 through FY 2006-07

Membership Category	FY 2003-04 Count	FY 04-05 Count	FY 2005-06 Count	FY 2006-07 Count	FY 2007-08 Count
Health Maintenance Organizations and Prepaid Inpatient Health Plans	74,439	77,354	71,799	35,985	36,701
Primary Care Physician Program	68,557	51,669	36,563	29,243	25,875
Fee-for-Service	219,535	273,779	291,343	327,849	325,492
TOTALS	**362,531**	**402,802**	**399,705**	**393,077**	**388,068**

Source: Department Budget Request

A Few Characteristics of the Medicaid Caseload and Expenditures

Unduplicated Client counts for Community Long Term Care Waiver Programs

HCBS Waiver Programs Administered by Department of Health Care Policy and Financing (HCPF)

Fiscal Year	Elderly Blind and Disabled and Consumer Directed Care to the Elderly	Children's Home and Community Based Services	Persons with Brain Injury	Persons with Mental Illness	Persons Living with AIDS	Children with Autism	Total HCPF
FY 2003-04	15,734	631	376	2,065	98	0	**18,559**
FY 2004-05	14,833	618	322	1,844	66	0	**17,407**
FY 2005-06	16,415	1,049	297	1,948	58	0	**19,534**
FY 2006-07	17,019	1,254	306	2,160	62	17	**20,553**
FY 2007-08	17,627	1,360	264	2,312	71	73	**21,522**

HCBS Waiver Programs Administered by Department of Human Services (DHS)

Fiscal Year	Children's Habilitation Residential Program	Supported Living Services	Developmentally Disabled	Children's Extensive Support	Total DHS	Total HCPF and DHS HCBS Waiver Programs
FY 2003-04	214	3,113	3,958	226	**7,364**	**25,923**
FY 2004-05	204	2,935	3,688	220	**6,927**	**24,334**
FY 2005-06	191	3,092	3,690	375	**7,212**	**26,746**
FY 2006-07	165	2,982	4,112	381	**7,521**	**28,057**
FY 2007-08	149	3,057	4,207	430	**7,692**	**31,683**

Source: Department Budget Request

A Few Characteristics of the Medicaid Caseload and Expenditures

Unduplicated Client counts for Nursing Facility and Other Long-Term Care Services

Long Term Care Programs Administered by Department of Health Care Policy and Financing

Fiscal Year	Home Health	Program for All-Inclusive Care for the Elderly	Class I Nursing Facilities	Class II Nursing Facilities	Total Nursing Facilities (Class I and II)
FY 2003-04	8,275	1,046	14,196	16	**14,212**
FY 2004-05	8,687	1,187	13,919	17	**13,936**
FY 2005-06	9,430	1,271	14,287	20	**14,299**
FY 2006-07	10,161	1,376	14,045	21	**14,066**
FY 2007-08	10,272	1,501	13,886	21	**13,907**

Source: Department's Budget Request

A Few Characteristics of the Medicaid Caseload and Expenditures

FY 2007-08 – TOP 10 MAJOR DIAGNOTIC CATEGORIES (Inpatient Hospital)
Ranked by Expenditures

Rank	MDC Code	Description	Expenditures	Unduplicated Client Count
1	14	Pregnancy, Childbirth and the Puerperium	$94,666,271	23,067
2	4	Respiratory System	$27,235,360	4,316
3	15	Conditions of Newborns	$24,860,403	2,899
4		Pre-MDC Other	$19,150,681	209
5	5	Circulatory System	$18,777,480	1,409
6	6	Digestive System	$16,295,494	2,146
7	8	Musculoskeletal System and Connective Tissue	$15,898,841	1,487
8	1	Nervous System	$13,335,188	1,401
9	11	Kidney and Urinary Tract	$9,467,180	1,015
10	18	Infectious & Parasitic Diseases	$7,865,031	807
		Top Ten Total	**$247,551,929**	**38,756**

A Few Characteristics of the Medicaid Caseload and Expenditures

FY 2007-08 – TOP 10 INPATIENT HOSPITAL DIAGNOSIS RELATED GROUPS
Ranked by Expenditures

Rank	DRG	Description	Expenditures	Unduplicated Client Count
1	373	Vaginal Delivery without Complicating Diagnoses	$41,494,220	13,996
2	371	Cesarean Section without Complicating Diagnoses	$17,580,230	3,045
3	370	Cesarean Section with Complicating Diagnoses	$15,185,794	2,006
4	372	Vaginal Delivery with Complicating Diagnoses	$10,500,711	2,717
5	541	Tracheostomy with Mechanical Ventilator with Major Operating Room Procedure	$9,905,316	97
6	801	Neonates < 1,000 Grams	$6,684,676	84
7	898	Bronchitis and Asthma, Age < 17 with Complicating Diagnoses	$5,218,821	1,409
8	802	Neonates, 1,000 - 1,499 Grams	$4,258,586	141
9	542	Tracheostomy with Mechanical Ventilator without Major Operating Room Procedure	$4,052,197	66
10	803	Neonates, 1500 - 1,999 Grams	$3,982,973	318
		Top Ten Total	**$118,863,523**	**23,879**

Source: Department's Budget Request.

A Few Characteristics of the Medicaid Caseload and Expenditures

FY 2007-08 – TOP 10 OUTPATIENT HOSPITAL PRINCIPAL DIAGNOSIS CATEGORIES
Ranked by Expenditures

Rank	Principal Diagnosis Group Number	Description	Expenditures	Unduplicated Client Count
1	789	Other Symptoms Involving Abdomen and Pelvis	$6,440,547	10,194
2	786	Symptoms Involving Respiratory System and Other Chest Symptoms	$4,371,717	10,971
3	521	Diseases of Hard Tissues of Teeth	$4,364,120	2,599
4	780	General Symptoms	$3,843,225	11,548
5	585	Chronic Renal Failure	$3,768,378	248
6	784	Symptoms Involving Head and Neck	$2,170,975	4,708
7	787	Symptoms Involving Digestive System	$2,098,188	8,499
8	648	Other Current Conditions in the Mother Complicating Pregnancy, Childbirth, and the Puerperium	$2,089,978	6,385
9	474	Chronic Disease of Tonsils and Adenoids	$1,893,970	1,681
10	724	Other and Unspecified Disorders of Back	$1,824,141	4,785
		Top Ten Total	**$32,865,239**	**61,618**

Source: Department Budget Request.

