This document contains the JBC Staff Briefing for the Commission on Family Medicine and for the Department of Health Care Policy.

Information on the Mental Health Programs and the Medicaid Programs Administered by the Department of Human can be found under the Department of Human Services.

COLORADO GENERAL ASSEMBLY
JOINT BUDGET COMMITTEE

Fiscal Year 2007-08 Staff Budget Briefing

Commission on Family Medicine

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

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December 13, 2006

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FY 2007-08 Joint Budget Committee Staff Budget Briefing

Commission on Family Medicine

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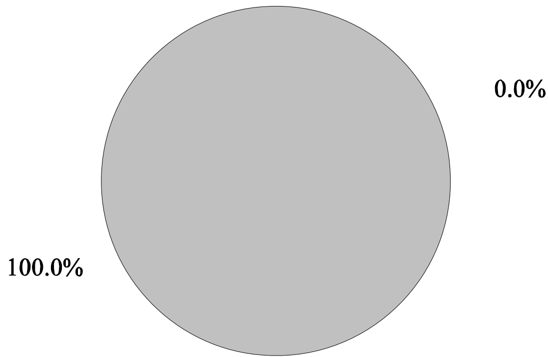
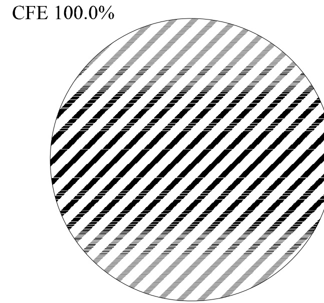
Share of State General Fund FY 2006-07

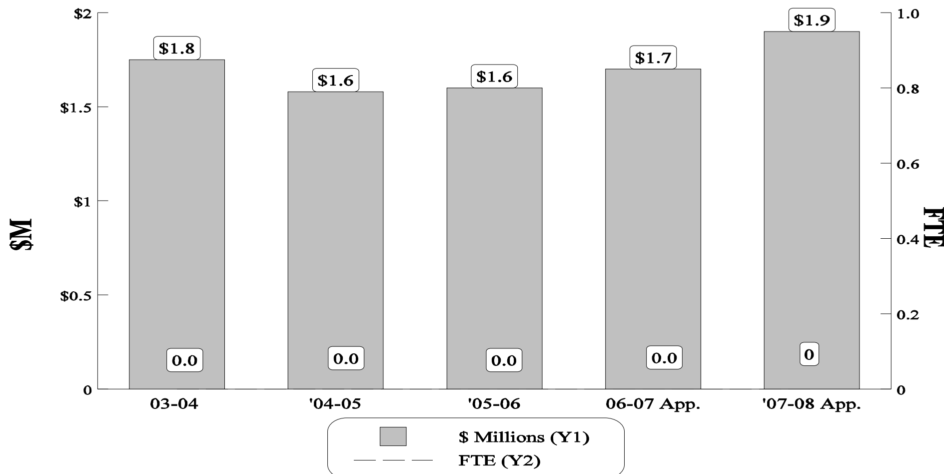


Funding Source Split FY 2006-07



Note: The Commission receives $851,779 in Medicaid General Fund. This amount is too small of a percentage to show up on this chart. The General Fund appropriation appears in the Department of Health Care Policy and Financing's budget.

Budget History



COMMISSION ON FAMILY MEDICINE
OVERVIEW

Key Responsibility

- Distributes funds for the support of the nine family medicine residency programs at hospitals throughout the state and assists in the recruitment of residents.

Factors Driving the Budget

Funding for the Commission consists 100 percent of cash fund exempt. However, the cash fund exempt appropriation represents a transfer of Medicaid funding from the Department of Health Care Policy and Financing (HCPF). The appropriation for the Commission had been relatively flat until FY 2002-03. In FY 2002-03, FY 2003-04 and FY 2004-05, the budget was reduced as part of the statewide effort to reduce General Fund appropriations in order to balance the state budget. In FY 2002-03, each hospital residency program received approximately $211,754. In FY 2006-07, each hospital residency program will receive approximately $189,284 from this appropriation. This represents a decrease in state funding of approximately 10.6 percent.

Major Funding Changes FY 2005-06 to FY 2006-07

Action	Cash Fund Exempt -- Medicaid Cash Funds	Total Funds	Total FTE
FY 2005-06 Appropriation	$1,576,502	**$1,576,502**	**0.0**
Restore a portion of previous year budget cuts	$127,056	**$127,056**	**0.0**
FY 2006-07 Appropriation*	$1,703,558	**$1,703,558**	**0.0**

*Of this amount, $851,779 is General Fund and $851,779 is Federal Funds. This funding is transferred from the Department of Health Care Policy and Financing to the Commission as cash funds exempt.

FY 2007-08 Budget Briefing
Department of Health Care Policy and Financing
Change Requests: Decision Items

Priority	Division: Description *[Statutory Authority]*	GF	CF	CFE	FF	Total	FTE
1	**Commission on Family Medicine, Residency Training Programs and Expense Line Item.** Increase funding for the 9 Family Medicine Residency programs. This restores some of the funding that was cut during the budget crisis years. [Section 25-1-901 through 25-1-904, C.R.S. (2006)	0	0	200,000	0	200,000	0.00
	Subtotal Decision Item Requests	**0**	**0**	**200,000**	**0**	**200,000**	**0.00**
	Change to Medicaid Funds	**$100,000**	**$0**	**$0**	**$100,000**	**$200,000**	

	FY 2004-05 Actual	FY 2005-06 Actual	FY 2006-07 Approp.	FY 2007-08 Request		% Change

DEPARTMENT OF HIGHER EDUCATION
Health Sciences Center -- Advisory Commission on Family Medicine
Chancellor James Shore, M.D. Executive Director: Tony Prado-Gutierrez

Advisory Commission on Family Medicine
(Primary Functions: Distributes funds for the support of family medicine residnecy programs at hospitals throughout the state and assists in the recruitment of residents. Charge is to maintain family medicine standards, allocate the annual appropriation to family medicine residencies, monitor the residency programs and make recommendations accordingly and determine the level of need for family physicians statewide.)

	FY 2004-05 Actual	FY 2005-06 Actual	FY 2006-07 Approp.	FY 2007-08 Request		% Change
Residency Training Programs	1,576,501	1,576,502	1,703,558	1,903,558	DI #1	
Cash Funds Exempt	1,576,501	1,576,502	1,703,558	1,903,558		
TOTAL - Commission on Family Medicine	**1,576,501**	**1,576,502**	**1,703,558**	**1,903,558**		11.7%
FTE	0.0	0.0	0.0	0.0		0.0%
Cash Funds Exempt	1,576,501	1,576,502	1,703,558	1,903,558		11.7%
Medicaid Cash Funds	1,576,501	1,576,502	1,703,558	1,903,558		11.7%
Net General Fund (Medicaid + Other GF)	788,251	788,251	851,779	951,779		11.7%

FY 2007-08 Joint Budget Committee Staff Budget Briefing
COMMISSION ON FAMILY MEDICINE
Assessment of Commission's Performance Measures

ISSUE:

Commission on Family Medicine's Mission, Goals, and Performance Measures

DISCUSSION:

Commission Mission

Mission Statement:

> To address the health care needs of the people of Colorado through the education of family physicians and the promotion of health care policy.

Goals and Performance Measures

The Commission's FY 2007-08 strategic plan is a total of 37 pages long and is comprised of three major goals, 11 strategic objectives, and 30 performance measures for the current year. The strategic plan also identifies ongoing responsibilities with seven identified data driven performance measures. In addition, the strategic plan identifies key accomplishments from the past year's selected objectives and performance measures. In the Commission's strategic plan, strategic objectives are tied to the achievement of key goals and performance measures are written for each objective. The Commission's strategic planning document also contains narrative explaining the statutory background for the Commission as well as current trends in family medicine practice in Colorado.

Staff Analysis

Joint Budget Committee staff reviewed the Commission's performance measures submitted in their budget document. The following checklist was used for staff's assessment of the Commission's performance measures:

Commission's Strategic Plan and Performance Measure Evaluation Criteria

1. Do the goals and performance measures correspond to the program's directives provided in statute?
2. Are the performance measures meaningful to stakeholders, policymakers, etc.?
3. Does the Commission use a variety of performance measures (including input, output, efficiency, quality, outcome)?
4. Do the performance measures cover all key areas of the budget?
5. Are the data collected for the performance measures valid, accurate, and reliable?
6. Are the performance measures linked to the proposed budget base?
7. Is there a change or consequence if the Commission's performance targets are not met?

Based on the criteria above, staff's overall assessment of the Commission's strategic plan and performance measures is that the plan provides general and specific information regarding the Commission's activities. While some of the Commission's performance measures are written as task to be completed rather than results to be achieved, the Commission does include outcome based measures for what the Commission identifies as continuing responsibilities. Following is staff's analysis of the key components of the Commission's strategic plan and performance measures.

Assessment of Mission, Goals, and Objective Statements (Criteria #1)

The Commission's overall mission and goal statements are consistent with the legislative duties for the Commission (Section 25-1-903, C.R.S.). In addition, the Commission has organized their strategic plan so that objectives statements and performance measures are tied back to specific goals. For the most part, staff believes that the Commission has written goals and objectives that are consistent and appropriate for their mission. The following table provides *some* examples of the Commission's goal and objective statements.

Example -- ***Commission Goals***	**Example --** ***Commission Objectives Tied to Goal***
Goal A: Advance the quality of Colorado's Family Medicine Residency Training	**New Objectives** Objective 1: Refine and revamp, as needed, Colorado's collaborative approach to recruiting residents. Objective 2: Develop a collaborative, state-wide approach for faculty development. **Continuing Objectives** Objective 1.1: To fill all training slots with qualified medical students. Objective 1.2: To increase the number of graduating residents practicing in Colorado Objective 1.3: To increase the number of graduating residents practicing in rural and underserved areas of Colorado

Assessment of Performance Measures (Criteria 2 through 7)

The Commission selects performance measures each year for specific actions that the Commission hopes to achieve during the course of the year. The Commission also has performance measures for items that the Commission considers as continuing responsibilities. The first set of the Commission's measures are mainly output measures based on annual action plans to be completed.

However, the second set of measures that the Commission reports on are more outcome driven. Because the Commission selects both output and outcome type of measures, staff believes the Commission has selected and reports on measures that have meaning to both policy makers and stakeholders as well as the management of the Commission. Following are examples of some of the Commission's performance measure that helps illustrate staff's point.

Example -- Commission's Performance Measure (Related to Goal A Above and Objective 1 -- Output Measures for Current Year)	***Example -- Commission's Performance Measures*** **(Continuing Responsibilities Measures -- Outcome Measures)**			
		FY 2005 Actual	FY 2006 Actual	FY 2007 Future Year Target
1) Complete a top-to-bottom critical review of current recruitment program by 6/30/07 and implement changes with 2007 National Conference.	% of Training Slots Filled	100%	100%	100%
2) Complete a critical review of each residency's recruitment program and share "best practices" in a Director's Retreat by 6/30/07	% of Residency Graduates practicing in Colorado	74%	61%	84%
Staff comment: The Commission's current performance measures are tasks that are to be completed by Commission staff. These are output measures that do not focus on a result to be achieved.	*Staff Comment:* The Commission's continuing responsibility measures are outcome based measures. The Commission also reports passed year results and current and future year targets. The measures are well written and are meaningful in assessing the Commission's activities and achievement of key goals.			

In summary, staff believes that for the most part the Commission has selected a variety of performance measures that are meaningful and useful. Therefore, it is staff's assessment that if the Joint Budget Committee were to move toward performance-based budgeting, the Commission's current strategic planning process would be good starting point.

Questions for Commission

Staff recommends that the Committee discuss the following questions with the Commission during the FY 2007-08 budget hearing:

1. How do your performance measures influence Commission activities and budgeting?

2. To what extent do the performance outcomes reflect appropriation levels?

3. To what extent do you believe that appropriation levels in your budget could or should be tied to specific performance measure outcomes?

4. As a Commission director, how do you judge your department's performance? What key measures and targets do you used?

FY 2007-08 Joint Budget Committee Staff Budget Briefing
COMMISSION ON FAMILY MEDICINE
Additional Funding for Family Medicine Residency Programs

ISSUE: The Commission requests an increase of $200,000 in the cash fund exempt transfer from the Department of Health Care Policy and Financing. Of this amount, $100,000 will be Medicaid General Fund and $100,000 will be matching Medicaid federal funds.

SUMMARY:

- In FY 2001-02, the Commission's total funds budget was $2,364,545. The Commission's FY 2006-07 total fund appropriation is $1,703,558 -- 28.0% lower than the FY 2001-02 amount. The Commission's FY 2007-08 total fund budget request is $1,903,558 -- an 11.7% increase over the FY 2006-07 appropriation but still 19.5% lower than the Commission's FY 2001-02 appropriation.

RECOMMENDATION:

Staff recommends that the Committee ask the Commission the following questions at their hearing:

1. Please describe how the additional funding for the Commission will aid the state in recruiting and retaining family medicine physicians in Colorado.

2. Even though the General Assembly has increased funding for the nine remaining family residency programs during the last two years, most of the family medicine residency programs have reduced residency slots. Will additional funding allow more residency slots to be created or will the funding merely offset current cost increases for existing slots?

DISCUSSION:

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. The appropriation remained flat for FY 2005-06 but increased in FY 2006-07 by a total fund amount of $127,056, or 8.0 percent. For FY 2007-08, the Commission seeks an increase of total funds of $200,000. While this increase is an 11.7 percent increase over the current FY 2006-07 appropriation, the FY 2007-08 budget request of $1,903,558 is still 19.5 percent below the FY 2001-02 appropriation.

The Commission's FY 2006-07 appropriation provides funding for 9 family medicine residency programs. These residency programs provide primary care training for medical students entering family medicine practices. Many of the residency programs provide rural rotations and thus, help to

provide health care in rural Colorado. In addition, these residency programs tend to be part of the safety net of providers who will see Medicare, Medicaid and uninsured patients. All nine residency program are connected to hospitals and are eligible to receive Medicaid funding for some of their training activities. Staff would note that the Commission's funding provides only a fraction of the funding necessary to maintain residency programs. The majority of funding for the residency programs comes from the Medical Education program funded by the federal government. However, the state funding helps to mitigate the operating losses that many of the residency programs have been experiencing. The following table shows the total state funding for each residency program.

Residency Program (connected to hospitals and therefore, eligible for Medicaid)	FY 2004-05	FY 2005-06	FY 2006-07 Approp.	FY 2007-08 Request
Ft. Collins	161,049	175,167	189,284	211,506
North Colorado	161,049	175,167	189,284	211,506
Rose	161,049	175,167	189,284	211,506
St. Anthony	161,049	175,167	189,284	211,506
St. Joseph	161,049	175,167	189,284	211,506
St. Mary	161,049	175,167	189,284	211,506
Southern Colorado	161,050	175,167	189,284	211,506
Swedish	161,050	175,167	189,284	211,506
University/AF Williams	161,050	175,167	189,284	211,506
TOTAL Medicaid Funded Residency Programs (HCPF Budget and Commission Budget Medicaid Funds Request)	**$1,449,444**	**$1,576,502**	**$1,703,558**	**$1,903,558**
Colorado Springs (non-Medicaid funded -- Commission Budget Only)	127,057	0	0	0
TOTAL Residency Program Line Item (Commission Budget Request)	**$1,576,501**	**$1,576,502**	**$1,703,558**	**$1,903,558**

In 2005, the Colorado Springs residency program closed. Because this residency program was not connected with a hospital, it was not eligible for Medicaid funding. Therefore, the entire $127,057 of its funding was state funding through indirect cost recoveries within the Department of Higher Education. The FY 2005-06 Long Bill reallocated $63,528 of the Colorado Springs residency program into the other nine programs. Because the other nine residency programs are eligible for Medicaid funding, the reallocated $63,528 in state funding was able to draw down a matching amount in federal funds. Therefore, the Commission's budget was able to stay exactly the same while the state

received a General Fund savings within the Department of Higher Education of $63,528 by redirecting the indirect cost recoveries to other General Fund programs.

In FY 2006-07, the General Assembly increased the Commission's Medicaid General Fund by $63,528 and an additional $63,528 in matching federal Medicaid funds. This increase restored approximately 16 percent of the funding cuts that were made to the Commission's budget during the proceeding four years. The Commission's FY 2007-08 budget requests that an additional $100,000 in Medicaid General Fund be appropriated. This funding will be matched by $100,000 in federal Medicaid funding for a total increase of $200,000. The Commission requests the increase to further restore some of the budget reductions that were made to the program during the early 2000's and to help defray the continuing cost increases associated with training family medicine physicians.

COLORADO GENERAL ASSEMBLY
JOINT BUDGET COMMITTEE

Fiscal Year 2007-08 Staff Budget Briefing

Department of Health Care Policy and Financing
(All programs except for Medicaid Mental Health Community Programs
and Department of Human Services Medicaid-Funded Programs)

JBC Working Document - Subject to Change

Staff Recommendation Does Not Represent Committee Decision

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FY 2007-08 Joint Budget Committee Staff Budget Briefing

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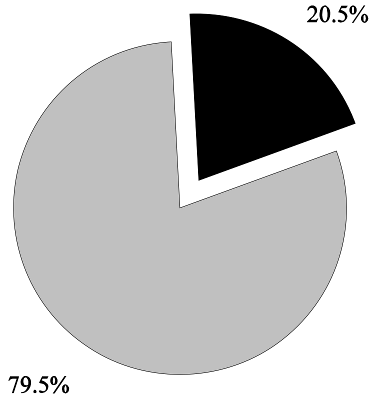
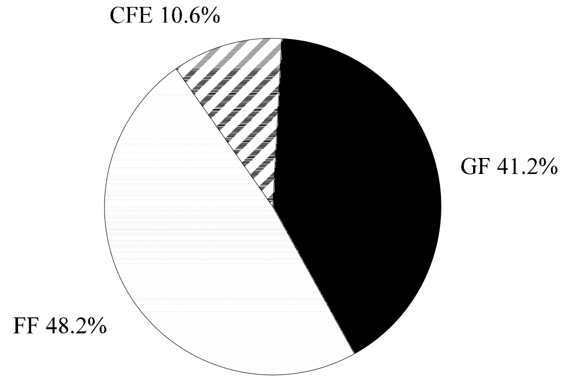
Department of Health Care Policy and Financing
Graphic Overview

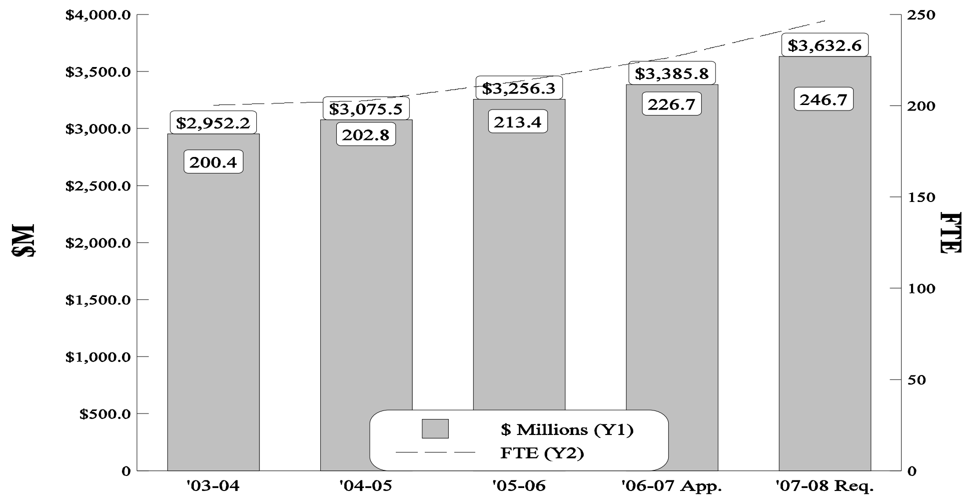
Share of State General Fund FY 2006-07



Funding Source Split FY 2006-07



Appropriation History



DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
OVERVIEW

Key Responsibilities

- Administers the State's Medicaid program which provides health care services to a forecasted 429,222 low-income people in FY 2006-07.
- Administers the Children's Basic Health Plan, a health insurance program for a forecasted 42,590 low-income children and approximately 1,578 adult pregnant women.
- 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 2004-05 (last year with data) this program served approximately 179,129 low-income individuals.
- Administers the Old Age Pension Health and Medical Fund which provides health care to a forecasted 5,989 elderly persons who do not qualify for Medicaid or Medicare in FY 2006-07.
- 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 consists of 41.2 percent General Fund, 10.6 percent cash funds and cash funds exempt, and 48.2 percent federal funds. Sources for the cash funds and cash funds exempt include (1) the Old Age Pension Health and Medical Care Fund and Supplemental Fund; (2) the small enrollment fee for the Children's Basic Health Plan Program; (3) the provider fees paid by intermediate care facilities; (4) the certification of expenditures from other government entities (mainly public hospitals and school districts) that qualify for matching federal funds through the Medicaid program; (5) Amendment 35 Tobacco Tax Revenues in the Health Care Expansion Fund; and (6) Tobacco Tax Settlement monies. Some of the most important factors driving the budget are reviewed below. (This section does ***not*** include a discussion on mental health issues or programs administered by the Department of Human Services. For information on these programs, please see other related staff briefing materials.)

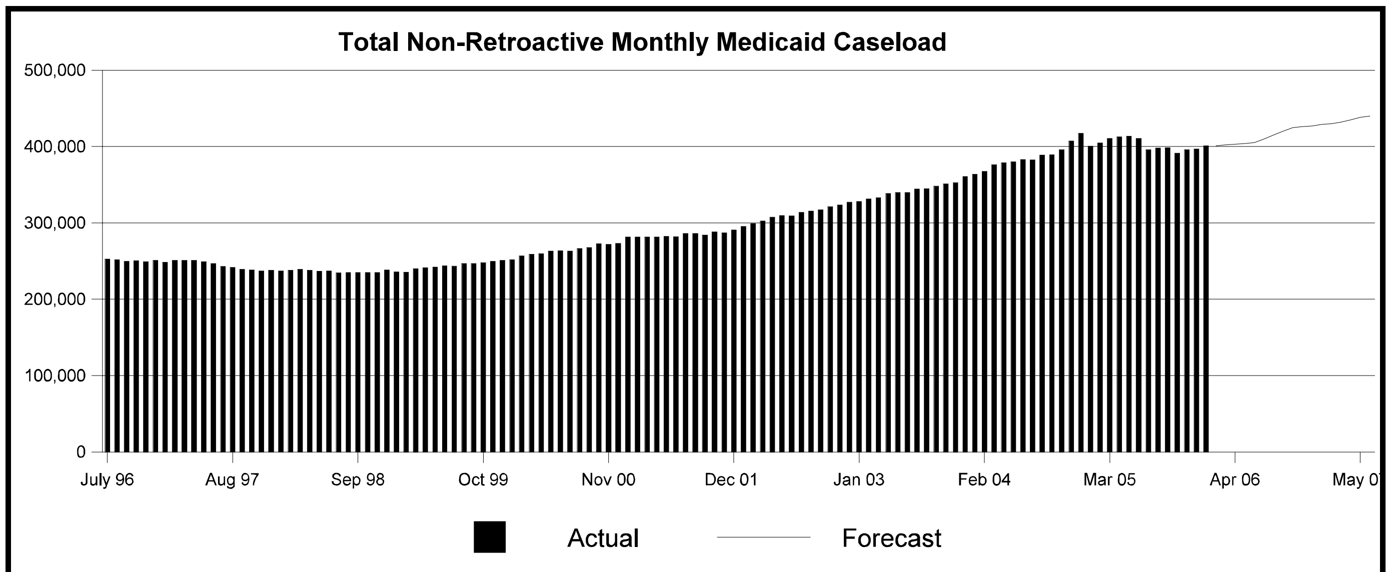
Medical Services Premiums

The medical services premiums section provides funding for the health care services for 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 both

within nursing facilities and community alternatives). The Department contracts with health care providers in both fee-for-service, health maintenance organization (HMO) arrangements, and prepaid inpatient health plan (PIHP) contracts in order to provide medical services to eligible clients. Total costs for the program result from the number of clients, the costs of providing health care services, and utilization of health care services.

Medicaid Caseload Growth

The following factors impact 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. During the late 1990s, the Medicaid caseload declined due to the impacts of federal welfare reform and the strong economic expansion. However, since early 1999 the Medicaid caseload has increased sharply. This increase is partly due to federal legislation authorizing new populations to become eligible (mainly children) and the economic recession in the early 2000s. The following chart shows the monthly Medicaid caseload growth from FY 1996-97 through the forecast period for FY 2006-07.



For FY 2006-07, the caseload is forecasted to grow by approximately 29,523 clients, or 7.4 percent.

Medicaid Caseload/1	FY 01-02 Actual	FY 02-03 Actual	FY 03-04 Actual	FY 04-05 Actual	FY 05-06 Actual	FY 06-07 Approp.
Elderly Populations						
Suppl. Security Income (SSI) Ages 65+	33,916	34,485	34,149	35,615	36,219	37,036
Suppl. Security Income (SSI) Ages 60 - 64	5,184	5,456	5,528	6,103	6,048	6,241
Qualified Medicare Beneficiaries/Special Low-income Medicare Beneficiaries	8,428	8,949	9,787	9,572	11,012	12,570
Subtotal Elderly	47,528	48,890	49,464	51,290	53,279	55,847
Disabled	46,349	46,378	46,565	47,626	47,565	48,447
Low-Income Adult						
Categorical Eligible	33,347	40,021	46,754	56,453	57,747	63,127
Expansion Adults	0	0	0	0	0	4,850
Baby Care Adults	7,131	7,579	8,203	6,110	5,050	4,890
Subtotal Low-Income Adults	40,478	47,600	54,957	62,563	62,797	72,867
Breast and Cervical Cancer Treatment	0	46	103	86	188	223
Children						
Children	143,909	166,537	192,048	220,592	213,600	228,438
Foster Children	13,121	13,843	14,790	15,669	16,311	17,091
Subtotal Children	157,030	180,380	206,838	236,261	229,911	245,529
Non-Citizens	4,028	4,101	4,604	4,976	5,959	6,309
Total Caseload	295,413	327,395	362,531	402,802	399,699	429,222
Percent Change	7.27%	10.83%	10.73%	11.11%	-0.77%	7.39%

/1 Includes all Medicaid caseload. Of the total FY 2006-07 caseload, approximately 25,175 clients are eligible for their state match to be paid from Amendment 35 monies instead of the General Fund.

Amendment 35 Caseload Growth

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 and H.B. 05-1086 to implement the provisions of Amendment 35. House Bill 05-1086 allowed optional legal immigrants to be funded with Amendment 35 monies for the state match (optional legal immigrants were not eligible for Medicaid funding under current state law when Amendment 35 passed). Since FY 2004-05, approximately 3,512 legal immigrants have received a portion or all of their state match from Amendment 35 monies. House Bill 05-1262 expanded the Medicaid caseload as follows: (1) increased the waiver slots available to for Extensive Support Services and Home and Community-Based Services for disabled children; (2) removed the Medicaid asset test; (3) increased the eligibility for the Breast and Cervical Cancer program up to 250 percent of the federal poverty level (FPL); and (4) increased the eligibility for low income adults up to 60 percent FPL. Due to implementation challenges, the asset test was not removed in FY 2005-06. However, beginning in FY 2006-07, the asset test should be removed and low income adults up to 60 percent of FPL should be eligible for Medicaid coverage. The total FY 2006-07 caseload forecasted to be eligible for Medicaid and funded with Amendment 35 monies is 18,814. Over the next five years, this caseload is forecasted to grow to 36,649 clients. Over the next five years, the majority of the Medicaid caseload growth is anticipated to be from the new eligibility clients added through Amendment 35.

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. Recent budget increases for medical services are primarily related to nursing home rate increases and utilization increases in the areas of community long-term care and pharmaceuticals. However, because of recent budget reduction initiatives, the implementation of the U.S. Medicare Modernization Act of 2003, and to higher growth in the lower cost categories of low-income children and adults, the average cost per Medicaid client for FY 2006-07 is actually lower than it was in FY 2002-03. The following table provides a five-year history of average cost-per-client.

	FY 02-03 Actual	**FY 03-04 Actual**	**FY 04-05 Actual**	**FY 05-06 Actual**	**FY 06-07 Approp.**
Medical Service Cost Per Capita	*$5,044.88*	*$5,080.22*	*$4,700.29*	*$4,962.33*	*$4,887.95*
Percent Change	*(3.0)%*	*0.7%*	*(7.5)%*	*5.6%*	*(1.5)%*

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 179,129 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 passed 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 (these are cash fund exempt appropriations).

In FY 2003-04, through the Medicare Upper Payment Limit (UPL) financing mechanism, the State was able to increase funding for the program by approximately $23.3 million. 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 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, funding for existing programs is anticipated to increase by $11.2 million total funds. In addition to this increase, an increase of $15.0 million will be available for additional indigent care costs through S.B. 06-044. The table on the following page provides a five-year funding history for the Indigent Care Program.

	FY 02-03 Actual	**FY 03-04 Actual**	**FY 04-05 Actual**	**FY 05-06 Actual**	**FY 06-07 Approp.**
Safety Net Provider Payments[/1]	$233,394,276	$255,976,646	$264,013,206	$287,296,074	$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
Pediatric Speciality Hospital	0	0	0	5,452,134	7,732,072
Medically Indigent Program	***$0***	***$0***	***$0***	***$0***	***$14,262,663***
Total	***$239,514,036***	***$262,096,406***	***$270,132,966***	***$298,867,968***	***$324,303,125***
General Fund	***14,663,540***	***13,555,006***	***12,492,364***	***18,362,593***	***19,500,662***
Cash Fund Exempt	***104,535,651***	***115,400,000***	***122,574,119***	***131,071,391***	***149,782,232***
Federal Funds	***120,314,845***	***133,141,400***	***135,066,483***	***149,433,984***	***155,020,231***
Total funding percent increase	***n/a***	***9.43%***	***3.07%***	***10.64%***	***8.51%***

/1 Prior to FY 2003-04, the safety net provider payments were contained in several line items in the Long Bill. These line items were consolidated in FY 2003-04 into the "safety net provider payment" line item in order to simplify appropriations and the methodology used to distribute the funding. For purposes of this table, the FY 2001-02 and FY 2002-03 appropriations have been consolidated to match the new methodology used beginning in FY 2003-04.

New Programs Under Amendment 35

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 will provide 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 will decrease to $32.9 million. The decrease solely reflects the fact that program will have only twelve months of revenue in FY 2006-07 instead of the 18 months of revenue collections that were available in FY 2005-06. Funding for this program is solely from the increase in tobacco taxes; there are no matching federal funds available for this program.

Children's Basic Health Plan

The Children's Basic Health Plan (CBHP) was originally implemented in 1997 to provide health care insurance to children from families at or below 185 percent of the federal poverty level. 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 of the federal poverty level. 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 Children's Basic Health Plan for both children and women up to 200 percent of the federal poverty level (approximately $38,700 for a family of four in 2006). Additionally, H.B. 05-1262 allowed caseload growth over the FY 2003-04 level to be funded through Amendment 35 monies and allowed for increased marketing activities to further expand caseload enrollment. The following table provides a five-year funding history for the Children's Basic Health Plan medical and dental costs.

	FY 02-03 Actual	**FY 03-04 Actual**	**FY 04-05 Actual**	**FY 05-06 Actual**	**FY 06-07 Approp.**
Medical Services	$51,548,754	$51,777,408	$52,000,289	$65,919,891	$70,371,177
Dental Services	5,649,083	5,405,336	5,084,701	5,368,921	***5,913,659***
Total Service Costs	***$57,197,837***	***$57,182,744***	***$57,084,990***	***$71,288,812***	***$76,284,836***
Cash Fund Exempt	*20,167,514*	*20,114,345*	*20,059,529*	*25,305,261*	*26,824,539*
Federal Funds	*37,030,323*	*37,068,399*	*37,025,461*	*45,983,551*	*49,460,297*
Total funding percent increase	*n/a*	*-0.03%*	*-0.17%*	*24.88%*	*7.01%*

The following table provides a five year history of the caseload served by the Children's Basic Health Plan. The number of children in the traditional caseload is anticipated to decrease in FY 2006-07 from the FY 2005-06 level once the elimination of the Medicaid asset test occurs and some of the children currently eligible for the CBHP program become eligible for the Medicaid program.

	FY 02-03 Actual	FY 03-04 Actual	FY 04-05 Actual	FY 05-06 App.*	FY 06-07 Approp.
Children's Traditional Caseload	49,216	46,694	41,101	42,547	38,635
Children's Expansion Caseload	n/a	n/a	n/a	1,630	3,955
Traditionally Eligible Adult Prenatal Member Months up to 185% FPL	4,779	1,428	6,684	1,428	1,428
Amendment 35 Eligible Adult Prenatal Member Months up to 200% FPL and above FY 2003-04 Enrollment	n/a	n/a	n/a	13,019	17,508

* At the time this section was written, final FY 2005-06 caseload was still be developed. The CBHP program uses retroactive caseload reporting therefore, final caseload numbers are not available until several months after the close of the fiscal year.

Department of Human Services Medicaid-Funded Programs

Many programs in 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 cash funds exempt). A five-year funding history for the DHS Medicaid related programs is provided in the table on the following page.

	FY 02-03 Actual	FY 03-04 Actual	FY 04-05[/1] Actual	FY 05-06 Actual	FY 06-07 Approp.
Expenditures	$529,215,363	$567,683,764	$420,876,735	$429,711,475	$404,911,178
Annual Percent Increase	-0.5%	7.3%	-25.9%	2.1%	-5.8%

[/1] The majority of this decrease relates to the transfer of Medicaid mental health services from this section to the newly created Medicaid Mental Health Community Programs section.

Summary of Major Legislation

✔ **S.B. 06-044: (Hagedorn/Green)** This bill increases eligibility into the medically indigent program to clients with incomes up to 250 percent of the federal poverty level. The bill creates the Health Care Services Fund and requires that the General Assembly appropriate $14,962,408 into this fund from the General Fund in each year for FY 2005-06, FY 2007-08, FY 2008-09 and FY 2009-10. In FY 2005-06, this bill reduces the appropriation for the Children's Hospital,

Indigent Care Program by a total of $29,924,816. Of this amount, $14,962,408 is from the General Fund and $14,962,408 is from federal funds. The bill then appropriates the General Fund savings of $14,962,408 into the Health Care Services Fund as required by the bill. For FY 2006-07, the bill appropriates $14,962,408 from the Health Care Services Fund to the Health Care Services Fund program to be used to increase eligibility into the Medically Indigent Care Program as specified in the bill.

- ✔ **S.B. 06-128 (Owen/Riesberg):** This bill directs a non-profit organization to submit a proposal to the Department for a pilot program to improve the overall quality of care received by Medicaid recipients with disabilities. The proposed pilot program must be submitted to the Department by September 1, 2006. The bill contains a total fund appropriation of $126,780 and 1.0 FTE to the Department for the administrative expenses involved in evaluating and implementing the pilot program. Of this amount, $45,070 is cash funds exempt from the Coordinated Care for People with Disabilities Fund (whose revenue source is interest earnings from the Breast and Cervical Cancer Fund) and $81,710 is matching federal funds.

- ✔ **S.B. 06-129 (Keller/Buescher):** This bill clarifies that non-administrative programs that qualify for federal participation under Title XIX of the U.S. Social Security Act shall be on the cash basis of accounting. The bill results in a one-time savings of $5,643,341 in FY 2005-06 resulting from moving the Nurse Home Visitor and School Based Services Programs from accrual accounting to cash accounting. Of this amount, $2,821,670 is cash funds exempt and $2,821,671 is matching federal funds.

- ✔ **S.B. 06-131 (Tochtrop/McFadyen):** This bill requires the Department to conduct a feasibility study for a new pricing model for class I nursing facilities. The bill also requires that each class I nursing facility's reimbursement rate be at least 85 percent of the statewide average for FY 2006-07. However, a provider's reimbursement rate is limited to a 10 percent increase over its current rate. Finally, the bill removes the 8 percent limit on health care services costs for class I and class V nursing facilities for FY 2006-07. The bill contains a total fund appropriation of $2,376,406. Of this amount, $1,188,203 is from the General Fund and $1,188,203 is matching federal funds.

- ✔ **S.B. 06-165 (Hagedorn/Gardner):** This bill authorizes the Department to adopt rules that would eliminate the requirement for in-person medical consultation for telemedicine services under the Medicaid program. The bill also requires the Department to establish a pilot program using telemedicine for the treatment of patients with chronic conditions. The bill appropriates a total of $433,757 and 1.0 FTE for the initial administrative and services costs required under the bill's provisions. Of this amount, $203,558 is General Fund and $230,199 is matching federal funds.

- ✔ **S.B. 06-208 (Hanna/Larson):** This bill establishes the Blue Ribbon Commission on Health Care Reform for the purpose of studying and establishing health care reform models to expand health care coverage and to decrease health care costs. In FY 2005-06, the bill reduces the appropriation for the Children's Hospital, Indigent Care Program by a total of $200,000. Of this amount,

$100,000 is from the General Fund and $100,00 is from federal funds. The General Fund savings is then placed into Health Care Reform Cash Fund to be available for appropriation to the Department of Regulatory Agencies, Division of Insurance, to provide funding for the Blue Ribbon Commission as outlined in the bill. See the Department of Regulatory Agencies for additional information.

✔ **S.B. 06-219 (Keller/Jahn):** This bill reorganizes and amends statutes relating to all programs administered by the Department. The bill clarifies and transfers administrative responsibilities between the Department and the Department of Human Services for county administration, and the Home Care Allowance and Adult Foster Care Program. The bill decreases the total appropriations to the Department of Health Care Policy and Financing by $7,319,962. Of this amount, 10,485,986 is a decrease from the General Fund and $3,166,024 is an increase in cash funds exempt. The bill also decreases the appropriations to the Department of Human Services by a total of $19,996,252. Of this amount $10,485,986 is an increase to the General Fund that is offset by a decrease to cash funds exempt of $30,482,238.

✔ **H.B. 06-1270 (Merrifield/Gordon):** This bill creates a demonstration project in the Department of Health Care Policy and Financing to authorize public school personnel to perform eligibility determinations for the Medicaid program. The bill contains a total fund appropriation of $59,532 and 1.0 FTE in FY 2006-07 for the administrative costs associated with developing the demonstration project. Of this amount, $29,766 is General Fund and $29,766 is matching federal funds.

✔ **H.B. 06-1310 (Buescher/Owen):** This bill simplifies the distribution of funds from the Tobacco Litigation Settlement Cash Funds to the various programs authorized to receive such funding. The bill eliminates a total of $23,595,753 in double counted appropriations from the Department of Health Care Policy and Financing. For more information on this bill, see the Department of Public Health and Environment briefing.

✔ **H.B. 06-1395 (Buescher/Keller):** This bill established the Psychiatric Residential Treatment Facility (PRTF) which will be eligible to earn federal medicaid revenue for children placed in out-of-home settings. The bill appropriated $5.8 million General Fund, and matching federal funds to the Department of Health Care Policy and Financing that was exempt from the 6.0 percent limit pursuant to the definition of a "requirement of federal law." For more information on this bill, see the Department of Human Services Briefing on child welfare issues.

✓ **H.B. 05-1086 (Plant/Tapia):** Reinstated Medicaid eligibility for optional legal immigrants on January 1, 2005. During the 2003 Legislative Session, the General Assembly passed S.B. 03-176, which eliminated Medicaid coverage for legal immigrants considered "optional" under federal law. Due to legal challenges, S.B. 03-176 was not anticipated to be implemented until January 2005. However, with the passage of Amendment 35 to the Colorado Constitution in November 2004, additional funding became available to expand Medicaid eligibility to individuals not currently covered under the law. The General Assembly passed H.B. 05-1086 to repeal S.B. 03-

176 and to fund the optional legal immigrant population with moneys from the new tobacco tax revenues authorized by Amendment 35. For FY 2004-05, House Bill 05-1086 appropriated $3.8 million to the Department of Health Care Policy to fund legal immigrants from January 1, 2005 through June 30, 2005. This amount is net of a reduction of $838,528 to the General Fund and increases of $2.5 million from the Health Care Expansion Fund and $2.2 million federal funds. Because this bill was passed before the 2005 Long Bill, the FY 2005-06 appropriation for legal immigrants is contained within the Long Bill (05-209) appropriations.

✓ **H.B. 05-1131 (Cloer/Tochtrop):** Allows a licensed facility, or the patient's family, to return unused, individually packaged medication to a pharmacist to be redispensed to another patient of the facility. House Bill 05-1131 also allows pharmacists to accept and distribute medications to nonprofit organizations that provided medical care. Finally, the bill requires that pharmacists reimburse the Department of Health Care Policy and Financing for the cost of medications that the Department has paid if the medications are available to be dispensed to another person.

✓ **H.B. 05-1243 (Jahn/Johnson):** Allows Medicaid recipients who are enrolled in a Home- and Community-based Services (HCBS) waiver to receive services through a consumer-directed care service model. Additionally, the bill specifies that certain professional licensing requirements do not apply to a person who is directly employed by an individual participating in the consumer-directed care service model and who is acting within the scope and course of such employment.

✓ **H.B. 05-1262 (Boyd/Hagedorn):** Implements Section 21 of Article X of the Colorado Constitution, concerning taxes on tobacco products, that was adopted by vote of the citizens of the State in November 2004. House Bill 1262 expanded eligibility for the Medicaid and Children Basic Health Plan. Under the provisions of the bill, (1) the Medicaid asset test was eliminated, (2) Medicaid eligibility was expanded to up to 60% FPL for low income adults; (3) CBHP eligibility was expanded to up to 200% FPL for children and pregnant women; and (4) Medicaid waiver slots for disabled children were increased.

✓ **S.B. 04-177(Gordon/Hefley):** Established the "Home- and Community-based Services (HCBS) for Children with Autism Act" and required the Department of Health Care Policy and Financing to seek the federal authorization necessary to implement the act.

✔ **S.B. 04-206(McElhany/Witwer):** Required the Department to submit a federal waiver to add a hospice care benefit to the Medicaid program for children.

✓ **H.B. 04-1219 (Witwer/Reeves):** Added community transition services to the Home- and Community-Based Services for the Elderly, Blind, and Disabled program, and provided that such services shall not exceed $2,000 per eligible person per year unless authorized by the Department of Health Care Policy and Financing.

✔ **S.B. 03-11(Hagedorn/Spradley):** Required the generic drug equivalent of a brand-name drug to be prescribed in the Medicaid program if the generic drug is a therapeutic equivalent to the

brand-name drug and authorized the Department of Health Care Policy and Financing to adopt rules to allow for a mail order prescription drug program.

- ✔ **S.B. 03-196 (Teck/Witwer):** Changed the method of accounting for certain Medicaid services from an accrual basis to a cash basis. This change resulted in one-time savings in FY 2002-03.

- ✔ **H.B. 02-1155 (Clapp/Owen):** Expanded the Children's Basic Health Plan (CBHP) to include prenatal and postpartum care for pregnant women who are not Medicaid eligible. Covers pregnant women whose incomes are between 134-185 percent of the federal poverty level; covers postpartum care for 60 days after the birth of the child; automatically enrolls the child, upon birth in the CBHP; exempts a pregnant woman from paying the CBHP annual enrollment fee.

- ✔ **H.B. 02-1292 (Clapp/Reeves)**: Repealed the requirement that 75 percent of Colorado's Medicaid clients be served in managed care and instead requires the state managed care system to be implemented to the extent possible. Provided that for capitation payments effective after July 1, 2003, Managed Care Organizations shall certify that its contract rates are sufficient to assure the MCO's financial stability and provides that certification by a qualified actuary shall be conclusive evidence that the Department has calculated the capitation payment correctly.

- ✔ **S.B. 2S01-12 (Reeves/Spradley):** Expanded the Colorado Medicaid program to include a Medicaid treatment benefit for qualifying low-income women screened through the Centers for Disease Control system for breast and cervical cancer.

- ✔ **S.B. 00-128 (Lacy/Dean):** Established a case-mix system of reimbursement for Medicaid nursing facilities. Also suspended the 8.0 percent cap on the reimbursement for increases in health care services costs during the first two years that the case-mix adjusted reimbursement is implemented. HB 02-1497 furthered suspended the 8.0 percent cap on the reimbursement until a recommendation could be made by a statutorily created committee regarding the implementation of the cap again. In addition, HB 02-1497 repealed the QCIP and ResQUIP programs.

- ✔ **H.B. 98-1325 (Owen/Rizzuto): Child Health Insurance.** Made technical changes to allow the State to implement the new federal program, the State Children's Health Insurance Program (Title XXI) in FY 1997-98.

- ✔ **S.B. 97-101 (Rizzuto/Owen): Medicaid for School Districts.** Allowed school districts to receive federal Medicaid funds based on the school district's certified funds match.

- ✔ **H.B. 93-1317 (Anderson/Rizzuto): Creation of Department - Restructuring of Health and Human Services.** Restructured the former Departments of Institutions, Health, and Social Services to form the Departments of Health Care Policy and Financing, Human Services, and Public Health and Environment.

Major Funding Changes FY 2005-06 to FY 2006-07

The following table shows the major funding changes for the Department of Health Care Policy and Financing.

Department of Health Care Policy and Financing (all programs)						
	Total Funds	General Fund/1	Cash Funds	Cash Funds Exempt	Federal Funds	FTE
FY 2006-07 Appropriation:						
FY 2005-06 Appropriation	$3,256,303,708	$1,363,690,096	$741,183	$333,073,353	$1,558,799,076	213.4
Medical Service Division (Major Long Bill adjustments)						
Medicaid base adjustments	68,947,254	(6,227,987)	0	40,822,984	34,352,257	0.0
Medicaid provider rate increases	51,498,686	25,235,641	0	513,702	25,749,343	0.0
Other Medicaid Premium changes	(11,503,776)	(285,790)	0	(12,101,774)	883,788	0.0
Mental Health Division (Major Long Bill adjustments)						
Medicaid Mental Health changes	13,507,786	5,446,146	0	571,054	7,490,586	0.0
Indigent Care Division (Major Long Bill adjustments)						
Increase to Safety Net Provider Payments	8,892,556	514,136	0	3,932,142	4,446,278	0.0
Children's Basic Health Plan base cost adjustments	4,901,153	0	0	1,504,209	3,396,944	0.0
Pediatric Speciality Hospital Increase	2,279,938	623,933	0	516,036	1,139,969	0.0
Technical changes to the Indigent Care Division	(26,625,019)	(16,446,372)	(53,670)	(10,095,837)	(29,140)	(1.0)
Other Medical Services Division (Major Long Bill adjustments)						
Medicare Modernization Act State Contribution Payment	45,050,624	45,050,624	0	0	0	0.0
Increase to the Old Age Pension Medical Program	976,180	0	0	976,180	0	0.0
School-based services	352,607	0	0	183,122	169,485	0.0
Family Medicine Residency Training Program	127,056	63,528	0	0	63,528	0.0
Technical changes to the Other Medical Services Division	7,828,378	0	0	5,006,707	2,821,671	0.0

Department of Health Care Policy and Financing (all programs)	Total Funds	General Fund/1	Cash Funds	Cash Funds Exempt	Federal Funds	FTE
Department of Human Services Medicaid Programs Division						
Department of Human Services Medicaid Programs	(35,313,708)	(17,572,099)	0	449,570	(18,191,179)	0.0
Executive Director's Division						
County transportation	612,734	306,367	0	0	306,367	0.0
HIPAA national provider identifier	581,862	141,101	0	6,109	434,652	0.0
Salary, benefits and staffing adjustments	983,875	290,286	0	12,185	681,404	5.7
Other issues in Executive Director's Office Division	(870,712)	(197,169)	3,446	(495,401)	(181,588)	4.6
Special Legislation						
Sum of all 2006 Legislation adding appropriations	(2,704,882)	(3,950,639)	0	(5,421,680)	6,667,437	4.0
TOTAL FY 2006-07	**$3,385,826,300**	**$1,396,681,802**	**$690,959**	**$359,452,661**	**$1,629,000,878**	**226.7**
Increase/(Decrease)	$129,522,592	$32,991,706	($50,224)	$26,379,308	$70,201,802	13.3
Percentage Change	4.0%	2.4%	-6.8%	7.9%	4.5%	6.2%

Medicaid base adjustments: The FY 2006-07 appropriation contained a total fund increase of $68.9 million to fund the forecasted Medicaid caseload and cost estimates. This item represents the annual change needed each year to serve the medical needs of the Medicaid population before policy or law changes. In March 2006, the caseload forecast was anticipated to increase from 399,710 in FY 2005-06 to 429,222 in FY 2006-07 (7.4 percent increase). However, overall cost-per-clients was anticipated to decrease by from $5,002.74 in FY 2005-06 to $4,912.58 in FY 2006-07 (1.8% decrease). The main reasons for the decrease in the overall cost-per-client included annualizing the impact of the Medicare Modernization Act of 2003 and continued caseload growth in low-income adult and children populations (which has the affect of lowering the overall average cost-per-client). The Medicaid base adjustments for FY 2006-07 are discussed in greater detail in the issue section of this briefing.

Medicaid provider rate increases: The FY 2006-07 appropriation contained a $51.5 million total fund provider rate increase for certain Medicaid providers. The amount of the rate increases varied greatly by different provider classes. Therefore, this item is discussed in greater detail in the footnote and issue section of this briefing.

Other Medicaid Premium changes: The FY 2006-07 appropriation also made technical changes that resulted in a decrease of $11.5 million total funds. Most of these changes related from eliminating a double count of certified funds, allowing Denver Health to certify costs for outstationing activities in order to draw down federal funds to offset some of their costs, anticipated savings from implementing some of the State Auditor's findings regarding the drug rebate program and from increasing audits of the single entry point agencies.

Medicaid Mental Health changes: The FY 2006-07 appropriation included a total fund increase of $13.5 million for mental health issues. Greater detail about this change can be found in the staff briefing on Mental Health for the Departments of Human Services and Health Care Policy and Financing.

Increase to Safety Net Provider Payments: The FY 2006-07 appropriation included a total fund increase of $8.9 million to provide a 3.0 percent increase to the federal funds available to reimburse public hospitals for the uncompensated care that they provide to indigent clients. The appropriation also provided a 4.0 percent increase to the General Fund and federal funds available to reimbursement private hospitals for the uncompensated care that they provide to indigent clients.

Children's Basic Health Plan base cost adjustments: The FY 2006-07 appropriation included a total fund increase of $4.9 million to fund the caseload growth and cost-per-client increases in the Children's Basic Health Plan. Greater detail about this change can be found in the staff briefing on the Children's Basic Health Plan issue briefing.

Pediatric speciality hospital: The FY 2006-07 appropriation included an increase of $2.3 million total funds to provide additional funding to compensate pediatric specialty hospitals for the disproportionate share of Medicaid and Children's Basic Health Plan children that are served by this hospital.

Technical changes to the Indigent Care Division: The FY 2006-07 appropriation contained a total fund decrease of $26.6 million in other changes to the Indigent Care Division. These changes include the following: (1) a decrease of $15.0 million General Fund to reflect a one-year decrease of the amount of General Fund Exempt that must be deposited into the Colorado Health Services Fund; (2) a decrease of $2.0 million General Fund to the amount deposited into the Children's Basic Health Plan Trust Fund; and (3) a decrease of $11.2 million cash funds exempt to the Primary Care Fund Program to reflect a decrease in tobacco tax revenue available for that program. These decreases are offset by a total fund increase of approximately $1.5 million to reflect appropriations that must be made to different funds pursuant to the requirements of H.B. 05-1262.

Medicare Modernization Act State Contribution Payment: The FY 2006-07 appropriation contained an General Fund increase of $45.1 million General Fund to annualize the State Contribution Payment required by the Medicare Modernization Act (otherwise known as the clawback). In FY 2005-06 only six payments were required under the MMA; however, in FY 2006-07 a total of 12 payments will be made. In addition, the appropriation reflects the inflationary and caseload estimates required for the payment as well as the phase down factor allowed by the MMA. This appropriation was partially offset

by a decrease in the Medicaid base adjustments. This issue is discussed in greater detail in the footnote and issue section of this briefing.

Increase to the Old Age Pension Medical Program: The FY 2006-07 appropriation included an increase of $976,180 cash funds exempt to appropriate additional funds available in the Supplemental Old Age Pension Health and Medical Care Fund to the Old Age Pension (OAP) State Medical Program. At the time the appropriation was made, the OAP Medical Program's caseload was anticipated to increase from 5,343 clients in FY 2005-06 to 5,989 clients in FY 2006-07 (an increase of 12.1 percent). Because this is a capped program, caseload growth results in fewer benefits begin available to the eligible clients. The appropriation uses some of the fund balance currently in the Supplemental Old Age Pension Health and Medical Care Fund in order to help maintain benefits for the anticipated caseload growth. This issue is discussed in greater detail in the footnote and issue section of this briefing.

School-based services: The FY 2006-07 appropriation included an increase of $352,607 total funds to reflect an increase in anticipated services to Medicaid eligible children due to the elimination of the caps for the Children's Extensive services Waiver and for the Children's Home and Community-Based Services Waiver Program.

Family Medicine Residency Training Program: The FY 2006-07 appropriation includes an increase of $127,056 funding for the nine family medicine residency programs in the state. This increase is reflected as a cash funds exempt transfer in the Commission of Family Medicine's budget.

Technical changes to the Other Medical Services Division: The FY 2006-07 appropriation also makes the following technical changes: (1) contains an increase of $5.6 million to adjust for one-time savings that occurred in FY 2005-06 when the accounting methodology for the Nurse Home Visitor and Public School Health Services programs was changed to cash accounting; (2) includes an increase of $2.6 million to reflect the amount of Tobacco Tax Cash fund that is transferred to the General Fund pursuant to H.B. 05-1262; and (3) includes a decrease of $395,143 to eliminate a double counted appropriation related to the Autism Treatment Fund.

Department of Human Services Medicaid Programs: The FY 2006-07 appropriation contains a total fund decrease of $17.6 million to the Department of Human Services Medicaid funded programs. This reduction was mainly the result of a loss of Medicaid funding for residential treatment centers and was offset by increases in other program areas. The Department of Human Services Medicaid programs are discussed in other staff briefings for the Department of Human Services.

County transportation: The FY 2006-07 appropriation transferred county transportation funding from the Department of Human Services Medicaid Programs Division in order to consolidate county transportation funding into one line item. The appropriation also provided a 2.67 percent inflationary increase for transportation services.

HIPAA national provider identifier: The FY 2006-07 appropriation included a total funds increase of $581,862 in order to implement the new federal rules under the Health Insurance Portability and

Countability Act of 1996 (HIPAA) which requires that all health providers obtain a national provider identifier number by 2007.

Salary, benefits and staffing adjustments: The FY 2006-07 appropriation contained an increase of $983,875 total funds for salary survey, health, life and dental benefits, short-term disability, workers' compensation and to annualize the costs of prior year legislation. The appropriation also included an increase of 5.7 FTE and associated funding to restore some of the FTE and funding cuts that were taken from the Department's administration funding during the budget reduction years.

Other issues in the Executive Director's Office Division: The FY 2006-07 appropriation also included funding reductions related to eliminate one-time funding associated with eliminating prior year legislation and policy directives and for medical identification cards. These reductions were partially offset with increases for the prescription drug rebate program, the Medicaid Management Information System reprocurement process, nursing facility appraisals, a physician rate disparities study, and other audit, inspection and operating adjustments.

Special Legislation: In addition to the appropriation changes in the Long Bill, the General Assembly also passed eight bills that contained FY 2006-07 appropriations for the Department of Health Care Policy and Financing. The total sum of these appropriation adjustments was a reduction of $2.7 million total funds to the Department. A list and description of each of these bills is found on pages 8 through 10 of this briefing packet.

FY 2007-08 Budget Briefing
Department of Health Care Policy and Financing
Change Requests: Decision Items

Priority	Division: Description *[Statutory Authority]*	GF	CF	CFE	FF	Total	FTE
1	**Medical Service Premiums** anticipated number of clients who will be served in FY 2007-08 and the cost of providing medical services to those clients. The Department currently projects an increase in caseload of 5.7 percent. The Department is also projecting an increase in overall per-capita spending of 2.3 percent. Therefore, the total increase projected for the **base** change to medical services premiums is an estimated increase of 7.1 percent. This item is discussed in greater detail in the issue section of this briefing. *Sections 25.5-4-104 (1), and 25.5-5-101 (1), C.R.S. (2006)*	$53,959,687	($38,256)	$19,753,332	$75,751,403	$149,426,166	0.00
2	**Medicaid Community Mental Health Services, multiple line items** Estimated base increase for mental health services based on caseload and capitation projections. This decision item is discussed in the Mental Health Briefing. *Sections 25.5-5-308, C.R.S. (2006); 25.5-5-408, C.R.S. (2006); 25.5-5-411, C.R.S. (2006)*	$5,088,974	$0	($1,857,803)	$6,950,481	$10,181,652	0.00
3	**Indigent Care Program, Children's Basic Health Plan, multiple line items** Estimated base increase for medical and dental costs related to caseload growth and the cost of services before any policy changes. This item is discussed in greater detail in the issue section of this briefing. *Sections 25.5-8-105, C.R.S. (2006); 25.5-8-109, C.R.S. (2006); 25.5-8-107 (1) (a) (I)-(II), C.R.S. (2006); 24-22-117 (2) (a) (II) (A), C.R.S. (2006)*	$4,481,968	$47,163	$7,598,277	$14,023,499	$26,150,907	0.00

FY 2007-08 Budget Briefing
Department of Health Care Policy and Financing
Change Requests: Decision Items

Priority	Division: Description [Statutory Authority]	GF	CF	CFE	FF	Total	FTE
4	**Implementation of the Federal Deficit Reduction Act of 2005 & H.B. 06S-1023 (Immigration Reform) -- Multiple Divisions and Line Items** Estimated costs for implementing the Deficit Reduction Act of 2005 and H.B. 06S-1023. Both of these law changes require the Department to verify citizenship before authorizing Medicaid benefits. In order to comply with these law changes, the Department estimates additional costs for processing applications, revising application materials, making changes to computer systems, instituting temporary compliance procedures and conducting audits to insure citizenship is being verified as required by the new rule changes. This item is discussed in greater detail in the issue section of this briefing. *H.B. 06S-1023 (Sections 24-76.5-101 through 24-76.5-103); S.B. 06-219; Pub. L 109-171, Sec. 6036 (42 U.S.C. 1396b); and Pub. L. 104-193 (8 U.S.C. 1612).*	$979,398	$0	$576,871	$1,475,694	$3,031,963	3.00
5	**Executive Director's Office, Commercial Lease Space** This request is for additional commercial lease space to accommodate the Department's current and projected FTE. This item is discussed in greater detail in the issue section of this briefing. *Sections 24-1-107, C.R.S. (2006); 25.5-1-104 (2) and (4), C.R.S. (2006)*	$111,404	$0	$0	$111,404	$222,808	0.00
6	**Provider Rate Increase, Multiple Divisions and Multiple Line Items** This request is to provide rate increases to maintain inpatient hospital rates at 90% of Medicare's rates; increase reimbursement to single entry point agencies; increase rates for medical procedures and services which are paid below cost or have not received a rate increase over an extended period of time; and to provide an increase for county administration and administrative case management payments. This issue is discussed in greater detail in the footnote report section of this briefing as well as in the issue section of this briefing. *Sections 25.5-4-104 (1), C.R.S. (2006) and 25.5-5-101 (1), C.R.S. (2006)*	$7,009,313	$0	$138,113	$7,065,306	$14,212,732	0.00

FY 2007-08 Budget Briefing
Department of Health Care Policy and Financing
Change Requests: Decision Items

Priority	Division: Description *[Statutory Authority]*	GF	CF	CFE	FF	Total	FTE
7	**Executive Director's Office, Non-Emergency Transportation Services** This request seeks additional funding for non-emergency transportation services due to increases in contractor and county costs to administer the program. The adequacy of the non-emergency transportation appropriation first became an issue in FY 2005-06. Staff also anticipates that a January supplemental will be submitted on this issue. *Section 25.5-5-202 (1) (s) (II) (2), C.R.S. (2006)*	$732,398	$0	$0	$732,398	$1,464,796	0.00
8	**Executive Director's Office, Multiple Line Items, Processing Applications within Guidelines** On September 20, 2006, the Joint Budget Committee provided initial approval to the Department for a 1331 supplemental to increase their FTE by 4.0 positions and the corresponding operating costs in order to comply with federal guidelines for processing Medicaid and CBHP applications. This decision item reflects annualized costs of this decision for FY 2007-08 that is not included in the current appropriated base. *Sections 25.5-4-205 (1) (a),C.R.S. (2006)*	$38,737	$0	$26,367	$87,703	$152,807	4.00
9	**Executive Director's Office, Personal Services and Other Medical Services, S.B. 97-101 Public School Health Services** This request is a technical correction on how the funding for the Public School Health Services program is shown in order to be in compliance with a federal CMS audit of the program. The technical adjustment eliminates a double counted transfer of funds to the Department of Education for its administrative oversight of *Section 25.5-5-318 (8) (a), C.R.S. (2006)*	$0	$0	$0	$184,520	$184,520	0.00

FY 2007-08 Budget Briefing
Department of Health Care Policy and Financing
Change Requests: Decision Items

Priority	Division: Description *[Statutory Authority]*	GF	CF	CFE	FF	Total	FTE
10	**Multiple Divisions and Line Items** This requests transfers a total of $22,705,084 of administrative costs from the Medical Services Premiums line items into different line items in the Executive Director's Office. This decision item would consolidate all administrative costs in the EDO Division. Currently, costs for disease management and single entry points are contained in the Medical Services Premiums line items. These costs are mainly administrative in nature and the Department believes that they should be more accurately reflected by transferring them from the Medical Services Premiums line item to the Executive Director's Office. *Section 26-4-104 C.R.S. (2005)*	$0	$0	$0	$0	$0	0.00
11	**Other Medical Services, Services for Old Age Pension State Medical Program Clients** The Department requests that all of the fund balance remaining in the Old Age Pension State Medical Care Fund at the end of FY 2006-07 be appropriated in FY 2007-08 in order to alleviate some of the $1.2 million reduction that will occur without this decision item. With this decision item the reduction in FY 2007-08 will only be approximately $500,000. *Sections 25.5-2-101 (2), C.R.S. (2006); 24-22-117 (1) © (II), C.R.S. (2006)*	$0	$0	$725,468	$0	$725,468	0.00
12	**Executive Director's Office, Personal Services and Indigent Care Program Primary Care Fund Program** This item requests that $75,200 be transferred from the Primary Care Fund Program line item into the Department's Personal Services line item. The funding is being transferred in order to conduct an audit of the Primary Care Fund program. The funding is cash funds exempt from the Primary Care Fund. Because this decision is a transfer of funds from the program line item, no new funding is needed for the audit. *Section 25.5-3-102, et seq., C.R.S. (2006)*	$0	$0	$0	$0	$0	0.00

Priority	Division: Description *[Statutory Authority]*	GF	CF	CFE	FF	Total	FTE
13	**Executive Director's Office, Personal Services** This item is a technical request to increase the appropriated full-time equivalent (FTE) count of the Department by 12.8, without a corresponding increase in appropriated funding. The Department believes that 12.8 FTE can be absorbed within the Department's existing resources; therefore, no new funding is requested with this decision item. *Section 24-1-107, C.R.S. (2006); 25.5-1-104 (2) and (4), C.R.S. (2006)*	$0	$0	$0	$0	$0	12.80
	Total Decision Items	**$72,401,879**	**$8,907**	**$26,960,625**	**$106,382,408**	**$205,753,819**	**19.8**

FY 2007-08 Budget Briefing
Department of Health Care Policy and Financing
Change Requests: Base Reductions Items

Priority	Division: Description *[Statutory Authority]*	GF	CF	CFE	FF	Total	FTE
1	**Executive Director's Office, Hospital and Federally Qualified Health Clinic Audits and Medical Services Premiums** The Department requests an additional $131,350 for more audits of hospitals and FQHCs. The Department offsets this increase by a decrease in Medical Services Premiums of $497,147. Based on FY 2005-06 audits, each $1 spent on auditing activities achieved $2.72 in savings for desk audits and $5.00 in savings for onsite audits. *Sections 25.5-4-401 (1) (a), C.R.S. (2006); 25.5-4-402, C.R.S. (2006); and 25.5-5-408 (1) (d), C.R.S. (2006)*	($182,898)	$0	$0	($182,899)	($365,797)	0.0
2	**Executive Director's Office, Drug Utilization Review** The Department requests a technical adjustment to this line item to (1) reflect a reduction of $84,832 due to lower contract costs and (2) a technical adjustment to fund splits to match the anticipated federal financial participation for this program. *Section 25.5-5-506, C.R.S. (2006)*	($18,458)	$0	$0	($66,347)	($84,805)	0.0
	Total Base Reduction Items	**($201,356)**	**$0**	**$0**	**($249,246)**	**($450,602)**	**0.0**

FY 2006-07 Budget Briefing
Department of Health Care Policy and Financing
Change Requests: Non-prioritized Items

Item Number	Description	GF	CF	CFE	FF	Total	FTE
1	**DHS - Regional Centers Staffing Shortfalls** Funding to address staffing shortfalls and DD Regional Centers. See DHS briefings for more detail.	$239,391	$0	$0	$239,392	$478,783	0.0
2	**DHS -Division of Youth Corrections Contract Placements** Funding for additional youth contract placements. See DHS briefings for more detail.	$268,157	$0	$0	$268,157	$536,314	0.0
3	**DHS-Provide Resources to Specific Populations** This request adds additional funding for DD services. See DHS briefings for more detail.	$1,719,641	$0	$0	$1,719,640	$3,439,281	0.0
4	**DHS Facilities Management Operating Funds** This request is for additional funding for direct care facilities. See DHS briefings for more detail.	$105,732	$0	$0	$105,732	$211,464	0.0
5	**DHS CBMS-EDS Annual Contract Increase** This request is for additional funds for the CBMS Contract. See DHS briefings for more detail.	$66,712	$0	$8,519	$67,172	$142,403	0.0
6	**DHS-Child Welfare Services Block Increase** This increase is for more funding for the child welfare block grant. See DHS briefings for more detail.	$191,597	$0	$0	$191,596	$383,193	0.0

FY 2006-07 Budget Briefing
Department of Health Care Policy and Financing
Change Requests: Non-prioritized Items

Item Number	Description	GF	CF	CFE	FF	Total	FTE
7	**DHS - OITS Disaster Recovery** This request adds funding an OITS Disaster Recovery support FTE. See DHS briefings for more detail.	$1,567	$0	$0	$1,567	$3,134	0.0
8	**DHS-Provider Rate Increase of 2.0%** Provider Rate increase for DHS providers. See DHS briefings for more detail.	$2,822,367	$0	$10,510	$2,832,877	$5,665,754	0.0
9	**DPHE -Implementation of H.B. 06S-1023** Implements immigration reform legislation. This decision item is reflected in the Executive Director's Office, DPHE Facility Survey and Certification line item in this briefing document.	$68	$0	$0	$67	$135	0.0
10	**DHS-Division of Mental Health** Adjusts funding for the Mental Health and Alcohol and Drug Abuse Services, Residential Treatment for Youth line item. See DHS briefings for more detail.	$0	$0	($196,848)	($196,848)	($393,696)	0.0
11	**DHS - CBMS Hardware-Disaster Recovery** This request adjusts funding for CBMS. See DHS briefings for more detail.	$91,452	$0	$11,679	$92,084	$195,215	0.0

FY 2006-07 Budget Briefing
Department of Health Care Policy and Financing
Change Requests: Non-prioritized Items

Item Number	Description	GF	CF	CFE	FF	Total	FTE
12	**DHS-Vehicle Replacement State-wide** This request is a common policy adjustment for vehicles in the Department of Human Services. See DHS briefings for more detail.	$11,112	$0	$0	$11,111	$22,223	0.0
13	**DHS-Multi-use Network Payment Statewide** This request makes common policy adjustments to the multi-use network. See DHS briefings for more detail.	($729)	$0	$0	($729)	($1,458)	0.0
14	**DHS-HIPAA Security Remediation Maintenance Costs** This request adds additional funding for HIPAA Security Remediation. See DHS briefings for more detail.	$22,238	$0	$0	$22,237	$44,475	0.0
15	**Commission on Family Medicine** This request is for additional funding for the Commission on Family Medicine. See the Commission on Family Medicine for more detail.	$100,000	$0	$0	$100,000	$200,000	0.0
	Total Non-Prioritized Items	**$5,639,305**	**$0**	**($166,140)**	**$5,454,055**	**$10,927,220**	**0.0**

	GF	CF	CFE	FF	Total	FTE
Department's Total Change Requests						
Decision Items	**$72,401,879**	**$8,907**	**$26,960,625**	**$106,382,408**	**$205,753,819**	**19.80**
Base Reduction Items	**($201,356)**	**$0**	**$0**	**($249,246)**	**($450,602)**	**0.00**
Non-prioritized Item Requests	**$5,639,305**	**$0**	**($166,140)**	**$5,454,055**	**$10,927,220**	**0.00**
TOTAL CHANGE REQUESTS	**$77,839,828**	**$8,907**	**$26,794,485**	**$111,587,217**	**$216,230,437**	**19.80**

FY 2007-08 Joint Budget Committee Staff Budget Briefing
Department of Health Care Policy and Financing
Overview of Numbers Pages

The Department of Health Care Policy and Financing's FY 2007-08 request is $247.0 million ($103.2 million General Fund) higher than the FY 2006-07 appropriation. The following table shows the total increase reflected in the November request.

Requested Changes FY 2006-07 to FY 2007-08					
Category	**Total**	**GF & GFE[/1]**	**CF**	**CFE**	**FF**
FY 2006-07 Appropriation	$3,385,826,300	$1,396,681,802	$690,959	$359,452,661	$1,629,000,878
FY 2007-08 Request	$3,632,784,577	$1,499,926,277	$700,190	$381,802,874	$1,750,355,236
Increase	**$246,958,277**	**$103,244,475**	**$9,231**	**$22,350,213**	**$121,354,358**
Percent Change	**7.3%**	**7.4%**	**1.3%**	**6.2%**	**7.5%**

/1 This amount includes General Fund Exempt amounts which are detailed in the number pages that follow.

