This document contains the staff briefing for the Commission on Family Medicine and for all Divisions of the Department of Health Care Policy and Financing, except for those programs administered by the Department of Human Services.

COLORADO GENERAL ASSEMBLY
JOINT BUDGET COMMITTEE

Fiscal Year 2008-09 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 04, 2007

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Commission on Family Medicine

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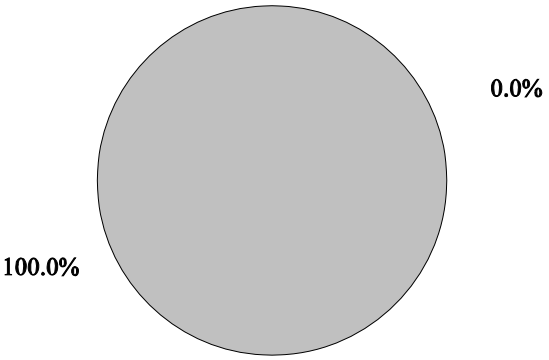
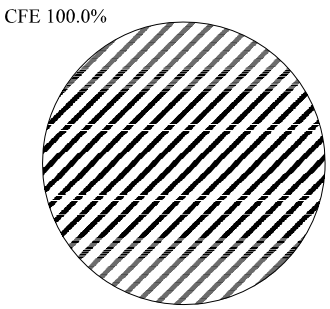
Graphic Overview

Share of State General Fund
FY 2007-08

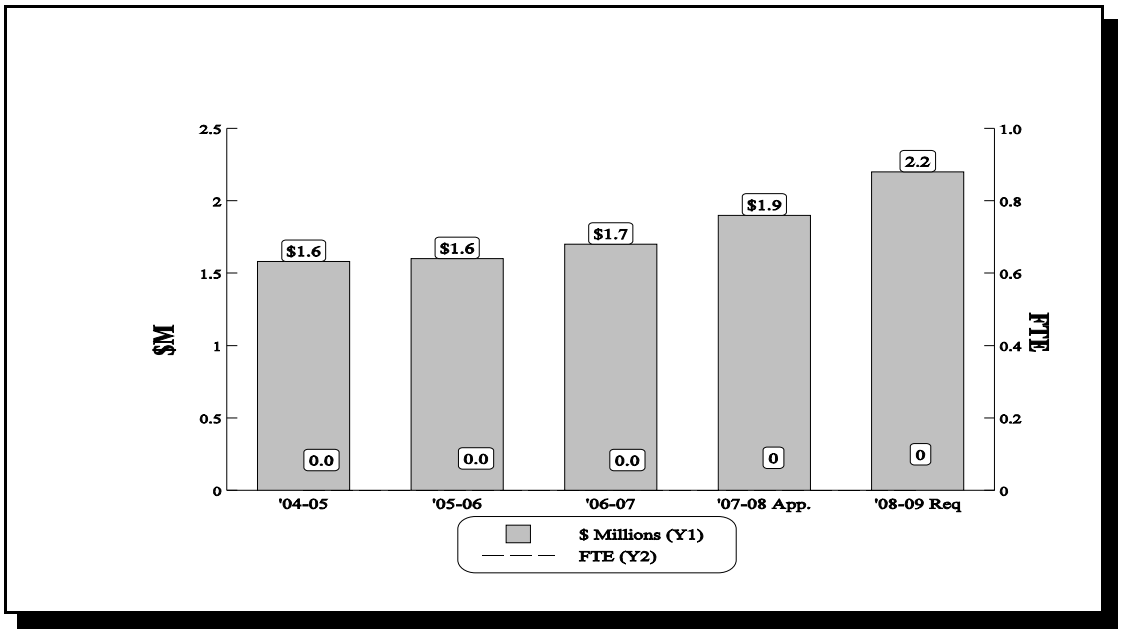


Funding Source Split
FY 2007-08



Note: The Commission receives $951,779 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 and FY 2007-08, the JBC approved additional funding for this program to restore some of the previous years' budget reductions. In FY 2007-08, each hospital residency program will receive approximately $211,506 from this appropriation.

Major Funding Changes FY 2006-07 to FY 2007-08

Action	Cash Fund Exempt -- Medicaid Cash Funds	Total Funds	Total FTE
FY 2006-07 Appropriation	$1,703,558	**$1,703,558**	**0.0**
Restore a portion of previous year budget cuts	$200,000	**$200,000**	**0.0**
FY 2006-07 Appropriation*	$1,903,558	**$1,903,558**	**0.0**

*Of this amount, $951,779 is General Fund and $951,779 is Federal Funds. This funding is transferred from the Department of Health Care Policy and Financing to the Commission as cash funds exempt.

FY 2008-09 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 is the estimated cost of actually training one family medicine resident. [Section 25-1-901 through 25-1-904, C.R.S. (2006)	0	0	270,000	0	270,000	0.00
	Subtotal Decision Item Request	**0**	**0**	**270,000**	**0**	**270,000**	**0.00**
	Change to Medicaid Funds	**$135,000**	**$0**	**$0**	**$135,000**	**$270,000**	

	2005-06 Actual	FY 2006-07 Actual	FY 2007-08 Approp.	FY 2008-09 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.)					
Residency Training Programs	1,576,502	1,703,558	1,903,558	2,173,558 DI #1	
Cash Funds Exempt	1,576,502	1,703,558	1,903,558	2,173,558	
TOTAL - Commission on Family Medicine	**1,576,502**	**1,703,558**	**1,903,558**	**2,173,558**	14.2%
FTE	0.0	0.0	0.0	0.0	0.0%
Cash Funds Exempt	1,576,502	1,703,558	1,903,558	2,173,558	14.2%
Medicaid Cash Funds	1,576,502	1,703,558	1,903,558	2,173,558	14.2%
Net General Fund (Medicaid + Other GF)	788,251	851,779	951,779	1,086,779	14.2%

FY 2008-09 Joint Budget Committee Staff Budget Briefing
COMMISSION ON FAMILY MEDICINE
Additional Funding for Family Medicine Residency Programs

ISSUE:

The Commission requests an increase of $270,000 in the cash fund exempt transfer from the Department of Health Care Policy and Financing. Of this amount, $135,000 will be Medicaid General Fund and $135,000 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 2007-08 total fund appropriation is $1,903,558 -- 19.5% lower than the FY 2001-02 amount. The Commission's FY 2008-09 total fund budget request is $2,173,558 -- a 14.2% increase over the FY 2007-08 appropriation but still 8.1% lower than the Commission's FY 2001-02 appropriation.

- Currently the Commission's appropriations from the Department of Health Care Policy and Financing is transferred to Department on Higher Education as a cash funds exempt appropriation. This was done because in the past, some of the administrative expenses for the Commission were shared with the University of Colorado, School of Medicine. However, since FY 2003-04, there has been no state funding for the Commission's administrative funding. All of the funding in HCPF is distributed directly to residency programs to help subsidy a portion of the costs associated with training family medicine residents.

RECOMMENDATION:

Staff recommends that the double-counted appropriation in the Department of Higher Education be eliminated. The Department of Higher Education has no administrative oversight for the Commission and the transfer of the appropriation is unnecessary and confusing. In addition, staff recommends that appropriation line item name in the Department of Health Care Policy and Financing be changed from University of Colorado Family Medicine Residency Training Program to the Commission on Family Medicine Residency Training Programs.

Staff also recommends that the Committee discuss the applicable common hearing questions with the Commission at their hearing.

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 (8.0 percent over the prior year) and increased again in FY 2007-08 by $200,000 (11.7 percent over the prior year. For FY 2008-09, the Commission requests a total fund increase of $270,000 (14.2 percent) for a total appropriation of $2,173,558. Even with this increase, the Commission appropriation will remain slightly lower than it was in FY 2001-02.

The Commission's FY 2007-08 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	FY 2007-08 App.	FY 2008-09 Req.
Ft. Collins	161,049	175,167	189,284	211,506	241,506
North Colorado	161,049	175,167	189,284	211,506	241,506
Rose	161,049	175,167	189,284	211,506	241,506
St. Anthony	161,049	175,167	189,284	211,506	241,506
St. Joseph	161,049	175,167	189,284	211,506	241,506
St. Mary	161,049	175,167	189,284	211,506	241,506
Southern Colorado	161,050	175,167	189,284	211,506	241,506
Swedish	161,050	175,167	189,284	211,506	241,506
University/AF Williams	161,050	175,167	189,284	211,506	241,506

Residency Program (connected to hospitals and therefore, eligible for Medicaid)	FY 2004-05	FY 2005-06	FY 2006-07	FY 2007-08 App.	FY 2008-09 Req.
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**	**$2,173,558**
Colorado Springs (non-Medicaid funded -- Commission Budget Only)	127,057	0	0	0	0
TOTAL Residency Program Line Item (Commission Budget Request)	**$1,576,501**	**$1,576,502**	**$1,703,558**	**$1,903,558**	**$2,173,558**

Questions for the Commission

1. What are the Commission's principal goals and objectives? What are the metrics by which you measure success or failure?

2. Given the change in the Administration, have there been any changes to the Commission's principal goals and objectives since last year?

3. What progress did you make during the last year in achieving your goals?

4. How is the additional money provided to the Commission in FY 2007-08 being used to achieve your goals? What improvements is the Commission making in its outputs?

5. Please identify the Commission's 3 most effective programs and your 3 least effective programs. Explain why you identified them as such. Explain how your most effective programs further the Commission's goals.

COLORADO GENERAL ASSEMBLY
JOINT BUDGET COMMITTEE

Fiscal Year 2008-09 Staff Budget Briefing

Department of Health Care Policy and Financing

(All programs except for Department of Human Services Medicaid-Funded Programs)

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December 4 , 2007

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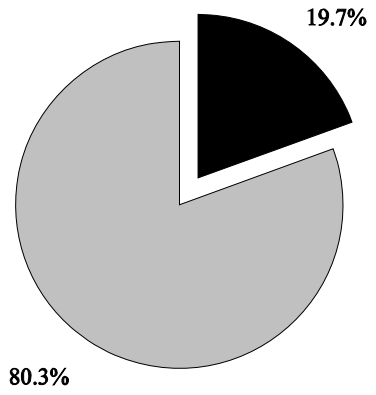
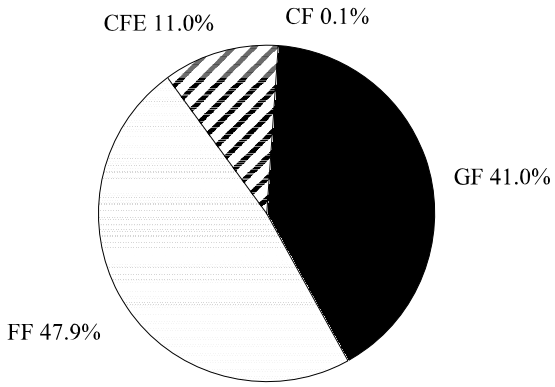
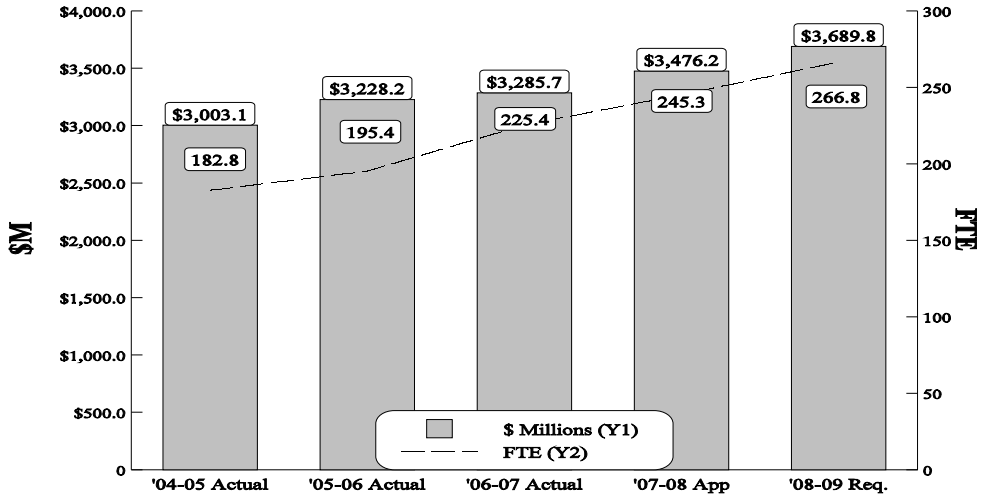
FY 2007-08



Funding Source Split
FY 2007-08



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 383,784 low-income people in FY 2007-08 (base forecast from figure setting). An additional 1,471 clients are anticipated to be added to Medicaid eligibility in FY 2007-08 as a result of the passage of S.B. 07-002 which allowed foster children to retain Medicaid eligibility up to age 21.
- Administers the Children's Basic Health Plan, a health insurance program for a forecasted 53,716 low-income children and approximately 1,656 adult pregnant women in FY 2007-08.
- 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 2005-06 (last year with data) this program served approximately 180,411 low-income individuals.
- Administers the Old Age Pension Health and Medical Fund which provides health care to a forecasted 6,051 elderly persons who do not qualify for Medicaid or Medicare in FY 2007-08.
- Administers the Primary Care Fund and the Comprehensive Primary and Preventive Care Grant Program.
- Acts as the single-state agency to receive Title XIX (Medicaid) funds from the federal government and therefore, passes these federal funds to other state agencies that have qualifying programs (mainly the Department of Human Services).

Factors Driving the Budget

Funding for the Department in FY 2007-08 consists of 41.0 percent General Fund, 48.0 percent federal funds, and 11.0 percent cash funds exempt, and less than 0.1 percent cash 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 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 from 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.

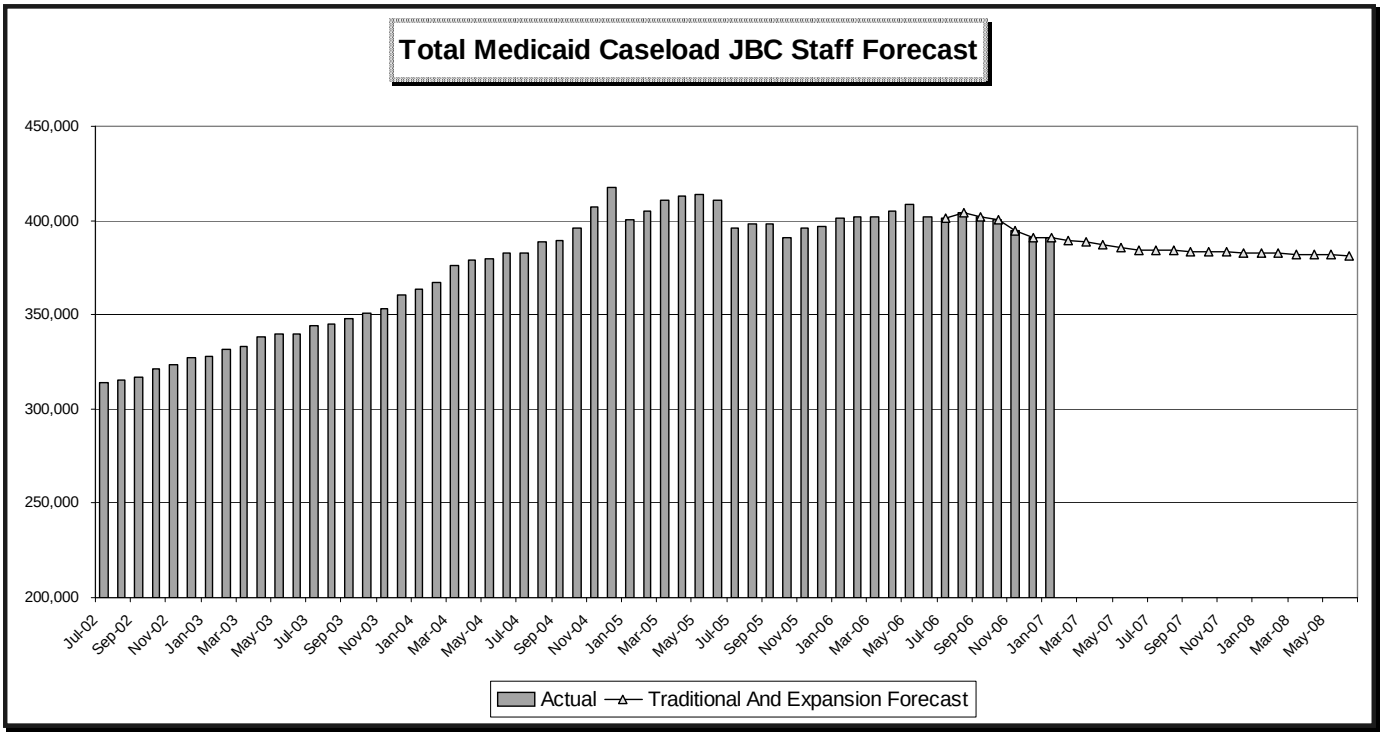
Medical Services Premiums

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, managed care organization (MCO) 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 price paid for health care services, and utilization of health care services.

Medicaid Caseload Growth

The following factors affect the number of clients participating in the Medicaid program: (1) general population growth; (2) policy changes at the state and federal level regarding who is eligible for services; and (3) economic cycles. During the late 1990s, the Medicaid caseload declined due to the impacts of federal welfare reform and the strong economic expansion. However, beginning in 1999, the Medicaid caseload began to increase sharply. This increase was partly due to federal legislation authorizing new populations to become eligible (mainly children) and partly due to the economic recession in the early 2000's. In November 2004, the voters of Colorado passed Amendment 35 to the State Constitution. Amendment 35 authorized additional taxes on tobacco products in order to fund new health programs, including an expansion of the Medicaid program. House Bill 05-1262 expanded the eligibility for the Medicaid program by eliminating the asset test for both low-income adults and children and by expanding eligibility for low-income adults up to 60 percent of the poverty level. However, despite these recent expansion in Medicaid eligibility, the overall Medicaid caseload is forecasted to decline in FY 2007-08. This is mainly due to the impact of the economic recovery and impacts from the Federal Deficit Reduction Act of 2005 which required stricter proof of citizenship. The following chart shows the monthly Medicaid caseload from FY 2002-03 through the forecast period for FY 2007-08.



For FY 2007-08, the baseline caseload was forecasted to decrease to 383,784 average monthly clients. This represents a decrease of 9,295 (2.36 percent) average monthly clients from the FY 2006-07 actual.

Medicaid Caseload	FY 02-03 Actual	FY 03-04 Actual	FY 04-05 Actual	FY 05-06 Actual	FY 06-07 Actual	FY 07-08 Baseline Approp./1
Supplemental Security Income (SSI) Ages 65+	34,485	34,149	35,615	36,219	35,977	36,703
Supplemental. Security Income (SSI) Ages 60 - 64	5,456	5,528	6,103	6,048	6,042	6,252
Qualified Medicare Beneficiaries/Special Low-income Medicare Beneficiaries	8,949	9,787	9,572	11,012	12,818	13,294
Disabled	46,378	46,565	47,626	47,565	48,567	48,942
Categorically Eligible Adults	40,021	46,754	56,453	57,747	51,361	46,708
Expansion Low-Income Adults	0	0	0	0	4,974	10,377
Baby Care Adults	7,579	8,203	6,110	5,050	5,123	5,264
Breast and Cervical Cancer Treatment	46	103	86	188	230	277
Low-Income Children	166,537	192,048	220,592	213,600	206,170	193,981
Foster Children	13,843	14,790	15,669	16,311	16,601	17,295
Non-Citizens	4,101	4,604	4,976	5,959	5,214	4,691
Total Medicaid Caseload	327,395	362,531	402,802	399,699	393,077	383,784
Annual Percent Change	10.83%	10.73%	11.11%	(0.77)%	(1.66)%	(2.36)%

/1 Does not include the impact of S.B. 07-002. This bill extended Medicaid eligibility to children leaving the foster care program up to age 21. The fiscal note anticipated that another 1,471 clients would be eligible for coverage in FY 2007-08 due to the passage of this bill.

Medical Cost Increases

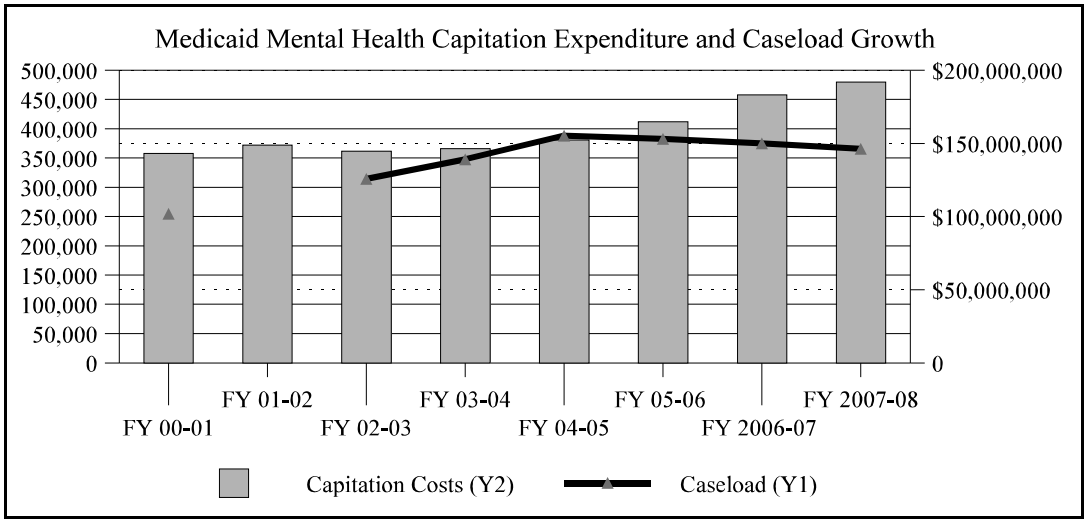
In addition to increased costs due to caseload growth, the Medicaid budget also grows as a result of higher medical costs and greater utilization of medical services. Recent budget increases for medical services are primarily related to rate increases for primary care provides, long-term care community providers, and nursing home rate increases as well as utilization increases in the areas of community long-term care and the change in case mix have caused the average medical cost per-client to increase.

	FY 03-04 Actual	*FY 04-05 Actual*	*FY 05-06 Actual*	*FY 06-07 Actual*	*FY 07-08 Approp.*
Medical Service Cost Per Capita	*$5,080.22*	*$4,700.29*	*$4,959.65*	*$5,211.29*	*$5,492.60*
Percent Change	*0.7%*	*(7.5)%*	*5.5%*	*5.1%*	*5.4%*

Medicaid Mental Health Capitation

Most Medicaid clients are eligible to receive mental health services as a benefit under the Medicaid program (some Medicare recipients and non-citizens are excluded from the Medicaid mental health benefit). Mental health services are provided through managed care contracts with Behavioral Health Organizations (BHOs) that serve specific geographical areas of the state. The contracts with the BHOs are based on a contracted amount (a capitation payment per member per month) for the number of Medicaid clients eligible for services in their area. The BHO is then required to provide appropriate mental health services to all Medicaid-eligible persons needing such services.

Mental health capitation payments are driven by the following factors: (1) caseload changes; (2) case-mix of clients seeking services (i.e. the mix of clients within the BHOs population -- i.e. number of foster children compared to number of elderly, etc.); (3) utilization of services; and (4) rate increases provided to the BHOs. The following chart shows the growth in mental health capitation payments compared to caseload growth for the last several years.



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

	FY 02-03 Actual	FY 03-04 Actual	FY 04-05 Actual	FY 05-06 Actual	FY 06-07 Actual	FY 07-08 Appropriation[/1]
Medicaid Mental Health Capitation Funding	$144,704,276	$146,346,423	$152,435,998	$164,839,222	$184,640,568	$196,303,651
Annual Dollar Change	n/a	$1,642,147	$6,089,575	$12,403,224	$19,801,346	$11,663,083
Annual Dollar Percent Change	n/a	1.1%	4.2%	8.1%	12.0%	6.3%
Individuals Eligible for Medicaid Mental Health Services (Caseload)	314,345	348,140	388,254	382,734	375,045	365,799
Annual Caseload Change	314,345	33,795	40,114	(5,520)	(7,508)	(9,246)
Annual Caseload % Change	n/a	10.8%	11.5%	(1.4)%	(2.0)%	(2.5)%

/1 The caseload reported in the table is the baseline forecast only. It does not include the impact of S.B. 07-002 which extended Medicaid eligibility to children leaving the foster care program up to age 21. The fiscal note anticipated that another 1,471 clients would be eligible for coverage in FY 2007-08 due to the passage of this bill (note this is the number of clients eligible which is not the same as monthly average caseload). However, the appropriation amount above does include the appropriation from S.B. 07-002.

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 180,411 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 was available for additional indigent care costs through S.B.

06-044. However, in FY 2006-07, the Department reverted $16.2 million from the appropriation because they were unable to certify $8.1 million in public expenditures from public hospitals which then led to a loss of $8.1 million in federal funds. In FY 2007-08 a provider rate increase was included for the pediatric speciality hospital line item. Other than that, funding was relatively stable when compared to the FY 2006-07 appropriation. The table below provides a five-year funding history for the Indigent Care Program.

	FY 03-04 Actual	FY 04-05 Actual	FY 05-06 Actual	FY 06-07 Approp.	FY 07-08 Approp.
Safety Net Provider Payments	$255,976,646	$264,013,206	$287,296,074	$279,933,040	$296,188,630
Children's Hospital Clinic Based Indigent Care (w/o S.B. 06-044)	6,119,760	6,119,760	6,119,760	6,119,760	6,119,760
Pediatric Speciality Hospital	0	0	5,452,134	7,732,072	8,499,289
S.B. 06-044 Funding Available	0	0	0	14,962,408	15,000,000
Total	**$262,096,406**	**$270,132,966**	**$298,867,968**	**$308,747,280**	**$325,807,679**
General Fund	13,555,006	12,492,364	18,362,593	19,500,662	19,701,662
Cash Fund Exempt	115,400,000	122,574,119	131,071,391	142,354,182	150,687,822
Federal Funds	133,141,400	135,066,483	149,433,984	146,892,436	155,418,195
Total funding percent increase	9.43%	3.07%	10.64%	3.31%	5.53%

Comprehensive Primary Care Program

In November 2004, the voters passed Amendment 35 to the Colorado Constitution which increased the taxes on tobacco products in order to expand several health care programs. During the 2005 Legislative Session, the General Assembly passed H.B. 05-1262 to implement the provisions of Amendment 35. Specifically, H.B. 05-1262 created the Comprehensive Primary Care program. This program provides additional funding to qualifying providers with patient caseloads that are at least 50 percent uninsured, indigent, or enrolled in the Medicaid or Children's Basic Health Plan programs. For FY 2005-06, the amount of funding available for this program was $44.1 million. Funding in FY 2005-06 included tobacco tax revenues that were collected in both FY 2004-05 and FY 2005-06. In FY 2006-07, funding for this program decreased to $32.9 million. The decrease reflects solely the fact that the 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. For FY 2007-08, funding for this program is estimated at $32.4 million. There are no matching federal funds available for this program.