A Few Characteristics of the Medicaid Caseload and Expenditures

FY 2007-08 – TOP 10 OUTPATIENT SURGICAL PROCEDURES
Ranked by Expenditures

Rank	Surgical Procedure Code	Description	Expenditures	Unduplicated Client Count
1	23.41	Application of crown	$1,914,915	781
2	23.2	Restoration of tooth by filling	$836,054	335
3	28.3	Tonsillectomy with adenoidectomy	$789,441	338
4	99.29	Injection or infusion of other therapeutic or prophylactic substance	$710,713	926
5	66.29	Other bilateral endoscopic destruction or occlusion of fallopian tubes	$522,783	373
6	89.17	Polysomnogram	$521,272	335
7	20.01	Myringotomy with insertion of tube	$448,158	278
8	93.54	Application of splint	$396,017	1,444
9	51.23	Laparoscopic cholecystectomy	$383,926	129
10	37.23	Combined right and left heart cardiac catheterization	$373,972	45
		Top Ten Total	**$6,897,251**	**4,984**

Source: Department Budget Request.

A Few Characteristics of the Medicaid Caseload and Expenditures

FY 2007-08 – TOP 10 FEDERALLY QUALIFIED HEALTH CENTER (FQHC) PRINCIPAL DIAGNOSIS CATEGORIES

Ranked by Expenditures

Rank	Principal Diagnosis Group Number	Description	Expenditures	Unduplicated Client Count
1	V20	Health Supervision of Infant or Child	$12,006,874	46,216
2	V72	Special Investigations and Examinations	$7,350,927	25,118
3	V22	Normal Pregnancy	$5,018,277	6,527
4	465	Acute Upper Respiratory Infections of Multiple or Unspecified Sites	$2,786,565	13,941
5	382	Suppurative and Unspecified Otitis Media	$1,360,042	6,592
6	250	Diabetes Mellitus	$826,624	2,156
7	780	General Symptoms	$809,762	4,197
8	650	Normal Delivery	$798,498	1,090
9	V70	General Medical Examination	$787,422	3,726
10	462	Acute Pharyngitis	$759,368	4,467
		Top Ten Total	**$32,504,360**	**114,030**

Source: Department Budget Request

A Few Characteristics of the Medicaid Caseload and Expenditures

FY 2007-08 – TOP 10 RURAL HEALTH CENTER (RHC) PRINCIPAL DIAGNOSIS CATEGORIES
Ranked by Expenditures

Rank	Principal Diagnosis Group Number	Description	Expenditures	Unduplicated Client Count
1	V20	Health Supervision of Infant or Child	$603,359	3,395
2	465	Acute Upper Respiratory Infections of Multiple or Unspecified Sites	$297,920	1,856
3	382	Suppurative and Unspecified Otitis Media	$294,895	1,552
4	V72	Special Investigations and Examinations	$211,304	622
5	V22	Normal Pregnancy	$180,143	395
6	462	Acute Pharyngitis	$119,016	1,015
7	466	Acute Bronchitis and Bronchiolitis	$109,823	731
8	780	General Symptoms	$105,098	802
9	034	Streptococcal Sore Throat and Scarlet Fever	$104,202	578
10	461	Acute Sinusitis	$103,583	856
		Top Ten Total	**$2,129,345**	**11,802**

Source: Department Budget Request.

A Few Characteristics of the Medicaid Caseload and Expenditures

FY 2007-08 – TOP 10 PHYSICIAN AND EARLY PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) PROGRAM PRINCIPAL DIAGNOSIS CATEGORIES

Ranked by Expenditures

Rank	Principal Diagnosis Group Number	Description	Expenditures	Unduplicated Client Count
1	V20	Health Supervision of Infant or Child	$10,146,172	75,408
2	650	Normal Delivery	$7,793,890	11,868
3	780	General Symptoms	$4,179,544	35,086
4	789	Other Symptoms Involving Abdomen and Pelvis	$3,944,922	24,004
5	786	Symptoms Involving Respiratory System and Other Chest Symptoms	$3,911,590	38,982
6	V25	Encounter For Contraceptive Management	$3,829,557	14,352
7	367	Disorders of Refraction and Accommodation	$3,823,733	31,235
8	V22	Normal Pregnancy	$3,479,803	15,165
9	765	Disorders Relating to Short Gestation and Unspecified Low Birthweight	$3,445,251	2,217
10	654	Abnormality of Organs and Soft Tissues of Pelvis	$2,963,767	3,407
		Top 10 Totals	**$47,518,231**	**251,724**

Source: Department Budget Request.

A Few Characteristics of the Medicaid Caseload and Expenditures

FY 2007-08 – TOP 10 DENTAL PROCEDURES
Ranked by Expenditures

Rank	Procedure Code	Description	Expenditures	Unduplicated Client Count
1	D2930	Prefab Stainless Steel Crown Primary	$4,365,214.77	16,104
2	D8090	Comprehen Ortho Adult Dentition	$3,693,886.25	1,195
3	D1120	Prophylaxis Child	$2,874,149.42	80,687
4	D2391	Resin Based Comp One Surface Posterior	$2,729,221.52	20,099
5	D2140	Amalgam One Surface Permanent	$2,131,794.82	19,751
6	D7140	Extraction Erupted Tooth/Exposed Root	$2,114,745.28	19,375
7	D3220	Therapeutic Pulpotomy	$1,897,790.31	12,539
8	D2392	Resin Based Comp Two Surfaces Posterior	$1,848,554.34	13,364
9	D2150	Amalgam Two Surfaces Permanent	$1,805,301.12	16,026
10	D0120	Periodic oral evaluation	$1,608,146.68	68,295
		Top Ten Total	**$25,068,804.51**	**267,435**

Source: Department Budget Request.