The Department's change requests (technical changes, decision items, non-prioritized items, and base reduction items) total $103.2 million in additional General Fund spending. The majority of the General Fund increase, $54.0 million, is for Medicaid caseload growth and medical cost increases. Another $18.4 million (17.8%) of the General Fund increase is related to other decision items that the Department has submitted including provider rate increases. Approximately $5.6 million of the General Fund increases is related to Medicaid programs administered by the Department of Human Services. Finally, $25.4 million of the General Fund increase is related to technical adjustments including $15.0 million for the Colorado Health Services Fund (S.B. 06-044), $6.2 million to annualize provider rate increases that begin in April 2007, and $4.2 million in other technical budget adjustments (including common policy and prior year legislation annualization). These increases are offset by a reduction of $0.2 million General Fund related to base reduction items.

FY 2007-08 Increases Detail					
Category	**Total**	**GF & GFE**	**CF**	**CFE**	**FF**
Technical Changes	$30,727,817	$25,404,597	$324	($4,444,272)	$9,767,168
Decision Items	$205,753,819	$72,401,879	$8,907	$26,960,625	$106,382,408
Base Reductions	($450,629)	($201,356)	$0	$0	($249,273)
Non-Prioritized	$10,927,220	$5,639,305	$0	($166,140)	$5,454,055
Total Increases	$246,958,227	$103,244,425	$9,231	$22,350,213	$121,354,358

The tables on the next pages provides a breakdown the Department's change requests by division. Following those tables are the Department's number pages (a breakdown of the Department's request by Long Bill line item).

Health Care Policy and Financing

Number Page Summary -- Budget Request for FY 2006-07 and FY 2007-08 -- By Division

Source: November 1st Submitta

	FY 2006-07 Appropriation	FY 2006-07 Estimate	Difference Est. - App	FY 2007-08 Request	Difference from FY 06-07 App	% Difference	Difference from FY 06-07 Est.	% Difference
Executive Director's	**87,278,411**	**87,953,170**	**674,759**	**114,924,027**	**27,645,616**	**31.7%**	**26,970,857**	**30.7%**
FTE	**226.7**	**230.7**	**4.0**	**246.70**	**20.0**	**8.8%**	**16.0**	**6.9%**
General Fund	29,131,557	29,334,070	202,513	42,183,244	13,051,687	44.8%	12,849,174	43.8%
Cash Funds	422,375	422,375	0	422,375	0	0.0%	0	0.0%
Cash Funds Exempt	5,197,296	5,237,737	40,441	6,733,653	1,536,357	29.6%	1,495,916	28.6%
Federal Funds	52,527,183	52,958,988	431,805	65,584,755	13,057,572	24.9%	12,625,767	23.8%
Medical Services Premiums	**2,111,287,559**	**2,133,114,030**	**21,826,471**	**2,265,503,653**	**154,216,094**	**7.3%**	**132,389,623**	**6.2%**
General Fund & GFE	996,821,857	1,008,548,589	11,726,732	1,052,721,290	55,899,433	5.6%	44,172,701	4.4%
Cash Funds	76,512	38,256	(38,256)	38,256	(38,256)	-50.0%	0	0.0%
Cash Funds Exempt	55,563,806	53,890,163	(1,673,643)	75,455,251	19,891,445	35.8%	21,565,088	40.0%
Federal Funds	1,058,825,384	1,070,637,022	11,811,638	1,137,288,856	78,463,472	7.4%	66,651,834	6.2%
Medicaid Mental Health	**211,550,200**	**213,857,211**	**2,307,011**	**234,006,933**	**22,456,733**	**10.6%**	**20,149,722**	**9.4%**
General Fund	87,803,777	93,518,980	5,715,203	99,030,292	11,226,515	12.8%	5,511,312	5.9%
Cash Funds	0	0	0	0	0			
Cash Funds Exempt	33,783,245	24,678,208	(9,105,037)	31,925,442	(1,857,803)	-5.5%	7,247,234	29.4%
Federal Funds	89,963,178	95,660,023	5,696,845	103,051,199	13,088,021	14.5%	7,391,176	7.7%
Indigent Care Program	**444,110,702**	**444,231,712**	**121,010**	**481,414,434**	**37,303,732**	**8.4%**	**37,182,722**	**8.4%**
General Fund & GFE	20,016,698	20,016,698	0	39,450,963	19,434,265	97.1%	19,434,265	97.1%
Cash Funds	192,072	192,072	0	239,559	47,487	24.7%	47,487	24.7%
Cash Funds Exempt	216,365,831	216,420,725	54,894	220,088,008	3,722,177	1.7%	3,667,283	1.7%
Federal Funds	207,536,101	207,602,217	66,116	221,635,904	14,099,803	6.8%	14,033,687	6.8%
Other Medical Services	**126,688,250**	**126,688,250**	**0**	**126,530,465**	**(157,785)**	**-0.1%**	**(157,785)**	**-0.1%**
General Fund	74,396,494	74,396,494	0	75,094,573	698,079	0.9%	698,079	0.9%
Cash Funds	0	0	0	0	0	n/a	0	n/a
Cash Funds Exempt	34,354,864	34,354,864	0	33,599,972	(754,892)	-2.2%	(754,892)	-2.2%
Federal Funds	17,936,892	17,936,892	0	17,835,920	(100,972)	-0.6%	(100,972)	-0.6%
DHS Programs	**404,911,178**	**384,917,406**	**(19,993,772)**	**410,405,015**	**5,493,837**	**1.4%**	**25,487,609**	**6.6%**
General Fund	188,511,419	178,713,261	(9,798,158)	191,445,865	2,934,446	1.6%	12,732,604	7.1%
Cash Funds	0	0	0	0	0	n/a	0	n/a
Cash Funds Exempt	14,187,619	13,991,271	(196,348)	14,000,548	(187,071)	-1.3%	9,277	0.1%
Federal Funds	202,212,140	192,212,874	(9,999,266)	204,958,602	2,746,462	1.4%	12,745,728	6.6%
DEPARTMENT TOTAL	**3,385,826,300**	**3,390,761,779**	**4,935,479**	**3,632,784,527**	**246,958,227**	**7.3%**	**242,022,748**	**7.1%**
FTE	**226.70**	**230.70**	**4.0**	**246.7**	**20.0**	**8.8%**	**16.0**	6.9%
General Fund & GFE	1,396,681,802	1,404,528,092	7,846,290	1,499,926,227	103,244,425	7.4%	95,398,135	6.8%
Cash Funds	690,959	652,703	(38,256)	700,190	9,231	1.3%	47,487	7.3%
Cash Funds Exempt	359,452,661	348,572,968	(10,879,693)	381,802,874	22,350,213	6.2%	33,229,906	9.5%
Federal Funds	1,629,000,878	1,637,008,016	8,007,138	1,750,355,236	121,354,358	7.4%	113,347,220	6.9%

Department of Health Care Policy Financing
Overview of the Number Pages -- Bullet List of Change Requests by Division

Department's Request (Source 11/1/2006 Request)	FTE	General Fund	General Fund Exempt	Cash Funds	Cash Funds Exempt	Federal Funds	Total Funds
Executive Director's Office (EDO)							
FY 2006-07 Current Appropriation	**226.7**	**$29,131,557**	**$0**	**$422,375**	**$5,197,296**	**$52,527,183**	**$87,278,411**
* T-1 Annualization Budget Adjmnts	0.2	(274,335)	0	0	(150,738)	(989,818)	(1,414,891)
* T-2 Annualize of Prior Year Leg.	0.0	(272,184)	0	0	(17,550)	(388,687)	(678,421)
* T-3 OSPB Common Policy Adj.	0.0	641,534	0	0	22,092	286,295	949,921
* T-4 Department Issue Not Classified	0.0	79,269	0	0	25,854	122,169	227,292
* D-4 Immigration Reform Implementation	3.0	971,116	0	0	569,938	1,460,788	3,001,842
* D-5 Commercial Lease Space	0.0	111,404	0	0	0	111,404	222,808
* D-6 Provider Rate Increases	0.0	254,003	0	0	0	254,002	508,005
* D-7 Contract Increase for County Trans.	0.0	732,398	0	0	0	732,398	1,464,796
* D-8 Applications Exceeding Guidelines	4.0	38,737	0	0	26,367	87,703	152,807
* D-9 Public School Correction	0.0	0	0	0	0	384,520	384,520
* D-10 Transfer Admin from MSP to EDO	0.0	10,722,460	0	0	985,194	10,997,430	22,705,084
* D-12 Audit of Primary Care Fund	0.0	0	0	0	75,200	0	75,200
* D-13 FTE Correction	12.8	0	0	0	0	0	0
* BRI -1 Hospital/FQHC Audits	0.0	65,675	0	0	0	65,675	131,350
* BRI -2 Decrease Drug Utilization	0.0	(18,458)	0	0	0	(66,374)	(84,832)
* NPI # 13 -- Immigration Reform	0.0	68	0	0	0	67	135
Subtotal -- Department FY 2007-08 EDO Request	**246.7**	**$42,183,244**	**$0**	**$422,375**	**$6,733,653**	**$65,584,755**	**$114,924,027**
Increase from Current Appropriation	**20.0**	**$13,051,687**	**$0**	**$0**	**$1,536,357**	**$13,057,572**	**$27,645,616**
% Increase from Current Appropriation	**8.11%**	**30.94%**	**n/a**	**n/a**	**22.82%**	**19.91%**	**24.06%**

Department of Health Care Policy Financing
Overview of the Number Pages -- Bullet List of Change Requests by Division

Department's Request (Source 11/1/2006 Request)	FTE	General Fund	General Fund Exempt	Cash Funds	Cash Funds Exempt	Federal Funds	Total Funds
Medical Services Premiums (MSP)							
FY 2006-07 Current Appropriation	**0.0**	**$740,721,857**	**$256,100,000**	**$76,512**	**$55,563,806**	**$1,058,825,384**	**$2,111,287,559**
* T-1 Annualization Budget Adjmnts	0.0	6,208,125	0	0	0	6,208,125	12,416,250
* T-2 Annualize of Prior Year Leg.	0.0	(54,005)	0	0	985,194	931,188	1,862,377
* D-1 Medical Services Base Adjustment	0.0	53,959,687	0	(38,256)	19,753,332	75,751,403	149,426,166
* D-4 Immigration Reform Implementation	0.0	1,349	0	0	0	7,456	8,805
* D-6 Provider Rate Increases	0.0	6,755,310	0	0	138,113	6,811,304	13,704,727
* D-10 Transfer Admin from MSP to EDO	0.0	(10,722,460)	0	0	(985,194)	(10,997,430)	(22,705,084)
* BRI - 1 Hospital/FQHC Audits	0.0	(248,573)	0	0	0	(248,574)	(497,147)
Subtotal -- Department FY 2007-08 MSP Request	**0.0**	**$796,621,290**	**$256,100,000**	**$38,256**	**$75,455,251**	**$1,137,288,856**	**$2,265,503,653**
Increase from Current Appropriation	**0.0**	**$55,899,433**	**$0**	**($38,256)**	**$19,891,445**	**$78,463,472**	**$154,216,094**
% Increase from Current Appropriation	**n/a**	**7.55%**	**0.00%**	**-50.00%**	**35.80%**	**7.41%**	**7.30%**
Mental Health Division (this division is covered in a separate staff briefing -- shown here for information purpose only)							
FY 2006-07 Current Appropriation	**0.0**	**$87,803,777**	**$0**	**$0**	**$33,783,245**	**$89,963,178**	**$211,550,200**
* D-2 Mental Health Caseload & Capitation Increase	0.0	11,226,515	0	0	(1,857,803)	13,088,021	22,456,733
Subtotal -- Department FY 2007-08 MH Request	**0.0**	**$99,030,292**	**$0**	**$0**	**$31,925,442**	**$103,051,199**	**$234,006,933**
Increase from Current Appropriation	**0.0**	**$11,226,515**	**$0**	**$0**	**($1,857,803)**	**$13,088,021**	**$22,456,733**
% Increase from Current Appropriation	**n/a**	**12.79%**	**n/a**	**n/a**	**-5.50%**	**14.55%**	**10.62%**
Indigent Care Program (ICP)							
FY 2006-07 Current Appropriation	**0.0**	**$19,500,662**	**$516,036**	**$192,072**	**$216,365,831**	**$207,536,101**	**$444,110,702**
* T-1 Annualizations & Revenue Changes	0.0	0	(54,636)	324	(3,882,825)	0	(3,937,137)
* T-2 Bill Annualization	0.0	0	15,000,000	0	74,992	68,854	15,143,846
* D-3 CBHP Caseload and Cost Changes	0.0	4,481,968	0	47,163	7,598,277	14,023,499	26,150,907
D-4 CBHP Immigration Reform Costs	0.0	6,933	0	0	6,933	7,450	21,316
* D-12 Audit of Primary Care Program	0.0	0	0	0	(75,200)	0	(75,200)
Subtotal -- Department FY 2007-08 ICP Request	**0.0**	**$23,989,563**	**$15,461,400**	**$239,559**	**$220,088,008**	**$221,635,904**	**$481,414,434**
Increase from Current Appropriation	**0.0**	**$4,488,901**	**$14,945,364**	**$47,487**	**$3,722,177**	**$14,099,803**	**$37,303,732**
% Increase from Current Appropriation	**n/a**	**23.02%**	**2896.19%**	**24.72%**	**1.72%**	**6.79%**	**8.40%**

Department of Health Care Policy Financing
Overview of the Number Pages -- Bullet List of Change Requests by Division

Department's Request (Source 11/1/2006 Request)	FTE	General Fund	General Fund Exempt	Cash Funds	Cash Funds Exempt	Federal Funds	Total Funds
Other Medical Services (OMS)							
FY 2006-07 Current Appropriation	**0.0**	**$74,396,494**	**$0**	**$0**	**$34,354,864**	**$17,936,892**	**$126,688,250**
* T-1 Annualizations Revenues	0.0	598,079	0	0	(1,480,360)	(972)	(883,253)
* D-9 Federal Audit Correction		0	0	0	0	(200,000)	(200,000)
* D-11 Use OAP Medical Fund Balance		0	0	0	725,468	0	725,468
* NPI - 15 Commission on Family Medicine	0.0	100,000	0	0	0	100,000	200,000
Subtotal -- Department FY 2007-08 OMS Request	**0.0**	**$75,094,573**	**$0**	**$0**	**$33,599,972**	**$17,835,920**	**$126,530,465**
Increase from Current Appropriation	**0.0**	**$698,079**	**$0**	**$0**	**($754,892)**	**($100,972)**	**($157,785)**
% Increase from Current Appropriation	**n/a**	**0.94%**	**n/a**	**n/a**	**-2.20%**	**-0.56%**	**-0.12%**
DHS Medicaid Programs (DHS) (this division is discussed in separate staff briefings -- shown for information purposes only)							
FY 2006-07 Current Appropriation	**0.0**	**$188,511,419**	**$0**	**$0**	**$14,187,619**	**$202,212,140**	**$404,911,178**
* T-1 Annualization Budget Adjustments	0.0	3,532,750	0	0	(20,931)	3,530,014	7,041,833
* D-2 Mental Health Caseload & Capitation Increase	0.0	(6,137,541)	0	0	0	(6,137,540)	(12,275,081)
* NP #1-#8 & #10-#14 {See DHS Briefings}	0.0	5,539,237	0	0	(166,140)	5,353,988	10,727,085
Subtotal -- Department FY 2007-08 DHS Request	**0.0**	**$191,445,865**	**$0**	**$0**	**$14,000,548**	**$204,958,602**	**$410,405,015**
Increase from Current Appropriation	**0.0**	**$2,934,446**	**$0**	**$0**	**($187,071)**	**$2,746,462**	**$5,493,837**
% Increase from Current Appropriation	**n/a**	**1.56%**	**n/a**	**n/a**	**-1.32%**	**1.36%**	**1.36%**
Department Total							
FY 2006-07 Current Appropriation	**226.7**	**$1,140,065,766**	**$256,616,036**	**$690,959**	**$359,452,661**	**$1,629,000,878**	**$3,385,826,300**
* EDO Adjustment Subtotal	20.0	13,051,687	0	0	1,536,357	13,057,572	27,645,616
* MSP Adjustment Subtotal	0.0	55,899,433	0	(38,256)	19,891,445	78,463,472	154,216,094
* MHP Adjustment Subtotal	0.0	11,226,515	0	0	(1,857,803)	13,088,021	22,456,733
* ICP Adjustment Subtotal	0.0	4,488,901	14,945,364	47,487	3,722,177	14,099,803	37,303,732
* OMS Adjustment Subtotal	0.0	698,079	0	0	(754,892)	(100,972)	(157,785)
* DHS Adjustment Subtotal	0.0	2,934,446	0	0	(187,071)	2,746,462	5,493,837
TOTAL HCPF FY 2007-08 Request	**246.7**	**$1,228,364,827**	**$271,561,400**	**$700,190**	**$381,802,874**	**$1,750,355,236**	**$3,632,784,527**
Increase from Current Appropriation	**20.0**	**$88,299,061**	**$14,945,364**	**$9,231**	**$22,350,213**	**$121,354,358**	**$246,958,227**
% Increase from Current Appropriation	**8.82%**	**7.75%**	**5.82%**	**1.34%**	**6.22%**	**7.45%**	**7.29%**

	FY 2004-05 Actual	FY 2005-06 Actual	FY 2006-07 Appropriation	FY 2007-08 Request	Change Req. #

Department of Health Care Policy and Financing
Executive Director: Steve Tool

(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).

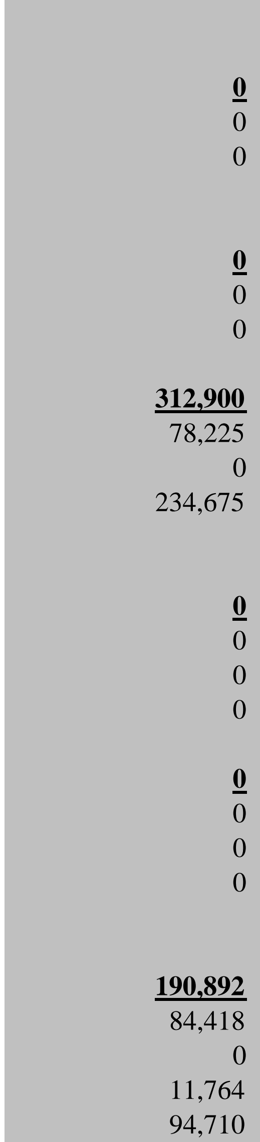
(1) Executive Director's Office

(Primary Functions: Provides all of the administrative, audit and oversight functions for the Department.)

	FY 2004-05 Actual	FY 2005-06 Actual	FY 2006-07 Appropriation	FY 2007-08 Request	Change Req. #
Personal Services/1	**12,795,241**	**13,785,054**	**15,362,691**	**16,579,738**	DI #s 4, 8
FTE	202.8	212.4	226.7	246.7	9, 12, & 13
General Fund	5,358,465	5,641,891	6,493,748	7,044,442	T #1 & 2
General Fund Exempt	96,464	281	0	0	
Cash Funds Exempt	110,984	541,735	506,203	618,538	
Federal Funds	7,229,328	7,601,147	8,362,740	8,916,758	
Health, Life, and Dental	**411,229**	**520,256**	**629,640**	**877,922**	T-#3
General Fund	190,929	334,973	272,418	385,020	
Cash Funds Exempt	1,990	17,112	11,294	27,462	
Federal Funds	218,310	168,171	345,928	465,440	
Short-term Disability	**15,992**	**16,354**	**14,888**	**18,090**	T-#3
General Fund	7,439	7,305	6,173	8,080	
Cash Funds Exempt	57	525	458	499	
Federal Funds	8,496	8,524	8,257	9,511	
S.B. 04-257 Amortization Equalization Disbursement	**0**	**24,391**	**96,544**	**168,509**	T-#3
General Fund	0	10,889	38,697	75,261	
Cash Funds Exempt	0	855	3,043	4,644	
Federal Funds	0	12,647	54,804	88,604	

	FY 2004-05 Actual	FY 2005-06 Actual	FY 2006-07 Appropriation	FY 2007-08 Request	Change Req. #
Salary Survey and					
Senior Executive Service	**248,845**	**394,534**	**459,483**	**566,815**	T-#1 & 3
General Fund	112,580	172,506	198,893	254,461	
Cash Funds Exempt	1,393	8,260	11,087	15,628	
Federal Funds	134,872	213,768	249,503	296,726	
Performance-based Pay Awards	**136,130**	**0**	**0**	**126,818**	T-#3
General Fund	61,418	0	0	56,613	
Cash Funds Exempt	795	0	0	3,527	
Federal Funds	73,917	0	0	66,678	
Worker's Compensation	**44,667**	**39,404**	**42,834**	**44,831**	T-#3
General Fund	22,334	19,702	21,417	22,416	
Federal Funds	22,333	19,702	21,417	22,415	
Operating Expenses	**812,837**	**978,207**	**1,020,609**	**1,003,887**	DI # 4 & 8
General Fund	403,153	446,865	493,252	485,035	T-#1, 2 &3
General Fund Exempt	0	25,366	0	0	
Cash Funds Exempt	729	14,076	14,393	13,506	
Federal Funds	408,955	491,900	512,964	505,346	
Legal and Third Party Recovery					
Legal Services	**662,705**	**799,877**	**859,595**	**859,595**	T-#3
General Fund	265,709	311,609	348,589	348,589	
General Fund Exempt	0	25,000	0	0	
Cash Funds	63,131	62,912	72,375	72,375	
Cash Funds Exempt	1,759	306	5,945	5,945	
Federal Funds	332,106	400,050	432,686	432,686	
Administrative Law Judge Services	**609,643**	**505,921**	**540,855**	**398,743**	T-#3
General Fund	304,822	252,961	270,428	199,372	
Federal Funds	304,821	252,960	270,427	199,371	

	FY 2004-05 Actual	FY 2005-06 Actual	FY 2006-07 Appropriation	FY 2007-08 Request	Change Req. #
Computer Systems Costs	**154,382**	**93,083**	**94,815**	**19,310**	T-#3
General Fund	60,956	30,307	31,173	7,986	
Cash Funds Exempt	16,235	16,235	16,235	3,337	
Federal Funds	77,191	46,541	47,407	7,987	
Payment to Risk Management and Property Funds	**58,795**	**21,976**	**58,143**	**78,288**	T-#3
General Fund	29,398	10,988	29,072	39,144	
Federal Funds	29,397	10,988	29,071	39,144	
Capitol Complex Leased Space	**339,179**	**332,915**	**344,022**	**361,021**	T-#3
General Fund	169,590	166,458	172,011	180,511	
Federal Funds	169,589	166,457	172,011	180,510	
Commercial Leased Space	**0**	**33,228**	**49,510**	**272,318**	DI #5
General Fund	0	1,561	19,255	130,659	
Cash Funds Exempt	0	15,053	5,500	5,500	
Federal Funds	0	16,614	24,755	136,159	
Transfer to the Department of Human Services for Related Administration	**73,120**	**69,784**	**74,564**	**74,564**	T #1
General Fund	36,560	34,892	37,282	37,282	
Federal Funds	36,560	34,892	37,282	37,282	
Medicaid Management Information System Contract	**21,076,845**	**21,737,076**	**23,185,837**	**22,937,942**	T #1 & 2
General Fund	5,187,882	5,214,619	5,486,108	5,442,455	
Cash Funds Exempt	370,212	435,293	629,859	611,540	
Federal Funds	15,518,751	16,087,164	17,069,870	16,883,947	
Medicaid Management Information System Reprocurement	**9,450**	**429,770**	**740,100**	**382,800**	T #1
General Fund	2,363	98,014	155,783	80,575	
Cash Funds Exempt	0	4,490	7,771	4,019	
Federal Funds	7,087	327,266	576,546	298,206	



	FY 2004-05 Actual	FY 2005-06 Actual	FY 2006-07 Appropriation	FY 2007-08 Request	Change Req. #
CBMS Eligibility Audit-Transfer to State Auditor	**0**	**68,250**	**0**	**0**	
Cash Funds Exempt	0	34,125	0	0	
Federal Funds	0	34,125	0	0	
Medicare Modernization Act of 2003 CBMS Costs	**0**	**190,128**	**0**	**0**	
General Fund	0	95,064	0	0	
Federal Funds	0	95,064	0	0	
HIPAA Web Portal Maintenance	**510,804**	**314,345**	**312,900**	**312,900**	
General Fund	73,012	74,307	78,225	78,225	
General Fund Exempt	23,889	5,213	0	0	
Federal Funds	413,903	234,825	234,675	234,675	
HIPAA National Provider Identifier Assessment and Implementation	**0**	**101,600**	**690,962**	**0**	T-#1
General Fund	0	9,855	167,558	0	
Cash Funds Exempt	0	1,067	7,255	0	
Federal Funds	0	90,678	516,149	0	
HIPAA Security Rule Implementation	**58,755**	**0**	**0**	**0**	
General Fund	28,723	0	0	0	
Cash Funds Exempt	458	0	0	0	
Federal Funds	29,574	0	0	0	
Medical Identification Cards	**54,483**	**103,263**	**190,892**	**190,892**	
General Fund	26,902	40,837	84,418	84,418	
Cash Funds	679	0	0	0	
Cash Funds Exempt	0	11,550	11,764	11,764	
Federal Funds	26,902	50,876	94,710	94,710	

	FY 2004-05 Actual	FY 2005-06 Actual	FY 2006-07 Appropriation	FY 2007-08 Request	Change Req. #
Department of Public Health and Environment Facility Survey and Certification	**3,721,129**	**3,816,393**	**4,304,925**	**4,440,452**	NP DI #9
General Fund	863,219	1,016,971	1,142,007	1,166,229	T-#3
Federal Funds	2,857,910	2,799,422	3,162,918	3,274,223	
Acute Care Utilization Review	**1,140,104**	**1,139,989**	**1,375,906**	**1,375,906**	
General Fund	284,777	284,713	344,703	344,703	
Cash Funds Exempt	249	284	17,245	17,245	
Federal Funds	855,078	854,992	1,013,958	1,013,958	
Long-Term Care Utilization Review	**1,295,715**	**1,518,061**	**1,744,966**	**1,744,966**	
General Fund	344,728	379,553	598,813	598,813	
Cash Funds Exempt	0	38,429	38,429	38,429	
Federal Funds	950,987	1,100,079	1,107,724	1,107,724	
External Quality Review	**889,149**	**808,077**	**812,193**	**812,193**	
General Fund	194,440	194,519	203,048	203,048	
General Fund Exempt	28,214	7,500	0	0	
Federal Funds	666,495	606,058	609,145	609,145	
Drug Utilization Review	**152,520**	**278,366**	**372,025**	**287,193**	BRI #2
General Fund	38,130	69,591	90,256	71,798	
Federal Funds	114,390	208,775	281,769	215,395	
Mental Health External Quality Review	**322,226**	**352,700**	**352,807**	**352,807**	
General Fund	80,557	80,675	88,202	88,202	
General Fund Exempt	0	7,500	0	0	
Federal Funds	241,669	264,525	264,605	264,605	
Actuarial Analysis Payments for Transfer to State Auditor's Office & MH Actuarial Serv	**24,999**	**0**	**0**	**0**	
General Fund	12,500	0	0	0	
Federal Funds	12,499	0	0	0	

	FY 2004-05 Actual	FY 2005-06 Actual	FY 2006-07 Appropriation	FY 2007-08 Request	Change Req. #
Early and Periodic Screening, Diagnosis, and Treatment Program	**2,281,138**	**2,351,694**	**2,468,383**	**2,468,383**	
General Fund	1,140,569	1,175,847	1,234,192	1,234,192	
Federal Funds	1,140,569	1,175,847	1,234,191	1,234,191	
Nursing Facility Audits	**1,094,796**	**1,095,396**	**1,097,500**	**1,097,500**	
General Fund	547,398	547,698	548,750	548,750	
Federal Funds	547,398	547,698	548,750	548,750	
Hospital and Federally Qualified Health Clinic Audits	**250,000**	**350,000**	**367,850**	**499,200**	BRI #1
General Fund	125,000	175,000	183,925	249,600	
Federal Funds	125,000	175,000	183,925	249,600	
Disability Determination Services	**974,743**	**1,163,662**	**1,173,662**	**1,173,662**	
General Fund	487,372	581,831	581,831	581,831	
Cash Funds Exempt	0	0	5,000	5,000	
Federal Funds	487,371	581,831	586,831	586,831	
Nursing Home Preadmission and Resident Assessments	**1,010,040**	**1,009,481**	**1,010,040**	**1,010,040**	
General Fund	252,510	252,370	252,510	252,510	
Federal Funds	757,530	757,111	757,530	757,530	
Nurse Aide Certification	**297,769**	**293,623**	**308,766**	**325,343**	T-#1
General Fund	136,041	0	0	148,020	
Cash Funds Exempt	12,844	146,812	154,383	14,652	
Federal Funds	148,884	146,811	154,383	162,671	
Nursing Home Quality Assessment	**26,954**	**0**	**0**	**0**	
General Fund	6,738	0	0	0	
Federal Funds	20,216	0	0	0	

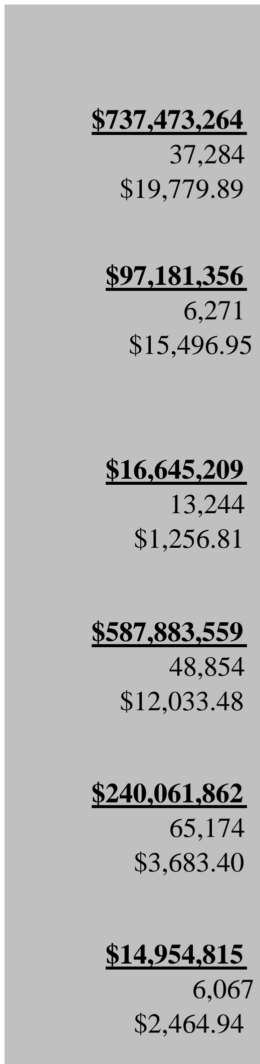
	FY 2004-05 Actual	FY 2005-06 Actual	FY 2006-07 Appropriation	FY 2007-08 Request	Change Req. #
Nursing Facility Appraisals	**0**	**0**	**279,746**	**0**	
General Fund	0	0	139,873	0	
Federal Funds	0	0	139,873	0	
Estate Recovery	**541,822**	**627,588**	**700,000**	**700,000**	
Cash Funds	270,911	313,794	350,000	350,000	
Federal Funds	270,911	313,794	350,000	350,000	
Single Entry Point Administration	**40,480**	**50,084**	**53,000**	**53,000**	
General Fund	20,240	25,042	26,500	26,500	
Federal Funds	20,240	25,042	26,500	26,500	
Single Entry Point Audits	**0**	**40,030**	**112,000**	**112,000**	
General Fund	0	20,015	56,000	56,000	
Federal Funds	0	20,015	56,000	56,000	
S.B. 97-05 Enrollment Broker	**875,756**	**875,756**	**942,784**	**942,784**	
General Fund	437,878	437,878	437,878	437,878	
Cash Funds Exempt	0	0	33,514	33,514	
Federal Funds	437,878	437,878	471,392	471,392	
Department of Regulatory Agency In-Home Support Review	**0**	**0**	**6,000**	**4,000**	T-#1
General Fund	0	0	3,000	2,000	
Federal Funds	0	0	3,000	2,000	
Primary Care Provider Rate Task Force & Study	**0**	**0**	**58,000**	**19,334**	T-#1
General Fund	0	0	29,000	9,667	
Federal Funds	0	0	29,000	9,667	
County Administration	**0**	**0**	**18,306,628**	**21,522,450**	DI #4 & 6
General Fund	0	0	5,435,396	6,513,502	
Cash Funds Exempt	0	0	3,717,918	4,287,856	
Federal Funds	0	0	9,153,314	10,721,092	

	FY 2004-05 Actual	FY 2005-06 Actual	FY 2006-07 Appropriation	FY 2007-08 Request	Change Req. #
Administrative Case Management	**0**	**0**	**1,593,624**	**1,625,496**	DI #6
General Fund	0	0	796,812	812,748	
Federal Funds	0	0	796,812	812,748	
H.B. 01-1271 Medicaid Buy-in	**34,922**	**0**	**0**	**0**	
Federal Funds	34,922	0	0	0	
Non-Emergency Transportation Services	**3,450,394**	**5,577,485**	**5,068,722**	**6,149,959**	DI #6 & 7
General Fund	1,725,197	2,788,743	2,534,361	3,074,980	T-#3
Federal Funds	1,725,197	2,788,742	2,534,361	3,074,979	
Disease Management	**0**	**0**	**0**	**4,949,482**	DI #10
General Fund	0	0	0	1,489,547	
Cash Funds Exempt	0	0	0	985,194	
Federal Funds	0	0	0	2,474,741	
Single Entry Point Case Management	**0**	**0**	**0**	**17,755,602**	DI #10
General Fund	0	0	0	9,232,913	
Federal Funds	0	0	0	8,522,689	
School District Eligibility Determination	**0**	**0**	**0**	**227,292**	T-#4
General Fund	0	0	0	79,269	
Cash Funds Exempt	0	0	0	25,854	
Federal Funds	0	0	0	122,169	

	FY 2004-05 Actual	FY 2005-06 Actual	FY 2006-07 Appropriation	FY 2007-08 Request	Request vs. Appropriation
SUBTOTAL -- Executive Director's Office					
Total Funds	**56,497,758**	**61,907,801**	**87,278,411**	**114,924,027**	**31.68%**
FTE	202.8	212.4	226.7	246.7	8.82%
General Fund	19,039,529	21,006,050	29,131,557	42,183,244	44.80%
General Fund Exempt	148,567	70,860	0	0	n/a
Cash Funds	334,721	376,706	422,375	422,375	0.00%
Cash Funds Exempt	517,705	1,286,207	5,197,296	6,733,653	29.56%
Federal Funds	36,457,236	39,167,978	52,527,183	65,584,755	24.86%

(2) Medical Service Premiums

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



	FY 2004-05 Actual	FY 2005-06 Actual	FY 2006-07 Appropriation	FY 2007-08 Request	Change Req. #
Services for Supplemental Security Income Adults 65 and Older (SSI 65+)	**$654,969,459**	**$687,311,637**	**$702,875,343**	**$737,473,264**	DI #1
Medicaid Clients	35,615	36,219	37,036	37,284	T #1 & 2
Cost per Client	$18,390.27	$18,976.55	$18,978.17	$19,779.89	
Services for Supplemental Security Income Adults 60 to 64 (SSI 60 - 64)	**$81,445,060**	**$88,683,525**	**$83,054,400**	**$97,181,356**	DI #1
Medicaid Clients	6,103	6,048	6,241	6,271	T #1 & 2
Cost per Client	$13,345.09	$14,663.28	$13,307.87	$15,496.95	
Services for Qualified Medicare Beneficiaries (QMBs) and Special Low-Income Medicare Beneficiaries (SLIMBs)	**$10,925,341**	**$13,944,292**	**$11,969,839**	**$16,645,209**	DI #1
Medicaid Clients	9,572	11,012	12,570	13,244	T #1 & 2
Cost per Client	$1,141.39	$1,266.28	$952.25	$1,256.81	
Services for Supplemental Security Income Disabled Individuals	**$551,039,900**	**$560,232,378**	**$565,398,822**	**$587,883,559**	DI #1
Medicaid Clients	47,626	47,565	48,447	48,854	T #1 & 2
Cost per Client	$11,570.15	$11,778.25	$11,670.46	$12,033.48	
Services for Categorically Eligible Low-Income Adults	**$194,070,452**	**$203,325,773**	**$236,513,840**	**$240,061,862**	DI #1
Medicaid Clients	56,453	57,754	63,127	65,174	T #1 & 2
Cost per Client	$3,437.73	$3,520.55	$3,746.64	$3,683.40	
Services for Expansion Low-Income Adults	**$0**	**$0**	**$12,152,639**	**$14,954,815**	DI #1
Medicaid Clients	0	0	4,850	6,067	T #1 & 2
Cost per Client	$0.00	$0.00	$2,505.70	$2,464.94	

	FY 2004-05 Actual	FY 2005-06 Actual	FY 2006-07 Appropriation	FY 2007-08 Request	Change Req. #
Services for Baby Care Program Adults	**$41,751,434**	**$36,737,621**	**$37,957,337**	**$49,435,196**	DI #1
Medicaid Clients	6,110	5,050	4,890	5,828	T #1 & 2
Cost per Client	$6,833.30	$7,274.78	$7,762.24	$8,482.36	
Services for Breast and Cervical Cancer Treatment Clients	**$2,490,572**	**$3,367,952**	**$5,109,417**	**$12,674,622**	DI #1
Traditional Medicaid Clients	86	188	223	340	T #1 & 2
Cost per Client	$28,960.14	$17,914.64	$22,912.18	$37,278.30	
Services for Categorically Eligible Children	**$297,794,919**	**$301,049,408**	**$336,500,118**	**$387,466,707**	DI #1
Traditional Medicaid Clients	220,592	213,600	228,438	244,291	T #1 & 2
Cost per Client	$1,349.98	$1,409.41	$1,473.05	$1,586.09	
Services for Categorically Eligible Foster Children	**$47,460,303**	**$52,533,574**	**$57,892,689**	**$55,779,720**	DI #1
Traditional Medicaid Clients	15,669	16,311	17,091	17,385	T #1 & 2
Cost per Client	$3,028.93	$3,220.75	$3,387.32	$3,208.50	
Services for Non-Citizens	**$38,527,331**	**$52,223,406**	**$61,863,115**	**$75,436,042**	DI #1
Traditional Medicaid Clients	4,976	5,959	6,309	7,390	T #1 & 2
Cost per Client	$7,742.63	$8,763.79	$9,805.53	$10,207.85	
Reversion Not Spread to Aid Catagories	$0	($3,145,258)	$0	**$0**	
Change Request Total excluding DI #1 which is included in the caseload/ cost-per-client detail above	$0	$0	**$0**	**($9,488,699)**	DI # 4, 6 & 10; BRI #1

	FY 2004-05 Actual	FY 2005-06 Actual	FY 2006-07 Appropriation	FY 2007-08 Request	Request vs. Appropriation
SUBTOTAL -- Medical Services Premiums	**1,920,474,771**	**1,996,264,308**	**2,111,287,559**	**2,265,503,653**	**7.30%**
General Fund	935,078,890	714,906,453	740,721,857	796,621,290	7.55%
General Fund Exempt	0	261,300,000	256,100,000	256,100,000	0.00%
Cash Funds	0	0	76,512	38,256	-50.00%
Cash Funds Exempt	30,699,080	23,713,210	55,563,806	75,455,251	35.80%
Federal Funds	954,696,801	996,344,645	1,058,825,384	1,137,288,856	7.41%

(3) Medicaid Mental Health Community Programs

	FY 2004-05 Actual	FY 2005-06 Actual	FY 2006-07 Appropriation	FY 2007-08 Request	Change Req. #

1

(Primary Functions: Mental health programs for Medicaid eligible clients. This division is discussed in a separate briefing and is shown only as a division subtotal.

					Request vs. Appropriation
SUBTOTAL -- Medicaid Mental Health Community Programs	**202,207,076**	**193,176,030**	**211,550,200**	**234,006,933**	**10.62%**
General Fund	76,914,919	82,944,553	87,803,777	99,030,292	12.79%
General Fund Exempt	0	0	0	0	n/a
Cash Funds	0	0	0	0	n/a
Cash Funds Exempt	48,395,809	27,190,916	33,783,245	31,925,442	-5.50%
Federal Funds	76,896,348	83,040,561	89,963,178	103,051,199	14.55%

Line Item detail for this division is found in a separate staff briefing on Mental Health issues. This Division is impacted by Decision Item #2.

(4) Indigent Care Program

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

	FY 2004-05 Actual	FY 2005-06 Actual	FY 2006-07 Appropriation	FY 2007-08 Request	Change Req. #
Safety Net Provider Payments	**264,013,206**	**287,296,074**	**296,188,630**	**296,188,630**	
General Fund	9,432,484	12,576,646	13,090,782	13,090,782	
Cash Funds Exempt	122,574,119	131,071,391	135,003,533	135,003,533	
Federal Funds	132,006,603	143,648,037	148,094,315	148,094,315	
The Children's Hospital, Clinic Based Indigent Care	**6,119,760**	**6,119,760**	**6,119,760**	**6,119,760**	
General Fund	3,059,880	3,059,880	3,059,880	3,059,880	
Federal Funds	3,059,880	3,059,880	3,059,880	3,059,880	
Pediatric Speciality Hospital	**0**	**5,452,134**	**7,732,072**	**7,677,436**	T #1
General Fund	0	2,726,067	3,350,000	3,350,000	
Cash Funds Exempt	0	0	516,036	461,400	
Federal Funds	0	2,726,067	3,866,036	3,866,036	

	FY 2004-05 Actual	FY 2005-06 Actual	FY 2006-07 Appropriation	FY 2007-08 Request	Change Req. #
General Fund Appropriation to Pediatric Speciality Hospital	**0**	**0**	**516,036**	**461,400**	T #1
General Fund Exempt	0	0	516,036	461,400	
Appropriation from Tobacco Tax Fund to General Fund	**0**	**0**	**1,032,072**	**922,800**	T #1
Cash Funds Exempt	0	0	1,032,072	922,800	
Primary Care Fund	**0**	**44,041,879**	**32,939,958**	**29,099,458**	
Cash Funds	0	(163)	0	0	
Cash Funds Exempt	0	44,042,042	32,939,958	29,099,458	
Children's Basic Health Plan Trust	**21,157,946**	**29,431,057**	**192,072**	**4,728,460**	DI #3 & 4
General Fund	3,296,346	2,000,000	0	4,488,901	T #1
Cash Funds	122,626	191,726	192,072	239,559	
Cash Funds Exempt	17,738,974	27,239,331	0	0	
Children's Basic Health Plan Administration	**4,229,706**	**5,273,572**	**5,521,207**	**5,535,590**	DI #4
Cash Funds Exempt	664,075	747,996	2,465,634	2,472,567	
Federal Funds	3,565,631	4,525,576	3,055,573	3,063,023	
Children's Basic Health Plan Premium Costs (Children & Pregnant Adults)	**52,000,289**	**65,919,891**	**70,371,177**	**91,380,525**	DI #3
Cash Funds Exempt	18,279,883	23,426,139	24,754,759	32,138,897	T #2
Federal Funds	33,720,406	42,493,752	45,616,418	59,241,628	
Children's Basic Health Plan Dental Costs	**5,084,701**	**5,368,921**	**5,913,659**	**6,632,341**	DI #3
Cash Funds Exempt	1,779,646	1,879,122	2,069,780	2,321,319	T #2
Federal Funds	3,305,055	3,489,799	3,843,879	4,311,022	

	FY 2004-05 Actual	FY 2005-06 Actual	FY 2006-07 Appropriation	FY 2007-08 Request	Change Req. #
Comprehensive Primary and Preventive Care Fund	**2,566,401**	**2,604,927**	**0**	**0**	
Cash Funds Exempt	2,566,401	2,604,927	0	0	
Comprehensive Primary and Preventive Care Grants	**2,566,401**	**2,604,927**	**2,621,651**	**2,668,034**	T -1
Cash Funds Exempt	2,566,401	2,604,927	2,621,651	2,668,034	
Medically Indigent Program	**0**	**14,962,408**	**14,962,408**	**30,000,000**	T -2
General Fund	0	14,962,408	0	15,000,000	
Cash Funds Exempt	0	0	14,962,408	15,000,000	
					Request vs. Appropriation
SUBTOTAL -- Indigent Care Program	**357,738,410**	**469,075,550**	**444,110,702**	**481,414,434**	**8.40%**
General Fund	15,788,710	35,325,001	19,500,662	38,989,563	99.94%
General Fund Exempt	0	0	516,036	461,400	-10.59%
Cash Funds	122,626	191,563	192,072	239,559	24.72%
Cash Funds Exempt	166,169,499	233,615,875	216,365,831	220,088,008	1.72%
Federal Funds	175,657,575	199,943,111	207,536,101	221,635,904	6.79%

(5) Other Medical Services

(This division provides funding for state-only medical programs including Home Care Allowance, Adult Foster Care, and Old-Age Pension Medical Program. The funds Medicaid programs for school-based services and the primary care physician incentive).

	FY 2004-05 Actual	FY 2005-06 Actual	FY 2006-07 Appropriation	FY 2007-08 Request	Change Req. #
Home Care Allowance	**10,510,584**	**9,967,297**	**0**	**0**	
General Fund	9,985,055	9,492,664	0	0	
Cash Funds Exempt	525,529	474,633	0	0	
Adult Foster Care	**122,382**	**82,029**	**0**	**0**	
General Fund	116,263	78,123	0	0	
Cash Funds Exempt	6,119	3,906	0	0	

	FY 2004-05 Actual	FY 2005-06 Actual	FY 2006-07 Appropriation	FY 2007-08 Request	Change Req. #
Old Age Pension State Medical Program	**9,999,321**	**14,426,967**	**14,262,663**	**13,780,951**	DI #11
Cash Funds	9,999,321	0	0	0	T #1
Cash Funds Exempt	0	14,426,967	14,262,663	13,780,951	
Tobacco Tax Transfer from General Fund to the Old Age Pension State Medical Program	**0**	**0**	**2,580,180**	**2,307,000**	T #1
Cash Funds Exempt	0	0	2,580,180	2,307,000	
University of Colorado Family Medicine Residency Training	**1,449,444**	**1,576,502**	**1,703,558**	**1,903,558**	NPI #15
General Fund	724,722	788,251	851,779	951,779	
Federal Funds	724,722	788,251	851,779	951,779	
Enhanced Prenatal Care Training and Technical Assistance	**102,346**	**102,338**	**102,346**	**102,346**	
General Fund	51,173	51,169	51,173	51,173	
Federal Funds	51,173	51,169	51,173	51,173	
Nurse Home Visitor Program	**2,877,898**	**2,419,685**	**3,010,000**	**3,010,000**	
Cash Funds Exempt	1,438,949	1,209,843	1,505,000	1,505,000	
Federal Funds	1,438,949	1,209,842	1,505,000	1,505,000	
Public School Health Services	**20,232,638**	**18,646,352**	**31,535,961**	**31,334,989**	DI #9
Cash Funds Exempt	10,056,485	9,249,432	16,007,021	16,007,021	
Federal Funds	10,176,153	9,396,920	15,528,940	15,327,968	
Colorado Autism Treatment Fund	**0**	**32,093**	**0**	**0**	
Cash Funds Exempt	0	32,093	0	0	
Medicare Modernization Act of 2003 Maintenance of Effort Payment	**0**	**31,461,626**	**73,493,542**	**74,091,621**	T #1
General Fund	0	31,461,626	73,493,542	74,091,621	

	FY 2004-05 Actual	FY 2005-06 Actual	FY 2006-07 Appropriation	FY 2007-08 Request	Change Req. #
					Request vs. Appropriation
SUBTOTAL -- Other Medical Programs	**45,294,613**	**78,714,889**	**126,688,250**	**126,530,465**	**-0.12%**
General Fund	10,877,213	41,871,833	74,396,494	75,094,573	0.94%
General Fund Exempt	0	0	0	0	n/a
Cash Funds	9,999,321	0	0	0	n/a
Cash Funds Exempt	12,027,082	25,396,874	34,354,864	33,599,972	-2.20%
Federal Funds	12,390,997	11,446,182	17,936,892	17,835,920	-0.56%

(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 that Departm first appropriated in this division, then transferred as Cash Funds Exempt.). The line items in this division are discussed in other staff briefings. Therefore, only subtotal information is included.

	FY 2004-05 Actual	FY 2005-06 Actual	FY 2006-07 Appropriation	FY 2007-08 Request	Request vs. Appropriation
SUBTOTAL -- DHS Medicaid Programs	**420,876,735**	**429,711,475**	**404,911,178**	**410,405,015**	**1.36%**
General Fund	195,472,378	202,571,252	188,511,419	191,445,865	1.56%
General Fund Exempt	686,669	219,762	0	0	n/a
Cash Funds	0	0	0	0	n/a
Cash Funds Exempt	12,195,638	9,165,181	14,187,619	14,000,548	n/a
Federal Funds	212,522,050	217,755,280	202,212,140	204,958,602	1.36%

Note: This division is impacted by DI # 2, NP #1-8 & 10-14 and T-1.

	FY 2004-05 Actual	FY 2005-06 Actual	FY 2006-07 Appropriation	FY 2007-08 Request	Change Req. #

1

	FY 2004-05 Actual	FY 2005-06 Actual	FY 2006-07 Appropriation	FY 2007-08 Request	Request vs. Appropriation
TOTAL -- Department of Health Care Policy and Financing (with Mental Health & DHS programs)	**3,003,089,363**	**3,228,850,053**	**3,385,826,300**	**3,632,784,527**	**7.29%**
FTE	**202.80**	**212.40**	**226.70**	**246.70**	8.82%
General Fund	1,253,171,639	1,098,625,142	1,140,065,766	1,243,364,827	9.06%
General Fund Exempt	835,236	261,590,622	256,616,036	256,561,400	-0.02%
Cash Funds	10,456,668	568,269	690,959	700,190	1.34%
Cash Funds Exempt	270,004,813	320,368,263	359,452,661	381,802,874	6.22%
Federal Funds	1,468,621,007	1,547,697,757	1,629,000,878	1,750,355,236	7.45%

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

	FY 2004-05 Actual	FY 2005-06 Actual	FY 2006-07 Appropriation	FY 2007-08 Request	Request vs. Appropriation
TOTAL -- Department of Health Care Policy and Financing (w/o Mental Health & DHS divisions)	**2,380,005,552**	**2,605,962,548**	**2,769,364,922**	**2,988,372,579**	**7.91%**
FTE	**202.80**	**212.40**	**226.70**	246.70	8.82%
General Fund	980,784,342	813,109,337	863,750,570	952,888,670	10.32%
General Fund Exempt	148,567	261,370,860	256,616,036	256,561,400	-0.02%
Cash Funds	10,456,668	568,269	690,959	700,190	1.34%
Cash Funds Exempt	209,413,366	284,012,166	311,481,797	335,876,884	7.83%
Federal Funds	1,179,202,609	1,246,901,916	1,336,825,560	1,442,345,435	7.89%

Note: The General Fund and General Fund Exempt percent change together equals 7.95% (this excludes the Mental Health & DHS Medicaid Funded programs)

FY 2007-08 Joint Budget Committee Staff Budget Briefing
Department of Health Care Policy and Financing
2006 Long Bill Footnote Update

NOTE: The Department of Health Care Policy and Financing has a total of 19 footnotes that were added to the FY 2006-07 Long Bill. Of the 19 footnotes, two are common to all departments, one is applicable to a program managed by the Department of Human Services, and the remaining 16 apply to this budget briefing. Last year, the Governor vetoed 10 of the 19 footnotes.

2 **All Departments, Totals** -- The General Assembly requests that copies of all reports requested in other footnotes contained in this act be delivered to the Joint Budget Committee and the majority and minority leadership in each house of the General Assembly. Until such time as the Secretary of State publishes the code of Colorado regulations and the Colorado register in electronic form pursuant to section 24-4-103 (11) (b), C.R.S., each principal department of the state is requested to produce its rules in an electronic format that is suitable for public access through electronic means. Such rules in such format should be submitted to the Office of Legislative Legal Services for publishing on the Internet. Alternatively, the Office of Legislative Legal Services may provide links on its internet web site to such rules. It is the intent of the General Assembly that this be done within existing resources.

Comment: It is staff's understanding that the Department is complying with the provision of this footnote to deliver reports to the majority and minority leadership. Furthermore, the Department's rules can be accessed at the following web addresses:

- Http://www.chcpf.state.co.us/HCPF/StateRules/newToc2.asp
- Http://www.chcpf.state.co.us/HCPF/titlexxi/StatePlan/rules/rulesindex.asp.

3 **All Departments, Totals** -- Every Department is requested to submit to the Joint Budget Committee information on the number of additional federal and cash funds exempt FTE associated with any federal grants or private donations that are applied for or received during FY 2006-07. 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: *This footnote was vetoed by the Governor on the basis that it violates the separation of powers "in that it is attached to federal funds and private donations, which are not subject to legislative appropriation."*

Although the Governor vetoes this footnote based on constitutional reasons, the Department staff does respond to specific questions regarding grant and federal funding when asked by staff. For example, staff requested that the Department provide an update on the how the Federal Flexible Grant monies that the Department received in 2003 were expended and how much funding remains unexpended at this time. The Department responded with the following information.

The Department received a total of $3.0 million from the Federal Flexible Grant monies that was provided as part of a State relief package passed by Congress in 2003. The Department allocated the $3.0 million for two purposes: (1) $2.0 million to improve access to dental care for Medicaid and Children's Basic Health Plan children, and (2) $1.0 in development funds to enhance and expand consumer directed support programs.

The funding that was allocated for the expand dental services was fully expended by FY 2004-05. The Department had entered into an Interagency Agreement with the University of Colorado Health Sciences Center, School of Dentistry. Pursuant to this agreement, the Department transferred $2.0 million to the School of Dentistry that was used for the following purposes: (1) provided additional dental equipment to the Lazarra Center for Oral-Facial Health at the Fitzsimmons campus; (2) provided additional equipment for mobile dental clinics for preventative care to support rural health centers and health fairs; (3) provide some direct care to uninsured low-income children or to low-income children (funding for this program will be exhausted by December 2007).

For the Consumer Directed Support Program, the Department has used the funding as follows.

FY 2004-05
The Department expended $117,430 for consulting services related to marketing, outreach and training and for system changes for the program.

FY 2005-06
The Department expended $113,157 for informational and educational packets regarding the program.

FY 2006-07
The Department plans to use the remaining $769,413 in FY 2006-07 for further development of training and education materials about the program and evaluation of the program.

It is staff's understanding that the administration of the Federal Flexible Grant program was done with existing staff resources as most of the funding was contracted out.

20 **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 budget to the Joint Budget Committee, by the third Monday 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 submits monthly reports as required by this footnote. These monthly reports allow staff to track monthly expenditures and caseload in order to assess the accuracy of current appropriations and forecasts. Appendix C contains the year-to-date expenditure and caseload numbers from the monthly reports on the Medical Services Premiums lines item.

The Department continues to work with staff to make sure that these monthly reports contain the information staff needs to assess current expenditure and caseload levels. One of the recent challenges has been how to track caseload and expenditures related to the Amendment 35 (H.B. 05-1262) expansion populations. As of November 2006, the monthly reports do not yet indicate the new caseload aid category for "Expansion Adults". In addition, tracking expenditures and caseload related to the asset test elimination continues to be a challenge for both the Medicaid and Children's Basic Health Plan programs. Staff and the Department will continue to work together to address these technical difficulties.

20a **Department of Health Care Policy and Financing, Executive Director's Office** -- It is the intent of the General Assembly that the Department comply with the federal regulations that the Medicaid program by the payer of last resort to the fullest extent possible (42 CFR 433.138 and 42 CFR 433.139). If the State Auditor's report finds that the Department is deficient in collecting from third party payers, the Department is authorized to seek federal waiver authority to pay providers first and then seek reimbursement from the obligated third-party payer. The Department is requested to submit a report to the Joint Budget Committee by November 1, 2006, on the effectiveness of its third party collections and how the Department plans to address an recommendations contained in the State Auditor's review of this issue. The Department's report is requested to include a cost benefit analysis of when it is in the state's interest to pursue third party recovery.

Comment: *This footnote was vetoed by the Governor on the basis that it "violates the Colorado Constitution, Article III and possibly Article V, Section 32, because it interferes with the ability of the executive's branch to administer the appropriation and may constitute substantive legislation that cannot be included in the general appropriation bill." The Governor also stated that the footnote required a substantial dedication of resources and constituted an unfunded mandate.*

Although the Governor vetoed this footnote, the Department complied in sending a report to the Joint Budget Committee regarding their efforts at third party recovery. At this time,

the State Auditor's Office review of the Department's efforts on third party recovery is not complete. The State Auditor's Office will not have findings to report until March 2007. During the summer, the State Auditor's Office contacted JBC staff for input related to the scope of the audit. The State Auditor's Office audit is limiting the scope to the dual eligible population and will specially audit claims for durable medical equipment. After the State Auditor's Office has completed this review, the Joint Budget Committee may want to expand the audit to other areas if deficiencies are found. Staff plans on addressing this issue with the Committee during the March figure setting presentation for the Department after the audit findings have been competed.

The Department performs third party recoveries in four major areas: (1) tort and casualty; (2) trust recovery and repayment of Medicaid expenditures from trusts; (3) estate recovery; and (4) post pay recoveries and retractions from providers and Medicare. In the footnote report, the Department shows that between FY 2004-05 and FY 2005-06, the amount of third party recoveries increased from a total of $18.1 million to $24.7 million -- an increase of 36 percent. Following is a brief discussion of the type of third party recoveries that the Department performs.

Tort/Casualty Recovery

The Department recoveries from third parties who are liable for medical costs incurred by Medicaid clients for injuries or harm caused by the third party. Typically, these third parties have insurance that can be assessed some of the costs related to the accident or injury. The Department's Benefits Coordination unit manages these recovery activities and contacts the Colorado Attorney General's staff in difficult legal issues arise. In addition, the Department has a contingency fee based contractor who pursues to aid the Department in tracking down possible third parties and looking at workers' compensation cases. The contractor's fee is 8.25 percent of recoveries.

The Department states that the Medicaid program attempts to recover payments from all responsible third parties and their insurers. However, the Department does not seek recovery from cases with recovery liens under $300. The Department also does not seek recovery if significant fees and costs would occur to the State with little chance of recover (e.g. a product liability case).

Trust Recovery and Repayment of Medicaid Expenditures

Income and disability trusts allow individuals to qualify for Medicaid who normally would not because their incomes and assets make them ineligible for Medicaid coverage but are too low to pay for the long-term care services. When the trust is no longer needed by the client for Medicaid eligibility, the balance of the trust is paid to the Department.

The Medicaid program attempts to recover all income and disability trust amounts up to the total cost of medical expenditures when the trust is no longer needed for Medicaid eligibility. There are few instances when the amount of potential recovery from a trust is less than the cost to track down the recovery.

Estate Recovery

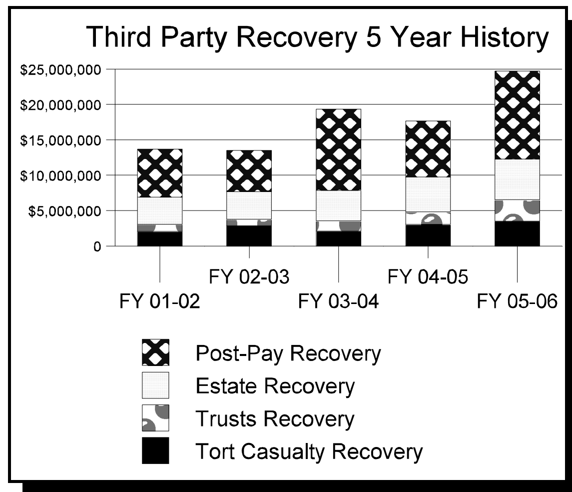
Estate Recovery is a federally mandated program that requires the State to recover the costs of benefits paid on behalf of a Medicaid client from their estate. The Department contracts for this activity. The Estate Recover Program will place a lien on property owned by the Medicaid client if it has been determined that the client is unlikely to be discharged from a nursing facility. The contractor is paid a contingency fee of 10.9% of the amount of recoveries.

Pursuant to the Colorado State Plan, recoveries under $500 are not pursued. However, the Department states that if the public administrator, personal representative or executor identifies the State as a creditor and makes notification of probate filing, a claim may be made even if under the $500 threshold.

Post Pay Recoveries and Retractions

Lastly, the Department has a contractor to recover costs paid on behalf of Medicaid client where a third party was liable for these payments (private health insurance or Medicare coverage). The Department, through the Medicaid Management Information System contractor, retracts the value of Medicaid-paid claims if a third party is later identified. The contractor's contingency fee is 6.15% of recoupments. The Department did not provide information in their report on what level of claims are not pursued from a cost-benefit stand point for post pay recoveries.

Over the last several years, third party recoveries have increased. The increase was related partly to Department efforts to improve third party recoveries due to the state budget situation as well as general increases in the Medicaid program. This chart shows a five year history of third party recoveries. During this five-year period, the Department has recovered a total of $90.8 million in third party recoveries.



Other Issues

In addition to third party recovery efforts, the Joint Budget Committee approved the Department's plan to use a contingency based contract to examine the accuracy of hospital coding and billing for Diagnosis Related Group (DRG) codes. At the time the JBC approved the Department moving forward with the RFP for this project, the Joint Budget Committee asked the Department to report back on the progress by November 1, 2006. The Department submitted the report as requested.

The Department posted a RFP on June 2, 2006. Based on the results of the RFP, the Department selected Health Management Systems, Inc. (HMS) to perform the contract on July 31, 2006. However, a protest was filed a week later by another vendor who had participated in the bidding processing. The Department of Personnel and Administration denied the vendor's appeal on October 13, 2006. The Department now anticipates that the contract with HMS will be fully executed and in place at the end of November 2006.

Due to the amount of time it has taken to issue the RFP and respond to vendor appeals, there have been no recoveries to date from this project.

Staff Recommendations

Staff recommends that the Committee ask the Department the following questions at their hearing:

1. Is the Department aware of any technology available or that could be developed to improve the identification of third party payers? Please describe how the Department currently identifies clients that may have access to other insurance?

2. The Department's footnote report seems to indicate that for Medicare recoveries and commercial insurance recoveries these are post-pay recoveries. Is it accurate to conclude from this statement that Medicaid initially pays the claim and then attempts to recover from these providers? If so, how can the state do this and be in compliance with 42 CFR 433.139 (b) (1)? Please describe specifically how claims are paid for dual eligible clients where Medicare may be responsible for the cost before Medicaid?

3. During last year's hearing, the Department indicated that it has been unable to quantify a direct impact to Medicaid expenditures or third party recoveries that can be attributable to a tort auto insurance system. Please provide an update on how auto insurance reform may have impacted the Department's ability to collect from post-payment recovery or from tort/casualty recovery.

4. Given the late start for the HMS contract, does the Department anticipate that there will be any cost savings in FY 2006-07 from this contract? What is a reasonable estimate of cost savings for FY 2007-08 from this contract?

5. FY 2005-06 third party recoveries resulted in recoveries of $24.7 million (of which half would be General Fund). This represents approximately 1.2 percent of the total expenditures for Medical Services Premiums. Would it be a fair performance target to set 1.0 percent of Medical Services Premiums as a third party recovery target?

20b **Department of Health Care Policy and Financing, Executive Director's Office** -- The Department is requested to provide a status report on the implementation schedules and anticipated FY 2006-07 fiscal impact for the following legislation: S.B. 04-177, H.B. 05-1015, H.B. 05-1066, H.B. 05-1131, and H.B. 05-1243. This report is requested to be submitted to the majority and minority leadership in each house of the General Assembly and to the Joint Budget Committee by no later than August 1, 2006.

Comment: *This footnote was vetoed by the Governor on the basis that it "violates the Colorado Constitution, Article III and possibly Article V, Section 32, because it interferes with the ability of the executive's branch to administer the appropriation and may constitute substantive legislation that cannot be included in the general appropriation bill." The Governor also stated that the footnote required a substantial dedication of resources and constituted an unfunded mandate. However, the Governor requested the Department to comply with the intent of the footnote to the extent feasible.*

Even though the Governor vetoed this footnote, the Department complied with the footnote by submitting the requested report on the date requested. Last year, the Joint Budget Committee needed to make several supplemental adjustments to the FY 2005-06 appropriation to reflect the slow implementation of prior year legislation. Specifically, adjustments had to be made reflect that S.B. 04-177 (Home and Community-Based Services for Children with Autism), H.B. 05-1015 (Substance Abuse Treatment under Medicaid), H.B. 05-1066 (Obesity Treatment Under Medicaid), H.B. 05-1131 (Redispensing Specified Unused Medications), and H.B. 05-1243 (Consumer-Directed Care Under Medicaid) had not been implemented as original assumed in the fiscal note. In addition, to the bills listed in this footnote, H.B. 05-1262 (implementation of Amendment 35) had also had delays. The delay in implementing these bill helped contribute to the large negative supplemental for the Department in FY 2005-06. Therefore, the General Assembly requested this footnote in order to receive a status report for the bills mentioned. Following is a summary of the implementation schedule that the Department anticipates for these bills.

H.B. 04-177: This program was originally assumed to begin in July 2005. The Department now anticipates that Autism Waiver will be operational in October 2006. The Department anticipates that program will cost

$1,013,795 ($506,124 Autism Treatment funds and $507,671 federal funds) in FY 2006-07.

H.B. 05-1015: The outpatient substance abuse treatment program was originally assumed to be operation on January 1, 2006. The revised implementation was July 1, 2006 and the program was implemented on July 1, 2006. This program only required a state plan amendment as opposed to a waiver requirement. This bill is anticipated to have a fiscal impact of $5.9 million in FY 2006-07.

H.B. 05-1066: The obesity pilot program was originally going to be implemented in FY 2005-06. However, the bill was contingent on the Department receiving gifts, grants, and donations for the state match for the program. The Department never received any gifts, grants, and donations. Because the time frames established in the original bill can no longer be met, this bill can no longer be implemented without a change in statute.

H.B. 05-1131: The original fiscal note for redispensing unused medications assumed a September 1, 2005 implementation date. However, due to delays in adopting Board of Pharmacy rules, the program could not be implemented by the Department until March 30, 2006. The current anticipated fiscal impact of this bill is a savings of $48,867 in FY 2006-07.

H.B. 05-1243: The consumer-directed care program was originally assumed to begin on January 2006. The new implementation plan calls for clients to begin enrolling on July 2007. The FY 2006-07 appropriation only contains administrative costs for this program only of $27,761.

Staff recommends that the Committee ask the Department to discuss the following questions at their hearing:

1) Please describe the current status of the Autism Waiver program. Was the program implemented in October 2006? What information and outreach is the Department providing to clients that potentially could benefit from the services of this program?

2) Does the Department have any current cost information for the outpatient substance abuse benefit? What have been the costs for this program from July 1 through October 31, 2006?

3) Obesity and morbid obesity is becoming one of the leading public health concerns in this century. Given that the time frames in H.B. 05-1066 have expired and the bill can not be implemented without statutory changes, does the Department see any benefit from trying to institute a obesity pilot program or disease management

program. If so, what type of program does the Department believe would be appropriate for the Medicaid clientele? Should a program focus on weight management programs, heart disease and/or diabetes control, or nutritional education? Because benefits from these programs take a long time to occur, would the program be better situated to the Adult Medicaid caseload rather than to the Family Medicaid caseload?

4) Please provide the Committee with an update on the consumer-directed care waiver process.

22 **Department of Health Care Policy and Financing, Executive Director's Office, Primary Care Provider Rate Task Force and Study** -- The Department is requested to work with the provider community to examine any issues of rate disparity and rate shortfalls for physician and acute care providers. The Department is requested to report on its preliminary findings by November 1, 2006, and its final analysis by November 1, 2007. The Department's appropriation contains $58,000 total funds for the expenses of any task force that the Department may assemble and for temporary staffing costs for conducting such a study.

Comment: *This footnote was vetoed by the Governor on the basis that it "violates the Colorado Constitution, Article III and possibly Article V, Section 32, because it interferes with the ability of the executive's branch to administer the appropriation and may constitute substantive legislation that cannot be included in the general appropriation bill." However, the Governor did not veto the funding in the line item that this footnote was attached to.*

Although the Governor vetoed this footnote, the Department submitted a letter informing the Committee of the status of this project. Currently, the Department is seeking proposals from consultants with the background necessary to assist the Department with the study. To date, the Department has not conducted the study required by this footnote. However, the Department has submitted a decision item to address some of the current problems in the physician and primary care rate.

23 **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 2006-07 to the Joint Budget Committee by July 25, 2006. 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 25.5-408, C.R.S.

Comment: *This footnote was vetoed by the Governor on the basis that it "violates the Colorado Constitution, Article III and possibly Article V, Section 32, because it interferes*

with the ability of the executive's branch to administer the appropriation and may constitute substantive legislation that cannot be included in the general appropriation bill."

This footnote or a similar version of it has been included in the Long Bill for the last four years. Even though the Governor vetoes this footnote each year, the Department has complied by submitting a report containing the current capitation rates for each Medical MCO and Behavior Health Organization.

Federal rules and regulations (42 CFR 438.6 c) require that proposed capitation rates be actuarially sound. The state contracts with Deloittee Consulting LLP to certify rates for each MCO that contracts with the Medicaid medical program. The rates are developed to the cover the following services: inpatient hospital, outpatient hospital, post hospital- nursing home care, physician services, laboratory and x-ray, prescription drugs, early periodic screening, diagnosis, and treatment, family planning, home health, durable medical equipment emergency transportation and emergency dental. For rates developed beginning in FY 2003-04, Colorado statute provides, "...the state department shall recalculate the base calculation every three years. The three year cycle for the recalculation of the base calculation shall begin with capitation payments effective for fiscal year 2003-04. In the year in which the base calculation is not recalculated, the state department shall annually trend the base calculation after consulting with the MCOs. The state department shall take into consideration when trending the base calculation any public policy changes that affect reimbursement under the "Colorado Medical Assistance Act" (Section 25.5-5-408, C.R.S.). For purposes of rate development, the base population, is an actuarially equivalent population from the Fee-for-Service (FFS) and Primary Care Case Management (PCCP) program. The costs for the base population are used to set the capitation rates for participating MCOs. During non-base years, the state sets rates by performing the following steps:

- ✓ Trend rates for the next year are developed and applied to the prior year rates;
- ✓ Recent policy and law changes are applied to the prior year rates;
- ✓ Rates for each plan is adjusted based on Health Status Based Risk Adjustment Case Mis Indices; and
- ✓ Durational Adjustments are updated.

The rates that were developed for FY 2006-07 were the first year that rates had to be re-based for Medicaid Medical program pursuant to Section 26-5-119 (9), C.R.S. As the Committee is aware, after the re-base rates were developed, Colorado Access decided that their rates would not be sufficient for their financial stability and therefore, decided to no longer contract with the State for this program (Colorado Access continues to have a contract as a Mental Health provider). Therefore, in this year's report, only Denver Health and Hospital Authority remains as a Medicaid Medical Program MCO provider.

The following table shows a history of MCO Rates for Denver Health.