	FY 03-04 Actual	FY 04-05 Actual	FY 05-06 Actual	FY 06-07 Approp.	FY 07-08 Approp.
Comprehensive Primary Care Program	$0	$0	$44,041,879	$31,980,929	$32,365,298

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. In 2007, S.B. 07-097 expanded eligibility for the children and adult pregnant women program to 205 percent FPL using additional tobacco litigation settlement funds to pay for the increased for the additional caseload.

Similar to the Medicaid program, funding for this program is mainly driven by the caseload and the cost of medical services provided. The following table provides a five-year funding history for the Children's Basic Health Plan medical and dental costs.

	FY 03-04 Actual	FY 04-05 Actual	FY 05-06 Actual	FY 06-07 Actual	FY 07-08 Approp.
Medical Services	$51,777,408	$52,000,289	$65,919,891	$89,657,433	$86,426,598
Dental Services	5,405,336	5,084,701	5,368,921	6,834,843	6,886,799
Total Service Costs	**$57,182,744**	**$57,084,990**	**$71,288,812**	**$96,492,276**	**$93,313,397**
Cash Fund Exempt	20,114,345	20,059,529	25,305,261	33,923,185	32,818,721
Federal Funds	37,068,399	37,025,461	45,983,551	62,569,091	60,493,196
Total funding percent increase	0.00%	(0.17)%	24.88%	35.35%	(3.29)%

The table on the following page provides a five-year history of the caseload served by the Children's Basic Health Plan. The Children's Basic Health Plan Trust Fund provides the state match for the CBHP caseload up to 185 percent of the poverty level (FPL) that does not exceed the caseload in FY 2003-04 (the year the prenatal program was suspended and the children's population was capped). The Health Care Expansion Fund provides the state match for the CBHP caseload up to 185 percent of FPL that exceeds the FY 2003-04 enrollment and for any caseload between 185 percent of FPL and 200 percent

of FPL. Beginning in FY 2007-08, the children's population under 185 percent of FPL is forecasted to exceed the FY 2003-04 caseload for the first time. In addition, as stated earlier S.B. 07-097 allows the tobacco litigation settlement funds to pay for children's caseload between 200 percent of FPL to 205 percent of FPL.

	FY 03-04 Actual	FY 04-05 Actual	FY 05-06 Actual	FY 06-07 Approp.	FY 07-08 Approp.
Children's CBHP Trust Fund Caseload	*46,694*	*41,101*	*42,547*	*46,489*	*46,694*
Children's Health Care Expansion Caseload	*n/a*	*n/a*	*1,630*	*3,562*	*7,022*
Children's Tobacco Litigation Fund	***n/a***	***n/a***	***n/a***	***n/a***	***109***
Total Children Caseload	**46,694**	**41,101**	**44,177**	**50,051**	**53,716**
Adult Prenatal Member Months CBHP Trust Fund	*1,428*	*6,684*	*1,428*	*1,428*	*1,428*
Adult Prenatal Member Months Health Care Expansion	*n/a*	*n/a*	*13,019*	*15,450*	*18,447*
Total Prenatal Member Months	*1,428*	*6,684*	*14,447*	*16,878*	*19,875*

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 below. The FY 2006-07 reduction primarily reflects federal restrictions on Medicaid reimbursement for residential child care services that became effective in FY 2006-07, as well as one-time reductions to funding for developmental disability services associated with federally-required billing system changes. The FY 2007-08 increase primarily reflects increases in Medicaid reimbursement for developmental disability services, including the restoration of one-time FY 2006-07 reductions.

	FY 03-04 Actual	FY 04-05/1 Actual	FY 05-06 Actual	FY 06-07 Approp.	FY 07-08 Approp.
Expenditures	$567,683,764	$420,876,735	$446,257,606	$372,336,043	$401,713,130
Annual Percent Increase	n/a	(25.9)%	6.0%	(16.6)%	7.9%

/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. 07-1** ***(Hagedorn/Madden)*****:** Established the Colorado Cares Rx Program to provide generic prescription drugs to eligible persons at discounted rates. Participants are uninsured, ineligible for Medicaid or the Children's Basic Health Plan (CBHP), and have family income under 300 percent of the federal poverty level. In addition, participants pay a fee of up to $20. Also created the Colorado Cares Rx Program Cash Fund, which will consist of participant fees. Program costs in FY 2007-08 are appropriated at $2.3 million.

✔ **S.B. 07-2** ***(Sandoval/Stafford)*****:** Expanded Medicaid eligibility to young adults, who are under 21 years of age and who were in the foster care system immediately prior to their 18th birthday or emancipation. Currently, most foster children lose Medicaid eligibility on their 18th birthday or when they graduate from high school. This bill is anticipated to increase the Medicaid caseload by 1,471 young adults in FY 2007-08 (please note that this caseload is in addition to caseload noted in charts and tables in the narrative section of this report). The total costs for this bill are estimated at $8.3 million in FY 2007-08.

✔ **S.B. 07-4** ***(Shaffer/Todd)*****:** Required the Department of Human Services, in conjunction with other public and private entities, to develop a coordinated system of payment for early intervention services for infants and toddlers with developmental disabilities and delays, consistent with the requirements of Part C of the federal Individuals with Disabilities Education Act (IDEA). Required insurance coverage of such services without copayments or deductible up to a maximum annual liability of $5,725, for affected policies and services. Required the Department of Health Care Policy and Financing to make associated adjustments to the Children's Basic Health Plan and the Medicaid program. Appropriated in FY 2007-08 $53,730 cash funds exempt, $72,850 federal funds, and 1.0 FTE to the Department of Health Care Policy and Financing, with cash funds exempt amounts originating from the S.B. 07-97 Grant Fund.

✔ **S.B. 07-36** ***(Keller/Stafford)*****:** Added additional mental disorders to mandatory health insurance coverage for mental illness. Defines mental disorders subject to the provisions of the bill to include post-traumatic stress disorders, alcohol and drug disorders, dysthymia, cyclothymia, social phobia, agoraphobia with panic disorder, and general anxiety disorder. Included anorexia nervosa and bulimia nervosa to the extent treated on an outpatient, day-treatment, and in-patient basis, but excludes residential treatment. Included an appropriation of $31,459 to the Department of Health Care Policy and Financing for Children's Basic Health Program Premium Costs, including $11,011 General Fund and $20,448 matching federal funds.

✔ **S.B. 07-97** ***(Fitz-Gerald/Madden)*****:** Allocated tobacco litigation settlement funds not previously allocated, and provided appropriations to multiple departments. The bill increased the eligibility for the Children's Basic Health Plan to 205 percent of the federal poverty level (estimated impact in FY 2007-08 109 children). The bill contained the following FY 2007-08 appropriations for the Department of Health Care Policy and Financing: (1) $200,000 cash funds exempt to the pediatric speciality hospital line item; (2) $1.5 million total funds to the various Children's Basic

Health Plan line items; and (3) $2.0 million cash funds exempt to the comprehensive primary and preventative care grant program.

✔ **S.B. 07-130 *(Boyd/Carrol M.)*:** Defined a medical home as a qualified medical specialty, developmental, therapeutic, or mental health care practice that ensures access to and coordination of all medically-related services to a child. The bill required the Department of Health Care Policy and Financing (HCPF) and the Department of Public Health and Environment (DPHE) to work together to develop systems to maximize the number of children in Medicaid and the Children's Basic Health Plan who have a medical home by July 1, 2008. Beginning January 30, 2008, HCPF will annually report progress towards increasing the number of children with a medical home to the Health and Human Services Committees of the General Assembly. The bill appropriated a total of $118,128, including $44,965 General Fund and $73,163 in matching federal funds, in FY 2007-08 to HCPF for the administrative costs associated with the bill.

✔ **S.B. 07-133 *(Tapia/Buescher)*:** Authorized the cash basis of accounting to be used for non-administrative expenses for the Children's Basic Health Plan, the Old Age Pension Medical Program, and for the State Contribution Payment for the Medicare Modernization Act of 2003 (MMA). Because the FY 2007-08 accrued expenses for the Old Age Pension, State Contribution Payment for the MMA, and the Children's Basic Health Plan will not be paid until FY 2008-09 using the cash basis of accounting, there is a one-time appropriation reduction in FY 2007-08. Therefore the bill resulted in a one-time savings of $11.9 million as shown in the table below.

FY 07-08	General Fund	Cash Funds Exempt	Federal Funds	Total Funds
Department of Health Care Policy and Financing				
State Contribution Payment for MMA	($7,173,368)	$0	$0	($7,173,368)
Children's Basic Health Plan	0	(1,430,885)	(2,657,358)	(4,088,243)
Old Age Pension Medical Program	0	(680,779)	0	(680,779)
Total HCPF	($7,173,368)	($2,111,664)	($2,657,358)	($11,942,390)

✔ **S.B. 07-196 *(Hagedorn/Massey)*:** Created a health information technology advisory committee and expanded the use of telemedicine for Medicaid clients. Contained a FY 2007-08 total fund appropriation of $127,288, including $40,019 in General Fund and $87,269 in matching federal funds, for the administrative costs associated with implementing the bill.

✔ **S.B. 07-211 *(Hagedorn/McGihon)*:** Established a 15-member Advisory Committee on Covering All Children in Colorado to develop a plan to provide health coverage for all low-income children by 2010. Effective January 1, 2008, children whose family income does not exceed the applicable income level for Medicaid or the Children's Basic Health Plan (CBHP) are presumptively eligible for coverage. In addition, required the Department to annually report information on access to and quality of health care for children eligible for Medicaid and CBHP to the General Assembly.

The Department must also develop clinical standards and methods for collecting, analyzing, and disclosing information regarding clinical performance, and it must make recommendations annually to the General Assembly. Contains a FY 2007-08 total fund appropriation of $161,427, including $62,562 General Fund, $1,237 cash funds exempt and $97,628 in federal funds, for the administrative costs associated with implementing this bill.

✔ **H.B. 07-1021 *(Frangas/Keller)*:** Created the Prescription Drug Information and Technical Assistance Program to provide advice about prescription drugs to Medicaid clients. The Department is required to administer the program and provide incentive payments to pharmacists and physicians who consult with Medicaid clients about how to avoid dangerous drug interactions, improve outcomes, and save money. The bill is anticipated to result in a net FY 2007-08 savings of $545,281, including $276,877 General Fund and $268,404 in federal funds.

✔ **H.B. 07-1183 *(White/Isgar)*:** Established the Nursing Facility Rate Grant Program to provide assistance to certain nursing facilities that would experience a rate reduction in FY 2007-08 without the assistance from the grant program. Also extended the deadline to November 1, 2007, for a feasibility study for a new nursing home reimbursement methodology. Contained a total FY 2007-08 appropriation to the Department of $397,000, including $198,500 from the General Fund and $198,500 in matching federal funds.

✔ **H.B. 07-1301 *(Buescher/Williams)*:** Added cervical cancer immunizations as an optional Medicaid service for girls under 20 years of age and as a mandatory coverage provision for all individual and group health plans as of January 1, 2008. Also directed the Department of Public Health and Environment (DPHE) to research methods to administer cervical cancer vaccines economically. In addition, established the Cervical Cancer Immunization Awareness Campaign Fund to allow the DPHE to conduct a public awareness campaign on the benefits of receiving cervical cancer immunization. The total FY 2007-08 appropriation to the Department of Health Care Policy and Financing is $298,177, including$104,362 cash funds exempt and $193,815 federal funds, for the increase in immunization costs to the Children's Basic Health Plan. The bill also made several appropriation adjustments to DPHE.

✔ **H.B. 07-1346 *(Buescher/Tapia)*:** Provided the statutory authority for the Department of Health Care Policy and Financing to enter into prepaid inpatient health plan agreements (a form of managed care). The bill also eliminated the requirement that managed care capitation rates be no more than 95 percent of fee-for-service rates for an equivalent group. However, the bill prohibited managed care rates from being more than 100 percent of the costs of serving an equivalent population in the fee-for-service program. Lastly, the bill changed the financial solvency requirements for managed care organizations (MCOs) serving only the populations enrolled in Medicaid, Medicare and the Children's Basic Health Plan. These MCOs must maintain a minimum surplus of $4.0 million and a claims liability within its financial statements equal to the greater of: (1) one month of federal and state reimbursements received by the MCO for services provided to health care recipients; or (2) the MCO's total outstanding claims liabilities. At the time of passage, the bill's estimated impact for FY 2007-08 was $75,000 total

funds in order for the Department to conduct a study of the administrative costs associated with entering into inpatient health plan agreements.

✔ **H.B. 07-1359 *(Buescher/Fitz-Gerald)*:** Accelerated the use of a portion of the moneys that Colorado receives under the Master Settlement Agreement (MSA) and makes up to $24.4 million of MSA moneys available prior to April 16, 2008 to pay for FY 2006-07 and FY 2007-08 over-expenditures and supplementals of the Children's Basic Health Plan and the Colorado Benefits Management System.

✔ **S.B. 06-044 *(Hagedorn/Green):*** This bill increased eligibility into the medically indigent program to clients with incomes up to 250 percent of the federal poverty level. The bill created the Health Care Services Fund and requires that the General Assembly appropriate $15.0 million into this fund from the General Fund each year for FY 2005-06, FY 2007-08, FY 2008-09 and FY 2009-10. Without additional legislation, this program will not be funded after FY 2009-10.

✔ **S.B. 06-128 *(Owen/Riesberg):*** This bill directed 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.

✔ **S.B. 06-129 *(Keller/Buescher):*** This bill clarified 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.

✔ **S.B. 06-131 *(Tochtrop/McFadyen):*** This bill required the Department to conduct a feasibility study for a new pricing model for class I nursing facilities. The bill also required 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 removed the 8 percent limit on health care services costs for class I and class V nursing facilities for FY 2006-07. The study due from this bill was pushed back to November 1, 2007 by H.B. 07-1183.

✔ **S.B. 06-165 *(Hagedorn/Gardner):*** This bill authorized 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 required the Department to establish a pilot program using telemedicine for the treatment of patients with chronic conditions.

✔ **S.B. 06-208 *(Hanna/McGihon):*** This bill established 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. The Blue Ribbon Commission is anticipated to report their recommendations in January 2008.

✔ **H.B. 06-1270** ***(Merrifield/Gordon):*** This bill created 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.

✔ **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.

✓ **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.

✓ **H.B. 05-1131** ***(Cloer/Tochtrop):*** Allowed 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 required 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):*** Allowed 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 specified 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):*** Allowed school districts to receive federal Medicaid funds based on the school district's certified funds match.

✔ **H.B. 93-1317** ***(Anderson/Rizzuto):*** 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 2006-07 to FY 2007-08

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 2007-08 Appropriation Build:						
FY 2006-07Appropriation (Base)	$3,338,839,093	$1,380,460,170	$684,480	$356,470,768	$1,601,223,675	231.8
Medical Service Division (Major Long Bill adjustments)						
Medicaid base adjustments	64,714,021	11,101,307	0	21,582,316	32,030,398	0.0
Medicaid provider rate increases	21,069,590	10,396,680	0	138,113	10,534,797	0.0
Other Medicaid Premium changes	601,029	300,515	0	0	300,514	0.0
Mental Health Division (Major Long Bill adjustments)						
Medicaid Mental Health changes	8,387,445	2,940,316	0	1,071,719	4,375,410	0.0
Indigent Care Division (Major Long Bill adjustments)						
Colorado Health Care Services Fund	15,000,000	15,000,000	0	0	0	0.0
Children's Basic Health Plan base cost adjustments/Trust Fund	(2,076,677)	(11,243,215)	21,615	3,214,887	5,930,036	0.0
Pediatric Speciality Hospital provider rate Increase	595,928	201,000	0	(3,036)	397,964	0.0
Other changes to Indigent Care Division	(993,650)	(3,036)	0	(990,614)	0	0.0
Other Medical Services Division (Major Long Bill adjustments)						
Medicare Modernization Act State Contribution Payment	3,226,279	3,226,279	0	0	0	0.0

Department of Health Care Policy and Financing (all programs)						
	Total Funds	**General Fund/1**	**Cash Funds**	**Cash Funds Exempt**	**Federal Funds**	**FTE**
Family Medicine Residency Training Program	200,000	100,000	0	0	100,000	0.0
Other and technical changes to the Other Medical Services Division	(369,387)	3,327	0	(367,892)	(4,822)	0.0
Department of Human Services Medicaid Programs Division						
Department of Human Services Medicaid Programs	29,350,152	18,799,653	0	(4,104,171)	14,654,670	0.0
Executive Director's Division						
County administration increase	2,209,022	759,836	0	344,675	1,104,511	0.0
Salary and benefit adjustments	1,026,492	709,548	0	48,663	268,281	0.0
Provider rate increases	451,248	225,624	0	0	225,624	0.0
Other issues in Executive Director's Office Division	(7,459,633)	(1,509,367)	4,549	20,483	(5,975,298)	6.2
Special Legislation						
Sum of all 2007 Legislation adding appropriations	1,418,634	(7,093,188)	2,255,432	4,144,900	2,111,490	7.3
TOTAL FY 2007-08	**$3,476,189,586**	**$1,424,375,449**	**$2,966,076**	**$381,570,811**	**$1,667,277,250**	**245.3**
Increase/(Decrease)	$137,350,493	$43,915,279	$2,281,596	$25,100,043	$66,053,575	13.5
Percentage Change	4.1%	3.2%	333.3%	7.0%	4.1%	5.8%

Medicaid base adjustments: The FY 2007-08 appropriation contained a total fund increase of $64.7 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.

Medicaid provider rate increases: The FY 2007-08 appropriation contained an increase of $21.1 million total funds for provider rate increases.

Other Medicaid Premium changes: The FY 2007-08 appropriation also contained an net total fund increase of $601,029 for other items impacting Medicaid medical services. These items included the following increases: (1) $1.0 million for HPV vaccination costs and (2) $758,467 for quality incentive payments for Denver Health. These increases were partially offset by the following decreases: (1)

$670,376 for cost savings assumed due to the implementation of the preferred drug list; and (2) $497,146 in savings for additional audits of Federally Qualified Health Centers and hospitals.

Medicaid Mental Health changes: The FY 2007-08 appropriation included a total fund increase of $8.4 million for mental health issues related mainly to caseload growth and change in capitation rates.

Colorado Health Care Services Fund: The FY 2007-08 appropriation included a general fund increase of $15.0 million for the Colorado Health Care Services Fund as required by S.B. 06-044.

Children's Basic Health Plan base cost adjustments trust fund: The FY 2007-08 appropriation included the following caseload and cost-of-services increases (1) $8.3 million total funds for the CBHP medical program; and (2) $803,080 for dental and administrative costs. The appropriation also reflected a decrease of $11.3 million General Fund into the CBHP Trust Fund. This reflected a decrease of one-time funding that was placed into the CBHP Trust Fund in FY 2006-07 and was not necessary to support the program in FY 2007-08.

Pediatric Speciality Hospital provider rate increase: The FY 2007-08 appropriation included an increase of $602,000 to reflect a 6.0 percent provider rate increase. This increase was partially offset by a decrease of $6,072 due to a lower forecast for the tobacco tax revenues available to fund this program.

Other changes to Indigent Care Division: The FY 2007-08 appropriation also included a net decrease of $993,650 total funds related mainly to a transfer of appropriation to the Department of Public Health and Environment related to the General Fund transfer from Tobacco Tax programs and also related lower tobacco tax revenue forecasts.

Medicare Modernization Act State Contribution Payment: The FY 2007-08 appropriation contained an General Fund increase of $3.2 million for the state contribution payment for the Medicare drug benefit for dual eligible individuals (individuals eligible for both Medicaid and Medicare). This increase is related to caseload projections and the monthly per-capita charge for prescription drugs for the program.

Family Medicine Residency Training Program: The FY 2007-08 appropriation included an increase of $200,000 funding for the nine family medicine residency programs in the state.

Other and technical changes to the Other Medical Services Division: The FY 2007-08 appropriation also made the following changes: (1) an increase of $6,654 for the enhanced prenatal care program; (2) a decrease of $288,212 to eliminate one-time funding from the Old Age Pension medical program; (3) a decrease of $79,680 to reflect decreased revenue projections for tobacco taxes; and (4) a decrease of $8,149 to reflect a transfer of funds to the Department of Education for administrative costs associated with their oversight responsibilities for the Public School Health Services program.

Department of Human Services Medicaid Programs: The FY 2007-08 appropriation contains a total fund increase of $29.4 million for programs administered by the Department of Human Services that are

eligible to receive Medicaid funding. These increases are discussed in the Department of Human Services budget briefings and are noted here only to help explain the HCPF's total budget increase.

County administration increase: The FY 2007-08 appropriation included a total fund increase of $2.2 million to narrow the gap between the funding the State provides counties to perform eligibility determinations for programs administered by the Department and the amount of funding the counties actually spend on such activities.

Salary and benefits adjustments: The FY 2007-08 appropriation contained an increase of $1.0 million total funds for salary and employee-related benefit adjustments for state employees at the Department.

Provider rate increases: The FY 2007-08 appropriation contained an increase of $451,248 total funds to provide rate increases for county administration, non-emergency transportation services, and for administrative case management services.

Other issues in the Executive Director's Office Division: The FY 2007-08 appropriation included a net decrease of $7.5 million total funds. This decrease related mainly to eliminating one-time funding adjustments that were provided in FY 2006-07 and were not necessary in FY 2007-08.

Special Legislation: In addition to the appropriation changes in the Long Bill, the General Assembly also passed fifteen bills that contained FY 2007-08 appropriations for the Department of Health Care Policy and Financing. The total sum of these appropriation adjustments was an increase of $1.4 million total funds to the Department. A list and description of each of these bills is found on pages 10 through 13 of this briefing packet.

FY 2008-09 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** Estimated base increase to the medical services premiums line item based on the anticipated number of clients who will be served in FY 2008-09 and the cost of providing medical services to those clients. The Department currently projects an increase in caseload of .89 percent over their revised FY 2007-08 estimate. The Department is also projecting an increase in overall per-capita spending of 3.7 percent over their revised FY 2007-08 estimate. Therefore, the total increase projected for the**base** change to medical services premiums is an estimated increase of 5.3 percent over the current FY 2007-08 appropriation. 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. (2007)*	$60,266,483	($38,256)	($2,888,520)	$56,447,119	$113,786,826	0.00
2	**Medicaid Community Mental Health Services, multiple line items** Estimated base increase to the Medicaid Community Mental Health line items. The request is based on the anticipated growth in the Medicaid caseload describe above as well as an increase in the overall capitation payments of 5.3 percent. The request also eliminates the informational only appropriation for antipyschotic prescription drugs (the controlling appropriation for prescripton drugs is in the Medical Services Premiums line item). This item is discussed in greater detail in the issue section of this briefing *Sections 25.5-5-308, C.R.S. (2007); 25.5-5-408, C.R.S. (2007); 25.5-5-411, C.R.S. (2007)*	$4,140,689	$0	($31,568,588)	$4,897,424	($22,530,475)	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. (2007); 25.5-8-109, C.R.S. (2007); 25.5-8-107 (1) (a) (I)-(II), C.R.S. (2007); 24-22-117 (2) (a) (II) (A), C.R.S. (2007)*	$2,382,423	$59,962	$11,083,854	$20,469,689	$33,995,928	0.00

FY 2008-09 Budget Briefing
Department of Health Care Policy and Financing
Change Requests: Decision Items

Priority	Division: Description *[Statutory Authority]*	GF	CF	CFE	FF	Total	FTE
3A	**Additional Children's Basic Health Plan Outreach, Multiple divisions and line items** This request is to increase marketing an outreach efforts for the CBHP program to find and enroll existing eligible but uninsured children. The decision item includes $1.4 million for the CBHP Administration contract to perform more outreach services. The remaining $3.0 million of the request is the anticipated increase in the CBHP and Medicaid children caseloads that will result from the additional effort to find eligible but unenrolled children. *Sections 25.5-8-111, C.R.S. (2007)*	$4,415,375	$39,520	$5,526,162	$13,952,438	$23,933,495	0.00
4	**Other Medical Services, MMA State Contribution Payment** This request is for the additional funds that are needed due to an increase in the projected caseload for dual eligibles (individuals eligible for both Medicare and Medicaid) and the projected increase in the per capita rate paid by the State, per federal regulations. *Sections 25.5-4-105 and 25.5-5-503 (2007); 42 CFR 423.908-910 (federal code)*	$2,854,636	$0	$0	$0	$2,854,636	0.00
5	**MMIS Fixed Price Increase** This request is for the increase to the fixed price contract for the second year of the MMIS contract. The amount requested represents the cost-of-living increase that was negotiated in the contract. *Section 25.5-4-204 C.R.S. (2007)*	$75,905	$0	$3,287	$233,818	$313,010	0.00

FY 2008-09 Budget Briefing
Department of Health Care Policy and Financing
Change Requests: Decision Items

Priority	Division: Description *[Statutory Authority]*	GF	CF	CFE	FF	Total	FTE
6	**Medical Services Premiums (Provider Rate Increases)** This request provides rate increases for the following services: (1) inpatient hospital rates; (2) preventative medicine procedures; (3) to develop a medical home pilot program; (4) substance abuse treatment; (5) vision benefits; (6) dental benefits; (7) radiology services; and (8) the Prenatal Plus program. This issue is discussed in greater detail in the issue section of this briefing. *Sections 25.5-4-104 and 25.5-5-101, C.R.S. (2007)*	$8,264,081	$0	$281,858	$8,545,936	$17,091,875	0.00
7	**Executive Director's Office, Personal Services & Operating Expenses** This request is for additional FTE to improve the Department's ability to meet productivit demands. *Sections 25.5-1-104 C.R.S. (2007)*	$269,735	$0	($51,420)	$269,733	$488,048	7.30
8	**Executive Director's Office, Operating Expenses** This request is to provide additional training and professional development opportunities for the Department's employees. *Section 25.5-1-104 (3), C.R.S. (2007)*	$50,000	$0	$0	$50,000	$100,000	0.00
9	**Executive Director's Office, Personal Services, Operating Expenses** This request is for increased funding to reinstate a computer and peripheral equipment life cycle replacement program at the Department and to re-establish a funding stream to pay for obligated software license renewal costs that are incurred annually. Of the total requested, $27,500 is for one-time Personal Services to obtain a contractor to assist in the Department's website redesign. *Section 25.5-1-104 (2) (4), C.R.S. (2007)*	$47,169	$0	$0	$47,168	$94,337	0.00