A Few Characteristics of the Medicaid Caseload and Expenditures

FY 2007-08 – TOP 10 LABORATORY PROCEDURES RANKED

Ranked by Expenditures

Rank	Principal Diagnosis Group Number	Description	Expenditures	Unduplicated Client Count
1	87491	Chlamydia Tracholmatis, DNA, Amplified Probe Technique	$1,430,268	24,164
2	87591	Neisseria Gonorrhea, DNA, Amplified Probe Technique	$1,375,182	23,422
3	80101	Drug Screen, Single	$1,205,393	5,400
4	85025	Complete Blood Count with Automated White Blood Cells Differentials	$1,024,400	58,105
5	80053	Comprehensive Metabolic Panel	$788,600	34,486
6	84443	Thyroid Stimulus Hormone	$739,776	26,132
7	87086	Urine Culture / Colony Count	$449,928	29,668
8	80050	General Health Panel	$444,323	8,572
9	80061	Lipid Panel	$443,337	19,412
10	88305	Tissue Exam by Pathologist	$437,258	6,925
		Top 10 Totals	**$8,338,465**	**236,286**

Source: Department Budget Request

A Few Characteristics of the Medicaid Caseload and Expenditures

FY 2007-08 – TOP 10 DURABLE MEDICAL EQUIPMENT AND SUPPLIES PROCEDURES
Ranked by Expenditures

Rank	Principal Diagnosis Group Number	Description	Expenditures	Unduplicated Client Count
1	S8121	Oxygen Contents Liquid, per Pound	$9,211,608	5,745
2	E1390	Oxygen Concentrator	$8,498,293	9,389
3	B4160	Enteral Formula for Pediatrics, Calorie Dense	$3,380,521	1,239
4	E0434	Portable Liquid Oxygen	$1,715,947	5,149
5	T4527	Adult Sized Disposable Incontinence Product	$1,541,503	2,226
6	T4535	Disposable Line / Shield / Pad for Incontinence	$1,402,485	3,880
7	B4035	Neteral Feeding Supply Pump per Day	$1,399,900	784
8	A4253	Blood Glucose Test or Reagent Strips, per 50 Strips	$1,309,209	5,202
9	E0445	Oximeter Non-Invasive	$1,276,193	1,254
10	B4161	Enteral Formula for Pediatrics, Hydrolyzed / Amino Acid	$1,272,949	288
		Top 10 Totals	**$31,008,608**	**35,156**

Source: Department Budget Request.

A Few Characteristics of the Medicaid Caseload and Expenditures

FY 2007-08 – TOP 10 PRESCRIPTION DRUGS
Ranked by Expenditures

Rank	Drug Name	Therapeutic Class	Expenditures	Unduplicated Client Count
1	Seroquel	Antipsychotic	$10,097,265	4,896
2	Abilify	Antipsychotic	$9,301,054	3,494
3	Synagis	Monoclonal Antibody (prevention/treatment of respiratory virus in infants)	$9,200,292	830
4	Risperdal	Antipsychotic	$7,514,525	4,104
5	Zyprexa	Antipsychotic	$5,931,861	1,687
6	Lamictal	Anti-Convulsant	$4,737,403	2,488
7	Depakote	Anti-Convulsant	$4,188,172	3,565
8	Topamax	Anti-Convulsant	$4,002,509	2,493
9	Advair	Bronchodilator and Corticosteroid	$3,680,523	6,153
10	Oxycodone	Analgesic	$3,578,185	20,845
		Top Ten Total	**$62,231,790**	**50,555**

Source: Department Budget Request.