Table 1: Colorado Medicaid MCO Rates for Denver Health (Metro)					
	FY 2004-05	**FY 2005-06**	**% Change**	**FY 2006-07**	**% Change**
AFDC - Adults F	$225.83	$270.10	19.60%	$200.48	-25.78%
AFDC - Adults M (combined with F in previous years)	n/a	n/a	n/a	$230.84	n/a
AFDC - Children	$52.52	$64.40	22.62%	$49.51	-23.12%
AFDC - Infants	$217.37	$286.16	31.65%	$233.18	-18.51%
Baby Care/Kids Care - Adults	$281.98	$269.89	-4.29%	$204.99	-24.05%
Baby Care/Kids Care -Children	$50.78	$54.62	7.56%	$49.51	-9.36%
Baby Care/Kids Care - Infants	$213.11	$263.34	23.57%	$233.18	-11.45%
Foster Care	$187.50	$206.88	10.34%	$205.69	-0.58%
Aid to Needy Disabled/Aid to the Blind (AND/AB)					
Institutional/Third Party Liability	$843.80	$919.70	9.00%	$132.53	-85.59%
Institutional/Medicaid Only	$1,281.89	$1,320.25	2.99%	$1,244.37	-5.75%
Non-Institutional/Third Party Liability	$388.84	$449.71	15.65%	$133.46	-70.32%
Non-Institutional/Medicaid Only	$690.68	$759.92	10.02%	$633.46	-16.64%
Old Age Pensioner - Age 65+ (OAP-A) -- Called SSI 65+ in Other Tables					
Institutional/Third Party Liability	$417.50	$443.74	6.29%	$171.84	-61.27%
Institutional/Medicaid Only	$518.54	$519.07	0.10%	$620.26	19.49%
Non-Institutional/Third Party Liability	$257.11	$271.95	5.77%	$147.58	-45.73%
Non-Institutional/Medicaid Only	$538.02	$527.16	-2.02%	$404.68	-23.23%
Old Age Pensioners - Under Age 65					
Institutional/Third Party Liability	$557.35	$606.14	8.75%	$132.53	-78.14%
Institutional/Medicaid Only	$885.94	$923.80	4.27%	$1,244.37	34.70%
Non-Institutional/Third Party Liability	$310.57	$381.88	22.96%	$133.46	-65.05%
Non-Institutional/Medicaid Only	$669.67	$788.54	17.75%	$633.46	-19.67%
Delivery	$3,861.15	$4,440.10	14.99%	$4,622.84	4.12%

The following table shows a history of MCO Rates for Colorado Access -- Metro.

Table 2: Colorado Medicaid MCO Rates for Colorado Access (Metro)							
	FY 2003-04	FY 2004-05	% Change	FY 2005-06	% Change	FY 2006-07*	% Change
AFDC - Adults F	$213.71	$230.74	7.97%	$271.28	17.57%	$199.63	-26.41%
AFDC - Adults M (combined with F in previous years)	n/a	n/a	n/a	n/a	n/a	$228.22	n/a
AFDC - Children	$62.37	$57.25	-8.21%	$63.83	11.49%	$54.94	-13.93%
AFDC - Infants	$310.11	$239.83	-22.66%	$302.53	26.14%	$197.14	-34.84%
Baby Care/Kids Care - Adults	$294.83	$283.91	-3.70%	$265.79	-6.38%	$195.80	-26.33%
Baby Care/Kids Care -Children	$58.36	$53.01	-9.17%	$57.04	7.60%	$54.94	-3.68%
Baby Care/Kids Care - Infants	$227.22	$229.88	1.17%	$272.43	18.51%	$197.14	-27.64%
Delivery	$3,826.67	$3,861.15	0.90%	$4,108.16	6.40%	$4,622.84	12.53%
Foster Care	$184.29	$187.53	1.76%	$206.65	10.20%	$198.58	-3.91%
Aid to Needy Disabled/Aid to the Blind (AND/AB)							
Institutional/TPL	$783.87	$843.89	7.66%	$919.04	8.91%	$133.89	-85.43%
Institutional/Medicaid Only	$1,216.53	$1,282.03	5.38%	$1,319.30	2.91%	$1,253.41	-4.99%
Non-Institutional/TPL	$418.62	$409.29	-2.23%	$473.37	15.66%	$135.59	-71.36%
Non-Institutional/Medicaid Only	$748.04	$727.01	-2.81%	$799.90	10.03%	$710.15	-11.22%
Old Age Pensioner - Age 65+ (OAP-A) (Called SSI 65+ in Other Tables)							
Institutional/TPL	$410.19	$422.84	3.08%	$444.66	5.16%	$162.92	-63.36%
Institutional/Medicaid Only	$519.52	$525.18	1.09%	$520.14	-0.96%	$586.57	12.77%
Non-Institutional/TPL	$251.44	$258.87	2.96%	$271.85	5.01%	$145.78	-46.37%
Non-Institutional/Medicaid Only	$533.98	$541.69	1.44%	$526.98	-2.72%	$400.01	-24.09%
Old Age Pensioners - Under Age 65 (Called SSI 60-64 in Other Tables)							
Institutional/TPL	$574.38	$555.06	-3.36%	$606.05	9.19%	$133.89	-77.91%
Institutional/Medicaid Only	$786.90	$882.30	12.12%	$923.67	4.69%	$1,253.41	35.70%
Non-Institutional/TPL	$378.06	$388.97	2.89%	$399.96	2.83%	$135.59	-66.10%
Non-Institutional/Medicaid Only	$673.20	$838.71	24.59%	$825.87	-1.53%	$710.15	-14.01%

*Colorado Access cancelled their contract for Medical Medicaid based on the outcome of this year's rate setting process.

The following table shows a history of MCO Rates for Colorado Access -- Non-Metro areas.

Table 3: Colorado Medicaid MCO Rates for Colorado Access (Non Metro Areas)							
	FY 2003-04	**FY 2004-05**	**% Change**	**FY 2005-06**	**% Change**	**FY 2006-07***	**% Change**
AFDC - Adults F	$206.18	$208.71	7.97%	$266.69	17.57%	$191.98	-29.23%
AFDC - Adults M (combined with F in previous years)	n/a	n/a	n/a	n/a	n/a	$165.23	n/a
AFDC - Children	$58.32	$53.15	-8.21%	$62.65	11.49%	$54.16	-15.15%
AFDC - Infants	$233.41	$188.44	-22.66%	$238.09	26.14%	$193.82	-35.93%
Baby Care/Kids Care - Adults	$250.01	$251.09	-3.70%	$231.91	-6.38%	$199.16	-25.07%
Baby Care/Kids Care -Children	$58.27	$53.93	-9.17%	$59.67	7.60%	$54.16	-5.05%
Baby Care/Kids Care - Infants	$175.35	$182.26	1.17%	$217.10	18.51%	$193.82	-28.86%
Delivery	$3,826.67	$3,861.15	0.90%	$4,108.16	6.40%	$4,032.12	-1.85%
Foster Care	$168.04	$174.18	1.76%	$191.10	10.20%	$189.42	-8.34%
Aid to Needy Disabled/Aid to the Blind (AND/AB)							
Institutional/TPL	$730.42	$787.01	7.66%	$842.34	8.91%	$153.61	-83.29%
Institutional/Medicaid Only	$1,019.00	$1,079.13	5.38%	$1,137.41	2.91%	$1,206.31	-8.56%
Non-Institutional/TPL	$323.13	$309.23	-2.23%	$378.72	15.66%	$119.79	-74.69%
Non-Institutional/Medicaid Only	$525.53	$500.93	-2.81%	$605.88	10.03%	$588.51	-26.43%
Old Age Pensioner - Age 65+ (Called SSI 65+ in Other Tables)							
Institutional/TPL	$442.78	$456.50	3.08%	$472.71	5.16%	$168.61	-62.08%
Institutional/Medicaid Only	$460.71	$468.58	1.09%	$474.98	-0.96%	$570.23	9.63%
Non-Institutional/TPL	$249.67	$258.69	2.96%	$273.80	5.01%	$97.71	-64.06%
Non-Institutional/Medicaid Only	$385.85	$395.21	1.44%	$405.31	-2.72%	$347.88	-33.99%
Old Age Pensioners - Under Age 65 (Called SSI 60-64 in Other Tables)							
Institutional/TPL	$627.47	$603.47	-3.36%	$650.69	9.19%	$153.61	-74.65%
Institutional/Medicaid Only	$819.42	$894.57	12.12%	$979.17	4.69%	$1,206.31	30.60%
Non-Institutional/TPL	$398.14	$328.47	2.89%	$387.35	2.83%	$119.79	-70.05%
Non-Institutional/Medicaid Only	$663.43	$645.85	24.59%	$774.79	-1.53%	$588.51	-28.74%

*Colorado Access cancelled their contract for Medical Medicaid based on the outcome of this year's rate setting process.

It is important to note that some of the large rate decreases in the adult Medicaid categories (SSI disabled, older than 65+, etc.) have to do with the Medicare Drug Benefit be taken out of the rates. It was Colorado's Access testimony in August that the main reason for their leaving the Medicaid

Medical program was because of the decline in rates in the Family Medicaid program (i.e. low-income adults and children). These are the aid categories that benefitted from a much larger risk pool in the fee-for-service population during the last three years which drove down the FFS costs and therefore, resulted in a lowering the MCO rates (which have to be 95 percent of the FFS rates per statute).

On September 20, 2006, staff presented a memo to the Committee about the recent decision by Colorado Access to leave the Medicaid medical program (they still participate in the mental health program). In that memo staff made the following observations and recommendations.

> *"The current statutory framework for at-risk capitated MCOs for the general Medicaid caseload will not attract new providers to the Medicaid program. Therefore, with the exception of Denver Health, it is unlikely that the Department will contract with new MCOs in the future using the current statutory framework of ensuring rates are at or below 95 percent of the FFS per capita cost. If it is the policy of Colorado to encourage MCO arrangements in the Medicaid program, then the MCO statute needs to be revisited to: (1) clarify the Department's authority, if any, to enter into PIHP (pre-paid inpatient hospital plan) agreements (these are the ASO type agreements with Rocky Mountain); and (2) revise a MCO rate structure that is based on the actual encounter data from the MCO rather than a comparison to the FFS.*
>
> *Staff recommends that if the General Assembly remains committed to the MCO model, that the first step will need to be establishing a task force of the Department, MCO providers, clients, and an outside consulting expert, to design the new framework for establishing an MCO program. The task force would need to revisit the following issues:*
>
> *1) Populations served in the MCO;*
> *2) State wideness or pilot nature of the program;*
> *3) How to ensure a significant risk pool for a contracting MCOs;*
> *4) Rate adjustments, if any, for declining caseload in a MCO;*
> *5) Overall rate structure for MCO contracts;*
> *6) The breadth of the managed care program (i.e. what type of contracts should be included MCOs, PIHP, PAHP, PCCM, and disease management);*
> *7) What benefits, if any, are there from a MCO program;*
> *8) What are the budget goals and quality goals of an MCO program (budget neutrality, cost containment, or cost reductions -- better access to care, same access, more flexibility)."*

Staff recommends that the Joint Budget Committee discuss the following questions with the Department at their hearing.

1) Please describe for the Committee the advantageous and disadvantageous of entering into more PIHP agreements.

2) Does the Department believe that there is any state benefit to having an traditional capitation MCO program in the Medicaid Medical program? In the Department's opinion, what should the goals of a MCO program be?

3) What steps (statutory changes, rate adjustment, policy directives) does the Department believe are necessary for a viable MCO program to be reestablished in the Colorado Medical Medicaid program?

4) Why has managed care struggled in the Colorado Medical Medicaid program but has been somewhat successful in the Children's Basic Health Plan?

5) Which populations ought to be served in a Medical Medicaid MCO program? Should the program be statewide or limited to certain geographic areas or populations?

6) If competition between plans is encouraged, how would the Department ensure a significant risk pool for participating providers? Should adjustments be made to rates if a providers risk pool is declining?

24 **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 Service Premiums to have flexibility in spending the Medical Services Premium line. The detail by population is provided for tracking and policy making purposes only.

25 **Department of Health Care Policy and Financing, Medical Services Premiums** -- The General Assembly has determined that the average appropriated rates provide sufficient funds to pay reasonable and adequate compensation to efficient and economical providers. The Department should take actions to ensure that the average appropriated rates are not exceeded.

Comment: This footnote states legislative intent in the area of Medicaid rates.

26 **Department of Health Care Policy and Financing, Medical Services Premiums** -- The calculations for this line item include $9,917,925 total funds for a 3.25 percent reimbursement rate increase for primary care providers beginning July 1, 2006. It is the intent of the General Assembly that the Medical Services Board adopt rules to increase reimbursement rates for provider codes paid from the physician, dental, Early and Periodic Screening, Diagnosis and Treatment, lab and x-ray, and durable medical equipment services

categories. The Department is requested to provide a report to the Joint Budget Committee by August 1, 2006, on the status of the rules adopted by the Medical Services Board regarding this reimbursement rate increase.

Comment: *This footnote was vetoed by the Governor on the basis that it "violates the Colorado Constitution, Article III and possibly Article V, Section 32, because it interferes with the ability of the executive's branch to administer the appropriation and may constitute substantive legislation that cannot be included in the general appropriation bill."*

Even though the Governor vetoed this bill on constitutional grounds, the Department complied with the legislative intent expressed in the footnote to increase primary care provider rates. In responding to the footnote, the Department first determined the dollar amount if the 3.25 percent were applied to all physician codes. This amount equaled $6.8 million. The Department then applied this dollar amount to the 25 most frequently billed physician service codes. The remaining $3.1 million was then applied to the fee-for-service dental and durable medical equipment (DME) codes. The DME services that are paid by invoice plus 19 percent were increased to invoice plus 20 percent. This restored these DME rates back to the rates in place before the 2004 budget reductions. Other DME claims and dental service rates were increased by 3.25 percent.

In addition to the rate increases contained in H.B. 06-1385, the General Assembly also increased rates for DME in H.B. 06-1369 (the second supplemental bill for FY 2005-06). The rate increase for DME in H.B. 06-1369 was effective April 1, 2006. The Department was asked to report the rate increase in a footnote report. The Department's report indicates that a 2.25 percent rate increase was provided to all DME billing codes that were not paid by invoice plus 19 percent. The rate increases were effective April 1, 2006.

27 **Department of Health Care Policy and Financing, Medical Services Premiums** -- The calculations for this line item include $11,713,742 total funds for a 3.25 percent rate increase for inpatient hospital services provided to Medicaid clients beginning July 1, 2006. It is the intent of the General Assembly that the Medical Services Board adopt rules that increase each individual hospital's Medicaid reimbursement rate by 3.25 percent for inpatient hospital services provided to Medicaid clients. The Department is also requested to provide a report to the Joint Budget Committee by August 1, 2006, on the status of the rules adopted by the Medical Services Board regarding this rate increase.

Comment: *This footnote was vetoed by the Governor on the basis that it "violates the Colorado Constitution, Article III and possibly Article V, Section 32, because it interferes with the ability of the executive's branch to administer the appropriation and may constitute substantive legislation that cannot be included in the general appropriation bill."*

Even though the Governor vetoed this bill on constitutional grounds, the Department submitted a footnote report on June 8, 2006. In their footnote report, the Department indicated that they added an additional $11.7 million to the hospital rebase rates for FY

2006-07. The added increase resulted in Medicaid rates being set at approximately 92 percent of their corresponding Medicare rate.

In addition to the rate increases that were improved for FY 2006-07, the General Assembly had also approved a 1.0 percent increase to inpatient hospital rates that was effective April 1, 2006 pursuant to H.B. 06-1369. In their June 1, 2006 report in response to Footnote 37a in H.B. 06-1369, the Department informed the Committee that they had implemented the 1.0 percent rate increase.

28 **Department of Health Care Policy and Financing, Medical Services Premiums** -- The calculations for this line item include $4,138,750 for rate increases for home- and community-based waiver services, private duty nursing services, and home health services beginning April 1, 2007. It is the intent of the General Assembly that the Medical Services Board adopt rules to provide the following rate increases:

Provider Class	Rate Increase
Assisted Living Facilities	12.50%
Day Care Services	1.00%
Skilled Nursing	23.60%
Physical Therapy	23.60%
Speech Therapy	23.60%
Occupational Therapy	23.60%
Private Duty Registered Nursing	23.60%
Private Duty Licensed Nursing	23.60%

The Department is requested to report to the Joint Budget Committee by June 1, 2007, the rate plan that has been adopted by the Medical Services Board.

Comment: *This footnote was vetoed by the Governor on the basis that it "violates the Colorado Constitution, Article III and possibly Article V, Section 32, because it interferes with the ability of the executive's branch to administer the appropriation and may constitute substantive legislation that cannot be included in the general appropriation bill."*

The report for this footnote is not due until June 1, 2007 since the rate increase are not anticipated to become effective until after April 1, 2007. This footnote represented the second phase of a multi-year rate increase for community providers. The first year of rate increases occurred on April 1, 2006 pursuant to H.B. 06-1369 (the second round of supplementals approved last year). H.B. 06-1369 contained an increase of $5.1 million to

implement for home and community-based service provider rate increases as shown in the table below:

Provider Class	Rate Increase
Assisted Living Facilities	15.07%
Day Care Services	3.57%
Skilled Nursing	7.2%
Home Health Aides	4.2%
Physical Therapy	36.3%
Speech Therapy	35.9%
Occupational Therapy	29.2%
Private Duty Registered Nursing	3.8%
Private Duty Licensed Nursing	8.0%
Personal Care Homemaker	10.0%
All Other	2.57%

In their June 1, 2006 report to the Committee, the Department confirmed that the above rate increase were indeed implemented by the Department with an effective date of April 1, 2006.

It has come to staff's attention that the rate increases were applied only to the rate codes for individuals working through an agency and were not provided to individuals who are compensated through the Consumer Directed Attendant Support Services programs (CDAS). At that time the JBC voted for the above rate increases, the JBC did not make a distinction between CDAS and individuals employed by Home Health agencies. Staff recommends that the Committee discuss the following questions with the Department at their hearing.

1. Please explain the Department's rationale for applying the above rate increases to only the Home Health agencies rather than to all individuals who perform these services through an approved waiver.

2. What is the Department's cost estimate for extending the Footnote 40a (H.B. 06-1369) rate increases to the Consumer Directed Attendant Support Services waiver services? Could extending these rate increases be made retroactive to July 1, 2006? If not, could the rate increases begin by January 1, 2007 with supplemental funding?

29 **Department of Health Care Policy and Financing, Medical Services Premiums** -- Beginning in January 2006, individuals fully eligible for the Medicare and Medicaid

coverage will receive their drug benefits through the Medicare Modernization Act of 2003, Part D Drug Benefit Program. While this program is anticipated to create prescription drug savings in the state's Medicaid program, these savings will be reduced by the mandatory state contribution to the federal government. The Department is requested to provide the Joint Budget Committee with quarterly reports regarding the calculations for the mandatory State contribution payment to the federal government for the Medicare Modernization Act of 2003. The reports should contain an estimate of how the State contribution payment compares to the savings estimate of transferring the prescription drug benefit from the Medicaid program to the Medicare program.

Comment: The Department has been submitting these quarterly reports as requested by Footnote 29. The most recent quarterly report was submitted on October 30, 2006.

The current FY 2006-07 appropriation assumed a savings impact to the Medical Services Premiums line item of $146.8 million (of this amount, $73.4 million is General Fund). However, there is little savings anticipated from the MMA in FY 2006-07 because of the State Contribution Payment requirement. The FY 2006-07 appropriation assumed a clawback payment amount of $73.4 million (all General Fund).

For the first three months in FY 2006-07, drug expenditures in the fee-for-service program are averaging $13.4 million (pre-rebate). This compares to $23.2 million in the first three months of FY 2005-06 (pre-MMA). This shows approximately a 42.2 percent reduction in prescription drug costs thus far in FY 2006-07 over the same period in FY 2005-06 (this despite higher caseload).

As of December 11, 2006, the Department received four invoices for the MMA State Contribution Payment. The Department has thus far paid $23.3 million or an average of $5.8 million per month. The remaining balance of the appropriation of $50.1 million would allow an average monthly payment of $6.3 million for the remaining 8 months of the fiscal year.

30 **Department of Health Care Policy and Financing, Indigent Care Program, Safety Net Provider Payment** -- The Department is requested to submit a report by February 1, 2007, to the Joint Budget Committee, estimating the disbursement to each hospital from the Safety Net Provider Payment line item for FY 2006-07.

Comment: This report is due in February 2007 and will be discussed during the Figure Setting presentation for the Indigent Care Program, Safety Net Provider Payment line item.

31 **Department of Health Care Policy and Financing, Indigent Care Program, Children's Basic Health Plan Premium Costs** -- This appropriation assumes the following caseload and cost estimates: (1) traditional children's caseload of 38,635 at an average cost of $104.14 per month; (2) expansion of the children's caseload by 3,955 at an average cost of $104.14 per month; (3) traditional adult prenatal member months of 1,428 at an average cost of $905.54 per month; and (4) expansion of the adult prenatal member months by 17,508 at an

average cost of $905.54 per month. Traditional caseload is funded from the Children's Basic Health Plan. Expansion caseload is funded from the Health Care Expansion Fund.

Comment: *This footnote was vetoed by the Governor on the basis that it "violates the Colorado Constitution, Article III and possibly Article V, Section 32, because it interferes with the ability of the executive's branch to administer the appropriation and may constitute substantive legislation that cannot be included in the general appropriation bill." However, the Governor directed the Department to comply with footnote to the extent possible.*

This footnote is included each year in the Long Bill to provide an explanation for the amount of funding included in the Children's Basic Health Plan. The footnote merely describes the caseload assumption and cost assumptions (similar to the line item descriptions in the Medical Services Premiums division). The information in the footnote is the best estimate of caseload and cost that the Joint Budget Committee has at the time the appropriation is set. During supplementals, these caseload and cost assumptions are adjusted as needed.

32 **Department of Health Care Policy and Financing, Indigent Care Program, Children's Basic Health Plan Dental Benefit Costs** -- This appropriation assumes an average cost of $13.30 per month per child. The caseload is estimated at 87 percent of the caseload of the premiums line item to reflect that children are not eligible for services until one month after they enroll in the plan.

Comment: Although the Governor vetoed footnote 31, the Governor did not veto 32. This is despite the fact that footnote was written for the same purposes that footnote 31 was written -- to provide caseload and cost assumptions explaining how the appropriation was calculated. The inform information in this footnote is the best estimate of caseload and cost estimates for the Children's Basic Health Plan dental benefit that the Joint Budget Committee had at the time the appropriation was set. During supplementals, if these caseload and cost assumptions will result in an under appropriation, adjustments will be made to reflect new estimates.

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

Comment: *This footnote was vetoed by the Governor on the basis that it "violates the Colorado Constitution, Article III and possibly Article V, Section 32, because it interferes with the ability of the executive's branch to administer the appropriation and may constitute substantive legislation that cannot be included in the general appropriation bill."*

Even though the Governor vetoed this footnote, the Department complied with the intent of the footnote and submitted a report on the OAP State Medical Program to the JBC on November 1, 2006.

The Old Age Pension State Medical Program provides health and medical care to persons who qualify to receive old age pensions but who are not eligible for Medicaid. Individuals aged 60 and over are eligible for the OAP State Medical Program if they are Colorado residents, uninsured, a U.S. citizen or legal immigrant, and have a monthly income less than $628. The current caseload is anticipated to be 5,542 in FY 2006-07.

Funding for the OAP State Medical Program comes from three main sources: (1) the Colorado Constitution, Article XXIV allows up to $10.0 million annually; (2) the Supplemental Old Age Pension Health and Medical Care Fund, $750,000 appropriated annually; and (3) Cash Fund for Health Related Purposes (Amendment 35 and H.B. 05-1262) which will equal $2.4 million in FY 2006-07.

Because of increasing caseload, expenditure reductions have been necessary during the last several years in order for the program to stay within their appropriation. In fact, the Department estimates that if the OAP rates were set at 100 percent of the Medicaid rate, the expenditures for the program would reach $40.2 million in FY 2007-08 -- which would exceed the Department's requested FY 2007-08 appropriation of $13.1 million by $27.1 million. Therefore, the Department has taken action in reduce the provider rate reimbursements to 40 percent of the Medicaid rate for dental, medical supplies, home health care, emergency transportation, laboratory claims, and physician services. Additionally, outpatient services are set at 40 percent of the Medicaid rate and pharmacists will be paid at 70 percent of the Medicaid reimbursement rate.

Given the struggles of this program to stay within set appropriations and the low reimbursement rates, the Department indicates in their budget review that they are looking at how best to redesign the program. In the interim the Department requests that the unused balance in the Supplemental Old Age Pension Health and Medical Care Fund be appropriated in FY 2007-08 until a new program could be implemented. Staff recommends that the Committee discuss the following questions with the Department at their hearing.

1) Given the growing caseload and costs of the program, would the OAP Medical Program be better as a primary care (physician and practioner services only) and pharmacy benefit program only.

2) When does the Department believe that they will have a recommendation ready on what the redesign of the OAP Medical program should look like.

3) Please discuss how changes that the Department believes could be made to the OAP Medical program without a Constitutional Change or statute change (i.e. could it be

a insurance subsidy only, could it be a pharmacy benefit only, could it be a physician reimbursement program only, etc.).

34 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 complied with this footnote request and submitted the requested report on the S.B. 97-101 Public School Health Services program on November 1, 2006. Following is a brief summary of the information contained in this report.

Services Provided and Number of Children Served: In FY 2005-06, 43,205 Medicaid eligible children received services from the School Health Services program. The services provided to these children included direct services that qualify under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) federal mandate including rehabilitative therapies, Targeted Case Management and Specialized Non-Emergency Transportation services.

Medical Necessity of the Services: In order for a school to receive reimbursement from the Medicaid program, the services provided must meet a medical necessity standard. The determination of medical necessity is made through the referral and authorization process (which can include the child's Individual Plan when developed according to the Department of Education's guidelines). The Department also provides technical assistance and oversight monitoring to ensure schools comply with this standard.

Federal Dollars Distributed to School Districts: In FY 2005-06, 114 school districts received Medicaid reimbursement that totaled over $9.8 million. These federal reimbursements are then used by the school district to provide new and expanded health care services to children as authorized the district's Local Service Plan. Some of the expanded health care services include:

(1) Increasing school nursing services;

(2) Improving and enhancing the quality of school health services; and

(3) Increasing access to health care services for the uninsured and underinsured.

Staff recommends that the Committee discuss the following issues with Department at their hearing:

1) The school districts are allowed to develop their own Local Service Plan to address the health needs of their school children. School districts use the federal reimbursement in a number of ways, including covering some medical costs for children who are uninsured or underinsured. The Department of Education's annual report on the Medicaid Extended School Health Program indicates that in FY 2003-04, 2.37 percent of the federal reimbursement was spent on insurance outreach for the CHP+ and Medicaid programs. Does the Department have any information on many children are enrolled into CHP+ and Medicaid due to efforts of school districts?

2) Does the Department have information on the amount of federal reimbursement funding used by the school districts to pay for direct medical or dental costs for children who are uninsured that is provided by a non-school provider (i.e. private physician, clinic, or dentist)?

3) What is the future of increasing federal reimbursement for additional Medicaid services?

4) Please provide additional information regarding the ability of the school districts to charge for non-emergency transportation. In FY 2003-04, the state changed the rules for non-emergency transportation to ensure that transportation services were only be charged for medically necessary travel. How does travel to and from school translate to medically necessary? In a related area, please provide information on any non-emergency transportation reimbursement to National Jewish Hospital for their private school. How does Medicaid funding for non-emergency transportation relate to a school districts responsibility to transport children to and from school?

5) It is staff's understanding that as of 2005, the Office of Inspector General has finalized audits of this program in eleven different states. Thus far, its audit work has shown that Federal Medicaid funds were claimed for (1) services that were not approved in the state plan; (2) services that were not sufficiently documented to ensure that services prescribed in the students' individualized educational plans (IEP) were delivered; (3) services that were not authorized or were in excess of the quantity authorized in the IEP; (4) transportation services when there was no authorized Medicaid service on the same day; (5) services rendered by health care providers that did not have the qualifications required by Medicaid regulations; (6) services provided free to other students; and (7) students who were absent. OIG's audit work in this area continues. Please describe any input that the Department has received from CMS or the OIG regarding Colorado's school based program. Please describe the oversight activities that the Department performs to ensure that only federally accepted services are billed to Medicaid.

35 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 appropriation 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 appropriations 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 was included last year in the Long Bill at the request of the Department of Health Care Policy and Financing. This footnote provides legislative intent to allow some flexibility in the transfer of funds in the Department of Human Services Medicaid -funded programs in order to reconcile to centralized appropriation transfers made in the Department of Human Services.

FY 2007-08 Joint Budget Committee Staff Budget Briefing
DEPARTMENT OF Health Care Policy and Financing

ISSUE:

Department of Health Care Policy and Financing's Mission, Goals, and Performance Measures

DISCUSSION:

Department Mission

Mission Statement:

> The mission of the Department of Health Care Policy and Financing is to purchase cost-effective health care for qualified low-income Coloradoans

Goals and Performance Measures

The Department's FY 2007-08 strategic plan is a total of 55 pages long (without attachments) and is comprised of six major goals, 20 strategic objectives, and 79 performance measures. The strategic objectives are tied to the achievement of key goals. The Department's then writes performance measures for each strategic objective for each affected administrative division. The strategic plan also includes objectives and performance measures for FY 2006-07 and FY 2005-06 as well as a narrative describing the progress towards or achievement of their past performance measures. In addition, the Department's strategic plan document contains attachments showing data from the Consumer Assessment of Health Plans Study (CAHPS) and the Health Plan Employer Data Information Set (HEDIS) as well as background and statistical information for the Department.

Staff Analysis

Joint Budget Committee staff reviewed the Department's performance measures submitted in the budget. The following checklist was used for staff's assessment of the Department's performance measures:

Department's Strategic Plan and Performance Measure Evaluation Criteria

1. Do the goals and performance measures correspond to the program's directives provided in statute?
2. Are the performance measures meaningful to stakeholders, policymakers, etc.?
3. Does the Department use a variety of performance measures (including input, output, efficiency, quality, outcome)?
4. Do the performance measures cover all key areas of the budget?
5. Are the data collected for the performance measures valid, accurate, and reliable?
6. Are the performance measures linked to the proposed budget base?
7. Is there a change or consequence if the Department's performance targets are not met?

Based on the criteria above, staff's overall assessment of the Department's strategic plan and performance measures is that the plan is an internal management document that is not a useful tool to communicate the Department's performance to policymakers or stakeholders. Following is staff's analysis of the key components of the Department's strategic plan and performance measures.

Assessment of Mission, Goals, and Objective Statements (Criteria #1)

The Department's overall mission and goal statements are consistent with the legislative declarations for the Department's three major programs [the Colorado Medical Assistance Act (Section 26-4-102, C.R.S.), the Children's Basic Health Plan (Section 26-19-102, C.R.S.), and the Indigent Care Program (Section 26-15-102, C.R.S.)]. In addition, the Department has organized their strategic plan so that objectives statements and performance measures are tied back to specific goals.

While it is staff's assessment that the Department's selected goals and objectives are generally consistent with statutory intent, the statements could be strengthened to better communicate the desired result of achieving a goal or objective. For the most part, the Department's goal statements and objectives are vague platitudes that do not indicate a desired result. Following are two examples of the Department's goal and objective statements that illustrate this point.

Example -- Department's Goal A	***Staff's Recommended Improvement*** **(for discussion only)**
The Department will operate its programs to assure that the health care the Department purchases is medically necessary, appropriate, and cost-effective.	Maintain annual per capita cost increases at or below _____ (pick a target -- 6%, Denver Metro health inflation factor, etc.).
Staff Comment: The main focus of this goal seems to be containing costs by ensuring that the medical services purchased are necessary and cost-effective. Staff's assessment is that this goal statement is too broad to get a specific sense of what the Department is trying to accomplish.	*Staff Comment:* In staff's example above, a clear desired result would be indicated. With this type of goal statement, specific strategies could then be implemented in order to accomplish the goal.

Example -- Department's Objective Statement 1.1 (Related to Goal A)
To maximize the opportunity to preserve health care services through the purchase of services in the most cost-effective manner possible.
Staff Comment: Again this objective statement is too broad (and somewhat just restates goal A above) to convey a desired result. Objective or strategy statements that could be used to help achieve staff's example goal above could include: 1) Institute drug utilization review programs to reduce prescription drug costs in order to contain costs and to ensure proper medications are dispensed. 2) Evaluate primary care provider rates to ensure sufficient primary care is available in order to avoid costly emergency room visits.

Example -- Department's Goal C	*Staff's Recommended Improvement* **(for discussion only)**
The Department will partner with public and private entities to maximize the resources to improve the health status of Coloradans.	The Department will partner with public and private entities to ensure 100% of Medicaid eligible clients have access to a primary care provider.
Staff Comment: While the Department's goal A seemed to indicate a desire at cost-containment, Goal C indicates a desire for improving health quality. This goal statement has a little bit of "mission creep". The goal talks about improving the health status of all Coloradans. This is a little beyond the Department's control or mission. The Department can only provide access to health care for Coloradans eligible for the Department's programs.	*Staff Comment:* Staff's example narrows the goal to the population served by the Department. This goal statement also states a desired result that all enrolled clients will have access to a primary care provider.

Example -- Department's Objective Statement 1.4 (Related to Goal C)
To assure delivery of appropriate, high quality care. To design programs that result in improved health status for clients served and to improve health outcomes. To ensure that the Department's programs are responsive to the service needs of enrolled clients in a cost-effective manner.
Staff Comment: This objective statement is really several objectives and restates previous goals or objectives. Staff would recommend a shortened statement as follows: "To provide access to effective health care services for eligible clients by managing and designing appropriate health care programs."

Assessment of Performance Measures (Criteria 2 through 7)

The biggest weakness in the Department's strategic plan is their selected performance measures. The majority of the Department's performance measures are a list of administrative tasks to be completed (reports to be filled out, data to collect, audits to perform, quarterly payments to make). While the Department's performance measures may be helpful as an internal management tool to list tasks the Department will complete in order to work towards their goal and objective statements, the measures do not provide any useful information to stakeholders or policymakers for assessing the results of the Department's programs (i.e. why does the Department exist and why does the State spend the amount of money it does on each program). Most of the Department's performance measures are output measures (number of tasks completed) and do not give a sense of efficiency, quality, or outcomes. In addition, the Department selects different performance measurers for each fiscal year (related on new tasks for that year). While the Department's strategic plan does indicate if the former year's tasks were completed, the performance measures do not provide a historical record of the Department's achievement of its mission. Nor do the performance measures provide benchmarks of where the Department wants to go in the future. Finally, the performance measures that the Department has chosen relate only to administrative functions (e.g. there is not one performance measure that indicates the total number of clients receiving health care services from the Department

-- the number one input or workload measure that drives funding for the Department). It is staff's assessment that the Department has not chosen performance measures that would allow the Committee to assess the outcomes of the Department's programs (i.e. Medicaid, Children's Basic Health Care Plan, etc.). Following is an example of one of the Department's performance measure that helps illustrate staff's point.

Example -- Department's Performance Measure (Related to Goal C Above and Objective 1.4)	**Staff's Example** **(Related to Goal B Above and Objective 1.4)** **For Discussion ONLY**			
The Quality Improvement Section will measure and report the quality of health care services provided to Medicaid through nationally recognized performance measures (HEDIS) and plan an intervention to improve the score of at least one measure.	% of overall Medicaid children with access to a primary care provider	FY 2006 Actual*	FY 2007 Current Year Target*	FY 2008 Future Year Target*
	1) 12-24 Months	21.1%	21.1%	25.0%
	2) 25 Month to 6 yrs	26.6%	26.6%	30.0%
	3) 7 yrs to 11 yrs	33.5%	33.5%	33.0%
Staff comment: This performance measure merely states the Department collects the HEDIS survey data (collect data and do very little with it). While the Department does indicate that they will select one score to try and improve, the plan doesn't indicate what score, why it would be chosen, the target for improve, and funding necessary, if any, to improve the score.	In staff's example, performance measures would allow the managers, stakeholders, and policymakers to consider past year, current year, and future year performance and targets. In addition, performance measures would be somewhat consistent overtime so that multiple years of data could be used in order to judge performance. **Illustration only. Does not represent the Department's request or staff's recommendation.*			

In summary, as stated earlier the Department selects performance measures that are administrative tasks to be completed each year. For the most part, the measures are not "data driven" (i.e. the Department will hold annual Employee Appreciation meetings in a location where all staff can attend; the Budget Division will submit all budget requests on time; the Safety Net Financing Section will solicit feedback by December 31, 2007 from providers regarding the administrative precesses and responsiveness to questions and needs regarding the Comprehensive Primary Grant Program and the Primary Care Fund). While the Department does report back in the next year's strategic plan if the prior year's tasks have been completed, the measures for the next year change as tasks change. Therefore, there is little historical record to judge past performance with present performance or future performance. In addition, there is no attempt to indicate the resources used or needed to achieve a goal or measure. ***If the Committee were to move toward performance-based budgeting, it is staff's assessment that the Department's current strategic planning process would have limited use in a performance-based budgeting environment.***

Questions for Department

Staff recommends that the Committee discuss the following questions with the Department during the FY 2007-08 budget hearing:

1. How do your performance measures influence department activities and budgeting?

2. To what extent do the performance outcomes reflect appropriation levels?

3. To what extent do you believe that appropriation levels in your budget could or should be tied to specific performance measure outcomes?

4. As a department director, how do you judge your department's performance? What key measures and targets do you used?

FY 2007-08 Joint Budget Committee Staff Budget Briefing
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
Colorado's Medicaid Program *Preliminary* Budget Outlook

ISSUE:

The Department's November 2006 budget request currently forecasts a FY 2006-07 General Fund supplemental of $11.7 million in the Medical Services Premiums (MSP) line item over the current FY 2006-07 appropriation. The Department's FY 2007-08 request indicates a General Fund increase of $55.9 million in the Medical Services Premiums line item over the current FY 2006-07 appropriation.

SUMMARY:

- ❑ The final FY 2005-06 Medical Services Premiums line item expenditures were $1.99 billion total funds. A total of $3.4 million (0.17 percent) of the final FY 2005-06 appropriation reverted at the end of the fiscal year. Of this amount, $544,121 was from the General Fund.
- ❑ The Department's budget request shows a ***preliminary*** FY 2006-07 Medical Services Premiums line item supplemental need of $21.8 million total funds (1.0 percent). Of this amount, $11.7 million is from the General Fund (a 1.2 percent increase to General Fund).
- ❑ The Department's FY 2007-08 budget request for Medical Services Premiums line item is $154.2 million total funds higher than the current FY 2006-07 appropriation. Of this amount, $55.9 million is from the General Fund (a 5.6 percent increase).

RECOMMENDATION:

Staff recommends that the Committee discuss the Department's request for the Medical Service Premiums line item at their hearing by asking the questions listed at the end of this issue.

DISCUSSION:

FY 2005-06 Final Appropriation and Actual

The final FY 2005-06 appropriation for the Medical Services Premiums line item (MSP) was $1,999,646,558. The final FY 2005-06 expenditures for the MSP line item was $1,996,264,308. Therefore, a total of $3,382,250 (0.17 percent) of the MSP line item appropriation reverted at the end of the fiscal year. Table 1 shows the final FY 2005-06 appropriations and expenditures by fund source.

Table 1: FY 2005-06 Final Expenditures				
	GF & GFE	CF and CFE	Federal Funds	Total Funds
Original FY 2005-06 Appropriation	$1,042,362,634	$66,142,115	$1,069,716,621	$2,178,221,370
2006 Session Adjustments (all bills)	($65,612,060)	($39,736,709)	($73,226,043)	($178,574,812)
FY 2005-06 Final Appropriation	$976,750,574	$26,405,406	$996,490,578	$1,999,646,558
FY 2005-06 Final Expenditures	$976,206,453	$23,713,210	$996,344,645	$1,996,264,308
Difference (+ reversion/ - overexpenditure)	$544,121	$2,692,196	$145,933	$3,382,250
% Difference from final appropriation	0.06%	10.20%	0.01%	0.17%
% Difference from original appropriation	6.35%	64.15%	6.86%	8.35%

As Table 1 above shows, the original FY 2005-06 General Fund appropriation was 6.35 percent higher than the FY 2005-06 General Fund actual and 8.35 percent higher for total funds. Table 2 shows the supplemental adjustments that were approved during the 2006 Session to correct most of the original over forecast in the Medical Services Premiums line item.

Table 2: FY 2005-06 -- 2006 Session Adjustments to Correct Original Appropriation				
	GF & GFE	CF and CFE	Federal Funds	Total Funds
Original FY 2005-06 Appropriation	**$1,042,362,634**	**$66,142,115**	**$1,069,716,621**	**$2,178,221,370**
H.B. 06-1217 -- Transfer State Contribution Payment for the Medicare Modernization Act from Medical Service Premiums to Other Medical Services	($30,984,982)	$0	$0	($30,984,982)
H.B. 06-1217 -- Move to calendar year rather than fiscal year to certify public expenditures & Denver Health out stationing	$7,592,694	($13,722,753)	($6,130,059)	($12,260,118)
H.B. 06-1369 -- Provider rate increases	$3,120,000	$0	$3,120,000	$6,240,000
H.B. 06-1385 -- Eliminate appropriations for Legislation not implemented as originally assumed	$3,267,844	($25,129,829)	($22,336,124)	($44,198,109)
H.B. 06-1385 -- New forecast of caseload and cost-per-client	($48,607,616)	($884,127)	($47,879,860)	($97,371,603)
Final FY 2005-06 Appropriation	**$976,750,574**	**$26,405,406**	**$996,490,578**	**$1,999,646,558**

Transfer MMA State Contribution Payment from MSP to OMS: Originally staff had recommended that the MMA State Contribution Payment (clawback) be appropriated in the Medical Services Premiums (MSP) division in order to allow the Department maximum flexibility during the first year of administering the Medicare Modernization Act (MMA) program. In their supplemental request in January 2006, the Department requested that the clawback payment be transferred from

MSP to the Other Medical Services (OMS) division. The JBC approved the Department's request and transferred the clawback appropriation from the MSP line item to the OMS division. This issue does not represent a miscalculation of the original appropriation, it was a technical change to the appropriation structure.

Move to a calendar year basis for certifying public expenditures and Denver Health out stationing costs: During the supplemental process last year, at the Department's request, the JBC approved moving from a fiscal year basis to a calendar year basis for the timing of certifying the Medicare Upper Payment Limit (UPL) adjustments at public hospitals. This change was based on audit recommendations from the Centers of Medicare and Medicaid Services (CMS). In addition, the JBC also approved certifying additional funds at Denver Health for the costs related to performing administrative functions for the Medicaid program in order to increase their federal reimbursement for these services. These were issues that arose after the original FY 2005-06 appropriation was approved in March 2005.

Provider rate increases: With the passage of Referendum C, the JBC was able to address provider rate issues during the 2006 Session.

Eliminate appropriations for legislation not implemented as originally assumed: Last year's final supplemental bill eliminated or reduced the appropriation clauses in several bills passed during the 2005 Session based on new implementation schedules for these bills. These bills include the bills discussed in the Footnote 20b report (see pages 53 & 54) and H.B. 05-1262. House Bill 05-1262 was the implementing legislation for Amendment 35. Due to delays in removing the Medicaid asset test, most of the original caseload increases anticipated in H.B. 05-1262 did not occur in FY 2005-06. Therefore, the final supplemental bill for FY 2005-06 adjusted for the implementation time lines for the special bills enacted during the 2005 Session.

New forecast of caseload and cost-per-client: Every year in February and March the Department and staff reforecast the Medical Services Premiums line item for the current year based on year-to-date caseload and expenditure data. Last year, these new forecasts showed that the original forecast (March 2005) had over estimated the caseload and costs for FY 2005-06. Therefore, based on the most current data available, the appropriation was reduced to reflect the new cost estimates. By the time the final forecast is made each year, staff has approximately 7 to 8 months of current year data. Therefore, the final March forecast is only predicting 5 to 4 months out from the final expenditures while the original appropriation is trying to predict the final expenditures from 17 to 16 months in advance.

March 2005	March 2006	March 2007
FY 2004-05 Final Forecast FY 2005-06 Original Forecast	FY 2005-06 Final Forecast FY 2006-07 Original Forecast	FY 2006-07 Final Forecast FY 2007-08 Original Forecast

The main reason that the original FY 2005-06 forecast needed to be reduced downward was because the Department and staff had both over estimated the original caseload growth back in March 2005 (staff had over estimated it more than the Department had). In March 2005, the Colorado Benefits Management System had just recently been implemented. Due to implementation problems, the Department had a court order that temporarily issued a benefit freeze until the implementation issues could be addressed. This benefit freeze distorted caseload reporting. Therefore, caseload growth appeared to be higher than it actually was in March 2005 (to what extent is still an unknown). This led to a modeling error in both the Department's and staff's caseload and cost-estimates. Once the Department and staff had sufficient data to correct the error, caseload was reforecasted from the original estimate of 427,147 clients (traditional Medicaid -- does not include H.B. 05-1262 caseload) to the final estimate of 399,710 clients.

How Accurate Was the Final FY 2005-06 Forecast (March 2006)

The final FY 2005-06 forecast for both caseload and expenditures was the most accurate the final estimate has been over the last five years (and the most accurate it is likely to ever be). Table 3 shows the final estimates (the March forecasts) for caseload for the last five years.

Table 3: Accuracy of Caseload Estimates (Traditional -- Excludes H.B. 05-1262)

Total Medicaid Caseload	FY 2001-02[1]	FY 2002-03[1]	FY 2003-04[1]	FY 2004-05[2]	FY 2005-06
Original Caseload Estimate				375,411	427,147
Final Caseload Estimate			359,784	403,904	399,710
Actual Caseload	295,413	327,395	362,531	402,802	399,705
% Original Different from Actual				7.30%	(6.42)%
% Final Difference from Actual			0.76%	(0.27)%	0.00%

[1]Original Caseload estimates included retroactivity while the actuals have been modified to exclude retroactivity in order to better match caseload with cash accounting. Therefore, original estimates for these years can not be accurately compared to final caseload reported.

[2] This is the year CBMS was implemented. Staff believes that the impact of the benefit flag freeze distorts the actual caseload by showing it to be higher than it actually was.

As Table 3 shows, the final caseload estimate for the last three years has been fairly accurate when compared with the actual average caseload for all of the Medicaid aid categories (forecast error differs for the individual aid categories within the Medicaid population). In fact, in FY 2005-06 the final caseload was only five clients higher than the actual caseload for all aid categories. Nevertheless, the table above shows that there is considerable room for improvement in the original

forecast. However, now that both the Department and staff are use to forecasting without retroactivity and have adjusted for any data problems from the CBMS benefit freeze, staff believes that the future original caseload forecasts will improve. Table 4 shows the difference between the Department's and JBC's caseload forecasts for the last three actual years.

Table 4: Department and JBC Caseload Estimates (Traditional -- Excludes H.B. 05-1262)			
Total Medicaid Caseload	**FY 2003-04[1]**	**FY 2004-05**	**FY 2005-06**
Original JBC Caseload Estimate		375,411	427,147
Final JBC Caseload Estimate	359,784	403,904	399,710
Original Department Caseload Estimate		376,986	424,374
Final Department Caseload Estimate	356,133	405,022	404,261
Actual Caseload	**362,531**	**402,802**	**399,705**
Actual Caseload - Department Final	6,398	(2,220)	(4,556)
Actual Caseload - JBC Final	2,747	(1,102)	(5)

The JBC Final caseload projection tends to be a little more accurate than the Department's final caseload data mainly because the JBC staff usually has about two more months of actual data in the forecast model than does the Department. Please note that the above tables shows the average caseload for all Medicaid aid categories. Individual forecasts for each category vary in accuracy (the more detail to the forecast the more variance in the accuracy).

Although the number of clients served does drive a portion of the Medical Services Premiums budget, it is not the only factor in the overall expenditure forecast. The expenditure forecast also predicts the average anticipated cost-per-client for each Medicaid Aid Category as well as predicts adjustments for what is called bottom of the line financing and the impacts of special legislation. The average cost-per-client is driven by both price of services as well as utilization of services. Unlike the Medicaid mental health program, the Medicaid Medical program is not a managed care program for the most part (i.e. it is not a fully capitated program -- although there are some capitated programs within the Medical Services Premium line item). Therefore, there is added complexity in forecasting the average cost-per-client each year because the State does not have a contracted capitation rate for each aid category. The average cost-per-client is calculated each year based on current expenditure trends for each aid category and then is adjusted by both special legislation and bottom of the line financing. Table 5 on the next page shows the final estimates (the March forecasts) for Medical Service Premiums for the last five years.

Table 5: Accuracy of General Fund and Total Fund Expenditures Medical Services Premiums					
Total Medicaid Medical Expenditures	**FY 2001-02**	**FY 2002-03[2]**	**FY 2003-04[2]**	**FY 2004-05**	**FY 2005-06**
Original Total Fund Estimate	$1,555,222,982	$1,729,799,673	$1,844,485,672	$1,934,644,559	$2,178,221,370
Original General Fund Estimate	$774,901,434	$838,461,881	$864,399,617	$936,641,159	$1,042,362,634
Final Total Fund Estimate[1]	$1,593,208,305	$1,550,350,117	$1,854,919,776	$1,966,958,051	$1,999,646,558
Final General Fund Estimate[1]	$763,790,045	$701,341,861	$846,564,816	$957,699,084	$976,750,574
Actual Total Fund	**$1,585,471,639**	**$1,549,735,300**	**$1,868,658,515**	**$1,920,474,771**	**$1,996,264,308**
Actual General Fund	**$758,706,995**	**$705,572,289**	**$855,002,797**	**$935,078,890**	**$976,206,452**
% Actual GF Different from Original Estimate	(2.09)%	(15.85)%	(1.09)%	(0.17)%	(6.35)%
% Actual GF Different from Final Estimate	(0.67)%	0.60%	1.00%	(2.36)%	(0.06)%

[1] Does not include appropriations to adjust for over-expenditure authority. This represents the final appropriation estimate before the Actual Expenditures were known.

[2] 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 FY 2002-03 & 2003-04 appropriation were 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 2001-02, FY 2002-03, & 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 2002-03 and FY 2003-04 also reflect the move to cash accounting for this line item. Therefore, the change in from the original appropriation to the final appropriation reflected different circumstances within the total state budget, not just the Medicaid forecast.

Table 5 shows that the final estimate of the General Fund has been fairly accurate over the last five years. In FY 2003-04, the main reason for final estimate being 1.0 percent under estimated was the Department settled the Colorado Access HMO lawsuit after the General Assembly adjourned. The Department made the decision to immediately pay the lawsuit in 2004 in order to reduce the amount of the General Fund payment by taking advantage of the temporary increase the State was receiving in the FMAP percentage due to the Federal Job and Growth Tax Relief Reconciliation Act of 2003. If the amount of the Colorado Access lawsuit payment was excluded from the FY 2003-04 actual,

the General Fund would have been over expended in FY 2003-04 by only $1,560,055 (0.17 percent increase from the final estimate). The other instance when the final estimate was quite a bit different from the final appropriation was FY 2004-05 when the implementation of the CBMS implementation was over inflating caseload data. However, the original estimate for FY 2004-05 was very close to the actual expenditures for that year (which was forecasted before CBMS was implemented). The error in forecasting for the original FY 2005-06 estimate was mainly related to building off the FY 2004-05 final appropriated base, transferring the clawback payment from the MSP division to the OMS division, delays in implementing special legislation, and over forecasting the growth of the Medicaid traditional caseload. Once the these problems were addressed, the final expenditure estimate was the closest to the actual expenditures in recent history.

What is the Impact of Under Forecasting or Over Forecasting the Medical Services Premiums

Under Forecasting: When the Medical Services Premiums line item is under forecasted, the result is an overexpenditure in the line item at year end. In order to close the books each fiscal year, state statute (Section 24-75-109) allows certain state departments to over expend their appropriations within certain limits. Because of the entitlement nature of the Medicaid program, the Medicaid line items are provided with ***unlimited*** overexpenditure authority as long as the overexpenditure is consistent with the statutory provisions of the Medicaid program. However, when an overexpenditure occurs, the State Controller is instructed to "*restrict, in an amount equal to said overexpenditure, 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 overexpenditure during the next Legislative Session. ***The statute also provides that over expenditures within the Medicaid program are not counted against the six percent appropriation limit.*** Therefore, there is the potential that the Executive or General Assembly could purposely under forecast the Medicaid Service Premiums line item in order stay within the six percent limit and fund other State priorities since any over expenditure in the Medicaid programs would not be counted against the six percent limit.

Over Forecasting: When the MSP line item is over forecasted, the General Fund appropriation reverts at the end of the fiscal year. In any fiscal year when the 4.0 percent statutory reserve is fully funded, any reversion from General Fund appropriations will increase the excess General Fund reserve. Per current statute, the excess General Fund reserve is transferred two thirds to the Highway Users Tax Fund and one third to the capital construction fund (Section 24-75-218, C.R.S.). Therefore, over forecasting the Medical Services Premiums line item may lead to more funding for roads and capital construction funds. In addition, over forecasting the MSP line item means a missed opportunity to fund other state priorities or other Department issues (Corrections, Higher Education, K-12, etc.).

While different political consequences can occur from either under forecasting or over forecasting the Medical Service Premiums line item, staff does not believe that either the Executive or General Assembly have manipulated any forecasts for such a purpose. In staff's opinion, the forecasts have

always been the Executive's and General Assembly's best estimate of expenditures based on the current data available.

Table 6 shows the Department's and the JBC's original and final General Fund estimates for the Medical Services Premiums line item for the last three years.

Table 6: Comparison of Accuracy of General Fund Expenditures for Medical Services Premiums

Medicaid Medical General Fund Expenditures	FY 2003-04[/2]	FY 2004-05	FY 2005-06
Original Department General Fund Estimate (Original February Request from prior year -- Adjusted by Special Bills)	$859,204,528	$937,874,916	$1,043,679,707
Original General Fund Appropriation (JBC Action & Special Bills)	$864,399,617	$936,641,159	$1,042,362,634
Final Department General Fund Estimate (February request of current year-- Adjusted by Special Bills)	$836,125,926	$973,356,222	$974,551,592
Final General Fund Appropriation (JBC Action & Special Bills)[/1]	$846,564,816	$957,699,084	$976,750,574
Actual General Fund	**$855,002,797**	**$935,078,890**	**$976,206,452**
Actual - Department Final Estimate	$18,876,871	($38,277,332)	$1,654,860
Actual - JBC Final Estimate	$8,437,981	($22,620,194)	($544,122)

/1 Does not include appropriations for over expenditures. This represents the final appropriation before actuals were known in order to represent how accurate the forecast was.

/2 Adjusts the estimates for the actual FMAP change due to the Federal Job and Growth Tax Relief Reconciliation Act of 2003 in order to make a more accurate comparison.

FY 2006-07 Appropriation and Supplemental Estimate

In order to calculate their FY 2007-08 request for the MSP line item, the Department provides a new expenditure estimate for FY 2006-07 in their November budget request. While this estimate of current year expenditures is not a formal supplemental request, it is an early indicator of what the Department's supplemental request may be in February 2007. For FY 2006-07, the Department is currently forecasting that $2.13 billion will be necessary to meet the obligations for the MSP line item. The Department's forecast indicates that the current appropriation of $2.11 under funds the anticipated need by approximately $21.8 million total funds (1.0 percent increase). Of this amount, $11.7 million is General Fund (a 1.2 percent increase).

Because the Department anticipates that the current year appropriation is slightly under funded, the amount of funding requested for FY 2007-08 is $154.2 million total funds (7.3% increase) higher than the current FY 2006-07 appropriation but is only $132.4 million (6.2% increase) higher than the Department's revised estimate for FY 2006-07. Table 7 below summarizes the Department's FY 2006-07 expenditure estimate and FY 2007-08 budget request.

Table 7: FY 2006-07 Estimate & FY 2007-08 Budget Request						
Funds	**Current** *FY 2006-07* Appropriation	Department's **Estimated** *FY 2006-07* Expenditure	**Difference Possible Supplemental Amount**	**Department's** *FY 2007-08* **Budget Request**	*FY 2007-08* Increase Compared to Current FY 2006-07 Appropriation	*FY 2007-08* Increase Compared to Estimated FY 2006-07 Expenditure
GF/GFE	$996,821,857	$1,008,548,589	**$11,726,732**	$1,052,721,290	$55,899,433	$44,172,701
CF	76,512	38,256	**(38,256)**	38,256	(38,256)	0
CFE	55,563,806	53,890,163	**(1,673,643)**	75,455,251	19,891,445	21,565,088
FF	1,058,825,384	1,070,637,022	**11,811,638**	1,137,288,856	78,463,472	66,651,834
Total	$2,111,287,559	$2,133,114,030	**$21,826,471**	$2,265,503,653	$154,216,094	$132,389,623
Percent (Decrease) / Increase			**1.03%**	n/a	7.30%	6.21%

Table 8 shows the reasons for the anticipated increase in Medical Service Premiums for FY 2006-07.

Table 8: Medical Service Premiums FY 2006-07 Estimated Expenditures Detail					
Item	**Total Funds**	**GF / GFE**	**Cash Funds**	**Cash Fund Exempt**	**Federal Funds**
Current FY 2006-07 Appropriation	$2,111,287,559	$996,821,857	$76,512	$55,563,806	$1,058,825,384
Department's Estimated Decreases for FY 2006-07 (Nov 1, 2006 Request)					
New UPL financing estimate	2,357,131	(2,357,131)	(38,256)	2,395,387	2,357,131
Updated caseload and cost-per-client estimates	19,469,340	14,083,863	0	(4,069,030)	9,454,507
Department's New Estimate for FY 2006-07 (Nov 1, 2006)	**$2,133,114,030**	**$1,008,548,589**	**$38,256**	**$53,890,163**	**$1,070,637,022**
(Decrease)/Increase from current FY 2005-06 appropriation	$21,826,471	$11,726,732	($38,256)	($1,673,643)	$11,811,638

New UPL financing estimate: For the last several years, the Department has reimbursed public hospitals, nursing homes, and home health agencies at the Medicare Upper Payment Limit (UPL). The Department then certifies public expenditures at these facilities as the state match for the higher

reimbursement. The higher reimbursement draws down additional federal match that the state uses to offset General Fund expenditures in the MSP line item. Based on current charges and caseload estimates, the Department has revised their estimate on how much General Fund will be offset using the UPL financing mechanism. The Department's request reflects a $16,759,985 General Fund offset from the UPL financing instead of the $14,364,778 General Fund offset anticipated in the current FY 2006-07 appropriation. Based on this new estimate, the General Fund appropriation can be reduced by an additional $2,357,131in FY 2006-07. However, this decrease in General Fund is offset by increases to the General Fund due mainly to higher cost-per-client estimates.

Updated caseload and cost-per-client estimates: This item represents the Department's current FY 2006-07 estimate for medical services for the Medicaid caseload. This calculation is based on an overall caseload forecast decrease of 1,289 clients (-0.30%). However, this decrease in caseload is offset by an overall increase estimate for medical costs and utilization. This forecast will be recalculated when the Department submits their final budget request in February 2007. This item is discussed in greater detail in Issue #2 -- Factors Increasing/Decreasing the Medicaid Medical Budget.

The Department's November request indicates that a possible supplemental of $11.7 million General Fund may be submitted in the February 2007 request. This represents an increase to the current MSP line item General Fund appropriation of approximately 1.2 percent. While the November 1, 2006 request does not represent the Department's final calculations and supplemental request, staff emphasizes this issue so that the Committee is aware of the potential supplemental amount according to the Department's current calculations. If the Department's current estimate is correct, the State would exceed the 6.0 percent appropriation limit (currently, the State is approximately $2.0 to $3.0 million under the 6.0 percent appropriation limit when 1331 supplementals are included).

Thus far, monthly expenditure reports from the Medical Services Premiums line item indicate that expenditures are tracking fairly close to anticipated levels. Table 9 shows the actual monthly expenditures through October 2006.

Table 9:
FY 2006-07 Medical Services Premiums Monthly Expenditures

	July	Aug	Sept	Oct	YTD	YTD Monthly Average
Acute Care Services & Administrative	$117,641,074	$83,528,924	$86,601,270	$116,915,769	$404,687,037	$101,171,759
Community Long-Term Care	18,854,703	16,542,922	16,616,118	19,090,630	71,104,373	17,776,093
Long Term Care & Insurance	53,121,699	48,996,940	50,238,359	57,235,862	209,592,860	52,398,215
Total Services	$189,617,476	$149,068,786	$153,455,747	$193,242,261	$685,384,270	$171,346,068

As table 9 above shows, the average monthly expenditures for medical services during the first four months of FY 2006-07 are $171.3 million. The current FY 2006-07 appropriation would support average monthly expenditures of $174.6 million for medical services (excludes bottom of the line financing). Furthermore, monthly expenditures should be somewhat higher in April through June 2007 because of new rate increases that are scheduled to begin April 2007 pursuant to H.B. 06-1385. Therefore, at this time, the monthly reports *neither validates nor invalidates* the Department's analysis that FY 2006-07 expenditures will be below the current appropriated level. When staff completed a five year projection for the Staff Director in October, based on caseload issues alone, staff estimated that the current appropriation was over funded by $35.7 million. Of this amount, staff estimated a decrease in the General Fund appropriation of $7.6 million. Table 10 below shows the difference between the current appropriation, the Department's initial FY 2006-07 estimate and staff's initial FY 2006-07 estimate.

Table 10: FY 2006-07 Estimate & FY 2007-08 Budget Request

Funds	**Current** *FY 2006-07* Appropriation	Department's **Estimated** *FY 2006-07* Expenditure	**Staff's Initial Est.** *FY 2006-07* **Budget Request**	Staff Difference From Department FY 2006-07	Staff Difference From Current FY 2006-07 Appropriation
GF/GFE	$996,821,857	$1,008,548,589	$989,191,459	($19,357,130)	($7,630,398)
CF	76,512	38,256	76,512	38,256	0
CFE	55,563,806	53,890,163	47,751,147	(6,139,016)	(7,812,659)
FF	1,058,825,384	1,070,637,022	1,038,600,059	(32,036,963)	(20,225,325)
Total	$2,111,287,559	$2,133,114,030	$2,075,619,177	($57,494,853)	($35,668,382)

Please note that both of the Department's and staff's FY 2006-07 estimates are preliminary. These estimates will be refined as more data becomes available. Currently, staff and the Department are $19.4 million apart on their General Fund estimates (with the Department estimating a under appropriation of $11.7 million General Fund and staff estimating an over appropriation of $7.6 million). In January and March 2007, staff will revisit the FY 2006-07 appropriation estimates in greater detail. However, at this point, staff does not believe the Committee needs to be overly concerned about either a looming large negative or positive supplemental appropriation for the Medical Services Premiums line item.

FY 2007-08 Department Budget Request

For FY 2007-08, the Department anticipates that Medical Service Premiums expenditures will increase by $154.2 million total funds over the current FY 2006-07 appropriation. This is an increase of 7.3 percent. Table 11 summarizes the Department's FY 2007-08 request.

Table 11: Medical Service Premiums FY 2007-08 Budget Request					
Item	**Total Funds**	**GF & GFE**	**Cash Funds**	**Cash Fund Exempt**	**Federal Funds**
Current FY 2006-07 Appropriation	**$2,111,287,559**	**$996,821,857**	**$76,512**	**$55,563,806**	**$1,058,825,384**
Department's Estimated Increases for FY 2007-08 (Nov 1, 2006 Request)					
Base caseload growth & cost-per-client (DI #1)	$149,426,166	$53,959,687	($38,256)	$19,753,332	$75,751,403
Provider rate increases (DI #6)	13,704,727	6,755,310	0	138,113	6,811,304
Annualize April 2007 provider rate increases	12,416,250	6,208,125	0	0	6,208,125
Immigration reform (DI #4)	8,805	1,349	0	0	7,456
Annualize prior year legislation changes	1,862,377	(54,005)	0	985,194	931,188
Savings from increased hospital & FQHC audit activity (BRI #1)	(497,147)	(248,573)	0	0	(248,574)
Transfer administrative costs from MSP to EDO division (DI #10)	(22,705,084)	(10,722,460)	0	(985,194)	(10,997,430)
Department's FY2007-08 Budget Request	**$2,265,503,653**	**$1,052,721,290**	**$38,256**	**$75,455,251**	**$1,137,288,856**
Increase above current FY 2006-07 appropriation	**$154,216,094**	**$55,899,433**	**($38,256)**	**$19,891,445**	**$78,463,472**
Percent Increase	**7.30%**	**5.61%**	**-50.00%**	**35.80%**	**7.41%**

Base caseload growth & cost-per-client (DI #1): This amount represents the Department's funding estimates for new caseload and cost-per-client calculations. This item is discussed in greater detail in in Issue #2 -- Factors Increasing/Decreasing the Medicaid Medical Budget.

Provider rate increases (DI #6): The Department's request contains $13.7 million for new provider rate increases in FY 2007-08. The Department is targeting four types of providers in the Medical Services Premiums line item: inpatient hospital; single entry points; specialty providers, and emergency transportation. This item is discussed in greater detail the Provider Rate Increases.

Annualize April 2007 provider rate increases: The Department's request also contains an increase of $12.4 to annualize provider rate increases that were approved in H.B. 06-1385 to begin in April 2007 (one quarter of funding in FY 2006-07). Because the FY 2006-07 appropriation only contains a partial year of funding for these rate increases, the rates increases must be annualized in the FY 2007-08 budget to a full-year impact.

Immigration reform: The Department estimates that the total impact to the Medical Services Premiums line item for immigration reform will by $8,805 total funds. However, other line items in the Department (mainly county administration in the Executive Director's Office) will also have impacts from immigration reform.

Annualize prior year legislation changes: The Department estimates a total fund increase of $1.9 million to annualize prior year legislation. This includes the costs for annualizing S.B. 04-177 (Home and Community Based Services for Children with Autism); H.B. 05-1015 (Outpatient Substance Abuse Treatment), H.B. 05-1262 (Disease Management Programs), H.B. 06-1270 (Public Schools Determine Eligibility for Public Medical Benefits); and S.B. 06-165 (Telemedicine Transmission Costs).

Savings from increased hospital & FQHC audit activity (BRI #1): The Department estimates a savings of $497,147 total funds to the Medical Services Premiums line item from increasing auditing activities for hospitals and Federally Qualified Health Centers.

Transfer administrative costs from MSP to EDO division (DI #10): The Department also requests that $10.7 million total funds be transferred from the MSP division to the EDO division. This would consolidate all administrative costs into the EDO. Currently, the MSP division funding includes costs related to disease management and single entry point contracts. Because the functions of these contracts are primarily administrative in nature rather than providing direct medical care to clients, the Department believes that these functions should be moved from the Medical Services Premiums line item into the EDO division so that the true medical cost per client is not distorted by these administrative costs.

Questions for the Department

Staff recommends that the Committee discuss the following questions and issues with the Department at their hearing.

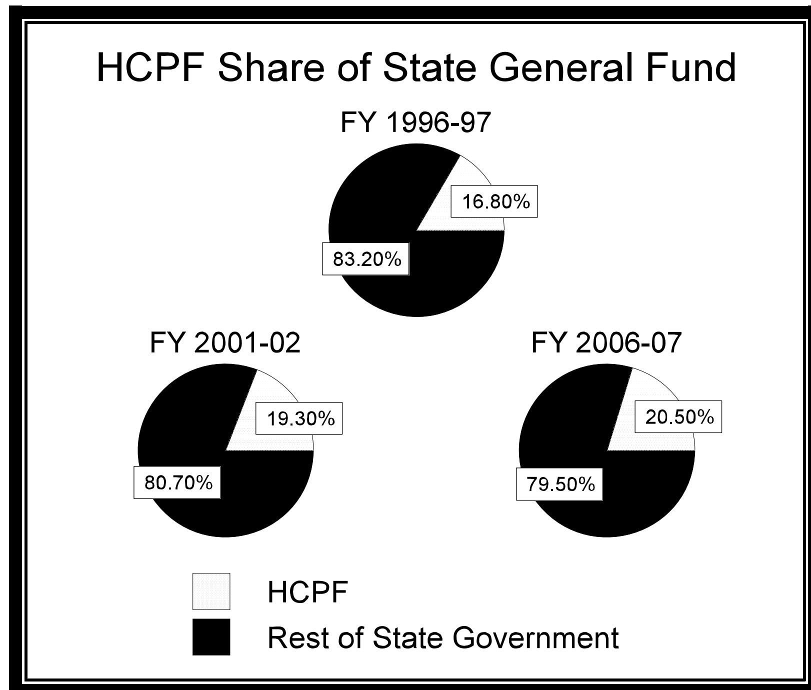
1. Please describe what the Department believes to be the current strengths and weaknesses in the Department's forecasting methodologies for the Medical Services Premiums line item? How does the Department's forecasting methodologies and accuracy compare to forecasting models and accuracy in other states? Does the Department believe that more accurate forecasts could be developed if other methodologies were used? If so, how much funding or resources would be necessary to help develop and test new methodologies for the Medical Services Premiums line item (i.e. would an outside consulting firm or university need to be involved in developing a new methodology -- would anything be gained from such an effort)?

   (Please note: Staff believes that the caseload forecast methodologies are fairly similar to other states in using some method of time series or regression forecasting. However, the Department's current methodology for developing the cost-per-client estimates is probably not as sophisticated as other forecasting methodologies used. The questions above attempt to give

the Department an opportunity to discuss where they believe weaknesses and strengths in the forecasting methodology are and if they believe that forecasting could ***be significantly*** improved to increase accuracy.)

2. If a FY 2006-07 supplemental is needed for the Medical Services Premiums line item, does the Executive have suggestions on how to avoid being over the 6.0 percent appropriations limit?

3. The Department's current FY 2007-08 appropriation indicates a General Fund increase to the Medical Services Premiums line item of $55.9 million. This is 5.61 percent increase over the current FY 2006-07 appropriation. If Decision Item #10 is excluded for the request (since it is a transfer of funds to another division and does not represent a true decrease), the General Fund increase for the Medical Services Premiums line item is $66.6 million or a 6.7 percent increase over the current FY 2006-07 appropriation. Whenever, the Medical Services Premiums line item grows by more than 6.0 percent, this affects the amount of funding that other State programs can grow under the 6.0 percent appropriations limit. Does the Executive have a long-term strategy on how to reduce or maintain the growth in the Medical Services Premiums line item to within 6.0 percent growth?



FY 2007-08 Joint Budget Committee Staff Budget Briefing
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
Factors Increasing and Controlling the Medicaid Medical Budget

ISSUE:

The Department forecasts that the FY 2006-07 final caseload growth rate will be 7.06 percent higher than the FY 2005-06 actual. However, the overall cost-per-client will decrease by 0.34 percent from the FY 2005-06 actual. For FY 2007-08, the Department forecasts a caseload growth rate of 5.65 percent with an overall cost-per-client increase of 0.97 percent.