FY 2008-09 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	**Executive Director's Office, Personal Services, Operating Expenses, Leased Space** This decision item is for increased funding for additional office space for new Department staff and for replacement cubicles and to convert some space from high-walled cubicles into actual manger offices. *Section 25.5-1-104 (2) (4), C.R.S. (2007)*	$143,267	$0	$0	$143,267	$286,534	0.00
11	**Executive Director's Office, Operating Expenses, Enrollment Broker** This request asks for additional funding for the enrollment broker contract. Last year, the JBC cut funding for this contract by $242,784 to reflect declining caseload and the fact there were fewer managed care options available in the state. The Department renegotiated the contract to reduce the scope of work in the current contract in order to stay within the appropriation. However, the centers for Medicare and Medicaid (CMS) have stated that the Department's current contract does not meet CMS's regulation requirements that clients need to receive hard copy infomration materials instead of information via the web. *42 C.F.R. Section 438.10 (a)-(f), Federal Code*	$79,785	$0	$0	$79,785	$159,570	0.00
12	**Medical Services Premiums** This request increases funding for managed care organizations from 95 percent of fee-for-service to 100 percent of fee-for-service as allowed under H.B. 07-1346. *Sections 25.5-5-402 & 408, C.R.S. (2007)*	$2,186,498	$0	$0	$2,186,498	$4,372,996	0.00
13	**Executive Director's Office, HIPAA Web Portal** This request is for the necessary hardware and software to increase the capacity and provided needed maintenance for the Department's internet-based secured web portal services. The web portal is used to insure privacy and electronic security for data transmitted from the MMIS, CBMS, Business Utilization System (BUS), medical providers, and CMS.	$29,458	$0	$0	$88,375	$117,833	0.00

FY 2008-09 Budget Briefing
Department of Health Care Policy and Financing
Change Requests: Decision Items

Priority	Division: Description *[Statutory Authority]*	GF	CF	CFE	FF	Total	FTE
	Section 25.5-4-105, C.R.S. (2007)						
14	**Executive Director's Office, Non-Emergency Transportation; Medical Services Premiums** This request transfers the funding for non-emergency transportation services from the Executive Director's Office back into the Medical Services Premiums line item. The funding for this request nets to zero. *Section 25.5-5-202(1) (s) (2), C.R.S. (2007), 42 C.F.R. Section 431.53*	$0	$0	$0	$0	$0	0.00
15	**Executive Director's Office, Administrative Case Management** This request transfers $650,000 from the Department of Human Services to the HCPF in order to maximize the amount of federal funds available for county case management services. This transfer is recommended because of the actual expenditures for case management due to the Medicaid program. *Sections 25.5-1-120 (1), (a) and 24-75-106 (1), C.R.S. (2007)*	$650,000	$0	$0	$650,000	$1,300,000	0.00
	Total Decision Items	**$85,855,504**	**$61,226**	**($17,613,367)**	**$108,061,250**	**$176,364,613**	**7.3**

FY 2008-09 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	**DHS Medicaid Funded Programs, Office of Information Technology Services, CBMS** This request refinances $417,996 in General Fund with Health Care Expansion Fund for the CBMS program. The Department believes that the Health Care Expansion Fund is an appropriate revenue source to fund CBMS costs that result from expanding the Medicaid and CBHP programs. Currently, the CBMS calculator does not use Health Care Expansion Fund as a revenue source and this issue would resovle that problem. *Section s24-37.5-101, and 25.5-4-205, C.R.S. (2007)*	($417,996)	$0	$417,996	$0	$0	0.0
2	**Executive Director's Office, Drug Utilization Review and Medical Services Premiums** This request is a reduction in fund due to anticipated savings from the preferred drug list. The request also correct the federal match rate for the Drug Utilization Review line including the new preferred drug list contractor, the drug utilization review contraction and the pharmacist incentive payments. *Sections 25.5-5-506, C.R.S. (2007) and 42 CFR 456.719*	($320,510)	$0	$0	($472,581)	($793,091)	0.0
	Total Base Reduction Items	**($738,506)**	**$0**	**$417,996**	**($472,581)**	**($793,091)**	**0.0**

FY 2008-09 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 - Division of Youth Corrections** Funding for additional youth contract placements. See DHS briefings for more detail.	$20,604	$0	$0	$20,604	$41,208	0.0
2	**HCPF - Other Medical Services, Commission on Family Medicine** Increase for the Commission on Family Medicine. See Commission on Family Medicine briefing packet for more information.	$135,000	$0	$0	$135,000	$270,000	0.0
3	**DHS - Executive Director's Office** Human Resources Staffing needs. See DHS briefing for more detail.	$16,458	$0	$0	$16,457	$32,915	0.0
4	**HCPF -- Executive Director's Office, DPHE Facility Survey and Certification; DHS -- Executive Director's Office, DD Community & DD Regional Centers** DHS Regional Center ICF-MR Conversion and Year 2 of the Staffing Study. See DPHE and DHS briefings for more detail.	$1,065,711	$0	$0	$1,135,916	$2,201,627	0.0
5	**DHS -- Office of Information Technology** IT infrastructure support. See DHS briefings for more detail.	$3,276	$0	$0	$3,276	$6,552	0.0
6	**DHS -- Office of Information Technology Services** Adjustments to Statewide Multiuse Network Payments. See DHS briefings for more detail.	$6,189	$0	$0	$6,188	$12,377	0.0

FY 2008-09 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 -- Executive Director's Office** Statewide C-SEAP program staffing. See DHS briefings for more detail.	$13,589	$0	$0	$13,589	$27,178	0.0
8	**DHS -- Office of Operations** Adjustment to Statewide Vehicle Lease Payments. See DHS briefings for more information.	($17,857)	$0	$0	($17,858)	($35,715)	0.0
9	**DHS- Child Welfare; DHS- Mental Health and Drug and Alcohol Services; DHS Developmental Disabilities; DHS Youth Corrections** Provider rate increases. See DHS briefings for more information.	$2,086,081	$0	$0	$2,086,081	$4,172,162	0.0
10	**DHS-Developmental Disabilities** New Resources Request. See DHS briefings for more information.	$3,670,650	$0	$0	$3,670,649	$7,341,299	0.0
11	**HCPF -- Executive Director's Office, Worker's Compensation** Statewide C-SEAP Program staffing.	$174	$0	$0	$174	$348	0.0
	Total Non-Prioritized Items	**$6,999,875**	**$0**	**$0**	**$7,070,076**	**$14,069,951**	**0.0**

Department's Total Change Requests						
Decision Items	**$85,855,504**	**$61,226**	**($17,613,367)**	**$108,061,250**	**$176,364,613**	**7.30**
Base Reduction Items	**($738,506)**	**$0**	**$417,996**	**($472,581)**	**($793,091)**	**0.00**
Non-prioritized Item Requests	**$6,999,875**	**$0**	**$0**	**$7,070,076**	**$14,069,951**	**0.00**
TOTAL CHANGE REQUESTS	**$92,116,873**	**$61,226**	**($17,195,371)**	**$114,658,745**	**$189,641,473**	**7.30**

FY 2008-09 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 2008-09 request is $213.6 million ($102.1 million General Fund) higher than the current FY 2007-08 appropriation. The following table shows the total increase reflected in the November 2007 request.

Requested Changes FY 2007-08 Appropriation to FY 2008-09 Budget Request					
Category	**Total**	**GF & GFE[/1]**	**CF**	**CFE**	**FF**
FY 2007-08 Appropriation	$3,476,189,586	$1,424,375,449	$2,966,076	$381,570,811	$1,667,277,250
FY 2008-09 Request	$3,689,785,301	$1,526,459,330	$4,694,158	$369,491,780	$1,789,140,033
Increase	**$213,595,715**	**$102,083,881**	**$1,728,082**	**($12,079,031)**	**$121,862,783**
Percent Change	**6.1%**	**7.2%**	**58.3%**	**(3.2)%**	**7.3%**

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

As shown above, the Department's FY 2008-09 budget request includes a total increase of $102.1 million in additional General Fund spending. The majority of the General Fund increase, $64.3 million, is for Medicaid caseload growth and corresponding medical and mental health cost increases. Another $20.9 million of the General Fund increase is related to other decision items that the Department submitted including provider rate increases and caseload growth for the Children's Basic Health Plan. Approximately $6.9 million of the General Fund increases is related to Medicaid programs administered by the Department of Human Services. Finally, $10.6 million (9.8%) of the General Fund increase is related to technical adjustments including $7.2 million to adjust funding to account for the one-time savings that resulted when the Children's Basic Health Plan, Old Age Pension Program, and Medicare Modernization Act of 2003 were moved to cash accounting and $2.8 million in other technical adjustments. These increases are offset by a reduction of $0.7 million General Fund related to base reduction items.

FY 2008-09 Increases Detail					
Category	**Total**	**GF & GFE**	**CF**	**CFE**	**FF**
Technical Changes	$18,372,200	$10,646,466	$1,666,856	$5,116,340	$942,538
Decision Items	$174,946,780	$85,176,046	$61,226	($17,613,367)	$107,322,875
Base Reductions	($793,091)	($738,506)	$0	$417,996	($472,581)
Non-Prioritized	$21,069,826	$6,999,875	$0	$0	$14,069,951
Total Increases	$213,595,715	$102,083,881	$1,728,082	($12,079,031)	$121,862,783

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 2007-08 and FY 2008-09 -- By Division

Source: November 1st Submittal

	FY 2007-08 Appropriation	FY 2007-08 Estimate	Difference Est. - App	FY 2008-09 Request	Difference from FY 07-08 App	% Difference	Difference from FY 07-08 Est.	% Difference
Executive Director's	**97,363,795**	**98,774,585**	**1,410,790**	**96,436,378**	**(927,417)**	**-1.0%**	**(2,338,207)**	**-2.4%**
FTE	**245.3**	**257.3**	**12.0**	**266.80**	**21.5**	**8.8%**	**9.5**	**3.7%**
General Fund	32,971,841	32,873,758	(98,083)	31,194,815	(1,777,026)	-5.4%	(1,678,943)	-5.1%
Cash Funds	2,680,877	2,680,877	0	4,345,982	1,665,105	62.1%	1,665,105	62.1%
Cash Funds Exempt	6,289,822	7,896,775	1,606,953	7,635,302	1,345,480	21.4%	(261,473)	-3.3%
Federal Funds	55,421,255	55,323,175	(98,080)	53,260,279	(2,160,976)	-3.9%	(2,062,896)	-3.7%
Medical Services Premiums	**2,147,858,908**	**2,161,523,892**	**13,664,984**	**2,296,447,978**	**148,589,070**	**6.9%**	**134,924,086**	**6.2%**
General Fund & GFE	996,321,500	1,008,618,325	12,296,825	1,072,914,449	76,592,949	7.7%	64,296,124	6.4%
Cash Funds	38,256	0	(38,256)	0	(38,256)	-100.0%	0	n/a
Cash Funds Exempt	76,001,368	71,344,569	(4,656,799)	74,187,505	(1,813,863)	-2.4%	2,842,936	4.0%
Federal Funds	1,075,497,784	1,081,560,998	6,063,214	1,149,346,024	73,848,240	6.9%	67,785,026	6.3%
Medicaid Mental Health	**230,114,249**	**197,862,293**	**(32,251,956)**	**210,160,435**	**(19,953,814)**	**-8.7%**	**12,298,142**	**6.2%**
General Fund	92,060,148	91,706,890	(353,258)	96,568,457	4,508,309	4.9%	4,861,567	5.3%
Cash Funds	0	0	0	0	0	n/a		n/a
Cash Funds Exempt	39,151,106	7,216,576	(31,934,530)	8,503,229	(30,647,877)	-78.3%	1,286,653	17.8%
Federal Funds	98,902,995	98,938,827	35,832	105,088,749	6,185,754	6.3%	6,149,922	6.2%
Indigent Care Program	**477,448,509**	**477,448,509**	**0**	**533,000,054**	**55,551,545**	**11.6%**	**55,551,545**	**11.6%**
General Fund & GFE	35,225,673	35,225,673	0	38,109,662	2,883,989	8.2%	2,883,989	8.2%
Cash Funds	246,943	246,943	0	348,176	101,233	41.0%	101,233	41.0%
Cash Funds Exempt	222,997,647	222,997,647	0	241,844,322	18,846,675	8.5%	18,846,675	8.5%
Federal Funds	218,978,246	218,978,246	0	252,697,894	33,719,648	15.4%	33,719,648	15.4%
Other Medical Services	**121,690,995**	**121,690,995**	**0**	**131,812,857**	**10,121,862**	**8.3%**	**10,121,862**	**8.3%**
General Fund	70,552,732	70,552,732	0	80,719,942	10,167,210	14.4%	10,167,210	14.4%
Cash Funds	0	0	0	0	0	n/a	0	n/a
Cash Funds Exempt	33,306,193	33,306,193	0	33,126,504	(179,689)	-0.5%	(179,689)	-0.5%
Federal Funds	17,832,070	17,832,070	0	17,966,411	134,341	0.8%	134,341	0.8%
DHS Programs	**401,713,130**	**401,757,099**	**43,969**	**421,927,599**	**20,214,469**	**5.0%**	**20,170,500**	**5.0%**
General Fund	197,243,555	197,264,155	20,600	206,952,005	9,708,450	4.9%	9,687,850	4.9%
Cash Funds	0	0	0	0	0	n/a	0	n/a
Cash Funds Exempt	3,824,675	3,827,304	2,629	4,194,918	370,243	9.7%	367,614	9.6%
Federal Funds	200,644,900	200,665,640	20,740	210,780,676	10,135,776	5.1%	10,115,036	5.0%
DEPARTMENT TOTAL	**3,476,189,586**	**3,459,057,373**	**(17,132,213)**	**3,689,785,301**	**213,595,715**	**6.1%**	**230,727,928**	**6.7%**
FTE	**245.30**	**257.30**	**12.0**	**266.8**	**21.5**	**8.8%**	**9.5**	3.7%
General Fund & GFE	1,424,375,449	1,436,241,533	11,866,084	1,526,459,330	102,083,881	7.2%	90,217,797	6.3%
Cash Funds	2,966,076	2,927,820	(38,256)	4,694,158	1,728,082	58.3%	1,766,338	60.3%
Cash Funds Exempt	381,570,811	346,589,064	(34,981,747)	369,491,780	(12,079,031)	-3.2%	22,902,716	6.6%
Federal Funds	1,667,277,250	1,673,298,956	6,021,706	1,789,140,033	121,862,783	7.3%	115,841,077	6.9%

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

Department's Request (Source 11/1/2007 Request)	FTE	General Fund	General Fund Exempt	Cash Funds	Cash Funds Exempt	Federal Funds	Total Funds
Executive Director's Office (EDO)							
FY 2007-08 Current Appropriation	**245.3**	**$32,971,841**	**$0**	**$2,680,877**	**$6,289,822**	**$55,421,255**	**$97,363,795**
* T-1 Annualize Prior Year Budget Issues	0.0	(195,986)	0	0	(140,512)	(45,366)	(381,864)
* T-2 Annualize 1331 Supplementals	12.0	($92,864)	$0	$0	$1,548,938	($92,926)	$1,363,148
* T-3 Annualize Prior Year Legislation	2.2	38,160	0	1,665,531	(71,333)	(160,625)	1,471,733
* T-4 Remove One-Time Funding	0.0	(10,000)	0	0	(75,200)	(10,000)	(95,200)
* T-5 Adjust Fund Split Issues	0.0	233,351	0	0	50,919	(284,270)	0
* T-6 Common Policy Adjustments Employee Relatec	0.0	454,155	0	(426)	80,801	501,093	1,035,623
* T-7 Common Policy Adjustments -- OE & Other	0.0	14,182	0	0	0	14,183	28,365
* DI #5 MMIS Contract Adjustment	0.0	75,905	0	0	3,287	233,818	313,010
* DI # 7 Addition FTE for Productivity Gains	7.3	269,735	0	0	(51,420)	269,733	488,048
* DI #8 -- Training for Department Staff	0.0	50,000	0	0	0	50,000	100,000
* DI # 9 Restore IT Funding	0.0	47,169	0	0	0	47,168	94,337
* DI #10 Funding for Additional Lease Space	0.0	143,267	0	0	0	143,267	286,534
* DI #11 Restore Enrollment Broker Contract	0.0	79,785	0	0	0	79,785	159,570
* DI #13 -- Web Portal Adjustment	0.0	29,458	0	0	0	88,375	117,833
* DI #14 -- Transfer Non-Emergency Trans.	0.0	(3,649,651)	0	0	0	(3,649,651)	(7,299,302)
* DI #15 -- Accuracy in Budgeting	0.0	650,000	0	0	0	650,000	1,300,000
* BRI #1 -- Implement Preferred Drug List	0.0	76,036	0	0	0	(76,036)	0
* NP DI #4 DHS Regional Centers ICF/MR Conv	0.0	10,098	0	0	0	80,302	90,400
* NP DI #11 -- C-SEAP Program Staffing	0.0	174	0	0	0	174	348
Subtotal -- Department FY 2008-09 EDO Request	**266.8**	**$31,194,815**	**$0**	**$4,345,982**	**$7,635,302**	**$53,260,279**	**$96,436,378**
Increase from Current Appropriation	**21.5**	**($1,777,026)**	**$0**	**$1,665,105**	**$1,345,480**	**($2,160,976)**	**($927,417)**
% Increase from Current Appropriation	**8.06%**	**-5.70%**	**n/a**	**38.31%**	**17.62%**	**-4.06%**	**-0.96%**

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

Department's Request (Source 11/1/2007 Request)	FTE	General Fund	General Fund Exempt	Cash Funds	Cash Funds Exempt	Federal Funds	Total Funds
Medical Services Premiums (MSP)							
FY 2007-08 Current Appropriation	**0.0**	**$652,421,500**	**$343,900,000**	**$38,256**	**$76,001,368**	**$1,075,497,784**	**$2,147,858,908**
* T-1 Annualize Prior Year Budget Adjustments	0.0	(335,188)	0	0	0	(335,188)	(670,376)
* T-3 Annualize Prior Year Legislation	0.0	(573,570)	0	0	792,799	219,229	438,458
* DI #1 Base Adjustments to MSP	0.0	60,266,483	0	(38,256)	(2,888,520)	56,447,119	113,786,826
* DI #3A CBHP Child Outreach	0.0	3,531,540	0	0	0	3,531,540	7,063,080
* DI #6 Provider Rate Increase	0.0	8,264,081	0	0	281,858	8,545,936	17,091,875
* DI #12 Increase HMO Rates to 100%	0.0	2,186,498	0	0	0	2,186,498	4,372,996
* DI #14 Transfer Non-Emergency Transportation	0.0	3,649,651	0	0	0	3,649,651	7,299,302
* BRI #2 Implement Preferred Drug List	0.0	(396,546)	0	0	0	(396,545)	(793,091)
Subtotal -- Department FY 2008-09 MSP Request	**0.0**	**729,014,449**	**343,900,000**	**0**	**74,187,505**	**1,149,346,024**	**2,296,447,978**
Increase from Current Appropriation	**0.0**	76,592,949	0	(38,256)	(1,813,863)	73,848,240	148,589,070
% Increase from Current Appropriation	**n/a**	**11.74%**	**0.00%**	**-100.00%**	**-2.39%**	**6.87%**	**6.92%**
Mental Health Division							
FY 2007-08 Current Appropriation	**0.0**	**$92,060,148**	**$0**	**$0**	**$39,151,106**	**$98,902,995**	**$230,114,249**
* Annualize Prior Year Legislation	0.0	0	0	0	920,711	920,711	1,841,422
* DI #2 -- Base Adjustments for Mental Health	0.0	4,140,689	0	0	(31,568,588)	4,897,423	(22,530,476)
* DI #3A -- CBHP Outreach	0.0	367,620	0	0	0	367,620	735,240
Subtotal -- Department FY 2008-09 MH Request	**0.0**	**$96,568,457**	**$0**	**$0**	**$8,503,229**	**$105,088,749**	**$210,160,435**
Increase from Current Appropriation	**0.0**	**$4,508,309**	**$0**	**$0**	**($30,647,877)**	**$6,185,754**	**($19,953,814)**
% Increase from Current Appropriation	**n/a**	**4.90%**	**n/a**	**n/a**	**-78.28%**	**6.25%**	**-8.67%**
Indigent Care Program (ICP)							
FY 2007-08 Current Appropriation	**0.0**	**$34,712,673**	**$513,000**	**$246,943**	**$222,997,647**	**$218,978,246**	**$477,448,509**
* T-1 Annualize Prior Year Budget Adjustments	0.0	0	0	0	605,548	0	605,548
* T-3 Prior Year Legislation	0.0	11,751	0	1,751	3,280,009	3,196,681	6,261,481
* T-8 Revenue Adjustments	0.0	0	(26,400)	0	(1,648,898)	0	(1,675,298)
* DI #3 CBHP Premium and Dental Forecast	0.0	2,382,423	0	59,962	11,083,854	20,469,689	33,995,928
* DI #3a -- CHBP Outreach	0.0	516,215	0	39,520	5,526,162	10,053,278	16,135,175
Subtotal -- Department FY 2008-09 ICP Request	**0.0**	**$37,623,062**	**$486,600**	**$348,176**	**$241,844,322**	**$252,697,894**	**$533,000,054**
Increase from Current Appropriation	**0.0**	**$2,910,389**	**($26,400)**	**$101,233**	**$18,846,675**	**$33,719,648**	**$55,551,545**
% Increase from Current Appropriation	**n/a**	**8.38%**	**-5.15%**	**40.99%**	**8.45%**	**15.40%**	**11.64%**

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

Department's Request (Source 11/1/2007 Request)	FTE	General Fund	General Fund Exempt	Cash Funds	Cash Funds Exempt	Federal Funds	Total Funds
Other Medical Services (OMS)							
FY 2007-08 Current Appropriation	**0.0**	**$70,552,732**	**$0**	**$0**	**$33,306,193**	**$17,832,070**	**$121,690,995**
* T-1 Annualizations Prior Year Budget Adj.	0.0	4,206	0	0	(792,968)	(659)	(789,421)
* T-3 Annualize Prior Year Legislation		7,173,368	0	0	680,779	0	7,854,147
* T-8 Revenue Adjustments		0	0	0	(67,500)	0	(67,500)
* DI #4 State Contribution Caseload Cost Increase		2,854,636	0	0	0	0	2,854,636
* NP DI #2 Commission on Family Medicine	0.0	135,000	0	0	0	135,000	270,000
Subtotal -- Department FY 2008-09 OMS Request	**0.0**	**$80,719,942**	**$0**	**$0**	**$33,126,504**	**$17,966,411**	**$131,812,857**
Increase from Current Appropriation	**0.0**	**$10,167,210**	**$0**	**$0**	**($179,689)**	**$134,341**	**$10,121,862**
% Increase from Current Appropriation	**n/a**	**14.41%**	**n/a**	**n/a**	**-0.54%**	**0.75%**	**8.32%**
DHS Medicaid Programs (DHS) (this division is discussed in separate staff briefings -- shown for information purposes only)							
FY 2007-08 Current Appropriation	**0.0**	**$197,243,555**	**$0**	**$0**	**$3,824,675**	**$200,644,900**	**$401,713,130**
* T-1 Annualization Budget Adjustments	0.0	2,991,258	0	0	370,243	2,582,278	5,943,779
* BRI #1 Fund Split revision for CBMS	0.0	(417,996)	0	0	0	417,996	0
* NP DI 1, 3-10	0.0	7,135,188	0	0	0	7,135,502	14,270,690
Subtotal -- Department FY 2008-09 DHS Request	**0.0**	**$206,952,005**	**$0**	**$0**	**$4,194,918**	**$210,780,676**	**$421,927,599**
Increase from Current Appropriation	**0.0**	**$9,708,450**	**$0**	**$0**	**$370,243**	**$10,135,776**	**$20,214,469**
% Increase from Current Appropriation	**n/a**	**4.92%**	**n/a**	**n/a**	**9.68%**	**5.05%**	**5.03%**
Department Total							
FY 2007-08 Current Appropriation	**245.3**	**$1,079,962,450**	**$344,413,000**	**$2,966,076**	**$381,570,811**	**$1,667,277,249**	**$3,476,189,586**
* EDO Adjustment Subtotal	21.5	(1,777,026)	0	1,665,105	1,345,480	(2,160,976)	(927,417)
* MSP Adjustment Subtotal	0.0	76,592,949	0	(38,256)	(1,813,863)	73,848,240	148,589,070
* MHP Adjustment Subtotal	0.0	4,508,309	0	0	(30,647,877)	6,185,754	(19,953,814)
* ICP Adjustment Subtotal	0.0	2,910,389	(26,400)	101,233	18,846,675	33,719,648	55,551,545
* OMS Adjustment Subtotal	0.0	10,167,210	0	0	(179,689)	134,341	10,121,862
* DHS Adjustment Subtotal	0.0	9,708,450	0	0	370,243	10,135,776	20,214,469
TOTAL HCPF FY 2008-09 Request	**266.8**	**$1,182,072,731**	**$344,386,600**	**$4,694,158**	**$369,491,780**	**$1,789,140,032**	**$3,689,785,301**
Increase from Current Appropriation	**21.5**	**$102,110,281**	**($26,400)**	**$1,728,082**	**($12,079,031)**	**$121,862,783**	**$213,595,715**
% Increase from Current Appropriation	**8.76%**	**9.45%**	**-0.01%**	**58.26%**	**-3.17%**	**7.31%**	**6.14%**