A Few Characteristics of the Medicaid Caseload and Expenditures

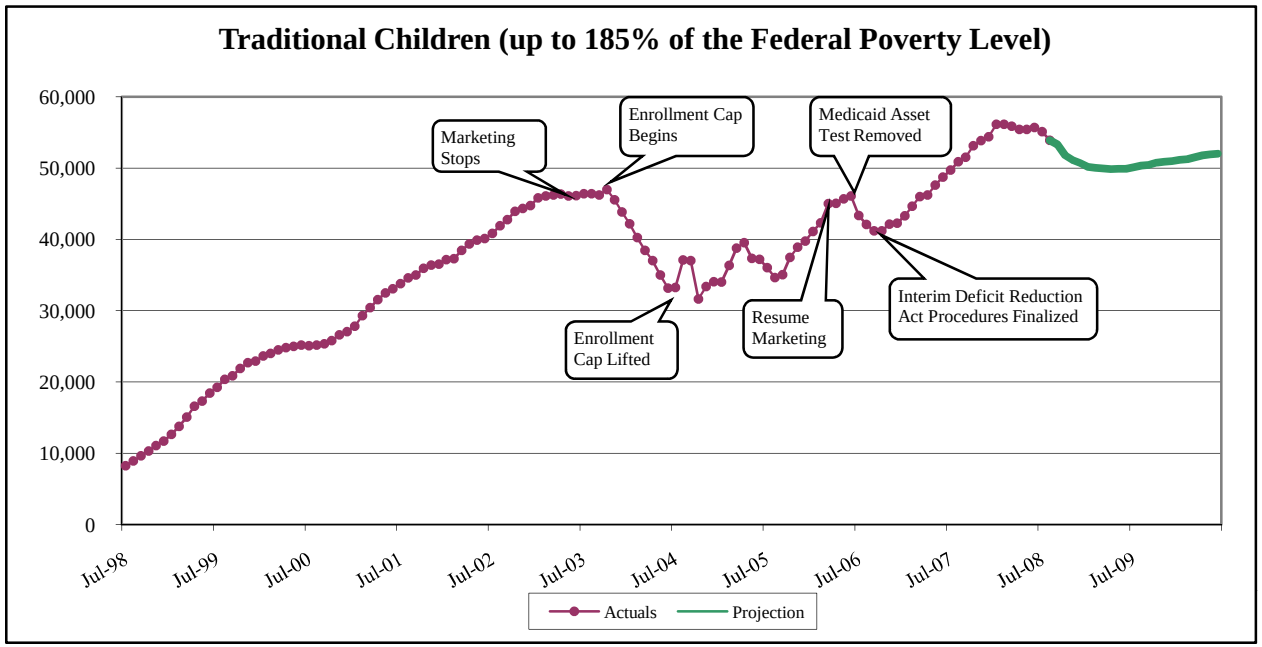
FY 2007-08 – TOP 10 PRESCRIPTION DRUGS

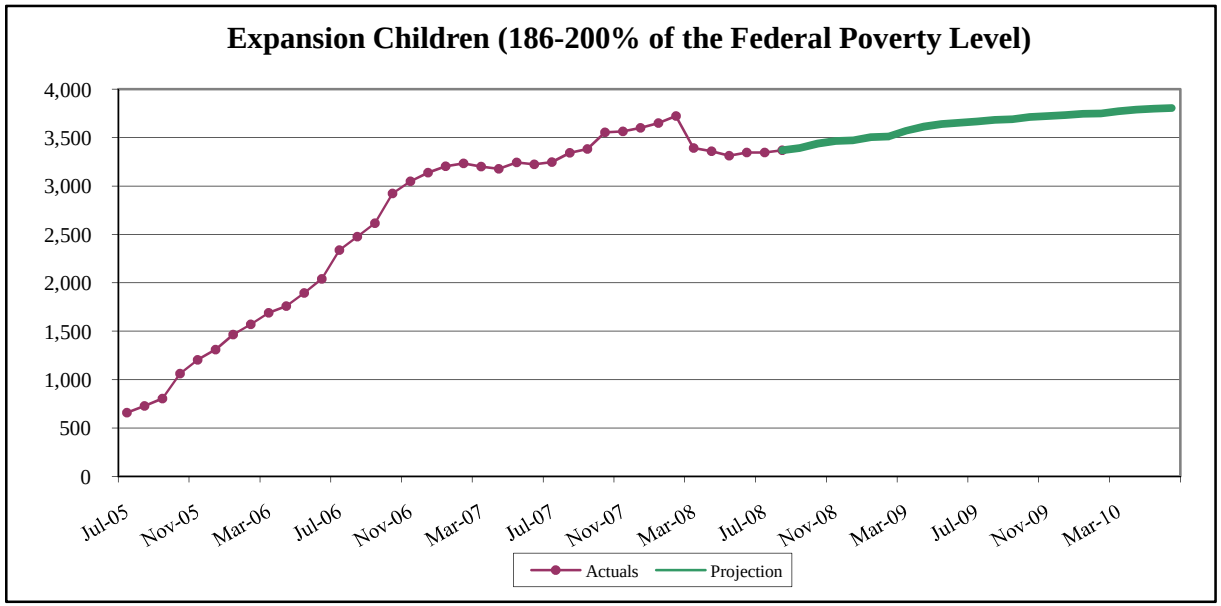
Ranked by Number of Prescriptions Filled

Rank	Drug Name	Therapeutic Class	Total Prescriptions Filled	Expenditures
1	Hydrocodone	Analgesic	99,270	$1,168,731
2	Amoxicillin	Antibiotic	84,396	$788,216
3	Oxycodone	Analgesic	72,974	$3,578,185
4	Azithromycin	Antibiotic	45,974	$1,468,426
5	Lorazepam	Anti-Anxiety Drug (benzodiazepine)	44,536	$1,154,163
6	Albuterol	Bronchodilator	40,243	$818,956
7	Lisinopril	Hypotensive (angiotensin converting enzyme inhibitor)	37,710	$714,348
8	Proair	Bronchodilator	36,286	$1,212,405
9	Clonazepam	Anti-Convulsant	36,065	$706,729
10	Levothyroxine	Thyroid Hormone (to treat hypothyroidism)	34,575	$312,866
		Top Ten Total	**532,029**	**$11,923,024**

Source: Department's Budget Request.

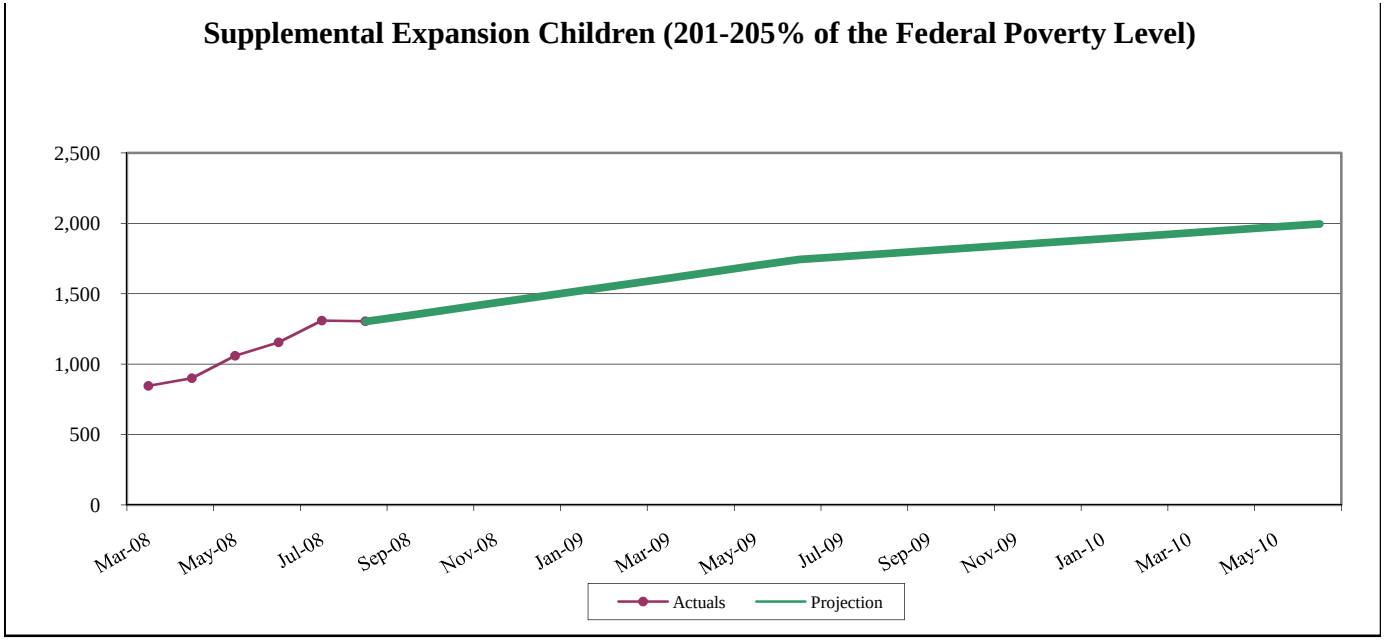
Children's Basic Health Plan Caseload Graphs