SUMMARY:

- ❑ Three factors affect growth in the Medical Services Premiums budget: caseload growth, utilization, and cost of services. Prior to FY 2005-06, caseload growth rates for low income adults and children have increased by double digits each year. While growth rates in these categories are expected to slow during the new forecast period, they were anticipated to remain fairly high because of the addition of Amendment 35 expansion caseloads. Thus far, in FY 2006-07 caseload growth for low-income adults and children are below forecast.
- ❑ The Department anticipates that overall cost-per-client in FY 2006-07 will decrease by 0.34 percent from the FY 2005-06 actual. The cost-per-client decrease is attributed mainly caused because the majority of caseload growth is in the lower cost aid categories (i.e. low income children and adult). However, the Department's request for FY 2007-08 shows that the overall per capita cost will increase by 0.97 percent. The Department's FY 2007-08 forecasted overall cost-per-client is only $40.00 higher than the overall cost-per-client was ten years ago in FY 1998-99.

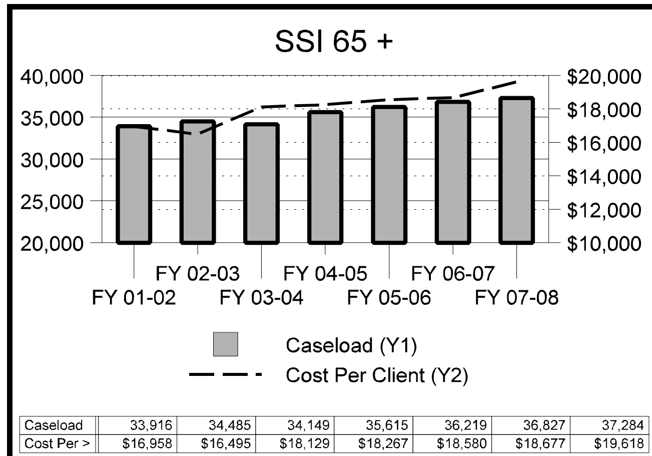
RECOMMENDATION:

Staff recommends that the Committee discuss the Medical Services Premiums line item request at the hearing, including the specific questions raised in the discussion portion of this issue.

DISCUSSION:

General Discussion of Medicaid Caseload and Cost-Per-Client Projections by Aid Category

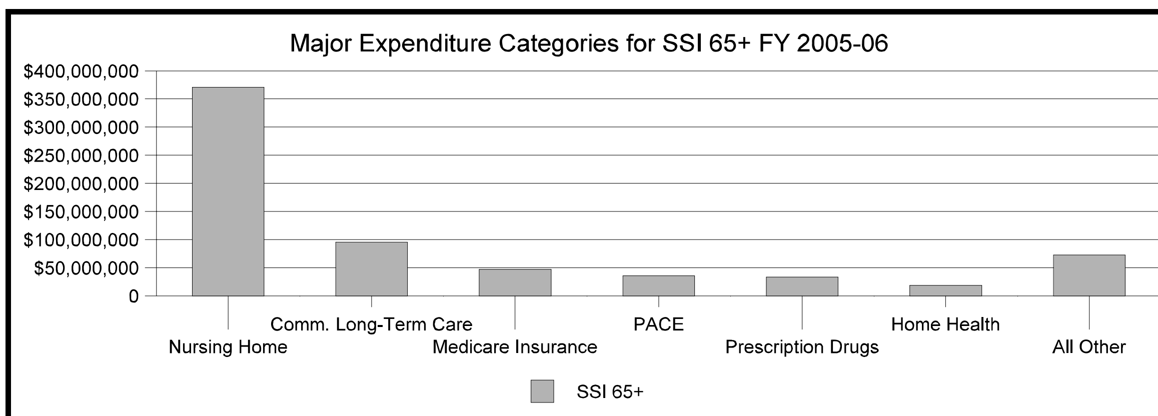
The budget for the Medical Services Premiums line item is calculated by first forecasting the average monthly enrollment and the average cost-per-client for each of the Department's 12 eligibility aid categories. The following charts provide a brief description and history of the caseload and cost-per-client growth for the different aid categories.



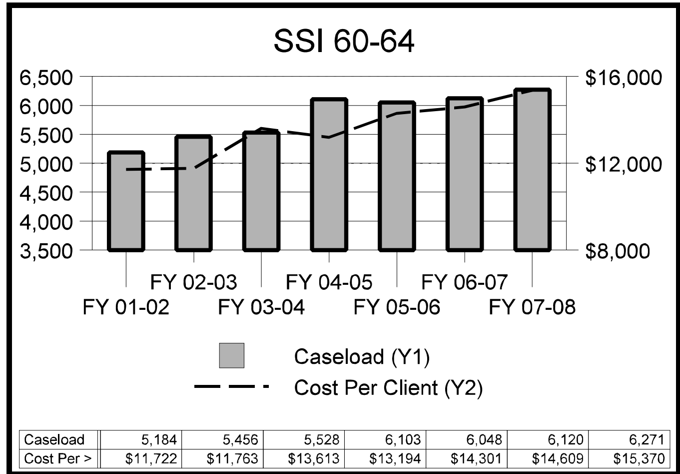
Caseload	33,916	34,485	34,149	35,615	36,219	36,827	37,284
Cost Per >	$16,958	$16,495	$18,129	$18,267	$18,580	$18,677	$19,618

SSI 65+: This aid category includes (1) individuals who are eligible for Supplemental Security Income under Title XVI of the Social Security Act, (2) individuals who do not receive SSI payments but meet other Medicaid resource and income requirements; and (3) individuals with incomes up to 300 percent above the SSI maximum limit who are in need of long-term care services. In FY 2005-06, 71.4 percent of these clients were female and 28.6 percent were male. Approximately 24.8 percent of the this aid category is under 70 years of age, 38.1 percent is between 71 and 80 years of age, 26.1 percent is between 81 and 90 years of age, and 11.0 percent is over 90 years of age. Over a five year period from FY 2001-02 to FY 2005-06, the total caseload growth for this aid category was 2,303 clients, or 6.8 percent. Growth in this category is not impacted as much by economic conditions. However, future growth rates in this category should exceed general population growth rates as the baby boomer generation begins to age.

While caseload growth has been fairly steady, cost-per-client growth has been a little more dramatic. Over the last five year period (FY 2001-02 to FY 2005-06), the total growth in the average cost-per-client is approximately $1,622, or a 9.6 percent increase in cost. The growth in the cost-per-client would have been even greater if several of the cost containment measures enacted during the last several years had not impacted this aid category and if the Medicare Modernization Act of 2003 had not gone into effect on January 2006 (which significantly lowered the prescription drug costs for this population). Because the majority of the clients in this aid category are eligible for Medicare, the primary cost drivers for this population have been institutional long-term care services, community long-term care services, home health, prescription drugs, and Medicare co-insurance and supplemental insurance. This aid category has the second highest average per-client-costs of any of the aid categories.

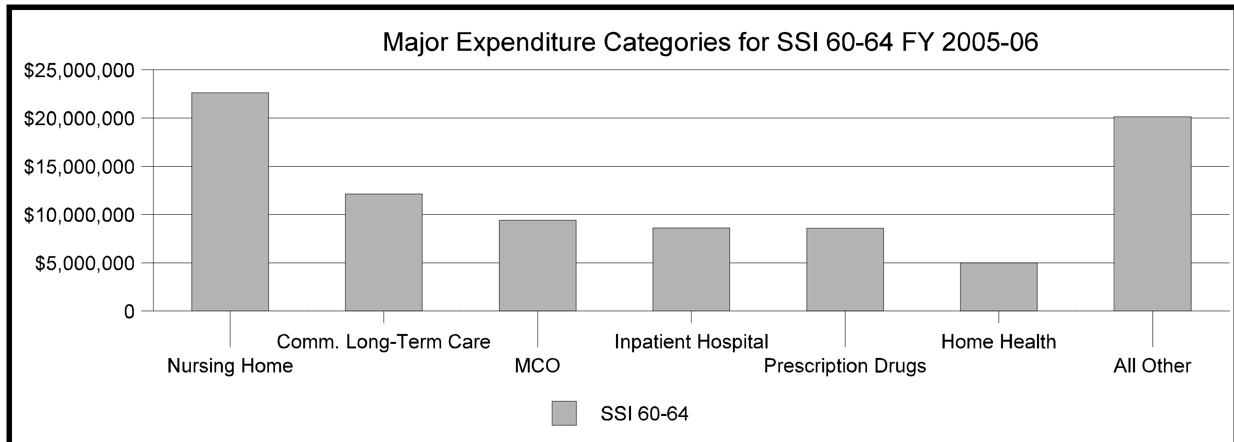


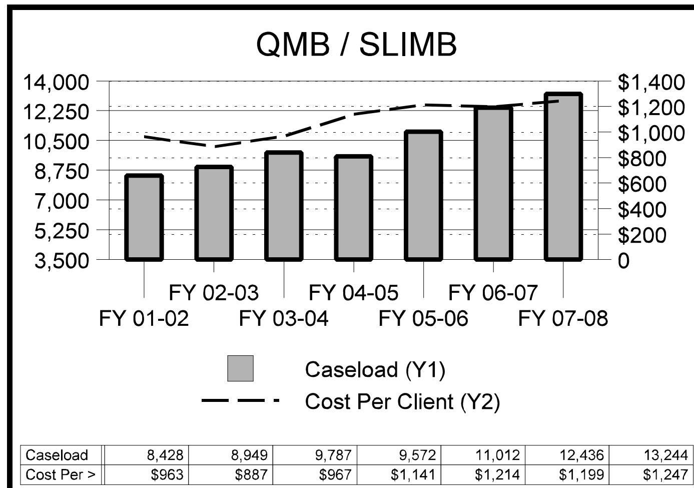
SSI 60-64: This aid category includes individuals who are eligible for SSI between the ages of 60 to 64. The category may also include individuals with incomes up to 300 percent above the SSI maximum limit who are in need of long-term care services. Individuals in this category are 63.9 percent female and 36.1 percent male.



Over the last five years (FY 2001-02 through FY 2005-06), the average monthly caseload has grown by 864 clients (an increase of 1.7 percent). Increases in the caseload for this population are not usually impacted by economic conditions and growth is fairly stable. Staff does anticipates that the caseload growth rate for this aid category will be slightly higher in coming years with the beginning of the baby boomer generation turning 60 years of age this year.

In FY 2005-06, the major expenditure for clients in this aid category was nursing home expenses. Other major expenses included community long-term care services, capitation payments to Manage Care Organizations, inpatient hospital care, prescription drugs, home health, and Medicare insurance. From FY 2001-02 to FY 2005-06, the average cost-per-client for this aid category increased by $2,579 (an increase of 22.0 percent). This aid category has the third highest average cost-per-client costs.





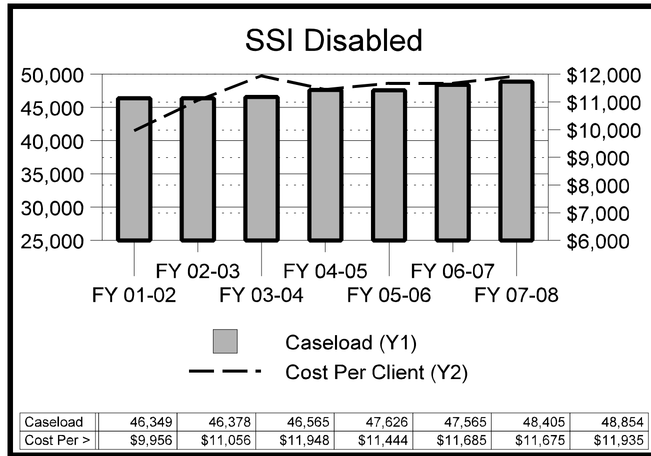
Caseload	8,428	8,949	9,787	9,572	11,012	12,436	13,244
Cost Per >	$963	$887	$967	$1,141	$1,214	$1,199	$1,247

QMB / SLIMB: This aid category includes individuals who are eligible for Medicare but because of their low income and resources qualify for Medicaid to pay some of their Medicare premiums, coinsurance, or deductibles. Qualified Medicare Beneficiaries (QMBs) have incomes at or below 100 percent of the federal poverty level (FPL) and resources twice the standard allowed under the federal SSI program. Special Low Income Medicare Beneficiaries (SLIMBs) have incomes between 100 percent and 120 percent of the FPL. However, the SLIMBS receive only supplementary medical insurance premiums.

Clients in this category are 57.1 percent female and 42.9 percent male. Approximately 22.4 percent of the clients in this aid category are age 50 or younger, 19.0 percent are between ages 51 to 60, 10.2 percent are between ages 61 to 65, and 48.4 percent are older than 65. Caseload growth in this category are somewhat related to economic indicators and may have recently been impacted by the implementation of the Medicare Modernization Act (more clients may have found out they were eligible for Medicaid assistance when they signed up for the low-income drug subsidies). From fiscal year 2001-02 to FY 2005-06, the caseload for this aid population has increased by 2,584 clients (an increase of 35.0 percent).

Qualified Medicare Beneficiaries receive hospital and supplementary medical insurance premium coverage along with Medicare coinsurance and deductible help from the Medicaid program. The Special Low Income Medicare Beneficiaries receive only supplementary medical insurance premium coverage from the Medicaid program. Therefore, 96.4 percent all of the costs for this aid category are for Medicare co-insurance and premium and deductible assistance. The remaining 3.6 percent of the costs include some costs for nursing home stays, durable medical equipment, home health, and some prescription drugs. The Centers for Medicare and Medicaid Services establishes the annual cost increases for premiums and deductibles for the Medicare program. In recent years, there have been large increases to Medicare premiums and deductibles. From FY 2001-02 to FY 2005-06, the average cost-per-client has increased by $254.01 (an increase of 26.4 percent). Because they clients are not eligible for a full-range of Medicaid services, this aid category has the lowest average per-client-costs of any of the aid categories.

SSI Disabled: This aid category includes individuals under age 60 who receive SSI because of a disability. This category includes both adults and children. Individuals in this aid category may also include clients with incomes up to 300 percent of the SSI limit who are in need of long-term care services.

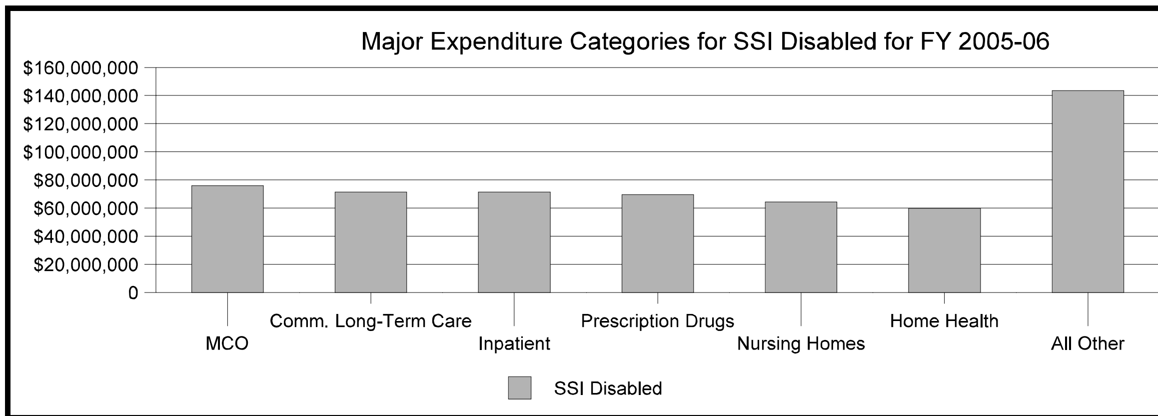


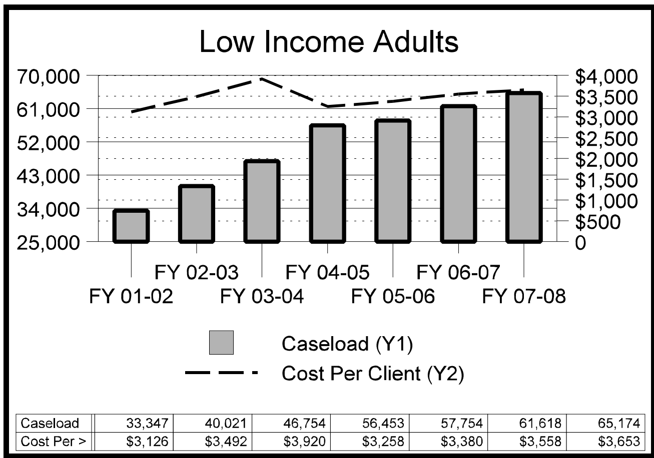
Caseload	46,349	46,378	46,565	47,626	47,565	48,405	48,854
Cost Per >	$9,956	$11,056	$11,948	$11,444	$11,685	$11,675	$11,935

Clients in this category are 51.2 percent female and 48.8 percent male. Approximately 20.0 percent of the clients in this aid category are under age 21, 55.2 percent are between the ages of 21 to 50 years of age, and 24.8 percent are between 51 to 60 years of age. The caseload growth in this aid category is generally steady and is not generally impacted be economic conditions.

From FY 2001-02 to FY 2005-06, the average cost-per-client increased by $1,718.20 (an increase of 17.3 percent). This aid category has the highest expenditures for prescription drugs. In FY 2006-07, the Department is actually forecasting an overall decline in the average cost-per-client for this aid category because of the impact of the MMA (in FY 2006-07 a full year impact of the MMA will occur while in FY 2005-06 there was only a half year impact).

In FY 2005-06, the major expenditure for clients in this aid category was capitation payments to MCOs. Other major expenses included community long-term care services, inpatient hospital care, prescription drugs, nursing home care and home health.

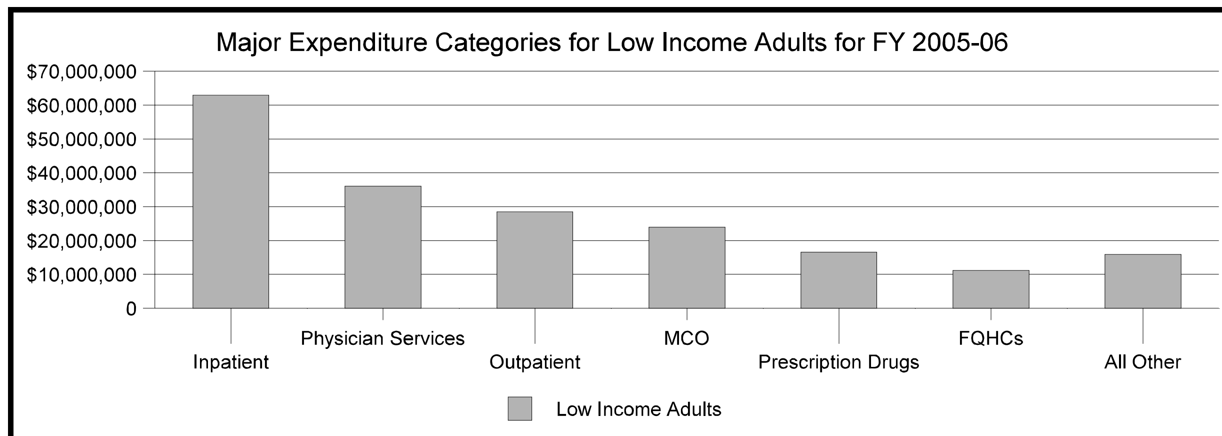




Low Income Adults: This aid category includes (1) individuals who would have been eligible for cash assistance under the former AFDC program, (2) individuals eligible for TANF and Medicaid, and (3) individuals enrolled in the transitional Medicaid program.

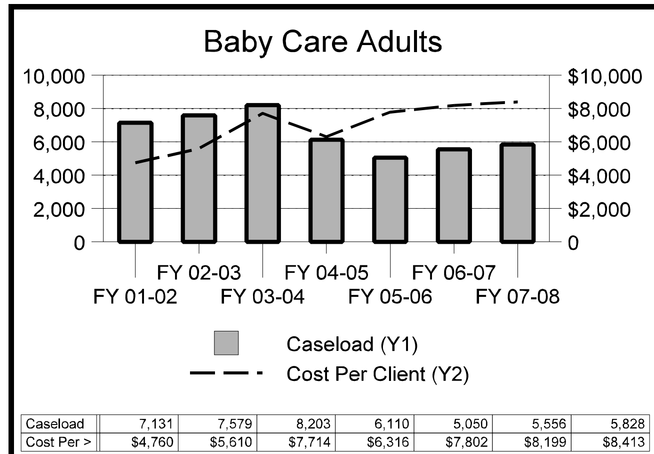
Clients in this aid category 85.4 percent female and 14.6 percent male. Clients are between 19 through 65 years of age. Growth in this aid category is significantly impacted by economic conditions. From FY 2001-02 through FY 2005-06, the average monthly caseload grew by 24,407 clients (an increase of 73.2 percent). However, growth began to moderate in FY 2005-06. The Department is forecasted future growth in this aid category because of the impact of H.B. 05-1262 which eliminated the Medicaid asset test. The Department is forecasting that 2,891 clients (75 percent of the forecasted growth) will be eligible for the Medicaid program as a result of eliminating the asset test. For FY 2007-08, the Department is forecasting that 5,482 clients will be eligible for the Medicaid program as a result of eliminating the asset test. If these clients were not added to the Department's forecast, the Department's forecast in FY 2007-08 would actually be for negative growth in this aid category.

From FY 2001-02 to FY 2005-06, the average cost-per-client increased by $254.77 (an increase 8.2 percent). However, there have been years during this five year period where the average cost-per-client decreased. The highest expenditure in this aid category is for inpatient hospital care followed by physician services, outpatient care, capitation payments to MCOs, prescription drugs, and federal qualifying health centers.



Expansion Adults: This aid category was added in FY 2006-07 pursuant to H.B. 05-1262. This aid category increases eligibility for parents of enrolled children up to 60 percent of the federal poverty level (currently, for non pregnant adults the AFDC standard is approximately 35 percent FPL). The Department forecasts that in FY 2006-07, 3,220 clients will be added because of this change and in FY 2007-08 this caseload will grow to 6,067 clients. Because this aid category does not include pregnant adults, the average per-client-costs are lower than the low-income adult category. The Department estimates the average per capita costs in FY 2006-07 at $2,381.98 and in FY 2007-08 at $2,444.75.

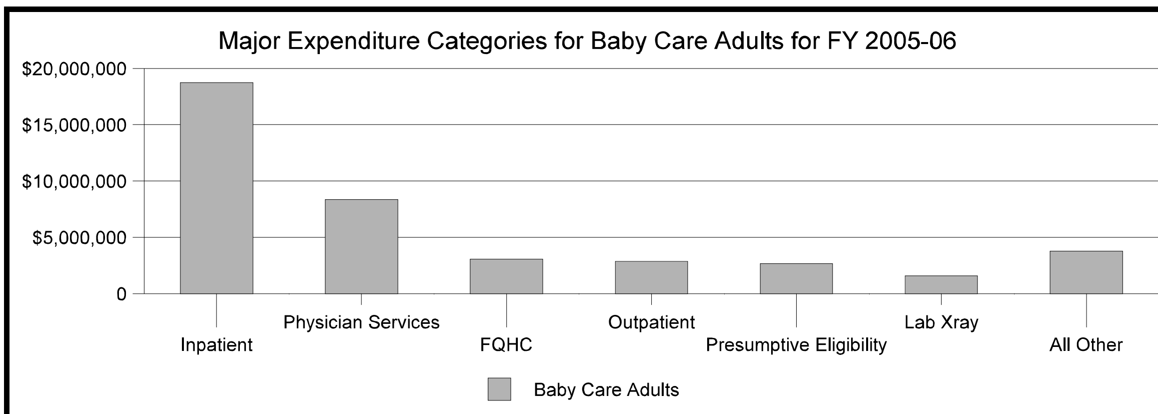
Baby Care Adults: This aid category includes pregnant or post-partum women with incomes below 133 percent FPL who are not eligible for Medicaid through the old AFDC standard or through TANF. This caseload can be age 12 (pregnant children over 100 percent poverty) through age 50 and of course are all female.



Caseload	7,131	7,579	8,203	6,110	5,050	5,556	5,828
Cost Per >	$4,760	$5,610	$7,714	$6,316	$7,802	$8,199	$8,413

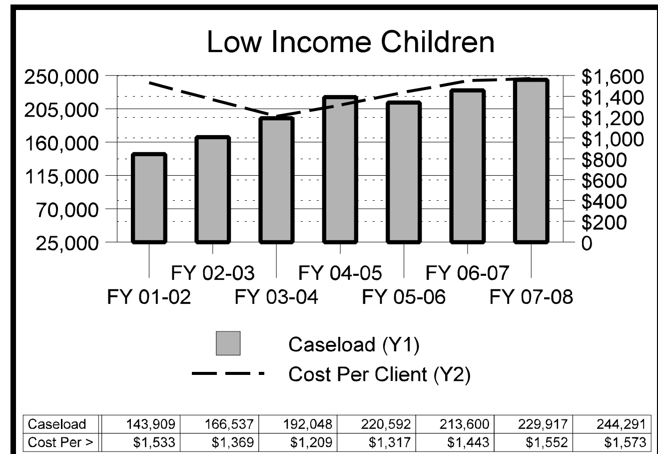
The caseload was increasing sharply during the economic hardship years. However, the caseload in FY 2005-06 was actually 2,081 clients lower than it was in FY 2001-02. Because of the volatility in this caseload category it can be somewhat difficult to forecast.

The general trend for average cost-per-client is upward (FY 2004-05 may have been impacted by CBMS implementation). From FY 2001-02 to FY 2005-06, the average cost-per-client increased by $3,041.07 (an increase of 63.9 percent). In FY 2005-06, the highest expenditure in this aid category is for inpatient hospital care followed by physician services, FQHCs, outpatient care, presumptive eligibility, and lab/x-ray.



Breast and Cervical Adults: This aid category provides Medicaid coverage to women who are under age 65, uninsured, and otherwise not eligible for Medicaid who were found to have breast or cervical cancer through using the Centers for Disease Control's national breast and cervical cancer early detection and prevention guidelines. This program was first enacted during a Special Session in September 2001. From FY 2002-03 through FY 2005-06, the caseload has grown from 43 clients to 188. The average cost per client in FY 2002-03 was $31,060.42 and the average cost-per-client in FY 2005-06 was $36,273.76. Caseload and expenditures for this aid category are expected to grow because of the increase in eligibility due to additional screenings authorized by H.B. 05-1262. This aid category has the highest average cost-per-client of any aid category.

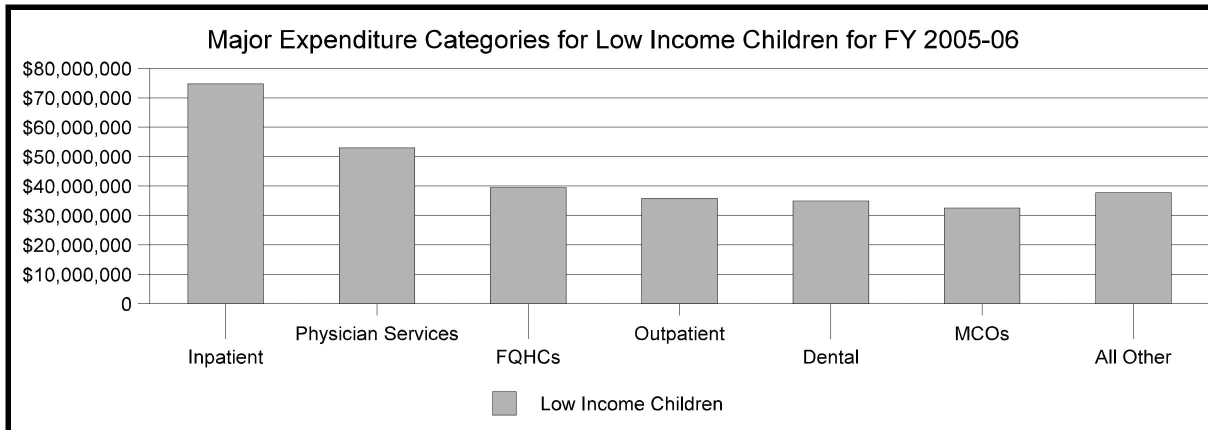
Low Income Children: This aid category includes children who are (1) eligible because they would qualify under the old AFDC standard, (2) children who are ages 6 through 18 who live in families at or below 100 percent of poverty, (3) children between birth and age 6 who live in families at or below 133 percent of poverty, and (4) are on the transitional Medicaid program.

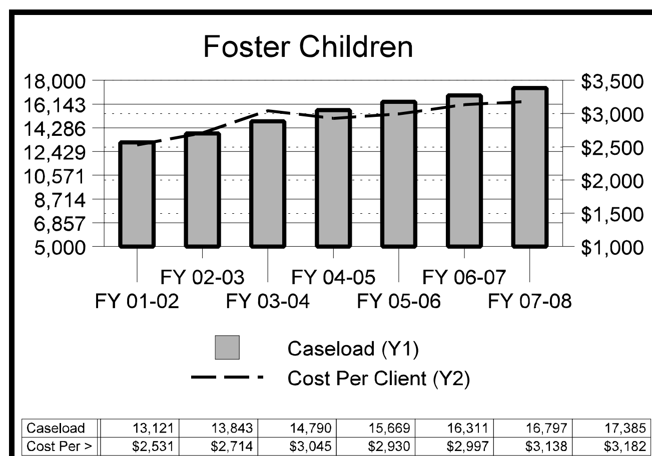


Caseload	143,909	166,537	192,048	220,592	213,600	229,917	244,291
Cost Per >	$1,533	$1,369	$1,209	$1,317	$1,443	$1,552	$1,573

Clients in this aid category are 50.2 percent male and 49.8 percent female. Approximately 21.7 percent of the caseload is under 1 year of age, another 30.1 percent of the caseload is between ages 2 and 5, and 48.2 percent are school aid children between ages 6 through 18. Growth in this aid category is significantly impacted by economic conditions. From FY 2001-02 through FY 2005-06, the average monthly caseload grew by 69,691 clients (an increase of 48.4 percent). However, growth began to moderate in FY 2005-06. The Department is forecasting future growth in this aid category because of the impact of H.B. 05-1262 which eliminated the Medicaid asset test. The Department is forecasting that 12,045 clients will be eligible for the Medicaid program as a result of eliminating the asset test (this represents 73.8 percent of the forecasted growth for this aid category in FY 2006-07). For FY 2007-08, the Department is forecasting that a total of 22,841clients will be eligible for the Medicaid program as a result of eliminating the asset test. If these clients were not added to the Department's forecast, the Department's forecast in FY 2007-08 would actually be for negative growth in this aid category.

The FY 2005-06 average cost-per-client for this aid category was actually lower than it was in FY 2001-02. Because of the large number of new clients added, this aid category has experienced a more favorable client mix. However, now that caseload is beginning to stabilize (with the exception of the new clients from eliminating the asset test), the Department is forecasting that there will be an increase in average cost-per-clients. The highest expenditures in this aid category is for inpatient hospital care followed by physician services, FQHCs, dental care, outpatient services, and capitation payments to MCOs.

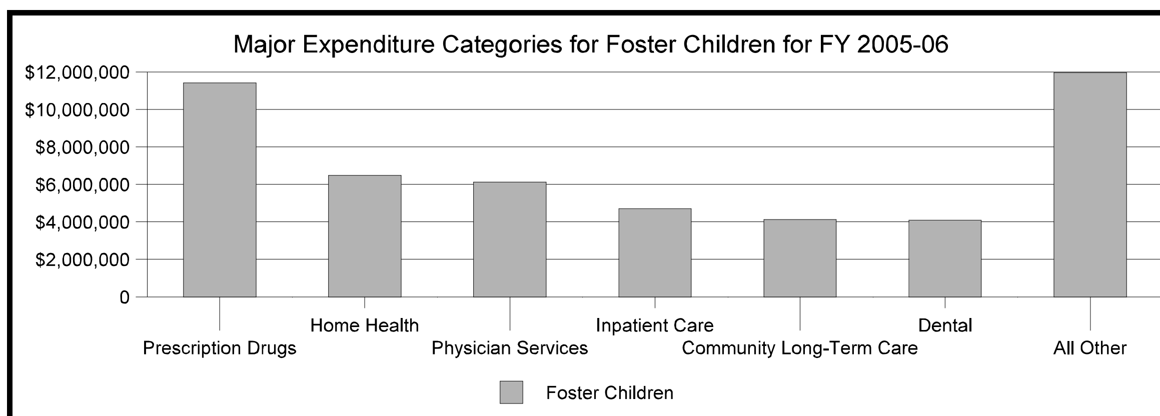




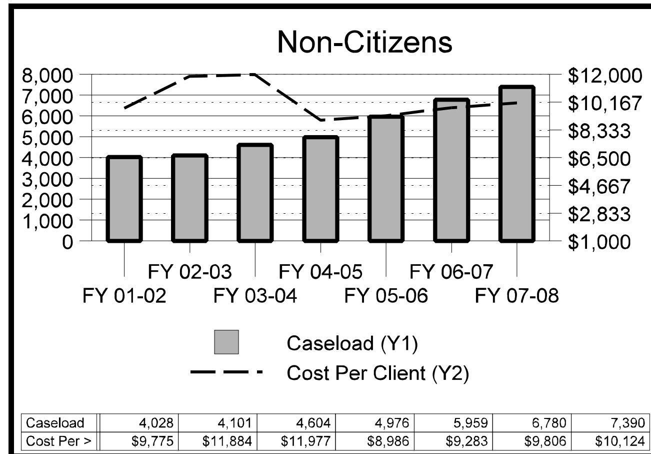
Caseload	13,121	13,843	14,790	15,669	16,311	16,797	17,385
Cost Per >	$2,531	$2,714	$3,045	$2,930	$2,997	$3,138	$3,182

Foster Children: This category includes children in foster care or eligible for adoption assistance between the ages of 0 to 20 years. Clients in this category are 53.9 percent male and 46.1 percent female. From FY 2001-02 through FY 2005-06, the average monthly caseload increased by 3,190 clients (an increase of 24.3 percent).

In FY 2005-06, the average cost-per-client for children in foster care was double the cost of the low-income children. Foster care children typically have special health care needs and therefore, utilize more medical care than the low-income children. From FY 2001-02 to FY 2005-06, the average cost-per-client increased by approximately $466 (an increase of 18.4 percent). In FY 2005-06, the highest expenditure in this aid category was for prescription drugs, followed by home health, physician services, inpatient hospital care, community long-term care, and dental services.



Non-Citizens: This category includes individuals who would be eligible to receive Medicaid if they were U.S. citizens. This includes legal immigrants who are banned from Medicaid coverage during their first five years of residency as well as undocumented immigrants. For the most, the individuals in this caseload are only eligible for emergency type care. In FY 2005-06, 99.0 percent of the clients served in this aid category were female and 1.0 percent were male.

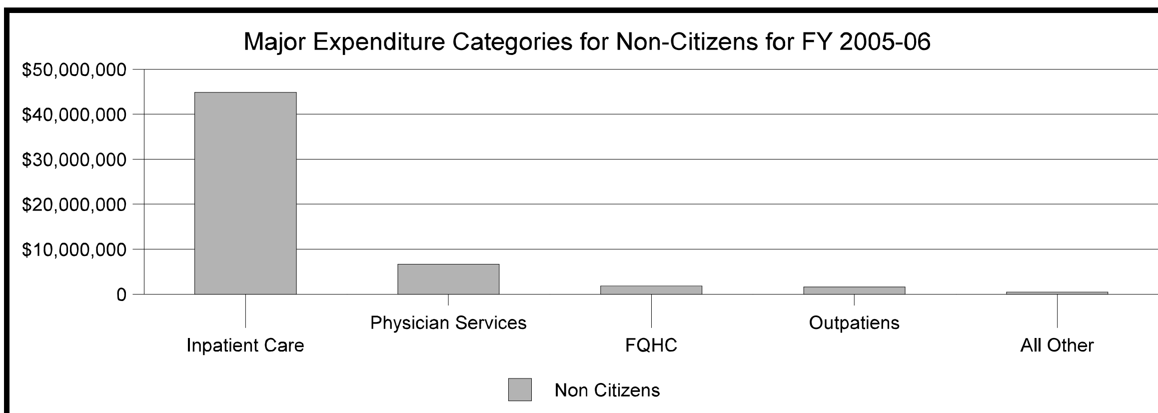


Caseload	4,028	4,101	4,604	4,976	5,959	6,780	7,390
Cost Per >	$9,775	$11,884	$11,977	$8,986	$9,283	$9,806	$10,124

Caseload growth in this aid category has had a positive trend since FY 2001-02. From FY 2001-02 to FY 2005-06, the average monthly caseload has increased by 2,752 clients (an increase of 68.3 percent). The Department continues to forecast healthy growth for this aid category in FY 2006-07 and FY 2007-08 for two reasons: (1) improvement in the economic condition of the state should draw new migration into the state, and (2) clients who can not prove their citizenship or legal immigration status for regular Medicaid may fall into this category.

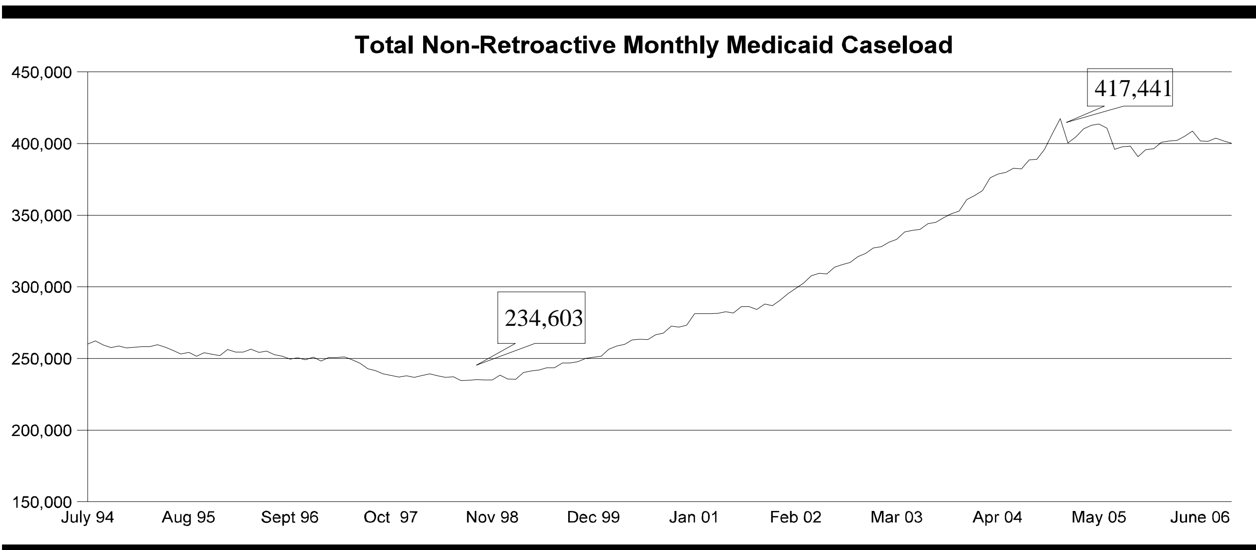
From FY 2001-02 to FY 2005-06, the average cost-per-client in this aid category actually declined by $491.99 (a decrease of 5.0 percent). However, within that five year period there were years that experienced increases as well as decreases in the average cost-per-client. Because the majority of the care provided to this aid category is for emergency care, outlier cases may significant impact the average cost-per-client in any given year. Therefore, predicting the expenditures for this aid category can be challenging.

In FY 2005-06 the majority of the expenditures for this aid category were inpatient care followed by physician services, FQHCs, and outpatient services.



The Department's Specific Caseload Projections for FY 2006-07 & FY 2007-08

The chart below shows the actual non-retroactive monthly Medicaid caseload for all aid categories from July 1994 through October 2006.



As the chart illustrates, the Medicaid caseload was fairly stable from July 1994 through September 1996. However, in 1997 the Medicaid caseload began to decline with the implementation of the national welfare reform act. During the time period shown in the chart, the Medicaid caseload reached its lowest point on July 1998 at 234,603 clients and reached its highest point on December 2004 at 417,441 clients.[1] Since reaching its high point in 2004, the total Medicaid caseload began to show an overall decline and has now stabilized around 400,000 clients. As of October 2006, approximately 1 out of every 11 Colorado residents is enrolled in the Medicaid program.

The final caseload projection for FY 2005-06 was 399,710 average monthly enrollment. The actual FY 2005-06 caseload was 399,705 average monthly enrollment. This was a difference of 5 clients (0.0 percent difference). The final FY 2005-06 caseload growth was actually negative growth of 0.77 percent from the FY 2004-05 actual caseload of 402,802.

FY 2005-06 was the first time in seven years where there was negative growth in the Medicaid caseload. In the three prior fiscal years, there was double digit growth rates in the Medicaid caseload.

[1]The December 2004 caseload number is probably over inflated due to the implementation of the Colorado Benefits Management System. A court order required a benefit freeze while implementation issues were being worked out. Therefore, some of the natural attrition to the caseload did not occur for several months in FY 2004-05. Staff believes that this had the impact of over inflating the caseload.

However, staff will remind the Committee that the final FY 2004-05 caseload probably is over inflated somewhat because of the benefit flag freeze that was implemented during the CBMS start-up. However the extent that the total FY 2004-05 caseload may have been overinflated is unknown.

Both the Department's and staff's initial estimates for FY 2006-07 indicate a decrease to the original caseload forecasts.

The current FY 2006-07 appropriation is based on a total Medicaid caseload forecast of 429,222 clients. In October 2006, staff reforecasted the Medicaid caseload as part of the five-year projections required by the JBC Staff Director.[2] Based on early trends for the fiscal year, staff has revised her total Medicaid caseload forecast downward to 419,128 clients. This forecast is very preliminary and will continue to be refined through March 2007. The Department's preliminary FY 2006-07 budget estimate also revises caseload downward. The Department's current FY 2006-07 estimated forecast is a total Medicaid caseload of 427,933 clients. These forecasts have been revised downward based on the most recent caseload data at the time the forecast was made. Thus far in FY 2006-07, the average monthly caseload for the Medicaid program is 401,834 clients (through October 2006). This represents growth of approximately 0.53 percent over the average monthly enrollment of 399,705 in FY 2005-06. Furthermore, when looking at the data on a monthly basis, the overall trend in the Medicaid caseload seems to be declining slightly. Thus far, growth in the low-income adult and children aid categories from elimination of the asset test and increasing the adult eligibility to 60 percent of the federal poverty level have not occurred at the levels originally forecasted.

For FY 2007-08, the Department is currently forecasting an average monthly Medicaid enrollment of 452,128. This is an increase of 5.65 percent over the Department's current forecast for FY 2006-07. Staff's initial caseload forecast for FY 2007-08 is 437,458 total clients. Staff initial forecast is for an increase of 4.37 percent over staff current FY 2006-07 estimate. As stated earlier, both the Department's and staff's forecasts are preliminary and will continue to be revised through March 2007. Most of the variance in the caseload forecasts are related to the growth rates in the low-income populations and on how fast enrollment for the Amendment 35 expansion populations will occur. Table 1 on the following page shows the the Department's current forecast for the Medicaid caseload. (Detail on staff's forecast are contained in appendix D. Because this briefing is about the Department's request, staff discusses her initial forecast only to give a frame of reference for the Department's request).

[2]Staff's October five-year forecast can be found in Appendix D of this document. This forecast is provided for information purposes only. The forecast will be updated through the figure setting process and is anticipated change.

Table 1: Non-retroactive Medicaid Caseload -- Department's November 2006 Forecast INCLUDES AMENDMENT 35 EXPANSION POPULATIONS						
	FY 2005-06 Actual	**FY 2006-07 Current App. Estimate**	**FY 2006-07 November HCPF Forecast**	**% Change FY 2006-07 Forecast Compared to FY 2005-06 Actual**	**FY 2007-08 November HCPF Forecast**	**%Change FY 2007-08 Forecast Compared to FY 2006-07 Forecast**
SSI 65+	36,219	37,036	36,827	1.68%	37,284	1.24%
SSI 60-64	6,048	6,241	6,120	1.19%	6,271	2.47%
QMB/SLIMB	11,011	12,570	12,436	12.94%	13,244	6.50%
SSI Disabled	47,565	48,447	48,405	1.77%	48,854	0.93%
Low-Income Adults	57,754	63,127	61,618	6.69%	65,174	5.77%
Expansion Low-Income Adults	0	4,850	3,220	n/a	6,067	n/a
Baby-Care Adults	5,050	4,590	5,556	10.02%	5,828	4.90%
Breast & Cervical Cancer Program	188	223	257	36.70%	340	32.30%
Eligible Children	213,600	228,438	229,917	7.64%	244,291	6.25%
Foster Care Children	16,311	17,091	16,797	2.98%	17,385	3.50%
Non-Citizens	5,959	6,309	6,780	13.78%	7,390	9.00%
Total	**399,705**	**428,922**	**427,933**	**7.06%**	**452,128**	**5.65%**

Discussion of Medicaid Caseloads Eligible to Be Funded from the Health Care Expansion Fund

In November 2004, the voters approved Amendment 35 to the Colorado Constitution to increase taxes on tobacco products with the majority of the new funding going to expand health care programs for low-income populations. Amendment 35 provided that 46 percent of the revenues be appropriated annually to (1) increase the number of children and pregnant women enrolled in the Children's Basic Health Plan (CBHP) above the average enrollment for state FY 2003-04; (2) add the parents of enrolled children; and (3) expand eligibility of low income adults and children in the CBHP or Medicaid programs. Amendment 35 also provided that these revenues could not supplant other revenues already appropriated for the CBHP or Medicaid programs (Article X, Section 21 (5) (a) of the Colorado Constitution). During the 2005 Session, the General Assembly passed H.B. 05-1086 and

H.B. 05-1262 to provide the implementing legislation for Amendment 35. Through H.B. 05-1086 and H.B. 05-1262, the Medicaid caseload was expanded in six different ways:

- ✓ House Bill 05-1086 allows Medicaid eligibility for optional legal immigrants. During the budget crisis years, the General Assembly eliminated Medicaid eligibility for optional legal immigrants (S.B. 03-176). However, due to legal challenges the population continued to be funded through December 2004. Because the state had won the legal challenges, the population was scheduled to begin losing Medicaid coverage in January 2005. After Amendment 35 passed, the Joint Budget Committee introduced H.B. 05-1086 as a fast track bill to allow this population to be funded through Amendment 35 revenues. Because optional legal immigrants were currently eligible for Medicaid under state law at the time Amendment 35 was passed, funding legal immigrants from the Health Expansion Fund was allowed under the provisions of Amendment 35.

- ✓ House Bill 05-1262 eliminated the Medicaid asset test. The Medicaid asset test was originally suppose to be eliminated in July 2005. However, due to delays in implementing H.B. 05-1262, the asset test was not eliminated until July 2006. Eliminating the Medicaid asset test was anticipated to increase enrollment in the low-income adult and children categories. Eliminating the Medicaid asset test falls under the provision of Amendment 35 that calls for expanding eligibility for the Medicaid program and therefore is eligible for funding from the Health Expansion Fund.

- ✓ House Bill 05-1262 provided for an increase in the marketing activities for the Children's Basic Health Plan (CBHP). Because a Medicaid screen must be performed on all children who apply for the CBHP program, this provision is also anticipated to increase It is assumed that some of the children who apply for CBHP will be actually be Medicaid eligible. While this provision is anticipated to have an impact on Medicaid enrollment, last year JBC staff recommended that any Medicaid impact from this provision be funded from the General Fund not the Health Care Expansion Fund. This provision increases enrollment of already eligible children but does not increase eligibility criteria for the Medicaid program. Therefore, this activity is not eligible for the Amendment 35 revenues.

- ✓ House Bill 05-1262 provides for an expansion of the Breast and Cervical Cancer Treatment screening program. Additional clients are anticipated to be enter the treatment program because of the additional screening services. This population is funded from the Prevention, Early Detection, and Treatment Fund.

- ✓ House Bill 05-1262 lifts the caps on the Home and Community-Based waiver programs for children. Last year, the Joint Budget Committee voted to continue to increase the number of waiver slots available for these populations. Because this provision is an expansion of the eligibility in the Medicaid program, the expanded number of waiver slots can be funded from the Health Care Expansion Fund.

✓ Beginning in FY 2006-07 (the Department estimates October 2006), H.B. 05-1262 expands Medicaid coverage for the parents of eligible children up to 60 percent of the federal poverty level. These clients will be tracked as a separate aid category for low income adults. Because this is an increase in eligibility criteria for the Medicaid program, this population is funded from the Health Care Expansion Fund.

In addition to the caseload expansions, Amendment 35 revenues will be used for two Medicaid services:

✓ House Bill 05-1262 allows the use of Amendment 35 revenues for prenatal care for pregnant women during their presumptive eligibility period. The presumptive eligibility program was temporary eliminated by the Department in September 2005. Because the presumptive eligibility program increases eligibility (allows coverage while eligibility is being determined), this program is eligible for Amendment 35 revenues and is therefore paid from the Health Care Expansion Fund.

✓ House Bill 05-1262 allows the use of Amendment 35 revenues for disease management programs. This service is paid from the Prevention, Early Detection, and Treatment Fund.

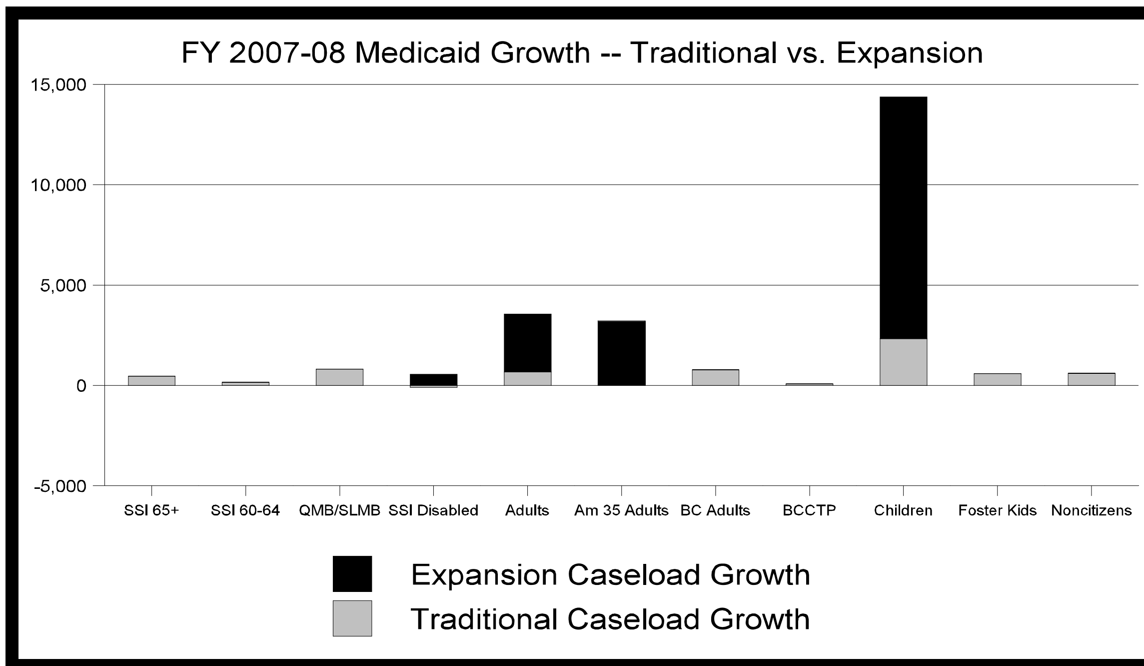
Table 2 breaks-out the Department's current caseload forecasts by the traditional Medicaid caseload and the Amendment 35 expansion populations.

Table 2: Impact of the H.B. 05-1262 Medicaid Populations -- Department November 2006 Forecast (H.B. 05-1086 legal immigrants are still shown in the Traditional Medicaid Population)

	FY 2006-07	FY 2007-08	Difference	% Change
Traditional Medicaid Population*	409,224	416,978	7,754	1.86%
H.B. 05-1262 Medicaid Populations	18,709	35,150	16,441	46.77%
Total Caseload	427,933	452,128	24,195	5.35%

*The Department's request does not break out the legal immigrants from the Traditional Medicaid Forecast. Because the legal immigrants never actually left the Medicaid caseload, they are part of the original caseload modeling.

As Table 2 and the chart on the next page show, the majority of the growth that the Department is anticipated in FY 2007-08 is due to the Medicaid Expansion caseload enrollment. The Traditional Medicaid caseloads is forecasted to grow only by 1.85 percent while the Expansion population is anticipated to grow by 46.77 percent. The Department's overall increase to caseload is forecasted at only 5.35 percent.



Staff Recommends the Committee Discuss the Following Questions or Issues with Department at their Hearing:

Tracking Amendment 35 Caseload and Expenditures: Last year the Department and the JBC agreed on methodologies on how to track the Amendment 35 caseload. How the Department tracks caseload and expenditures for the Amendment 35 populations needs to be defensible with reliable data and methodologies because of the Constitutional requirement that Amendment 35 monies not be used to supplant General Fund spending for populations who were *eligible* for Medicaid before Amendment 35 passed. Thus far (through October 2006), monthly caseload reports have not broken-out the Expansion caseloads from the Traditional caseloads.

1) What is the status of the system changes for being able to identify optional legal immigrants? It is staff's understanding that CBMS has been modified in order to identify legal immigrants in the "Family Medicaid" categories. However, staff understands that the Department has encountered problems with modifying CBMS to identify legal immigrants in the "Adult Medicaid" categories. Please explain the difficulties that have occurred and update the Committee on the current status of the effort to identify optional legal immigrants. Currently the Department's budget request continues to grow both the caseload and expenditure costs for this eligibility group without hard data to back up the growth rates. Would it be a more conservative approach to maintain the original optional legal immigrant cost estimates until final system changes could verify both caseload and costs for this population?

2) Because separate aid categories were not created for adults and children who become Medicaid eligible due to the elimination of the Medicaid asset test, population growth attributable to this

change is not tracked in the monthly reports. Has the Department been able to identify how many new clients have become eligible for Medicaid due to change in the asset test? Has the Department been able to match how many children have left the Children's Basic Health Plan and been enrolled in Medicaid due to the elimination of the Medicaid asset test? Please provide a break-out of the caseload by aid category that have been added thus far in FY 2006-07 due to elimination of the asset test. If the Department is unable to do so, please explain why.

3) The Department's budget request indicates that parents of eligible children in the CBHP and Medicaid became eligible for Medicaid beginning July 1, 2006. Although this population has its own aid category and can be tracked separately from all other Medicaid clients, the monthly reports do not yet show this enrollment (as of the October 2006 report). Please provide the Committee with monthly enrollment for this population as of July 2006 and explain any trends that the Department sees in enrolling this population up to the original appropriation projections.

4) Please describe for the Committee any other ongoing issues with tracking and allocating funds for the Amendment 35 populations. Please discuss with the Committee if the Department will need any additional funding in FY 2006-07 for system changes in order to track the Expansion population. Initially last year the JBC voted to provide the Department with some additional funding for system changes but the funding was left out of the final appropriation bills. Has the Department been able to fund the necessary system changes within existing resources?

5) What impact, if any, does the Department anticipate from the passage of Amendment 42 (raising the minimum wage) on the number of clients eligible for Medicaid. Please discuss specifically the possible impacts to the low-income children and adult categories with special emphasis on how it may change the number of parents eligible at or below 60 percent of FPL. In the Department's opinion, will the passage of Amendment 42 result in more uninsured because of loss of Medicaid eligibility?

	34% FPL	60% FPL	100% FPL	133% FPL
Family of 1	$3,332	$5,880	$9,800	$13,034
Family of 2	$4,488	$7,920	$13,200	$17,556
Family of 3	$5,644	$9,960	$16,600	$22,078
Family of 4	$6,800	$12,000	$20,000	$26,600
Annual Salary for worker earning old minimum wage of $5.51 working 2,080 hours a year				$11,461
Annual Salary for worker earning new minimum wage of $6.85 working 2,080 hours a year				$14,248

The Department's Specific Cost - Per -Client Projections for FY 2006-07 & FY 2007-08

Please Note: The following discussion relates to the Department's Decision Item #1 -- base cost estimates for the Medical Services Premium line item before new policy initiatives. The following discussion does not include the impacts from Decision Item #4, 6, 10, or BRI #1. Therefore, the costs in these tables may not add to other tables showing the Department's total request.

After forecasting the Medicaid enrollment, the next step in developing the ***base*** cost estimates for the Medical Services Premiums 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). The following is a discussion of the Department's forecast for cost-per-client costs broken out by each of the service categories.

Acute Care Services

Approximately 60.0 percent of expenditures for Medicaid medical services are for Acute Care Services in both FY 2006-07 and FY 2007-08.

Acute care costs include costs for inpatient and outpatient hospital care, prescription drugs, MCO and PIHP capitation payments, physician, EPSDT and dental services, and other medical services. Currently, the Department is forecasting a total acute care service need of $1.27 billion in FY 2006-07 and $1.34 billion in FY 2007-08. The total cost for acute care services is impacted by both caseload growth and increases to the cost of services due to utilization and price changes. Table 3 below shows the Department's cost-per-client estimates for acute care services for each aid category.

Table 3: Acute Care Per Capita Costs by Aid Category

Aid Category	FY 2005-06 Actual	Dept. FY 2006-07 Est.	% Change	Dept. FY 2007-08 Est.	% Change from Dept. FY 06-07 Est.
SSI 65	$3,295.33	$2,393.08	-27.4%	$2,408.53	0.6%
SSI 60-64	$7,534.06	$7,103.91	-5.7%	$7,236.06	1.9%
SSI Disabled	$8,306.43	$7,945.38	-4.3%	$7,982.65	0.5%
QMB / SLIMB	$187.80	$184.84	-1.6%	$177.45	-4.0%
Low-Income Adult	$3,363.52	$3,534.95	5.1%	$3,624.80	2.5%
Expansion Adult	$0.00	$2,381.98	n/a	$2,444.75	2.6%
Baby Care Adult	$7,780.87	$8,166.83	5.0%	$8,369.50	2.5%
Breast & Cervical Cancer	$36,270.37	$36,966.33	1.9%	$36,944.13	-0.1%

Table 3: Acute Care Per Capita Costs by Aid Category					
Aid Category	**FY 2005-06 Actual**	**Dept. FY 2006-07 Est.**	**% Change**	**Dept. FY 2007-08 Est.**	**% Change from Dept. FY 06-07 Est.**
Children	$1,426.07	$1,533.87	7.6%	$1,553.38	1.3%
Foster Children	$2,730.34	$2,822.11	3.4%	$2,842.14	0.7%
Non-Citizen	$9,281.40	$9,804.65	5.6%	$10,122.77	3.2%
ALL CLIENTS	**$3,019.45**	**$2,957.01**	**-2.1%**	**$2,971.77**	**0.5%**

Reasons for the Department's forecasted change in per-client-costs for FY 2006-07 include the following:

✓ The Department is forecasting a slight increase to the overall cost trend for the SSI 65+, SSI 60-64, and SSI disabled populations. In addition to the forecast trend, the Department has adjusted the per-capita-cost increases to reflect the impact of rate increases for inpatient hospital, acute care providers, and durable medical equipment that was provided for FY 2006-07 and for any special legislation that passed during the 2006 Session. However, these increases are offset by the negative impact of eliminating prescription drug coverage for dual eligible clients (those eligible for both Medicare and Medicaid) pursuant to the Medicare Modernization Act of 2003. Therefore, the overall trend for these populations in FY 2006-07 is negative when compared to the FY 2005-06 actual costs (which only had 6 months of impact from the MMA).

✓ The negative trend for the QMB / SLIMB is being impacted more by caseload change than by cost or utilization changes. The QMB / SLIMB has two types of clients. The majority of the caseload growth is forecasted in the SLIMB category than in the QMB category. Because these clients qualify only for only supplemental medical insurance premiums, they have lower overall costs. Therefore, because SLIMB's are lower cost clients increases in their caseload drives the overall per-client-cost downward for this category.

✓ For the rest of the aid categories, the Department is forecasting upward trends in the per capita costs. This reflects the Department's forecasting methodology of selecting an overall trend based on historical data and then making adjustments to reflect the recent rate increases that are not reflected in the current historical data.

✓ When the total acute care expenditure estimate for all aid categories is divided by the total Medicaid caseload, the total request for acute care services shows a decline in the overall per-client-cost. This is a function of the adjustments that are discussed above as well as the overall caseload growth being skewed towards the lower cost clients in the low-income adults, expansion adults, and children categories.

For FY 2007-08, the majority of the change in the per-client-costs represents the Department's forecasted trend for each aid category adjusted by annualizing costs for special legislation. The overall acute care trend for all clients is only an increase of 0.5 percent over the Department's FY 2006-07 estimate. Again, the small amount of growth in the per-client-costs is impacted mainly by the favorable case mix of clients with the majority of caseload growth continuing to be in the low-income adult and children categories.

While the average cost-per-client for acute care services shows declining to modest growth during the forecast period, the Department forecasts and overall increase in acute care services of $58.5 million in FY 2006-07 when compared to the FY 2005-06 actual. However, when compared to the ***current*** FY 2006-07 appropriation, the Department's FY 2006-07 forecast is actually a decrease of $13.6 million for acute care services. This is attributable to the Department forecasting both fewer clients and slightly lower overall cost-per-client than what was used to build the assumptions for the current FY 2006-07 appropriation.

For FY 2007-08, the Department is forecasting growth in acute care services of $78.2 million when compared to their current FY 2006-07 forecast. However, when compared to current FY 2006-07 appropriation, the increase is only $64.6 million. Table 4 shows staff analysis of how much of the Department's forecasted growth for acute care services is attributable to caseload growth and how much is impacted by the cost-per-client changes.

Table 4: Analysis of Factors Driving the Acute Care Services Cost Estimates

	FY 2006-07 Current Appropriation*	FY 2006-07 New Estimate Department's Request	FY 2007-08 Department Request	FY 2006-07 New Estimate Compared to Current App.	FY 2007-08 compared to FY 2006-07 Current App.	FY 2007-08 compared to FY 2006-07 Estimate
Total Cost Estimated	$1,279,052,431	$1,265,403,764	$1,343,618,940	($13,648,667)	$64,566,509	$78,215,176
Caseload	429,222	427,933	452,128	(1,289)	22,906	24,195
$/Client*	$2,979.93	$2,957.01	$2,971.77	($22.92)	($8.17)	$14.75
Impact Associated with Caseload Change				($3,841,133)	$68,258,325	$71,544,948
Impact Associated with Cost per Client Changes (includes compounding effect)				($9,807,534)	($3,691,816)	$6,670,228
Subtotal Acute Care Services Cost Increases				($13,648,667)	$64,566,509	$78,215,176

* Based on estimate of acute care costs in original appropriation. The Long Bill and special legislation does not make appropriations by service category.

As Table 4 above shows, the majority of the overall cost increase for acute care services in FY 2007-08 is being driven by caseload increases rather than the average per-client-increase.

Community Long-Term Care Services

Community Long-Term Care Services include waiver services that reduce the need for institutional care for individuals with long-term health and living assistance needs. Waiver services include day care and treatment, alternative care facilities, home modification, homemaking services, respite care, non-medical transportation, and personal care. Besides these waiver services, this category also includes private duty nursing and hospice care services. Currently, the Department is forecasting a total community long-term care service need of $183.6 million in FY 2006-07 and $217.3 million in FY 2007-08.

Approximately 10.3 percent of expenditures for Medicaid medical services are for Community Long-Term Care Services in both FY 2006-07 and FY 2007-08.

Like acute care services, the Department forecasts community long-term care services by trending the per-client-costs for each aid category and then making adjustments for policy initiatives that are not part of the historic trends. Staff believes that forecasting per-client-cost for community long-term care based on the total Medicaid caseload for each aid category distorts the true cost-per-client because not all of the Medicaid caseload utilize these services. Therefore, staff believes that it would be more accurate to calculate the cost-per-client based on the number of clients actually using the services instead of against the whole caseload for the aid category. However, the Department has not in the past, nor do they currently, report caseload in this manner (i.e. they do not break-out long-term care clients from other clients in their caseload numbers). Although this year, the Department has provided the unduplicated client counts for each of their waiver services in their request (these counts can be found in Appendix B of this briefing). Unduplicated client counts can not be used to establish average per-client-costs because this data is not a caseload count.

Because staff believes that the Department's per-client-cost analysis distorts the true costs for the clients that use the services, staff has not prepared a table showing the Department's per capita costs. Rather table 5 below shows the Department's total cost estimate for each aid category where there are estimated costs (i.e. expansion adults, baby care adults, breast and cervical cancer patients, and non-citizens are not forecasted to have costs for these services).

Table 5: Community Long-Term Care Costs by Aid Category

Aid Category	FY 2005-06 Actual	Dept. FY 2006-07 Est.	% Change	Dept. FY 2007-08 Est.	% Change from Dept. FY 06-07 Est.
SSI 65	$95,295,727	$112,796,429	18.4%	$120,360,972	6.7%
SSI 60-64	$12,130,404	$14,191,859	17.0%	$15,200,947	7.1%
SSI Disabled	$71,302,410	$84,499,644	18.5%	$89,938,699	6.4%
QMB / SLIMB	$41,208	$52,322	27.0%	$57,168	9.3%
Low-Income Adult	$150,551	$186,368	23.8%	$207,197	11.2%

Table 5: Community Long-Term Care Costs by Aid Category					
Aid Category	**FY 2005-06 Actual**	**Dept. FY 2006-07 Est.**	**% Change**	**Dept. FY 2007-08 Est.**	**% Change from Dept. FY 06-07 Est.**
Children	$529,206	$658,622	24.5%	$733,902	11.4%
Foster Children	$4,121,260	$4,935,332	19.8%	$5,381,718	9.0%
ALL CLIENTS	**$183,570,766**	**$217,320,576**	**18.4%**	**$231,880,603**	**6.7%**

As table 5 above shows, the Department's FY 2006-07 forecast is an 18.4 percent increase ($33.7 million) for community long-term care services when compared to the FY 2005-06 actual. The majority of the FY 2006-07 increase ($25.0 million) is related to rate increases that were approved in April 1, 2006 and April 1, 2007 for these providers. In addition to the rate increases, the Department forecasts approximately $7.8 million for caseload growth and utilization changes and another $940,000 for the autism waiver (not part of the historical growth trends). For FY 2007-08, the Department forecasts an overall increase of 6.7 percent ($14.6 million) when compared to their FY 2006-07 estimate. Of this amount, $12.4 million is to annualize the April 2007 rate increases. The Department also forecasts an increase of $8.3 million for caseload growth and utilization changes and an increase of $313,000 to annualize the impact of the Autism Waiver. These increases are offset by a decrease of $6.4 million, the estimated savings for the consumer directed care. These changes are summarized in Table 6 below.

Table 6: Analysis of Factors Driving the Community Long-Term Care Cost Estimates						
	FY 2006-07 Current Appropriation*	FY 2006-07 New Estimate Department's Request	FY 2007-08 Department Request	FY 2006-07 New Estimate Compared to Current App.	FY 2007-08 compared to FY 2006-07 Current App.	FY 2007-08 compared to FY 2006-07 Estimate
Prior Year Cost	$183,570,766	$183,570,766	$217,320,576	$0	$33,749,810	$33,749,810
Estimated Change in Caseload & Utilization**	(6,871,242)	7,861,138	8,271,330	14,732,380	15,142,572	410,192
Impact of Rate Increases	24,951,408	24,951,408	12,416,250	0	(12,535,158)	(12,535,158)
Other Impacts	(2,635,457)	937,264	(6,127,553)	3,572,721	(3,492,096)	(7,064,817)
Total Estimated Cost	$199,015,475	$217,320,576	$231,880,603	$18,305,101	$32,865,128	$14,560,027

* Based on estimate of community long-term care costs in original appropriation. The Long Bill and special legislation does not make appropriations by service category.

** When the FY 2006-07 appropriation was made, the growth in community long-term care services for FY 2005-06 was assumed to be only $172.8 million with the April 1, 2006 rate increases included. However, the actual FY 2005-06 expenditures were $183.6 million. For the purposes of Table 6, the caseload and utilization estimate builds off of the last year actual or estimate. Since the last year actual of $183.6 million was unknown at the time the FY 2006-07 was made, the original FY 2006-07 appropriation would now have to assume negative growth of $6.9 million from the prior year in order to stay within the current appropriation.

As Table 6 shows, the Department's FY 2006-07 estimate is $18.3 million (9.2 percent) higher than the estimate that was used to build the current FY 2006-07 estimate. The Department's FY 2007-08 estimate is $32.8 million (16.5 percent) higher than current FY 2006-07 appropriation. However, when compared to their FY 2006-07 estimate, the FY 2007-08 request is only a $14.6 million (6.7 percent) increase.

Institutional Long-Term Care

Approximately 24.9 percent of expenditures for Medicaid medical services are for Institutional Long-Term Care Services in both FY 2006-07 and FY 2007-08.

Institutional Long-Term Care includes the cost estimates for Class I and II nursing care facilities and the Program for All-Inclusive Care for the Elderly (PACE). For Class I nursing care facilities, the Department estimates the cost based on a patient day estimate times a calculated average per diem rate for all facilities. For the Class II nursing facilities and the PACE program, the Department trends forward a per-client-cost and then applies it to the total Medicaid caseload for each applicable aid category (similar to how the Department calculates the acute care services and community long-term care service categories).

Again, staff believes that showing per-client-costs for these service categories that include the entire Medicaid caseload distorts to the true cost-per-client for these services (i.e. not all Medicaid clients in each service category are eligible for long-term care services). Even though the Department has included unduplicated client counts for these services, the cost-per-client can not be determined from this information because what the Department provided is not a caseload equivalent count. The one exception is Class I nursing facilities. For this service category, the Department reports both the unduplicated count and a caseload equivalent count. For example, the number of clients who used nursing home services in FY 2005-06 was 14,287 clients. However, the number of patient days for these clients was 3,555,623 days which translates into a caseload number of 9,741 clients per day. Table 7 below shows the Department's total cost estimate for each aid category for Institutional Long-Term Care Services.