	FY 2005-06 Actual	FY 2006-07 Actual	FY 2007-08 Appropriation	FY 2008-09 Request	Change Req. #
Department of Health Care Policy and Financing					
Executive Director: Joan Henneberry					
(Primary Functions: Administration of Medicaid, the Colorado Indigent Care Program, S.B. 00-71 Comprehensive Primary and Preventative Care Grant Program, Old Age Pension Health and Medical Fund Services, and the Children's Basic Health Plan).					
(1) Executive Director's Office					
(Primary Functions: Provides all of the administrative, audit and oversight functions for the Department.)					
Personal Services/1	**13,753,841**	**15,260,951**	**16,715,590**	**19,312,598**	DI #7, 9, 10
FTE	194.35	225.36	245.3	266.8	T #1, 2,3,4,5,6
General Fund	6,278,844	6,054,845	7,261,822	8,017,916	
General Fund Exempt	281	0	0	0	
Cash Funds	0	0	140,495	212,681	
Cash Funds Exempt	494,021	399,006	592,486	2,074,525	
Federal Funds	6,980,695	8,807,100	8,720,787	9,007,476	
Health, Life, and Dental	**520,256**	**748,309**	**929,293**	**1,051,422**	T #6
General Fund	334,973	334,784	414,460	456,357	
Cash Funds Exempt	17,112	24,355	37,568	71,371	
Federal Funds	168,171	389,170	477,265	523,694	
Short-term Disability	**16,354**	**15,110**	**19,548**	**19,761**	T #6
General Fund	7,305	6,286	8,509	8,784	
Cash Funds Exempt	525	401	635	981	
Federal Funds	8,524	8,423	10,404	9,996	
S.B. 04-257 Amortization Equalization Disbursement	**24,391**	**93,197**	**178,339**	**243,206**	T #6
General Fund	10,889	41,256	76,448	108,110	
Cash Funds Exempt	855	2,092	5,855	12,070	
Federal Funds	12,647	49,849	96,036	123,026	
S.B. 06-235 Supplemental AED	**0**	**0**	**34,950**	**77,872**	T #6
General Fund	0	0	13,722	34,615	
Cash Funds Exempt	0	0	1,220	3,866	
Federal Funds	0	0	20,008	39,391	

	FY 2005-06 Actual	FY 2006-07 Actual	FY 2007-08 Appropriation	FY 2008-09 Request	Change Req. #
Salary Survey and					
Senior Executive Service	**394,534**	**459,483**	**480,923**	**600,470**	T #1, 6
General Fund	172,506	198,893	217,149	266,581	
Cash Funds Exempt	8,260	11,087	15,225	30,417	
Federal Funds	213,768	249,503	248,549	303,472	
Performance-based Pay Awards	**0**	**0**	**206,506**	**234,203**	T #1, 6
General Fund	0	0	92,725	104,107	
Cash Funds Exempt	0	0	6,484	11,625	
Federal Funds	0	0	107,297	118,471	
Worker's Compensation	**39,404**	**25,760**	**24,247**	**33,211**	NP DI #11
General Fund	19,702	12,880	12,124	16,606	T #6
Federal Funds	19,702	12,880	12,123	16,605	
Operating Expenses	**927,475**	**1,196,014**	**1,039,465**	**1,379,135**	DI #7, #8, #9, #10
General Fund	446,865	586,457	494,229	666,315	DI #11
Cash Funds	0	0	14,395	3,800	T #2, 3
Cash Funds Exempt	14,076	8,151	14,546	22,343	
Federal Funds	466,534	601,406	516,295	686,677	
Legal and Third Party Recovery					
Legal Services	**749,877**	**763,821**	**913,629**	**913,629**	
General Fund	311,609	318,913	370,501	370,501	
Cash Funds	62,912	62,998	76,924	76,924	
Cash Funds Exempt	306	0	6,319	6,319	
Federal Funds	375,050	381,910	459,885	459,885	
Administrative Law Judge Services	**505,921**	**380,930**	**407,509**	**453,207**	T #7
General Fund	252,961	190,465	203,755	226,604	
Federal Funds	252,960	190,465	203,754	226,603	
Computer Systems Costs	**93,083**	**0**	**18,516**	**17,250**	T #7
General Fund	30,307	0	7,590	6,957	
Cash Funds Exempt	16,235	0	3,337	3,337	
Federal Funds	46,541	0	7,589	6,956	

	FY 2005-06 Actual	FY 2006-07 Actual	FY 2007-08 Appropriation	FY 2008-09 Request	Change Req. #
Payment to Risk Management and Property Funds	**21,976**	**101,810**	**91,727**	**72,367**	T #7
General Fund	10,988	50,905	45,864	36,184	
Federal Funds	10,988	50,905	45,863	36,183	
Capitol Complex Leased Space	**332,915**	**344,022**	**391,079**	**394,372**	T #7
General Fund	166,458	172,011	195,540	197,186	
Federal Funds	166,457	172,011	195,539	197,186	
Commercial Leased Space	**33,228**	**166,899**	**272,318**	**336,339**	
General Fund	1,561	77,950	130,659	162,670	DI #10
Cash Funds Exempt	15,053	5,500	5,500	5,500	
Federal Funds	16,614	83,449	136,159	168,169	
Transfer to the Department of Human Services for Related Administration	**69,783**	**74,564**	**74,564**	**74,564**	
General Fund	34,892	37,282	37,282	37,282	
Federal Funds	34,891	37,282	37,282	37,282	
Medicaid Management Information System Contract	**21,737,076**	**26,018,831**	**22,306,209**	**23,130,559**	DI #5
General Fund	5,214,619	6,204,550	5,265,859	5,304,171	T #1, 3, 5
Cash Funds	0	0	368,971	1,303,749	
Cash Funds Exempt	435,293	596,657	706,330	614,096	
Federal Funds	16,087,164	19,217,624	15,965,049	15,908,543	
Medicaid Management Information System Reprocurement	**429,770**	**357,379**	**0**	**0**	
General Fund	98,014	72,284	0	0	
Cash Funds Exempt	4,490	3,672	0	0	
Federal Funds	327,266	281,423	0	0	
CBMS Eligibility Audit-Transfer to State Auditor	**68,250**	**0**	**0**	**0**	
Cash Funds Exempt	34,125	0	0	0	
Federal Funds	34,125	0	0	0	

	FY 2005-06 Actual	FY 2006-07 Actual	FY 2007-08 Appropriation	FY 2008-09 Request	Change Req. #
Medicare Modernization Act of 2003 CBMS Costs	**190,128**	**0**	**0**	**0**	
General Fund	95,064	0	0	0	
Federal Funds	95,064	0	0	0	
HIPAA Web Portal Maintenance	**293,740**	**314,800**	**312,900**	**430,733**	DI #13
General Fund	74,307	78,700	78,225	107,683	
Federal Funds	219,433	236,100	234,675	323,050	
HIPAA National Provider Identifier Assessment and Implementation	**101,600**	**2,030,583**	**0**	**0**	
General Fund	9,855	211,033	0	0	
Cash Funds Exempt	1,067	7,255	0	0	
Federal Funds	90,678	1,812,295	0	0	
Prepaid Inpatient Health Plan Feasibility Study	**0**	**0**	**75,000**	**0**	T #1
Cash Funds Exempt	0	0	37,500	0	
Federal Funds	0	0	37,500	0	
Medical Identification Cards	**103,263**	**92,592**	**120,000**	**120,000**	
General Fund	40,837	35,314	48,444	48,444	
Cash Funds Exempt	11,550	11,716	12,352	12,352	
Federal Funds	50,876	45,562	59,204	59,204	
Department of Public Health and Environment Facility Survey and Certification	**3,816,393**	**4,006,727**	**4,539,038**	**4,932,027**	NP DI #4
General Fund	1,016,971	1,015,448	1,346,102	1,300,605	T #1, 3
Federal Funds	2,799,422	2,991,279	3,192,936	3,631,422	
Acute Care Utilization Review	**1,139,989**	**1,375,906**	**1,375,906**	**1,375,906**	
General Fund	284,713	326,732	344,703	345,428	
Cash Funds Exempt	284	17,245	17,245	16,520	
Federal Funds	854,992	1,031,929	1,013,958	1,013,958	

	FY 2005-06 Actual	FY 2006-07 Actual	FY 2007-08 Appropriation	FY 2008-09 Request	Change Req. #
Long-Term Care Utilization Review	**1,518,061**	**1,719,438**	**1,744,966**	**1,744,966**	
General Fund	379,553	423,647	598,813	598,813	
Cash Funds Exempt	38,429	38,429	38,429	38,429	
Federal Funds	1,100,079	1,257,362	1,107,724	1,107,724	
External Quality Review	**778,077**	**807,832**	**882,193**	**812,193**	T #3
General Fund	194,519	201,958	220,548	203,048	
Federal Funds	583,558	605,874	661,645	609,145	
Drug Utilization Review	**278,366**	**291,438**	**304,143**	**304,143**	BRI #2
General Fund	69,591	72,859	76,036	152,072	
Federal Funds	208,775	218,579	228,107	152,071	
Mental Health External Quality Review	**322,700**	**352,654**	**352,807**	**352,807**	
General Fund	80,675	88,164	88,202	88,202	
Federal Funds	242,025	264,490	264,605	264,605	
CBMS & Program Contractor CO RX	**0**	**0**	**1,656,566**	**2,278,378**	
Cash Funds	0	0	1,656,566	2,278,378	
Early and Periodic Screening, Diagnosis, and Treatment Program	**2,351,694**	**2,444,273**	**2,468,383**	**2,468,383**	
General Fund	1,175,847	1,222,137	1,234,192	1,234,192	
Federal Funds	1,175,847	1,222,136	1,234,191	1,234,191	
Nursing Facility Audits	**1,095,396**	**1,095,396**	**1,097,500**	**1,097,500**	
General Fund	547,698	547,698	548,750	548,750	
Federal Funds	547,698	547,698	548,750	548,750	
Hospital and Federally Qualified Health Clinic Audits	**350,000**	**367,850**	**499,200**	**499,200**	
General Fund	175,000	183,925	249,600	249,600	
Federal Funds	175,000	183,925	249,600	249,600	

	FY 2005-06 Actual	FY 2006-07 Actual	FY 2007-08 Appropriation	FY 2008-09 Request	Change Req. #
Disability Determination Services	**1,163,662**	**1,173,662**	**1,173,662**	**1,173,662**	
General Fund	581,831	581,831	581,831	581,831	
Cash Funds Exempt	0	5,000	5,000	5,000	
Federal Funds	581,831	586,831	586,831	586,831	
Nursing Home Preadmission and Resident Assessments	**1,009,481**	**879,481**	**1,010,040**	**1,010,040**	
General Fund	252,370	219,870	252,510	252,510	
Federal Funds	757,111	659,611	757,530	757,530	
Nurse Aide Certification	**293,623**	**308,766**	**325,343**	**325,343**	
General Fund	0	0	148,020	148,020	
Cash Funds Exempt	146,812	154,383	14,652	14,652	
Federal Funds	146,811	154,383	162,671	162,671	
Nursing Facility Appraisals	**0**	**279,745**	**0**	**0**	
General Fund	0	139,873	0	0	
Federal Funds	0	139,872	0	0	
Estate Recovery	**627,588**	**432,784**	**700,000**	**700,000**	
Cash Funds	313,794	216,392	350,000	350,000	
Federal Funds	313,794	216,392	350,000	350,000	
Single Entry Point Administration	**50,084**	**46,060**	**53,000**	**53,000**	
General Fund	25,042	23,030	26,500	26,500	
Federal Funds	25,042	23,030	26,500	26,500	
Single Entry Point Audits	**29,950**	**62,468**	**112,000**	**112,000**	
General Fund	14,975	31,234	56,000	56,000	
Federal Funds	14,975	31,234	56,000	56,000	
S.B. 97-05 Enrollment Broker	**875,756**	**860,786**	**700,000**	**957,418**	DI #11
General Fund	437,878	411,485	316,486	445,195	
Cash Funds Exempt	0	18,908	33,514	33,514	
Federal Funds	437,878	430,393	350,000	478,709	

	FY 2005-06 Actual	FY 2006-07 Actual	FY 2007-08 Appropriation	FY 2008-09 Request	Change Req. #
Department of Regulatory Agency In-Home Support Review	**0**	**5,986**	**4,000**	**0**	T #1
General Fund	0	2,993	2,000	0	
Federal Funds	0	2,993	2,000	0	
Primary Care Provider Rate Task Force & Study	**0**	**53,075**	**19,334**	**0**	T #1
General Fund	0	26,538	9,667	0	
Federal Funds	0	26,537	9,667	0	
County Administration	**0**	**24,003,023**	**23,756,209**	**23,803,133**	T #3
General Fund	0	7,216,315	7,248,943	7,248,943	
Cash Funds	0	0	73,526	120,450	
Cash Funds Exempt	0	4,881,494	4,632,531	4,632,531	
Federal Funds	0	11,905,214	11,801,209	11,801,209	
Administrative Case Management	**0**	**2,861,494**	**1,617,528**	**2,917,528**	DI #15
General Fund	0	1,430,747	808,764	1,458,764	
Federal Funds	0	1,430,747	808,764	1,458,764	
Non-Emergency Transportation Services	**5,577,485**	**7,583,761**	**7,299,302**	**0**	DI #14
General Fund	2,788,743	3,791,881	3,649,651	0	
Federal Funds	2,788,742	3,791,880	3,649,651	0	
PERM Contract	**0**	**0**	**441,375**	**0**	T #1
General Fund	0	0	110,348	0	
Cash Funds Exempt	0	0	77,240	0	
Federal Funds	0	0	253,787	0	
Public School Administration	**0**	**200,000**	**391,696**	**396,561**	T #1
Federal Funds	0	200,000	391,696	396,561	
School District Eligibility Determination	**0**	**0**	**227,292**	**227,292**	
General Fund	0	0	79,269	79,269	
Cash Funds Exempt	0	0	25,854	25,854	
Federal Funds	0	0	122,169	122,169	

	FY 2005-06 Actual	FY 2006-07 Actual	FY 2007-08 Appropriation	FY 2008-09 Request	Change Req. #
					Request vs. Appropriation
SUBTOTAL -- Executive Director's Office					
Total Funds	**61,685,171**	**99,657,660**	**97,363,795**	**96,436,378**	**-0.95%**
FTE	194.35	225.36	245.3	266.8	8.76%
General Fund	21,637,963	32,643,173	32,971,841	31,194,815	-5.39%
General Fund Exempt	281	0	0	0	n/a
Cash Funds	376,706	279,390	2,680,877	4,345,982	62.11%
Cash Funds Exempt	1,238,493	6,185,351	6,289,822	7,635,302	21.39%
Federal Funds	38,431,728	60,549,746	55,421,255	53,260,279	-3.90%
(2) Medical Service Premiums (Provides acute care medical and long-term care services to individuals eligible for Medicaid).					
Services for Supplemental Security Income Adults 65 and Older (SSI 65+)	**$677,636,284**	**$681,708,325**	**$730,927,996**	**$755,844,189**	DI #1, T #1, 3
Medicaid Clients	36,219	35,977	36,703	35,498	
Cost per Client	$18,709.41	$18,948.45	$19,914.67	$21,292.59	
Services for Supplemental Security Income Adults 60 to 64 (SSI 60 - 64)	**$87,089,547**	**$89,709,160**	**$99,820,380**	**$97,182,620**	DI #1, T #1, 3
Medicaid Clients	6,048	6,042	6,252	6,106	
Cost per Client	$14,399.73	$14,847.59	$15,966.15	$15,915.92	
Services for Qualified Medicare Beneficiaries (QMBs) and Special Low-Income Medicare Beneficiaries (SLIMBs)	**$13,456,846**	**$17,132,545**	**$16,999,249**	**$23,895,140**	DI #1, T #1, 3
Medicaid Clients	11,012	12,818	13,294	15,360	
Cost per Client	$1,222.02	$1,336.60	$1,278.72	$1,555.67	
Services for Supplemental Security Income Disabled Individuals	**$559,681,577**	**$568,932,898**	**$604,513,591**	**$640,050,566**	DI #1, T #1, 3
Medicaid Clients	47,565	48,567	48,942	49,556	
Cost per Client	$11,766.67	$11,714.39	$12,351.63	$12,915.70	
Services for Categorically Eligible Low-Income Adults	**$196,592,991**	**$200,074,498**	**$172,576,628**	**$191,771,122**	DI #1, T #1, 3
Medicaid Clients	57,754	51,361	46,708	44,183	
Cost per Client	$3,403.97	$3,895.46	$3,694.80	$4,340.38	

	FY 2005-06 Actual	FY 2006-07 Actual	FY 2007-08 Appropriation	FY 2008-09 Request	Change Req. #
Services for Expansion Low-Income Adults	**$0**	**$7,406,101**	**$25,530,366**	**$15,614,936**	DI #1, T #1, 3
Medicaid Clients	0	4,974	10,377	9,462	
Cost per Client	$0.00	$1,488.96	$2,460.28	$1,650.28	
Services for Baby Care Program Adults	**$39,671,364**	**$47,989,940**	**$47,267,283**	**$57,407,298**	DI #1, T #1, 3
Medicaid Clients	5,050	5,123	5,264	5,649	
Cost per Client	$7,855.72	$9,367.55	$8,979.35	$10,162.38	
Services for Breast and Cervical Cancer Treatment Clients	**$6,858,042**	**$5,750,514**	**$7,096,871**	**$7,020,368**	DI #1, T #1, 3
Medicaid Clients	188	230	277	278	
Cost per Client	$36,478.95	$25,002.23	$25,620.47	$25,253.12	
Services for Categorically Eligible Children	**$310,351,460**	**$332,386,215**	**$331,886,554**	**$342,396,189**	DI #1, T #1, 3
Medicaid Clients	213,600	206,170	193,981	192,717	
Cost per Client	$1,452.96	$1,612.19	$1,710.92	$1,776.68	
Services for Categorically Eligible Foster Children	**$49,223,938**	**$53,963,402**	**$64,272,970**	**$69,888,796**	DI #1, T #1, 3
Medicaid Clients	16,311	16,601	17,295	19,305	
Cost per Client	$3,017.84	$3,250.61	$3,716.27	$3,620.24	
Services for Non-Citizens	**$55,702,259**	**$56,343,210**	**$46,967,020**	**$60,342,592**	DI #1, T #1, 3
Medicaid Clients	5,959	5,214	4,691	4,953	
Cost per Client	$9,347.58	$10,806.14	$10,012.16	$12,183.04	
Change Requests Total excluding DI #1 which is included in the caseload/ cost-per-client detail above	$0	$0	**$0**	**$35,034,162**	BRI #2, DI #3A, DI #6, DI #12, DI #14
SUBTOTAL -- Medical Services Premiums	**1,996,264,308**	**2,061,396,808**	**2,147,858,908**	**2,296,447,978**	Request vs. Appropriation **6.92%**
General Fund	614,561,650	633,377,714	652,421,500	729,014,449	11.74%
General Fund Exempt	361,644,803	343,100,000	343,900,000	343,900,000	0.00%
Cash Funds	0	0	38,256	0	-100.00%
Cash Funds Exempt	23,713,210	48,860,206	76,001,368	74,187,505	-2.39%
Federal Funds	996,344,645	1,036,058,888	1,075,497,784	1,149,346,024	6.87%

	FY 2005-06 Actual	FY 2006-07 Actual	FY 2007-08 Appropriation	FY 2008-09 Request	Change Req. #
(3) Medicaid Mental Health Community Programs					
(Primary Functions: Mental health programs for Medicaid eligible clients.)					
Mental Health Capitation for Medicaid Clients	**164,839,222**	**184,640,568**	**196,303,651**	**208,837,395**	DI #2, DI #3A, T #3
General Fund	82,328,858	89,832,730	91,315,646	95,906,937	
Cash Funds Exempt	85,498	2,481,026	6,829,511	8,503,229	
Federal Funds	82,424,866	92,326,812	98,158,494	104,427,229	
Medicaid Mental Health Fee for Service Payments	**1,231,390**	**1,367,867**	**1,489,003**	**1,323,040**	DI #2
General Fund	615,695	683,934	744,502	661,520	
Federal Funds	615,695	683,933	744,501	661,520	
Medicaid Anti-Psychotic Pharmaceuticals	**27,105,418**	**34,294,729**	**32,321,595**	**0**	DI #2
Cash Funds Exempt	27,105,418	34,294,729	32,321,595	0	
					Request vs. Appropriation
SUBTOTAL -- Medicaid Mental Health Community Programs	**193,176,030**	**220,303,164**	**230,114,249**	**210,160,435**	**-8.67%**
General Fund	82,944,553	90,516,664	92,060,148	96,568,457	4.90%
Cash Funds Exempt	27,190,916	36,775,755	39,151,106	8,503,229	-78.28%
Federal Funds	83,040,561	93,010,745	98,902,995	105,088,749	6.25%
(4) Indigent Care Program					
(Primary functions: Provides assistance to hospitals and clinics serving a disproportionate share of uninsured or underinsured populations, provides health insurance to qualifying children a pregnant women who are ineligible for Medicaid, and provides grants to providers to improve access to primary and preventive care for the indigent population.					
Safety Net Provider Payments	**287,296,074**	**279,933,040**	**296,188,630**	**296,188,630**	
General Fund	12,576,646	13,090,782	13,090,782	13,090,782	
Cash Funds Exempt	131,071,391	126,875,738	135,003,533	135,003,533	
Federal Funds	143,648,037	139,966,520	148,094,315	148,094,315	

	FY 2005-06 Actual	FY 2006-07 Actual	FY 2007-08 Appropriation	FY 2008-09 Request	Change Req. #
Colorado Health Care Services Fund	**14,962,408**	**0**	**15,000,000**	**15,000,000**	
General Fund	14,962,408	0	15,000,000	15,000,000	
The Children's Hospital, Clinic Based Indigent Care	**6,119,760**	**16,180,483**	**16,205,760**	**16,205,760**	
General Fund	3,059,880	3,059,880	3,059,880	3,059,880	
Cash Funds Exempt	0	10,060,723	10,086,000	10,086,000	
Federal Funds	3,059,880	3,059,880	3,059,880	3,059,880	
Health Services Fund Programs	**0**	**4,901,685**	**4,914,000**	**4,914,000**	
Cash Funds Exempt	0	4,901,685	4,914,000	4,914,000	
Pediatric Speciality Hospital	**5,452,134**	**7,732,072**	**8,499,289**	**8,728,000**	T #3, #8
General Fund	2,726,067	3,350,000	3,551,000	3,551,000	
Cash Funds Exempt	0	516,036	684,289	913,000	
Federal Funds	2,726,067	3,866,036	4,264,000	4,264,000	
General Fund Appropriation to Pediatric Speciality Hospital	**0**	**516,036**	**513,000**	**486,600**	T #8
General Fund Exempt	0	516,036	513,000	486,600	
Appropriation from Tobacco Tax Fund to General Fund	**0**	**1,032,072**	**513,000**	**486,600**	T #8
Cash Funds Exempt	0	1,032,072	513,000	486,600	
Primary Care Fund	**44,041,879**	**31,980,929**	**32,365,298**	**30,818,000**	T #1, 8
FTE	1.0	0	0.0	0.0	
Cash Funds	(163)	0	0	0	
Cash Funds Exempt	44,042,042	31,980,929	32,365,298	30,818,000	
Children's Basic Health Plan Trust	**29,431,057**	**11,475,351**	**256,475**	**3,269,576**	DI #3, DI #3A
General Fund	2,000,000	11,243,215	11,011	2,921,400	T #3
Cash Funds	191,726	232,136	245,464	348,176	
Cash Funds Exempt	27,239,331	0	0	0	

	FY 2005-06 Actual	FY 2006-07 Actual	FY 2007-08 Appropriation	FY 2008-09 Request	Change Req. #
Children's Basic Health Plan Administration	**5,273,572**	**5,507,031**	**5,541,590**	**6,936,590**	DI #3A
Cash Funds Exempt	747,996	2,459,420	2,474,735	3,010,621	T #3
Federal Funds	4,525,576	3,047,611	3,066,855	3,925,969	
Children's Basic Health Plan Premium Costs (Children & Pregnant Adults)	**65,919,891**	**89,657,433**	**86,426,598**	**132,595,075**	DI #3, DI #3A
Cash Funds	0	0	1,479	0	T #3
Cash Funds Exempt	23,426,139	31,530,990	30,408,342	46,634,590	
Federal Funds	42,493,752	58,126,443	56,016,777	85,960,485	
Children's Basic Health Plan Dental Costs	**5,368,921**	**6,834,843**	**6,886,799**	**11,374,223**	DI #3, DI #3A
Cash Funds Exempt	1,879,122	2,392,195	2,410,380	3,980,978	T #3
Federal Funds	3,489,799	4,442,648	4,476,419	7,393,245	
Comprehensive Primary and Preventive Care Fund	**2,604,927**	**0**	**0**	**0**	
Cash Funds Exempt	2,604,927	0	0	0	
Comprehensive Primary and Preventive Care Grants	**2,604,927**	**2,310,510**	**4,138,070**	**5,997,000**	T #3
Cash Funds Exempt	2,604,927	2,310,510	4,138,070	5,997,000	
					Request vs. Appropriation
SUBTOTAL -- Indigent Care Program	**469,075,550**	**458,061,485**	**477,448,509**	**533,000,054**	**11.64%**
FTE	1.0	0.0	0.0	0.0	
General Fund	35,325,001	30,743,877	34,712,673	37,623,062	8.38%
General Fund Exempt	0	516,036	513,000	486,600	-5.15%
Cash Funds	191,563	232,136	246,943	348,176	40.99%
Cash Funds Exempt	233,615,875	214,060,298	222,997,647	241,844,322	8.45%
Federal Funds	199,943,111	212,509,138	218,978,246	252,697,894	15.40%

	FY 2005-06 Actual	FY 2006-07 Actual	FY 2007-08 Appropriation	FY 2008-09 Request	Change Req. #
(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 division also funds Medicai for school-based services and the primary care physician incentive).					
Home Care Allowance	**9,967,297**	**0**	**0**	**0**	
General Fund	9,492,664	0	0	0	
Cash Funds Exempt	474,633	0	0	0	
Adult Foster Care	**82,029**	**0**	**0**	**0**	
General Fund	78,123	0	0	0	
Cash Funds Exempt	3,906	0	0	0	
Old Age Pension State Medical Program	**14,426,967**	**12,578,662**	**13,293,672**	**13,181,483**	T #1, 3
Cash Funds Exempt	14,426,967	12,578,662	13,293,672	13,181,483	
Tobacco Tax Transfer from General Fund to the Old Age Pension State Medical Program	**0**	**2,580,179**	**2,500,500**	**2,433,000**	T #8
Cash Funds Exempt	0	2,580,179	2,500,500	2,433,000	
University of Colorado Family Medicine Residency Training	**1,576,502**	**1,703,558**	**1,903,558**	**2,173,558**	NPI #2
General Fund	788,251	851,779	951,779	1,086,779	
Federal Funds	788,251	851,779	951,779	1,086,779	
Enhanced Prenatal Care Training and Technical Assistance	**102,338**	**102,155**	**108,999**	**117,411**	T #1
General Fund	51,169	51,078	54,500	58,706	
Federal Funds	51,169	51,077	54,499	58,705	
Nurse Home Visitor Program	**2,419,685**	**2,621,943**	**3,010,000**	**3,010,000**	
Cash Funds Exempt	1,209,843	1,310,972	1,505,000	1,505,000	
Federal Funds	1,209,842	1,310,971	1,505,000	1,505,000	

	FY 2005-06 Actual	FY 2006-07 Actual	FY 2007-08 Appropriation	FY 2008-09 Request	Change Req. #
Public School Health Services	**18,646,352**	**21,049,585**	**31,327,813**	**31,322,948**	T #1
Cash Funds Exempt	9,249,432	10,472,200	16,007,021	16,007,021	
Federal Funds	9,396,920	10,577,385	15,320,792	15,315,927	
Colorado Autism Treatment Fund	**32,093**	**0**	**0**	**0**	
Cash Funds Exempt	32,093	0	0	0	
Medicare Modernization Act of 2003 Maintenance of Effort Payment	**31,461,626**	**72,494,301**	**69,546,453**	**79,574,457**	DI #4, T #3
General Fund	31,461,626	72,494,301	69,546,453	79,574,457	
					Request vs. Appropriation
SUBTOTAL -- Other Medical Programs	**78,714,889**	**113,130,383**	**121,690,995**	**131,812,857**	**8.32%**
General Fund	41,871,833	73,397,158	70,552,732	80,719,942	14.41%
General Fund Exempt	0	0	0	0	n/a
Cash Funds	0	0	0	0	n/a
Cash Funds Exempt	25,396,874	26,942,013	33,306,193	33,126,504	-0.54%
Federal Funds	11,446,182	12,791,212	17,832,070	17,966,411	0.75%

(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 Department are 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.