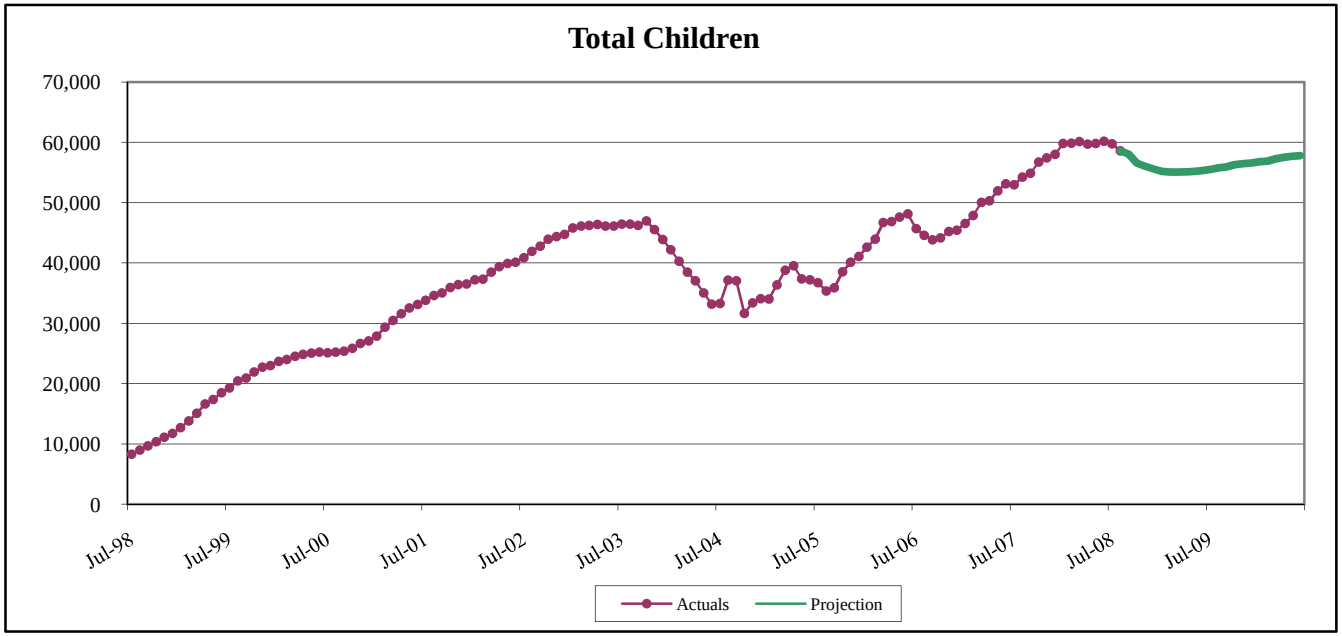


Children's Basic Health Plan Caseload Graphs

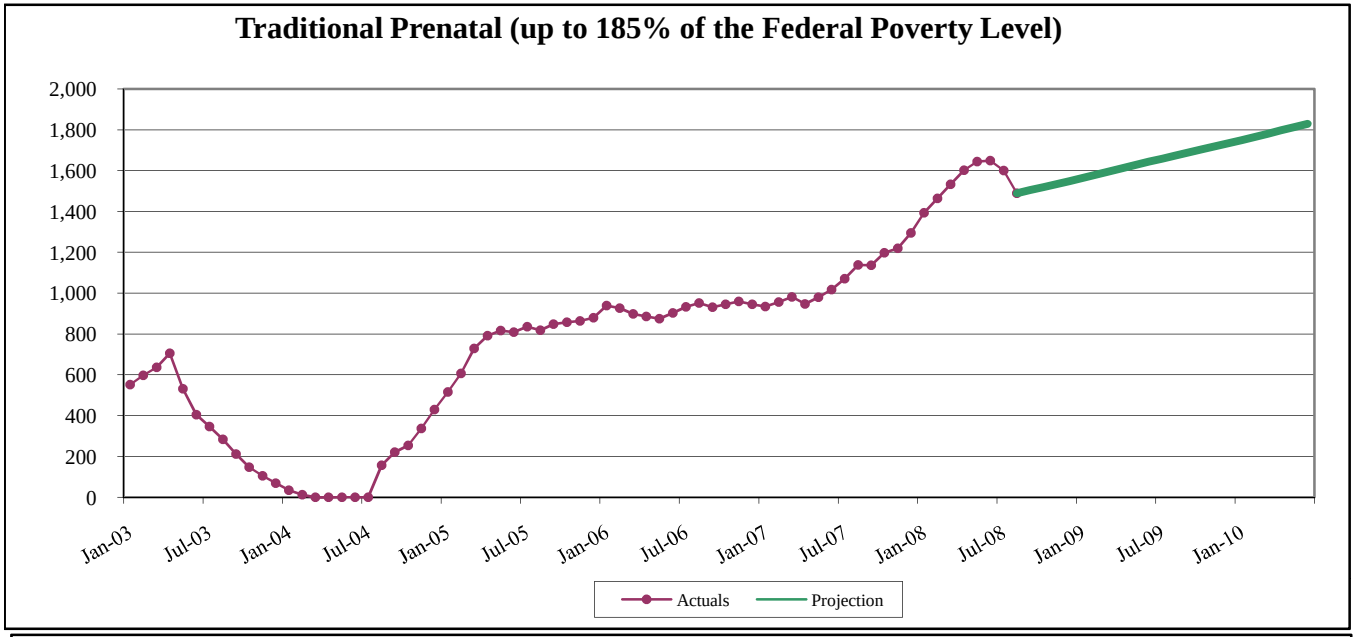
Supplemental Expansion Children (201-205% of the Federal Poverty Level)