Table 7: Institutional Long-Term Care Costs by Aid Category (includes Class I & II Nursing Facilities & PACE Program)

Caseload Aid Category	FY 2005-06 Actual	Dept. FY 2006-07 Est.	% Change	Dept. FY 2007-08 Est.	% Change from Dept. FY 06-07 Est.
SSI 65	$406,275,321	$429,480,892	5.7%	$456,972,276	6.4%
SSI 60-64	$25,594,107	$28,156,925	10.0%	$31,721,949	12.7%

Table 7: Institutional Long-Term Care Costs by Aid Category (includes Class I & II Nursing Facilities & PACE Program)					
Caseload Aid Category	**FY 2005-06 Actual**	**Dept. FY 2006-07 Est.**	**% Change**	**Dept. FY 2007-08 Est.**	**% Change from Dept. FY 06-07 Est.**
SSI Disabled	$66,248,281	$69,525,008	4.9%	$72,726,724	4.6%
QMB / SLIMB	$318,690	$180,809	-43.3%	$96,330	-46.7%
Low-Income Adult	($10,541)	($96)	-99.1%	$0	-100.0%
Baby Care Adults	$0	$0		$0	
Children	$1,810	$17	-99.1%	$0	-100.0%
ALL CLIENTS	**$498,427,668**	**$527,343,555**	**5.8%**	**$561,517,279**	**6.5%**

As table 7 above shows, the Department's FY 2006-07 forecast is a 5.8 percent increase ($28.9 million) for institutional long-term care services when compared to the FY 2005-06 actual. Of this increase, $21.5 million is for Class I nursing facilities, $7.4 million is for the PACE program, and approximately $37,193 for Class II nursing facilities. For FY 2007-08, the Department forecasts an overall increase of 6.5 percent ($34.2 million) when compared to their FY 2006-07 estimate. Of this increase, $21.7 million is for Class I nursing facilities, $12.4 million is for the PACE program, and approximately $38,155 for Class II nursing facilities. Table 8 on the next page summarizes the Department's request by Long-Term Care service category.

Table 8: Institutional Long-Term Care Costs by Service Category (includes Class I & II Nursing Facilities & PACE Program)						
Service Category	**FY 2005-06 Actual**	**Current FY 2006-07 App.***	**Dept. FY 2006-07 Est.**	**% Change Cur. App.**	**Dept. FY 2007-08 Est.**	**% Change from Dept. FY 06-07 Est.**
Class I Nursing Homes	$456,520,328	$473,120,955	$477,996,274	1.0%	$499,738,898	4.5%
Class II Nursing Homes	$1,436,850	$1,496,474	$1,474,043	-1.5%	$1,512,198	2.6%
PACE Program	$40,470,490	$42,028,258	$47,873,238	13.9%	$60,266,183	25.9%
All Services	**$498,427,668**	**$516,645,687**	**$527,343,555**	**2.1%**	**$561,517,279**	**6.5%**

* Based on estimate of institutional long-term care costs in original appropriation and special legislation. The Long Bill and special legislation does not make appropriations by service category.

Class I Nursing Homes: For FY 2006-07, the Department is only forecasting a 0.02 percent increase in the number of patient days from the FY 2005-06 actual. Therefore, the majority of the Class I Nursing Facilities costs are being driven by the rate adjustments that are required by state statute every year. In FY 2005-06, the average cost per patient day after all adjustments were made was $128.39. For FY 2006-07, the Department is forecasting an average cost per patient day after all adjustments of $134.40. This represents a 4.7 percent increase to the average rates for nursing facilities. The Department's current estimate for Class I Nursing Facilities is only 1.0 percent higher than the original

FY 2006-07 appropriation. Most of this increase can be contributed to adjusting the cost assumptions for S.B. 06-131 and for slightly different patient day and per diem assumptions.

For FY 2007-08, the Department is forecasting a 0.7 percent increase in the number of patient days over their current FY 2006-07 estimate and an average cost per patient day after all adjustments of $139.48. The rate increase is a 3.8 percent increase to costs. The rest of the expenditure increase can be attributed to growth in the number of patient days.

Class II Nursing Facilities: This service category is for specialized private nursing facility care for developmentally disabled clients. Currently, there is one facility (Good Shepherd Lutheran) that provides services to 16 clients. The Department does not forecast major changes to either the rates or the census for this facility in either FY 2006-07 or FY 2007-08.

PACE: Similar to how the Department calculates community long-term care services, the Department develops a trend analysis based on historical data for each aid category using the PACE program. The Department then adjusts the trend for policy changes affecting the category (such as the Medicare Modernization Act). In recent years, growth in PACE enrollment has slowed significantly, indicating that the rapid expenditure growth experienced in prior years will also slow. However, the Department has received applications for additional PACE sites, and the Department staff believe that approximately 80 more clients may enroll. Therefore, the Department has included in their FY 2006-07 and FY 2007-08 estimates an adjustment for possible new clients. However, as of October 2006, staff believes that the current FY 2006-07 appropriation is tracking fairly close to actual expenditures.

Insurance Aid Category

Approximately 3.8 percent of expenditures for Medicaid medical services are for insurance aid category in FY 2006-07 and 4.0 percent in FY 2007-08.

The Insurance Aid Category is made up of the cost estimates for the Supplemental Medicare Insurance Benefit and the Health Insurance Buy-In Program. The Supplement Medicare Insurance Benefit pays the premium costs for Medicare Part A (inpatient hospital care) and Medicare Part B (physician and ambulatory care) for qualified Medicaid clients. This service category does *not* include co-pays or deductibles (these costs are part of the expenditures in the acute care category). The Medicaid program also purchases the premiums for private health insurance for individuals eligible for Medicaid if it is cost effective for the State to cover the individual by a private group health insurance plan.

Table 9 on the next page summarizes the Department's request for the Insurance Service category.

Table 9: Insurance Service Category						
Service Category	FY 2005-06 Actual	Current FY 2006-07 App.*	Dept. FY 2006-07 Est.	% Change Cur. App.	Dept. FY 2007-08 Est.	% Change from Dept. FY 06-07 Est.
Supplemental Medicare Insurance Benefit	$70,775,604	$71,365,272	$80,096,751	12.2%	$90,645,493	13.2%
Health Insurance Buy-In	$524,194	$639,694	$558,766	-12.7%	$590,676	5.7%
All Services	**$71,299,798**	**$72,004,966**	**$80,655,517**	**12.0%**	**$91,236,169**	**13.1%**

* Based on estimate of insurance service category costs in original appropriation. The Long Bill and special legislation does not make appropriations by service category.

Supplemental Medicare Insurance Benefit: Cost increases for this service is driven both by caseload growth and increases in Medicare Insurance Premiums. Currently, for FY 2006-07 the Department is projecting an increase in the per-client costs of 13.1 percent (the increase to Medicare Part B premiums for calendar year 2006). The Department's current FY 2006-07 request is $9.3 million (13.1 percent) higher than the FY 2005-06 actual and $8.7 million higher (12.2 percent) than the current FY 2006-07 appropriation. The Medicare premium rate increase for 2007 announced by the Centers of Medicare and Medicaid Services (CMS) in September 2006 are only 5.6 percent higher than the 2006 rates. This fact may help result in the Department lowering their current FY 2006-07 and FY 2007-08 estimates. However, current expenditure trends for FY 2006-07 are tracking close to the Department's current estimate. For FY 2007-08 the Department continues to forecast another 13.1 percent increase to Medicare premiums rates.

Health Insurance Buy-In: The Health Insurance Buy-In program is a relatively small program within the Medical Services Premiums line item. During FY 2005-06, the costs of this program were impacted by the implementation of the MMA because some health plans were no longer cost-effective once Medicare began paying for a drug benefit. However, the Department believes that expenditures for those program will return to historical growth patterns again in FY 2006-07 and FY 2007-08. While the Department now forecasts that the FY 2006-07 costs will be 12.7 percent lower than the original FY 2006-07 estimate, the Department's FY 2006-07 estimate does represent an increase of 6.5 percent over the FY 2005-06 actual. For FY 2006-07 and FY 2007-08, the Department is anticipated per-client costs will increase by 3.09 percent. The remaining of the cost increases for this program can be attributable to caseload growth and the case mix for this service.

Administrative Services Category

The Medical Services Premium line item also has three services that are administrative in nature: single entry point, disease management, and ASO Administrative Fees. Table 10 on the next page shows the Department's estimates for these services.

Approximately 1.1 percent of expenditures for Medicaid medical services are for insurance aid category in FY 2006-07 and 1.2 percent in FY 2007-08.

Table 10: Administrative Services						
Service Category	FY 2005-06 Actual	Current FY 2006-07 App.*	Dept. FY 2006-07 Est.	% Change Cur. App.	Dept. FY 2007-08 Est.	% Change from Dept. FY 06-07 Est.
Single Entry Points	$16,547,063	$18,855,798	$16,747,227	-11.2%	$17,967,584	7.3%
Disease Management	$322,355	$4,568,554	$2,598,166	-43.1%	$4,949,482	90.5%
ASO Fee Agreements	$5,340,741	$5,533,959	$5,077,407	-8.3%	$5,184,518	2.1%
All Services	**$22,210,159**	**$28,958,311**	**$24,422,800**	**-15.7%**	**$28,101,584**	**15.1%**

* Based on estimate of administrative costs in original appropriation. The Long Bill and special legislation does not make appropriations by service category.

Single Entry Point Agencies: These expenditures are for contracts the Department has with different agencies to provide information, screening assessments and referrals, care plans, case management services, and targeted outreach services to Medicaid clients who qualify for either community or institutional long-term care services. Because of the administrative nature of these contracts, the Department does not forecast these costs by trending per capita costs. Rather, expenditure increases reflect only adjustments for caseload growth and policy changes. Currently, the Department's FY 2006-07 estimate is for only a $200,164 increase (1.2 percent) over the FY 2005-06 actual. However, the Department's estimate is 11.1 percent lower than the assumptions for the current FY 2006-07 appropriation. For FY 2007-08 the Department is projecting an increase of $1.2 million (7.3 percent). Most of this increase is related to the Department's estimate of what the consumer directed care waiver will have on this program.

Disease Management: Beginning in 2002, the Department implemented several disease management pilot programs to address the utilization of services by several high cost clients. The targeted populations included high-risk infants, clients with asthma, clients with diabetes, clients with schizophrenia, breast and cervical cancer patients, and clients with obstructive pulmonary disease. These programs were initially funded through pharmaceutical companies from July 2002 through December 2004. Based on the outcome of the pilots, the Department decided to enter into two permanent contracts for disease management of clients with diabetes and asthma. These are fixed contracts and are anticipated to be $627,778 in both FY 2006-07 and FY 2007-08. The other amount of funding in this service area relates to the disease management funding that is provide in H.B. 05-1262. The H.B. 05-1262 disease management is a transfer of funding from the Department of Public Health and Environment for disease management of heart disease, cancer, and lung disease. The implementation of this program has been delayed until January 2007. Therefore, the Department's estimate for disease management in FY 2006-07 reflects only partial year funding while their FY 2007-08 request shows annualized funding.

ASO Administrative Fees: These costs represents the administrative fees that the Department pays to Rocky Mountain Health Plan for case management and care coordination for clients enrolled in their plan. The adjustments to this line item reflect the Department's current caseload forecast plus the Department's current estimate for the cost avoidance payment (i.e. the current contract requires the

Department estimate savings from the contract and share a portion of the savings back with the contractor).

Service Costs Conclusion

Table 11 summarizes the Department's Medicaid medical service cost estimates by service area for FY 2006-07 and FY 2007-08.

Table 11: Department November Forecast by Service Category						
	FY 2005-06 Actual	FY 2006-07 Cur. App.	FY 2006-07 Estimate	% Change to Cur. App.	FY 2007-08 Estimate	% Change to Dept. Est.
Acute Care Services	$1,206,887,685	$1,279,052,431	$1,265,403,764	-1.07%	$1,343,618,940	6.18%
Community Long-Term Care	$183,570,766	$199,015,475	$217,320,576	9.20%	$231,880,603	6.70%
Institutional Long-Term Care	$498,427,668	$516,645,687	$527,343,555	2.07%	$561,517,279	6.48%
Supplemental Insurance	$71,299,798	$72,004,967	$80,655,517	12.01%	$91,236,169	13.12%
Administrative Fees	$22,210,159	$28,958,311	$24,422,800	-15.66%	$28,101,584	15.06%
TOTAL	$1,982,396,076	$2,095,676,871	$2,115,146,212	0.93%	$2,256,354,575	6.68%
Increase from current FY 2006-07 App.			**$19,469,341**	**0.93%**	**$160,677,704**	**7.67%**
Bottom Line Financing	**$13,868,232**	**$15,610,688**	**$17,967,818**	**15.10%**	**$18,637,777**	**19.39%**
TOTAL BASE with Bottom Line Financing	**$1,996,264,308**	**$2,111,287,559**	**$2,133,114,030**	**1.03%**	**$2,274,992,352**	**7.75%**

*This is the base request for medical services. Does not reflect impact of decision items (other than decision item #1 and technical adjustments). A summary of the total request with all other decision items can be found on page 84 of this briefing packet).

Staff estimates that of the majority of the Department's FY 2006-07 estimate for medical service costs (without bottom of the line financing) is related to higher per-client-costs with an offsetting decrease for a lower caseload estimate. For FY 2007-08, the majority of the Department's medical service cost increase (without bottom of the line financing) is related to caseload growth due to the maturing of the Expansion Medicaid caseload (H.B. 05-1262 changes). Table 12 summarizes staff's analysis of what is driving the base medical service costs increases in the Department's preliminary requests.

Table 12: Analysis of Factors Driving the Medicaid Budget (Medical Service Costs ONLY)						
	FY 2006-07 Current Appropriation	FY 2006-07 New Estimate Department's Request	FY 2007-08 Department Request	FY 2006-07 New Estimate Compared to Current App.	FY 2007-08 compared to FY 2006-07 Current App.	FY 2007-08 compared to FY 2006-07 Estimate
Total Cost Estimated	$2,095,676,871	$2,115,146,212	$2,256,354,575	$19,469,341	$160,677,704	$141,208,363
Caseload	429,222	427,933	452,128	(1,289)	22,906	24,195
$/Client*	$4,882.50	$4,942.70	$4,990.52	$60.20	$108.02	$47.82
Impact Associated with Caseload Change				($6,293,544)	$111,838,569	$119,588,727
Impact Associated with Cost per Client Changes (includes compounding effect)				$25,762,885	$48,839,135	$21,619,636
Subtotal Medical Services Increase				$19,469,341	$160,677,704	$141,208,363

*Detail for the caseload increases, cost-per-client, and compounding calculations can be found in Appendix C of this document. This chart does not include bottom of the line financing.

Questions for the Department

1. Objective 1.1 in the Department's strategic plan is "to maximize the opportunity to preserve health care services through the purchase of services in the most cost-effective manner possible". Please describe for the Committee the Department's current and recent past initiatives to improve the cost-effectiveness of Medicaid medical services.

2. Please describe the difficulties that would be associated with developing caseload numbers (rather than client counts) for individuals eligible for the different long-term care waiver and institutional care counts? Would it be possible for the Department to submit a "long-term care" caseload with their monthly reports? What would be the costs of developing such a report?

3. In FY 2004-05, there was a 6.1 percent decrease in the number of clients served by the Home and Community Based Service Programs (L-112 of the Department's Strategic Plan). However, in FY 2005-06 there was an increase 9.9 percent increase over the FY 2004-05 count. Does the Department have an explanation on why these years had such dramatic changes in client counts numbers (previous year changes were much more stable)?

4. The Department's request indicates that additional PACE sites may be approved during FY 2006-07. Please describe the current status of these applications.

5. Please explain the increase in the disease management program funding for FY 2007-08. House Bill 05-1262 only allows a transfer of funding from the Department of Public Health and Environment for FY 2005-06 and FY 2006-07 only.

FY 2007-08 Joint Budget Committee Staff Budget Briefing
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
Immigration Reform

ISSUE:

The Department's FY 2007-08 budget request includes a total fund increase of $3.0 million and 3.0 FTE in order to implement immigration reform. Of this amount, $979,398 is from the General Fund.

SUMMARY:

- ❑ In February 2006, the President signed the Deficit Reduction Act of 2005 which contained provision requiring all Medicaid clients to verify their identity and citizenship prior to obtaining Medicaid eligibility. Under the provisions of the Deficit Reduction Act, the State is prohibited from receiving federal reimbursement for any non-emergency medical assistance for any Medicaid client who can not prove their citizenship or legal immigrant status.

- ❑ In July 2006, the General Assembly passed H.B. 06S-1023 which require the Department to verify the identity of all applicants for state benefits who are over age 18 and their legal status as citizens or legal immigrants. Affidavits from lawfully present non-citizens must be verified through the federal Systematic Alien Verification of Entitlement (SAVE) program.

- ❑ Both the Deficit Reduction Act of 2005 and HB 06S-1023 require the Department to follow new procedures which have increased administrative costs. However, the Department does not indicate any significant change to the number of clients served because of enforcement of these new laws. Although the amount is not specified, the Department's budget request indicates that the Department will be submitting a FY 2006-07 supplemental request to address the administrative costs that have already and will be incurred in FY 2006-07 to implement these laws.

RECOMMENDATION:

Staff recommends that the Committee ask the Department to discuss at their hearing the common hearing questions regarding the costs of H.B. 06S-1023 that are being asked to all state agencies. Staff also recommends the Committee discuss the additional questions listed at the end of this issue with the Department at their hearing.

Staff also recommends that the Committee ask for a formal opinion from Legal Services staff on exempting the first year Medicaid expenditures for immigration reform from the 6.0 percent appropriation limit.

DISCUSSION:

Background

There are currently three immigration reform laws that impact an individual seeking medical services through HCPF:

✓ ***PRWORA:*** In 1996, Congress passed the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, P.L. 104-193. In this Act, Congress prohibited granting Medicaid eligibility for any non-citizens who can not confirm their lawful presence in the United States and also barred Medicaid coverage for certain legal immigrants until they had been in this country for over five years (although some mandatory legal immigrants, such as refugees, can receive Medicaid coverage before the five year requirement is met). Under PRWORA, only non-citizens are required to confirm their lawful immigration status. In addition, PRWORA requires the Department to verify an individuals legal immigration status through the Systematic Alien Verification of Entitlement (SAVE) program.

✓ ***Deficit Reduction Act of 2005:*** In February 2006, the President signed the Deficit Reduction Act of 2005 which prohibits States from receiving Title XIX federal matching monies for any services (except for emergency services) provided to individuals who have not provided sufficient documentation to verify their citizenship or legal immigrant status. However, the Deficit Reduction Act did exempt certain individuals from this requirement: (1) Dual Eligible clients (eligible for both Medicare and Medicaid), (2) SSI eligible individuals, and (3) another clients specified by the U.S. Secretary of Health and Human Services through rule. The Deficit Reduction Act applies these requirements only to the Medicaid program, the Children's Basic Health Plan (which Title XXI of the Social Security Act) was not impacted. States had to begin enforcing this law on July 1, 2006.

✓ ***H.B. 06S-1023:*** This law provides that all persons 18 years an older must verify their lawful presence in the United States before receiving public benefits. Exception to this requirement include: (1) purposes that do not require lawful presence as a matter of law, ordinance, or rule; (2) emergency health care services not related to organ transplant; (3) short-term, noncash, in-kind emergency disaster relief; (4) public health assistance fo immunizations; (5) crisis counseling and intervention for food and shelter programs; and (5) prenatal care. House Bill 06S-1023 became effective on August 1, 2006.

While H.B. 06S-1023 exempted children from the requirements, the Federal Deficit Reduction Act did not. In addition, while the Federal Deficit Reduction Act did not apply to the Children's Basic Health Plan, H.B. 06S-1023 does for anyone over the age of 18 years. The table on the next page show which medical services populations are impacted by the need to verify their citizenship.

Table 1: Clients Included and Exempted Under Each Law Affecting Proof of Lawful Presence & Identity for Medical Benefits

	PRWORA (Effective Since 8/22/1996)	Deficit Reduction Act of 2005 (Effective Since 7/1/2006)	H.B. 06S - 1023 (Effective Since 8/1/2006)	Notes
Family and Children Medical Programs <u>INCLUDED</u>	--Low-Income Adults --Low-Income Children --Transitional Medicaid --Baby Care Adults --Foster Care & Subsidized Adoption --State Prenatal --Psych 21	--Low Income Adults --Low-Income Children --Transitional Medicaid --Baby Care Adults --Non IV-E Foster Care --State Prenatal --Psych 21	--Low Income Adults --Transitional Medicaid Adults --Baby Care Adults --Foster Care IV-E (over 18) --State Prenatal --Psych 21 --CBHP (over 18) --CBHP (Prenatal)	***PRWORA required non-citizens in these aid categories to prove their legal status. PRWORA did not apply to citizens. The Deficit Reduction Act applies to all Medicaid recipients unless exempted and did not apply to CBHP. H.B. 06S -1023 applies to all public assistance programs unless specifically exempted. H.B. 06S-1023 does not include individuals under 18.***
Family and Children Medical Programs <u>EXCLUDED</u>	--Emergency Medical Services	--All Medicare Clients --Foster Care/Title IV E --Subsidized Adoption --Refugee --State Prenatal --Presumptive Eligibility --Needy Newborn --CBHP --CBHP Prenatal	--All Medicare Clients --Children Under 18 --Foster Care IV E (under 18) --Subsidized Adoption --Refugee --State Prenatal --Presumptive Eligibility --Needy Newborn --CHP + (under 18) --Emergency services (showing medical exemptions only -- not all exemptions listed)	***H.B. 06S-1023 provides an exemption from its provisions for "any purpose for which lawful presence in the United States is not required by law, ordinance, or rule". Because the DRA of 2005 and the rules adopted by CMS exempt certain aid categories, these aid categories are also exempted under H.B. 06S-1023. In addition, H.B. 06S-1023 specifically exempts children from its provisions. However, because the federal law does not exempt children, children are still impacted by the citizenship & identity requirements.***
Adult Medical Programs <u>INCLUDED</u>	--Any applicant who is not a citizen	--Adults and children not in the family Medicaid programs who are not eligible for Medicare or SSI benefits. --Breast and Cervical Cancer patients	--Adults and children not in the family Medicaid programs who are not eligible for Medicare or SSI benefits. --Breast and Cervical Cancer patients --Old Age State Medical	***Again, the PRWORA affected any non-citizens and the DRA of 2005 affects all Medicaid applicants except for those specifically exempted. H.B. 06S-1023 affects all public programs unless specifically exempted.***
Adult Medical Programs EXCLUDED	Emergency Medical Services Only	--All Medicare eligible clients --Refugee --Clients eligible for Medicaid due to SSI determination	--All Medicare eligible clients --Refugee --Clients eligible for Medicaid due to SSI determination --Emergency Services	***H.B. 06S-1023 excludes any clients that would be excluded under federal law.***

Current Compliance with These Laws:

The Department began complying with these acts upon their effective dates in FY 2006-07 by revising and passing emergency Medical Services Board rules; issuing new policies and procedures to staff, counties, and medical assistance sites; and making information about the new requirements accessible to interested parties. Currently, the Department is absorbing some of the costs for these new requirements within their existing appropriations. However, the Department's budget request indicates that the Department will be submitting a FY 2006-07 supplemental related to system changes to the Colorado Benefits Management System (CBMS) and Medicaid Management Information System (MMIS), to hire 3.0 additional FTE to manage new workload requirements from these Acts, and for additional assistance for the administrative costs of the counties in implementing these laws. For FY 2007-08, the Department estimates that the total costs for implementing these acts will be $3.0 million total funds. Table 2 below shows the Department's estimated costs for FY 2007-08.

Table 2: FY 2007-08 Immigration Reform Estimated Costs by Line Item
(Department's Decision Item #4 -- Does Not Reflect Costs in Decision Item #1)

	Total Funds	General Fund	Cash Funds Exempt	Federal Funds
Personal Services (3.0 FTE)	$149,543	$74,772	$0	$74,771
Operating Expenses	2,610	1,305	0	1,305
County Administration	2,849,689	895,039	569,938	1,384,712
Medical Services Premiums	8,805	1,349	0	7,456
CBHP Trust Fund	6,933	6,933	0	0
CBHP Administration	14,383	0	6,933	7,450
TOTAL COSTS	**$3,031,963**	**$979,398**	**$576,871**	**$1,475,694**

Personal Services: Department estimates that they will need 3.0 FTE positions in order to comply with the law changes. According to their budget request, the Department plans to hire these FTE by January 2007 (currently, the Department is using existing staff resources). If a supplemental is approved for FY 2006-07, staff anticipates that the personal services amount in Table 1 will be reduced to reflect annualizing the supplemental amount rather than providing the full cost amount. Staff anticipates a budget amendment to be submitted with January 2007 supplementals to reflect this change.

Specifically, the Department is requesting 1.0 FTE in their Eligibility Operations Section to help coordinate changes to the Colorado Benefits Management System and to provide technical and monitoring support to the counties and medical sites and clients. The Department also requests 1.0

FTE in their Audit Section to audit samples of case files to insure that the correct documentation is being collected and to ensure corrective action is taken when necessary. Lastly, the Department requests 1.0 FTE in their Information Technology Support Section to serve as a Security Administrator to oversee the large volume of additional SAVE system user that are needed to comply with H.B. 06S-1023.

Operating Costs: The Department's request reflects the operating costs associated with 3.0 additional FTE positions. Staff anticipates that the Department's FY 2006-07 supplemental request will include the one-time operating expenses associated with the FTE since the Department plans to hire this FTE in January 2007.

County Administration: This request reflects the costs related to the added time that it will take county technicians to process applications due to the identification and citizenship verification requirements of both acts. The Department estimates that it will take an additional 5 minutes per application to comply with the provisions of the Deficit Reduction Act and H.B. 06S-1023. Because of the additional 5 minutes per application, the counties will need to hire additional staff in order to stay in compliance with federal processing guidelines and to manage workload. Staff anticipates that the Department will also request additional funding in FY 2006-07 for county administration because of these law changes.

Medical Services Premiums: The Department currently pays for accessing the SAVE program to verify citizenship from the Medical Services Premiums line item. Because the Department already uses the SAVE program to verify citizenship as required by PRWORA, the Department believes they can absorb the costs associated with the Deficit Reduction Act. However, the Department has identified the costs they believe they will incur to verify Title IV-E Foster Care (over age 18), Old Age Pension State medical Program, and the Children's Health Plan Plus as required under H.B. 06S-1023. The Department will also need to verify the legal status of contractors for the Comprehensive Primary and Preventive Care grants programs. The Department estimates that all these costs can be 100 percent federally funded except for the verifications for the Old Age State Medical Program.

While not part of Decision Item #4, the Department's budget request also reflects that there will be some caseload changes due to these new law requirements. In their Decision Item #1 (Base Medicaid Budget Request), the Department's request estimates a total decrease in caseload of 200 clients in FY 2006-07 and a decrease of 198 clients in FY 2007-08. The majority of these clients (172 and 170, in each respectively) are estimated to be children. The remainder of the clients in the low-income adult and expansion aid categories. The Department also adjusts their caseload for non-citizen emergency care slightly upward by 28 and 29 clients each year to adjusts for some additional clients being eligible for this category rather than full-Medicaid. Based on the Department's estimated average per-client-costs for FY 2006-07, these net caseload adjustments could result in a savings in the Medical Services Premiums line item of approximately $170,250 (approximately the same amount of savings would occur in FY 2007-08). Please note, this savings is not specifically identified in the Department's budget request. This is staff's estimate on how the

Department's Medical Service Premiums forecast model is impacted by the Department's estimated change to their caseload projections from implementing these acts.

CBHP Trust Fund and CBHP Administration: The General Fund appropriation into the CBHP Trust Fund is the Department's estimate of the state share needed for this issue. Because the CBHP Trust Fund balance is anticipated to be "zero" in FY 2007-08 without additional funding sources, the Department requests a General Fund appropriation into the CBHP Trust Fund. The Department then re-requests this funding as Cash Funds Exempt from the CBHP Trust Fund for the state match for the CBHP Administration Costs.

The CBHP Administration Costs are related to funding the CBHP applications that are not processed by the counties but are processed by Affiliated Computer Services (the Department's contractor for CBHP program). The costs in the CBHP program are related to clients who are over 18 (mainly pregnant women).

At this time, the Department's request does not reflect costs associated with the system changes to CBMS and MMIS. As stated earlier, these system changes will occur in FY 2006-07 and are anticipated to be reflected in the Department's supplemental request.

How Are Clients Impacted?

Affected clients who are citizens or legal qualifying immigrants, will not be impacted by the law changes besides the need to produce further documentation establishing their citizenship and identity. Due to the initial need to educate clients about which documents are acceptable, there may be delays in establishing their eligibility for their initial application. There may also be some clients who temporarily lose coverage at redetermination if they are unable to produce these documents in a timely manner. Applicants have 10 business days to furnish the necessary documentation. If the client does not provide the documentation within the 10 day time frame, their medical assistance application can be denied or their medical benefits discontinued.

In addition, clients may experience costs associated with obtaining the necessary documentation if they do not already have it and the costs of notarizing photocopies of original documentation in some cases. Currently, a Colorado driver's license is $15.60 for a minor and adult. A Colorado identification card is $7.60 for minors and adults up to age 60. For adults older than 60, a Colorado identification card is free. Currently, ordering a birth certificate from the Department of Public Health and Environment costs $17.00.

Table 3 on the following page provides a list of the documentation that is necessary to meet the requirements of the three laws impacting immigration reform.

Table 3 -- List of Acceptable Documentation			
	PRWORA	**DRA of 2005**	**H.B. 06S-1023**
Documents that establish both citizenship & identity	--None	--US Passport --Certificate of Naturalization --Certificate of Citizenship	--None
Citizenship Documents (If one of these are submitted then one from the Identification list must also be submitted)	--INS documentation proving legal status (documents verified in SAVE)	--Birth Certificate/Record proving citizenship --US Citizen ID Card --Native American ID Card --Civil Servant or Military Record --Hospital record --Insurance record showing birth location --Census record (1900 to 1950) --Written affidavit Other requirements for U.S. Territories	--Written affidavit of proof of lawful presence in the United States ***For Qualified Non-Citizens*** --Written Affidavit of Proof of Lawful Presence; and --INS documentation verified in SAVE
Identification Documents (If one of these are submitted then one from the Citizenship List must also be submitted)	Not Applicable	--A Native American Certificate --Driver License --ID Care issued by fed, state, or local government --School ID card --US military card or draft record --Military dependent card For applicants under 16 --School records, including nursery or daycare or --A written affidavit as proof of identification	A document from the Proof of Lawful Presence plus one of the following: --Colorado Driver's license --Colorado State issued ID Card --US military card --Military dependent card --Native American Certificate
NOTE: Please see the Department's website for a more comprehensive explanation of the documentation needed. Information presented here is summarized for presentation and discussion and should not be construed to be a complete list of all information that may be needed to verify citizenship and identification.			

6.0 Percent Appropriation Limit

The state law also new federal programs to be exempted from the 6.0 percent appropriation limit. Staff has had informal discussions with Legal Services on whether or not the costs associated with the Deficit Reduction Act of 2005 would qualify as an exemption from the 6.0 percent limit. Staff was informed that Legal Services believes that exempting the Medicaid costs for implementing the DRA and H.B. 06-1023 can be exempted from the 6.0 percent limit. Staff recommends that the Committee receive a formal response from legal services on this issue.

Questions for the Department

Staff recommends that Committee discuss the following questions with the Department at their briefing.

Standard Questions for all Departments (modify slightly for HCPF)

1. Provide a list of programs in your department that are subject to the provisions of H.B. 06S-1023 and the Budget Reconciliation Act of 2005?

2. How has your department implemented the provisions of H.B. 06S-1023 and the Budget Reconciliation Act of 2005? What problems have been encountered in implementing them? Please describe how the state and federal requirements are similar and different.

3. Provide an estimate of the costs your department will incur in FY 2006-07 to implement these laws. Are any additional costs anticipated in FY 2007-08? If so, please elaborate.

4. Provide a summary of anticipated savings in FY 2006-07 in your department as a result of not providing services to individuals who are in the country illegally. Are any additional savings anticipated in FY 2007-08? If so, please elaborate.

Questions Specific to Department of Health Care Policy and Financing

5. The Department's decision item #4 seems to indicate that the 3.0 FTE positions would be a permanent need. Once procedures and initial training of the counties and medical application sites is complete, would all of these costs need to be continued?

6. Once a client has established citizenship or lawful presence, the counties will not have to verify these documentation upon redetermination or a new application. Does the Department anticipate that the costs to the counties will diminish overtime?

7. Please describe for the Committee other costs to the counties that may occur due to the need to store additional records.

8. Currently, the Department's monthly caseload reports show a declining trend in the low-income adult and children populations. These caseload were originally forecasted to increase due to eliminating the Medicaid asset test. Does the Department have an data or anecdotal evidence if some of the decline may be due to implementing the Budget Reform Act of 2005 or H.B. 06S-1023?

9. Please describe generally the challenges the Department and counties have experienced in implementing these laws. Please describe the procedures and policies the Department has adopted until system changes can be made to CBMS and MMIS.

FY 2007-08 Joint Budget Committee Staff Budget Briefing
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
Provider Rate Increases

ISSUE:

The Department's FY 2007-08 budget request includes a total fund increase of $14.2 million in provide additional rate increases for providers. Of this amount, $7.0 million is from the General Fund.

SUMMARY:

❑ During the budget reduction years, several provider rates were either reduced or did not receive increases for several years. Reducing or keeping provider rates static from FY 2001-02 through FY 2004-05 helped to control the costs in the Medicaid program during a period of rapid caseload growth.

❑ Beginning in FY 2005-06, the Joint Budget Committee began to provide funding in order to address some of the rate issues for selected providers. The Joint Budget Committee continued to address rate issues in FY 2005-06 and FY 2006-07 for Community Long-Term Care providers, primary care providers, durable medical equipment, and inpatient hospitals. In FY 2006-07, the Joint Budget Committee also provided the Department with an appropriation to study provider rates and report back with a plan on how to address major disparities between Medicaid and other carrier rates (including Medicare).

❑ For FY 2007-08, the Department has requested $14.2 million in total funds to address specific rate issues that the Department sees as priorities. These areas include non-emergency transportation services, county administration, administrative case management payments to counties, single entry point agencies, and certain procedure codes within acute care services in the Medical Services Premium line item.

RECOMMENDATION:

Staff recommends that if funding is available in FY 2007-08, the Joint Budget Committee continue to provide targeted rate adjustments that address specific services or procedure codes that are falling substantially behind Medicare or market rates rather than across the board "COLA" adjustments.

Staff also recommends that the Committee discuss the Department's rate proposal during the briefing by asking the questions listed at the end of this issue.

DISCUSSION:

Background:

There are many different laws, rules, and policies that govern the reimbursement rates that are paid to different Medicaid providers. Table 1 summarizes the

Table 1: Rate Setting Authority and Process for Major Service Categories

Service Required	Rate Set	Service Category	Explanation
federal	federal	Rural Health Clinic Services	Reimbursed on a per visit encounter rate. The encounter rate is the higher of the prospective payment system allowed by federal law or the Medicare Rate. Annual rate increases for rural health clinics are part of the base calculations for the Medical Services Premiums line item and do not require separate decision items.
federal	federal	Federal Qualified Health Center Services	Reimbursed on a per visit encounter rate at 100% of reasonable costs. The encounter rate is the higher of the prospective payment system allowed by federal law or an alternative rate established by the Department. The Department's alternative rate uses a base rate that receives an inflationary increase each year. Every three years the base rate is recalculated. Annual rate increase for FQHC are included in the base calculations for the Medical Services Premium line item and do not require separate decision items.
federal	federal	Indian Health Services	Paid 100% with federal funds. Rates are set by the federal government. Annual rate increases are included in the base calculations for the Medical Services Premiums line item and do not require separate decision items.
federal	federal rule	Supplemental Medicare Insurance Benefit	Set annually by the Centers for Medicare and Medicaid Services by federal rule. Annual rate increases are included in the base calculations for the Medical Services Premium line item and do not require separate decision items.
state/federal	federal law and state rule	Prescription Drugs	The Deficit Reduction Act of 2005 changes the methodology for reimbursing the ingredient costs for drugs from average wholesale price (AWP) to average manufacturer price (AMP) and sets the Federal Upper Limit at 250 percent of AMP for multiple source drugs. State rules determine the dispensing fees. Annual price changes are included in the base calculations for the Medical Services Premium line item and do not require separate decision items. However, if the Department makes a major changes to the methodology used to determine reimbursement or dispensing fees, those items are usually submitted as decision items.
federal	**state** law	Nursing Facilities	Nursing home rates are based on a statutory formula based on each facilities reasonable or actual costs for administrative and health services and a fair rental allowance for capital assets. These costs are or may be subject to various reimbursement limits. Annual rate increases are included in the base calculations for the Medical Services Premium lin item and do not require separate decision items. Any change in the reimbursement methodology used requires a statutory change.

Table 1: Rate Setting Authority and Process for Major Service Categories			
Service Required	**Rate Set**	**Service Category**	**Explanation**
federal	state rule	Physician/Nurse Practioner Services/EPSDT	Rates set by State rule based on procedure codes. Increases to these rates typically require a separate decision item.
federal	state rule	Hospitals (Inpatient & Outpatient)	Outpatient hospitals rates based on 72% of costs. As costs increase so does the reimbursement rate. Annual rate increases for outpatient are included in the base calculations for the Medical Services Premium lin item and do not require separate decision items. Current state regulations require inpatient hospital rates to be rebased every year based on Medicare rates. During the budget crisis years, the Department maintained a budget neutral policy of decreasing the percentage that the Medicaid rate would be compared to the Medicare rate in order not to drive additional price costs. Recently, the JBC has approved rate increases to insure that the Medicaid rate does not fall further behind the Medicare rate. Annual rate increases are generally approved as separate decision items.
federal	state rule	Laboratory/ X-ray	Rates set by State rule based on procedure codes. Increases to these rates typically require a separate decision item.
federal	state rule	Emergency Transportation	Rates set by State rule based on procedure codes. Increases to these rates typically require a separate decision item.
federal	state rule	Family Planning	Rates set by State rule based on procedure codes. Increases to these rates typically require a separate decision item.
federal	state rule	Home Health	Rates set by State rule based on procedure codes. Increases to these rates typically require a separate decision item.
federal	state rule	Dental (Colorado does not provide optional Dental services)	Rates set by State rule based on procedure codes. Increases to these rates typically require a separate decision item.
state/federal	state rule	Hospice	Rates set by State rule based on procedure codes. Increases to these rates typically require a separate decision item.
state/federal	state rule	PACE	PACE is a Medicare and Medicaid managed care program. Rates are based on both Medicare and Medicaid services. Annual rate increases for the Medicaid capitation payment are included in the base calculations for the Medical Services Premium lin item and do not require separate decision items.
state/federal	state & federal law	HMOs*	The federal law requires HMO capitation payments to be actuarially sound. State statute dictates an upper payment limit (95% of fee-for-service) and how rates are adjusted and rebased. Annual rate increases for the Medicaid capitation payment are included in the base calculations for the Medical Services Premium lin item and do not require separate decision items.
state	state rule	Home and Community-Based Service Waivers	Rates set by State rule based on procedure codes. Increases to these rates typically require a separate decision item.

Table 1: Rate Setting Authority and Process for Major Service Categories			
Service Required	**Rate Set**	**Service Category**	**Explanation**
state	state rule	consumer directed care waiver	Rates are set by State rule. Increases to these rates typically require a separate decision item.
state	state rule	durable medical equipment	Rates are set by State rule. Increases to these rates typically require a separate decision item. Some of the items are reimbursed at invoice plus 20 percent. Price increase for these items are included in the base calculations for the Medical Services Premium lin item and do not require separate decision items. However, changing the methodology for the payment would include a separate decision item.
state	state rule	breast and cervical cancer	Rates are set by State rule. Increases to these rates typically require a separate decision item.
state	state rule	private duty nursing	Rates are set by State rule. Increases to these rates typically require a separate decision item.
state	state rule	single entry points	Rates are set by State rule. Increases to these rates typically require a separate decision item.
state	state rule	Health Insurance Buy-in	Rates are set by State rule. Increases to these rates typically require a separate decision item.
state	state rule	Administrative Service Organizations*	Rates are set by State rule. Increases to these rates typically require a separate decision item.

*Method of service delivery -- includes mandatory services within the expenditures noted.

As the table above shows, any services that are related to the fee-schedule maintained by the Department do not receive rate increases unless funding is provided by the General Assembly for such a purpose. During the budget crisis years (FY 2001-02 through FY 2004-05), several providers had rate decreases including: durable medical equipment, lab and x-ray, prescription drugs (both dispensing fee and ingredient reimbursement), inpatient hospital, private duty nursing, and transportation. In addition to these rate decreases, other providers did not receive their typical cost-of-living adjustments. The lack of COLA increases mainly impacted the community long-term care providers.

Recent Rate Increases

✓ ***S.B. 05-206:*** Beginning in FY 2005-06, the General Assembly began to address some of the rate issue problems that had resulted from the rate decreases and lack of COLA adjustments. Specifically, in S.B. 05-206 the General Assembly appropriated a total of $18.9 million to adjust rates for inpatient hospital services, to increase the top five physician procedure codes to within 80 percent of the Medicare rate, and to provide a 2.0 percent COLA adjustment for the home and community-based service providers.

✓ ***H.B. 06-1369:*** In addition to the rate increases provided in S.B. 05-206, the General Assembly appropriated an additional $5.4 million in provider rate increases effective April 1, 2006 in H.B. 06-1369. These rate increases included an additional 1.0 percent rate increase for inpatient hospital and a 2.0 percent rate increase for durable medical equipment. In addition, the General Assembly approved a plan to begin to increase the home and community-based service rates to within 80 percent of the Medicare rate (see footnote 28 comments for list of specific rate increase).

✓ ***H.B. 06-1385:*** In addition to annualizing the costs of the rate increases provided in H.B. 06-1369 (a cost of $25.7 million), H.B. 06-1385 also provided additional rate increases. Generally, H.B. 06-1385 provided $21.6 million to provide a 3.25 percent increase for primary care providers and inpatient hospital effective July 1, 2006. H.B. 06-1385 also appropriated $4.1 million to finish moving home and community-based provider rates to within 80 percent of Medicare rates effective April 1, 2006. H.B. 06-1385 also provided a 2.57 percent increase in non-emergency transportation services.

As discussed in the footnote report section of this briefing, for the most part the Department complied with the intent of the General Assembly. However, instead of giving an across the board 3.25 percent increase for all primary care provider codes, the Department targeted the rate increase to the top twenty-five most frequently billed physician services codes. However, for dental and durable medical equipment, the Department provided the equivalent of a 3.25 percent increase. The Department's targeted rate increases for physician codes did leave some providers without rate adjustments. In addition, staff has learned that the home and community-based rate adjustments were not applied to providers in the consumer directed-care waiver program.

In addition to providing appropriations for specific rate increases, last year the Joint Budget Committee expressed an interest in examining areas where gross rate disparities for primary care providers have occurred when compared to Medicare or market rates. The General Assembly appropriated $58,000 for the Department to conduct a study on this topic. The Department was asked to report their initial findings on November 1, 2006. As stated in the footnote section of this briefing, the Department is in the process of hiring a contractor for the study. However, until the study results are produced, the Department has identified specific rate increases that they recommend for FY 2007-08.

Department's Rate Plan for FY 2007-08

For FY 2007-08 the Department is targeting six provider classes for rate increases: inpatient hospital; single entry points; speciality acute care providers; emergency transportation, non-emergency transportation, and county administration. Table 2 shows the estimated fiscal impacts of the rate increases that the Department is requesting.

Table 2: Department's FY 2007-08 Rate Plan

Provider Class	Total Funds	General Fund	Health Care Expansion Fund	Federal Funds	Comments
Non-Emergency Transportation*	$110,000	$55,000	$0	$55,000	The Department's rate increase reflects only the Department's reimbursements for private transportation codes (does not include the transportation broker contract). The Department's request reflects a 31 percent increase for the private transportation codes to reflect the increase in fuel costs since the last time the rates were adjusted in 2002.
County Administration	366,133	183,067	0	183,066	The Department is proposing a 2.0 percent cost-of-living adjustment for county administration.
Administrative Case Management County Payment	31,872	15,936	0	15,936	The Department is proposing a 2.0 percent cost-of-living adjustment for county administrative case management payments.
Inpatient Hospital	2,162,874	1,050,893	30,545	1,081,436	The Department's request would allow inpatient rates to remain at 90 percent of Medicare rates. Under the Medicare Modernization Act of 2003 (MMA), Medicare rates for are adjusted each year for inflationary increases. If the state does not increase Medicaid rates, the Medicaid reimbursement rate will fall in relation to the Medicare rate. The Department has set a goal of maintaining inpatient hospital rates at 90 percent of the Medicare rate.
Emergency Transportation	300,000	145,763	4,237	150,000	In FY 2002-03, emergency transportation rates were cut by 5.0 percent. Since that time, rates have not increased despite the large increase in fuel costs. The Department's request is to provide a 5.0 percent increase to rates which will restore rates to their pre-FY 2002-03 level.
Adult Immunizations	600,000	291,527	8,473	300,000	Currently the Department adult immunization at a rate of $6.50 -- the same prize that the Department reimburses for the administration of immunizations that practitioners receive for free from the Vaccines for Children's program. The Department recommends increasing adult immunizations to average wholesale price plus 10 percent, plus a $2 administration fee.

Table 2: Department's FY 2007-08 Rate Plan

Provider Class	Total Funds	General Fund	Health Care Expansion Fund	Federal Funds	Comments
Anesthesia	3,150,000	1,530,515	44,485	1,575,000	Anesthesia rates have not increased since 1999 and are currently about $14.33 for 15 minutes of services. The Department proposes increasing these rates to $21.49 for 15 minutes of services in order to address some of the disparities in the rate when compared to other state programs (such as worker's compensation), providers, and states.
Durable Medical Equipment Repair	500,000	242,939	7,061	250,000	The Department recommends an increase from $15.35 per 15 minutes to $35.48 per 15 minutes for wheelchair repair in order to cover the costs of travel and labor for providers.
Intrauterine Devices	90,000	8,746	254	81,000	Current reimbursement does not cover the cost of the device. The Department recommends increasing reimbursement from $301.64 to $398.37 (the current cost of the device is $377.00)
Surgical Procedures	1,650,000	801,698	23,302	825,000	The Department recommends increasing the conversion factor for surgical codes from $33.43 to $34.58 (a 3.45 percent increase). The last time the conversion factor was increased was in 1990.
Therapy Services	1,000,000	485,878	14,122	500,000	Increases therapy rates by 9.05 percent for outpatient services to match some of the increase that was provided for home and community-based services.
Health Maintenance Organization	398,966	193,849	5,634	199,483	Estimated impact to the MCO contract with Denver Health for the rate increases above. MCO rates are set by statute.
Single Entry Point	3,852,887	2,003,502	0	1,849,385	The Department recommends a 20.5 percent increase to the rates paid to single entry point agencies to recognize the additional services these agencies perform but are not reimbursed for.
TOTAL	$14,212,732	$7,009,313	$138,113	$7,065,306	

Additional Information on Non-emergency transportation

In addition to the rate increase noted in Table 2 for non-emergency transportation, staff anticipates a FY 2006-07 supplemental for the non-emergency transportation broker contract for the eight metro counties. In June 2006, the Committee approved an emergency supplemental for FY 2005-06 in order to pay for an emergency contract after a failed procurement process (i.e. no contractor would except a contract to broker non-emergency transportation services at the current contract provided by the Department). The current contract entered into on July 1, 2006 is for $446,992 per month. This will equal $5,363,904 for FY 2006-07 for the eight front range counties. For the remaining 56 counties, the Department estimates non-emergency transportation costs of $1,081,300. Therefore, the Department's total estimated FY 2006-07 non-emergency transportation cost is $6,445,204 which is $1,376,482 total funds over the current appropriation. Staff anticipates a supplemental request for approximately this amount from the Department in January 2007. The Department's decision item #7 for FY 2007-08 requests an increase of $1,464,796. If a FY 2006-07 supplemental is approved, then this increase would be reduced accordingly to the based on the new FY 2006-07 base.

Staff comment:

The Department's rate plan addresses the Joint Budget Committee's desire last year to target appropriations to the areas of greatest need rather than provide across the board rate adjustments. In addition, the Department has set rate "goals" for certain provider classes. Staff believes that setting such goals will help the Joint Budget Committee in the future to prioritize rate increases and appropriations. Staff believes the Department's submitted rate plan is a good place to start the discussion this year for provider rate changes.

Questions for the Department:

1) Last year the General Assembly attempted to move most of the home and community-based service provider rates to within 80 percent of their comparable Medicare rate. The Department's rate plan does not contain any FY 2007-08 rate increases for these providers. Will these provider rates stay within 80 percent of the Medicare rate without an COLA increase in FY 2007-08? Is 80 percent of the Medicare rate an acceptable goal to try to maintain? What impact, if any, does the Department anticipate from the increase in the minimum wage on home health agencies and home and community based services providers?

2) When does the Department anticipate the final report for the acute care provider rate disparity study? Please describe the specific rate issues the Department hopes the address in the study that have not been addressed by the Department's current decision item on provider rates.

3) Please describe the reasons why there was a sharp increase in the non-emergency transportation need from FY 2004-05 to FY 2005-06. Please describe the estimated supplemental that the Department will be submitting on this issue for FY 2006-07? Given the fact that the State is within $2.0 to $3.0 million of the 6.0 percent limit, does the Department have any strategies on this supplemental can be without exceeding the 6.0 percent limit? Does the Department believe that the current rules and regulations for non-emergency transportation is meeting the needs of the Medicaid clients?

4) Staying within 90 percent of the Medicare rate for inpatient hospitals will continue to drive costs in the future. Given the constraints of a 6.0 percent limit, does the Department believe that this is a reasonable goal that the State can maintain into the future? Does this goal create an unrealistic expectation that this level of reimbursement can be maintained?

FY 2007-08 Joint Budget Committee Staff Budget Briefing
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
Long Term Care Reform

ISSUE:

During the last two Legislative Sessions, the General Assembly has passed two bills to study ways to reform the long-term care system. In addition, the Deficit Reduction Act of 2005 made modifications to long-term care system in attempt to reduce future expenditures.

SUMMARY:

❑ Expenditures for community and institutional long-term care services were $682.0 million in FY 2005-06 and are anticipated to be $750.2 million (10.0 percent increase) in FY 2006-07 and $799.3 million (6.5 percent increase) in FY 2007-08.

❑ In 2005, the General Assembly passed S.B. 05-173 which established a Community Long-Term Care (LTC) Advisory Committee to make recommendations on how to restructure and improve the delivery of community long-term care services. The Advisory Committee submitted their final report on November 1, 2006.

❑ In 2006, the General Assembly passed S.B. 06-131 which required the Department to study the feasibility of implementing a new reimbursement system for class I nursing facilities. The Department's final report issued November 1, 2006 concluded that the Department was not yet ready to make any recommendations to change the current reimbursement structure and will continue to meet through 2007 with the hope of making recommendations by November 1, 2007.

❑ The Deficit Reduction Act of 2005 contained several provisions with the aim of reducing expenditures for long-term care services.

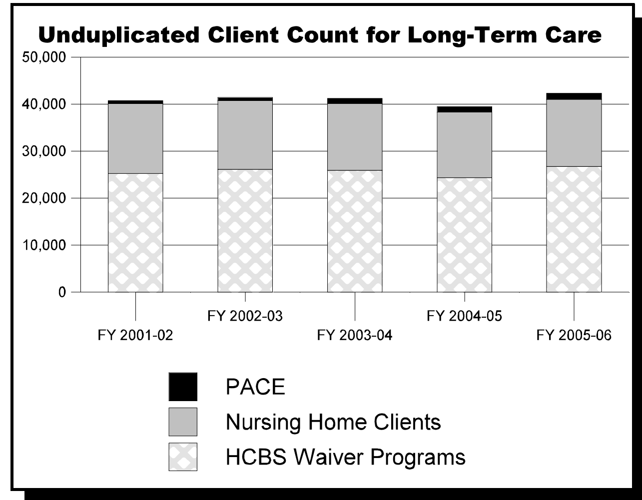
RECOMMENDATION:

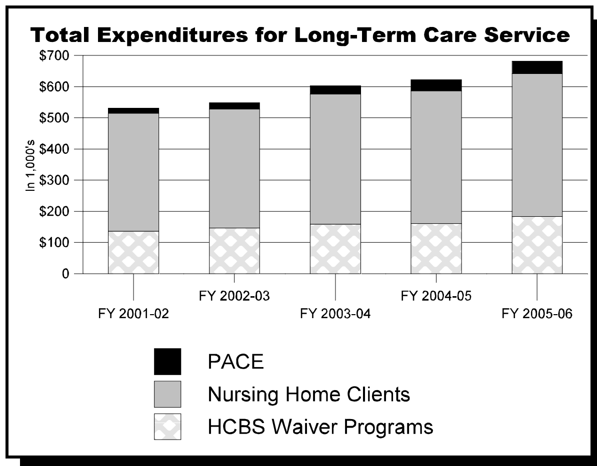
Staff recommends that the Committee discuss with the Department recommendations from the LTC Advisory Committee at their hearing. Staff also recommends that the Committee discuss the questions listed in this issue with the Department at their hearing.

DISCUSSION:

Background:

Long-term care services (community long-term care waivers, class I & II nursing facilities, and the PACE program) were 34.4 percent of total Medical Service Premium costs in FY 2005-06. 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. For the most part, cost increases are being driven by the utilization and price of services. As the chart to the right shows, for the last four years, the <u>*unduplicated client count*</u> has remained rather stable at around 40,000 clients (there was a slight decline from FY 2002-03 through FY 2004-05 but FY 2005-06 showed a slight increase in the number clients served).





However, while the number of clients served has remained relatively stable, costs have continued to increase each year. As the chart to the left shows, expenditures have climbed from $531.3 million in FY 2001-02 to $682.0 million in FY 2005-06 (an increase of $150.7 million or 28.4 percent). The majority of this cost increase, $80 million, is attributable to the cost increases for nursing home care. Another $46.8 million is for the home and community-based waiver programs, and $23.9 million is for the PACE program (the one program that has had a dramatic increase in the number of clients served over this time period).

Due to people living longer and aging of the baby boomer population, caseload for long-term care services are anticipated to increase dramatically during the next few decades. Because of the high costs of these services, several initiatives have been attempted to reduce costs for the future. These initiatives include but are not limited to the following:

✓ ***Home and Community-Based Waiver programs.*** Although home and community waiver programs are major expense in the Medical Services Premiums line item, these services help

to serve the needs of the long-term care clients in a manner that is both less restrictive and expensive than nursing facility care. Colorado has a long history of long-term care waiver programs.

✓ ***Single Entry Points.*** These agencies help to coordinate and plan the long-term care for individuals. Case management services are assumed to help make sure appropriate care is provided in the appropriate setting.

✓ ***PACE.*** This program tries to integrate the acute care needs and long-term care needs of clients into one managed care model. This model is assumed to promote savings in the area of hospitalization and institutional care by coordinating the client's primary and community long-term care needs. This model works well in urban centers where PACE sites can provide the medical and day care needs of their clients.

✓ ***Consumer-Directive Care Waiver.*** H.B. 05-1243 will allow long-term care clients to have a more direct role in deciding their care needs. It is assumed that consumer-directed care will be less expensive than care directed by medical professionals, resulting in Medicaid savings.

✓ ***Coordinated Care for People with Disabilities.*** S.B. 06-128 establishes a pilot program for a non-profit agency to develop a program to provide coordinated care for the disabled in the hopes reducing costly acute care and secondary disability conditions.

In addition to these programs, the General Assembly over the years has also attempted to control the costs and improve quality by passing several different pieces of legislation that include: (1) encouraging long-term care insurance, (2) trying to award nursing homes for quality of care, and (3) authorizing funds to help move individuals move from institutional settings to a community settings. During the 2005 Session, the General Assembly passed S.B. 05-173 which established a Community Long-Term Care (LTC) Advisory Committee to make recommendations on how to restructure and improve the delivery of community long-term care services. The final report from this Advisory Committee was submitted in November 2006. In addition, the General Assembly passed S.B. 06-131 which required the Department to look at different reimbursement methodologies for nursing home care. The Department submitted a status report on this issue also in November 2006.

Long-Term Care Advisory Committee Recommendations

The LTC Advisory Committee developed 18 recommendations and organized them into four groupings: (1) person-centered service continuum; (2) seamless care planning; (3) eligibility and financing options; and (4) statewide leadership. Following is a brief discussion of the *major* recommendations and the Department's response.

Person-centered service continuum. This area of the Committee's recommendation focused on housing, transportation, and personal care needs of clients who are Medicaid eligible or not yet Medicaid eligible. The focus of these recommendations attempted to strengthen community support

systems in order for clients to remain in the least restrictive care environment possible. Recommendations included: (1) collaborating more effectively with Section 8 and HUD housing programs for the elderly and disabled; (2) pilot alternative adult foster care housing programs; (3) provide incentives for nursing facilities to convert licensed beds to assisted living or adult day care programs; (4) add a personal care optional benefit to the Medicaid state plan; (5) pool Medicaid transportation funding with transportation funding for the Older Americans act; (6) authorize a fully integrated primary care and long-term care pilot program; and (7) clarify the eligibility for the Home Care Allowance Program to ensure non-Medicaid eligible clients have access to the program.

The Department noted that several of the recommendations would require a possible statute change or authorization as well as rule changes. The Department also noted that many of the recommendations would have a fiscal impact. In one instance, the pooling of transportation monies, the Department indicated that federal law would have to be changed in order to implement the recommendation. Also, for the pilot project to integrate primary care and long-term care needs, the Department indicate that the Department will be issuing the request for proposals in November 2006. Proposals will be due by February 15, 2007.

Seamless Care Planning: Recommendations in this area had to do with strengthening the case management for long-term care services. The Commission recommended the following: (1) care managers receive additional training on uniform statewide accountability standards based on consumer outcomes; (2) caseload for single entry point care managers be reduced; (3) a fully automated system for assessing, allocating and managing the care of clients be developed; and (4) long-term care information be included in patient's comprehensive health record.

The Department noted that most of the above recommendations would have an initial fiscal impact to implement. The Department did note that care management agencies began the transition to the Benefits Utilization System (BUS) in July 2005. This database is used for program monitoring and oversight of the HCBS waivers, Home Care Allowance, Adult Foster Care, and nursing facilities.

Eligibility and Financing Options: Recommendations in this area included the following: (1) implementing a pilot program with the policy goal of ensuring that LTC clients are assessed within 48 hours of hospital discharge or upon an imminent institutional placements; (2) provide comprehensive training to hospital discharge planners about the full continuum of LTC services; (3) increase awareness about transitional services; (4) institute rate reforms that promote person-centered and consumer-identified service outcomes; and (5) develop and implement quality benchmarks for all LTC services.

Again, the Department noted that most of these recommendations may require statute or rule changes and also may have fiscal impacts to implement. The Department has issued requests of proposals for the pilot to expedited financial eligibility determination for long-term clients and for awarding a selective contract to a LTC provider for a specific geographic area. In addition, the Department has adopted rules to aid in promoting awareness regarding transitional services. The Department also has a full time staff member devoted to developing and implementing a HCBS quality program.

The Department also noted their accomplishments in developing programs that try to promote the least restrictive care possible for the client as well as giving the client more control and input into their care (such as the consumer directed care waiver program).

Statewide and Local Leadership: The Advisory Commission's recommendations in this area related to better coordination between the state and local agencies involved in planning and providing long-term care services for the different groups involved. Specifically, the Commission recommended that Single Entry Point and Community Center Board's be allowed to (1) expedite financial eligibility determination; (2) have online access to the CBMS system; (3) blend funding streams that include Medicaid and non-Medicaid programs; and (4) implement a "virtual one-stop" system to aid clients in accessing the system. The Commission also recommended that a blue-ribbon commission on long-term care be formed in order to oversee the development and implementation of a long-term care system transformation plan.

The Department expressed concerns about allowing other entities other than the counties to have access to the CBMS system (even if just to view data) and to allow single entry point agencies to have participate in the Medicaid financial eligibility function. The Department also noted that several of the recommendations would require statute or rule changes and may have fiscal impacts.

Staff Comment

Many of the recommendations formed by the Advisory Committee may require legislation and have a initial or ongoing fiscal impact. However, investment now in improving program coordination may eliminate current inefficiencies and improve overall quality of life issues for seniors and the disabled. Therefore, staff recommends the JBC discuss the following questions with the Department at their hearing:

1) Please describe for the Committee any RFP's the Department has issued for pilot programs recommended by the Advisory Committee on Long Term Care or that may address some of the issues raised by the Advisory Committee. Specifically, address the status of the RFP's for pilot programs for alternative housing options, integrated primary care and long-term care pilot programs, expediting financial eligibility determinations, and selective contracting for geographic service areas.

2) What are the Department's five top priorities for improving the efficiency and effectiveness for the Medicaid Long-Term Care System? What challenges and opportunities does the Department see in the next five to ten years for long-term care delivery? Why do some geographic areas in the state have higher participation in community care delivery when compared to nursing home delivery.

3) Please discuss the recommendations from the Advisory Committee report that the Department believes should be implemented as soon as possible. What are the possible fiscal impacts from these recommendations.

S.B. 06-131 Status Report

Last Session, the General Assembly also passed S.B. 06-131 which addressed several nursing facility issues. Senate Bill 06-131 codified a process that the Department had began a year earlier to look at the reimbursement model for Class I nursing facilities by requiring the Department to conduct a feasibility study of a new reimbursement system for class I nursing facilities based upon a pricing model or a pay for performance model. In compliance with S.B. 06-131, the work group met seven times between August 4, 2006 through October 27, 2006 and issued a status report on November 1, 2006. The conclusion of the report was that the workgroup would not be able to develop a pricing study or recommendation by November 1, 2006. The workgroup unanimously agreed that they will not propose recommendations for a new reimbursement methodology for consideration in the 2007 Session but will continue to meet with the hopes of producing final recommendations to the General Assembly in 2008. In addition, the majority of the workgroup members recommended continuing to lift the 8.0 percent cap in FY 2007-08 until a new pricing model could be developed. This recommendation would require a statutory change.

Staff Comment:

The issue of how to reimburse nursing homes has had several modifications and changes over the years. Currently, the nursing home reimbursement model reimburses nursing facilities for their actual or reasonable costs for services rendered, their case-mix adjusted nursing costs, and a fair rental allowance for capital-related costs. Because the formula is based on costs, the statute also places certain capped limits on the reimbursement rates in order to control the growth of costs.

The S.B. 06-131 study looked at two different nursing reimbursement models. The first model was a pricing model presented by consultants for the Colorado Health Care Association. Under this model, the specific nursing home in which a patient is provided services should not affect the Medicaid programs rate. Rather, the rate would consider the acuity of the patient, the geographic variance in labor costs, the value of the facility, the special needs of the patient population and the measurable quality of services. Under a pricing model, the Department would set the "rate or price" that they were willing to pay for nursing

Caps on Nursing Home Reimbursement.

Administrative Costs:
1) Can not exceed 120 % of the weighted actual costs of all class I facilities.
2) In any given year, administrative costs can not exceed a 6.0 percent increase.
3) Administrative costs include actual administration, property, and room and board costs, excluding capital-related assets and exclude food costs.

Health Costs:
1) Can not exceed 125 percent of the weighted actual costs of all class I facilities.
2) Health costs can not exceed an 8.0 percent increase, except in FY 2006-07 the 8.0 percent shall not apply to class I facilities with an average annual Medicaid census that exceeds 64 percent of the actual residents for that same time period.
3) Health costs include actual health care services and food costs excluding Part B direct costs for Medicare.

Capital Assets:
1) The fair rental allowance means the base cost (appraisal or adjusted appraisal cost) multiplied by the average annualized composite rate for 10 year U.S. treasury bonds plus two percent -- not to exceed 10.75 percent or fall below 8.25 percent.

S.B. 06-131 provides that for FY 2006-07, a Class I nursing facility provider's rate shall not fall below 85% of the statewide average total overall reimbursement for all

care and adjustments to the price would be made for special cost allowance (i.e. acuity of patient mix, geographic labor costs, etc.). This system is much more like the prospective pay system that Medicare is using for nursing home care. In staff's assessment, Colorado's current reimbursement system has many aspects of a pricing model already in place either directly or indirectly.

The other pricing model discussed was a quality model presented by consultant's for the American Association of Homes and Services for the Aging. A quality model would have some aspects of a pricing model (i.e. a base price adjusted for certain cost factors such as acuity mix). However, a quality model would incorporate accountability measures and reward facilities based on compliance or achievement of certain quality measures. Minnesota and Iowa were suggested as states attempting this type of reimbursement system. There are many challenges associated with this type of modeling including deciding on what measures represent quality, collecting data, and making sure the base rate is sufficient to help poor facilities improve their quality measures.

Based on the complexities involved in changing the current reimbursement methodologies, the Department and the two nursing home associations do not plan to recommend any major changes to the current reimbursement system for the 2007 Session. However, it is staff's understanding that the associations may support legislation to eliminate the 8.0 percent cap for FY 2007-08. Staff recommends that the Committee discuss the following questions with the Department at their hearing.

1) Please provide the Committee with a fiscal analysis on how much eliminating the 8.0 percent cap on health care costs would cost in FY 2007-08.

2) From the Department's perspective, what are the advantageous and disadvantageous of a pricing or prospective-pay model for nursing homes.

3) From the Department's perspective, what are the advantageous and disadvantageous of a quality add-ons incentives for nursing home rates.

Deficit Reduction Act of 2005

The federal Deficit Reduction Act of 2005 (DRA 2005) had several provisions to try to control the costs of long-term care in the Medicaid program. Specifically, DRA 2005 increased the look back period for asset transfers from three years to five years and changed the penalty time frame from the time when an asset transfer was made to the date the client applies for Medicaid. The DRA 2005 also makes single individuals with home equity of more than $500,000 ineligible for Medicaid (states have the option of raising this to $750,000). The DRA also counts as assets some previously exempt financial instruments (such as certain annuities, promissory notes and mortgages). In addition, the DRA allows for the Long-Term Care Partnership program to be expanded throughout the country. In 1992, four states (Connecticut, Indiana, New York, and California) instituted a Long-Term Care Partnership Program that allowed a person to protect his or her assets from Medicaid

estate recovery up to the amount paid by a qualifying long-term care insurance policy. The DRA now allows all states to implement such a program.

In addition to making changes regarding nursing home care, the DRA also made some changes to the home and community-based waiver programs. Specifically, the DRA made home and community-based services an optional benefit for certain individuals and for these individuals the state is no longer required to determine that the level of care needed would be institutional care without the HCBS services. In addition, the DRA would provide an enhanced federal match for demonstration programs that increase the use of home and community-based services over institutional care.

Staff recommends that the Committee discuss the following questions with the Department at their hearing.

1) What future fiscal impact does the Department anticipate from increasing the look back period from three years to five years and changing the penalty time frame (impact will not be felt until 2009 but how large of impact does the Department anticipate)?

2) Please provide the Department's perspective on the Long-Term Care Partnership program? What could be the potential fiscal impact of implementing such a program in Colorado?

3) Is there any way that the State can qualify for the enhanced federal match for programs that help place more individuals in community-based service programs rather than in nursing facility care? Is the Department applying for any demonstration programs?

FY 2007-08 Joint Budget Committee Staff Budget Briefing
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
Prescription Drug Costs

ISSUE: In 2006, the Department implemented the Medicare Modernization Act of 2003 which is the most dramatic policy change for prescription drugs coverage in Medicaid program in decades. In addition, the Deficit Reduction Act of 2005 also impacts how the Department reimburses pharmacies for prescription drugs in the Medicaid program.

SUMMARY:

❑ The Medicare Modernization Act of 2003 was implemented in January 2006. In FY 2005-06, the MMA reduced prescription drug costs in the Medical Services Premiums line item by an estimated $68.8 million. Of this amount, $34.3 million was General Fund. However, these savings were mainly offset by the State Contribution payment (clawback) which totaled $31.5 million in FY 2005-06.

❑ The Deficit Reduction Act of 2005 changes the maximum price Medicaid pays for multiple-source drugs from 150 percent of the lowest published price (usually the wholesale price) for a drug to 250 percent of the lowest average manufacturer price (AMP). The revised limit takes effect on January 1, 2007.

RECOMMENDATION

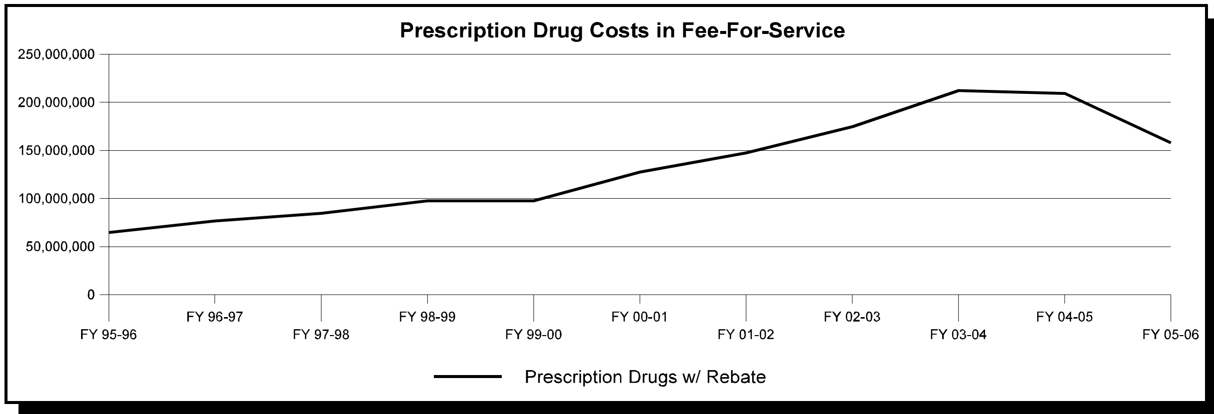
Although the MMA and DRA mark two of the most significant changes to Medicaid prescription drug coverage in recent years, the Joint Budget Committee should continue to encourage policies for cost effective prescription drug purchasing and utilization. These policies may include expanding existing drug utilization review programs, continuing to promote the use of generic drugs when appropriate, and perhaps implementing drug formularies, additional rebate programs, or multi-state pooling options. Staff recommends that the Committee discuss these issues with the Department at there hearing and the specific questions listed in this issue.

DISCUSSION

Background

For the last ten years, prescription drugs have been one of the fastest growing benefits within the the acute care services in the Medicaid program. In FY 1995-96, prescription drug costs (after rebate) was $64.9 million or 10.5 percent of acute care spending. In FY 2004-05, prescription drug costs (after rebate) was $209.3 million or 17.6 percent of acute care spending. Beginning in January 2006, the Medicaid program no longer pays for prescription drugs for dual eligibles. This led to a

significant drop in overall prescription drug costs in FY 2005-06. However, the majority of savings from this policy change is eliminated by the MMA's State Contribution Payment.