					Request vs. Appropriation
SUBTOTAL -- DHS Medicaid Programs	**429,305,626**	**333,128,748**	**401,713,130**	**421,927,599**	**5.03%**
General Fund	202,571,252	159,238,552	197,243,555	206,952,005	4.92%
General Fund Exempt	0	0	0	0	n/a
Cash Funds	0	0	0	0	n/a
Cash Funds Exempt	9,165,181	6,931,705	3,824,675	4,194,918	n/a
Federal Funds	217,569,193	166,958,491	200,644,900	210,780,676	5.05%

	FY 2005-06 Actual	FY 2006-07 Actual	FY 2007-08 Appropriation	FY 2008-09 Request	Change Req. #
					Request vs. Appropriation
TOTAL -- Department of Health Care Policy and Financing (with DHS programs)	**3,228,221,574**	**3,285,678,248**	**3,476,189,586**	**3,689,785,301**	**6.14%**
FTE	**195.35**	**225.36**	**245.30**	**266.80**	8.76%
General Fund	998,912,252	1,019,917,138	1,079,962,449	1,182,072,730	9.45%
General Fund Exempt	361,645,084	343,616,036	344,413,000	344,386,600	-0.01%
Cash Funds	568,269	511,526	2,966,076	4,694,158	58.26%
Cash Funds Exempt	320,320,549	339,755,328	381,570,811	369,491,780	-3.17%
Federal Funds	1,546,775,420	1,581,878,220	1,667,277,250	1,789,140,033	7.31%

Note: The General Fund and General Fund Exempt percent change together equals 7.2%.

					Request vs. Appropriation
TOTAL -- Department of Health Care Policy and Financing (w/o DHS divisions)	**2,798,915,948**	**2,952,549,500**	**3,074,476,456**	**3,267,857,702**	**6.29%**
FTE	**194.35**	**225.36**	**245.30**	266.80	8.76%
General Fund	796,341,000	860,678,586	882,718,894	975,120,725	10.47%
General Fund Exempt	361,645,084	343,616,036	344,413,000	344,386,600	-0.01%
Cash Funds	568,269	511,526	2,966,076	4,694,158	58.26%
Cash Funds Exempt	311,155,368	332,823,623	377,746,136	365,296,862	-3.30%
Federal Funds	1,329,206,227	1,414,919,729	1,466,632,350	1,578,359,357	7.62%

Note: The General Fund and General Fund Exempt percent change together equals 7.5% (this excludes the DHS Medicaid Funded programs)

FY 2008-09 Joint Budget Committee Staff Budget Briefing
Department of Health Care Policy and Financing
2007 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 2007-08 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 13 of the 19 footnotes. However, the vetoes were overridden by the General Assembly.

4 **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.

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.

5 **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 2007-08. 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: *The Governor vetoed this footnote on May 2, 2007 stating the following reasons: (1) the footnote violates the separation of powers in Article III of the Colorado Constitution by attempting to administer the appropriation; (2) the footnote is substantive legislation; (3) this footnote requires a substantial dedication of resources and constitutes an unfunded mandate. After the General Assembly overrode all Long Bill vetoes, the Department was directed to comply to the extent that this request can be adhered to without adversely impacting the operation of the delivery of government services, pursuant to the August 16, 2007 letter from the director of the Office of State Planning and Budgeting to the leadership of the General Assembly. The Department did not provide a report.*

As the Committee is aware, approximately 48.0 percent of the Department's appropriated funds are from federal monies distributed according to Title XIX (Medicaid) and Title XXI (State Children's Health Insurance Plans) of the U.S. Social Security Act. Because these federal funds are matching funds to the state's costs for these programs, these federal funds are appropriated and reported in the Department's budget as well as any FTE associated with

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

21 **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 Governor vetoed this footnote on May 2, 2007 stating the following reasons: (1) the footnote violates the separation of powers in Article III of the Colorado Constitution by attempting to administer the appropriation and (2) the footnote is substantive legislation. The General Assembly overrode this veto and the Department has complied with the footnote and has submitted these reports on a monthly basis.*

A version of this footnote was first included in H.B.02-1420 (footnote #39) and has been included in every Long Bill since. In H.B. 02-1420, S.B. 03-258, S.B. 04-1422, S.B. 05-209, and H.B. 06-1385 this footnote was not vetoed by the Governor. Therefore, Governor Ritter's veto of this footnote represented the first time that the Governor's Office believed this footnote violated the separation of powers or was substantive legislation.

The reason this footnote has been included in the Long Bill for the last six years is to ensure that the Joint Budget Committee is kept informed regarding the trend in Medicaid and CBHP spending and caseloads. This footnote report is essential in helping JBC staff build and maintain forecast models as well as monitor the current year appropriation for any possible reversions or over-expenditures. In addition, this footnote report is usually posted on the Department's website and allows other interested parties to track and comment on Medicaid and CBHP caseload and expenditures for their different endeavors.

When Alexis Senger, former JBC analyst, recommended that this footnote be included in the 2002 Long Bill, she stated:

"Economic downturns drive Medicaid caseload and expenditures. The General Assembly is only informed of Medicaid changes at only three times during the year (November 1, January 1, February 15) and information transmission to the General Assembly has become more challenging in recent years.

In 1992, monthly Medicaid caseload and expenditure reporting was initiated by the Joint Budget Committee in order to track Medicaid expenditures. This monthly reporting, which was provided to the JBC and to the State Auditor’s Office, was eliminated by the Department while it moved to its new Medicaid Management

Information System (MMIS) with Consultec/ACS. Such monthly reporting has not been reinstated.

Staff recommends that the JBC request reinstatement of the Department monthly caseload and expenditure reporting on Medical Services Premiums implemented by the JBC during1992 over expenditures." (JBC Staff Briefing, HCP, December 12, 2001, page 94).

Staff brings this point up to demonstrate that the Department did not always submit this information to the JBC and it was only with the reinstatement of the footnote requesting these reports that the Department began submitting them again. While the Department has complied with this footnote request and has worked with staff to make sure the format and content of the reports are sufficient, staff is concerned that this footnote was vetoed in the first place for the following reasons:

(1) Staff disagrees that monitoring expenditures and caseload is administering the appropriation. Monthly reports only provide expenditure and caseload information for the past month. These reports are only useful as a tool to monitor appropriations and to build forecast models.

(2) Staff disagrees that forwarding a report that management in the Department receives is substantive legislation. This footnote does not create a new program, a new service, or a new responsibility for Department staff. It simply requires that the Joint Budget Committee and General Assembly, who have the ultimate responsibility for appropriating the Department's funding, be copied on a standard management report that the Department currently produces.

Because staff feels very strongly that the information in these reports are essential to the JBC's work, the JBC may want to consider making these reports a statutory requirement rather than a session law requirement in the annual Long Bill. For example, in Arizona, the Medicaid agency has a statutory requirement to submit the following information monthly: (1) actual year-to-date expenditures (all of the Department's programs and line items) and projected annual expenditures; (2) actual member months by rate code; (3) actual caseload for Medicaid and dual eligibles; (4) number of vacant positions by division; (5) monies recovered monthly from third party payers; (6) the amount and origin of any donation or grant from a private entity and impact to the implementation of the program; and (7) cost savings that result from interagency agreements for information systems. Section 36-2920 & 36-2994, A.R.S. (2007).

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

1. Please explain why the Governor vetoed footnote 21 this year when footnotes similar to this footnote were not vetoed in previous years (2002, 2003, 2004, 2005, and 2006)? (P.S. we have read the Governor's veto letter, please help the JBC understand why all of a sudden this footnote became "administering the appropriation" and "substantive legislation"). Does the Department have suggested language that would still meet the JBC's need to receive this information and not cause a Governor's veto?

2. Would the Department rather see a statute requiring the Department to submit this information (and perhaps more information) to Joint Budget Committee in the future? Please describe any difficulties that the Department would have in producing monthly reports with the following information:

Caseload Reporting

a) Medicaid caseload by aid category (JBC gets this now);
b) Medicaid caseload enrolled in MCOs by aid category (JBC gets this now);
c) Medicaid caseload by aid category for each BHO (not required, but submitted);
d) Medicaid caseload enrolled in an HCBS waiver program (new);
e) Medicaid caseload qualified for Long-Term Care programs broken-out by HCBS, nursing homes, and PACE (new);
f) Medicaid caseload that are dual eligibles (new);
g) Children's Basic Health Plan by aid category (JBC gets this now);
h) Old Age Pension Medical Program caseload (new);

Expenditures

i) Medicaid Medical Services Premiums year-to-date expenditures by service category (get this now) and projected annual expenditures for the fiscal year (new);
j) Medicaid Medical Services Premiums monthly expenditures by aid category and service category (new);
k) Medicaid Mental Health Capitation year-to-date expenditures and projected annual expenditures for the fiscal year (new);
l) Children's Basic Health Plan monthly expenditures (JBC gets this now);
m) Medicare Modernization's Act State Contribution Payment monthly expenditures (new);
n) Old Age Pension Medical Program expenditures (new);

Other

o) Personal Services expenditures and filled and vacant positions (new);
p) Amount of third party recoveries (new); and
q) Monthly expenditures for all other Department line items (new).

Staff also recommends either: (1) keeping this footnote in future Long Bills with the addition of asking for mental health expenditures to also be reported; or (2) considering a statutory

change to require monthly reports with all or most of the information above included (some could be left off if the Department believes it would absolutely be too burdensome to provide monthly).

22 **Department of Health Care Policy and Financing, Executive Director's Office** – The Department is requested to submit a plan to the Joint Budget Committee on or before October 1, 2007, on how to restructure the Executive Director's Office Division's line item appropriations into a more programmatic format than the current Long Bill structure.

Comment: *The Governor vetoed this footnote on May 2, 2007 stating the following reasons: (1) the footnote violates the separation of powers in Article III of the Colorado Constitution by attempting to administer the appropriation and (2) the footnote is substantive legislation. The General Assembly overrode this veto, but the Governor's OSPB office did not direct to the Department to comply. Upon further requests from staff, the Department submitted a reply to this footnote on November 7 , 2007.*

Unlike many other state departments, the Long Bill structure for the Executive Director's Office, contains all administrative funding for the Department (except for the CBHP contract administration which is still located with the other CBHP line items). This allows all administrative funding to be kept separate from funding that provides direct aid and services to clients. However, over the years, the line item structure for the Executive Director's Office has become increasing long as new administrative activities and responsibilities have been added. Currently, the Executive Director's Office Long Bill line item structure contains a total of 43 appropriation line items. Many of these line items are for individual contracts (i.e. acute care utilization review, long-term care utilization review) and rarely have appropriation adjustments. Other line items have been added for special projects that are one-time in nature and frequently change.

During figure setting this year, staff is going to recommend that the appropriation structure for the EDO Division be reorganized to better reflect the administrative duties of the Department. In doing this, staff hopes to accomplish the following objectives:

1) Reduce the number of line items to reduce administrative burdens associated with budgeting and tracking the expenditures for small dollar amounts (i.e. some line items have funding splits that result in $50 appropriations from a fund source -- this probably creates more accounting costs to track this appropriation than it saves the General Fund to do the fund split allocation);

2) Organize administrative line items so that if the state ever moves to program/performance-based budgeting funding for specific administrative activities can be identified and tied to specific goals and objectives; and

3) Reduce the number of small supplemental or decision items related to small contract price changes by consolidating some contracts in order to give the Department more flexibility in administering their appropriation. For example, in recent years the JBC has approved funding increases related to a small COLA adjustments for one auditing contract while another auditing contract line item has reverted funding.

In complying with Footnote 22, the Department provided the Committee with input on how they would like the EDO Division restructured. In the Department's plan, the EDO's current appropriation structure would be reduced from 46 lines (based on their FY 2008-09 budget request) to 30 lines items. Staff will continue to review the Department's suggested line item structure and will make a formal recommendation on this issue during the Department's figure setting presentation.

23 **Department of Health Care Policy and Financing, Executive Director's Office** -- The Department is requested to provide a report to the Joint Budget Committee by November 1, 2007 regarding the amount spent on pharmaceuticals by each managed care organization (MCO) that contracts with the Department in the Medicaid program. Included in the report should be information on the prices that each MCO pays for each prescription drug provided on its formulary. The report should compare the prices that each MCO pays compared to the prices the Department pays in the fee-for-service program for the same drug. In making such comparison, the Department should include in its pricing the amount of rebates that the Department receives from drug manufacturers for each drug. The report should also provide information on which drugs are covered on each MCO's formulary compared to the list of drugs available in the fee-for-service program.

Comment: *The Governor vetoed this footnote on May 2, 2007 citing that the footnote: (1) violates the separation of powers; (2) constitutes substantive legislation; and (3) dictates the provision of financial information from a private contractor over which neither the Department nor the State has authority. After the General Assembly overrode all Long Bill vetoes, the Department was directed to comply to the extent that this request can be adhered to without adversely impacting the operation of the delivery of government services, pursuant to the August 16, 2007 letter from the director of the Office of State Planning and Budgeting to the leadership of the General Assembly. Specifically, the Department was instructed to request this information from the MCOs and to comply with the footnote to the extent that the information is available from the MCOs.*

On November 1, 2007, the Department submitted a letter to the Joint Budget Committee in response to this footnote. The Department was able to receive the following responses from the two MCOs with contracts in the Medicaid medical Program: (1) Denver Health and Hospital Authority spent $10,304,159 for pharmaceuticals under it Medicaid managed care program for FY 2006-07. This represented 12.7 percent of the total payments paid to Denver Health. (2) Rocky Mountain Health Plans spent $16,012,946 for pharmaceuticals under its Medicaid managed care program for FY 2006-07. This represented 44.6 percent of the total

payments paid to Rocky Mountain Health Plan. To put these costs into context, in the fee-for-service program, pharmaceutical costs (adjusted by the drug rebates) were $131,188,645 in the fee-for-service program in FY 2006-07 (or 12.0 percent of the total Acute care costs excluding MCO payments).

In their letter, the Department stated that they do not currently have the resources available to compare the prices of all the drugs each MCO covers to the prices the Department pays in the Medicaid fee-for-service program. In their letter, the Department indicated that they believe they would need an appropriation of at least $11,730 to complete such a study. Because this activity was not funded in their current appropriation, the Department did not attempt to answer this part of the footnote request. In addition, the Department believes compiling this price list would require a substantial amount of work from the MCOs which is also not a covered cost within their contracts.

As part of their report, the Department restated their current reimbursement methodologies for pharmaceutical drugs for the fee-for-service program, with the lowest price being used:

-- Average wholesale price (AWP) minus 13.5% for brand name drugs;
-- Average wholesale price (AWP) minus 35% for generic drugs;
-- Direct price plus 18%
-- State Maximum Allowable Cost (M.A.C.), pharmacy acquisition cost of generic drugs available in the state marketplace plus 18%;
-- Federal Upper Limit (FUL).

In addition, the Medicaid fee-for-service program pays a dispensing fee as follows:

-- $4.00 for retail pharmacies;
-- $1.89 for institutional pharmacies;
-- Government pharmacies that have the cost of dispensing covered as part of an all-inclusive Medicaid payment receive no fee;
-- Dispensing physicians whose office or sites of practice are located more than 25 miles from the nearest participating pharmacy receive a fee of $1.89.

The Medicaid fee-for-service program also receives rebates that range from 22.3 percent to 30.9 percent.

The Department's report did not contain reimbursement methodologies used by the MCOs. The Department's report also did not contain a comparison of drugs that are excluded or require a prior authorization compared to drugs that the MCOs may or may not cover in their formulary.

Please note, this footnote was added during the debate on the Long Bill last year. The footnote arose out of questions on whether or not MCOs (1) do not receive the best

manufacturer price for drugs because they do not qualify for the manufacturer drug rebate and (2) do not reimburse pharmacies adequately. The information in the Department's response does not answer these concerns. Please see the staff issue on prescription drugs for more discussion on this issue.

24 **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 final analysis by November 1, 2007. The Department's appropriation contains$19,334 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: *The Governor vetoed this footnote on May 2, 2007 for the following reasons: (1) violated the separation of powers by attempting to administer the appropriation, and (2) constituted substantive legislation. The General Assembly overrode this veto and the Governor instructed the Department to comply with the footnote requirements.*

This footnote was originally added to the FY 2006-07 Long Bill (H.B. 06-1385) and was continued in the FY 2007-08 Long Bill (S.B. 07-239) in order to complete the study. A total of $77,400 was appropriated to fund this study (over two years). The Department contracted with Navigant Consulting for the purpose of conducting an analysis of existing Medicaid rates for physician and other acute care services to identify areas of rate disparities and shortfalls. The contract with Navigant Consulting also included facilitating the Primary Care Provider Rate Task Force in review and analyzes of the rate disparities and shortfalls identified in the data analysis, coordinate discussion among the task force members and summarize the recommendations in the final report.

Key findings from the report that staff would like to emphasize for the Committee included:

1) There are pronounced differences in fees among the different types of CPT codes. For example, fees for medical, surgical and diagnostic services and procedures; durable medical equipment; orthotics; prosthetics and medical supples billed with Healthcare Common Procedure Coding System codes are approximately 76 percent of Medicare fees; while fees for surgery and radiology codes are 45 percent and 23 percent, respectively, of Medicare fees.

2) A 2004 study of United States Medicaid reimbursement for SFY 2003 found that State Medicaid departments paid, on average, 69 percent of Medicare for all services. For primary care, the percentage of Medicare reimbursement was 62 percent, and for obstetrical care, the percentage of Medicare was 84 percent. The Medicaid reimbursement for Colorado exceeded the national average: the State paid 74 percent

of Medicare for all services, with 68 percent and 86 percent for primary care and obstetric care, respectively.[1]

The Task Force made the following recommendations:

1) Increase Medicaid fees for physicians and other practitioners to levels that approximate commercial insurance payments.

2) Implement Medicare's Resource-Based Relative Value System (RBRVS) for physician and other practitioner services but that any conversion factor be calculated to yield an amount that approximates commercial payment levels.

3) Implement fee schedules for durable medical equipment and injected drugs that is based on the Medicare methodology.

Please note that the cost to the state for increasing Medicaid rates to commercial payment levels was estimated by Navigant Consulting to be more than **$174 million** in State matching funds (over $347 million total). Despite this cost and the Department's staff request that the Task Force consider incremental rate changes that would not have such a large impact, the Task Force "ultimately decided to recommend the increase to commercial payment levels because the increase represented the optimal level of reimbursement, and the Task Force wanted the Colorado Legislature to understand the true financial needs of the provider community. The Task Force did not want to suggest to the Colorado Legislature an increase in fees to levels that would be less than Medicare rates, or moreover, than commercial insurance rates, would be adequate to enroll additional Medicaid providers or retain existing providers to assure access." (Colorado Provider Rate Task Force, Medicaid Physician and Other Practitioners Reimbursement Analysis, page 18). To put the $174 million into perspective, that represent 2.4 percent of the total General Fund appropriated for all of state government in FY 2007-08. For the provider rates considered, this funding increase would represent an increase in expenditures of over 116 percent for these rate codes (not taking into account caseload and utilization changes since SFY 2006). Please remember this study was only looking at physician and other acute care provider rates -- it does not include inpatient hospital, outpatient, FQHCs, prescription drugs, HMOs, nursing homes, and other home-and-community based services.

While staff appreciates the Task Force's sincere desire to emphasize the inadequacy of certain Medicaid rates, their approach and recommendations are unrealistic for the budgetary environment that Colorado exists under and therefore, can not be implemented. Therefore,

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[1]Stephen Zuckerman, Joshua McFeeters, Peter Cunningham and Len Nichols, "Changes in Medicaid Physician Fees, 1998-2003." Health Affairs (June 23, 2004), pp. 374-384. Cited in the Colorado Provider Rate Task Force, Recommendations Regarding Medicaid Physician and Other Practitioner Reimbursement, September 26, 2007, p. 7.

staff is disappointed in the final output from this study because it doesn't help the JBC implement a more rationale approach to address the worst rate disparities in the Medicaid program (please note last year's rate increases tried to identify and solve some of these problems). However, the report did address some issues that are worth pursuing with the Department and staff recommends that the Committee ask the Department to respond to the following questions at their hearing:

1) What obstacles exist to implementing a physician fee schedule that is based on the Medicare Resource-Based Relative Value Scale system in a cost-neutral manner (i.e. all Medicaid rates would remain at the same percentage of Medicare rates as they are now but we would use the Medicare methodology to set the rate and then use a multiplication factor (i.e. 23 percent, 85 percent, etc. of the Medicare rate) to ensure budget neutrality). This question is attempting to understand the obstacles involved in establishing a more ration, albeit inadequate, rate methodology in order to address the Task Force's observation that "the current fee schedule does not have a rational basis and Medicaid should consider RVU alternatives" (Colorado Provider Rate Task Force, Medicaid Physician and Other Practitioners Reimbursement Analysis, page 12).

2) While the study indicated that Arizona, Idaho, Nebraska, and Wyoming have rates that are a higher percentage of the Medicare rate (sometimes exceeding them) than are the Colorado rates, how does Colorado's per capita costs for acute care services per aid group (i.e. children, pregnant women, etc.) compare to these states?

3) What is the cost to implement the Task Force's recommendations to move durable medical equipment and drugs that are not self-administered based on the Medicare fee schedule?

4) What is the cost to make sure that no acute care provider rate (including in-patient hospitals) fall lower than that the current percent the Medicare rate for the same service for FY 2008-09?

5) Would it be possible to include a special "incentive payment or grant program" for any acute care provider whose practice exceeded more than 30, 40, 50, 60 percent Medicaid (similar to what we do for Children's Hospital in the Indigent Care division) -- i.e. a high volumn Medicaid practice adjustment to reimbursement rates?

Please note that question 5 above is trying to address a very serious problem that staff sees in Medicaid reimbursement rate. Over 1/3 of all births in Colorado are funded by Medicaid and CBHP and approximately 1 in 5 to 6 children are enrolled in Medicaid and CBHP. This represents a large market share for obstetricians and pediatricians. While it is unrealistic to assume that Medicaid rates will exceed Medicare rates or equal private insurance rates, it may be possible to give some relief to providers who have practices with an extraordinary

amount of clientele with Medicaid insurance without the ability to cost-shift some of the practices costs to private payers.

Please see the staff issue on provider rate increases included in this year's budget for additional information on provider rates.

25 **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 2007-08 to the Joint Budget Committee by July 25, 2007. The Department is requested to include in the report a copy of each managed care organization's certification that the reimbursement rates are sufficient to assure the financial stability of the managed care organization with respect to delivery of services to the Medicaid recipients covered in their contract pursuant to Section 25.5-5-403 (1) (l), C.R.S.

Comment: *This footnote or a similar version of it has been included in the Long Bill for the last five years and the Governor has typically vetoed this footnote each year stating that the footnote: (1) violates the separation of powers by attempting to administer the approach; and (2) constitutes substantive legislation. However, each year the Governor's veto letter has directed the Department to comply and the Department has submitted the requested information (although this year delays in setting the rates led to the report being sent later than the requested date). Again, staff does not believe requesting public information to be forward to the JBC administers the appropriation or is substantive legislation. This footnote merely provides JBC with information regarding the final rates that are negotiated with MCOs and BHOs for the current fiscal year. If this footnote continues to be objectionable, the JBC may want to add a statutory requirement for the Department to submit this information* ***(although staff does not recommend this at this time unless the Department stops submitting the information).***

Capitation Program for the Medicaid Medical Program

Colorado law requires that capitation rates for the Medicaid medical program be rebased every three years and in years were the base is not recalculated, the Department shall annually trend the base calculation after consulting with the MCOs (Section 25.5-5-408(8), C.R.S. (2007)). In addition, MCOs are required to certify that proposed rates are sufficient to assure the financial stability of the MCO for the contract year (Section 25.5-5-404 (k), C.R.S. (2007)). Furthermore, federal rules and regulations (42 CFR 438.6 c) require that proposed capitation rates be actuarially sound. In order to comply with both federal and state law, the Department contracts with Deloitte Consulting LLP to review the proposed capitation rates and their development, and to certify that they are actuarially sound. For FY 2007-08, the capitation rates were trended forward from the rebased rates from FY 2006-07. Therefore, the rates developed for FY 2007-08 made the following adjustments to the FY 2006-07 rates:

- ✓ The existing base rates were trended forwarded based on projected FY 2007-08 utilization and cost trends;

- ✓ Policy changes that occurred since the base rate were established are applied (i.e. provider rate increases, new populations, etc.);

- ✓ Rates are adjusted for anticipated case mix indices; and

- ✓ Durational adjustments are updated.