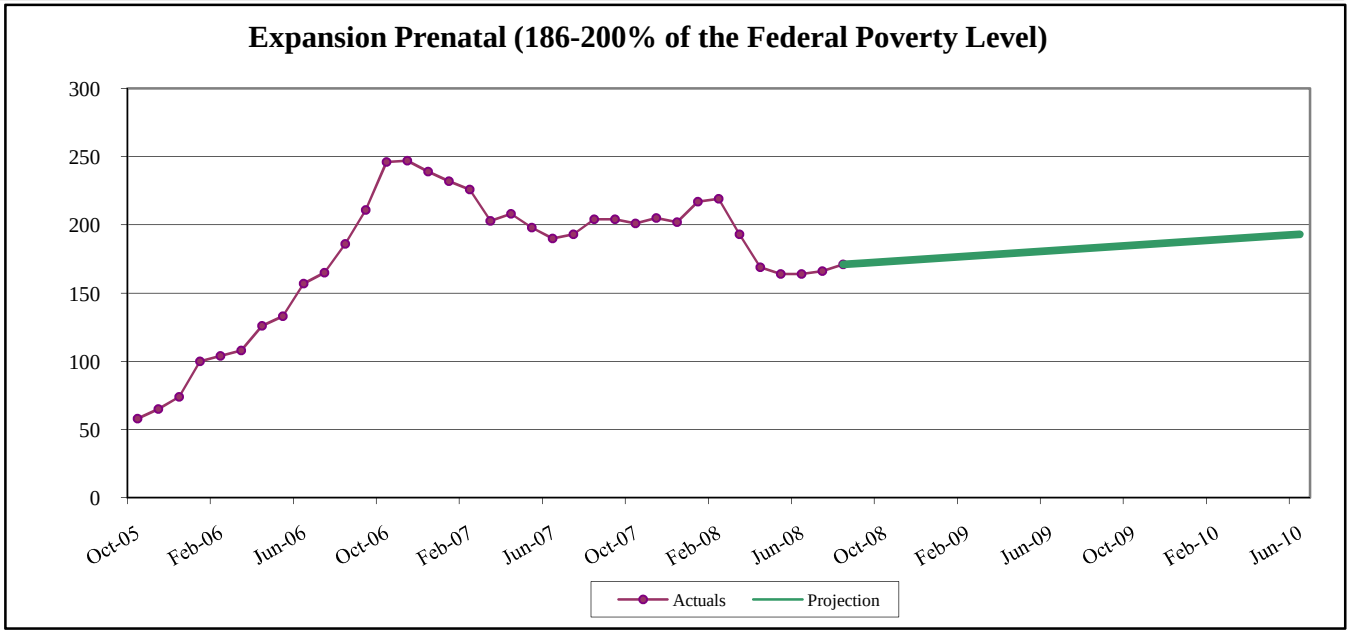


Total Children

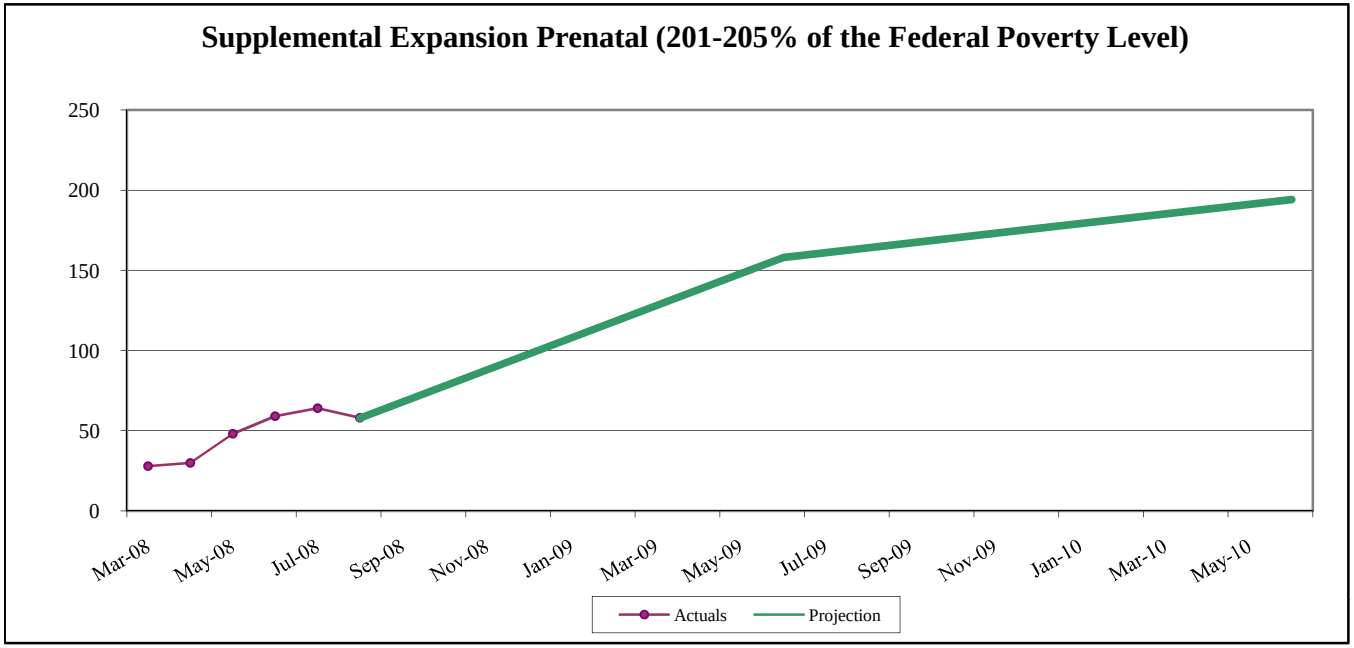


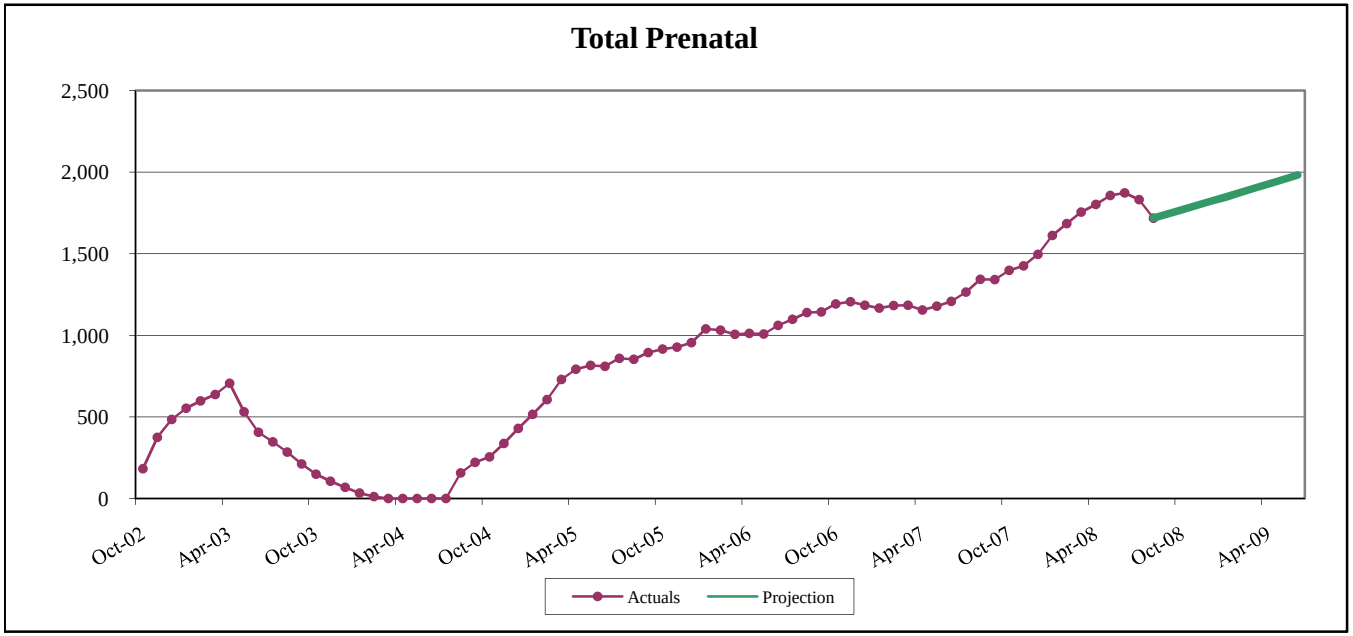
Children's Basic Health Plan Caseload Graphs