Medicare Modernization Act of 2003 Impacts

For FY 2005-06, staff estimated that the total MMA impact to the premiums line item would be a $68.7 million decrease (for six months). Of this amount, $34.4 million was estimated to be General Fund (FY 2006-07 figure setting packet page 130). Therefore, the average estimated decrease for prescription drugs was estimated at $11.4 million per month. In FY 2005-06, the average monthly expenditures for fee-for-service prescription drugs fell from $25.6 million (average from July through December) to $13.9 million (average from January to June). This was a decrease in average monthly prescription drug expenditures of $11.7 million per month. However, not all of the savings can be contributed to the MMA -- some of the savings may have resulted from passive enrollment being turned back on in May 2006 (decreasing prescription drug costs in FFS and increasing the costs in the MCO program) and a slight decline in caseload. In addition, the FFS does not capture the PACE program or MCO savings. Nevertheless, it does appear that the estimated FY 2005-06 MMA impact was fairly close to the actual experience. While there are savings in the Medical Service Premiums line item, most of these savings were offset the by the FY 2005-06 State Contribution Payment (clawback). The final State Contribution Payment in FY 2005-06 was $31.5 million General Fund.

The current FY 2006-07 appropriation assumes a total fund savings from the MMA in the Medical Service Premiums line item of $146.8 million (of which $73.4 million would be from the General Fund). Again most of these potential General Fund Savings are offset by the claw back payment. The current FY 2006-07 assumes a clawback payment of $73.4 million General Fund.

For FY 2007-08, the Department's request does not identify a specific savings for the MMA in the premiums line item because it has now been incorporated into the base calculations. However, the Department estimates that the clawback payment will be $74.1 million (an increase of about $700,000).

Although the MMA was a major policy shift, Colorado anticipates little to no fiscal savings to the General Fund as a result of this policy change. Staff recommends the Committee discuss the following questions with the Department at their hearing.

1. Please update the Committee about ongoing issues with implementing the MMA. Please discuss any problems that dual eligible clients have experienced or are experience as they sign up for Medicare Part D plans? Does the Department believe that most dual eligible clients are now able to access their drug benefit through Medicare and have understanding of how the program works? What assistance is the Department still providing to dual eligible clients regarding the Medicare Part D program.

2. In addition to the costs for the clawback payment, what other costs does the Department estimate for the Medicare Part D program.

Deficit Reduction Act of 2005

The Deficit Reduction Act of 2005 changes the maximum price Medicaid pays for multiple-source drugs from 150 percent of the lowest published price (usually the wholesale price) for a drug to 250 percent of the lowest average manufacturer price (AMP). The revised limit takes effect on January 1, 2007. Currently, the Department budget request does not reflect any savings in FY 2006-07 or FY 2007-08 due to the implementation of the DRA. It is staff's understanding that the Department believes that the change in methodology will not result in a major impact in prescription drug costs. Staff recommends that the Committee discuss the following questions with the Department at their hearing.

1. Nationally, the Congressional Budget Office forecasts that the change in pricing methodology will save the Medicaid program $3.8 billion from FY 2006 through FY 2010. However, the Department's budget request currently does not contain any cost saving estimates for prescription drugs due to the DRA. Please explain the possible impact the DRA will have on Colorado Medicaid prescription drug reimbursement or the difficulties in estimating the potential impact.

2. It is staff's understanding that the DRA also modified the definition of Medicaid "best price" to include the lowest price for authorized generics. Recently, a major U.S. retailer began promoting a program to offer $4.00 generic prescription drugs in Colorado. Please provide the Committee with information on the amount of sales volume that the Department currently does with this retailer for the affected drugs. Does the Department believe that there will be a potential cost savings in prescription drugs due to this policy change?

Other Prescription Drug Issues

Over the last few years, the members of the General Assembly have introduced several bills with the goal reducing prescription drug costs in the Medicaid program. Senate Bill 03-11 required that a

generic substitution whenever the generic drug is a therapeutic equivalent to the brand-name drug and S.B. 03-294 required the Department to implement drug utilization mechanisms, including but not limited to prior authorization, to control prescription drug costs. In addition to these two bills, the General Assembly has also introduced and debated bills that would require the Department to have a preferred drug list for the FFS program and to join multi-state purchasing pools. At this time, Colorado is one of seven states that has not implemented a preferred drug list and is one of 34 states that has not joined a multi-state purchasing pool.

Now that the MMA has shifted a large portion of the Medicaid drug costs over to Medicare, cost savings for a preferred drug list or from joining a multi-state purchasing pool may not be as high as before the MMA was implemented. Nevertheless, these policy choices remain options on how to reduce or slow the growth in Medicaid drug expenditures.

Staff recommends the Committee discuss the following issues with the Department at their hearing.

1) What are the potential savings or costs for developing a preferred drug list for the Medicaid FFS program?

2) What are the disadvantageous or advantageous to joining one of the three-existing multi-state purchasing pools?

3) According to the Department's current strategic plan, the Department estimates savings of between $100,000 to $500,000 for FY 2007-08 by identifying opportunities for cost avoidance within the drug program and providing a prescriber education program. Please describe the status of these projects for the Committee.

4) Please update the Committee on the cost savings to date from implementing S.B. 03-294 and S.B. 03-011.

FY 2007-08 Joint Budget Committee Staff Budget Briefing
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
Colorado's Children's Basic Health Plan *Preliminary* Budget Outlook

ISSUE:

The Department is currently forecasting an increase of $21.6 million total funds for the Children's Basic Health Plan (CBHP) for caseload and cost-per-client increases. In order to fund the CBHP's programs need, the Department estimates that $4.5 million will need to be deposited into the General Fund in FY 2007-08.

SUMMARY:

❑ The Department's November budget request indicates that a supplemental appropriation will be necessary for the CBHP program in FY 2006-07. Currently, the Department is estimating that a $1.5 million General Fund appropriation will be needed in order to keep the CBHP Trust Fund Balance solvent in FY 2006-07.

❑ The Department is anticipating healthy growth in the CBHP program in FY 2007-08. Currently, the Department anticipates caseload growth in the children's program at 1.8 percent and growth in the adult pregnant women program of 40.9 percent. Total expenditures are anticipated to grow 28.2 percent.

❑ In 2007 the United State Congress must re-authorize the State Children's Insurance Health Plan (SCHiP) program. The Congress may use this opportunity to make reforms to program in regards to eligibility for the program as well as federal financing. The General Assembly needs to watch this process carefully to make sure our CBHP program design allows us to maximize the federal funds available for this program without dramatically increasing the General Funds needs of the program.

RECOMMENDATION:

Staff recommends that the Committee discuss the Children's Basic Health Plan program with the Department at their hearing using the specific questions listed throughout this issue.

Staff also recommends that the Joint Budget Committee consider sponsoring legislation to increase the amount of tobacco settlement monies that is transferred to the CBHP Trust Fund. Increasing the amount of Tobacco Settlement monies transferred into the CBHP Trust Fund will eliminate the current need for an additional General Fund appropriation. In addition, this action will give the Joint Budget Committee more flexibility within the 6.0 percent for other potential General Fund supplementals.

In addition, staff recommends that the Joint Budget Committee consider eliminating the CBHP Trust Fund and instead making direct appropriations from the Tobacco Settlement Fund and General Fund into the CBHP program lines rather than first appropriating monies into a fund and then re-appropriating the same monies out of the fund again. This will eliminate a small double count appropriations and will focus attention on the amount of General Fund that is necessary to support the CBHP program.

DISCUSSION

Backgound

The State Children's Health Insurance Program (SCHIP) was enacted by Congress in1997 as Title XXI of the Social Security Act. The federal program provided states with the option to adopt a non-entitlement health insurance program for low income children who do not qualify for Medicaid. The federal program provided states with an enhanced federal match as an added incentive for the states to adopt this optional program. The federal government also capped the amount of federal funds that would be available for the program.

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 200 percent of the federal poverty level. In addition to covering children, the CBHP also has an adult pregnant woman program to provide prenatal care for women up to 200 percent of the federal poverty level.

Funding

The state match for the program is provided either from the CBHP Trust Fund or from the Health Expansion Fund. In November 2004, Colorado voters approved Amendment 35 which increased the taxes on tobacco products in order to expand health care programs. Amendment 35 specifically allowed that a portion of the health expansion monies could be used to (1) increase the enrollment in the CBHP program for children and adult pregnant women above the FY 2003-04 enrollment; (2) add parents; and (3) increase the eligibility standards for the CBHP or Medicaid program. The Amendment 35 implementation legislation, H.B. 05-1262, made the following changes to the CBHP program:

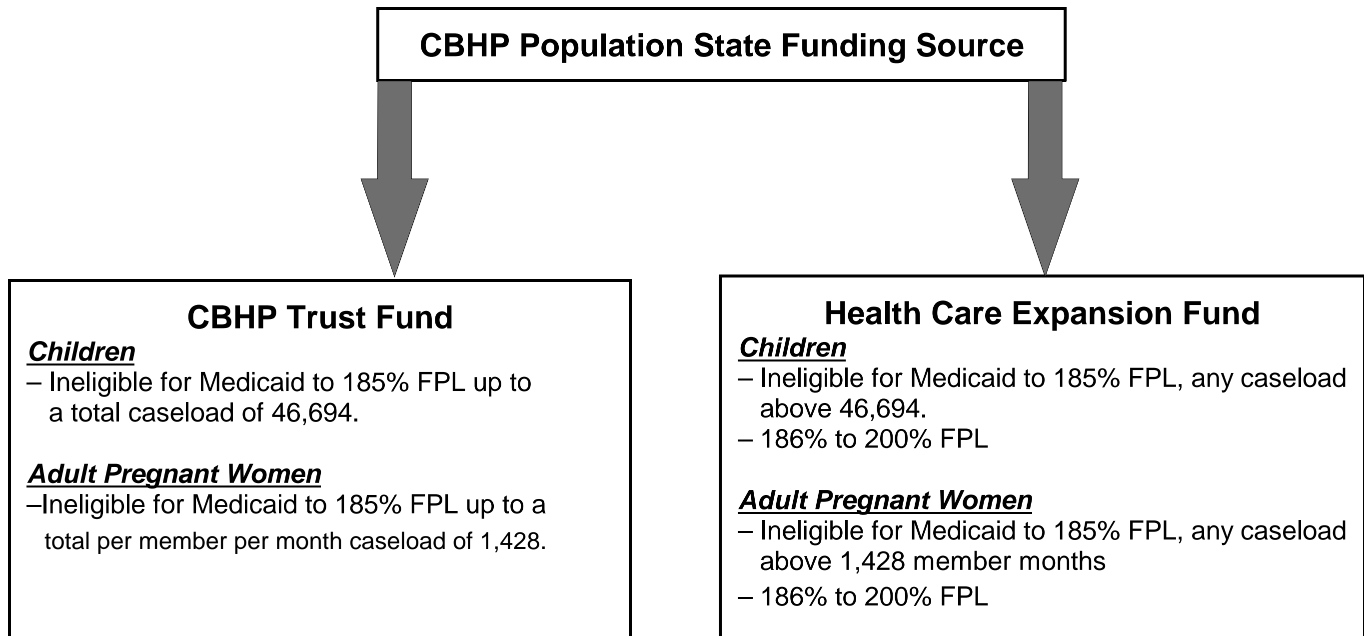
1) Eliminated the Medicaid asset test for children and adults. Currently, federal law requires that applicants for the CBHP program first be screened for Medicaid eligibility. When the Medicaid asset test was eliminated, any CBHP children who were not originally eligible for Medicaid because of the asset test, will be transferred to the Medicaid program upon redetermination if their family income qualifies them for Medicaid instead of the CBHP program.

2) Expanded the marketing effort for the CBHP program.

3) Allowed the Health Care Expansion Fund to fund the enrollment growth over the average monthly enrollment in FY 2003-04.

4) Expanded eligibility for both children and pregnant women from 185 percent FPL to 200 percent FPL.

The following chart shows which populations must be funded by the CBHP Trust Fund and which populations are eligible to be funded from the Health Care Expansion Fund.



CBHP Trust Fund

The majority of revenues in the CBHP Trust Fund 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 in order to fund the needs of the program. 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. During the budget downturn, the General Assembly made the following transfers out of the CBHP Trust Fund into the General Fund.

FY 2001-02:	$900,000	(Repaid in FY 2005-06)
FY 2002-03:	$1,200,000	
FY 2005-06:	$8,100,000	(Offset by an GF appropriation of $2.0 million in FY 2005-06)

Table 1 shows the Department's current estimate for the CBHP Trust Fund.

Table 1: CBHP Trust Fund Anticipated Revenues and Expenditure Needs				
	FY 2004-05 Actual	FY 2005-06 Actual	FY 2006-07 Dept. Estimate	FY 2007-08 Dept. Request
Beginning Balance	$5,389,901	$9,025,270	$4,411,882	$0
General App.	3,296,346	2,000,000	1,473,078	4,481,968
Transfer by State Controller	0	900,000	0	0
Tobacco Settlement App.	20,629,548	20,927,529	19,248,927	21,465,077
Other Revenue	867,420	990,140	785,245	852,325
Federal Match Earnings	40,591,093	41,801,325	46,430,785	48,071,835
SUBTOTAL REVENUE	**$70,774,308**	**$75,644,264**	**$72,349,917**	**$74,871,205**
State Match for Traditional Caseload	$20,723,603	$20,944,551	$25,041,079	$25,895,466
Federal Match for Traditional Caseload	40,591,093	41,801,325	46,430,785	48,071,835
Other Trust Fund Expenditures	434,342	386,506	878,053	903,904
SB 05-211 Transfer	0	8,100,000	0	0
SUBTOTAL EXPENDITURES	**$61,749,038**	**$71,232,382**	**$72,349,917**	**$74,871,205**
REMAINING BALANCE	**$9,025,270**	**$4,411,882**	**$0**	**$0**

For FY 2006-07, the current appropriations assumed that $20,973,924 would be deposited into the CBHP Trust Fund. However, shortly after the appropriation was set, it came to the State's attention that two of the four tobacco companies were disputing their contribution payments. These two tobacco companies have placed a portion of their payments into escrow accounts until this dispute can be arbitrated (Steve Allen will present more information on this issue in his briefing on December 14, 2006). Because of this dispute, the total amount of funding available to the CBHP Trust Fund from the Tobacco Settlement monies was reduced by $1,724,997.

In addition, the Department has revised their FY 2006-07 expenditure estimates upward based on current caseload and cost forecasts. *Based on the Department's November 2006 Budget Request, the General Assembly would need to appropriate $1,473,078 General Fund in FY 2006-07 in order to meet the CBHP expenditure needs.* Please note that the Department will be submitting updated estimates in February as an official supplemental request. At this time, the General Assembly has approximately $2.0 to $3.0 million under the 6.0 percent appropriations limit for FY 2006-07 supplementals submitted in January 2007.

Based on the fact that there is little room under the six percent limit and because the Tobacco Settlement monies are less than what was originally forecasted for the CBHP program, staff recommends that the Joint Budget Committee consider carrying legislation to increase the FY 2006-07 allocation into the CBHP Trust Fund from the Tobacco Settlement monies by $8.1 million (the amount that the State transferred from the CBHP Trust Fund to the General Fund in FY 2005-06).

Staff recommends legislation to increase the amount of Tobacco Settlement monies into the CBHP Trust. Staff recommends the JBC consider two options:

(1) A one-time $8.1 million transfer in FY 2006-07; or

(2) Increase the percent from 24% to 27% in FY 2006-07 and increase the percent to 30% for FY 2007-08 and thereafter.

This recommendation would accomplish two things:

1) It would fund any potential deficit in the CBHP Trust Fund in FY 2006-07. Staff's recommendation would eliminate the need for a General Fund supplemental appropriation that would count against the 6.0 percent appropriation limit.

2) The carryforward balance from FY 2006-07 would be enough to eliminate the need for all or most of the General Fund appropriation into the CBHP Trust Fund in FY 2007-08. The carryforward balance would also be enough to mitigate any change in the Tobacco Settlement monies that may result from a prolong arbitration of the amount owed by the tobacco companies.

The impact of the staff's recommendation would be that revenues into the General Fund would be reduced by $8.1 million in FY 2006-07. According to the Staff Director's November General Fund overview, staff's recommendation would end up reducing the one-third two-third transfer to capital and roads based on Legislative Council's revenue forecast.

Currently, staff is recommending a one-time adjustment of the amount of Tobacco Settlement monies flowing into the CBHP Trust Fund. Staff's recommendation would only eliminate the General Fund pressure for the CBHP program for two years (FY 2006-07 and FY 2007-08). However, according to current expenditure trends, the CBHP program would require General Fund appropriations beginning again in FY 2008-09. Therefore, the Joint Budget Committee may want to consider, as an option to staff's recommendation, increasing the CBHP Trust Fund allocation from the Tobacco Settlement permanently. Currently, at 24 percent of the Tobacco Tax Settlement monies, the CBHP is receiving $19.2 million. If the percentage was increased to 27 percent for FY 2006-07 (reducing the General Fund allocation by the 3.0 percent), the CBHP Trust Fund would receive $21.6 million. The legislation could then increase the percentage to 30 percent in FY 2007-08 (which would allow the CBHP Fund to receive approximately $24 million in revenue).

The JBC does not need to act on this recommendation until the CBHP supplemental is finalized.

Lastly, staff also recommends that if General Fund appropriations become necessary for the CBHP in the future, that the General Fund appropriations be made directly into the program line item rather than into the CBHP Trust Fund. Appropriating General Fund monies into the CBHP Trust Fund and then re-appropriating the monies out of the Trust Fund leads to a double appropriation. In addition, it hides somewhat the amount of General Fund necessary to support the program line items.

Health Care Expansion Fund

Currently, the Health Care Expansion Fund has sufficient balances to support both the Medicaid and CBHP populations funded from its revenue. A detailed analysis of the Health Care Expansion Fund can be found in the issue on Amendment 35 implementation on pages .

Expenditure Forecast

CBHP expenditures are driven by both caseload growth and increases to the projected capitation rate. Although the CBHP program is not an entitlement program, capping the program's caseload is very difficult. Federal rules require that children populations be served before any adult populations. Therefore, if it becomes necessary to cap the caseload in order to stay within appropriation limits, the adult pregnant women program must be capped or eliminated before the children's population can be capped. This would mean ending health coverage for pregnant women mid-pregnancy. Therefore, staff assumes that the CBHP has in fact become a "de-facto" entitlement program. Staff assumes that appropriations will be adjusted to reflect current caseload and cost estimates rather than trying to cap the caseload to stay within a set appropriation limit.

Caseload Forecast – Adult Pregnant Women

The adult prenatal program began in October 2002 for women with incomes up to 185 percent of the federal poverty level (FPL). With the passaged of H.B. 05-1262, eligibility will be expanded to 200 percent FPL. Table 2 shows the Department's projections for the adult prenatal program member months.

Table 2: Department Projections -- Pregnant Women 133% to 200% FPL

Month	FY 2004-05 Actual Enrollment	FY 2005-06 Actual Enrollment*	FY 2006-07 Estimated Enrollment	FY 2007-08 Estimated Enrollment
July	0	1,013	1,268	1,983
August	185	1,005	1,338	2,042
September	260	1,054	1,405	2,099
October	300	1,079	1,471	2,155

Table 2: Department Projections -- Pregnant Women 133% to 200% FPL					
Month	FY 2004-05 Actual Enrollment	FY 2005-06 Actual Enrollment*	FY 2006-07 Estimated Enrollment	FY 2007-08 Estimated Enrollment	
November	397	1,095	1,535	2,209	
December	507	1,125	1,597	2,261	
January	608	1,225	1,653	2,307	
February	714	1,216	1,708	2,352	
March	859	1,186	1,762	2,396	
April	933	1,191	1,815	2,440	
May	962	1,188	1,868	2,484	
June	954	1,239	1,921	2,528	
Total Member Months	6,679	13,616	19,341	27,256	40.92%
Average Monthly Enrollment	557	1,135	1,612	2,271	40.92%
Enrollment Below 186% FPL	6,679	13,439	16,325	21,840	33.78%
Enrollment Eligible for Amendment 35 Funding	n/a	12,011	17,913	25,828	44.19%

*This is caseload number is not yet finalized due to a retroactive adjustment.

Based on the Department's updated forecast, the average monthly enrollment for the adult prenatal program will be 1,612 women in FY 2006-07. The current FY 2006-07 appropriation assumed 18,936 prenatal months or an average monthly enrollment of 1,578. The difference between the current FY 2006-07 appropriation and the Department's new FY 2006-07 estimate is an increase of 34 clients (2.2 percent) on a monthly basis. Because all prenatal caseload over 119 clients per month (or 1,428 member months) can be funded from the Health Care Expansion Fund, the Department's revised FY 2006-07 prenatal caseload estimate will not drive additional appropriations from the CBHP Trust Fund or the General Fund.

The Department's FY 2007-08 forecast assumes prenatal months of 27,256 (average monthly enrollment of 2,271). Again all of the forecast above 1,428 member months can be funded from the Health Care Expansion Fund. Therefore, the Department's caseload forecast for pregnant women does not drive a CBHP Trust Fund or General Fund appropriation.

Caseload Forecast – Children's Population

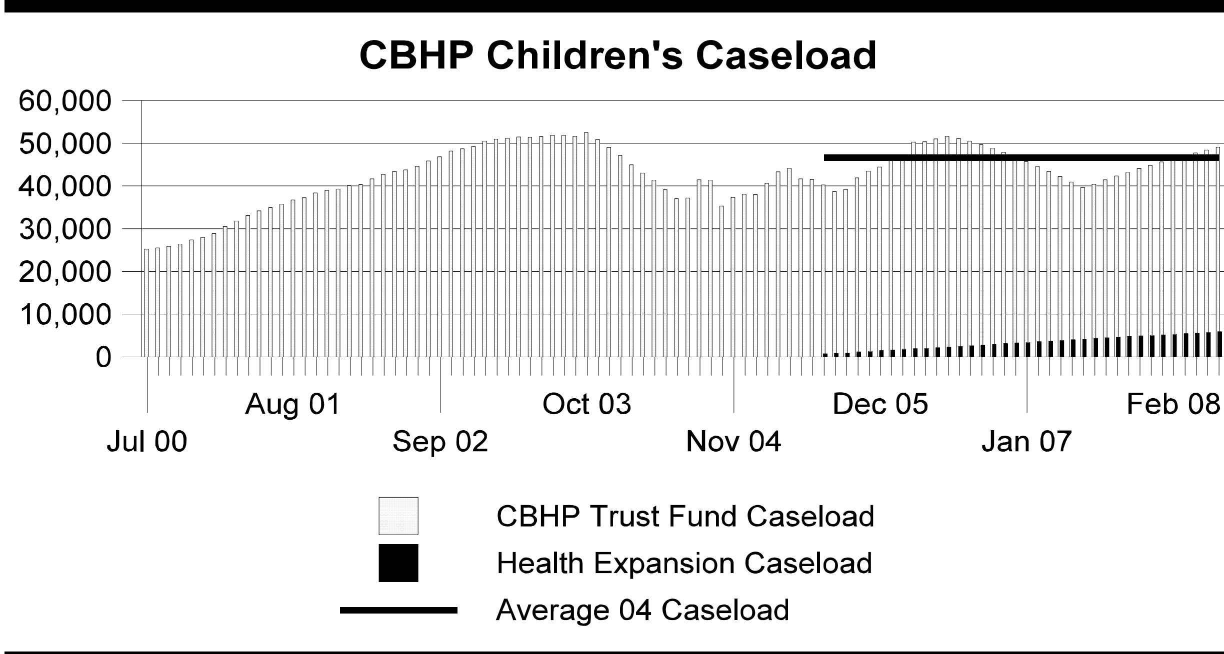
The children's program began in 1998 for children with incomes up to 185 percent of the federal poverty level (FPL) who were not eligible for Medicaid. With the passaged of H.B. 05-1262, eligibility was expanded to 200 percent FPL. Table 3 shows the Department's projections for the children's caseload.

Table 3: Estimated Monthly Enrollment for the CBHP Children Caseload

Month	FY 2003-04 Actual	FY 2004-05 Actual	FY 2005-06* Actual Est.	FY 2006-07 Dept. Forecast	FY 2007-08 Dept. Forecast
July	51,846	37,159	41,007	53,551	44,720
August	51,844	41,477	39,499	53,078	45,895
September	51,626	41,355	40,085	52,479	46,987
October	52,484	35,354	43,047	51,757	47,996
November	50,882	37,303	44,797	50,960	48,963
December	49,001	38,036	45,903	50,088	49,887
January	47,156	37,989	47,586	49,145	50,772
February	44,976	40,610	49,056	48,153	51,637
March	42,979	43,337	52,189	47,114	52,481
April	41,353	44,175	52,328	46,027	53,304
May	39,111	41,709	53,133	44,916	54,127
June	37,069	41,552	53,855	43,781	54,950
Average	46,694	40,005	46,874	49,254	50,143
% Growth from Prior Year	-5.12%	-14.33%	17.17%	5.08%	1.81%
Enrollment at or below 185% FPL		40,005	45,367	45,949	45,049
Enrollment Above FY 2003-04 Caseload		n/a	n/a	n/a	n/a
Enrollment Eligible for Amendment 35 (includes children enrolled from 185% to 200% FPL, children enrolled over the FY 2003-04 average monthly enrollment)				3,305	5,094

The following chart shows a five year history for the CBHP children's caseload and the two forecast years. The chart shows the impact to the CBHP caseload from capping the program in FY 2003-04 and lifting the cap in FY 2004-05. The chart also shows the impact of eliminating the Medicaid Asset

on the CBHP children population beginning in FY 2006-07. Finally, the chart shows the caseload impact of increasing eligibility up to 200 percent FPL.



The Department's current FY 2006-07 children's caseload forecast is 49,949 clients. This forecast is 7,359 (17.3 percent) clients higher than the current FY 2006-07 appropriation estimate of 42,590 total children. The Department's forecast includes a higher growth estimate and also slows the reduction in caseload due to eliminating the Medicaid asset test. Thus far in FY 2006-07, the caseload report indicates a lower amount than the Department's current estimate but it is too soon to tell because the caseload report has not been adjusted for retroactivity. Staff will continue to monitor actual monthly caseload before making a final recommendation during figure setting in March 2007.

Based on the FY 2006-07 revised forecast, the Department is forecasting a FY 2007-08 caseload of 50,143 children, which is only a 1.8 percent increase over the Department's average monthly enrollment for FY 2006-07.

Staff recommends that the Committee discuss the following issues with the Department at their hearing:

1) Current caseload reports seem to indicate that the decrease in the CBHP due to implementing the asset test has not been high as originally forecasted. Does the Department have any data on how many CBHP children, year-to-date, have moved into the Medicaid program?

2) Please discuss the difficulties of using accrual accounting for budgeting the CBHP instead of cash accounting as is used in the Medicaid program? If the Department was allowed to use the cash basis of accounting, would that approve caseload forecasting for the CBHP program? What would be the impact to the per capita costs?

CBHP Capitation Cost Estimates

Table 4 summarizes the Department's CBHP program request for both FY 2006-07 and FY 2007-08.

Table 4: CBHP Program Expenditures

	FY 2006-07 Current Appropriation	FY 2006-07 Department Estimate	FY 2006-07 Department Request
Adult Caseload			
CBHP Trust Fund Adult PMPM	1,428	1,428	1,428
Health Expansion Fund Adult PMPM	17,508	17,913	25,828
TOTAL Prenatal Member Months	18,936	19,341	27,256
Cost PMPM (includes delivery)	$905.54	$1,045.44	$865.10
Subtotal Prenatal Care	**$17,147,305**	**$20,219,855**	**$23,579,166**
CBHP Trust Fund Children Caseload	38,635	45,949	45,049
Health Expansion Fund Children Caseload	3,955	3,306	5,094
Medical Costs			
Number of Member Months	511,080	591,060	601,716
Cost PMPM	$104.14	$105.88	$112.68
Subtotal Children Medical Costs	**$53,223,871**	**$62,581,433**	**$67,801,359**
Dental Costs			
Number of Member Months	444,636	436,138	427,877
Dental PMPM	$13.30	$13.30	$13.97
Subtotal Dental Costs	$5,913,659	$5,800,640	$5,977,440
Subtotal Children	$59,137,530	$68,382,073	$73,778,799
Total CBHP Service Costs	$76,284,836	$88,601,928	$97,357,965

Table 4: CBHP Program Expenditures			
	FY 2006-07 Current Appropriation	**FY 2006-07 Department Estimate**	**FY 2006-07 Department Request**
Total Administrative Costs*	$5,521,207	$5,642,217	$5,535,590
Total CBHP Indigent Care Division Expenditures	**$81,806,043**	**$94,244,145**	**$102,893,555**

*CBHP Administrative Costs only. Does not include administrative costs for other Department functions (i.e. CBHP Trust Fund expenditures in the EDO and DHS-Medicaid Funded Programs divisions)

The Department contracts with an actuary to determine the medical and dental rates for the CBHP program. The rates in the table above are a "blended rate" for both the caseload served in the self-insured managed care network and the caseload served by health maintenance organizations.

Estimated Children's Medical Costs

The reason for the Department's revised PMPM rate for children in FY 2006-07 is based on the case mix between the self-insured network and the MCOs. Last year the Department's actuary estimated the costs for children in the self-insured network to $120.30 per month. Children in the MCOs were estimated to cost $95.44 per month. At the time the appropriation was estimated, it was assumed that 35 percent of clients were in the self-insured network and 65 percent of clients were in the MCOs. This resulted in the blended rate of $104.14 that was used for the FY 2006-07 appropriation. Based on more current data, the Department now estimates that 42 percent of clients are in the self-funded plan and 58 percent of clients are in the MCOs. This results in a new estimated blended rate of $105.88.

For FY 2007-08, the actuary is estimating that rates for the self-insured network will increase to $124.00 per month (an increase of 3.1 percent). However, the actuary is forecasting an increase to the MCO rate to $104.48 (a 9.4 percent increase). Assuming the same case mix ratio as is used in FY 2006-07, the Department forecasts that the blended rate will be $112.68 per month (a total increase of 6.4 percent). At this level, the average annual medical costs for child on the CBHP program is $1,352.16. This compares to the Department's estimated $1,573.09 average annual medical costs for child on the Medicaid program (before decision items).

Estimated Prenatal Medical Costs

The Department's budget request shows an increase to the FY 2006-07 prenatal member month rate of $139.90 (a 15.4 percent increase) from the current appropriation FY 2006-07 rate. The Department gives two major reasons for the increase to the rate: (1) the original appropriation assumed 9 months of care while the new assumption is 6 months of care which drives up the average per member per month costs, and (2) only 85 percent of the women are delivery while on the program.

For FY 2007-08, the actuary reduces the rate the PMPM to $865.10 (a 17.3 percent decrease from the actuaries FY 2006-07 rate). The reasons for the decrease to the rate is as the program matures, distortion in the data for a small caseload should be smoothed against a larger pool, and changes in the fee schedules and variation in the blend of services received by clients.

CBHP Dental Costs

The Department's revised FY 2006-07 estimate does not include any changes to the current appropriated rate for dental services of $13.30 per month. For FY 2007-08, the actuary estimates a 5.0 percent increase from the FY 2006-07 rate to $13.97 per month. The actuary used an industry trend in order to establish the new rate.

Questions for the Department

1) Over the last several years, the overall per capita costs for the Medicaid populations has decreased as the population increased. This was partly responsible for the large drop to Colorado Access's rates for children when the rate was rebased against the fee-for-service. However in the CBHP program, even though caseload is expanding, there does not seem to be the same lower cost resulting from an expanded risk pool. Does the Department have an explanation for this phenomenon?

2) Please describe the use of encounter data in the development of the actuary rate's for the CBHP program. Could this be a model on how to set MCO Medicaid rates in the future?

3) Does the Department have an explanation on why the case mix between the self-insured network and the MCOs changed from the original FY 2006-07 assumption?

4) Does the Department have any data on how many families have children enrolled in both the CBHP and Medicaid program based on their age and income (i.e. for a family under 133% FPL, their 4 year old would be in Medicaid but their 7 year would qualify for CBHP).

Federal Reauthorization in 2007

The Balanced Budget Act of 1997, which established SCHIP, set the program's annual federal funding levels for a ten-year period (1998-2007), after which SCHIP would need to be reauthorized. (States can continue to spend any unspent SChIP funds remaining after 2007, but will not receive any further SCHIP funds after 2007 unless the program is reauthorized). Staff fully anticipates that Congress will reauthorize the program. However, in reauthorizing the program, Congress may take the opportunity to modify, expand, or retract the program. One of the concerns that has been raised is if Congress decides to keep the federal allotment (remember SCHIP operates more like a block grant than an entitlement program in that it is a capped amount of funding) the same as 2007 allotment for FY 2008-2012.

Table 5 below shows the Department's estimate of what will happen to the CBHP program if the federal allotment stays the same over the next five years.

Table 5: Department's Estimated Federal Allotment for CBHP Program

State Fiscal Year	**FY 2005-06**	**FY 2006-07**	**FY 2007-08**	**FY 2008-09**	**FY 2009-10**	**FY 2010-11**
Total Estimated Expenditures	$79,391,679	$94,318,207	$103,437,689	$131,318,394	$157,939,841	$185,407,265
State Match at 35%	$27,787,088	$33,011,372	$36,203,191	$45,961,438	$55,278,944	$64,892,543
Federal Match at 65%	$51,604,591	$61,306,835	$67,234,498	$85,356,956	$102,660,897	$120,514,722
Federal Fiscal Year	**FFY 2006**	**FFY 2007**	**FFY 2008**	**FFY 2009**	**FFY 2010**	**FFY 2011**
Federal Allotment	$57,951,287	$57,951,287	$57,951,287	$57,951,287	$57,951,287	$57,951,287
Available from prior years	102,056,558	105,977,693	101,140,229	87,326,403	55,594,749	6,421,683
Total Federal Funds Available	$160,007,845	$163,928,980	$159,091,516	$145,277,690	$113,546,036	$64,372,970
Federal Fund Expenditures on FFY Basis	(54,030,152)	(62,788,751)	(71,765,113)	(89,682,941)	(107,124,353)	(120,514,722)
Unused Allotment for Next Year	$105,977,693	$101,140,229	$87,326,403	$55,594,749	$6,421,683	($56,141,752)

As Table 5 shows, beginning in FFY 2007 the federal match requirement for the CBHP program is anticipated to be larger than the federal allotment. This is not an immediate problem in that Colorado has a carryforward of unused federal allotment from prior years. However, if the federal allotment remains frozen at the 2007 level, the Department forecasts that by FFY 2011, the federal match will exceed the amount of federal funds available by $56.1 million. In staff's opinion, it is unlikely that Congress will keep the federal allotment frozen even though for budget purposes, the SCHIP is concerned a discretionary block grant program rather than an entitlement program that is allowed to grow. However, this issue must be watched carefully as Congress begins to debate the re-authorization of the CBHP program.

In addition to the federal allotment issue, Congress may also address if the CBHP program should be expanded to allow more children or adults to participate in the program. Following is a partial list of Section 1115 Waivers that have been used to expand SCHIP to cover more uninsured.

State	Key Features
AZ	Allows state to use SCHIP funds to expand eligibility for parents, subject to an enrollment cap, and to refinance existing (Medicaid-financed) childless adult coverage.
CA	Allows state to use SCHIP funds to expand eligibility for parents.
CO	Allows state to use SCHIP funds to expand eligibility for pregnant women.
IL	Allows state to use Medicaid and SCHIP funds to expand eligibility for parents and to refinance some state-funded health programs. Also allows the state to subsidize premiums for private coverage for some beneficiaries as an alternative to direct coverage.
NM	Allows state to use SCHIP funds to expand eligibility for parents and other adutls, providing a limited benefit package.

Question for the Department

Please describe any issues that the Department believes should be addressed as Congress re-authorizes the SCHIP program.

FY 2007-08 Joint Budget Committee Staff Budget Briefing
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
Amendment 35 Implementation

ISSUE

Due to the slow start of many of the Amendment 35 health care expansion programs, the Health Care Expansion Fund had a FY 2005-06 ending balance of $94.6 million.

SUMMARY

❑ By the end of FY 2007-08, the Department is anticipating that the Health Care Expansion Fund will have an ending fund balance of $130.2 million. However, beginning FY 2008-09, forecasted expenditures from the program are anticipated to exceed new revenue and the fund balance will begin to be used to sustain current programs. Nevertheless, the Department forecasts that the ending balance in FY 2010-11 will be approximately $106.0 million.

❑ Current law allows parent of children who are eligible for Medicaid or CBHP to be an optional Medicaid eligibility group. Current law provides the poverty level for this group to participate can not be set lower than at 60 percent FPL and the law is permissive for it to be higher than 60 percent (there is no upper limit set, just a lower limit).

RECOMMENDATION:

Staff recommends that the Joint Budget Committee consider the fiscal impact of increasing the eligibility for family Medicaid from 60 percent of FPL to 75 percent of FPL. Staff recommends that the Committee discuss this option with the Department at their hearing.

DISCUSSION:

When H.B. 05-1262 was originally introduced the bill allowed parents of enrolled children to be eligible for Medicaid if their income was at or below 100 percent of FPL. Due to concerns about the cost of the program, the final bill provided parents under 60 percent of FPL would be added. However, the language in the statute would allow the Department to add additional parents above 60 percent of FPL. The 60 percent of FPL is a statutory floor – not a ceiling – on who can be added as an optional Medicaid program using Health Care Expansion Funds.

Due to the slow start of implementing the H.B. 05-1262 programs last year, the fund balance in the Health Care Expansion Fund grew faster than originally forecasted in the fiscal note for H.B. 05-1262. At the end of FY 2005-06, the fund balance was $94.6 million. According to the Department's budget request the fund balance is anticipated to grow to $130.2 million by the end of FY 2007-08.

Table 1: Health Care Expansion Fund Balance – Department Estimate

State Fiscal Year	FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11
Fund Balance	$28,095,163	$94,635,519	$125,507,615	$130,200,057	$128,462,727	$121,046,797
New Revenues	78,095,126	73,278,000	70,748,000	68,402,000	66,516,000	64,952,000
Interest Earnings	2,339,116	3,698,730	4,323,038	4,374,724	4,294,911	1,945,451
Total Revenues	$108,529,405	$171,612,249	$200,578,653	$202,976,781	$199,273,638	$187,944,248
Administrative Expenses	$299,121	$522,861	$520,812	$520,812	$520,812	$520,812
Medical Service Premiums	8,219,778	34,096,458	54,186,982	56,225,280	57,903,973	59,673,477
Medicaid Mental Health	81,660	2,122,911	3,996,004	4,200,966	4,415,093	4,640,185
CBHP Expenditures	5,108,706	8,717,991	11,030,385	12,922,583	14,742,550	16,471,831
DHS Program Expenditures	184,621	644,413	644,413	644,413	644,413	644,413
Total Expenditures	$13,893,886	$46,104,634	$70,378,596	$74,514,054	$78,226,841	$81,950,718
Health Care Expansion Fund Balance	$94,635,519		$130,200,057	$128,462,727	$121,046,797	$105,993,530

As Table 1 shows, the Department anticipates that by FY 2007-08 the fund balance in the Health Care Expansion Fund will be $130.2 million. However, beginning in FY 2008-09 expenditures from the fund will be begin to exceed incoming revenues causing the fund balance to begin to be spent down. However, by the end of FY 2010-11 the fund balance will still be $106.0 million.

According to the Department's original fiscal estimates for H.B. 05-1262, the Department forecasted that the caseload for parents up to 75 percent FPL would be 8,273 clients in FY 2007-08. That is 2,206 more clients than the Department's current FY 2007-08 caseload estimate of 6,067 clients up to 60 percent FPL. Adding these clients in FY 2007-08, at the Department's current forecasted per capita costs, would cost an additional $5.8 million (of this amount, $2.9 million would be from the Health Care Expansion Fund and $2.9 million would be federal funds). Based on the Department's assumptions, staff estimates that the cumulative cost for the four-year period would be an additional $22.7 million. This would reduce the Health Care Expansion Fund balance to $83,267,114 in FY 2010-11. However, the fund balance would still be more than the amount that is required to remain in the fund as a reserve.

Table 2: Estimate Costs for Expanding from 60 % FPL to 75% FPL

	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11
60% FPL Estimated Caseload (Dept. Est.)	6,067	6,089	6,112	6,135
75% FPL Estimated Caseload (Dept. Original Fiscal Note Est.)	8,273	9,968	11,696	11,739
Difference in Caseload	2,206	3,879	5,584	5,604
Department's Per Capita Cost Estimate	$2,444.75	$2,433.99	$2,423.28	$2,412.62
Medical Service Premiums Costs	$5,393,119	$9,441,459	$13,531,615	$13,520,993
Department's MH Per Capita	$192.70	$199.95	$207.47	$215.27
Mental Health Costs	$425,096	$775,606	$1,158,512	$1,206,432
Total MSP & MH Additional Costs	$5,818,215	$10,217,065	$14,690,128	$14,727,425
Health Care Expansion (50%)	$2,909,107	$5,108,533	$7,345,064	$7,363,712
Cumulative Impact				**$22,726,416**

Because the tobacco tax revenue is anticipated to be a declining revenue source, staff believes that adding additional eligibility categories will drain the fund more quickly. Therefore, staff would urge caution in pursuing such a course. However, at the same time, a fund is being allowed to accumulate balances while some Colorado citizens are going without health care coverage today. There certainly may be pressure to increase the eligibility because of this fact. If the JBC decides to budget to a higher level (it does not require a bill, the Department can change their rules to 75 percent within

existing statute), the drawback is this course of action may not be sustainable after FY 2010-11 without additional changes to law or revenue sources.

Questions for the Department:

(1) Please discuss the drawbacks or advantages of increasing the eligibility for parents from 60 percent FPL to 75 percent FPL. According to the Department's estimates, when would the Health Care Expansion Fund fail to meet its reserve requirement if this eligibility change was made?

(2) Please briefly update the Committee on implementation of all H.B. 05-1262 Medicaid and CBHP expansion programs.

FY 2007-08 Joint Budget Committee Staff Budget Briefing
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
Informational Issue: Uninsurance Aid in Colorado

ISSUE

The Annual Demographic Survey by the U.S. Department of Labor and U.S. Census Bureau estimates that 17.0 percent of the Colorado population were not covered by health insurance during calendar year 2005. Fourteen states had higher uninsurance rates than Colorado and 36 states had lower uninsurance rates.

SUMMARY

- ❑ The U.S. Census Bureau estimated that the number of uninsured in Colorado in 2005 was 785,000 individuals. Of this amount, the U.S. Census Bureau estimates that 158,000 are under age 18 and 5,000 are over age 65.

- ❑ The Department of Health Care Policy and Financing has six major line items in the Long Bill that provide funding for the uninsured. These line items include the following: (1) Colorado Indigent Care Program; (2) Old Age Pension Medical Program; (3) Supplemental Payments to Clinics; (4) Supplemental Payments to Speciality Children's Hospitals; (5) the Primary Care Program; and (6) the Comprehensive Primary/Preventative Care Grant Program. Excluding certified public funds, the State and federal funds currently dedicated in FY 2006-07 for services to the uninsured total $239.3 million.

- ❑ Approximately $44.1 million of the funding currently going to the uninsured could be restructured to draw down additional Title XIX federal funds. However, Constitutional and statute changes would be necessary.

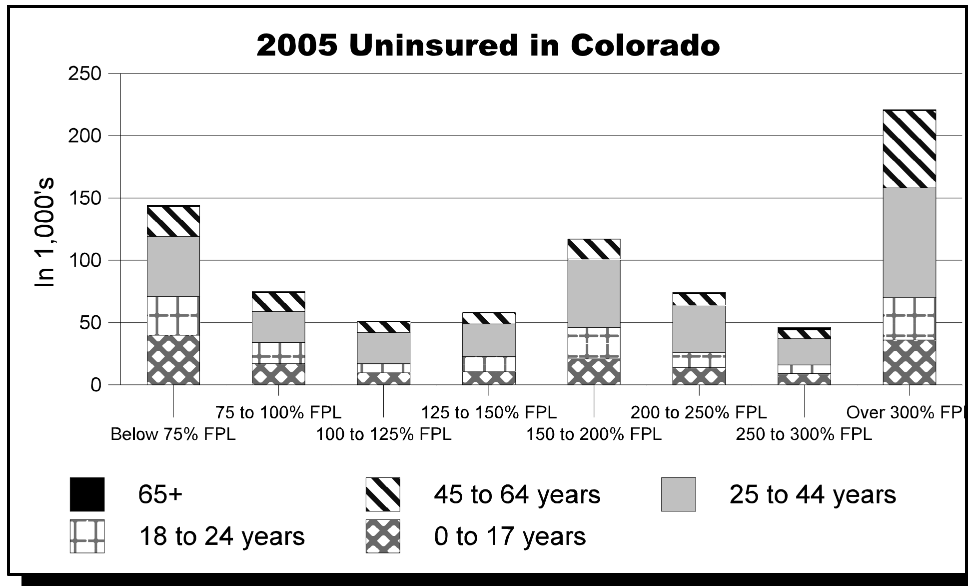
RECOMMENDATION:

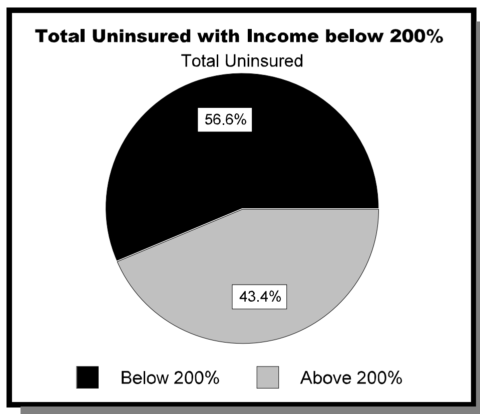
Staff recommends that the Committee discuss with the Department how current funding could be restructured in order to draw down additional federal funds to cover more of the uninsured through either the Medicaid or CBHP program.

DISCUSSION:

According to the U.S. Census Bureau Annual Demographic Survey, approximately 785,000 (17.0 percent) of Colorado citizens were without health insurance for all of 2005. Colorado's uninsurance rate is higher than the national average of 15.9 percent. A total of 36 states (including the District of Columbia) have lower uninsurance rate than does Colorado. Of the six states bordering Colorado, only Arizona and New Mexico have higher rates of uninsurance.

Approximately 444,000 (56.6 percent) of the uninsured are estimated to have incomes at or below 200 percent and 43.4 percent have incomes over 200 percent FPL. Approximately, 20.0 percent of the total uninsured are children, 18.0 percent are young adults between 18 to 24 years of age, 42.0 percent are adults ages 25 to 44, 19.0 percent are adults ages 45 to 64, and approximately 1.0 percent are adults older than 65 years of age. However, children account for approximately 45.2 percent of the uninsured who have incomes under 200 percent FPL. At this level of income, most children could be eligible for medical coverage through either Medicaid or the CBHP programs.





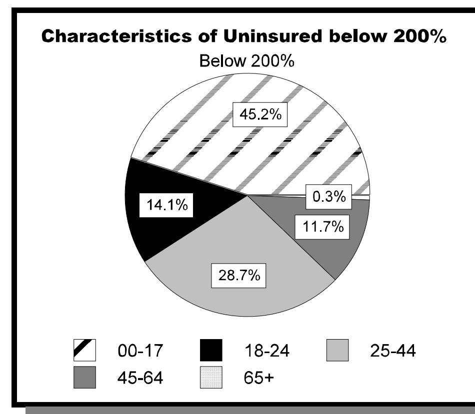


Table 1: U.S. Census Bureau Estimate of Uninsured in Colorado By Income and Age
(Numbers in 000's)

State Fiscal Year	Below 100%	100% to 150%	150% to 200%	200% to 250%	250% to 300%	300% and Over	Total
Children 0-17	57	21	21	14	9	36	158
% of Total	7.26%	2.68%	2.68%	1.78%	1.15%	4.59%	20.13%
Adults 18 to 24	48	19	25	12	7	34	145
% of Total	6.11%	2.42%	3.18%	1.53%	0.89%	4.33%	18.47%
Adults 25 to 44	73	51	55	38	21	88	326
% of Total	9.30%	6.50%	7.01%	4.84%	2.68%	11.21%	41.53%
Adults 45 to 64	39	18	16	9	7	62	151
% of Total	4.97%	2.29%	2.04%	1.15%	0.89%	7.90%	19.24%
Adults 65 +	2	0	0	0	1	2	5
% of Total	0.25%	0.00%	0.00%	0.00%	0.13%	0.25%	0.64%
Total Uninsured	219	109	117	73	45	222	785
% of Total	27.90%	13.89%	14.90%	9.30%	5.73%	28.28%	100.00%

As table 1 above shows, even if all of the children who could potentially be eligible for Medicaid or CBHP because of their income (i.e. children below 200 percent FPL), were to enroll in these programs, this would only address 12.62 percent of the total uninsured population(based on 2005 estimates). If these children would have enrolled in Medicaid or CBHP in 2005, the uninsurance rate would still have been 14.8 percent (still higher than 28 other states). Lastly, if 99,000 children were to enroll in Medicaid or CBHP, this would have increased the enrollment in these programs by approximately 38.0 percent (Medicaid and CBHP children low-income children enrollment totaled 260,597 in FY 2004-05).

Current Funding Devoted to the Uninsured

Currently, the Department has six major programs devoted to covering a portion of the health care costs for the uninsured.

CARE REIMBURSEMENT PROGRAMS

Colorado Indigent Care Program

Provides partial reimbursements to hospitals and clinics participating in the program for providing services to uninsured individuals up to 250 percent FPL. In FY 2004-05, the program provided services to approximately 179,129 clients (in FY 2004-05, the ICP only covered individuals up to 185 percent FPL). It is important to note that this program is not an insurance program. Rather, it is a way for providers to recoup some of their costs for the uninsured. The number of participating providers includes 49 hospitals, 18 clinics, and 51 satellite facilities.

Old Age Pension Medical Program

For individuals older than 60 years of age with incomes at or below 76.9 percent of FPL and who are not eligible for Medicaid, the Old Age Pension Medical Program provides some limited medical benefits. The number of clients served in FY 2004-05 was 4,766 clients. This program operates more like a regular Government medical program in that clients receive an eligibility card and have defined set of services that are covered.

Through these two programs, participating providers were reimbursed for some of the costs related to covering the uninsured at low income levels. In FY 2004-05, the number of clients served by these programs would represent approximately 23.4 percent of the number of uninsured estimated by the Census Bureau for 2005. Total FY 2004-05 expenditures for these programs was approximately $280.1 million (includes the total fund line item expenditures for Safety Net Provider Payments, Clinic Based Indigent Care, and Old Age Pension Medical Program). This averages approximately $1,523 per client served.

In addition to the programs that staff has identified as care reimbursement programs, the Department also has enhanced reimbursement and grant programs that attempt to aid providers serving a large number of uninsured and underinsured clients.

ENHANCED REIMBURSEMENT & GRANT PROGRAMS

Pediatric Speciality Hospital Line Item

This line item allows enhanced reimbursement for speciality hospitals that have a lot of Medicaid, CBHP, and uninsured clients.

Primary Care Program

This program provides grant funding to providers who serve indigent or uninsured clients.

Comprehensive Primary and Preventative Care Fund

This program provides grant funding to providers that demonstrate the intended use of funds to expand services to indigent Colorado residents. This funding is used mainly to increase the infrastructure (both clinic space and staff) to serve the indigent and uninsured populations.

For the most part, funding for the uninsured indigent population tends to be focused on providing financial aid to the providers who provide services to uninsured and indigent care programs rather than a direct aid program to individuals. Unlike low-income Medicaid and the CBHP programs, the indigent care program is much broader in that childless non-disabled adults can benefit from the provision of funding. Therefore, even as Medicaid and CBHP eligibility is currently being expanded to include a larger portion of uninsured, funding would still be needed to ensure that providers receive some reimbursement for attending to the needs of those individuals ineligible for the Medicaid or CBHP programs.

The current FY 2006-07 appropriation for these programs includes a total of $360.6 million. However of this amount, $135.0 million is certified local funds from qualifying public hospitals. Therefore, these expenditures do not represent state dollars provided but are specific expenditures by local entities that are used to draw down the federal match through the Disproportionate Share Program and Medicare Upper Payment limit programs within the Medicaid program.

For FY 2007-08, the Department's request for the indigent care programs totals $356.8 million. The decrease is related mainly to lower Tobacco Tax revenues for several of the programs. Table 2 provides a five-year history of the funding available for these programs and line items.

Table 2 -- Funding History for Programs for the Uninsured

	FY 2003-04 Actual	FY 2004-05 Actual	FY 2005-06 Actual	FY 2006-07 App.	FY 2007-08 Request
Safety Net Provider Payments	$255,976,646	$264,013,206	$287,296,074	$296,188,630	$296,188,630
S.B. 06-044 Expansion	0	0	0	14,962,408	15,000,000
Clinic Based Indigent Care	6,119,760	6,119,760	6,119,760	6,119,760	6,119,760
Old Age Pension Program	10,746,174	9,999,321	14,426,967	14,262,663	13,780,951
Pediatric Specialty Hospital	0	0	5,452,134	7,732,072	7,677,436
Primary Care Program	0	0	44,041,879	32,939,958	29,099,458
Comprehensive Primary Care Grant Program	5,064,339	2,566,401	2,604,927	2,621,651	2,668,034
Total Funding	**$277,906,919**	**$282,698,688**	**$359,941,741**	**$374,827,142**	**$370,534,269**

Staff Comment:

The Department's FY 2007-08 request for this issue $92.6 million higher (an increase of 33.3 percent) than the funding available five years ago for these programs. The majority of the funding increase resulted from the following:

(1) The passage Amendment 35 which increased tobacco taxes to expand clinic care for the medically indigent (primary care program);

(2) The passage of Referendum C and S.B. 06-044 which authorized an additional $15.0 million and increased eligibility for the indigent care program to 250 percent FPL; and

(3) Maximizing the use of the Medicare Upper Payment limit to increase the federal funds available.

Of the funding that is provided to the indigent care programs, staff has identified two streams of funding that could be used to draw down additional federal match if the funding was placed into Medicaid expansion rather than used as provider grant funding. These two streams of funding are the $15.0 million that is was approved in S.B. 06-44 and the $29.1 million for the primary care grant program. If this funding was used to expand Medicaid coverage for parents up to 100 percent FPL or to provide primary care services for childless adults (a waiver program similarly to Utah's program), then the state could draw a federal match and double the amount of funding available for these two programs currently. However, this would require both Constitutional and statute changes in order to restructure the purposes for these funding streams. However, if it becomes the policy of the state to provide health insurance to uninsured individuals, rather than grant funding to providers, then staff believes that General Assembly may want to pursue ways to maximize federal funds with existing revenue streams.

While maximizing federal funds may be an option for discussion, staff must warn that expanding Medicaid to more eligibility categories also has draw backs. The major draw back is the entitlement nature of Medicaid. Therefore, any expansion would need to be pursued as a waiver program with the ability to cap the expansion population and perhaps limit the benefit design. In addition, the current Medicaid program is forecasted to grow by more than 6.0 percent in FY 2007-08. Adding additional population unto a program that is already becoming a larger share of the state budget every year will create additional budgetary pressure for other state programs. In addition, the S.B. 06-44 is a temporary funding stream for five years (during the Referendum C time frame) and the funding stream from the Tobacco Tax (the source of funding for the Primary Care Grant program) is a stable or declining revenue stream. Therefore, placing additional health care costs on these revenue streams will create General Fund obligations in the future as health care costs for the expanded populations increase.

Other Uninsured Issues

Blue Ribbon Commission on Health Care Reform

Currently, the Blue Ribbon Commission on Health Care Reform established in S.B. 06-208 began meeting in November 2006 to discuss health reform issues. Specifically, the Commission's charge is to study and look at health care reform models that expand coverage and reduce the cost of health care insurance . The Commission is authorized to examine options for expanding affordable health coverage for all Colorado residents in both the public and private sector markets. The Commission's final report is not due until November 30, 2007. Therefore, staff anticipates that in next year's budget briefing there will be a lot more discussion about potential costs and impacts of possible Medicaid or CBHP expansions and other health care reform issues.

Recent Action in Massachusetts

Recently, Massachusetts passed health care reform to all require health insurance for all state residents. The key features of the plan include:

1) All state residents must obtain health coverage by July 1, 2007 and if proof insurance is not available the individual will be penalized on their state income tax reform;

2) The "Insurance Connector" will connect individuals and small businesses with health insurance options and allow for portability of coverage from one job to another;

3) The state will provide public subsidies (on a sliding scale) to families with incomes up to 300 percent of the federal poverty level and subsidized insurance products will be made available to individuals earning less than 100 percent FPL who do not already qualify for the Medicaid program.

4) The state will expand Medicaid coverage for children with family incomes between 200 to 300 percent FPL.

5) Businesses will be assessed a fee of $295 per worker with 10 or more employees that do not provide health coverage. Also a free rider surcharge will be imposed on employers without health plans who have employees that receive uncompensated care more than five times a year. The surcharge will range from 10 to 100 percent of the state's cost with the first $50,000 per employer exempted.

6) Incentives for insurance companies to offer low-cost "basic" insurance plans to individuals 19 to 26.

7) A phasing-out of the state's Uncompensated Care Pool (DSH program) as free care shifts to insured care.

Currently the Massachusetts plan is just beginning to be implemented. However, staff has the following observations.

✓ Massachusetts already had a generous Medicaid and CBHP program. Therefore, Massachusetts set about solving a 10 percent uninsurance rate rather than a 17 percent uninsurance rate.

✓ Restructuring the Colorado Safety Net Provider program would be difficult since the majority of the state match for this program comes from the public hospitals that offer the current care.

✓ A Massachusetts type plan could not be implemented in Colorado without additional revenues to support the program. Massachusetts does not have the TABOR or appropriation limits that Colorado budgets under.

Questions for the Department

1) Please discuss the impact that the funding increase for CBHP marketing program has had on enrollment in CBHP? Please update the Committee on the current implementation of pilot programs to increase enrollment of children into the Medicaid and CBHP through school sites.
2) Please discuss the potential fiscal impact if all children and adults currently eligible for Medicaid and CBHP were enrolled in the programs? What does the Department estimate that the current penetration rates are for both programs?

3) Please update the Committee on the grant awards for the Primary Care Program to date?

4) In the Department's opinion, could the Medicaid or CBHP program be modified to cover more of the uninsured without additional state funding requirements. Which uninsured populations and providers would win or lose if some of the current funding in the Indigent Care Program was restructured to expand Medicaid and CBHP eligibility (granted restructuring this funding could require both Constitutional and statutory changes)?

FY 2007-08 Joint Budget Committee Staff Budget Briefing
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
Department Staffing Issues

ISSUE

The Department has submitted to two decision items for FY 2007-08 to address staffing issues at the Department.

SUMMARY

❑ Last year the Committee restored the staffing budget reductions that were enacted in FY 2003-04. For FY 2007-08, the Department's requests authority for an additional 12.8 FTE without new funding to address their current FTE allotment with Departmental need and appropriation authority.

❑ The Department's budget request also includes a total fund increase of $222,808 for additional commercial lease space to accommodate current and future Department growth.

RECOMMENDATION

Staff recommends that the Department discuss the staffing improvements that have occurred during the last year in relation to turnover, overall productivity, and achieving the mission of the Department.

DISCUSSION:

The Department has the second largest state appropriation. However, if excluding elected official departments, the Department has the second smallest allocation of FTE positions (only the Department of Local Affairs has a smaller number of FTE). Over the years, as the Department's responsibilities have increased, only small adjustments have been made to staffing levels at the Department. Partly as a result of this, the Department has experienced a large turnover rate and a vacancy savings in their personal services line item that is greater than the amount budgeted. This has led to the Department to revert personal services at the end of each fiscal year for at least the last four years. Therefore, the Department requests that the Committee adjust the Department's FTE allotment by 12.8 FTE positions. The Department believes that the authority for the FTE positions can be added without the need for additional personal services.

In order to accommodate staff growth, the Department also requests $222,808 total funds for increased lease space. Last Session, shortly after the debate on the Long Bill was completed, the Department was informed by the Department of Personnel and Administration that the plan to use basement space at 1570 Grant Street for staffing space was unacceptable because of health and safety

issues related to the space. Therefore, the Department's plan on how to accommodate their current staff growth within their existing Capitol and commercial lease space was no longer workable. At that time it was too late for the Department to submit a budget amendment for FY 2006-07 to address this issue. Therefore, in June 2006, the Department submitted an emergency supplemental informing the Committee of the lease space issue and requesting funds to address the issue. In June, staff recommended against the Committee funding the Department's emergency request for the following reasons:

1) The request did not meet the emergency criteria in statute. The Department would have sufficient funding between their operating and commercial lease space to pay for additional space until the Committee could address the issue during the January supplementals.

2) The Department was requesting supplemental funding before the start of the fiscal year. Staff can not analyze the Department's total appropriation need to see if funding can be transferred from one line item to another line item until after the start of the fiscal year. In staff's opinion, approving early supplementals creates an expectation of the funding even though staff has no sense of how this request will be prioritized against other supplemental requests that are submitted in January. Therefore, unless staff believes a supplemental meets the emergency criteria or may reduce the state's exposure to possible additional costs (such as lawsuit settlements, etc.), staff will continue to recommend denying supplementals that are requested before the start of any fiscal year.

In denying the June supplemental request, the Committee anticipated that the Department would go ahead with addressing their commercial lease space issues and would submit a plan to the Committee in January 2007 during the regular supplemental time. Due to an opportunity to expand their commercial lease space at the same location, the Department went ahead and signed a contract for the additional space. The Department informed the Committee of this decision before they signed the contract in October 2006. The Department will be submitting a supplemental in January to address this issue. The full-year annualized cost for the decision to go ahead an sign the new lease is estimated at $222,808 (the Department's request for FY 2007-08). This contract allows the Department to lease an additional 13,056 square feet and is viewed by the Department to be a long-term solution to their overcrowding problem.

FY 2007-08 Joint Budget Committee Staff Budget Briefing
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
Legislation Issues

ISSUE

The Department has brought to staff's attention two statutory changes that they believe would aid in controlling or managing their budget.

SUMMARY

- ❑ In 2005, the JBC carried a bill to limit the Department's exposure of covering prescription drugs for Medicaid clients enrolled in Medicare Part D. The Department believes that the term "enrolled" should be replaced with the term "eligible".

- ❑ The Department believes the budget forecasting for the Children's Basic Health Plan and the Old Age Pension Medical Program would be improved if these programs were allowed to use the cash basis of accounting rather than the accrual basis.

RECOMMENDATION

Staff recommends that the Committee discuss these statute changes with the Department at their hearing and include them on the list as possible JBC bills for the 2007 Session.

DISCUSSION:

Medicare Modernization Act Part D – Enrolled to Eligible

In the 2005 Session, the JBC carried a bill to clarify that once Medicaid clients enrolled in Medicare Part D, they would not be eligible for prescription drug coverage under the Medicaid program except for those drugs not covered by Medicare Part D and authorized by the Department. This statute change was a precautionary measure to ensure that Medicaid did not have a double exposure of paying the federal government the State Contribution Payment for all dual eligibles and still continue to pay a prescription drug benefit for which the state would be ineligible to receive the federal match.

At the time the JBC bill was passed, staff was unsure if the Medicare Part D benefit would begin as scheduled and if there would be any changes related to how dual eligibles would be treated under the plan. Also, due to the vulnerability of the dual eligible population, the JBC did not want to eliminate the prescription coverage until after the clients were enrolled in Medicare Part D.

Now that Medicare Part D has been implemented and clients have more experience with receiving the coverage under Medicare Part D, the Department brought to staff's attention that the statute

should be strengthened to apply to anyone eligible for Medicare Part D. The Department's concern is that clients could become dissatisfied with their Medicare Part D plan sometime during the year before open enrollment allows them to change plans. Therefore, under the current statute the client could dis-enroll from their Medicare Part D plan and then would be eligible for Medicaid prescription drug coverage again. However, as a dual eligible, the client would counted in State Contribution payment calculations and the client would also not be eligible for federal match on any Medicaid drugs that are part of the Medicare Part D benefit.

Based on the possible state exposure, the Department recommended to staff that this statutory provisions be strengthened to ensure that dual eligible clients remain with the Part D plan until the open enrollment period when they are allowed to change plans (like all other Medicare beneficiaries).

Questions for the Department

✓ Has there been any incidents were a dual eligible client has dis-enrolled from their Medicare Part plan and tried to receive Medicaid prescription drug coverage.

✓ Please discuss the ramifications of what will happen to Medicaid clients who are on their birthday become eligible for Medicare Part D benefits but have not had the opportunity to enroll in a plan. Would there be a gap in coverage for these individuals if the language is changed to eligible?

Cash Accounting

In 2003, the JBC carried legislation to allow the Medicaid Premiums line item and non-administrative Medicaid DHS program line items to move from the accrual basis of accounting to the cash basis of accounting. At the time, this policy change was made in order to create a one-time budgetary savings (there was no program savings) of around $70 million General Fund. However, in staff's opinion the change has had longer term budget implications in that it has allowed staff and the Department to track current year budget expenditures in a more exact manner. Therefore, caseload and expenditure forecasts can use current year data without the fear of major year end adjustments. Over time, staff believes budgeting the Medicaid Premiums line item on a cash basis will allow for more accuracy in forecasting.

In 2006, the JBC carried legislation again to move certain Medicaid program line items to cash accounting that were excluded in the original bill. The bill was expanded to apply to any medical program (administration is excluded) that qualifies for Title XIX federal matching funds. This brought under the cash accounting umbrella the nurse aid visitor program, school-based health program, and enhanced prenatal care. However, the bill specifically exempted the programs under the Colorado Indigent Care program based on the recommendation of Department staff.

Currently, the Department believes that the Children's Basic Health Plan and the Old Age Pension Medical program would also be good candidates for cash accountings. Moving these programs to cash accounting would allow all of the Department's caseload driven programs, with the exception of the Medicare Modernization Act State Contribution Payment, to be on the cash basis of accounting. The Department believes this would create better administrative efficiencies and improve budget forecasting. Depending on when the move to cash accounting occurred there could be some one-time budget savings in either FY 2006-07 or FY 2007-08.

Questions for the Department

If the move to cash accounting was enacted in FY 2006-07 for the CBHP and OAP Medical program, how much savings does the Department anticipate? What would be the administrative costs associated with changing the accounting methodologies for these programs?

If CBHP and the OAP Medical program was moved to cash accounting, why not also move the MMA State Contribution Payment to cash accounting? What would be the estimated FY 2006-07 savings for moving the MMA State Contribution Payment to cash accounting?

Staff Comment

If the Committee decides to carry another cash accounting bill, staff would recommend that the MMA State Contribution Payment be included.

Staff would also recommend that any one-time General Fund savings (which staff would estimate at over $6.2 million) be directed to the State Education Fund. Because the funding is one-time in nature, staff would not recommend the use of this funding for any purpose with on-going costs.