. For the purpose of seeking rate approval from the Centers for Medicare and Medicaid Services (CMS), Deloitte Consulting develops a rate range that meets the actuarially sound criteria. The lower bound of the range represents an amount commensurate with what a very efficient MCO, with typical utilization and administrative levels, could achieve without denying medically necessary services. The upper bound represents the least amount of efficiency a state may be willing to purchase. Deloitte Consulting develops the upper bond without regards to Colorado's Upper Payment Limit (UPL) established in statute. Last year, in H.B. 07-1346, the General Assembly changed the state UPL from not to exceed 95 percent of fee-for-service to not to exceed 100 percent of fee-for-service costs. The following table shows the actuarially sound rate range developed by Deloitte Consulting, the state's UPL, and the rates certified by Denver Health for FY 2007-08.

Table 1: Denver Health FY 2007-08 Medical Capitation Rates

	Deloitte Certified Capitation Rates in accordance with (42 CFR 438.6 c)		State Statute Maximum	Denver Health Certification
Aid Category	**Minimum Allowed**	**Maximum Allowed**	**100% FFS**	**Contract**
AFDC-Adults Female	$184.68	$210.65	$193.38	$191.44
AFDC-Adults Male	$153.84	$182.09	$170.86	$169.15
Baby Care Adults	$183.01	$207.27	$190.41	$188.50
Children	$58.49	$64.53	$61.13	$60.52
Children - Infants	$187.71	$206.60	$201.82	$199.80
Foster Care Children	$205.94	$234.49	$224.42	$222.18
SSI 65+ Non-Institutional	$221.54	$256.50	$244.16	$241.72
SSI 65+ Institution	$186.83	$227.89	$226.10	$223.84
SSI Disable, Non-Institutional Medicaid Only	$681.67	$788.79	$764.21	$756.56
SSI Disabled, Non-Institutional Third Party Liability	$182.52	$211.94	$196.26	$194.30

Table 1: Denver Health FY 2007-08 Medical Capitation Rates				
	Deloitte Certified Capitation Rates in accordance with (42 CFR 438.6 c)		State Statute Maximum	Denver Health Certification
Aid Category	Minimum Allowed	Maximum Allowed	100% FFS	Contract
SSI Disabled, Institutional, Medicaid Only	$1,451.87	$1,685.89	$1,668.66	$1,651.98
SSI Disabled, Institutional, Third Party Liability	$171.88	$200.96	$191.47	$189.55
Delivery	$4,837.32	$5,036.81	$4,936.07	$4,886.71

Please note the rates agreed to by Denver Health are slightly under what was estimated by the Department to be the state's UPL for the rate. In addition, the number of aid categories were consolidated this year to eliminate small rate cells or rate categories where statistical analysis showed that was not a material difference in costs (i.e. for example baby-care children and regular low-income children were combined, all SSI disabled under 65 were combined, etc.).

Capitation Program for the Medicaid Mental Health Program

Footnote 25 also provides information about the capitation rates in effect for the Medicaid Mental Health Capitation Program. Rates of the Mental Health capitation program are certified by PricewaterhouseCoopers LLP. The rates for the Mental Health program are certified for the period of July 1, 2007 through June 30, 2008 and from July 1, 2008 through December 31, 2008 (capitation rates for this program are moving to a calendar year basis rather than a state fiscal year basis).

Capitation rate ranges are different for each eligible aid category as well as for each of the five Behavioral Health Organizations (BHOs). The capitation rate ranges must be based on the costs of doing services required by the state plan which include: inpatient hospital, under 21 psychiatric; 65 and over psychiatric; outpatient care; psychiatrist care; rehabilitation; medication management; emergency care; school-based services; psycho-social rehabilitation services; and clinic services/case management. However, the managed care contracts with HCPF, under which the BHOs operate allows the BHOs to provide alternative services in lieu of contractually covered services if those services improve outcomes and are of comparable of better cost-effectiveness. CMS regulations prevent these services from being included in the development of actuarially sound capitation rates; separate capitation rates must be developed for these services, designated as 1915 (b) (3) services. These services include: clubhouse/drop-in centers; home-based services for children and adolescents; intensive case management; assertive community treatment, respite care; vocational services, recovery services; prevention/early intervention/specialized services for addressing adoption issues; and residential services.

The tables below show the FY 2007-08 rates and the July 1, 2008 through December 31, 2008 rates for each BHO broken down by state plan services and 1915 (b) (3) services.

Table 2a: BHO: Metro -Access Behavioral Denver -- BHO Capitation Rates						
	FY 2007-08 Rate			July 1, 2008 through December 31, 2008 Rate		
Aid Category	Total Rate	State Plan Rate	1915 (b) (3) Rate	Total Rate	State Plan Rate	1915 (b) (3) Rate
Elderly	$19.03	$16.37	$2.67	$19.74	$16.97	$2.77
Disabled	$152.72	$131.32	$21.40	$158.37	$136.18	$22.19
Adults	$11.69	$10.05	$1.64	$12.12	$10.42	$1.70
Children	$10.82	$9.30	$1.52	$11.22	$9.65	$1.57
Foster Care	$202.28	$173.94	$28.35	$209.77	$180.37	$29.40

Table 2b: BHO: Metro East -Behavioral Health Inc. -- BHO Capitation Rates						
	FY 2007-08 Rate			July 1, 2008 through December 31, 2008 Rate		
Aid Category	Total Rate	State Plan Rate	1915 (b) (3) Rate	Total Rate	State Plan Rate	1915 (b) (3) Rate
Elderly	$8.76	$5.98	$2.78	$9.08	$6.20	$2.88
Disabled	$121.78	$83.15	$38.63	$126.29	$86.23	$40.06
Adults	$16.52	$11.28	$5.24	$17.13	$11.69	$5.43
Children	$14.00	$9.56	$4.44	$14.52	$9.91	$4.61
Foster Care	$289.94	$197.97	$91.97	$300.67	$205.30	$95.37

Table 2c: BHO: Metro West -Foothills Behavioral Health -- BHO Capitation Rates						
	FY 2007-08 Rate			July 1, 2008 through December 31, 2008 Rate		
Aid Category	Total Rate	State Plan Rate	1915 (b) (3) Rate	Total Rate	State Plan Rate	1915 (b) (3) Rate
Elderly	$13.81	$6.96	$6.85	$14.32	$7.22	$7.10
Disabled	$140.06	$70.59	$69.47	$145.24	$73.20	$72.04
Adults	$22.70	$11.44	$11.26	$23.54	$11.86	$11.68

Table 2c: BHO: Metro West -Foothills Behavioral Health -- BHO Capitation Rates						
	FY 2007-08 Rate			July 1, 2008 through December 31, 2008 Rate		
Aid Category	Total Rate	State Plan Rate	1915 (b) (3) Rate	Total Rate	State Plan Rate	1915 (b) (3) Rate
Children	$18.88	$9.51	$9.36	$19.58	$9.87	$9.71
Foster Care	$259.71	$130.89	$128.82	$269.32	$135.73	$133.59

Table 2d: BHO: Northeast - Northeast Behavioral Health -- BHO Capitation Rates						
	FY 2007-08 Rate			July 1, 2008 through December 31, 2008 Rate		
Aid Category	Total Rate	State Plan Rate	1915 (b) (3) Rate	Total Rate	State Plan Rate	1915 (b) (3) Rate
Elderly	$7.86	$6.56	$1.30	$8.15	$6.80	$1.35
Disabled	$82.30	$68.67	$13.64	$85.35	$71.21	$14.14
Adults	$15.70	$13.10	$2.60	$16.28	$13.59	$2.70
Children	$11.83	$9.87	$1.96	$12.27	$10.24	$2.03
Foster Care	$216.37	$180.52	$35.85	$224.38	$187.20	$37.18

Table 2e: BHO: Western/Southern - Colorado Health Partnership -- BHO Capitation Rates						
	FY 2007-08 Rate			July 1, 2008 through December 31, 2008 Rate		
Aid Category	Total Rate	State Plan Rate	1915 (b) (3) Rate	Total Rate	State Plan Rate	1915 (b) (3) Rate
Elderly	$13.98	$10.03	$3.95	$14.50	$10.40	$4.10
Disabled	$92.03	$66.02	$26.01	$95.44	$68.47	$26.97
Adults	$19.57	$14.07	$5.53	$20.30	$14.56	$5.74
Children	$14.80	$10.62	$4.18	$15.34	$11.01	$4.34
Foster Care	$292.52	$209.86	$82.67	$303.35	$217.62	$85.73

Please see the issue on the Medicaid Mental Health Capitation program for more information about the BHO capitation costs.

Please note that the Department's response to footnote 25 does not include a copy of a letter from Total Long Term Care certifying the rates for PACE program. Section 25.5-404 (1) (m) provides that, "An MCO providing services under the PACE program as described in section 25.5-5-412 shall certify that the capitation payments are in compliance with applicable federal and state requirements that govern said capitation payments and that the capitation payments and that the capitation payments are sufficient to assure the financial viability of the MCO with respect to the delivery of services to the PACE program participants covered in the contract". Additional information on the PACE program is discussed in the issue section of this briefing.

26 **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.

27 **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. It is the intent of the General Assembly that the Department take actions to ensure that the average appropriated rates are not exceeded.

Comment: *This footnote or a similar footnote has been included in the Long Bill since 2002. In H.B. 02-1420, S.B. 03-258, S.B. 04-1422, S.B. 05-209, and H.B. 06-1385 this footnote was not vetoed by the Governor. However, in S.B. 07-239 the Governor vetoed this note for the first time stating that it was (1) administering the appropriation and (2) substantive legislation. However, notwithstanding the veto, the Governor directed the Department to comply with footnote.*

The purpose of this footnote is to direct the Department that provider rates shall not be increased above the average appropriated rates in the Long Bill appropriation to help reduce possible supplementals related to Department actions.

While staff believes that this footnote has been useful in stating the General Assemblies intent regarding provider rates, the footnote is not essential and could be deleted from future Long Bills. In staff's opinion, this footnote is the closest to any footnote in HCPF's Long Bill that attempts to administer the appropriation.

28 **Department of Health Care Policy and Financing, Medical Services Premiums** -- The calculations for this line item include $5,081,736 total funds for a 1.5 percent reimbursement rate increase for home and community-based long-term care providers, home health, and private-duty nursing beginning in July 1, 2007. It is the intent of the General Assembly that

the Medical Services Board adopt rules to increase reimbursement rates for these provider codes consistent with this footnote. The Joint Budget Committee requests that the Department provide a report to the Joint Budget Committee by August 1, 2007, on the status of the rules adopted by the Medical Services Board regarding this reimbursement rate increase.

Comment: *On May 2, 2007, the Governor vetoed this footnote for the following reasons: (1) violates the separation of powers by administering the appropriation; (2) constitutes substantive legislation; and (3) rules changes are not necessary in order to implement these rate changes. Nevertheless, the Governor instructed the Department to comply with the footnote and General Assembly overrode the veto.*

The Department submitted a letter to the JBC on August 1, 2007 in response to this footnote informing the Committee that a 1.5 percent rate increase had been implemented for the providers mentioned in the footnote. In addition, the letter indicate that at the time implementation, the Department did not anticipate a major change from the estimate of $5,081,736 to implement these rate changes.

For informational purposes, the Department also responded on July 13, 2007 to a footnote request in H.B. 06-1385 that related to a provider rate increases that were scheduled to take place on April 1, 2007. The Department also implemented the rate increases that were indicated in H.B. 06-1385 Footnote 28.

Even though the Governor's Office typically vetoes the footnotes that the General Assembly has included in the HCPF Long Bill regarding rate increases, staff strongly recommends that such footnotes be continued whenever rate increases are provided that deviate from common policy COLAS. These footnotes allow there to be an official legislative record (including final votes) of the General Assembly's intent on these rate increases. These footnotes also allow the General Assembly as a whole, rather than just the JBC, an opportunity to debate, change, and approve the rate increases that are part of the calculation for the line item.

29 **Department of Health Care Policy and Financing, Medical Services Premiums** -- The calculations for this line item include $15,987,854 total funds for rate increases for acute care services. Included in this calculation is $4,446,001 for a 1.5 percent increase to inpatient hospital rates. The remaining $11,541,853 is for rate increases for other acute care services approved by the Joint Budget Committee based on the rate plan that the Department submitted to the Joint Budget Committee on November 1, 2006. The Joint Budget Committee requests that the Department provide a report to the Joint Budget Committee by August 1, 2007, on the status of the rules adopted by the Medical Services Board regarding these rate increases.

Comment: *On May 2, 2007, the Governor vetoed this footnote for the following reasons: (1) it violates the separation of powers by administering the appropriation; and (2) it*

constitutes substantive legislation. Nevertheless, the Governor instructed the Department to comply with the footnote and General Assembly overrode the veto.

The Department submitted a letter to the JBC on August 1, 2007 in response to this footnote informing the Committee that a 1.5 percent rate increase had been implemented for inpatient hospital providers. The Department indicated that this rate increases allows Medicaid rates to be set at approximately 91 percent of Medicare rates for inpatient hospital.

The Department also increased rates for specific providers and code sets as follows:

Provider Class	Rate Increase	Estimated Funding
Single Entry Points	20.5%	$3,852,887
Emergency Transportation	5.0%	$300,000
Anesthesia	50.0%	$3,150,000
Surgical Procedures	3.5%	$1,650,000
Physical, Occupational & Speech Therapy	9.1%	$1,000,000
Adult Immunizations	35.5%	$600,000
DME Repairs	131.0%	$500,000
Intrauterine Device	32.0%	$90,000
Corresponding HMO Increases	capitation calculation	$398,966

Again, even though the Governor has typically vetoed these footnotes, staff believes that are a useful tool for establishing the General Assembly's intent and legislative intent for whenever a rate plan deviates from a common policy COLA increase.

30 **Department of Health Care Policy and Financing, Indigent Care Program, Safety Net Provider Payments** -- The Department is requested to submit a report by February 1, 2008, to the Joint Budget Committee, estimating the disbursement to each hospital from the Safety Net Provider Payment line item for FY 2007-08.

Comment: *The Governor vetoed this footnote for the following two reasons: (1) it violates the separation of powers by attempting to administer the appropriation; and (2) is constitutes substantive legislation. Nevertheless, in the Governor's May 2, 2007 veto message, he directed the Department to comply with the footnote. For the Committee's information, this footnote was included in S.B. 05-209 and H.B. 06-1385 and were not vetoed. Staff disagrees with the Governor's veto message that requesting this information be forwarded to the JBC administers the appropriation or constitutes substantive legislation. This report merely informs the JBC of the amount of estimated payments that will be made to each provider participating in the Safety Net Provider program for the current year. The*

report is requested to be forwarded in February to make sure that all federal changes that may impact this line item are accounted for before the JBC finishes final supplementals for the current year or figure setting for the next year.

This report is due in February 2008 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, The Children's Hospital, Clinic Based Indigent Care** -- This line item includes $10,086,000 for funding for community health centers from the Health Care Services Fund pursuant to the requirements in S.B. 06-044. The Joint Budget Committee is aware that the Department may be able to enter into contracts with eligible hospitals to draw down matching federal funds for this funding. The Joint Budget Committee requests that the Department submit a report by February 1, 2008 to the Joint Budget Committee describing any federal financial participation received.

Comment: *The Governor vetoed this footnote for the following reasons: (1) it violates the separation of powers by attempting to administer the appropriation; (2) is constitutes substantive legislation; and (3) H.B. 07-1258 also requires that the Department seek federal participation if available. Nevertheless, in the Governor's May 2, 2007 veto message, he directed the Department to comply with the footnote.*

This report is due in February 2008 and will be discussed during the Figure Setting presentation for the Indigent Care Program, The Children's Hospital, Clinic Based Indigent Care line item.

32 **Department of Health Care Policy and Financing, Indigent Care Program, Health Care Services Fund Programs** -- Senate Bill 06-044 required the Department to submit a state plan amendment for federal financial participation for moneys appropriated to primary care clinic operated by a licensed or certified health care facility. Senate Bill 06-044 authorizes the Department to receive and expend all available federal moneys without a corresponding reduction in cash funds exempt spending authority from the fund if the state plan amendment is approved. The Joint Budget Committee requests that the Department submit a report by February 1, 2008 to the Joint Budget Committee on the status of the state plan amendment and on whether or not any additional federal match is available for distribution.

Comment: *The Governor vetoed this footnote for the following stated reasons: (1) it violates the separation of powers by attempting to administer the appropriation; and (2) is constitutes substantive legislation. Nevertheless, in the Governor's May 2, 2007 veto message, he directed the Department to comply with the footnote.*

This report is due in February 2008 and will be discussed during the Figure Setting presentation for the Indigent Care Program, Health Care Services Fund Programs line item.

33 **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 46,694 at an average cost of $112.68 per month; (2) expansion of the children's caseload of 7,022 at an average cost of $112.68 per month; (3) traditional adult prenatal member months of 1,428 at an average cost of $865.10 per month; and (4) expansion of the adult prenatal member months by 18,447 at an average cost of $865.10 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 is provided for informational purposes only. The footnote contains the caseload estimates and average cost per clients that were used in setting the appropriation estimate for the CBHP medical services premiums line item. If supplementals are requested or approved for the CBHP program, then this footnote would be updated to reflect whatever the most recent per capita costs and caseload estimates are for the program.

Staff anticipates that she will recommend a footnote similar to this footnote for the Medical Services Premiums program for next year's Long Bill rather than providing this descriptive information in each line item.

34 **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 $13.97 per month per child. The caseload is estimated at 79 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: This footnote is provided for informational purposes only. The footnote contains the caseload estimates and average cost per clients that were used in setting the appropriation estimate for the CBHP dental line item. If supplementals are requested or approved for the CBHP program, then this footnote would be updated to reflect whatever the most recent per capita costs and caseload estimates are for the dental program.

35 **Department of Health Care Policy and Financing, Other Medical Services, Services for Old Age Pension State Medical Program clients** -- The Department is requested to submit a report by November 1, 2007 recommending changes to the benefit structure or eligibility criteria for the Old Age Pension State Medical Program in order to stay within the current statutory appropriation limits for the program. 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: *The Governor vetoed this footnote on May 2, 2007 stating the following reasons: (1) the footnote violates the separation of powers by attempting to administer the appropriation; and (2) the footnote constitutes substantive legislation. The General*

Assembly overrode this veto and the Department complied with the footnote by submitting the requested report on November 1, 2007.

This footnote (or similar footnote) has been included in the last several Long Bills in order to keep attention on the problem that expenditures and caseloads for this program have been growing faster than available revenues. In order to address this problem, the Department and Medical Services Board over the last six years have been constantly adjusting the provider reimbursement rates in order to manage the program to the Constitutional and statutory appropriation caps.

The OAP Medical Program is a requirement under the Colorado Constitution (Article XXIV, Section 7) to provide health care services to individuals who qualify for the OAP Pension Program. For FY 2007-08 the OAP Medical Fund receives funding from four sources:

1) A $10.0 million transfer from the OAP Pension Fund to the OAP Medical Fund -- capped by the State Constitution at $10.0 million annually;

2) A $750,000 statutory required General Fund transfer from the OAP Pension Fund to the Supplemental OAP Medical Fund pursuant to Section 39-26-123 (3) (a) (IV);

3) A $2,500,500 (based on FY 2007-08 revenue estimates) transfer from the Tobacco Tax Fund to the Supplemental OAP Medical Fund pursuant to Section 24-22-117 (1) (d) (II); and

4) $723,951 that was appropriated from unused fund balance in the Supplemental OAP Medical Fund.

For FY 2007-08 the OAP program will receive revenues of $13,974,451. However, under S.B. 07-133, this program's appropriation was adjusted downward to a total of $13,293,672 to reflect moving this program to a cash-basis of accounting (which has a one-time accounting savings impact in FY 2007-08 by pushing out the payment of the accrual for as long as the program is in existence).

As discussed in the Department's footnote report, eligibility for the OAP State Medical Program and Medicaid eligibility, differ on three criteria related to age, financial resources and residency status. Individuals aged 60 (this age is set in the Constitution) and over are eligible for the OAP State Medical if they are:

1) a Colorado resident who is either a U.S. citizen or legal immigrant (no time requirement for legal immigrant);

2) uninsured (without Medicaid or Medicare coverage); and

3) have monthly income of less than $648 (76.2% of the Federal Poverty Level) and have less than $2,000 in available resources (although this does not include the cash surrender value of a life insurance policy up to $50,000).

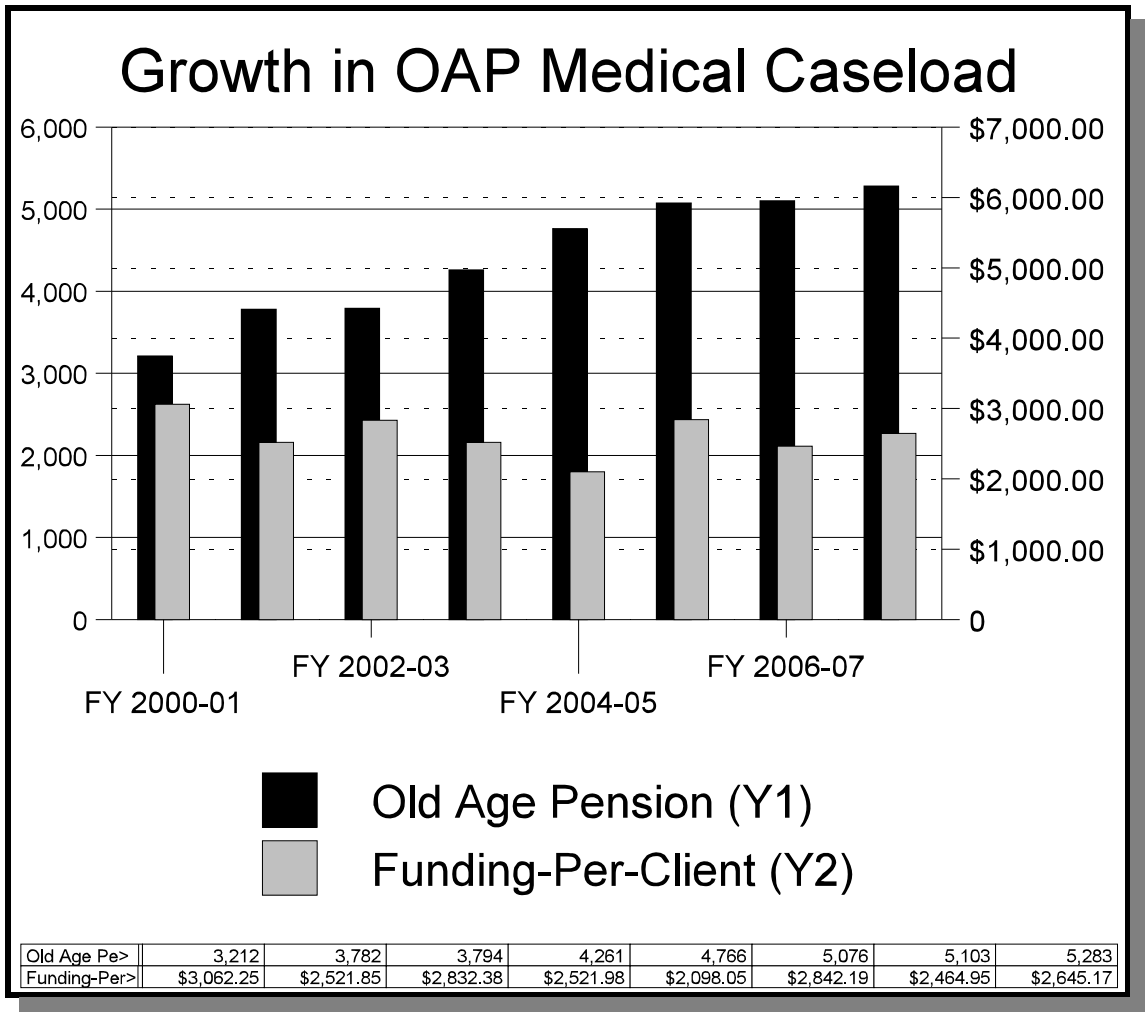
Generally, OAP State Medical Program clients are between the ages of 60 to 65 (since Medicare offers coverage after age 65 in most cases), do not meet the social security disability criteria needed to be Medicaid eligible, and have income significantly below the federal poverty level.

Because this program is not an entitlement program, the General Assembly can cap appropriations for the program. As described above, the total revenues (not appropriation) available for the program for FY 2007-08 were $13,974,451. Based on a current caseload forecast of 5,283 clients, the per-capita-cost for the program for FY 2007-08 is approximately $2,645.17 ($220.43 per month). To put this amount into perspective (but not totally comparable), low-income adults (non SSI) on Medicaid have an estimated per capita cost of $4,091.22 ($340.94) for acute care services in FY 2007-08. Table 1 below shows the actual expenditure history for this program for the last 8 years.

Table 1: OAP Medical Program Expenditure History, Current Appropriation, and FY 2008-09 Request

Fiscal Year	Expenditure/Appropriation/Request
FY 1999-00	$9,017,981
FY 2000-01	$9,835,943
FY 2001-02	$9,537,655
FY 2002-03	$10,746,065
FY 2003-04	$10,746,174
FY 2004-05	$9,999,321
FY 2005-06	$14,426,967
FY 2006-07	$12,578,662
FY 2007-08 Appropriation	$13,293,672
FY 2008-09 Dept. Request	$13,181,483

The following chart shows the caseload growth and per-capita costs for this program over the last 8 years.



Old Age Pe>	3,212	3,782	3,794	4,261	4,766	5,076	5,103	5,283
Funding-Per>	$3,062.25	$2,521.85	$2,832.38	$2,521.98	$2,098.05	$2,842.19	$2,464.95	$2,645.17

Please note that the chart above does not show the impact of S.B. 07-133 in order to provide a more accurate per-capita-cost estimate in FY 2007-08. Also, in FY 2005-06, the per capita cost estimate increased because the General Assembly appropriated unexpended fund balance in an attempt to keep the per-capita-cost from falling (this actually lead to an increase).