Children's Basic Health Plan Caseload Graphs





HCBS Rates for EBD, MI, PLWA

SERVICE TYPE	PROCEDURE CODE	7/1/2004	7/1/2005	4/1/2006	4/1/2007	7/1/2007	7/1/2008	UNIT VALUE	COMMENTS
Adult Day Services									
Basic Rate	S5105	$21.05	$21.47	$22.24	$22.46	$22.80	$23.14	4-5 Hours	An individual unit is 4-5 hours per day
Specialized Rate	S5105	$26.90	$27.44	$28.42	$28.70	$29.13	$29.57	3-5 Hours	An individual unit is 3-5 hours per day
Alternative Care Facility	T2031	$36.03	$36.75	$42.29	$47.58	$48.29	$49.01	Day	May be different for clients with 300% income
Homemaker	S5130	$3.14	$3.20	$3.52	$3.52	$3.57	$3.63	15 minutes	
Home Modification	S5165	$10,000.00	$10,000.00	$10,000.00	$10,000.00	$10,000.00	$10,000.00	Lifetime Max	
IHSS Health Maintenance Activities	H0038	$6.32	$6.45	$6.62	$6.62	$6.72	$6.82	15 minutes	
IHSS Personal Care	T1019 KX	$3.14	$3.20	$3.52	$3.52	$3.57	$3.63	15 minutes	
IHSS Relative Personal Care	T1019 HR KX	$3.14	$3.20	$3.52	$3.52	$3.57	$3.63	15 minutes	No limits on IHSS benefits provided by parents of adult children. For all other relatives, the limitations on payment to family applies as set forth in 10 C.C.R. 2505-10, Section 8.485.200
IHSS Homemaker	S5130 KX	$3.14	$3.20	$3.52	$3.52	$3.57	$3.63	15 minutes	
Non-Med. Transportation									
Taxi	T2001	$47.50	$48.45	$48.45	$48.45	$49.18	$49.91	1 Way Trip	Not to exceed the rate with the Public Utilities Commission
Mobility Van	T2001	$12.20	$12.44	$12.44	$12.44	$12.63	$12.82	1 Way Trip	
Wheelchair Van	T2001	$15.19	$15.49	$15.49	$15.49	$15.72	$15.96	1 Way Trip	Wheelchair Van Mileage Add-On: 62 cents per mile (FY 2008-09)
Personal Care	T1019	$3.14	$3.20	$3.52	$3.52	$3.57	$3.63	15 minutes	
Relative Personal Care	T1019 HR	$3.14	$3.20	$3.52	$3.52	$3.57	$3.63	15 minutes	Relative Personal Care cannot be combined with HCA Maximum reimbursement not to exceed 1776 units per year
Respite Care									
ACF	S5151	$51.94	$52.98	$52.98	$52.98	$53.77	$54.58	Day	Limit of 30 days per calendar year
NF	H0045	$115.81	$118.13	$118.13	$118.13	$119.90	$121.70	Day	Limit of 30 days per calendar year.
In Home	S5150	$2.97	$3.03	$3.03	$3.03	$3.08	$3.12	15 minutes	Limit of 30 days per calendar year Not to exceed the ACF per diem for respite care

Percentage Changes

SERVICE TYPE	PROCEDURE CODE	7/1/2004	7/1/2005	4/1/2006	4/1/2007	7/1/2007	7/1/2008	UNIT VALUE	COMMENTS
Adult Day Services									
Basic Rate	S5105		2.0%	3.6%	1.0%	1.5%	1.5%	4-5 Hours	An individual unit is 4-5 hours per day
Specialized Rate	S5105		2.0%	3.6%	1.0%	1.5%	1.5%	3-5 Hours	An individual unit is 3-5 hours per day
Alternative Care Facility	T2031		2.0%	15.1%	12.5%	1.5%	1.5%	Day	May be different for clients with 300% income
Homemaker	S5130		1.9%	10.0%	0.0%	1.5%	1.5%	15 minutes	
Home Modification	S5165		0.0%	0.0%	0.0%	0.0%	0.0%	Lifetime Max	
IHSS Health Maintenance Activities	H0038		2.1%	2.6%	0.0%	1.5%	1.5%	15 minutes	
IHSS Personal Care	T1019 KX		1.9%	10.0%	0.0%	1.5%	1.5%	15 minutes	
IHSS Relative Personal Care	T1019 HR KX		1.9%	10.0%	0.0%	1.5%	1.5%	15 minutes	No limits on IHSS benefits provided by parents of adult children. For all other relatives, the limitations on payment to family applies as set forth in 10 C.C.R. 2505-10, Section 8.485.200
IHSS Homemaker	S5130 KX		1.9%	10.0%	0.0%	1.5%	1.5%	15 minutes	
Non-Med. Transportation									
Taxi	T2001		2.0%	0.0%	0.0%	1.5%	1.5%	1 Way Trip	Taxi: up to $49.91 per trip, not to exceed the rate with the Public Utilities Commission
Mobility Van	T2001		2.0%	0.0%	0.0%	1.5%	1.5%	1 Way Trip	Mobility Van: $12.82 per trip
Wheelchair Van	T2001		2.0%	0.0%	0.0%	1.5%	1.5%	1 Way Trip	Wheelchair Van: $15.96 per trip Wheelchair Van Mileage Add-On: 62 cents per mile
Personal Care	T1019		1.9%	10.0%	0.0%	1.5%	1.5%	15 minutes	
Relative Personal Care	T1019 HR		1.9%	10.0%	0.0%	1.5%	1.5%	15 minutes	Relative Personal Care cannot be combined with HCA Maximum reimbursement not to exceed 1776 units per year
Respite Care									
ACF	S5151		2.0%	0.0%	0.0%	1.5%	1.5%	Day	Limit of 30 days per calendar year
NF	H0045		2.0%	0.0%	0.0%	1.5%	1.5%	Day	Limit of 30 days per calendar year.
In Home	S5150		2.0%	0.0%	0.0%	1.5%	1.5%	15 minutes	Limit of 30 days per calendar year Not to exceed the ACF per diem for respite care