Caseload and Cost Histroy -- JBC Document

Total Caseload (Both Traditional and Expansion)

		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		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		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		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		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		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	Dept. Forecast	36,827	6,120	12,436	48,405	61,618	5,556	257	3,220	229,917	16,797	6,780	427,933
FY 07-08	Dept. Forecast	37,284	6,271	13,244	48,854	65,174	5,828	340	6,067	244,291	17,385	7,390	452,128

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	Dept. Forecast	88,130,035	43,475,953	2,298,644	384,596,304	217,816,802	45,374,885	9,500,347	7,669,987	352,662,328	47,402,971	66,475,508	1,265,403,764
FY 07-08	Dept. Forecast	89,799,733	45,377,324	2,350,108	389,984,299	236,242,528	48,777,442	12,561,005	14,832,298	379,476,331	49,410,626	74,807,246	1,343,618,940

Community Based Long-Term Care

		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		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	Dept. Forecast	112,796,429	14,191,859	52,322	84,499,644	186,368	0	0	0	658,622	4,935,332	0	217,320,576
FY 07-08	Dept. Forecast	120,360,972	15,200,947	57,168	89,938,699	207,197	0	0	0	733,902	5,381,718	0	231,880,603

Long Term Care and Insurance

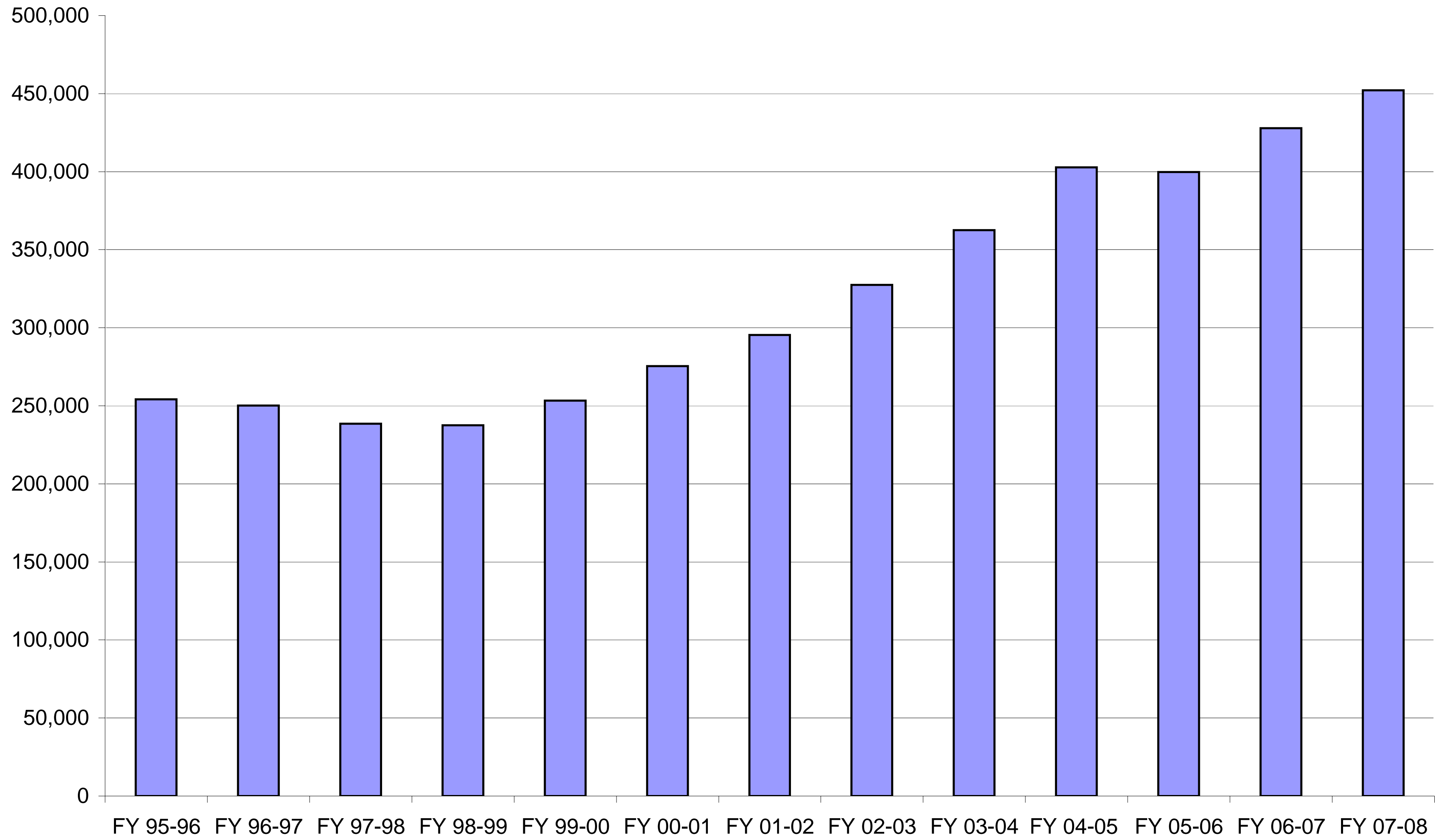
		SSI 65	SSI 60-64	QMB/SLIMB	SSI Disabled	Low Income Adults	BC Adults	BCCTP	Exp. Adults	Eligible Children	Foster Care	Non-Citizens	Total
FY 95-96		265,378,874	10,954,225	4,496,634	48,395,635	895,294	*333,694*	0	0	1,136,055	179,036	*104,233*	$331,873,680
FY 96-97		314,390,400	10,909,968	4,778,071	52,329,969	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	Dept. Forecast	472,418,725	30,667,157	12,544,582	92,080,194	181,240	15,001	0	0	71,291	11,254	*9,628*	$607,999,072
FY 07-08	Dept. Forecast	505,545,527	34,561,336	14,088,304	98,237,654	203,467	16,202	0	0	78,173	11,996	*10,789*	$652,753,448

Caseload and Cost Histroy -- JBC Document

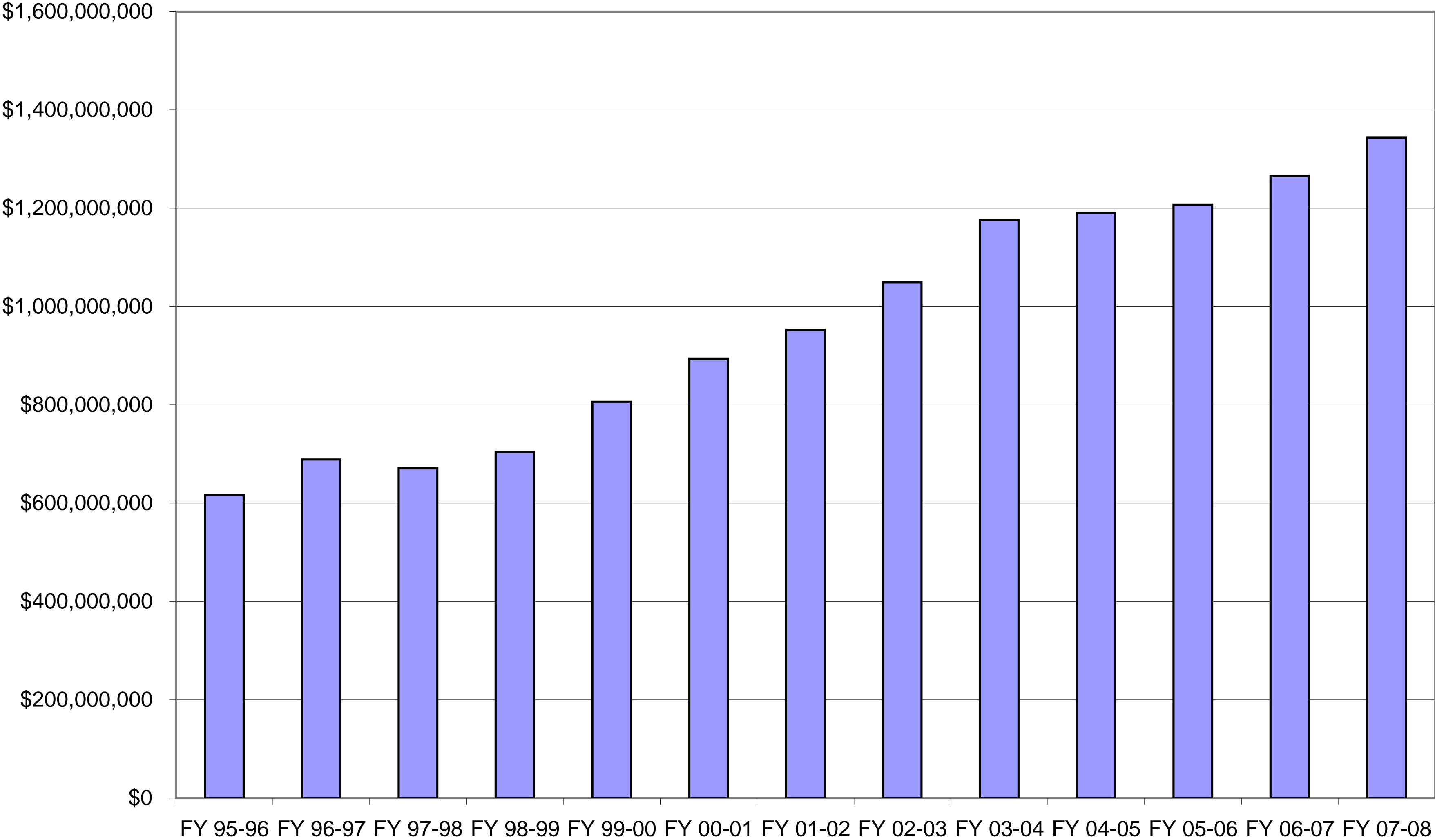
Total Caseload (Both Traditional and Expansion)

		SSI 65	SSI 60-64	QMB/SLIMB	SSI Disabled	Low Income Adults	BC Adults	BCCTP	Exp. Adults	Eligible Children	Foster Care	Non-Citizens	Total
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	Dept. Forecast	14,462,718	1,072,713	11,852	3,928,834	1,035,920	163,500	5,135	0	3,386,313	355,815	*0*	$24,422,800
FY 07-08	Dept. Forecast	15,725,314	1,245,595	13,264	4,906,696	1,441,974	236,556	9,781	0	4,003,997	518,407	*0*	$28,101,584
Total Expenditures (DOES NOT INCLUDE BOTTOM OF THE LINE FINANCING -- ONLY SERVICE COSTS)													
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	Dept. Forecast	687,807,907	89,407,682	14,907,400	565,104,976	219,220,330	45,553,386	9,505,482	7,669,987	356,778,554	52,705,372	66,485,136	2,115,146,212
FY 07-08	Dept. Forecast	731,431,546	96,385,202	16,508,844	583,067,348	238,095,166	49,030,200	12,570,786	14,832,298	384,292,403	55,322,747	74,818,035	2,256,354,575
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	Dept. Forecast	$18,676.73	$14,609.10	$1,198.73	$11,674.52	$3,557.73	$8,198.95	$36,986.31	$2,381.98	$1,551.77	$3,137.78	$9,806.07	$4,942.70
FY 07-08	Dept. Forecast	$19,617.84	$15,369.99	$1,246.51	$11,934.89	$3,653.22	$8,412.87	$36,972.90	$2,444.75	$1,573.09	$3,182.21	$10,124.23	$4,990.52

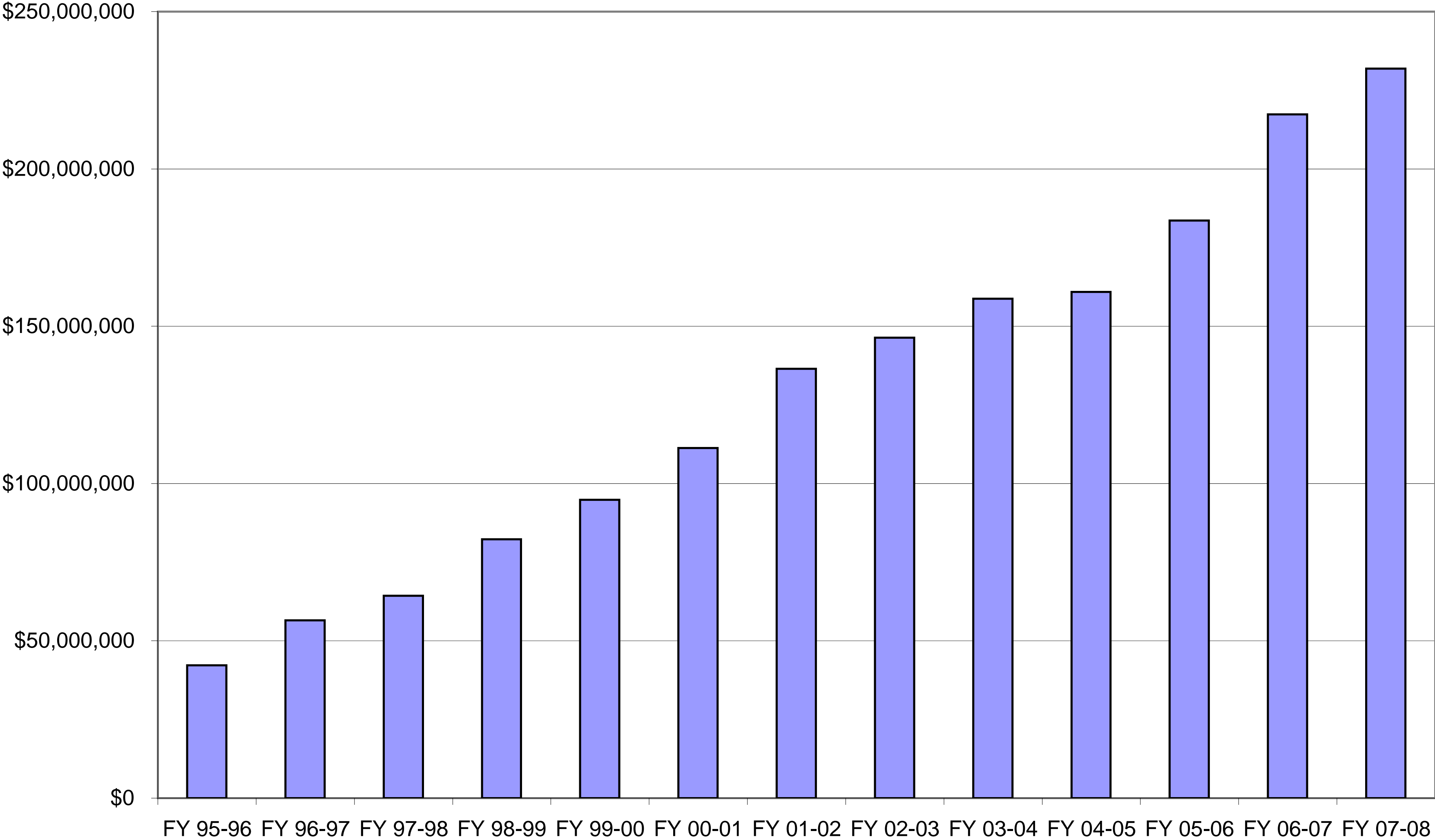
Average Yearly Medicaid Caseload



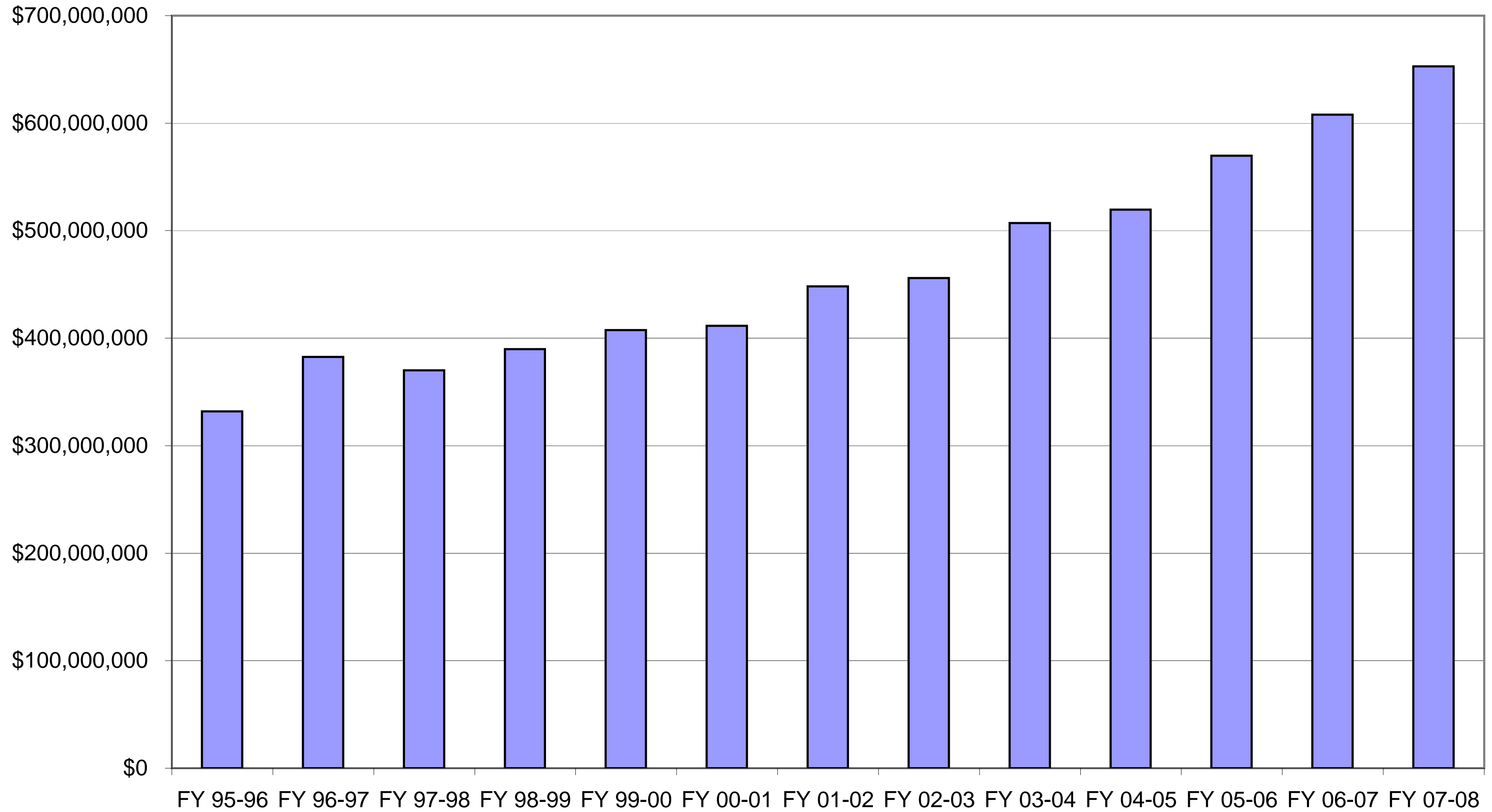
Acute Care Services Expenditure History

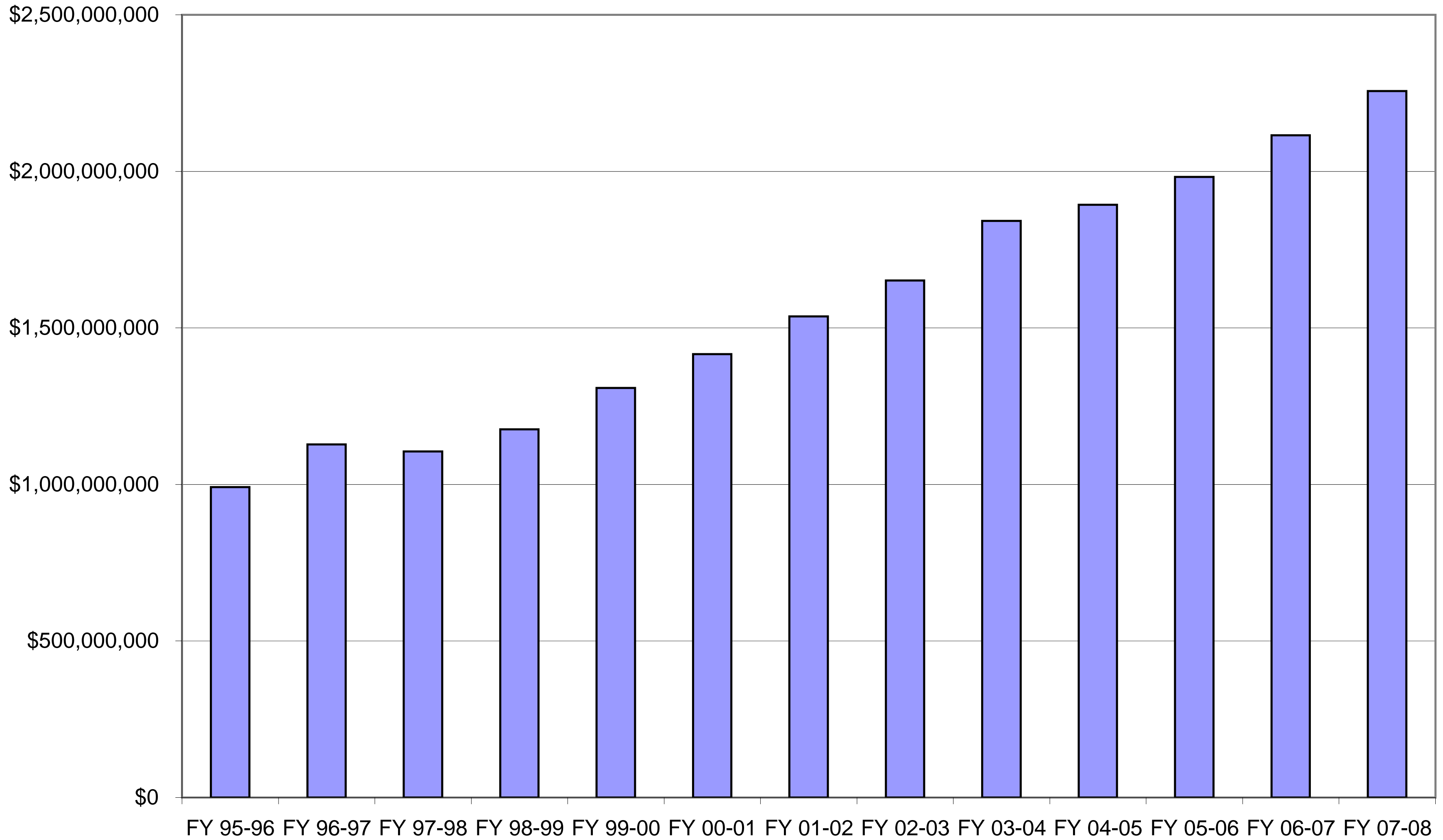


Community Based Long-Term Care Expenditure History

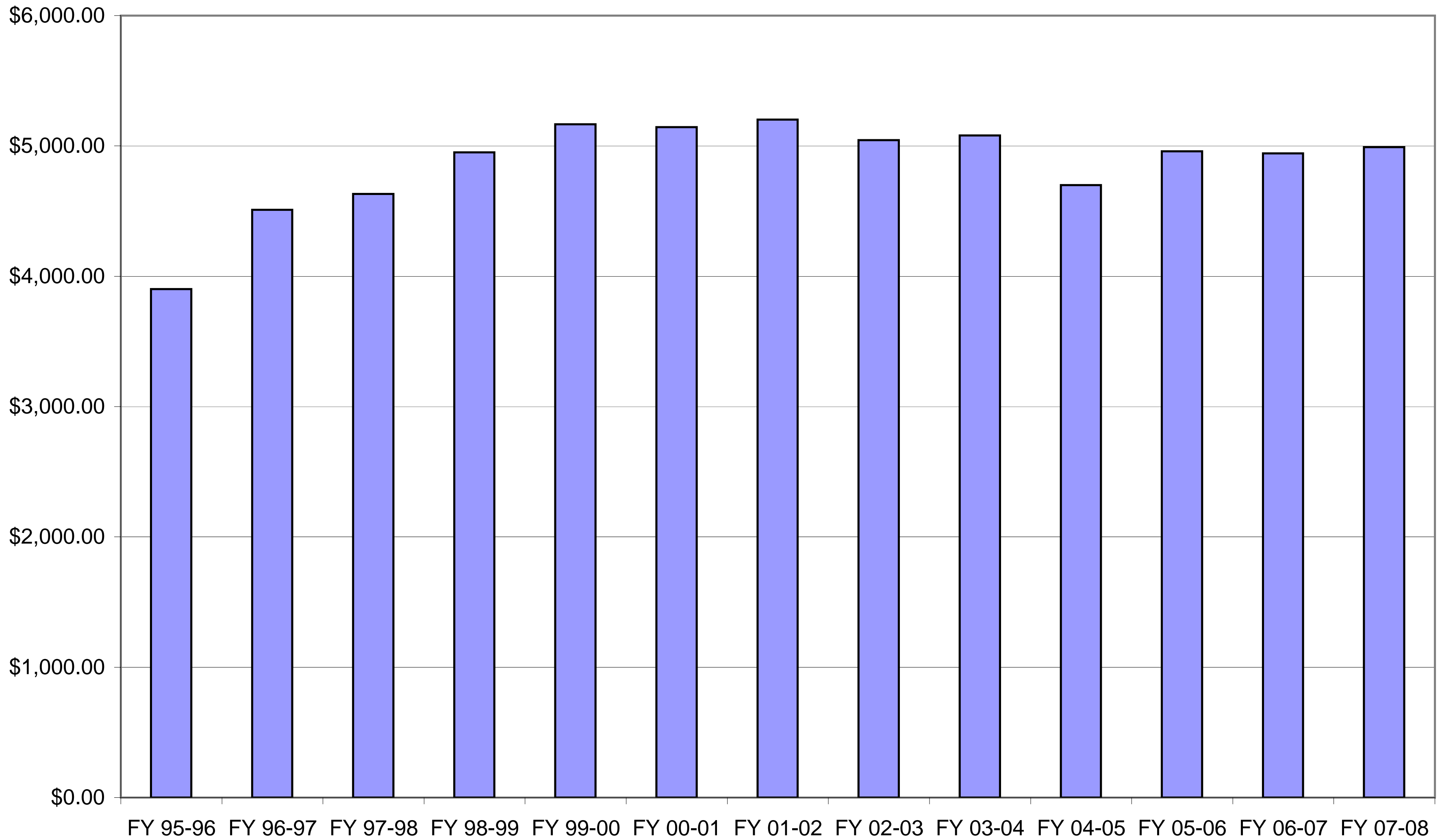


Institution Long-Term Care & Insurance Expenditure History





Total Medical Services Expenditure History
$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


Medical Services Premiums Cost-Per-Client History
$6,000.00
$5,000.00
$4,000.00
$3,000.00
$2,000.00
$1,000.00
$0.00
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

	SSI 65 >	SSI 60 to 64	QMB SLIMB	SSI Disabled	Adults	Pregnant Adults	BC Cancer Adults	Expansion Adults	Children	Foster Children	Noncitizens	TOTAL MEDICAID
FY 2005-06 Appropriation -- 2005 Session & 2006 Session												
Caseload Forecast Appropriations												
05-209 Traditional Medicaid Forecast	34,496	5,827	11,355	47,973	58,108	7,840	219	0	235,985	16,211	5,621	423,635
05-209 Expansion Medicaid Forecast	812	116	0	700	676	260	0	0	856	92	0	3,512
05-1262 Expansion Medicaid Forecast	0	0	0	527	3,440	0	91	0	15,135	0	0	19,193
TOTAL APPROPRIATED CASELOAD 2005 Session	35,308	5,943	11,355	49,200	62,224	8,100	310	0	251,976	16,303	5,621	446,340
H.B. 06-1385 Supplemental												
Change to Traditional Medicaid Forecast	1,261	164	(185)	(1,189)	(739)	(3,188)	(85)	0	(23,991)	60	172	(27,720)
Change to Expansion Medicaid Forecast	0	0	0	(302)	(3,440)	0	(33)	0	(15,135)	0	0	(18,910)
FINAL FY 2005-06 Forecast	36,569	6,107	11,170	47,709	58,045	4,912	192	0	212,850	16,363	5,793	399,710
Actual FY 2006-07 Caseload	36,219	6,048	11,012	47,565	57,754	5,050	188	0	213,600	16,311	5,959	399,706
Difference	350	59	158	144	291	(138)	4	0	(750)	52	(166)	4
% Error	0	0	0	0	0	(0)	0	0	(0)	0	(0)	0
Appropriation by Bill Source												
05-209 -- Long Bill	690,401,916	80,636,775	12,252,382	578,880,086	231,676,837	63,759,071	4,892,827	0	320,051,275	51,562,140	62,570,082	2,096,683,391
05-209 Clawback Payment (not spread)	0	0	0	0	0	0	0	0	0	0	0	30,984,982
05-1066 -- Obesity	18,419	3,100	5,923	25,390	30,665	4,225	114	0	123,549	8,505	2,932	222,822
05-1131 -- Redispense prescription drugs	(219,268)	(37,391)	(187)	(342,619)	(54,237)	(5,849)	0	0	(34,820)	(39,597)	(2)	(733,970)
05-1243 -- Consumer Directed Care	0	0	0	(1,004,415)	0	0	0	0	0	0	0	(1,004,415)
05-1262 Disease Management	325,788	54,836	104,773	449,107	542,401	74,739	2,021	0	2,185,339	150,428	51,865	3,941,297
05-1262 Breast and Cervical Cancer	0	0	0	0	0	0	2,587,905	0	0	0	0	2,587,905
05-1262 Expansion Medicaid (w/o legal immigrants)	0	0	0	11,599,362	13,528,178	0	0	0	20,411,818	0	0	45,539,358
06-1217 Supplemental	(3,040,802)	(474,614)	(218)	(3,757,728)	(1,494,078)	(685,964)	0	0	(2,209,954)	(467,470)	(129,290)	(43,245,100)
06-1369 Supplemental	2,881,053	316,340	732	2,299,320	185,851	52,730	0	0	259,191	153,931	90,852	6,240,000
06-1385 Supplemental	(8,333,442)	7,511,575	1,686,492	(22,542,315)	(41,200,780)	(26,519,977)	(4,121,575)	0	(38,494,115)	880,194	(10,435,769)	(141,569,712)
TOTAL FY 2005-06 APPROPRIATION	682,033,664	88,010,621	14,049,897	565,606,188	203,214,837	36,678,975	3,361,292	0	302,292,283	52,248,131	52,150,670	1,999,646,558
FINAL APPROPRIATION BY SERVICE AREA AND BOTTOM OF THE LINE FINANCING												
ACUTE CARE SERVICES ESTIMATE	139,514,998	48,294,714	2,011,497	402,964,781	198,555,946	35,990,875	3,360,000	0	296,245,988	47,490,838	51,996,757	1,226,426,394
COMMUNITY BASED SERVICES	88,113,326	11,724,098	15,533	68,083,435	134,612	78	0	0	500,776	4,206,086	0	172,777,944
LONG TERM SERVICES	435,972,242	26,493,472	12,020,964	86,254,762	108,742	15,733	0	0	74,947	12,564	9,750	560,963,176
SERVICE MANAGEMENT	15,640,730	1,062,501	1,701	4,852,488	237,751	42,368	1,292	0	635,400	109,365	25,435	22,609,031
Subtotal for Services w/o Bottom of Line Financing	679,241,296	87,574,785	14,049,695	562,155,466	199,037,051	36,049,054	3,361,292	0	297,457,111	51,818,853	52,031,942	1,982,776,545
ICMR FEE	0	0	0	76,512	0	0	0	0	0	0	0	76,512
UPPER PAYMENT LIMIT -- FINAL	2,792,368	435,838	201	3,374,210	2,715,151	629,921	0	0	3,372,538	429,278	118,727	13,868,232
DENVER HEALTH OUTSTATIONING	0	0	0	0	1,462,635	0	0	0	1,462,634	0	0	2,925,269
FINAL APPROPRIATION BY SERVICE AREA & BLF	682,033,664	88,010,623	14,049,896	565,606,188	203,214,837	36,678,975	3,361,292	0	302,292,283	52,248,131	52,150,669	1,999,646,558
ACTUAL FY 2005-06 EXPENDITURES BY SERVICE AREA												
ACUTE CARE SERVICES ESTIMATE	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
COMMUNITY BASED SERVICES	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
LONG TERM SERVICES	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
SERVICE MANAGEMENT	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
Subtotal for Services	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
Percent Difference from Forecast	-0.93%	-1.24%	-4.89%	-1.13%	-1.91%	9.28%	102.61%	0.00%	3.61%	-5.67%	6.31%	-0.02%
ICMR Fee	0	0	0	0	0	0	0	0	0	0	0	0
UPPER PAYMENT LIMIT	2,792,368	435,838	201	3,374,210	2,715,151	629,921	0	0	3,372,538	429,278	118,727	13,868,232
DENVER HEALTH OUTSTATIONING (?)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
TOTAL EXPENDITURES (Service Area & BLF)	675,721,050	86,920,366	13,363,561	559,167,628	197,942,392	40,025,684	6,810,399	0	311,567,958	49,311,253	55,434,017	1,996,264,308
Difference from Appropriation	(6,312,614)	(1,090,257)	(686,335)	(6,438,560)	(5,272,445)	3,346,709	3,449,107	0	9,275,675	(2,936,878)	3,283,348	(3,382,250)
% Difference	-0.93%	-1.24%	-4.88%	-1.14%	-2.59%	9.12%	102.61%	0.00%	3.07%	-5.62%	6.30%	-0.17%

	SSI 65 >	SSI 60 to 64	QMB SLIMB	SSI Disabled	Adults	Pregnant Adults	BC Cancer Adults	Expansion Adults	Children	Foster Children	Noncitizens	TOTAL MEDICAID
FY 2006-07 Appropriation -- 2006 Session												
Caseload -- H.B. 06-1385	**37,036**	**6,241**	**12,570**	**48,447**	**63,127**	**4,890**	**223**	**4,850**	**228,438**	**17,091**	**6,309**	**429,222**
Traditional Medicaid Caseload (can be funded with GF)	36,224	6,125	12,570	47,095	59,336	4,630	156	0	214,603	16,999	6,309	404,047
Expansion Medicaid Caseload (can be funded with Tobacco Tax)	812	116	0	1,352	3,791	260	67	4,850	13,835	92	0	25,175
TOTAL CASELOAD	**37,036**	**6,241**	**12,570**	**48,447**	**63,127**	**4,890**	**223**	**4,850**	**228,438**	**17,091**	**6,309**	**429,222**
Current FY 2006-07 Appropriation for Medical Service Premiums												
H.B. 06-1385	700,845,105	82,946,201	11,967,854	564,954,836	236,477,609	37,951,534	5,108,636	12,150,781	336,448,671	57,883,838	61,853,657	2,108,588,722
S.B. 06-131	1,928,835	117,808	1,659	328,149	(55)	0	0	0	9	0	0	2,376,406
S.B. 06-165	109,450	14,066	2,174	90,398	31,753	6,408	1,108	0	50,127	7,951	8,997	322,431
TOTAL	**702,883,390**	**83,078,076**	**11,971,686**	**565,373,383**	**236,509,307**	**37,957,942**	**5,109,744**	**12,150,781**	**336,498,808**	**57,891,789**	**61,862,654**	**2,111,287,559**
Current FY 2006-07 App. By Service Area												
Acute Care Services	116,260,144	45,631,526	2,238,434	383,135,626	232,786,878	37,490,526	5,082,754	12,150,781	330,581,592	52,263,237	61,430,934	1,279,052,431
Community Care Services	105,534,774	11,288,836	(117)	76,161,639	171,487	2,338	0	0	839,013	5,017,505	0	199,015,475
Long Term Care Services & Insurance	459,151,893	24,253,541	9,648,745	95,298,094	182,406	16,147	0	0	76,927	12,894	10,006	588,650,654
Administrative Services	17,374,192	1,338,462	8,045	6,948,270	898,750	175,188	9,532	0	1,778,290	275,088	152,494	28,958,311
SUBTOTAL SERVICE COSTS	698,321,003	82,512,366	11,895,106	561,543,629	234,039,521	37,684,199	5,092,286	12,150,781	333,275,823	57,568,724	61,593,434	2,095,676,871
Bottom of the Line Financing	4,562,387	565,710	76,580	3,829,754	2,469,786	273,743	17,458	0	3,222,985	323,065	269,220	15,610,688
TOTAL BY SERVICE AREA	**702,883,390**	**83,078,076**	**11,971,686**	**565,373,383**	**236,509,307**	**37,957,942**	**5,109,744**	**12,150,781**	**336,498,808**	**57,891,789**	**61,862,654**	**2,111,287,559**
Average Per Capita -- Services Only	$18,855.20	$13,221.02	$946.31	$11,590.89	$3,707.44	$7,706.38	$22,835.36	$2,505.32	$1,458.93	$3,368.36	$9,762.79	$4,882.50
Average Per Capita -- Total Appropriation	$18,978.38	$13,311.66	$952.40	$11,669.94	$3,746.56	$7,762.36	$22,913.65	$2,505.32	$1,473.04	$3,387.27	$9,805.46	$4,918.87
Per Capita Costs by Service Area												
Acute Care	$3,139.11	$7,311.57	$178.08	$7,908.35	$3,687.60	$7,666.77	$22,792.62	$2,505.32	$1,447.14	$3,057.94	$9,737.03	
Community Care	$2,849.52	$1,808.82	($0.01)	$1,572.06	$2.72	$0.48	$0.00	$0.00	$3.67	$293.58	$0.00	
Long Term Care and Insurance	$12,397.45	$3,886.16	$767.60	$1,967.06	$2.89	$3.30	$0.00	$0.00	$0.34	$0.75	$1.59	
Administrative Services	$469.12	$214.46	$0.64	$143.42	$14.24	$35.83	$42.74	$0.00	$7.78	$16.10	$24.17	

	SSI 65 >	SSI 60 to 64	QMB SLIMB	SSI Disabled	Adults	Pregnant Adults	BC Cancer Adults	Expansion Adults	Children	Foster Children	Noncitizens	TOTAL MEDICAID
Department's November FY 2006-07 Estimate (Original Relook at FY 2006-07 Appropriation)												
CASELOAD FORECAST												
Current Appropriated Caseload	37,036	6,241	12,570	48,447	63,127	4,890	223	4,850	228,438	17,091	6,309	429,222
Department FY 2006-07 Caseload Forecast -- November 2006	36,827	6,120	12,436	48,405	61,618	5,556	257	3,220	229,917	16,797	6,780	427,933
Difference	(209)	(121)	(134)	(42)	(1,509)	666	34	(1,630)	1,479	(294)	471	(1,289)
% Difference	-0.56%	-1.94%	-1.07%	-0.09%	-2.39%	13.62%	15.25%	0.00%	0.65%	-1.72%	7.47%	-0.30%
Department's Estimate By Funding Category												
Traditional Medicaid Caseload (includes LI & PE -- fund splits take care of)	36,827	6,120	12,436	47,855	58,776	5,561	257	0	218,043	16,797	6,752	409,424
Expansion Medicaid Caseload (w/o LI or PE -- see fund splits)	0	0	0	550	2,842	(5)	0	3,220	11,874	0	28	18,509
Total	36,827	6,120	12,436	48,405	61,618	5,556	257	3,220	229,917	16,797	6,780	427,933
Staff's October 5-year Forecast (PRELIMINARY)												
Traditional Medicaid Caseload (can be funded with GF)	35,581	5,944	12,535	46,962	57,677	4,799	161	0	213,485	16,701	6,470	400,315
Expansion Medicaid Caseload (can be funded w Tobacco Tax -- w/ LI est.)	812	116	0	1,352	3,040	260	69	2,364	10,708	92	0	18,813
TOTAL	36,393	6,060	12,535	48,314	60,717	5,059	230	2,364	224,193	16,793	6,470	419,128
(note: Staff tries to include an estimate of Legal Immigrants in the Expansion Medicaid -- therefore a direct comparison of the Department's request and staff forecast is not exactly accurate -- see fund split information for better accuracy)												
Difference from Department's Forecast	(434)	(60)	99	(91)	(901)	(497)	(27)	(856)	(5,724)	(4)	(310)	(8,805)
% Difference	-1.18%	-0.98%	0.80%	-0.19%	-1.46%	-8.95%	-10.51%	0.00%	-2.49%	-0.02%	-4.57%	-2.06%
Difference Current Appropriation	(643)	(181)	(35)	(133)	(2,410)	169	7	(2,486)	(4,245)	(298)	161	(10,094)
	-1.74%	-2.90%	-0.28%	-0.27%	-3.82%	3.46%	3.14%	0.00%	-1.86%	-1.74%	2.55%	-2.35%
Department 11/1/06 Client Forecast	36,827	6,120	12,436	48,405	61,618	5,556	257	3,220	229,917	16,797	6,780	427,933
Increase/(Decrease) from FY 2006-07 current appropriation	(209)	(121)	(134)	(42)	(1,509)	666	34	(1,630)	1,479	(294)	471	(1,289)
Increase/(Decrease) from FY 2005-06 Actual	608	72	1,424	840	3,864	506	69	3,220	16,317	486	821	28,227
% difference from current appropriation	-0.56%	-1.94%	-1.07%	-0.09%	-2.39%	13.62%	15.25%	0.00%	0.65%	-1.72%	7.47%	-0.30%
% difference from FY 2005-06 Actual	1.68%	1.19%	12.93%	1.77%	6.69%	10.02%	36.70%	n/a	7.64%	2.98%	13.78%	7.06%
% of Total Caseload	8.61%	1.43%	2.91%	11.31%	14.40%	1.30%	0.06%	0.75%	53.73%	3.93%	1.58%	100.00%
Department's Current FY 2006-07 Service Cost Estimates												
ACUTE CARE SERVICES ESTIMATE	88,130,035	43,475,953	2,298,644	384,596,304	217,816,802	45,374,885	9,500,347	7,669,987	352,662,328	47,402,971	66,475,508	1,265,403,764
COMMUNITY BASED SERVICES	112,796,429	14,191,859	52,322	84,499,644	186,368	0	0	0	658,622	4,935,332	0	217,320,576
LONG TERM SERVICES	472,418,725	30,667,157	12,544,582	92,080,194	181,240	15,001	0	0	71,291	11,254	9,628	607,999,072
SERVICE MANAGEMENT	14,462,718	1,072,713	11,852	3,928,834	1,035,920	163,500	5,135	0	3,386,313	355,815	0	24,422,800
BOTTOM OF THE LINE FINANCING (not spread across aid categories)	0	0	0	0	0	0	0	0	0	0	0	17,967,818
TOTAL PREMIUM	687,807,907	89,407,682	14,907,400	565,104,976	219,220,330	45,553,386	9,505,482	7,669,987	356,778,554	52,705,372	66,485,136	2,133,114,030
Cost Per Client												
ACUTE CARE	$2,393.08	$7,103.91	$184.84	$7,945.38	$3,534.95	$8,166.83	$36,966.33	$2,381.98	$1,533.87	$2,822.11	$9,804.65	$2,957.01
COMMUNITY BASED SERVICES	$3,062.87	$2,318.93	$4.21	$1,745.68	$3.02	$0.00	$0.00	$0.00	$2.86	$293.82	$0.00	$507.84
LONG TERM SERVICES	$12,828.05	$5,010.97	$1,008.73	$1,902.29	$2.94	$2.70	$0.00	$0.00	$0.31	$0.67	$1.42	$1,420.78
SERVICE MANAGEMENT	$392.72	$175.28	$0.95	$81.17	$16.81	$29.43	$19.98	$0.00	$14.73	$21.18	$0.00	$57.07
Total Medical Services Cost-per-Client	$18,676.73	$14,609.10	$1,198.73	$11,674.52	$3,557.73	$8,198.95	$36,986.31	$2,381.98	$1,551.77	$3,137.78	$9,806.07	$4,942.70
Percent Change from Current App./Cost Per Client												
ACUTE CARE	-23.77%	-2.84%	3.80%	0.47%	-4.14%	6.52%	62.19%	-4.92%	5.99%	-7.71%	0.69%	
COMMUNITY BASED SERVICES	7.49%	28.20%	-45301.52%	11.04%	11.34%	-100.00%	n/a	n/a	-22.01%	0.08%	n/a	
LONG TERM SERVICES	3.47%	28.94%	31.41%	-3.29%	1.79%	-18.23%	n/a	n/a	-7.92%	-11.19%	-10.46%	
SERVICE MANAGEMENT	-16.29%	-18.27%	48.91%	-43.41%	18.09%	-17.86%	-53.26%	n/a	89.20%	31.61%	-100.00%	
Total Medical Service Request Change Over Current App.	(10,513,096)	6,895,316	3,012,294	3,561,347	(14,819,191)	7,869,187	4,413,196	(4,480,794)	23,502,731	(4,863,352)	4,891,702	19,469,341
Total Bottom Line Financing Request	0	0	0	0	0	0	0	0	0	0	0	2,357,130
Change	(10,513,096)	6,895,316	3,012,294	3,561,347	(14,819,191)	7,869,187	4,413,196	(4,480,794)	23,502,731	(4,863,352)	4,891,702	21,826,471
Cost Associated with New Caseload	(3,940,736)	(1,599,743)	(126,805)	(486,817)	(5,594,526)	5,132,449	776,402	(4,083,665)	2,157,762	(990,299)	4,598,273	(4,157,704)
Service Cost Increase	(6,609,659)	8,663,017	3,172,923	4,051,676	(9,450,574)	2,408,684	3,155,662	(598,161)	21,207,662	(3,940,843)	273,044	22,333,432
Compounding Effect	37,299	(167,958)	(33,824)	(3,513)	225,908	328,054	481,132	201,031	137,307	67,791	20,384	1,293,612
Total	(10,513,096)	6,895,316	3,012,294	3,561,347	(14,819,191)	7,869,187	4,413,196	(4,480,794)	23,502,731	(4,863,352)	4,891,702	19,469,341
Total Medical Service Request Change Over App. (check)	(10,513,096)	6,895,316	3,012,294	3,561,347	(14,819,191)	7,869,187	4,413,196	(4,480,794)	23,502,731	(4,863,352)	4,891,702	19,469,341

JBC Staff Briefing Document

	SSI 65 >	SSI 60 to 64	QMB SLIMB	SSI Disabled	Adults	Pregnant Adults	BC Cancer Adults	Expansion Adults	Children	Foster Children	Noncitizens	TOTAL MEDICAID
Department's November FY 2007-08 Request												
CASELOAD FORECAST												
Caseload Forecast	37,284	6,271	13,244	48,854	65,174	5,828	340	6,067	244,291	17,385	7,390	452,128
Department's Estimate By Funding Category												
Traditional Medicaid including legal immigrants (includes LI & PE)	37,284	6,271	13,244	48,099	59,740	5,833	340	0	221,314	17,385	7,361	416,871
Expansion Medicaid	0	0	0	755	5,434	(5)	0	6,067	22,977	0	29	35,257
Total Caseload Forecast	37,284	6,271	13,244	48,854	65,174	5,828	340	6,067	244,291	17,385	7,390	452,128
Staff's October 5-year Forecast (PRELIMINARY)												
Traditional Medicaid (excluding legal immigrants)	36,157	6,150	13,334	47,353	58,341	4,928	195	0	215,398	17,531	6,967	406,354
Expansion Medicaid (including legal immigrants)	812	116	0	1,477	5,011	260	83	4,335	18,918	92	0	31,104
TOTAL	36,969	6,266	13,334	48,830	63,352	5,188	278	4,335	234,316	17,623	6,967	437,458

(note: Staff tries to include an estimate of Legal Immigrants in the Expansion Medicaid -- therefore a direct comparison of the Department's request and staff forecast is not exactly accurate -- see fund split information for better accuracy)

	SSI 65 >	SSI 60 to 64	QMB SLIMB	SSI Disabled	Adults	Pregnant Adults	BC Cancer Adults	Expansion Adults	Children	Foster Children	Noncitizens	TOTAL MEDICAID
Difference from Department's Forecast	(315)	(5)	90	(24)	(1,822)	(640)	(62)	(1,732)	(9,975)	238	(423)	(14,670)
% Difference	-0.84%	-0.08%	0.68%	-0.05%	-2.80%	-10.98%	-18.24%	0.00%	-4.08%	1.37%	-5.72%	-3.24%
Department 11/1/06 Client Forecast	37,284	6,271	13,244	48,854	65,174	5,828	340	6,067	244,291	17,385	7,390	452,128
Increase/(Decrease) from FY 2006-07 appropriation	248	30	674	407	2,047	938	117	1,217	15,853	294	1,081	22,906
Increase/(Decrease) from FY 2006-07 Dept estimate	457	151	808	449	3,556	272	83	2,847	14,374	588	610	24,195
% difference from FY 2006-07 current appropriation	0.67%	0.48%	5.36%	0.84%	3.24%	19.18%	52.47%	25.09%	6.94%	1.72%	17.13%	5.34%
% difference from FY 2006-07 Dept Estimate	1.24%	2.47%	6.50%	0.93%	5.77%	4.90%	32.30%	88.42%	6.25%	3.50%	9.00%	5.65%
% of Total Caseload	8.25%	1.39%	2.93%	10.81%	14.41%	1.29%	0.08%	1.34%	54.03%	3.85%	1.63%	100.00%
Department's Nov FY 2007-08 Service Cost Estimates												
ACUTE CARE SERVICES ESTIMATE	89,799,733	45,377,324	2,350,108	389,984,299	236,242,528	48,777,442	12,561,005	14,832,298	379,476,331	49,410,626	74,807,246	1,343,618,940
COMMUNITY BASED SERVICES	120,360,972	15,200,947	57,168	89,938,699	207,197	0	0	0	733,902	5,381,718	0	231,880,603
LONG TERM SERVICES	505,545,527	34,561,336	14,088,304	98,237,654	203,467	16,202	0	0	78,173	11,996	10,789	652,753,448
SERVICE MANAGEMENT	15,725,314	1,245,595	13,264	4,906,696	1,441,974	236,556	9,781	0	4,003,997	518,407	0	28,101,584
1262 DISEASE MANAGEMENT	0	0	0	0	0	0	0	0	0	0	0	0
BOTTOM OF THE LINE FINANCING (Not Spread)	0	0	0	0	0	0	0	0	0	0	0	16,298,622
DENVER HEALTH OUTSTATIONING (Not Spread)	0	0	0	0	0	0	0	0	0	0	0	2,339,155
TOTAL PREMIUM	731,431,546	96,385,202	16,508,844	583,067,348	238,095,166	49,030,200	12,570,786	14,832,298	384,292,403	55,322,747	74,818,035	2,274,992,352
Cost Compared to Current FY 2006-07 Appropriation	33,110,543	13,872,836	4,613,738	21,523,719	4,055,645	11,346,001	7,478,500	2,681,517	51,016,580	(2,245,977)	13,224,601	163,704,793
												*include BLF
% increase from Current FY 2006-07 Appropriation	4.74%	16.81%	38.79%	3.83%	1.73%	30.11%	146.86%	22.07%	15.31%	-3.90%	21.47%	7.75%
Cost Compared to Dept. FY 2006-07 Estimate	43,623,639	6,977,520	1,601,444	17,962,372	18,874,836	3,476,814	3,065,304	7,162,311	27,513,849	2,617,375	8,332,899	141,878,322
% increase from New Department FY 2006-07 Estimate	6.34%	7.80%	10.74%	3.18%	8.61%	7.63%	32.25%	93.38%	7.71%	4.97%	12.53%	6.65%
Department's Estimated Per-Capita's for Base W/O Bottom Line Financing	$19,617.84	$15,369.99	$1,246.51	$11,934.89	$3,653.22	$8,412.87	$36,972.90	$2,444.75	$1,573.09	$3,182.21	$10,124.23	
Decision Items (Other Than Base Adjustments -- DI #1)												
DI #4	2,989	384	59	2,469	867	175	30	0	1,369	217	246	8,805
DI #6	4,652,100	597,886	92,384	3,842,318	1,349,648	272,351	47,082	0	2,130,621	337,932	382,406	13,704,727
DI #10	(7,707,290)	(990,538)	(153,055)	(6,365,699)	(2,236,007)	(451,214)	(78,002)	0	(3,529,871)	(559,863)	(633,546)	(22,705,084)
BRI #1	(168,758)	(21,689)	(3,351)	(139,382)	(48,959)	(9,880)	(1,708)	0	(77,290)	(12,259)	(13,872)	(497,147)
TOTAL REQUEST (MATCHES SCHEDULE 3)	728,210,586	95,971,246	16,444,881	580,407,054	237,160,715	48,841,633	12,538,188	14,832,298	382,817,232	55,088,774	74,553,269	2,265,503,653

Fund Splits for FY 2005-06

	General Fund & General Fund Exempt	Cash Funds	Cash Funds Exempt: Certified Funds	Health Care Expansion Fund	Transfer from DPHE	Breast and Cervical Cancer Fund	Gifts Grants and Donations	Autisim Fund	Federal Funds	TOTAL FUNDS
Final FY 2005-06 Appropriation										
Expansion Medicaid Program										
Legal Immigrants	0	0	0	6,216,752	0	0	0	0	5,379,765	11,596,517
Breast and Cervical Cancer Expansion	0	0	0	0	352,936	0	0	0	655,452	1,008,388
Asset Test Elimination	0	0	0	0	0	0	0	0	0	0
Increase CBHP Marketing	146,718	0	0	0	0	0	0	0	146,718	293,436
Waiver Expansion	0	0	0	2,526,532	0	0	0	0	2,526,532	5,053,064
Disease Management for Expansion Populations	0	0	0	0	0	0	0	0	0	0
SUBTOTAL EXPANSION POPULATIONS	146,718	0	0	8,743,284	352,936	0	0	0	8,708,467	17,951,404
Traditional Medicaid										
Base Acute	605,143,357	0	0	0	0	0	0	0	605,143,357	1,210,286,715
Minus Breast and Cervical Cancer Expansion	(352,936)	0	0	0	0	0	0	0	(655,452)	(1,008,388)
Minus Legal Immigrant Acute	(4,987,699)	0	0	0	0	0	0	0	(4,150,712)	(9,138,411)
Minus Increased Children Waiver Expansion	(2,509,175)	0	0	0	0	0	0	0	(2,509,175)	(5,018,350)
Family Planning	843,070	0	0	0	0	0	0	0	7,587,622	8,430,692
Prenatal Costs	2,091,778	0	0	0	0	0	0	0	901,096	2,992,874
Breast and Cervical Cancer Program	472,488	0	0	0	0	350,566	0	0	1,528,548	2,351,602
Indian Health Services	0	0	0	0	0	0	0	0	931,076	931,076
Obsesity Bill	0	0	0	0	0	0	0	0	0	0
Redispense Prescription Drugs	0	0	0	0	0	0	0	0	0	0
Service Management/Disease Management Trans	0	0	0	0	0	0	0	0	0	0
Presumptive Eligibility Fund Transfer	(1,551,242)	0	0	1,551,242	0	0	0	0	0	0
SUBTOTAL ACUTE	599,149,642	0	0	1,551,242	0	350,566	0	0	608,776,360	1,209,827,810
Base Community Care	83,697,160	0	0	0	0	0	0	0	83,697,160	167,394,320
Staff Recommendation for additional caseload	141,812	0	0	0	0	0	0	0	141,812	283,624
Autism Program	0	0	0	0	0	0	0	0	0	0
Consumer Directed Care	0	0	0	0	0	0	0	0	0	0
Minus Legal Immigrants	(272,242)	0	0	0	0	0	0	0	(272,242)	(544,484)
SUBTOTAL COMMUNITY CARE	83,566,730	0	0	0	0	0	0	0	83,566,730	167,133,460
Nursing Facility 1	226,091,459	0	0	0	0	0	0	0	226,091,459	452,182,918
Minus Legal Immigrants	(956,811)	0	0	0	0	0	0	0	(956,811)	(1,913,622)
SUBTOTAL NURSING FACILITY	225,134,648	0	0	0	0	0	0	0	225,134,648	450,269,296

Fund Splits for FY 2005-06

	General Fund & General Fund Exempt	Cash Funds	Cash Funds Exempt						Federal Funds	TOTAL FUNDS
			Certified Funds	Health Care Expansion Fund	Transfer from DPHE	Breast and Cervical Cancer Fund	Gifts Grants and Donations	Autisim Fund		
Nursing Facility II	719,425	0	0	0	0	0	0	0	719,425	1,438,850
PACE	18,719,451	0	0	0	0	0	0	0	18,719,451	37,438,901
SMIB	41,567,522	0	0	0	0	0	0	0	27,711,682	69,279,204
HIBI	311,652	0	0	0	0	0	0	0	311,652	623,304
SUBTOTAL OTHER LTC & INSURANCE	61,318,050	0	0	0	0	0	0	0	47,462,209	108,780,259
Single Entry Point	8,837,450	0	0	0	0	0	0	0	8,837,450	17,674,900
Minus Single Entry Point for Waiver Expansion	(17,357)	0	0	0	0	0	0	0	(17,358)	(34,715)
ASO Service / Disease Management	2,467,065	0	0	0	0	0	0	0	2,467,065	4,934,130
SUBTOTAL Administrative Services	11,287,158	0	0	0	0	0	0	0	11,287,158	22,574,316
TOTAL MEDICAL SERVICES	980,542,111	0	0	10,294,526	352,936	411,400	0	0	984,935,571	1,976,536,545
Medicare Clawback	0	0	0	0	0	0	0	0	0	0
ICFMR Fee	(38,256)	76,512	0	0	0	0	0	0	38,256	76,512
UPL Financing	(6,967,130)	0	13,934,260	0	0	0	0	0	6,967,130	13,934,260
New UPL Financing Adjustment	33,014	0	(66,029)				0	0	(33,014)	(66,029)
Denver Health Outstationing	0	0	1,462,635	0	0	0	0	0	1,462,635	2,925,270
TOTAL BOTTOM LINE FINANCING	(6,972,372)	76,512	15,330,866	0	0	0	0	0	8,435,007	16,870,013
TOTAL Original Recommendation	973,569,739	76,512	15,330,866	10,294,526	352,936	411,400	0	0	993,370,578	1,993,406,558
Policy Issues										
JBC Action to Increase Hospital Rates	380,000	0	0	0	0	0	0	0	380,000	760,000
JBC Action to Increase 50a Provider Rates	2,550,000	0	0	0	0	0	0	0	2,550,000	5,100,000
JBC Action to Increase Durable Medical Equipment	190,000	0	0	0	0	0	0	0	190,000	380,000
TOTAL Appropriation	**976,750,574**	**76,512**	**15,330,866**	**10,294,526**	**352,936**	**350,565**	**0**	**0**	**996,490,578**	**1,999,646,558**
Total Actual	**976,206,452**	**0**	**13,868,231**	**9,494,414**	**0**	**350,565**	**0**	**0**	**996,344,645**	**1,996,264,307**
	544,122	**76,512**	**1,462,635**	**800,112**	**352,936**	**0**	**0**	**0**	**145,933**	**3,382,250**
% Difference from Final Appropriation	**0.06%**	**100.00%**	**9.54%**	**7.77%**	**100.00%**	**0.00%**	**n/a**	**n/a**	**0.01%**	**0.17%**

Fund Splits for FY 2006-07 Appropriation -- 2006 Session

	General Fund & General Fund Exempt	Cash Funds	Cash Funds Exempt: Certified Funds	Cash Funds Exempt: Health Care Expansion Fund	Cash Funds Exempt: Transfer from DPHE	Cash Funds Exempt: Breast and Cervical Cancer Fund	Cash Funds Exempt: Gifts Grants and Donations	Cash Funds Exempt: Autisim Fund	Federal Funds	TOTAL FUNDS
Expansion Medicaid										
Legal Immigrant Offset	0	0	0	6,216,752	0	0	0	0	5,379,765	11,596,517
Breast and Cervical Cancer Expansion	0	0	0	0	533,573	0	0	0	990,921	1,524,494
Asset Test Elimination	0	0	0	14,711,176	0	0	0	0	14,711,176	29,422,352
Up to 60% FPL Adults	0	0	0	5,932,957	0	0	0	0	5,932,957	11,865,914
Increase CBHP Marketing	537,144	0	0	0	0	0	0	0	537,144	1,074,288
Waiver Expansion	0	0	0	8,796,856	0	0	0	0	8,796,856	17,593,712
Total Expansion Offset/Populations	**537,144**	**0**	**0**	**35,657,741**	**533,573**	**0**	**0**	**0**	**36,348,819**	**73,077,277**
Traditional Medicaid										
Base Acute	618,361,837	0	0	0	0	0	0	0	618,361,837	1,236,723,674
Minus Breast and Cervical Cancer Expansion	(533,573)	0	0	0	0	0	0	0	(990,921)	(1,524,494)
Minus Legal Immigrant Acute	(4,987,699)	0	0	0	0	0	0	0	(4,150,712)	(9,138,411)
Minus Increased Children Waiver Expansion	(8,308,978)	0	0	0	0	0	0	0	(8,308,978)	(16,617,956)
Minus Asset Test Elimination	(14,711,176)	0	0	0	0	0	0	0	(14,711,176)	(29,422,352)
Minus 60% FPL	(5,932,957)	0	0	0	0	0	0	0	(5,932,957)	(11,865,914)
Minus CBHP Marketing	(537,144)	0	0	0	0	0	0	0	(537,144)	(1,074,288)
Family Planning	927,033	0	0	0	0	0	0	0	8,343,302	9,270,335
Estimated Prenatal Costs	2,041,047	0	0	0	0	0	0	0	964,526	3,005,573
Breast and Cervical Cancer Program	644,277	0	0	0	0	311,251	0	0	1,775,638	2,731,166
Indian Health Services	0	0	0	0	0	0	0	0	959,008	959,008
Presumptive Eligibility Fund Transfer	(1,584,040)	0	0	1,584,040	0	0	0	0	0	0
Drug Rebate Analysis	(247,460)	0	0	0	0	0	0	0	(247,460)	(494,920)
Acute Care Rate Adjustment	12,759,937	0	0	513,701	0	0	0	0	13,273,639	26,547,277
S.B. 06-165	161,216	0	0	0	0	0	0	0	161,215	322,431
SUBTOTAL ACUTE	598,052,320	0	0	2,097,741	0	311,251	0	0	608,959,817	1,209,421,129
Base Community Care	86,405,284	0	0	0	0	0	0	0	86,405,284	172,810,568
Community Based Services	12,475,704	0	0	0	0	0	0	0	12,475,704	24,951,408
Minus Increased Children Waiver Exp.	(483,190)	0	0	0	0	0	0	0	(483,190)	(966,380)
Autism Program -- In Base	0	0	0	0	0	0	0	626,750	626,750	1,253,500
Consumer Directed Care -- In Base	0	0	0	0	0	0	0	0	0	0
Minus Legal Immigrants	(272,242)	0	0	0	0	0	0	0	(272,242)	(544,484)
SUBTOTAL COMMUNITY CARE	98,125,556	0	0	0	0	0	0	626,750	98,752,306	197,504,612

Fund Splits for FY 2006-07 Appropriation -- 2006 Session

	General Fund & General Fund Exempt	Cash Funds	Cash Funds Exempt						Federal Funds	TOTAL FUNDS
			Certified Funds	Health Care Expansion Fund	Transfer from DPHE	Breast and Cervical Cancer Fund	Gifts Grants and Donations	Autisim Fund		
Nursing Facility I	235,372,275	0	0	0	0	0	0	0	235,372,275	470,744,550
Minus Legal Immigrants	(956,811)	0	0	0	0	0	0	0	(956,811)	(1,913,622)
S.B. 06-131	1,188,203	0	0	0	0	0	0	0	1,188,203	2,376,406
SUBTOTAL NURSING FACILTIES	235,603,667	0	0	0	0	0	0	0	235,603,667	471,207,334
Nursing Facility II	748,237	0	0	0	0	0	0	0	748,237	1,496,474
PACE	21,014,129	0	0	0	0	0	0	0	21,014,129	42,028,258
SMIB	42,819,163	0	0	0	0	0	0	0	28,546,109	71,365,272
HIBI	319,847	0	0	0	0	0	0	0	319,847	639,694
SUBTOTAL OTHER LTC & INSURANCE	64,901,376	0	0	0	0	0	0	0	50,628,322	115,529,698
Single Entry Point	9,838,578	0	0	0	0	0	0	0	9,081,764	18,920,342
Minus Waiver Expansion	(4,688)	0	0	0	0	0	0	0	(4,688)	(9,376)
Single Entry Point Audits	(38,330)	0	0	0	0	0	0	0	(38,330)	(76,660)
ASO Service	2,766,980	0	0	0	0	0	0	0	2,766,980	5,533,960
Disease Management	310,786	0	0	1,000	1,970,388	584	0	0	2,285,617	4,568,375
SUBTOTAL ADMINSTRATION SERVICES	12,873,326	0	0	1,000	1,970,388	584	0	0	14,091,343	28,936,641
TOTAL MEDICAL SERVICES	1,010,093,389	0	0	37,756,482	2,503,961	311,835	0	626,750	1,044,384,274	2,095,676,691
Bottom Line Financing										
ICFMR Fee	(38,256)	76,512	0	0	0	0	0	0	38,256	76,512
UPL Financing	(13,233,276)	0	26,466,552	0	0	0	0	0	13,233,276	26,466,552
UPL Adjustment	0	0	(13,271,352)	0	0	0	0	0	0	(13,271,352)
Denver Health UPL Adjustments	0	0	1,169,578	0	0	0	0	0	1,169,578	2,339,156
TOTAL BOTTOM LINE FINANCING	(13,271,532)	76,512	14,364,778	0	0	0	0	0	14,441,110	15,610,868
TOTAL FY 2006-07 APPROPRIATION	**996,821,857**	**76,512**	**14,364,778**	**37,756,482**	**2,503,961**	**311,835**	**0**	**626,750**	**1,058,825,384**	**2,111,287,559**

Fund Splits for FY 2006-07 Appropriation -- Department Request

	General Fund & General Fund Exempt	Cash Funds	Cash Funds Exempt					Federal Funds	TOTAL FUNDS
			Certified Funds	Health Care Expansion Fund	Transfer from DPHE	Breast and Cervical Cancer Fund	Autism Fund		
Expansion Medicaid									
Acute Care Offset	0	0	0	20,323,937	0	0	0	20,323,936	40,647,873
Community Care Offset	0	0	0	21,625	0	0	0	21,624	43,249
Long Term Care & Insurance	0	0	0	(2)	0	0	0	(2)	(4)
Long Term Care & Insurance	0	0	0	6,121	0	0	0	6,121	12,242
Service Management	0	0	0	113,006				113,004	226,010
Other Allocation (acute below?)	0	0	0	13,118,070	0	0	0	12,156,735	25,274,805
TOTAL	0	0	0	33,582,757	0	0	0	32,621,418	66,204,175
Traditional Medicaid									
Base Acute	607,730,524	0	0	0	0	0	0	608,021,965	1,215,752,489
Family Planning	941,549	0	0	0	0	0	0	8,473,938	9,415,487
Estimated Prenatal Costs	3,405,317	0	0	0	0	0	0	1,365,027	4,770,344
Breast and Cervical Cancer Program	1,746,659	0	0	0	0	1,578,463	0	6,175,224	9,500,346
Indian Health Services	0	0	0	0	0	0	0	878,400	878,400
Drug Rebate Analysis	(247,460)	0	0	0	0	0	0	(247,460)	(494,920)
Acute Care Rate Adjustment	12,759,937	0	0	513,701	0	0	0	13,273,639	26,547,277
MMA Impact	(36,128,881)	0	0	0	0	0	0	(36,128,880)	(72,257,761)
PERM Project	(398,355)	0	0	0	0	0	0	(398,355)	(796,710)
HB 05-1015 Outpatient Substance Abuse Treatment	2,921,851	0	0	0	0	0	0	2,921,851	5,843,702
S.B. 06-165	161,216	0	0	0	0	0	0	161,215	322,431
SUBTOTAL ACUTE	**592,892,358**	**0**	**0**	**513,701**	**0**	**1,578,463**	**0**	**604,496,564**	**1,199,481,086**
Base Community Care	95,694,327	0	0	0	0	0	0	95,694,327	191,388,654
Provider Rate Increase	12,475,704	0	0	0	0	0	0	12,475,704	24,951,408
Autism Waiver	0	0	0	0	0	0	470,063	470,062	940,125
HB 1131	(1,431)	0	0	0	0	0		(1,430)	(2,861)
SUBTOTAL COMMUNITY CARE	108,168,601	0	0	0	0	0	470,063	108,638,663	217,277,326

Fund Splits for FY 2006-07 Appropriation -- Department Request

	General Fund & General Fund Exempt	Cash Funds	Cash Funds Exempt					Federal Funds	TOTAL FUNDS
			Certified Funds	Health Care Expansion Fund	Transfer from DPHE	Breast and Cervical Cancer Fund	Autism Fund		
Nursing Facility I	236,871,670	0	0	0	0	0	0	236,871,670	473,743,339
S.B. 06-131	2,120,349	0	0	0	0	0	0	2,120,349	4,240,697
SUBTOTAL NURSING FACILTIES	238,992,018	0	0	0	0	0	0	238,992,018	477,984,036
Nursing Facility II	737,022	0	0	0	0	0	0	737,022	1,474,043
PACE	23,936,619	0	0	0	0	0	0	23,936,619	47,873,238
SMIB	48,058,051	0	0	0	0	0	0	32,038,700	80,096,751
HIBI	279,383	0	0	0	0	0	0	279,383	558,766
SUBTOTAL OTHER LTC & INSURANCE	73,011,075	0	0	0	0	0	0	56,991,724	130,002,798
Single Entry Point	8,411,944	0	0	0	0	0	0	8,411,944	16,823,888
Single Entry Point Audits	(38,330)	0	0	0	0	0	0	(38,330)	(76,660)
ASO Service	2,425,699	0	0	0	0	0	0	2,425,698	4,851,397
Disease Management	313,889	0	0	0	985,194	0	0	1,299,083	2,598,166
SUBTOTAL ADMINSTRATION SERVICES	11,113,202	0	0	0	985,194	0	0	12,098,395	24,196,791
TOTAL MEDICAL SERVICES	**1,024,177,252**	**0**	**0**	**34,096,458**	**985,194**	**1,578,463**	**470,063**	**1,053,838,782**	**2,115,146,211**
Bottom Line Financing									
ICFMR Fee	(38,256)	38,256	0	0	0	0	0	38,256	38,256
UPL Financing	(15,590,407)	0	15,590,407	0	0	0	0	15,590,407	15,590,407
Denver Health UPL Adjustments	0	0	1,169,578	0	0	0	0	1,169,578	2,339,156
TOTAL BOTTOM LINE FINANCING	**(15,628,663)**	**38,256**	**16,759,985**	**0**	**0**	**0**	**0**	**16,798,241**	**17,967,819**
TOTAL FY 2006-07 Dept. November Est.	**1,008,548,589**	**38,256**	**16,759,985**	**34,096,458**	**985,194**	**1,578,463**	**470,063**	**1,070,637,023**	**2,133,114,030**

Department's FY 2007-08 -- Department Request Fund Splits

				Cash Funds Exempt						
	General Fund	General Fund Exempt	Cash Funds	Certified Funds	Health Care Expansion Fund	Transfer from DPHE	Breast & Cervical Cancer Fund	Autism Fund	Federal Funds	TOTAL FUNDS
Acute Care Services										
Base Acute	$619,271,889	$0	$0	$0	$0	$0	$0	$0	$619,271,888	$1,238,543,777
Estimated Family Planning	$1,073,210	$0	$0	$0	$0	$0	$0	$0	$9,658,890	$10,732,100
Estimated Prenatal State-Only Program Costs	$3,623,699	$0	$0	$0	$0	$0	$0	$0	$1,380,354	$5,004,053
Health Care Expansion Fund Split Adjustment	$0	$0	$0	$0	$37,949,803	$0	$0	$0	$37,949,801	$75,899,604
Estimated Breast and Cervical Cancer Program (BCCP) [Change in funding via HB 04-1416 and HB 05-1262]	$2,308,085	$0	$0	$0	$0	$0	$2,088,268	$0	$8,164,653	$12,561,006
Estimated Indian Health Service (IHS) (Advisory Only)	$0	$0	$0	$0	$0	$0	$0	$0	$878,400	$878,400
Acute Care Services Sub-Total	**$626,276,883**	**$0**	**$0**	**$0**	**$37,949,803**	**$0**	**$2,088,268**	**$0**	**$677,303,986**	**$1,343,618,940**
Community Based Long Term Care Services										$0
Base Community Based Long Term Care	$115,270,528	$0	$0	$0	$0	$0	$0	$0	$115,270,528	$230,541,056
Children with Autism Waiver Services	$0	$0	$0	$0	$0	$0	$0	$626,750	$626,750	$1,253,500
Health Care Expansion Fund Split Adjustment	$0	$0	$0	$0	$43,024	$0	$0	$0	$43,023	$86,047
Community Based Long Term Care Sub-Total	**$115,270,528**	**$0**	**$0**	**$0**	**$43,024**	**$0**	**$0**	**$626,750**	**$115,940,301**	**$231,880,603**
Long Term Care and Insurance										$0
Base Long Term Care	$281,041,766	$0	$0	$0	$0	$0	$0	$0	$281,041,766	$562,083,532
Specialized Medicare Insurance Beneficiaries (SMIB)	$54,387,296	$0	$0	$0	$0	$0	$0	$0	$36,258,197	$90,645,493
Health Care Expansion Fund Split Adjustment	$0	$0	$0	$0	$12,212	$0	$0	$0	$12,211	$24,423
Long Term Care and Insurance Sub-total	**$335,429,062**	**$0**	**$0**	**$0**	**$12,212**	**$0**	**$0**	**$0**	**$317,312,174**	**$652,753,448**
Service Management										$0
Base Service Management	$2,848,784	$0	$0	$0	$0	$0	$0	$0	$2,848,784	$5,697,568
Single Entry Point	$9,343,144	$0	$0	$0	$0	$0	$0	$0	$8,624,440	$17,967,584
Tobacco Tax Funded Disease Management Adjustment	$0	$0	$0	$0	$0	$1,970,388	$0	$0	$1,970,388	$3,940,776
Health Care Expansion Fund Split Adjustment	$0	$0	$0	$0	$247,828	$0	$0	$0	$247,828	$495,656
Service Management Sub-total	**$12,191,928**	**$0**	**$0**	**$0**	**$247,828**	**$1,970,388**	**$0**	**$0**	**$13,691,440**	**$28,101,584**
Health Care Expansion Fund Allocations Split Adjustment	**($15,934,115)**	**$0**	**$0**	**$0**	**$15,934,115**	**$0**	**$0**	**$0**	**$0**	**$0**
FY 07-08 Estimate of Total Expenditures for Medical Services to Clients	**$1,073,234,286**	**$0**	**$0**	**$0**	**$54,186,982**	**$1,970,388**	**$2,088,268**	**$626,750**	**$1,124,247,901**	**$2,256,354,575**
HB 03-1292 ICFMR Fee(1)	($38,256)	$0	$38,256	$0	$0	$0	$0	$0	$38,256	$38,256
Impact of Upper Payment Limit Financing (Estimated)	($16,260,366)	$0	$0	$16,260,366	$0	$0	$0	$0	$16,260,366	$16,260,366
Denver Health Outstationing	$0	$0	$0	$1,169,578	$0	$0	$0	$0	$1,169,577	$2,339,155
Referendum C Funding	($256,100,000)	$256,100,000	$0	$0	$0	$0	$0	$0	$0	$0
Total Projected FY 07-08 Expenditures	**$800,835,664**	**$256,100,000**	**$38,256**	**$17,429,944**	**$54,186,982**	**$1,970,388**	**$2,088,268**	**$626,750**	**$1,141,716,100**	**$2,274,992,352**
Decision Items (Other Than Base Adjustments -- DI #1)										
DI #4	1,349	0	0	0	0	0	0	0	7,456	$8,805
DI #6	6,755,310	0	0	0	138,113	0	0	0	6,811,304	$13,704,727
DI #10	(10,722,460)	0	0	0	(985,194)	0	0	0	(10,997,430)	($22,705,084)
BRI #1	(248,573)	0	0	0	0	0	0	0	(248,574)	($497,147)
TOTAL REQUEST	**796,621,290**	**256,100,000**	**38,256**	**17,429,944**	**53,339,901**	**1,970,388**	**2,088,268**	**626,750**	**1,137,288,856**	**$2,265,503,653**