As the chart shows, the per-capita spending for this program is estimated to be less in FY 2007-08 ($2,645.17) than it was in FY 2000-01 ($3,113.32). In order for the Department to accommodate the caseload increase for this program within the capped appropriation limits, as stated earlier, the Department has frequently changed provider reimbursement rates. When the Department has forecasted that expenditures would exceed the current appropriation at current reimbursement rate levels, the Department has decreased rates. Conversely, when the Department has estimated that the current reimbursement rates and caseload would not use all of the available appropriation, the Department has increased rates. This strategy for managing the appropriation led to 4 different rate adjustments in calendar year 2006. Table 1 shows the recent rate changes as a percent of the Medicaid program's reimbursement rates.

Table 1: Percent of Medicaid Reimbursement Paid by the OAP Medical Program									
	Inpatient Hospital	Outpatient Hospital	Physician	E-Dental	Lab & X-ray	Medical Supply	Home Health	E-Trans.	Pharmacy
07/01/02	68.0%	82.0%	82.0%	82.0%	82.0%	82.0%	82.0%	82.0%	100.0%
01/01/04	0.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	100.0%
10/15/04	10.0%	50.0%	82.0%	50.0%	50.0%	50.0%	82.0%	82.0%	100.0%
07/15/05	10.0%	62.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
05/01/06	10.0%	53.0%	70.0%	53.0%	53.0%	53.0%	53.0%	53.0%	100.0%
07/01/06	10.0%	62.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
09/01/06	10.0%	40.0%	40.0%	40.0%	40.0%	40.0%	40.0%	40.0%	100.0%
11/01/06	10.0%	40.0%	40.0%	40.0%	40.0%	40.0%	40.0%	40.0%	70.0%
05/01/07	50.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%
07/01/07	10.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	70.0%

Source: Department's Footnote #35 Report, page 6.

Staff Recommendations

The Lewin Group (the contractor providing cost estimates for the 208 Blue Ribbon Commission on Health Care Reform) estimates that there are a total of 785,200 uninsured in Colorado. While the Old Age Pensioner clients represent only a small fraction of the total uninsured (i.e. 0.6 percent), the Old Age Pensioner clients do represent about 4.0 percent of the uninsured in the 55 to 64 age category. Because of these client's low-income status, it is most likely that any health care reform will include them in a group to receive subsidized health care insurance (either continuing through the OAP program, some successor program that covers more of the uninsured, or a state-only expansion of Medicaid). In context of the larger discussion on health care reform, staff recommends that the Committee discuss the following issues with the Department at their budget hearing:

1) If Health Care Reform goes to the ballot in 2008, what is the Administration's position on the following issues related to the Old Age Pension program:

   a) Should the Constitutional requirement for the Old Age Pension Medical Program (in place since 1957) be eliminated and this population be rolled into any future program that would provide subsidies to low-income uninsured to purchase health care insurance (or be rolled into a waiver expansion of Medicaid as a state-only population)?

   b) If the Old Age Pension Medical Program is retained, should the Constitutional limit for the program be changed from the $10.0 million cap to a more realistic amount with the ability to be adjusted upward based on caseload and medical

inflation growth? (Please note: the non-Amendment 35 revenues for this program are counted against the TABOR revenue limits but are outside the 6.0 percent appropriation limits).

2) Please provide the Joint Budget Committee with the detailed analysis for the Department's estimate that it would cost an additional $16.7 million to provide rates for the OAP Medical program at 100 percent of Medicaid rates for the same service (page 10 of the footnote report includes this estimate but without any supporting detail).

3) Please explain why this program reverted $1.6 million in FY 2006-07. Please explain why the Department's budget request for FY 2008-09 does not request using any of the available $2.4 million fund balance in the OAP Supplemental Medical Fund to increase provider rates for this program in FY 2008-09 (See page M-14 of the Department's request).

4) Does the Department anticipate that they will need to cut rates in FY 2008-09 in order to live within the requested appropriation? If so, how much of a funding increase would be necessary to make sure rates remain stable, as a percent of Medicaid rates, through FY 2008-09.

5) At the rates the Department is currently paying, what providers are participating in the program? In other words, where are the OAP Medical clients receiving care?

Staff also recommends that the Committee consider increasing the statutory diversion of $750,000 for this program (statutory change to 39-26-123 (3) (a) (IV)) for the following reasons:

1) The original diversion to the Supplemental OAP Medical Fund was $1.0 million (H.B. 02-1276) in FY 2002-03. However, beginning in FY 2003-04, this diversion was decreased to $750,000 due to the budget problems at that time (S.B. 03-299). Since FY 2003-04, the diversion has remained at $750,000.

2) This diversion is outside the 6.0 percent appropriation line item. Increasing revenues for the program may allow reimbursement to be increased for providers (hospitals and clinics) who see a disproportionate share of low-income and uninsured individuals outside the 6.0 percent limit. The Department's FY 2008-09 budget request does not include any increases for the Indigent Care Program line items (with the exception of the Pediatric Speciality line item).

3) Please note that staff's recommendation would decrease the amount of funding that would ultimately go to fund the one third / two third transfers or perhaps the S.B. 01 transfer.

36 **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 Governor vetoed this footnote on May 2, 2007 stating the following reasons: (1) the footnote violates the separation of powers by attempting to administer the appropriation; and (2) the footnote constitutes substantive legislation. Nevertheless, the Governor instructed the Department to comply with the footnote to the extent feasible. The General Assembly overrode this veto and the Department complied with the footnote by submitting the requested report on November 1, 2007.*

Under federal and state law, school districts are required to provide certain medical services for public school children. When these services are provided to Medicaid eligible students, some of the services qualify for Medicaid reimbursement. Under this program, school district expenses for these services are the state match to draw down the matching federal funding. The additional federal funding that school districts then receive are then used to expand health services for all children and to seek to expand health coverage for under or uninsured children.

In FY 2006-07, school districts received Medicaid reimbursement for providing services to 47,919 (unduplicated) Medicaid eligible children. Services for which school districts received reimbursement included: audiology, behavioral health services and evaluation; speech therapy; nursing services and evaluations; occupational therapy and evaluation; physical and motor therapies and evaluations, targeted case management, and specialized non-emergency transportation (if part of IEP).

In FY 2006-07 a total of 114 school health services program providers received Medicaid reimbursement totaling $9,995,873.

37 **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 in the last two Long Bills 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 2008-09 Joint Budget Committee Staff Budget Briefing
DEPARTMENT OF Health Care Policy and Financing
Informational Issues: Mission, Goals, and Performance Measures

ISSUE:

Last year the JBC staff discussed with the Committee each Department's mission, goals and performance measures. At that time, staff was critical of HCPF's strategic plan. This issue is to provide an update to the Committee on recent changes HCPF has adopted to their strategic plan.

DISCUSSION:

Department Mission

2006 Mission Statement:

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

2007 Mission Statement:

> The mission of the Department of Health Care Policy and Financing is to improve access to cost-effective, quality health care services for Coloradans.

Staff comment:

> The 2007 mission statement has "crept" beyond the statutory authority of the Department. The Department can only improve access to health care services for the populations that are eligible for their programs. Therefore, staff believes the 2006 mission statement's wording regarding "qualified low-income Coloradans" was more in line with current statutory authority for the Department than the current statement indicates.
>
> The 2007 mission statement indicates that the Department has a new emphasis in improving access to health care and the quality of the health care services received.

Goals and Performance Measures

The Department has completed rewritten their FY 2008-09 strategic plan, incorporating the new guidelines that were issued by OSPB in this year's budget instructions. In staff's opinion, the Department's FY 2008-09 strategic plan is a major improvement over the plan that was submitted last year. Areas where the Department has improved the plan including the following:

✓ **Performance measures are more data driven in this year's plan.** Last year staff was critical of the Department's performance measures because the measures changed every year. The Department' performance measures last year did not provide any historical basis for past performance nor did they indicate future performance targets. This year's performance measures have been written to indicate past year actuals for FY 2005-06 and FY 2006-07 as well as targeted outcomes for FY 2007-08 and FY 2008-09 (although many of the measures are new and do not have historical data available). Choosing performance measures that are more constant over time with multiple year's of data are more valuable in accessing performance than choosing new performance measures each year.

✓ **Performance measures are more relevant to policy makers and stakeholders this year than were last year's measures**. On the extreme example side, last year the Department had a performance measure that stated "the Department will hold annual Employee Appreciation meetings in a location where all staff can attend." While the Department's management should care about this issue, no stakeholder outside of Department staff would. This year the Department has written performance measures more in line with key goals of improving quality health care services for the Department's clients. For example, one of the measures in this year's plan is to ensure that customer satisfaction is in the 80th percentile for Medicaid programs. Compared to last year's plan, this year's plan does a much better job of choosing performance measures that stakeholders, policy makers, and management care about.

✓ **The Department has done a better job of choosing a variety of measures (input, output, efficiency, outcomes).** Last year's performance measures were mainly output measures related to the achievement of an administrative function (i.e. budget materials will be submitted 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, etc.). This year the Department's measures are more related to the clients served and specific outputs or outcomes that they want to achieve as shown in the following examples:

a) Increase the # of children served through a dedicated medical home service delivery model. FY 2007-08 Target: an increase by 15,000 clients; FY 2008-09 Target: an increase of 10% over FY 2007-08.

b) Conduct provider post payment audit to decrease fraud and abuse and increase recoveries. FY 2007-08 Target: increase total recoveries to $10,000,000; FY 2008-09 Target: increase recoveries to $12,000,000.

While staff believes that the Department's FY 2008-09 Strategic Plan is a vast improvement over last year's plan, the plan still exhibits weaknesses as follows:

- ✓ **Goal statements are written so broadly that they are almost meaningless.** The Department has four goal statements for the whole Department. Because statements are written for the Department, rather than for Divisions or Programs, the statements are overly broad and don't indicate the *desired result of achieving a goal or objective*

. *Example:* The Department will improve health outcomes for all clients and ensure that the health care the Department purchases are medically necessary, appropriate to the population, and cost effective.

Analysis: The above statement is really a "strategic issue" statement rather than a goal statement. The statement actually has three issues condensed into one issue statement relating to access to care/health outcomes, cost-effectiveness, and perhaps fraud. In addition, the Department may not be able to control what they are trying to achieve (improve health outcomes for *all* clients). Staff continues to believe that in order for goal statements to be meaningful, they must be written concisely with a desired, achievable result imbedded into the statement. For example, if the strategic issue relates to providing better access to health care providers, then a goal statement could be: The Department will initiate policies and programs so that 100 percent of Medicaid clients are assigned to a primary care physician. The performance measures for this goal would be the increase in # of children or adults assigned to a medical home (one of the measures the Department has indicated in this year's plan).

- ✓ **The document still doesn't give a clear direction of where the Department believes they will be in five-year years.** While an improvement over last year's document, the document still not a very good planning tool for describing what policy initiatives the Department wants to pursue and the funding that will be necessary to achieve such objectives. Because these two elements are missing from the plan, the document's overall usefulness is still as high as it could be for relevancy to policy makers or stakeholders (although, again much better than last year's document).

In summary, the Department's strategic plan has improved significantly over the document in last year's budget submission. The Department has done a much better job of choosing performance measurers. However, the strategic plan still does not provide information that would allow funding to be tied to the achievement of goals or performance measures. Therefore, if the Committee were to move toward performance-based budgeting, it is still staff's assessment that the Department's current strategic plan would have limited use for a performance-based budgeting environment.

Questions for the Department

Staff recommends that the Committee discuss the following questions with the Department during their FY 2008-09 budget hearing:

1. Given the change in the Administration, have there been any changes to your department's principal goals and objectives since last year?

2. What progress did you make during the last year in achieving your goals?

3. How is the additional money provided to your department in FY 2007-08 being used to achieve your goals? What improvements is your department making in its outputs?

4. Please identify your department's 3 most effective programs and your 3 least effective programs. Explain why you identified them as such. Explain how your most effective programs further the department's goals.

5. Are there programs that your department is required to perform that do not further your department's goals or have outlived their usefulness? If so, what are they and by whom are they required? Why don't they further your department's goals?

6. What are your department's principal goals and objectives? What are the metrics by which you measure success or failure? As a department director, how do you judge your department's performance? What key measures and targets do you used?

7. Please describe what impact the "Colorado Plan" has in determining the Department's goals and priorities for the next three years. Please also briefly describe major accomplishments or setbacks associated with moving forward with the following four issues that are specifically mentioned in the Colorado plan.

    a) What is the Department's current assessment for the loss of Medicaid managed care? What it the status of initiatives or negotiations to attract new managed care plans to the Medicaid market? Is the Department on target to adding one more plan in the Denver Metro area in FY 2007-08 (page N-10 of your strategic plan)?
    b) What problems or issues does the Department still have with the CBMS system?
    c) What is the status of linking the state Medicaid program with the Colorado Regional Health Information Organization.
    d) Please briefly describe any quality improvement/disease management programs that the Department is currently pursuing.

8. What are the five major challenges that the Department will face during this upcoming year?

FY 2008-09 Joint Budget Committee Staff Budget Briefing
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
Accuracy of the FY 2006-07 Final Forecast for the Medicaid Medical and Mental Health Programs

ISSUE:

The final FY 2006-07 appropriation for the Medicaid Medical Services Premiums (MSP) line item was under forecasted by $3.6 million total funds ($1.8 million General Fund). The final FY 2006-07 appropriation for the Medicaid Mental Health Capitation Program (MH) line items was under forecasted by $1.5 million total funds ($1.4 million General Fund).

SUMMARY:

- ❑ In FY 2006-07, the Department had a General Fund over-expenditures of $3.6 million. The majority of these General Fund over-expenditures were for the Medical Services Premiums (MSP) line item ($1.8 million) and for the Medical Mental Health Capitation (MH) program ($1.4 million).
- ❑ In FY 2006-07, the Department had General Fund reversions of $6.2 million. These reversions were in the following Department divisions: (1) $1,238,018 million in the Executive Director's Office; (2) $77,309 in the Mental Health Division; (3) $999,336 in Other Medical Services Division; and (4) $3.886,463 in the Department of Human Services - Medicaid Programs Division.
- ❑ Forecast accuracy for the ***final*** Medicaid overall average monthly caseload has been extremely good for the last several years. However, the accuracy for each aid category needs to improve in order to more accurately forecast actual expenditures in both the MSP and MH line items. In addition, the Department and staff need to continue to improve the forecast models, especially relating to forecasting new eligibility groups.
- ❑ Forecast accuracy for the ***final*** expenditures for the MSP line item has been within an acceptable range for the last five years (excluding FY 2004-05). However, the original forecast accuracy for the MSP could be improved as could the forecast for the MH program.

RECOMMENDATION:

1. The FY 2006-07 over-expenditure in the Medical Service Premiums line item is due to forecast error and not because of mismanagement of the appropriation. Therefore, JBC staff recommend that the JBC approve a FY 2006-07 General Fund supplemental for this line item in order to lift the current restriction on the FY 2007-08 appropriation. The JBC can take formal action on this recommendation during the January supplemental presentation for the Department.

2. Staff recommends that the Joint Budget Committee also lift the FY 2007-08 appropriation restriction on the Mental Health Capitation program line item due to the FY 2006-07 over-expenditure. Again, this over-expenditure is due to forecast error. The JBC can take formal action on this recommendation during the January supplemental presentation for the Department.

3. The Joint Budget Committee may want to consider amending Section 24-75-108 to allow the state controller the ability to transfer up to $1.0 million in General Fund expenditure authority between line items administered by the Department in order to close the books for the fiscal year. Staff recommends this issue in an attempt to reduce the amount of over-expenditures and reversions within the Department.

4. Staff recommends that the Committee discuss the questions contained within this issue with the Department at their budget hearing.

DISCUSSION:

The Impact of Under Forecasting or Over Forecasting the Department's Appropriations

Under Forecasting the Department's Expenditure Authority: In order to close the state books each fiscal year, the State Controller may authorize departments to over-expend their appropriations within certain limits if approved by the Governor (Section 24-75-109, C.R.S.). Because of the entitlement nature of the Medicaid program, the Medicaid line items are provided with ***unlimited*** overexpenditure authority as long as the overexpenditure are consistent with the statutory provisions of the Medicaid program. Therefore, most of HCPF's line items are allowed unlimited over-expenditure authority. The exceptions would be programs that are not eligible for Title XIX (Medicaid) funding. These line items include the Children's Basic Health Plan line items, the Old Age Pension Medical program, and the Medicare Modernization Act State Contribution payment. If these line items have over expenditures, they must currently either (1) ask for an emergency supplemental pursuant to Section 24-75-111, C.R.S, or (2) fit under the $1.0 million over-expenditure cap allowed for all Executive Departments, excluding Medicaid programs and the Department of Human Services programs (Section 24-75-109 (1) (c), C.R.S.).

Whenever 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 over-expenditure during the next Legislative Session. This restriction allows the JBC to review the reasons for over-expenditures and to decide if the over-expenditure could have been avoided with better management of the appropriation or if the over-expenditure occurred as a result of an unforeseen event or forecast error.

The statute also provides that any appropriation for an over-expenditures in the Medicaid program not be counted against the six percent appropriation limit for the General Fund (Section 24-75-109 (5), C.R.S.). However, all other over-expenditures and subsequent supplemental appropriations, not related to Medicaid programs, are subject to the 6.0 percent General Fund limit (Section 24-75-109 (5), C.R.S.).

Over Forecasting the Department's Expenditure Authority: When HCPF's line items are 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 General Fund reversions 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 Department's line item may lead to more funding for roads and capital construction funds. In addition, over forecasting the Department line items means a missed opportunity to fund other state priorities (Corrections, Higher Education, K-12, etc.) or other Department issues when the original budget decisions are made.

While different political and financial consequences can occur from either under-forecasting or over-forecasting the Department's line items, 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.

For FY 2006-07, HCPF had line items where the General Fund was over-expended and other line items where General Fund reverted. Table 1 below shows the General Fund over-expenditures and reversions summarized at the Department's division level.

Table 1: Department Over-Expenditures and Reversions -- General Fund Only

Division	Over-expenditure (under-forecasted)	Reversion (over-forecasted)	Net Total
Executive Director's Office	$0	$1,238,018	$1,238,018
Medical Services Premiums	($1,840,815)	$0	($1,840,815)
Mental Health Programs	($1,474,141)	$77,309	($1,396,832)
Indigent Care Programs[/1]	$0	$0	$0
Other Medical Services	$0	$999,336	$999,336
DHS-Administered Programs	($302,031)	$3,886,463	$3,584,432
Total HCPF	($3,616,987)	$6,201,126	$2,584,139

If the JBC decides to lift the FY 2006-07 overexpenditure restriction by approving supplemental appropriations of $3.6 million for FY 2006-07, these appropriations will not count against the 6.0 percent appropriation limit for FY 2006-07. In addition, these appropriations will also increase the 6.0 percent base available for FY 2007-08 appropriations. Also, because the General Fund reserve was fully funded in FY 2006-07, the $6.2 million in General Fund reversions will be transferred to the one-third/ two-third split for capital and transportation once the State's financial audit is complete.

Staff recommends that the Committee consider amending current statute to allow the State Controller to use any General Funds that will revert to first reduce the amount of any over-expenditures anticipated for the Department's General Fund appropriations (up to a cap that the Committee decides, staff suggests $1.0 million). Staff recommends that this transfer authority be in addition to the transfer authority of $2.0 million that the State Controller and Governor already have pursuant to Section 24-75-108 (8), C.R.S.

The advantage of this recommendation is that it may help reduce the impact of the overall Department appropriation forecasting error. The disadvantage is it may reduce (in years where there are over-expenditures) the ability to build the 6.0 percent limit and it may also reduce the amount of reversions that are transferred to the one-third / two-third allocation.

Accuracy of the Medicaid Caseload Forecast

One of the main factors that drives expenditures for both the Medical Services Premium (MSP) line item and the Medicaid Mental Health Capitation (MH) line item is the Medicaid average monthly caseload projection. During the last five years, factors that have impacted how accurate the caseload forecasts have been include the following:

1) In FY 2002-03 and FY 2003-04 there was unprecedented caseload growth (double digit growth) for the low-income adult and children categories. In addition, during these fiscal years, the state moved to cash accounting for the Medicaid program. Therefore, caseload was restated to remove the retroactive caseload adjustment out of reported monthly caseload in order to better match caseload counts with expenditures.

2) In FY 2004-05 the state moved to the Colorado Benefit Management System. During the transition, the State had a temporary eligibility freeze imposed by a court order. This caused caseload reports to overstate actual caseload (i.e. because eligibility was frozen some clients continued to show up on caseload reports even though the clients no longer required Medicaid services).

3) In FY 2005-06 and FY 2006-07, the original Medicaid caseload forecasts contained assumptions regarding how many new clients would result from the Amendment 35

Medicaid expansions (i.e. eliminating the asset test and increasing eligibility for low-income adults). In addition, during these fiscal years the economic recovery finally began to impact the Medicaid program with declining enrollment. Finally, in FY 2006-07, the impact of the Federal Deficit Reduction Act of 2005 was not originally factored into the caseload forecasts.

During the last five years, original caseload forecasts have not been accurate as staff would like (staff would like these forecasts to be less than 5 percent different from the actual and instead they have range from 6.4 percent to 8.4 percent different from the actual). However, the final forecasts for the overall Medicaid caseload have been extremely accurate (from 0.76 percent different to 0.0 percent different from the actual). Table 2 below shows the original and final JBC forecasts for the Medicaid caseload for the last five years.

Table 2: Accuracy of Medicaid Overall Average Monthly Caseload Forecasts

Total Medicaid Caseload	FY 2002-03[/1]	FY 2003-04[/1]	FY 2004-05[/2]	FY 2005-06	FY 2006-07[/3]
Original Caseload Estimate			375,411	427,147	429,222
Final Caseload Estimate		359,784	403,904	399,710	393,180
Actual Caseload	327,395	362,531	402,802	399,705	393,077
% Original Different from Actual			7.30%	(6.42)%	(8.42)%
% Final Difference from Actual		0.76%	(0.27)%	0.00%	(0.03)%

[/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.

[/3]The original forecast assumed that there would be caseload growth due to eliminating the Medicaid asset test and adding additional adults up to 60 percent of FPL. However, this caseload growth never materialized. Please see the March 8, 2007 Figure Setting document for a greater discussion on why the original caseload forecast was in error.

Because the final JBC caseload forecast uses two more months of actual data than does the Department's final caseload forecast, the JBC forecast has tended to be a little more accurate than the Department's final forecast. For the last five years, the Committee has used the JBC staff forecast rather than Department's forecast as the basis for the final supplemental appropriation. able 3 on the following page compares the overall JBC Medicaid caseload projections with the Department's overall caseload projections for the last four years.

Table 3: Department and JBC Caseload Estimates Comparison				
Total Medicaid Caseload	**FY 2003-04[/1]**	**FY 2004-05**	**FY 2005-06**	**FY 2006-07**
Original JBC Caseload Estimate		375,411	427,147	429,222
Final JBC Caseload Estimate	359,784	403,904	399,710	393,180
Original Department Caseload Estimate		376,986	424,374	440,177
Final Department Caseload Estimate	356,133	405,022	404,261	393,734
Actual Caseload	**362,531**	**402,802**	**399,705**	**393,077**
Actual Caseload - Department Final	6,398	(2,220)	(4,556)	(657)
Actual Caseload - JBC Final	2,747	(1,102)	(5)	(103)

[/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.

Although, the overall final Medicaid caseload forecast has been extremely accurate, the accuracy for the individual aid categories has not been as accurate. Because each aid category has different estimated per capita costs for both Medical Services Premiums and Mental Health capitation, the individual forecast errors for each aid category can drive expenditure difference from the final estimated appropriation. Table 4 below shows the forecast errors for each of the individual aid categories for FY 2006-07.

Table 4: FY 2006-07 Individual Aid Category Caseload Forecast Error				
Aid Category	**Final Forecast**	**Actual**	**# Difference (over-forecasted) + under forecasted**	**% Difference**
SSI 65+	36,218	35,977	(241)	(0.67)%
SSI 60-64	6,068	6,042	(26)	(0.43)%
SSI Disabled	48,489	48,567	78	0.16%
QMB/SLIMB	12,706	12,818	112	0.87%
Low-Income Adults	52,115	51,361	(754)	(1.47)%
Expansion Low-Income Adults	5,292	4,974	(318)	(6.39)%
Baby-Care Adults	5,018	5,123	105	2.05%
Breast and Cervical Cancer Adults	233	230	(3)	(1.30)%
Low-Income Children	205,213	206,170	957	0.46%

Table 4: FY 2006-07 Individual Aid Category Caseload Forecast Error				
Aid Category	Final Forecast	Actual	# Difference (over-forecasted) + under forecasted	% Difference
Foster Children	16,580	16,601	21	0.13%
Non-Citizens	5,248	5,214	(34)	(0.65)%
Total	393,180	393,077	(103)	(0.03)%

For the most part, the forecast error was under 1.0 percent with the exception of the non-disabled adult categories. The largest forecast error was in the low-income expansion adult category (this was the first year of forecasting this category and there was little historical data to base the forecast on). The baby care adults and low-income adults also had forecast errors over one percent. Because the base is so low for the Breast and Cervical Cancer patients, even a small forecast error of three clients leads to a forecast error over one percent.

Accuracy of the Medicaid Medical Services Premiums Expenditure Forecast

Although the number of clients served drives 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 forecasts adjustments for what is called bottom of the line financing and the impacts of special legislation. All of these calculations result in the overall expenditure forecast for the Medical Services Premiums.

The final FY 2006-07 appropriation for the Medical Services Premiums line item (MSP) was $2,057,801,212. The final FY 2006-07 expenditures for the MSP line item was $2,061,396,808. Thus, there was an over-expenditure of $3,595,596 (0.17 percent) total funds from the MSP line item appropriation at the end of the fiscal year. Table 5 shows the final FY 2006-07 appropriations and expenditures by fund source.