Home Health Rates

	REVENUE CODE								
SERVICE TYPE	**Acute Home Health**	**Long Term Home Health**	**7/1/2004**	**7/1/2005**	**4/1/2006**	**4/1/2007**	**7/1/2007**	**7/1/2008**	**UNIT VALUE**
RN Assess and Teach	589	None	$71.42	$72.85	$72.85	$96.53	$97.98	$99.45	Acute only- one visit up to 2 ½ hours
RN/LPN	550	551	$71.42	$72.85	$78.10	$96.53	$97.98	$99.45	One visit up to 2 ½ hours
RN Brief 1st of Day	n/a	590	$50.00	$51.00	$54.67	$67.57	$68.58	$69.61	One Visit
RN Brief 2nd or >	Na	599	$35.00	$35.70	$38.27	$47.30	$48.01	$48.73	One Visit
HHA BASIC	570	571	$31.66	$32.29	$33.65	$33.65	$34.15	$34.67	One hour
HHA EXTENDED	572	579	$9.46	$9.65	$10.06	$10.06	$10.21	$10.36	For visits lasting more than one hour, extended units of 15-30 minutes
PT	420	421 (for 0-17 years LTHH)	$61.43	$62.66	$85.41	$105.57	$107.15	$108.76	One Visit up to 2 ½ hours
PT for HCBS Home Mod Evaluation	424	424	$61.43	$62.66	$85.41	$105.57	$107.15	$108.76	1-2 visits
OT	430	431 (for 0-17 years LTHH)	$65.24	$66.54	$85.97	$106.26	$107.85	$109.47	One visit up to 2 ½ hours
OT for HCBS Home Mod Evaluation	434	434	$65.24	$66.54	$85.97	$106.26	$107.85	$109.47	1-2 visits
S/LT	440	441 (for 0-17 years LTHH)	$66.95	$68.29	$92.81	$114.71	$116.43	$118.18	One visit up to 2 ½ hours
Maximum Daily Amount Acute Home Health			$291.00	$296.82	$364.00	$449.79	$456.54	$463.38	24 hours, MN to MN
Maximum Daily Amount Long Term Home Health			$227.00	$231.54	$284.00	$350.94	$356.20	$361.55	24 hours, MN to MN

Private Duty Nursing Rates

SERVICE TYPE	**REVENUE CODE**	**7/1/2004**	**7/1/2005**	**4/1/2006**	**4/1/2007**	**7/1/2007**	**7/1/2008**	**UNIT VALUE**
PDN-RN	552	$29.20	$29.78	$30.91	$38.14	$38.71	$39.29	Hour
PDN-LPN	559	$21.02	$21.44	$23.16	$28.63	$29.06	$29.50	Hour
PDN-RN (group-per client)	580	$21.95	$22.30	$23.15	$28.57	$29.00	$29.44	Hour
PDN-LPN (group-per client)	581	$16.11	$16.43	$17.74	$21.93	$22.26	$22.59	Hour
"Blended" group rate / client*	582	$20.97	$21.39	$23.10	$28.55	$28.98	$29.41	Hour

Percentage Changes
Home Health Rates

	REVENUE CODE								
SERVICE TYPE	**Acute Home Health**	**Long Term Home Health**	**7/1/2004**	**7/1/2005**	**4/1/2006**	**4/1/2007**	**7/1/2007**	**7/1/2008**	**UNIT VALUE**
RN Assess and Teach	589	None		2.0%	0.0%	32.5%	1.5%	1.5%	Acute only- one visit up to 2 ½ hours
RN/LPN	550	551		2.0%	7.2%	23.6%	1.5%	1.5%	One visit up to 2 ½ hours
RN Brief 1st of Day	n/a	590		2.0%	7.2%	23.6%	1.5%	1.5%	One Visit
RN Brief 2nd or >	Na	599		2.0%	7.2%	23.6%	1.5%	1.5%	One Visit
HHA BASIC	570	571		2.0%	4.2%	0.0%	1.5%	1.5%	One hour
HHA EXTENDED	572	579		2.0%	4.3%	0.0%	1.5%	1.5%	For visits lasting more than one hour, extended units of 15-30 minutes
PT	420	421 (for 0-17 years LTHH)		2.0%	36.3%	23.6%	1.5%	1.5%	One Visit up to 2 ½ hours
PT for HCBS Home Mod Evaluation	424	424		2.0%	36.3%	23.6%	1.5%	1.5%	1-2 visits
OT	430	431 (for 0-17 years LTHH)		2.0%	29.2%	23.6%	1.5%	1.5%	One visit up to 2 ½ hours
OT for HCBS Home Mod Evaluation	434	434		2.0%	29.2%	23.6%	1.5%	1.5%	1-2 visits
S/LT	440	441 (for 0-17 years LTHH)		2.0%	35.9%	23.6%	1.5%	1.5%	One visit up to 2 ½ hours
Maximum Daily Amount Acute Home Health				2.0%	22.6%	23.6%	1.5%	1.5%	24 hours, MN to MN
Maximum Daily Amount Long Term Home Health				2.0%	22.7%	23.6%	1.5%	1.5%	24 hours, MN to MN

Private Duty Nursing Rates

SERVICE TYPE	**REVENUE CODE**	**7/1/2004**	**7/1/2005**	**4/1/2006**	**4/1/2007**	**7/1/2007**	**7/1/2008**	**UNIT VALUE**
PDN-RN	552		2.0%	3.8%	23.4%	1.5%	1.5%	Hour
PDN-LPN	559		2.0%	8.0%	23.6%	1.5%	1.5%	Hour
PDN-RN (group-per client)	580		1.6%	3.8%	23.4%	1.5%	1.5%	Hour
PDN-LPN (group-per client)	581		2.0%	8.0%	23.6%	1.5%	1.5%	Hour
"Blended" group rate / client*	582		2.0%	8.0%	23.6%	1.5%	1.5%	Hour

Federal Poverty Level

		60%	100%	133%	150%	185%	200%	205%	225%	250%	300%	400%	1000%
Family	1	6,240	10,400	13,832	15,600	19,240	20,800	21,320	23,400	26,000	31,200	41,600	104,000
Size	2	8,400	14,000	18,620	21,000	25,900	28,000	28,700	31,500	35,000	42,000	56,000	140,000
	3	10,560	17,600	23,408	26,400	32,560	35,200	36,080	39,600	44,000	52,800	70,400	176,000
	4	12,720	21,200	28,196	31,800	39,220	42,400	43,460	47,700	53,000	63,600	84,800	212,000
	5	14,880	24,800	32,984	37,200	45,880	49,600	50,840	55,800	62,000	74,400	99,200	248,000
	6	17,040	28,400	37,772	42,600	52,540	56,800	58,220	63,900	71,000	85,200	113,600	284,000
	7	19,200	32,000	42,560	48,000	59,200	64,000	65,600	72,000	80,000	96,000	128,000	320,000
	8	21,360	35,600	47,348	53,400	65,860	71,200	72,980	80,100	89,000	106,800	142,400	356,000