JBC Staff
Monthly Caseload Reports -- FY 2003-04 Through FY 2006-07 Caseload Reports

		SSI 65+	SSI 60-64	QMB/SLMB	SSI Disabled	Adults	Exp. Adults	BCP Adults	BCCTC	Children	Foster Children	Non-Citizens	Total	Growth
FY 2003-04														
	July	34,159	5,430	9,382	46,241	43,760	0	7,865	78	178,535	14,272	4,491	344,213	
	Aug	34,128	5,416	9,471	46,031	43,831	0	7,877	84	179,386	14,195	4,497	344,916	703
	Sept	34,205	5,441	9,529	46,170	44,358	0	8,068	90	181,465	14,256	4,466	348,048	3,132
	Oct	34,246	5,452	9,590	46,372	44,714	0	8,061	95	183,743	14,410	4,337	351,020	2,972
	Nov	34,187	5,528	9,662	46,386	45,008	0	7,942	102	185,267	14,506	4,267	352,855	1,835
	Dec	34,048	5,537	9,671	46,416	46,500	0	8,099	105	191,086	14,766	4,581	360,809	7,954
	Jan	34,062	5,586	9,827	46,510	46,805	0	8,223	103	193,356	14,796	4,461	363,729	2,920
	Feb	33,999	5,588	9,930	46,556	47,446	0	8,274	103	195,915	14,846	4,532	367,189	3,460
	Mar	34,126	5,580	10,007	46,766	49,067	0	8,681	108	201,875	15,200	4,727	376,137	8,948
	Apr	34,101	5,598	10,029	46,994	49,519	0	8,518	114	203,657	15,300	4,863	378,693	2,556
	May	34,220	5,582	10,144	47,129	49,831	0	8,369	123	204,254	15,401	4,922	379,975	1,282
	Jun	34,309	5,602	10,197	47,212	50,214	0	8,458	125	206,031	15,531	5,098	382,777	2,802
YTD		34,149	5,528	9,787	46,565	46,754		8,203	103	192,048	14,790	4,604	362,530	
FY 2004-05														
	July	34,378	5,614	10,285	47,195	49,885	0	8,491	131	206,125	15,370	4,977	382,451	(326)
	Aug	34,633	5,664	10,446	47,471	51,132	0	8,242	135	210,235	15,411	5,231	388,600	6,149
	Sept	34,666	5,488	10,328	47,846	51,764	0	6,866	139	211,593	15,263	5,141	389,094	494
	Oct	34,783	5,477	9,894	48,725	54,100	0	5,786	144	216,658	15,480	4,977	396,024	6,930
	Nov	35,270	6,944	9,257	48,293	56,714	0	6,102	153	223,736	15,705	5,037	407,211	11,187
	Dec	36,336	6,766	8,736	48,384	59,166	0	6,462	156	230,510	15,678	5,247	417,441	10,230
	Jan	36,119	6,202	8,886	46,977	54,804	0	5,504	23	221,800	15,601	4,553	400,469	(16,972)
	Feb	35,905	6,178	9,480	46,903	56,107	0	6,171	21	223,723	15,729	4,577	404,794	4,325
	Mar	36,222	6,266	9,425	47,334	59,450	0	5,135	29	226,082	15,838	4,599	410,380	5,586
	Apr	36,270	6,246	9,441	47,337	60,881	0	4,918	35	226,744	15,842	5,004	412,718	2,338
	May	36,386	6,223	9,351	47,533	61,749	0	4,797	38	226,241	16,061	5,295	413,674	956
	Jun	36,406	6,164	9,336	47,519	61,684	0	4,846	32	223,659	16,049	5,074	410,769	(2,905)
YTD		35,615	6,103	9,572	47,626	56,453		6,110	86	220,592	15,669	4,976	402,802	
Original FY 2004-05 App		**34,048**	**5,648**	**10,353**	**46,226**	**49,019**		**8,026**	**176**	**202,001**	**15,130**	**4,784**	**375,411**	
Supplemental App.		**34,799**	**5,904**	**10,151**	**48,225**	**54,951**		**6,971**	**158**	**221,849**	**15,669**	**5,227**	**403,904**	
Difference		(816)	(199)	579	599	(1,502)		861	72	1,257	0	251	1,102	
% Difference		-2.40%	-3.52%	5.59%	1.29%	-3.06%		10.73%	40.72%	0.62%	0.00%	5.25%	0.29%	
FY 2005-06	July	36,376	6,072	9,416	47,214	57,874	0	5,151	171	212,576	15,958	5,187	395,995	(14,774)
	Aug	36,351	6,060	9,710	47,358	57,799	0	5,434	178	213,413	16,078	5,588	397,969	1,974
	Sept	36,430	6,161	10,063	47,467	57,922	0	5,259	186	212,975	16,249	5,670	398,382	413
	Oct	36,396	6,132	10,162	47,365	56,658	0	4,834	192	207,644	16,237	5,523	391,143	(7,239)
	Nov	36,612	6,134	10,584	47,783	57,923	0	4,775	191	209,732	16,351	5,732	395,817	4,674
	Dec	36,256	6,061	11,378	47,429	57,944	0	4,682	191	210,394	16,427	5,744	396,506	689
	Jan	36,116	6,016	11,491	47,373	58,721	0	4,778	198	213,996	16,348	5,930	400,967	4,461
	Feb	36,176	5,990	11,673	47,541	57,872	0	4,887	181	215,042	16,366	6,120	401,848	881
	Mar	35,997	5,996	11,850	47,579	57,354	0	5,009	178	215,429	16,539	6,265	402,196	348
	Apr	35,925	5,995	11,891	47,705	57,730	0	5,161	188	217,685	16,334	6,496	405,110	2,914
	May	36,032	5,979	11,994	48,055	58,748	0	5,354	201	219,252	16,437	6,689	408,741	3,631
	Jun	35,959	5,975	11,934	47,912	56,416	0	5,273	198	215,060	16,410	6,563	401,700	(7,041)
YTD		36,219	6,048	11,012	47,565	57,747		5,050	188	213,600	16,311	5,959	399,705	(756)
Original FY 2005-06 App./1		35,132	5,943	10,814	48,673	58,784		8,100	219	236,841	16,303	5,621	426,430	
Supplemental App./2		36,569	6,107	11,170	47,709	58,045		4,912	192	212,850	16,363	5,793	399,710	
Difference		350	59	158	144	298		(138)	4	(750)	52	(166)	5	
% Difference		0.96%	0.97%	1.41%	0.30%	0.51%		-2.80%	2.21%	-0.35%	0.32%	-2.86%	0.0013%	
FY 2006-07	July	36,033	5,953	12,050	47,946	57,224	0	5,152	203	214,085	16,332	6,514	401,492	(208)
	Aug	36,190	5,985	12,250	48,192	58,541	0	4,990	213	214,766	16,492	6,248	403,867	2,375
	Sept	36,258	5,990	12,349	48,320	58,281	0	4,926	222	212,808	16,430	6,103	401,687	(2,180)
	Oct	36,233	6,040	12,438	48,611	58,402	0	5,026	231	211,000	16,461	5,849	400,291	(1,396)
	Nov													
	Dec													
	Jan													
	Feb													
	Mar													
	Apr													
	May													
	Jun													
YTD		36,179	5,992	12,272	48,267	58,112	0	5,024	217	213,165	16,429	6,179	401,834	(352)
Original FY 2006-07 App.		37,036	6,241	12,570	48,447	63,127	4,850	4,890	223	228,438	17,091	6,309	429,222	
Supplemental App.														
Difference														
% Difference														

/1 Does not include Expansion Population -- most of the expansion population originally forecasted did not materialize because of delayed implementation
/2 Includes Expansion population since caseload population can not track separately (however, in FY 2005-06 very little expansion population materialized)

Monthly Reports Expenditure Data

SERVICES	"FY 2004-05 July	FY 2004-05 Aug	FY 2004-05 Sept	FY 2004-05 Oct	FY 2004-05 Nov	FY 2004-05 Dec	FY 2004-05 Jan	FY 2004-05 Feb	FY 2004-05 Mar	FY 2004-05 Apr	FY 2004-05 May	FY 2004-05 June	FY 2004-05 YTD Total
Acute Care Services													
Physician Services & EPSDT	9,234,860	11,221,146	8,865,674	8,875,527	11,335,576	8,867,945	11,263,352	9,355,586	11,041,321	10,872,434	12,774,368	10,411,550	**124,119,339**
Emergency Transportation	327,197	431,393	356,668	314,400	316,728	254,327	379,614	269,038	292,469	341,335	336,368	(145,796)	**3,473,741**
County Transportation	174,975	(27,343)	77,956	(179)	(109)	(2,475)	(439)	(1,147)	(2,696)	(1,641)	(476)	(2,721)	**213,707**
Dental Services	2,652,232	3,738,064	3,001,922	2,984,996	3,416,128	3,028,737	3,538,953	3,092,988	3,522,005	3,605,495	4,169,843	3,262,486	**40,013,849**
Family Planning	34,454	2,986	10,805	15,647	16,222	4,861	16,741	16,742	13,691	14,594	27,384	11,894	**186,022**
Health Maintenance Organization	11,399,807	11,975,663	9,407,191	12,574,422	12,015,349	13,609,969	13,383,809	10,419,752	12,918,632	12,881,399	27,833,833	13,670,420	**162,090,247**
Inpatient Hospitals	21,945,174	25,293,270	20,405,063	16,597,823	18,503,339	20,798,654	24,015,047	22,908,320	22,104,720	24,458,076	26,851,737	22,130,223	**266,011,447**
Outpatient	5,801,299	8,433,966	6,362,117	7,116,184	9,022,072	6,163,191	8,579,029	8,692,524	5,357,357	8,643,159	9,813,531	9,633,688	**93,618,116**
Lab & X-Ray	1,422,088	1,741,252	1,405,498	1,168,101	1,536,141	1,165,424	1,548,996	1,370,771	1,452,872	1,481,747	1,741,007	1,450,858	**17,484,756**
Durable Medical Equipment	3,628,036	4,177,940	3,856,062	3,831,533	4,457,056	3,724,154	4,686,689	3,954,365	4,165,335	4,102,922	5,035,984	4,679,174	**50,299,251**
Prescription Drugs	20,209,905	25,557,517	20,995,902	19,512,739	27,320,932	21,327,488	27,975,376	23,249,297	23,159,448	22,209,618	27,003,365	22,409,312	**280,930,899**
Drug Rebate (OAP State Only & Medicaid)	0	(14,304,899)	(2,011,713)	(1,203,897)	(3,319,451)	(7,241,822)	0	(7,118,794)	0	(17,682,042)	(17,406,178)	(1,367,881)	**(71,656,675)**
Rural Health Centers	715,590	295,805	(279,014)	253,523	449,261	296,013	341,209	664,679	461,343	350,343	700,881	348,762	**4,598,395**
Federally Qualified Health Centers	4,112,639	4,699,011	4,532,549	3,907,489	4,962,241	4,253,292	5,180,106	4,680,650	4,961,431	4,939,494	5,690,190	4,926,472	**56,845,564**
Co-Insurance (Title XVIII-Medicare)	1,718,360	2,076,253	1,360,853	1,282,766	1,568,712	640,828	1,133,674	2,406,002	2,140,329	1,038,632	1,449,983	541,308	**17,357,700**
Breast and Cervical Cancer Program	284,585	305,753	288,607	238,772	281,684	271,994	231,420	136,570	59,180	110,393	144,297	136,836	**2,490,090**
Other Medical Services (Medicaid Refugee & ASO & DM)	2,996,895	4,623,861	11,157,052	9,737,514	2,049,521	5,042,609	11,237,929	6,273,810	6,350,572	5,272,260	6,935,993	(3,174,245)	**68,503,772**
Home Health	5,393,977	6,780,184	5,519,655	5,719,651	6,730,822	5,389,228	7,370,473	5,886,554	5,886,997	6,073,125	7,395,249	6,388,696	**74,534,611**
Acute Care Subtotal	92,052,073	97,021,825	95,312,848	92,927,011	100,662,226	87,594,417	120,881,978	96,257,707	103,885,006	88,711,343	120,497,360	95,311,036	**1,191,114,829**
Community Based Long-Term Care													
Home and Community Based Services-Case Management	7,354,772	8,843,626	7,104,577	7,355,048	8,644,351	7,363,676	8,597,641	7,472,585	7,487,459	7,643,945	8,682,572	7,665,930	**94,216,183**
Home and Community Based Services - Mentally Ill	1,068,279	1,263,219	1,101,775	1,056,950	1,126,023	1,053,063	1,137,718	1,019,364	937,492	1,074,745	1,142,076	1,038,757	**13,019,463**
Home and Community Based Services - Model 200	25,419	69,240	40,829	34,423	29,848	36,029	59,489	21,792	53,268	28,584	43,569	39,437	**481,927**
Home and Community Based Services - AIDS	41,527	49,632	34,925	35,900	45,187	37,285	42,336	31,208	30,970	36,646	37,580	35,254	**458,450**
Consumer Directed Attendant Support	425,868	450,724	427,559	235,548	623,697	464,325	493,703	511,209	469,685	483,909	495,940	830,205	**5,912,371**
Private Duty Nursing	1,180,079	1,318,301	963,631	1,100,740	1,092,212	948,796	1,579,050	1,137,975	1,012,534	1,121,966	1,340,300	1,276,307	**14,071,891**
Hospice	1,676,196	2,260,452	1,836,401	1,834,970	2,026,750	1,722,637	2,079,086	1,974,079	1,788,835	1,981,719	2,222,195	2,155,710	**23,559,031**
Brain Injury	693,905	801,274	674,536	1,025,099	825,691	803,588	777,059	689,703	688,151	726,760	740,158	779,668	**9,225,591**
Community Based Long-Term Care Subtotal	12,466,044	15,056,469	12,184,234	12,678,680	14,413,760	12,429,399	14,766,082	12,857,915	12,468,394	13,098,274	14,704,388	13,821,268	**160,944,907**
Long Term Care and Insurance													
Class I Nursing Facilities	33,718,440	37,585,866	35,094,223	32,917,860	36,289,410	32,820,671	37,110,768	43,540,199	31,971,522	30,562,933	36,640,818	35,625,623	**423,878,333**
Class II Nursing Facilities	102,801	121,355	121,481	117,139	121,355	117,139	114,355	120,488	101,598	125,519	109,693	110,522	**1,383,445**
Single Entry Points	1,557,053	1,773,427	1,302,705	1,391,475	1,761	1,745,843	1,297,999	943,011	1,520,610	2,587,071	440,963	2,694,917	**17,256,835**
Program for All-Inclusive Care for the Elderly	2,860,595	4,849,075	409,631	2,773,402	2,574,299	2,609,115	3,329,482	2,796,736	2,879,956	3,431,779	3,416,424	3,229,511	**35,160,006**
Supplemental Medicare Insurance Beneficiaries	5,195,700	4,378,063	4,447,323	4,473,032	4,318,934	4,365,569	4,986,748	5,218,871	5,123,165	5,648,991	5,190,663	5,102,695	**58,449,754**
Health Insurance Buy-In Program	53,429	50,045	58,575	45,093	49,887	49,952	47,098	48,121	52,329	46,689	46,073	60,042	**607,333**
Subtotal of Long Term Care and Insurance	43,488,019	48,757,831	41,433,937	41,718,000	43,355,647	41,708,289	46,886,450	52,667,426	41,649,180	42,402,982	45,844,635	46,823,310	**536,735,706**
Service Management (new in FY 2005-06)													
Single Entry Points													
Disease Management													
ASO Administrative Fee													
Subtotal of Service Management													
TOTAL	148,006,137	160,836,125	148,931,018	147,323,691	158,431,633	141,732,105	182,534,510	161,783,048	158,002,580	144,212,599	181,046,383	155,955,614	**1,888,795,441**
													157,399,620
Bottom Line Financings													
Prior Fiscal Year Accounts Payable	0	44,048	(44,048)	0	0	0	0	0	0	0	0	0	
Nursing Facility Upper Payment Limit	0	0	0	0	0	0	0	0	0	0	0	4,462,714	4,462,714
Inpatient Upper Payment Limit	0	0	0	0	0	0	0	0	0	0	0	0	0
Outpatient Upper Payment Limit	0	0	0	0	0	0	0	0	0	0	0	22,408,594	22,408,594
Home Health Upper Payment Limit	0	0	0	0	0	0	0	0	0	0	0	317,897	317,897
Total Bottom Line Financings	0	44,048	(44,048)	0	0	0	0	0	0	0	0	27,189,205	27,189,205
Grand Total	**148,006,137**	**160,880,173**	**148,886,969**	**147,323,691**	**158,431,633**	**141,732,105**	**182,534,510**	**161,783,048**	**158,002,580**	**144,212,599**	**181,046,383**	**183,144,819**	**1,915,984,646**

Monthly Reports Expenditure Data

SERVICES	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March	April	May	13 Month Ajd. June	YTD Total	FY 2005-06 YTD Average
Acute Care Services														
Physician Services & EPSDT	9,688,689	12,611,551	10,498,999	13,566,481	10,443,494	12,911,468	12,338,666	12,299,416	12,590,701	11,886,531	*14,461,742*	10,968,685	144,266,423	12,022,202
Emergency Transportation	255,690	276,055	261,656	334,835	221,099	296,899	282,046	321,767	283,802	288,085	*409,343*	380,164	3,611,441	300,953
County Transportation	(918)	(1,679)	6,076	(1,279)	(1,410)	(1,370)	(797)	(300)	(1,632)	(1,844)	*(3,085)*	(2,927)	(11,165)	(930)
Dental Services	3,086,894	4,426,469	3,365,710	3,971,206	3,077,228	3,756,237	3,784,118	3,811,026	3,748,833	4,200,008	*4,411,678*	5,066,107	46,705,514	3,892,126
Family Planning	12,153	10,261	23,230	22,654	19,979	13,668	29,504	27,159	11,148	15,240	*21,773*	202,350	409,119	34,093
Health Maintenance Organization	13,485,328	13,676,673	13,013,307	13,396,605	13,284,467	12,715,338	11,591,800	10,921,416	10,314,993	10,605,286	*14,682,632*	17,094,347	154,782,192	12,898,516
Inpatient Hospitals	20,243,821	27,481,517	18,882,397	22,124,054	13,055,083	39,056,074	22,820,338	26,051,647	24,871,270	25,322,116	*30,513,789*	26,378,018	296,800,124	24,733,344
Outpatient	8,199,867	10,054,510	7,512,941	9,916,743	7,740,331	9,632,861	6,784,590	9,884,822	9,179,872	8,914,081	*7,675,677*	9,717,448	105,213,743	8,767,812
Lab & X-Ray	1,400,205	1,733,104	1,362,427	1,798,886	1,370,431	1,664,715	1,460,674	1,643,006	1,572,350	1,697,837	*1,927,194*	1,619,208	19,250,037	1,604,170
Durable Medical Equipment	4,403,498	5,167,506	4,201,248	5,318,369	4,422,220	4,834,496	4,795,846	4,731,735	4,655,597	4,724,053	*6,001,941*	5,395,660	58,652,169	4,887,681
Prescription Drugs	21,680,172	26,577,758	21,213,451	30,737,098	23,067,017	30,476,687	13,507,510	13,123,051	13,766,859	12,968,393	*15,228,868*	14,600,961	236,947,825	19,745,652
Drug Rebate (OAP State Only & Medicaid)	(5,250)	(11,944,986)	(7,796,635)	(585,586)	(14,998,995)	(3,366,532)	(327,069)	(16,087,466)	(3,021,276)	(465,245)	*(11,998,085)*	(8,471,492)	(79,068,617)	(6,589,051)
Rural Health Centers	479,455	362,360	331,380	313,341	302,831	401,785	348,234	402,233	515,255	409,573	*471,914*	412,969	4,751,330	395,944
Federally Qualified Health Centers	4,051,943	5,229,344	4,902,160	5,631,192	4,723,003	5,919,303	4,416,174	5,906,690	5,404,187	5,417,872	*5,843,313*	4,512,537	61,957,718	5,163,143
Co-Insurance (Title XVIII-Medicare)	1,942,202	1,417,718	1,447,753	1,409,954	810,663	1,588,447	956,346	1,964,636	1,450,686	1,829,954	*2,099,909*	1,004,176	17,922,444	1,493,537
Breast and Cervical Cancer Program	149,638	142,539	99,818	115,243	119,729	201,167	97,381	77,431	224,633	456,859	*404,083*	4,719,743	6,808,264	567,355
Other Medical Services (Medicaid Refugee & ASO & DM)	3,134,359	5,386,181	9,610,128	3,924,835	11,171,248	1,291,410	13,014,431	7,787,082	7,694,082	5,763,289	*9,207,568*	(42,322,940)	35,661,673	2,971,806
Home Health	5,956,001	7,852,634	6,607,185	8,681,504	6,411,047	8,193,625	7,145,435	7,426,207	6,994,529	7,076,101	*9,664,773*	10,218,410	92,227,451	7,685,621
Acute Care Subtotal	98,163,747	110,459,515	95,543,231	120,676,135	85,239,465	129,586,278	103,045,227	90,291,558	100,255,889	101,108,189	*111,025,027*	61,493,424	1,206,887,685	100,573,974
Community Based Long-Term Care														
Home and Community Based Services-Case Management	7,391,574	8,550,347	7,941,113	9,609,903	7,669,534	8,873,395	8,215,894	8,045,868	8,092,051	8,374,852	*10,339,064*	14,172,970	107,276,565	8,939,714
Home and Community Based Services - Mentally Ill	1,065,671	1,176,129	1,045,078	1,207,686	1,081,136	1,229,062	1,161,352	1,122,159	1,076,500	1,192,003	*1,254,465*	2,372,932	14,984,173	1,248,681
Home and Community Based Services - Model 200	22,987	7,657	60,443	78,437	36,735	56,778	29,342	48,461	79,049	75,514	*89,377*	77,043	661,823	55,152
Home and Community Based Services - AIDS	34,676	45,667	36,859	44,091	36,694	36,407	31,429	39,002	29,565	44,155	*43,277*	50,961	472,783	39,399
Consumer Directed Attendant Support	245,572	604,547	585,538	314,048	820,635	606,970	609,978	742,595	1,017,073	285,187	*690,031*	715,715	7,237,889	603,157
Private Duty Nursing	1,099,069	1,430,623	1,158,616	1,158,804	1,109,636	1,241,721	1,520,545	1,377,950	1,182,611	1,187,886	*1,527,639*	1,621,660	15,616,760	1,301,397
Hospice	1,999,370	2,216,222	2,208,962	2,078,852	1,582,733	2,680,529	2,354,219	2,649,018	2,384,921	2,042,972	*2,727,301*	3,581,988	28,507,087	2,375,591
Brain Injury	680,081	775,842	710,805	765,149	671,032	759,526	627,933	746,015	617,312	721,310	*755,193*	983,488	8,813,686	734,474
Community Based Long-Term Care Subtotal	12,539,000	14,807,034	13,747,414	15,256,970	13,008,135	15,484,388	14,550,692	14,771,068	14,479,082	13,923,879	*17,426,347*	23,576,757	183,570,766	15,297,564
Long Term Care and Insurance														
Class I Nursing Facilities	32,816,132	39,868,824	36,634,349	39,377,456	36,627,161	43,050,482	33,443,444	36,004,499	34,492,105	34,914,111	*40,050,522*	49,241,243	456,520,328	38,043,361
Class II Nursing Facilities	112,835	130,298	121,566	110,402	117,739	110,231	99,104	128,437	95,703	113,509	*117,241*	179,785	1,436,850	119,738
Single Entry Points	1,392,494	2,385,843	146,636	2,666,911	1,485,732	1,422,608	1,316,163	1,193,073	1,674,541	1,227,079	*1,492,919*	(16,403,999)	0	0
Program for All-Inclusive Care for the Elderly	3,131,477	3,424,285	3,391,355	3,109,366	3,738,404	3,682,211	3,545,990	3,781,594	3,024,509	3,099,524	*3,237,308*	3,304,467	40,470,490	3,372,541
Supplemental Medicare Insurance Beneficiaries	5,329,146	5,041,668	5,028,048	6,021,173	5,501,539	5,715,293	6,111,707	6,994,560	6,203,406	6,069,629	*6,427,156*	6,332,279	70,775,604	5,897,967
Health Insurance Buy-In Program	57,762	49,540	54,911	49,721	47,529	34,124	37,218	34,611	36,328	43,075	*40,173*	39,202	524,194	43,683
Subtotal of Long Term Care and Insurance	42,839,846	50,900,458	45,376,865	51,335,029	47,518,104	54,014,949	44,553,626	48,136,774	45,526,592	45,466,927	*51,365,319*	42,692,977	569,727,466	47,477,289
Service Management (new in FY 2005-06)														
Single Entry Points												16,547,063	16,547,063	1,378,922
Disease Management												322,355	322,355	26,863
ASO Administrative Fee												5,340,741	5,340,741	445,062
Subtotal of Service Management												22,210,159	22,210,159	1,850,847
TOTAL	153,542,593	176,167,007	154,667,510	187,268,134	145,765,704	199,085,615	162,149,545	153,199,400	160,261,563	160,498,995	*179,714,692*	149,973,317	1,982,396,076	166,480,689
Bottom Line Financings														
Prior Fiscal Year Accounts Payable	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Nursing Facility Upper Payment Limit	0	0	0	0	0	0	0	0	0	0	0	1,929,949	1,929,949	160,829
Inpatient Upper Payment Limit	0	0	0	0	0	0	0	0	0	0	0	11,609,079	11,609,079	967,423
Outpatient Upper Payment Limit	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Home Health Upper Payment Limit	0	0	0	0	0	0	0	0	0	0	0	329,204	329,204	27,434
Total Bottom Line Financings	0	0	0	0	0	0	0	0	0	0	0	13,868,232	13,868,232	1,155,686
Grand Total	**153,542,593**	**176,167,007**	**154,667,510**	**187,268,134**	**145,765,704**	**199,085,615**	**162,149,545**	**153,199,400**	**160,261,563**	**160,498,995**	**179,714,692**	**163,841,549**	**1,996,264,308**	**166,346,859**

Monthly Reports Expenditure Data

SERVICES	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March	April	May	June	YTD Total	YTD Average
Acute Care Services														
Physician Services & EPSDT	13,096,524	9,331,900	11,794,023	15,654,622									49,877,069	12,469,267
Emergency Transportation	587,121	305,440	300,154	348,367									1,541,082	385,271
County Transportation	(1,176)	(1,784)	(789)	(2,226)									(5,975)	(1,494)
Dental Services	4,449,960	4,048,371	3,577,164	4,808,906									16,884,401	4,221,100
Family Planning	17,775	21,024	3,479	25,369									67,647	16,912
Health Maintenance Organization	19,374,317	19,323,753	7,265,540	7,656,083									53,619,693	13,404,923
Inpatient Hospitals	28,775,244	20,325,085	21,469,520	28,020,128									98,589,977	24,647,494
Outpatient	10,264,962	8,545,968	7,377,202	11,616,209									37,804,341	9,451,085
Lab & X-Ray	1,727,142	1,362,504	1,393,816	2,042,667									6,526,129	1,631,532
Durable Medical Equipment	5,472,881	4,389,957	4,553,251	6,236,213									20,652,302	5,163,076
Prescription Drugs	14,181,448	11,860,212	14,138,941	18,094,048									58,274,649	14,568,662
Drug Rebate (OAP State Only & Medicaid)	0	(9,701,086)	(2,985,719)	(13,057)									(12,699,862)	(3,174,966)
Rural Health Centers	402,643	310,711	445,966	447,377									1,606,697	401,674
Federally Qualified Health Centers	4,881,716	3,776,863	4,076,518	5,837,252									18,572,349	4,643,087
Co-Insurance (Title XVIII-Medicare)	2,294,663	(244,849)	551,124	1,362,062									3,963,000	990,750
Breast and Cervical Cancer Program	529,135	405,702	430,312	625,421									1,990,570	497,643
Other Medical Services (Medicaid Refugee & ASO & DM)	1,793,651	1,498,277	3,975,721	3,801,798									11,069,447	2,767,362
Home Health	9,793,068	7,970,876	8,235,047	10,354,530									36,353,521	9,088,380
Acute Care Subtotal	117,641,074	83,528,924	86,601,270	116,915,769									404,687,037	101,171,759
Community Based Long-Term Care														
Home and Community Based Services-Case Management	11,285,212	9,474,676	9,597,881	11,304,202									41,661,971	10,415,493
Home and Community Based Services - Mentally Ill	1,481,598	1,356,247	1,374,443	1,504,021									5,716,309	1,429,077
Home and Community Based Services - Model 200	69,227	57,762	49,425	96,416									272,830	68,208
Home and Community Based Services - AIDS	38,403	40,915	34,841	41,807									155,966	38,992
Consumer Directed Attendant Support	1,211,454	843,779	463,576	700,629									3,219,438	804,860
Private Duty Nursing	1,556,734	1,276,455	1,360,897	1,517,607									5,711,693	1,427,923
Hospice	2,377,904	2,716,788	2,621,885	2,919,441									10,636,018	2,659,005
Brain Injury	834,171	776,300	1,113,170	1,006,507									3,730,148	932,537
Community Based Long-Term Care Subtotal	18,854,703	16,542,922	16,616,118	19,090,630									71,104,373	17,776,093
Long Term Care and Insurance														
Class I Nursing Facilities	39,533,059	37,269,789	38,691,319	45,408,807									160,902,974	40,225,744
Class II Nursing Facilities	160,698	161,430	133,825	228,846									684,799	171,200
Single Entry Points	2,164,062	1,861,788	836,921	1,371,282									6,234,053	1,558,513
Program for All-Inclusive Care for the Elderly	3,548,486	3,224,784	4,016,293	3,821,693									14,611,256	3,652,814
Supplemental Medicare Insurance Beneficiaries	7,664,770	6,412,882	6,511,703	6,336,646									26,926,001	6,731,500
Health Insurance Buy-In Program	50,624	66,267	48,298	68,588									233,777	58,444
Subtotal of Long Term Care and Insurance	53,121,699	48,996,940	50,238,359	57,235,862									209,592,860	52,398,215
Service Management (new in FY 2005-06)														
Single Entry Points														
Disease Management														
ASO Administrative Fee														
Subtotal of Service Management														
TOTAL	189,617,476	149,068,786	153,455,747	193,242,261									685,384,270	171,346,068
Bottom Line Financings														
Prior Fiscal Year Accounts Payable	0	205,405	0										205,405	68,468
Nursing Facility Upper Payment Limit	0	0	0										0	0
Inpatient Upper Payment Limit	0	0	0										0	0
Outpatient Upper Payment Limit	0	0	0										0	0
Home Health Upper Payment Limit	0	0	0										0	0
Total Bottom Line Financings	0	205,405	0										205,405	68,468
Grand Total	**189,617,476**	**149,274,191**	**153,455,747**										**492,347,414**	**164,115,805**

October 2006 -- Initial Forecast
Five Year Forecast
Medicaid Caseload Only

	SSI 65	SSI 60-64	QMB/SLM	SSI Disabled	Low Income Adult	Expansion Adults	Baby Care Adult	BCCTP	Children	Foster Children	Non-Citizens	TOTAL	
FY 2005-06 Actual	36,219	6,048	11,012	47,565	57,747	0	5,050	188	213,600	16,311	5,959	399,699	
Current FY 2006-07 Appropriation													
Traditional Medicaid	36,224	6,125	12,570	47,095	59,336	0	4,630	156	214,603	16,999	6,309	404,047	
Expansion Medicaid (Legal Immigrants)	812	116	0	700	676	0	260	0	856	92	0	3,512	
Expansion Medicaid (1262)	0	0	0	652	3,115	4,850	0	67	12,979	0	0	21,663	
TOTAL CASELOAD	37,036	6,241	12,570	48,447	63,127	4,850	4,890	223	228,438	17,091	6,309	429,222	
Year-to-Date FY 2006-07 Caseload (through August)													
Traditional Medicaid	36,112	5,969	12,150	48,069	57,883	0	5,071	208	214,426	16,412	6,381	402,681	
Expansion Medicaid (unknown)	0	0	0	0	0	0	0	0	0	0	0	0	
TOTAL CASELOAD	36,112	5,969	12,150	48,069	57,883	0	5,071	208	214,426	16,412	6,381	402,681	
Preliminary FY 2006-07 Reforecast													
Traditional Medicaid (General Fund)	35,581	5,944	12,535	46,962	57,677	0	4,799	161	213,485	16,701	6,470	400,315	1.03%
Caseload that Can Be Funded with HCF	812	116	0	1,352	3,040	2,364	260	69	10,708	92	0	18,813	
TOTAL CASELOAD	**36,393**	**6,060**	**12,535**	**48,314**	**60,717**	**2,364**	**5,059**	**230**	**224,193**	**16,793**	**6,470**	**419,128**	
Preliminary FY 2007-08													
Traditional Medicaid (General Fund)	36,157	6,150	13,334	47,353	58,341	0	4,928	195	215,398	17,531	6,967	406,354	1.51%
Caseload that Can Be Funded with HCF	812	116	0	1,477	5,011	4,335	260	83	18,918	92	0	31,104	65.33%
TOTAL CASELOAD	**36,969**	**6,266**	**13,334**	**48,830**	**63,352**	**4,335**	**5,188**	**278**	**234,316**	**17,623**	**6,967**	**437,458**	4.37%
Preliminary FY 2008-09													
Traditional Medicaid (General Fund)	36,723	6,354	14,123	47,726	59,085	0	5,072	227	219,024	18,354	7,490	414,178	1.93%
Caseload that Can Be Funded with HCF	812	116	0	1,477	5,141	4,465	260	97	19,460	92	0	31,920	2.62%
TOTAL CASELOAD	**37,535**	**6,470**	**14,123**	**49,203**	**64,226**	**4,465**	**5,332**	**324**	**238,484**	**18,446**	**7,490**	**446,098**	1.98%
Preliminary FY 2009-10													
Traditional Medicaid (General Fund)	37,856	6,558	14,911	48,100	60,401	0	5,408	260	224,349	18,354	8,012	424,209	2.42%
Caseload that Can Be Funded with HCF	812	116	0	1,477	5,275	7,329	260	111	20,018	92	0	35,490	11.18%
TOTAL CASELOAD	**38,668**	**6,674**	**14,911**	**49,577**	**65,676**	**7,329**	**5,668**	**371**	**244,367**	**18,446**	**8,012**	**459,699**	3.05%
Preliminary FY 2010-11													
Traditional Medicaid (General Fund)	37,856	6,762	15,700	48,473	62,201	0	5,978	293	230,649	20,000	8,535	436,447	2.88%
Caseload that Can Be Funded with HCF	812	116	0	1,477	5,413	7,760	260	125	20,593	92	0	36,648	3.26%
TOTAL CASELOAD	**38,668**	**6,878**	**15,700**	**49,950**	**67,614**	**7,760**	**6,238**	**418**	**251,242**	**20,092**	**8,535**	**473,095**	2.91%
Preliminary FY 2011-12													
Traditional Medicaid (General Fund)	38,423	6,966	16,488	48,846	64,001	0	6,750	326	236,649	20,822	9,058	448,329	2.72%
Caseload that Can Be Funded with HCF	812	116	0	1,477	5,413	7,760	260	140	20,593	92	0	36,663	0.04%
TOTAL CASELOAD	**39,235**	**7,082**	**16,488**	**50,323**	**69,414**	**7,760**	**7,010**	**466**	**257,242**	**20,914**	**9,058**	**484,992**	2.51%
						3							

Five Year Forecast -- Per Capita Estimate

	SSI 65	SSI 60-64	QMB/SLM	SSI Disabled	Low Income Adult	Expansion Adults	Baby Care Adult	BCCTP	Children	Foster Children	Non-Citizens	TOTAL		Bottom Line Financing		
Current FY 2006-07 Appropriatior																
H.B. 06-1385	$18,923.35	$13,290.53	$952.10	$11,661.30	$3,746.06	$2,505.32	$7,761.05	$22,908.68	$1,472.82	$3,386.80	$9,804.04					
S.B. 06-131	$51.97	$19.04	$0.00	$6.87	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00					
S.B. 06-165	$2.89	$2.03	$0.15	$1.78	$0.57	$0.38	$1.19	$3.50	$0.23	$0.52	$1.50					
	$18,978.22	$13,311.60	$952.25	$11,669.95	$3,746.63	$2,505.70	$7,762.24	$22,912.18	$1,473.05	$3,387.32	$9,805.54					
Current Caseload	37,036	6,241	12,570	48,447	63,127	4,850	4,890	223	228,438	17,091	6,309					
Cost	702,877,639	83,077,702	11,969,727	565,374,087	236,513,690	12,152,660	37,957,338	5,109,417	336,499,503	57,892,650	61,863,147	2,111,287,559				
New Forecast Caseload																
Traditional	35,581	5,944	12,535	46,962	57,677	0	4,799	161	213,485	16,701	6,470	400,315				
Expansion	812	116	0	1,352	3,040	2,364	260	69	10,708	92	0	18,813				
	36,393	6,060	12,535	48,314	60,717	2,364	5,059	230	224,193	16,793	6,470	419,128				
Cost Per Client	$18,978.22	$13,311.60	$952.25	$11,669.95	$3,746.63	$2,505.70	$7,762.24	$22,912.18	$1,473.05	$3,387.32	$9,805.54					
Traditional	$675,263,942	$79,124,156	$11,936,398	$548,044,211	$216,094,541	$0	$37,250,974	$3,688,861	$314,473,058	$56,571,596	$63,441,838	$2,005,889,576				
Expansion	$15,410,312	$1,544,146	$0	$15,777,773	$11,389,764	$5,923,482	$2,018,182	$1,580,941	$15,773,368	$311,633	$0	$69,729,600				
	$690,674,254	$80,668,302	$11,936,398	$563,821,984	$227,484,305	$5,923,482	$39,269,156	$5,269,802	$330,246,426	$56,883,229	$63,441,838	$2,075,619,177				
Traditional GF	337,631,971	39,562,078	5,968,199	274,022,105	108,047,271	0	18,625,487	1,291,102	157,236,529	28,285,798	31,720,919	$1,002,391,459	$996,821,857	($13,200,000)	$989,191,459	
Traditional FF	337,631,971	39,562,078	5,968,199	274,022,105	108,047,271	0	18,625,487	2,397,760	157,236,529	28,285,798	31,720,919	$1,003,498,117				
Expansion CFE	7,705,156	772,073	0	7,888,886	5,694,882	2,961,741	1,009,091	553,329	7,886,684	155,817	0	$34,627,659	$55,640,318	$13,200,000	$47,827,659	
Expansion FF	7,705,156	772,073	0	7,888,886	5,694,882	2,961,741	1,009,091	1,027,611	7,886,684	155,817	0	$35,101,941	$1,058,825,384		$1,038,600,059	
	690,674,254	80,668,302	11,936,398	563,821,984	227,484,305	5,923,482	39,269,156	5,269,802	330,246,426	56,883,229	63,441,838	$2,075,619,177	$2,111,287,559		$2,075,619,177	
FORECAST																
Per Capita Increase Used -- 3.0% Rough Estimate																
FY 2007-08 Percapita Estimates	$19,547.56	$13,710.95	$980.81	$12,020.05	$3,859.03	$2,580.87	$7,995.10	$23,599.55	$1,517.24	$3,488.94	$10,099.71					
FY 2008-09 Per Capita Estimates	$20,133.99	$14,122.28	$1,010.24	$12,380.65	$3,974.80	$2,658.30	$8,234.96	$24,307.53	$1,562.75	$3,593.61	$10,402.70					
FY 2009-10 Per Capita Estimates	$20,738.01	$14,545.95	$1,040.54	$12,752.07	$4,094.05	$2,738.05	$8,482.01	$25,036.76	$1,609.64	$3,701.41	$10,714.78					
FY 2010-11 Per Capita Estimates	$21,360.15	$14,982.32	$1,071.76	$13,134.63	$4,216.87	$2,820.19	$8,736.47	$25,787.86	$1,657.93	$3,812.46	$11,036.22					
FY 2011-12 Per Capita Estimates	$22,000.96	$15,431.79	$1,103.91	$13,528.67	$4,343.37	$2,904.80	$8,998.56	$26,561.50	$1,707.66	$3,926.83	$11,367.31					
FY 2007-08 Funding with Forecasted Caseload & Per Capitas																
General Fund	$353,390,628	$42,161,168	$6,539,080	$284,592,688	$112,569,887	$0	$19,699,936	$1,610,669	$163,404,861	$30,582,281	$35,182,324	$1,049,733,523		($13,200,000)	$1,036,533,523	
CFE	$7,936,311	$795,235	$0	$8,876,806	$9,668,804	$5,594,045	$1,039,364	$685,567	$14,351,541	$160,491	$0	$49,108,163		$13,200,000	$62,308,163	
Federal Funds	$361,326,939	$42,956,403	$6,539,080	$293,469,494	$122,238,692	$5,594,045	$20,739,299	$4,264,438	$177,756,402	$30,742,772	$35,182,324	$1,100,809,889			$1,100,809,889	
TOTAL	$722,653,879	$85,912,806	$13,078,160	$586,938,988	$244,477,383	$11,188,090	$41,478,599	$6,560,674	$355,512,804	$61,485,544	$70,364,647	$2,199,651,575			$2,199,651,575	5.98%
FY 2008-09 Funding with Forecasted Caseload & Per Capitas																
General Fund	$369,690,267	$44,866,475	$7,133,791	$295,439,460	$117,425,611	$0	$20,883,851	$1,931,234	$171,140,280	$32,978,518	$38,958,098	$1,100,447,584		($13,200,000)	$1,087,247,584	
CFE	$8,174,400	$819,092	$0	$9,143,110	$10,217,230	$5,934,656	$1,070,544	$825,241	$15,205,593	$165,306	$0	$51,555,173		$13,200,000	$64,755,173	
Federal Funds	$377,864,667	$45,685,568	$7,133,791	$304,582,570	$127,642,841	$5,934,656	$21,954,395	$5,119,167	$186,345,873	$33,143,824	$38,958,098	$1,154,365,450			$1,154,365,450	
TOTAL	$755,729,334	$91,371,135	$14,267,582	$609,165,141	$255,285,682	$11,869,311	$43,908,791	$7,875,641	$372,691,746	$66,287,648	$77,916,197	$2,306,368,207			$2,306,368,207	4.85%
FY 2009-10 Funding with Forecasted Caseload & Per Capitas																
General Fund	$392,529,057	$47,696,156	$7,757,779	$306,687,281	$123,642,262	$0	$22,935,343	$2,278,345	$180,560,145	$33,967,874	$42,923,398	$1,160,977,641		($13,200,000)	$1,147,777,641	
CFE	$8,419,632	$843,665	$0	$9,417,404	$10,798,049	$10,033,582	$1,102,661	$972,678	$16,110,850	$170,265	$0	$57,868,785		$13,200,000	$71,068,785	
Federal Funds	$400,948,690	$48,539,821	$7,757,779	$316,104,684	$134,440,310	$10,033,582	$24,038,004	$6,037,615	$196,670,994	$34,138,139	$42,923,398	$1,221,633,017			$1,221,633,017	
TOTAL	$801,897,379	$97,079,642	$15,515,559	$632,209,369	$268,880,621	$20,067,164	$48,076,008	$9,288,638	$393,341,988	$68,276,277	$85,846,796	$2,440,479,442			$2,440,479,442	5.81%
FY 2010-11 Funding with Forecasted Caseload & Per Capitas																
General Fund	$404,304,929	$50,655,238	$8,413,322	$318,337,508	$131,146,711	$0	$26,113,296	$3,777,922	$191,199,414	$38,124,561	$47,097,072	$1,219,169,974		($13,200,000)	$1,205,969,974	
CFE	$8,672,221	$868,975	$0	$9,699,926	$11,412,954	$10,942,341	$1,135,741	$1,611,741	$17,070,829	$175,373	$0	$61,590,100		$13,200,000	$74,790,100	
Federal Funds	$412,977,150	$51,524,213	$8,413,322	$328,037,434	$142,559,665	$10,942,341	$27,249,037	$5,389,664	$208,270,242	$38,299,934	$47,097,072	$1,280,760,074			$1,280,760,074	
TOTAL	$825,954,301	$103,048,426	$16,826,645	$656,074,868	$285,119,330	$21,884,681	$54,498,074	$10,779,327	$416,540,485	$76,599,868	$94,194,144	$2,561,520,148			$2,561,520,148	4.96%
FY 2011-12 Funding with Forecasted Caseload & Per Capitas																
General Fund	$422,671,348	$53,748,938	$9,100,664	$330,410,731	$138,990,149	$0	$30,370,139	$3,030,667	$202,058,386	$40,882,225	$51,482,535	$1,282,745,782		($13,200,000)	$1,269,545,782	
CFE	$8,932,388	$895,044	$0	$9,990,923	$11,755,343	$11,270,611	$1,169,813	$1,301,513	$17,582,953	$180,634	$0	$63,079,223		$13,200,000	$76,279,223	
Federal Funds	$431,603,736	$54,643,982	$9,100,664	$340,401,654	$150,745,492	$11,270,611	$31,539,952	$8,045,478	$219,641,339	$41,062,859	$51,482,535	$1,349,538,302			$1,349,538,302	
TOTAL	$863,207,471	$109,287,964	$18,201,328	$680,803,308	$301,490,983	$22,541,222	$63,079,904	$12,377,659	$439,282,678	$82,125,719	$102,965,070	$2,695,363,306			$2,695,363,306	5.23%

Health Care Policy and Financing
5-Year Forecast -- October 2006
Source: JBC Staff Working Paper/MJB

	FY 2006-07 Appropriation	FY 2006-07 New Estimate	FY 2007-08 Forecast	Growth Over App.	FY 2008-09 Forecast	Growth Prior Year	FY 2009-10 Forecast	Growth Prior Year	FY 2010-11 Forecast	Growth Prior Year	FY 2011-12 Forecast	Growth Prior Year
Executive Director's	**87,278,411**	**87,451,818**	**87,451,818**	**173,407**	**87,451,818**	**0**	**87,451,818**	**0**	**87,451,818**	**0**	**87,451,818**	**0**
FTE	**226.7**	**230.7**	**230.7**	**0**	**230.70**	**0.0**	**230.70**	**0.0**	**230.70**	**0.0**	**230.70**	**0.0**
General Fund	29,131,557	29,205,515	29,205,515	73,958	29,205,515	0	29,205,515	0	29,205,515	0	29,205,515	0
Cash Funds	422,375	422,375	422,375	0	422,375	0	422,375	0	422,375	0	422,375	0
Cash Funds Exempt	5,197,296	5,197,296	5,197,296	0	5,197,296	0	5,197,296	0	5,197,296	0	5,197,296	0
Federal Funds	52,527,183	52,626,632	52,626,632	99,449	52,626,632	0	52,626,632	0	52,626,632	0	52,626,632	0
Medical Services Premiums	**2,111,287,559**	**2,075,619,177**	**2,199,651,575**	**88,364,016**	**2,306,368,207**	**106,716,632**	**2,440,479,442**	**134,111,235**	**2,561,520,148**	**121,040,706**	**2,695,363,306**	**133,843,159**
General Fund	996,821,857	989,191,459	1,036,533,523	39,711,666	1,087,247,584	50,714,061	1,147,777,641	60,530,056	1,205,969,974	58,192,333	1,269,545,782	63,575,808
Cash Funds	76,512	76,512	76,512	0	76,512	0	76,512	0	76,512	0	76,512	0
Cash Funds Exempt	55,563,806	47,751,147	62,231,651	6,667,845	64,678,661	2,447,010	70,992,273	6,313,612	74,713,588	3,721,315	76,202,711	1,489,123
Federal Funds	1,058,825,384	1,038,600,059	1,100,809,889	41,984,505	1,154,365,450	53,555,561	1,221,633,017	67,267,567	1,280,760,074	59,127,057	1,349,538,302	68,778,228
Medicaid Mental Health	**211,550,200**	**222,623,297**	**235,952,147**	**24,401,947**	**248,057,470**	**12,105,323**	**258,616,471**	**10,559,001**	**275,307,633**	**16,691,162**	**289,277,645**	**13,970,012**
General Fund	87,803,777	93,724,246	99,061,015	11,257,238	104,894,884	5,833,869	109,620,116	4,725,232	117,687,005	8,066,889	124,510,524	6,823,519
Cash Funds	0	0	0	0	0	0	0	0	0	0	0	0
Cash Funds Exempt	33,783,245	32,584,294	33,911,174	127,929	34,129,165	217,991	34,682,571	553,406	34,960,360	277,789	35,120,876	160,516
Federal Funds	89,963,178	96,314,757	102,979,958	13,016,780	109,033,421	6,053,463	114,313,784	5,280,363	122,660,268	8,346,484	129,646,245	6,985,977
Indigent Care Program	**444,110,702**	**444,110,702**	**471,205,213**	**27,094,511**	**482,109,390**	**10,904,177**	**493,510,228**	**11,400,838**	**500,820,345**	**7,310,117**	**494,130,462**	**6,310,117**
General Fund	20,016,698	20,016,698	38,128,659	18,111,961	42,722,719	4,594,060	47,813,440	5,090,721	48,813,440	1,000,000	35,813,440	(13,000,000)
Cash Funds	192,072	192,072	192,072	0	192,072	0	192,072	0	192,072	0	192,072	0
Cash Funds Exempt	216,365,831	216,365,831	217,544,256	1,178,425	218,789,433	1,245,177	220,034,610	1,245,177	221,279,787	1,245,177	222,524,964	1,245,177
Federal Funds	207,536,101	207,536,101	215,340,226	7,804,125	220,405,166	5,064,940	225,470,106	5,064,940	230,535,046	5,064,940	235,599,986	5,064,940
Other Medical Services	**126,688,250**	**126,688,250**	**128,588,250**	**1,900,000**	**130,488,250**	**1,900,000**	**132,388,250**	**1,900,000**	**134,288,250**	**132,388,250**	**136,288,250**	**2,000,000**
General Fund	74,396,494	74,396,494	76,296,494	1,900,000	78,196,494	1,900,000	80,096,494	1,900,000	81,996,494	1,900,000	83,996,494	2,000,000
Cash Funds	0	0	0	0	0	0	0	0	0	0	0	0
Cash Funds Exempt	34,354,864	34,354,864	34,354,864	0	34,354,864	0	34,354,864	0	34,354,864	0	34,354,864	0
Federal Funds	17,936,892	17,936,892	17,936,892	0	17,936,892	0	17,936,892	0	17,936,892	0	17,936,892	0
DHS Programs	**See DHS**	**See DHS**	**See DHS**	**n/a**	**See DHS**	**n/a**	**See DHS**	**n/a**	**See DHS**	**n/a**	**See DHS**	**n/a**
General Fund	**See DHS**	**See DHS**	**See DHS**	**n/a**	**See DHS**	**n/a**	**See DHS**	**n/a**	**See DHS**	**n/a**	**See DHS**	**n/a**
General Fund Exempt	**See DHS**	**See DHS**	**See DHS**	**n/a**	**See DHS**	**n/a**	**See DHS**	**n/a**	**See DHS**	**n/a**	**See DHS**	**n/a**
Cash Funds	**See DHS**	**See DHS**	**See DHS**	**n/a**	**See DHS**	**n/a**	**See DHS**	**n/a**	**See DHS**	**n/a**	**See DHS**	**n/a**
Cash Funds Exempt	**See DHS**	**See DHS**	**See DHS**	**n/a**	**See DHS**	**n/a**	**See DHS**	**n/a**	**See DHS**	**n/a**	**See DHS**	**n/a**
Federal Funds	**See DHS**	**See DHS**	**See DHS**	**n/a**	**See DHS**	**n/a**	**See DHS**	**n/a**	**See DHS**	**n/a**	**See DHS**	**n/a**
DEPARTMENT TOTAL w/o DHS Programs	**2,980,915,122**	**2,956,493,244**	**3,122,849,003**	**141,933,881**	**3,254,475,135**	**131,626,132**	**3,412,446,209**	**157,971,074**	**3,559,388,194**	**146,941,985**	**3,702,511,481**	**143,123,288**
FTE	**226.70**	**230.70**	**230.70**	**4.0**	**230.7**	**0.0**	**230.7**	**0.0**	**230.7**	**0.0**	**230.7**	**0.0**
General Fund	1,208,170,383	1,206,534,412	1,279,225,206	71,054,823	1,342,267,196	63,041,990	1,414,513,206	72,246,009	1,483,672,428	69,159,222	1,543,071,755	59,399,327
Cash Funds	690,959	690,959	690,959	0	690,959	0	690,959	0	690,959	0	690,959	0
Cash Funds Exempt	345,265,042	336,253,432	353,239,241	7,974,199	357,149,419	3,910,178	365,261,614	8,112,195	370,505,895	5,244,281	373,400,711	2,894,816
Federal Funds	1,426,788,738	1,413,014,441	1,489,693,597	62,904,859	1,554,367,561	64,673,964	1,631,980,431	77,612,870	1,704,518,912	72,538,481	1,785,348,057	80,829,145

Appendix H:
Medicaid Services Definitions

Brain Injury Waiver: The Brain Injury program offers an intensive, community-based care alternative to individuals with acquired and traumatic brain injuries who would otherwise remain hospitalized.

Class I Nursing Facilities: These nursing facilities provide services to clients, mostly elderly, who pass the nursing facility level of screen. The rates for these facilities are established in State Statute (put in more specific information).

Class II/IV Nursing Facilities: Refers to nursing facilities for physically or developmentally disabled individuals. Under the Health Care Policy and Financing portion of Medicaid data, this excludes the Regional Centers (also Class IV nursing facilities) which are operated and managed by the Colorado Department of Human Services (DHS).

County Transportation or Non-Emergency Transportation: This service includes non-emergency or non-wheelchair transportation services necessary to access health care services.

Day Program: Part of the Home and Community Based Services for the Developmentally Disabled, this is the day program part of the waiver.

Durable Medical Equipment and Supplies: This service includes items ranging from wheelchair to oxygen to disposable medical supplies.

Emergency Transportation: This service includes ambulance services and transportation provided to persons in wheelchairs.

F Plan: Family Planning refers to services which are paid through the family planning clinics for which an annual capitation is paid for all family planning services for one eligible for one year. Other family planning services are paid through the service categories (e.g. physician services, pharmacy) through which the claim is paid. 90 percent Federal Financial Participation is available for family planning services.

Federally Qualified Health Centers/Rural Clinics: The federal OBRA '89 required the recognition of a group of clinics which are federally designated Federally Qualified Health Centers. These clinics are reimbursed at 100 percent of allowable costs. Rural clinics which are federally designated fro serving under-served areas are reimbursed using Medicare payment rates.

Health Insurance Buy-In: This program pays the premium and coinsurance/deductible payments for private health insurance policies for Medicaid clients when it can be shown to be cost effective.

Health Maintenance Organization (HMO) or Managed Care Organization: The HMO service category covers a broad spectrum of services ranging from physicians care to inpatient hospital care. These organizations are frequently called Managed Care Organizations (MCOs).

HCBS EBD/CM: Home and Community Based Services for the Elderly, Blind and Disabled Case Management refers to the case plan development and management services provided to eligibles who qualify for nursing home care, but through passing the scrutiny of the Most in Need Screen have qualified for the waivered alternative to nursing home care program.

HCBS EBD/CS: Home and Community Based Services for the Elderly, Blind and Disabled Client Services refers to the actual service package consisting of items such as personal care, therapies, home health care, etc., provided to eligibles who qualify for nursing home care, but through passing the scrutiny of the Most in Need Screen have qualified for the waivered alternative to nursing home care program. In all respects, clients in the HCBS programs look like nursing home clients. These costs have been rolled together into one HCBS-EBD budget projection.

HCBS PLWA: Home and Community Based Services for Persons Living with AIDS is another waivered alternative to nursing home care program.

HH: Home Health Care services include nursing, home health aides, physical therapy, occupational therapy, and speech therapy provided in the home.

Hospice Care. These services are for providing care to an eligible client for whom a certified medical prognosis has been made indicating a life expectancy of six months or less and who has elected to receive such care.

Inpatient: Inpatient Hospital Care. This service can be paid through the DRG "Diagnosis Related Grouping" system or, on a limited basis, per diem.

Lab/X-ray: Laboratory and Radiology services.

Outpatient: Outpatient Hospital Services includes all hospital-based outpatient care ranging from emergency room to hospital based clinic care.

Physician Services. These services are those ranging from family practices to specialty care (e.g. surgeons, psychiatrists).

Prescription Drugs: Includes payment for all drugs provided through Medicaid including those dispensed in nursing homes, but excluding those which are dispensed in the inpatient hospital setting.

Prescription Drug Rebate: OBRA '90 changed the payment and formulary requirements for the Medicaid prescription drug optional benefit. In an effort to offset the additional costs related to the items above, manufacturers rebate Medicaid drug expenses for certain items.

PACE: Programs for the All-inclusive Care for the Elderly. This is a project designed to provide all needed care for long-term care eligibles, under a capitated method of payment.

Residential Program: Part of the Home and Community Based Services for the Developmentally Disabled, is the residential care provided for under the waiver.

RTC: Residential Treatment Centers for out of home placement children, specifically providing a mental health component of care. Related to Residential Child Care Facilities.

Single Entry Point. Authorized by H.B. 91-1287, these services are intended to provide improved access and cohesive case management for clients eligible for long-term care.

SMIB: Supplemental Medicare Insurance Benefit. Part A and Part B premium payments for eligibles who are both Medicare and Medicaid eligible. Because Medicaid is designed to be the payer of last resort, federal financial participation is not available for Medicaid services which Medicare would have paid, had the dually-eligible client been enrolled.

TCM-DD: Targeted Case Management -- Developmentally Disabled. Case Management services under the HCBS waiver for the Developmentally Disabled.

Title XVIII: Title XVIII refers to Title XVIII of the Social Security Act, i.e. Medicare. Refers to the Medicare Coinsurance and Deductibles paid on behalf of dually eligible persons.

Under 21 Psych: Private Psychiatric Hospital Care for Person Under Age 21. This service is replicated through the Department of Human Services portion of the data, except through State-owned and operated hospitals.

Unknown: Refers to appeal or adjustment activity which is not necessarily specific to one single claim/eligible or for a client who no longer has an active eligibility span on the recipient eligibility file in the Medicaid Management Information System (MMIS).

Explanation of Department's Line Item

<u>Executive Director's Office</u>

Personal Services: Includes all salaries and wages, whether to full-time, part-time, or temporary employees of the state, and also includes the state's contribution to the public employee's retirement fund, the state's share of federal Medicare tax paid for state employees, payments for unemployment insurance, and tuition reimbursement. The line item also contains professional services expenditures (services paid to contracted professionals) and temporary services expenditures (contracted administrative, clerical, or casual labor). The history in the Number Pages reflects the total personal services for the Department.

Health, Life, and Dental: Provides the State's contribution to employee health, life, and dental insurance pursuant to Section 24-50-609, Colorado Revised Statutes.

Short-term Disability: Provides the State's contribution for employee short-term disability pursuant to Section 24-50-603, Colorado Revised Statutes.

S.B. 04-257 Amortization Equalization Disbursement: This line item increases the employer contribution to the PERA Trust Fund to amortize the unfunded liability in the Trust Fund beginning in January 2006.

Salary Survey and Senior Executive Service: Contains the annual salary increases based on the survey of job and wage classifications performed by the Department of Personnel to Section 24-50-104 (c) (IV) (4), Colorado Revised Statutes, and the common policies established by the Joint Budget Committee.

Performance-based Pay Awards: Contains the performance-based pay awards based on demonstrated ability for satisfactory quality and quantity of performance. Each employee undergoes an annual performance evaluation, which is used to determine potential merit based salary increases each fiscal year. Each State department must abide by parameters established by the Department of Personnel.

Worker's Compensation: Provides the State's contribution for worker's compensation.

Operating Expenses: Includes expenditures for supplies and materials that are consumable and have a useful life of less than one system. Also includes charges for utilities, trash removal, custodial services, telecommunications, data processing,

advertising, freight, rentals of equipment and property, storage, parking, minor repair or maintenance, and printing and reproduction, and insurance premiums, dues, subscriptions, etc. The history in the Number Pages reflects the total for the Department.

Legal Services and Third Party Recovery Legal Services: This is the Department's representation of the cost of purchasing legal services from the Department of Law. This Department's request represents the rate set by the Governor's Office of Strategic Planning and Budgeting; however, during Figure Setting the Joint Budget Committee will set a common policy rate for these services.

Administrative Law Judge Services: This appropriation is for the purchase of administrative law judge and paralegal services from the Division of Administrative Hearings in the Department of Personnel and Administration. The State appropriates these funds based upon a historical cost allocation methodology.

Computer Systems Costs: Funding for computer system services provided to the Department by the General Governmental Computer Center (GGCC).

Payment to Risk Management and Property Funds: This is a statewide allocation appropriated to each department based on a shared risk formula and is used by departments to pay for two programs in the Department of Personnel and Administration: The State Liability Program and the State Property Program.

Capitol Complex Leased Space: This is the amount allocated to the Department based on the Department's square foot usage in the Capitol Complex.

Commercial Leased Space: This is the amount allocated for private lease space payments.

Transfer to the Department of Human Services for Related Administration: The Department has a shared services agreement with the Department of Human Services to support 1.0 FTE for the Baby Care Program help desk and Information Technology services activities.

Medicaid Management Information System Contract: Provides funding for the contract for the operation of the Medicaid Management Information System used to pay Medicaid provider claims and provide management information to assist the Department in the operation of the Medicaid program.

Medicaid Management Information System Reprocurement: This line item was added in FY 2004-05 to reflect the administrative costs associated with rebidding the MMIS system as required by the Centers for Medicare and Medicaid Services. These expenses are anticipated to be eliminated after FY 2007-08.

CBMS Eligibility Audit-Transfer to State Auditor: This line item represents expenditures for a state audit of CBMS eligibility functions that was performed by the State Auditor's Office.

HIPAA Web Portal Maintenance: This line item provide the administrative funding to maintain the Department's Internet and Intranet web sites and provides an application for claims to be submitted to the MMIS system as required by HIPAA.

HIPAA National Provider Identifier Assessment and Implementation: This line item represents the funding needed by the Department to comply with the HIPAA rule on national provider identification. Funding this line item is not necessary after FY 2006-07.

Medical Identification Cards: Provides funds to produce and mail Medicaid identification cards to each Medicaid recipient or family and also to mail identification cards for the Old Age Pension Medical Program.

Department of Public Health and Environment Facility Survey and Certification: Funds survey and certification by Department of Public Health and Environment of nursing facilities, hospices, home health agencies, and home and community based service agencies as required by federal regulations.

Acute Care Utilization Review: Funding for utilization review for acute care activities as required by federal regulation. This line item was a reorganization from last year.

Long-Term Care Utilization Review: Funding for utilization review for long-term care activities as required by federal regulation. This line item was a reorganization from last year.

External Quality Review: Funding for external review of quality of services as required by federal regulation. This line item was a reorganization from last year.

Drug Utilization Review: Funding for utilization review for drug uses as required by federal regulation. This line item was a reorganization from last year.

Mental Health External Quality Review: Funding for the contract to review the quality of mental health services provided to Medicaid clients.

Actuarial analysis Payments for Transfer to Sate Auditor's Office & Mental Health Actuarial Services: The funding in this line item represents the funding that was transferred to the State Auditor's Office to conduct an analysis of the actuary rates for mental health.

Early and Periodic Screening, Diagnosis, and Treatment Program: Funding for outreach and case management services for the Early and Periodic Screening, Diagnosis and Treatment program required by federal regulations and performed via agreement with the Department of Public Health and Environment.

Nursing Facility Audits: For contracting with an independent accounting firm to perform audits of nursing facility cost reports for rate setting.

Hospital and Federally Qualified Health Clinic Audits: For contracting with an independent accounting firm for audit of cost and rate data for Medicaid hospitals, Federally Qualified Health Clinics and Rural Health Clinics. The audited cost reports are the basis for setting annual facility rates to cover the reasonable and necessary costs of an efficiently run facility.

Nursing Home Preadmission and Resident Assessments: For screening and reviews mandated by federal law in OBRA-87 to determine appropriateness of nursing home placements for those with major mental illnesses or developmental disabilities.

Nurse Aide Certification: To pay the Department of Regulatory Agencies for the Medicaid portion of the federal requirement to certify nurse aids working in Medicaid facilities.

Nursing Home Quality Assessments: Funding for Department of Public Health and Environment for enforcement of federal quality assessment regulations in nursing homes.

Estate Recovery: A contractor operated program to recover funds from estates of Medicaid clients over age 55, who reside in nursing facilities or are the recipients of long-term care. The Department contracts with a private sector entity that pursues the recoveries on a contingency fee basis.

Single Entry Point Administration: Funds the administrative costs of training, resource materials, data and financial reporting, and staff travel to provide technical assistance to and monitoring of Single Entry Point agencies.

Single Entry Point Audits: Funding to support annual audits of Single Entry Point agencies performed by the Department of Human Services field audit staff through an Interagency Agreement.

SB 97-05 Enrollment Broker: Provides funding to contract for a broad range of managed care enrollment and disenrollment functions to promote voluntary enrollment by Medicaid clients into managed care organizations.

HB 01-1271 Medicaid Buy-in: Provides funding for a program for persons to purchase medical assistance for a period of time after the person is no longer eligible for Medicaid until the person is entirely self-sufficient (§26-4-110.5).

Non-Emergency Transportation: This line item provides the necessary transportation costs for Medicaid clients to acces care for their non-emergency medical needs.

Medical Services Premiums

Medical Service Premiums: Total Medicaid funding for the different eligibility groups. The eligibility groups are identified for policy and planning purposes only. An explanation of the different eligibility groups is found in Appendix B.

Medicaid Mental Health Community Programs

These line items are discussed as part of the Mental Health Services briefings, hearings, and figure settings.

Indigent Care Program

Safety Net Provider Payments: Contains all funding for the Disproportionate Share Program and Major Teaching Hospital Program. Payments are made to hospitals for caring for a disproportionate share of indigent patients.

The Children's Hospital, Clinic Based Indigent Care: Provides funding to offset a portion of CICP clinic-based provider's uncompensated costs to provide medical care to indigent persons. These clinics are located primarily outside the Denver metro area.

Pediatric Speciality Hospital: This a new line item in FY 2005-06 to provide additional funding to pediatric specialty hospitals to help offset the costs of providing care to a large number of Medicaid and indigent care clients.

HB 97-1304 Children's Basic Health Plan Trust: To provide for payments to the Children's Basic Health Plan Trust Fund from which the State's share of the costs of operating and providing medical and dental services to enrollees in the Children's Basic Health Plan are funded.

Children's Basic Health Plan Administration: Funds the costs of contracts to provide for the administration of the Children's Basic Health Plan.

Children's Basic Health Plan Premium Costs: Funds the costs of authorized medical services to eligible low-income children enrolled in the Children's Basic Health Plan and low-income adult pregnant women.

Children's Basic Health Plan Dental Benefit Costs: Funds the costs of authorized dental services to eligible low-income children enrolled in the Children's Basic Health Plan.

Comprehensive Primary and Preventive Care Fund: This Fund was created by the General Assembly as a technical adjustment in order to reflect payment directly from the Tobacco Litigation Settlement Trust to the Comprehensive Primary and Preventive Care Grants Fund with subsequent appropriation to the Comprehensive Primary and Preventive Care Grants Program.

Comprehensive Primary and Preventive Care Grants Program: A program funded through monies from the tobacco litigation settlement that provides the opportunity for low-income, uninsured Colorado residents to receive preventive health care services that otherwise they might not access. The program provides grants to health care providers to expand primary preventive health care services to low-income, uninsured residents of Colorado.

Other Medical Services

Home Care Allowance: This is not a Medicaid program or service; however, most Home Care Allowance eligibles are also Medicaid-eligible. Services are for person residing in their own homes and include personal care and supportive services. While these services are not medical in nature, they do represent an important component o f a "continuum" of long-term care. It is funded through 95 percent General Fund and 5 percent local match

(note that the 5 percent local match may not grow faster than 5 percent over the prior year actual for any single county).

Adult Foster Care: This is not a Medicaid program or service; however, many Adult Foster Care eligibles are also Medicaid eligible. This provides residential care with supervision for client medications, etc. While these services are not as extensive as those rendered in a nursing home, they do represent an important component of a "continuum" of long-term care. It is funded through 95 percent General Fund and a 5 percent local match.

Old Age Pension State Medical Program: Funding for the medical services to eligible individuals in the state old age pension program.

University of Colorado Family Medicine Residency Training Programs: Provides Medicaid funding for the Colorado Family Residency Training Program operated by the Department of Higher Education/University of Colorado/Health Sciences Center.

Enhanced Prenatal Care Training and Technical Assistance: Funds a program operated via an Interagency Agreement with the Department of Public Health and Environment to train health care providers in coordinating and evaluating services for at-risk pregnant women with the goal of reducing low-weight births.

Nurse Home Visitor Program: Medicaid funding related to nurse home visitor program which provides help to at-risk families.

SB 97-101 Public School Health Services: Funds services provided under contracts with public school districts, boards of cooperative services, and state K-12 educational institutions to Medicaid eligible children in school-based health clinics.

Department of Human Services Medicaid-Funded Programs

These line items are discussed as part of the Department of Human Services briefings, hearings, and figure settings.