Table 5: FY 2006-07 Final Expenditures				
	GF & GFE	CF and CFE[/1]	Federal Funds	Total Funds
Original FY 2006-07 Appropriation	$996,821,857	$55,640,318	$1,058,825,384	$2,111,287,559
2007 Session Adjustments (all bills)	($22,184,958)	($3,271,553)	($28,029,836)	($53,486,347)
FY 2006-07 Final Appropriation	$974,636,899	$52,368,765	$1,030,795,548	$2,057,801,212
FY 2006-07 Final Expenditures	$976,477,714	$48,860,206	$1,036,058,888	$2,061,396,808

Table 5: FY 2006-07 Final Expenditures				
	GF & GFE	**CF and CFE[/1]**	**Federal Funds**	**Total Funds**
Difference (+ reversion/ - overexpenditure)	($1,840,815)	$3,508,559	($5,263,340)	($3,595,596)
% Difference from final appropriation	(0.19)%	6.70%	(0.51)%	(0.17)%
% Difference from original appropriation	2.04%	12.19%	2.15%	2.36%

[/1] This reversion amount is over-stated in that $1,970,388 of this appropriation was allowed to roll-forward for expenditure in FY 2007-08 for the Disease Management program.

As Table 5 above shows, the original FY 2006-07 General Fund appropriation was 2.04 percent higher than the FY 2006-07 General Fund actual and the final General Fund appropriation was 0.19 percent lower than the actual FY 2006-07 expenditure. While these are relatively low forecast error rates, staff would point out that even a 1.0 percent error in the General Fund forecast results in an appropriation swing of $9.8 million (in either direction). Table 6 breaks down the reason for the forecast errors based on caseload and cost-per-client estimates.

Table 6: Analysis of Forecast Error for FY 2006-07					
	FY 2006-07 Original Appropriation	**FY 2006-07 Final Appropriation**	**FY 2006-07 Final Expenditure**	**FY 2006-07 Final Expenditure minus Original App.**	**FY 2006-07 Final Expenditure minus Final App.**
Total Cost Estimated	$2,111,287,559	$2,057,801,212	$2,061,396,808	($49,890,751)	$3,595,596
Caseload	429,222	393,180	393,077	(36,145)	(103)
$/Client*	$4,918.87	$5,233.74	$5,244.26	$325.39	$10.52
Impact Associated with Caseload Change				($177,792,585)	($539,075)
Impact Associated with Cost per Client Changes (includes compounding effect, i.e. caseload difference * cost difference)				$127,901,834	$4,134,671
Subtotal Acute Care Services Cost Increases				($49,890,751)	$3,595,596

As Table 6 shows, most of the final forecast error related to higher than anticipated cost-per-client rather than the final caseload forecast. Reasons for the cost-per-client error are very involved, including estimating the impacts for each service category (acute care services, community long-term care services, institutional long-term care services, Medicare insurance premiums and Medicaid buy-in programs), impacts of special legislation, and the case overall case mix (the number of clients in each aid category).

Table 7 shows the accuracy of the Medical Service Premiums line item original and final forecast for the last five years.

Table 7: Accuracy of General Fund and Total Fund Expenditures
Medical Services Premiums

Total Medicaid Medical Expenditures	FY 2002-03[1]	FY 2003-04[/1]	FY 2004-05	FY 2005-06	FY 2006-07
Original Total Fund Estimate	$1,729,799,673	$1,844,485,672	$1,934,644,559	$2,178,221,370	$2,111,287,559
Original General Fund Estimate	$838,461,881	$864,399,617	$936,641,159	$1,042,362,634	$996,821,857
Final Total Fund Estimate[/1]	$1,550,350,117	$1,854,919,776	$1,966,958,051	$1,999,646,558	$2,057,801,212
Final General Fund Estimate[/1]	$701,341,861	$846,564,816	$957,699,084	$976,750,574	$974,636,899
Actual Total Fund	**$1,549,735,300**	**$1,868,658,515**	**$1,920,474,771**	**$1,996,264,308**	**$2,061,396,808**
Actual General Fund	**$705,572,289**	**$855,002,797**	**$935,078,890**	**$976,206,452**	**$976,477,714**
% Actual GF Different from Original Estimate	15.85%	1.09%	0.17%	6.35%	2.04%
% Actual GF Different from Final Estimate (negative means over-expenditure, positive reversion)	(0.60)%	(1.00)%	2.36%	0.06%	(0.19)%

[/1] Adjusts the final estimate to include the impact of the Federal Job and Growth Tax Relief Reconciliation Act of 2003 which contained a provision to temporarily increase Colorado's Federal Match Rate (FMAP) from 50 percent to 52.95 percent from April 2003 through June 2004. The 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 2002-03 and 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 from the original appropriation to the final appropriation reflected different circumstances within the total state budget, not just the Medicaid forecast.

As Table 7 shows that the final estimate of the General Fund has been fairly accurate over the last five years. In FY 2002-03, state revenues fell short of the original Legislative Council estimates. Therefore, mid-year appropriation cuts were enacted for the MSP line item in order to help balance the state budget. In addition, the state moved to cash accounting for this line item during FY 2002-03.

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.

The error in forecasting for FY 2006-07 estimate again was mainly related to over forecasting the growth in the Medicaid caseload as discussed earlier. Once this error was corrected, the final forecast was again extremely accurate (99.81% accurate for the General Fund).

Lastly, Table 8 below compares the Department's forecasts with the JBC forecasts for the last four years.

Table 8: 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	FY 2006-07
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	$984,510,578
Original General Fund Appropriation (JBC Action & Special Bills)	$864,399,617	$936,641,159	$1,042,362,634	$996,821,857
Final Department General Fund Estimate (February request of current year-- Adjusted by Special Bills)	$836,125,926	$973,356,222	$974,551,592	$973,940,283
Final General Fund Appropriation (JBC Action & Special Bills)[/1]	$846,564,816	$957,699,084	$976,750,574	$974,636,899
Actual General Fund	**$855,002,797**	**$935,078,890**	**$976,206,452**	**$976,477,714**
Department Final Estimate - Actual	($18,876,871)	$38,277,332	($1,654,860)	($2,537,431)

Table 8: 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**	**FY 2006-07**
JBC Final Estimate - Actual	($8,437,981)	$22,620,194	$544,122	($1,840,815)

[/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. Therefore appropriations provided to release the restriction on over-expenditure are not included.

[/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.

Accuracy of the Medicaid Mental Health Capitation Program Expenditure Forecast

The final FY 2006-07 appropriation for the Medicaid Mental Health Capitation Program line item (MH) was $183,141,013. The final FY 2006-07 expenditures for the MH line item was $184,640,568. Thus, there was a total fund over-expenditure of $1,499,555 (0.82 percent) from the MH line item appropriation at the end of the fiscal year. Table 9 shows the final FY 2006-07 appropriations and expenditures by fund source for the MH program.

Table 9: FY 2006-07 Final Expenditures -- Medicaid Mental Health Capitation				
	GF & GFE	**CF and CFE[/1]**	**Federal Funds**	**Total Funds**
Original FY 2006-07 Appropriation	$86,935,767	$2,153,241	$89,095,169	$178,184,177
2007 Session Adjustments (all bills)	$1,422,822	$1,053,277	$2,480,737	$4,956,836
FY 2006-07 Final Appropriation	$88,358,589	$3,206,518	$91,575,906	$183,141,013
FY 2006-07 Final Expenditures	$89,832,730	$2,481,026	$92,326,812	$184,640,568
Difference (+ reversion/ - overexpenditure)	($1,474,141)	$725,492	($750,906)	($1,499,555)
% Difference from final appropriation	(1.67)%	22.63%	(0.82)%	(0.82)%
% Difference from original appropriation	(3.33)%	(15.22)%	(3.63)%	(3.62)%

In the State Controller's letter to the Governor (that the JBC Staff Director is copied on), it states: "*The Department believes that the over-expenditure is primarily due to the unexpected caseload increase for Foster Children and Disabled Adults.*" However, in their budget request, the Department provided a more accurate explanation for the overexpenditure by stating, "*While the actual caseload was 0.05% under the appropriation, a change in mix between high and low cost eligibility categories, and a change in the mix of various behavioral health organizations' rates, contributed to the overexpenditure*." As the Committee is aware, each eligible aid category receives

a different capitation rate for each Behavioral Health Organization (BHO). In forecasting the Medicaid MH program, a "blended rate" for each aid category is calculated and these capitation rates are multiplied by the forecasted caseload for the state. Table 10 below shows the final "blended" capitation rates that was used for the final forecast as well as the caseload projection and actual.

Table 10: Capitation Final Projections Compared to Actuals

	Final Caseload Projection	Blended Capitation Rate for Aid Category	Final Projection	Actual Caseload	Blended Capitation Rate for Aid Category	Final Expenditures
SSI 65+	36,218	$163.16	$5,909,329	35,977	$163.16	$5,870,007
SSI 60-64	6,068	$1,344.48	$8,158,305	6,042	$1,344.48	$8,123,348
SSI Disabled	48,489	$1,344.48	$65,192,491	48,567	$1,344.48	$65,297,360
LI Adults	52,115	$203.98	$10,630,418	51,361	$203.98	$10,476,617
Ex LI Adults	5,292	$203.98	$1,079,462	4,974	$203.98	$1,014,597
BC Adults	5,018	$203.98	$1,023,572	5,123	$203.98	$1,044,990
BCCTP	233	$154.83	$36,075	230	$154.83	$35,611
Children	205,213	$167.43	$34,358,813	206,170	$167.43	$34,519,043
Foster Children	16,580	$3,501.36	$58,052,549	16,601	$3,501.36	$58,126,077
Subtotal	375,226	n/a	$184,441,013	375,045	n/a	$184,507,650
Minus Recoupment	n/a	n/a	($1,300,000)	n/a	n/a	($1,198,341)
Capitation Blended Rate Error	n/a	n/a	n/a	n/a	n.a	$1,331,259
Total	375,226	n/a	$183,141,013	375,045	n/a	$184,640,568

As Table 10 above shows, the total difference between the forecasted caseload and actual caseload (using the same blended capitation rate, would have resulted in an overexpenditure of just $66,637. In addition, the actual recoupment when compared to forecasted recoupment would result in an overexpenditure of $101,659. Therefore, the majority of the overexpenditure, $1,331,259, must be related to errors within the "blended rate" calculations.

Questions for the Department

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

1) One of the Department's selected performance measurers is to "maintain or reduce the difference between the Department's spending authority and actual expenditures for Medicaid services." Where, if anywhere, does the Department believe improvements could be made in the annual budget process to ensure that over-expenditures and reversions are minimized at year-end close?

2) Please explain why the Department reverted $450,218 in General Fund from the Department's personal services line item. Please provide the Committee with an explanation on why the Department has reverted funding from this line item for the last three years. Should the JBC consider setting the Department's personal services line item using a different methodology from the "Option 8" calculations in order to realign the appropriation with the Department's actual expenditures?

3) Please explain why the Department reverted $175,165 in General Fund from the Long-Term Care Utilization Review line item.

4) Please explain why the Department reverted $26,393 from the enrollment broker line item.

5) What error rate does the Department believe is an appropriate standard when forecasting the original Medical Services Premiums line item?

6) What error rate does the Department believe is an appropriate standard when forecasting the original Mental Health Capitation program?

FY 2008-09 Joint Budget Committee Staff Budget Briefing
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
Preliminary Medical Services Premiums Budget Outlook for FY 2007-08 & FY 2008-09

ISSUE:

The Department currently forecasts a FY 2007-08 total fund supplemental for the Medical Services Premiums Line Item of $13.7 million ($12.3 million General Fund). The Department currently forecasts a FY 2008-09 total fund increase of $148.6 ($76.6 million General Fund) over the current FY 2007-08 appropriation.

SUMMARY:

- The Department's budget request shows a ***preliminary*** FY 2007-08 Medical Services Premiums line item supplemental need of $13.7 million total funds (0.6 percent). Of this amount, $12.3 million is from the General Fund (a 1.2 percent increase to General Fund).
- The Department's FY 2008-09 budget request for Medical Services Premiums line item is $148.6 million total funds higher than the current FY 2007-08 appropriation. Of this amount, $76.6 million is from the General Fund (a 7.7 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 2007-08 Medical Services Premiums -- Preliminary Supplemental Calculations

In order to calculate their FY 2008-09 request for the MSP line item, the Department provides a new expenditure estimate for FY 2007-08 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 2008. For FY 2007-08, the Department is currently forecasting that $2.16 billion will be necessary to meet the obligations for the MSP line item. The Department's forecast indicates that the current appropriation of $2.15 under funds the anticipated need by approximately $13.7 million total funds (0.6 percent increase). Of this amount, $12.3 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 2008-09 is $148.6 million total funds (6.9%) higher than the current FY 2007-08 appropriation but is only $134.9 million (6.2%) higher than the Department's revised estimate for FY 2007-08. Table 1 below summarizes the Department's FY 2007-08 expenditure estimate and FY 2008-09 budget request.

Table 1: FY 2007-08 Estimate & FY 2008-09 Budget Request

Funds	**Current** *FY 2007-08* Appropriation	Department's **Estimated** *FY 2007-08* Expenditure	**Difference Possible Supplemental Amount**	**Department's** *FY 2008-09* **Budget Request**	*FY 2008-09* Increase Compared to Current FY 2007-08 Appropriation	*FY 2008-09* Increase Compared to Estimated FY 2007-08 Expenditure
GF/GFE	$996,321,500	$1,008,618,325	**$12,296,825**	$1,072,914,449	$76,592,949	$64,296,124
CF	38,256	0	**(38,256)**	0	(38,256)	0
CFE	76,001,368	71,344,569	**(4,656,799)**	74,187,505	(1,813,863)	2,842,936
FF	1,075,497,784	1,081,560,998	**6,063,214**	1,149,346,024	73,848,240	67,785,026
Total	$2,147,858,908	$2,161,523,892	**$13,664,984**	$2,296,447,978	$148,589,070	$134,924,086
Percent (Decrease) / Increase			**0.64%**	n/a	6.92%	6.24%

Table 2 shows the reasons for the anticipated increase in Medical Service Premiums for FY 2007-08.

Table 2: Medical Service Premiums FY 2007-08 Estimated Expenditures Detail

Item	**Total Funds**	**GF / GFE**	**Cash Funds**	**Cash Fund Exempt**	**Federal Funds**
Current FY 2007-08 Appropriation	$2,147,858,908	$996,321,500	$38,256	$76,001,368	$1,075,497,784
Department's Estimated Changes for FY 2007-08 (Nov 1, 2007 Request)					
New UPL financing estimate	(1,161,904)	1,161,904	(38,256)	(1,123,647)	(1,161,905)
Updated caseload and cost-per-client estimates	14,826,888	11,134,921	0	(3,533,152)	7,225,119
Department's New Estimate for FY 2007-08 (Nov 1, 2007)	**$2,161,523,892**	**$1,008,618,325**	**$0**	**$71,344,569**	**$1,081,560,998**
(Decrease)/Increase from current FY 2007-08 appropriation	$13,664,984	$12,296,825	($38,256)	($4,656,799)	$6,063,214

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). However, because current Medicaid rates are below the Medicare UPL, the Department certifies public expenditures at these facilities for the difference 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 $12,755,822 General Fund offset from the UPL financing instead of the $13,879,470 General Fund offset anticipated in the current FY 2007-08 appropriation. This issue results in an increase to the General Fund of $1.1 million, and in a corresponding decreases of $1.1 million to both certified funds and matching federal funds. In addition, the Department's request eliminates a General Fund offset of $38,256 from provider fees from Intermediate Care Facilities for the Mentally Disabled. This results in an increase to the General Fund of $38,256 and decreases to cash funds and federal funds of $38,256. The Department's new estimate for FY 2007-08 did not change the estimates for the out-stationing payments to Denver Health from the current appropriation estimate of $623,073.

Updated caseload and cost-per-client estimates: This item represents the Department's current FY 2007-08 estimate for medical services costs for the Medicaid caseload. This calculation is based on the Department's current caseload forecast that the Medicaid caseload will decrease by 5,295 clients (-1.380%) from the current appropriated level. However, this decrease in caseload is offset by an overall increase to the average cost-per-client of $116.22 (2.1%). The Department's FY 2007-08 request also corrects fund split issues between the General Fund and Health Care Expansion Fund based on the current caseload and cost-per-client projections.

If the Department's current estimate is correct that an additional $12.3 million in General Fund is needed, then this amount will exceed the 6.0 percent appropriation limit (currently, the State is approximately $3.0 million under the 6.0 percent appropriation limit when including already approved 1331 supplementals for FY 2007-08).

The current FY 2007-08 MSP appropriation minus the bottom line financing adjustments is $2,133,356,366 for Medicaid medical and long-term care services. This appropriation level assumes monthly expenditures of approximately $177.8 million. Through October 2007, actual monthly expenditures have average $181.9 per month. With four months of data, the monthly expenditure reports indicate that the MSP line item's overall expenditures are tracking higher than originally anticipated levels. However, at this time, the monthly reports neither validate nor invalidate the Department's preliminary analysis. Staff will have a much better picture of what the supplemental need may be when staff develops the "placeholder recommendation" in January 2008.

For the Committee's information, when staff completed a five-year projection for the JBC Staff Director in October 2007 for the General Fund Overviews, staff estimated that the current FY 2007-08 appropriation for the MSP line item was over funded by $9.1 million total funds. However, staff's estimate indicated that there would be a supplemental need of $1.6 million for the General Fund.

Table 3 shows the difference between the current appropriation, the Department's initial FY 2007-08 estimate and staff's initial FY 2007-08 estimate.

Table 3 FY 2007-08 MSP Supplemental Estimate -- Department compared to Staff

Funds	**Current** *FY 2007-08* Appropriation	Department's **Estimated** *FY 2007-08* Expenditure	**Staff's Initial Est.** *FY 2007-08* Expenditure	Staff Difference From Department FY 2007-08	Staff Difference From Current FY 2007-08 Appropriation
GF/GFE	$996,321,500	$1,008,548,589	$997,943,423	($10,605,166)	$1,621,923
CF	38,256	38,256	76,512	38,256	38,256
CFE	76,001,368	71,344,569	70,460,308	(884,261)	(5,541,060)
FF	1,075,497,784	1,081,560,998	1,070,297,768	(11,263,230)	(5,200,016)
Total	$2,147,858,908	$2,161,492,412	$2,138,778,011	($22,714,401)	($9,080,897)

Currently, staff and the Department are $10.6 million apart on their General Fund estimates (with both the Department and staff estimating a need for a General Fund supplemental -- just at different levels). Please note that both of the Department's and staff's FY 2007-08 estimates are preliminary and will be revised again in January and March 2008. ***However, staff wanted to emphasize to the Committee that the Committee should not anticipate that there will be a negative General Fund supplemental in the MSP line item like there was in the past two years. As of right now, staff either anticipates that there will be a positive supplemental between 0.0 to 1.0 percent ($0 to 10.0 million)***.

FY 2008-09 Department Budget Request

For FY 2008-09, the Department anticipates that Medical Service Premiums expenditures will increase by $148.6 million total funds over the current FY 2007-08 appropriation. This is a total fund increase of 6.9 percent over the current appropriation. Table 4 summarizes the Department's FY 2008-09 request.

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

Item	Total Funds	GF & GFE	Cash Funds	Cash Fund Exempt	Federal Funds
Current FY 2007-08 Appropriation	**$2,147,858,908**	**$996,321,500**	**$38,256**	**$76,001,368**	**$1,075,497,784**
Department's Estimated Increases for FY 2008-09 (Nov 1, 2007 Request)					

Table 4: Medical Service Premiums FY 2008-09 Budget Request					
Item	**Total Funds**	**GF & GFE**	**Cash Funds**	**Cash Fund Exempt**	**Federal Funds**
Annualize prior year budget adjustments & legislation (T1 & T3)	($231,918)	($908,758)	$0	$792,799	($115,959)
Base caseload growth & cost-per-client (DI #1)	$113,786,826	$60,266,483	($38,256)	($2,888,520)	$56,447,119
Implement Preferred Drug List (BRI #1)	(793,092)	(396,546)	0	0	(396,546)
Increase Caseload for CBHP marketing (DI #3a)	7,063,080	3,531,540	0	0	3,531,540
Provider Rate Increases (DI #6)	17,091,875	8,264,081	0	281,858	8,545,936
HMO rates to 100% (DI #12)	4,372,996	2,186,498	0	0	2,186,498
Transfer non-emergency transportation from EDO to MSP (DI #14)	7,299,303	3,649,651	0	0	3,649,652
Department's FY2008-09 Budget Request	**$2,296,447,978**	**$1,072,914,449**	**$0**	**$74,187,505**	**$1,149,346,024**
Increase above current FY 2007-08 appropriation	**$148,589,070**	**$76,592,949**	**($38,256)**	**($1,813,863)**	**$73,848,240**
Percent Increase	**6.92%**	**7.69%**	**-100.00%**	**-2.39%**	**6.87%**

Following is brief discussion on the Department's base request (Decision Item #1). All other decision items and adjustments are discussed elsewhere in this briefing document.

Department's Specific Caseload Projections for FY 2007-08 & FY 2008-09

Both the Department's and staff's initial estimates for FY 2007-08 indicate a decrease to the original caseload forecasts.

The current FY 2007-08 appropriation is based on a total Medicaid caseload forecast of 385,010 (S.B. 07-259 & S.B. 07-002). In October 2007, staff reforecasted the Medicaid caseload as part of the five-year projections required by the JBC Staff Director.[1] Based on early trends for the fiscal year, staff has revised her total Medicaid caseload forecast downward to 384,312 clients. This

[1]Staff's October five-year forecast can be found in Appendix E 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.

forecast is very preliminary and will continue to be refined through March 2008. The Department's preliminary FY 2007-08 budget estimate also revises caseload downward. The Department's current FY 2007-08 estimated forecast is a total Medicaid caseload of 379,715 clients. These forecasts have been revised downward based on the most recent caseload trends. Thus far in FY 2007-08, the average monthly caseload for the Medicaid program is 382,694 clients (through October 2007). The current monthly average (with four months of data) is a decline in caseload of approximately 2.75 percent over the average monthly enrollment of 393,077 in FY 2006-07. The Department's current forecast assumes that there will be total decline of 3.4 percent in caseload from FY 2006-07 by the end of the fiscal year.

For FY 2008-09, the Department is currently forecasting an average monthly Medicaid enrollment of 383,067. This is an increase of 0.88 percent over the Department's current forecast for FY 2007-08. The significant portion of this increase is anticipated to be in the low-income expansion adults and the newly eligible foster children population (S.B. 07-002). Staff's initial caseload forecast for FY 2008-09 is 394,519 total clients. Staff initial forecast is for an increase of 2.65 percent over staff current FY 2007-08 estimate. As stated earlier, both the Department's and staff's forecasts are preliminary and will continue to be revised through March 2008. Table 5 shows the Department's current forecast for the Medicaid caseload (information on staff's forecast is in Appendix E).

Table 5: Non-retroactive Total Medicaid Caseload -- Department's November 2007 Forecast

	FY 2006-07 Actual	FY 2007-08 Current App. Estimate (includes S.B. 002)	FY 2007-08 November HCPF Forecast	% Change FY 2007-08 Forecast Compared to FY 2006-07 Actual	FY 2008-09 November HCPF Forecast	%Change FY 2008-09 Forecast Compared to FY 2007-08 Forecast
SSI 65+	35,977	36,703	35,272	-1.96%	35,498	0.64%
SSI 60-64	6,042	6,252	6,050	0.13%	6,106	0.93%
QMB/SLIMB	12,818	13,294	14,188	10.69%	15,360	8.26%
SSI Disabled	48,567	48,942	49,354	1.62%	49,556	0.41%
Low-Income Adults	51,361	46,708	45,228	-11.94%	44,183	-2.31%
Expansion Low-Income Adults	4,974	10,377	7,886	58.54%	9,462	19.98%
Baby-Care Adults	5,123	5,264	5,453	6.44%	5,649	3.59%
Breast & Cervical Cancer Program	230	277	260	13.04%	278	6.92%
Eligible Children	206,170	193,981	192,834	-6.47%	192,717	-0.06%

Table 5: Non-retroactive Total Medicaid Caseload -- Department's November 2007 Forecast

	FY 2006-07 Actual	FY 2007-08 Current App. Estimate (includes S.B. 002)	FY 2007-08 November HCPF Forecast	% Change FY 2007-08 Forecast Compared to FY 2006-07 Actual	FY 2008-09 November HCPF Forecast	%Change FY 2008-09 Forecast Compared to FY 2007-08 Forecast
Foster Care Children	16,601	18,521	18,428	11.01%	19,305	4.76%
Non-Citizens	5,214	4,691	4,762	-8.67%	4,953	4.01%
Total	**393,077**	**385,010**	**379,715**	**-3.40%**	**383,067**	**0.88%**

As the Committee is aware, since the passage of Amendment 35, the caseload projections have been harder because an estimate must be provided for how many clients are eligible to receive their state match from the Health Care Expansion Fund. Currently, the following Medicaid clients are eligible for funding from the Health Care Expansion Fund.

1. *Optional Legal Immigrants*: current caseload estimate is 3,512 for both FY 2007-08 and FY 2008-09. Per the JBC instructions in last year's figure setting, the Department is holding both the assumed caseload and costs for this population constant until such time as the CBMS system can identify and track these clients.

2. *Expansion Low-Income Adults*: These are low-income adults with income between approximately 34% and 60% of the federal poverty level (FPL). This caseload is identifiable and tracked through the CBMS system and monthly reports. The Department estimates this population to be 7,886 in FY 2007-08 and 9,462 in FY 2008-09.

3. *Expansion Foster Care*: This expansion population was added last year in S.B. 07-002 and includes young adults from the ages of 19 to 21 that were in the foster care system prior to emancipation. This caseload should be identifiable and tracked through the CBMS system. The Department estimates this population to be 1,226 in FY 2007-08 (note this is a slightly different calculation than in the original fiscal note) and 1,678 in FY 2008-09.

4. *New Waiver slots for Children's HCBS Waiver:* This caseload is assumed to be 678 for both FY 2007-08 and FY 2008-09.

5. *New Waiver slots for Children's Extensive Support Waiver*: This caseload is assumed to be 59 for both FY 2007-08 and FY 2008-09.

6. *Presumptive Eligibility for Pregnant Women*: This caseload is assumed to be 1,649 in FY 2007-08 and 1,708 in FY 2008-09.

7. *Medicaid Asset Test - Adult and Children Expansion*: The Department can not accurately track this population (since asset information in no longer collected). However, the Department has added flags to the CBMS system to indicate if clients have applied for other public assistance programs that require asset information (mainly Food Stamps). In FY 2007-08 and FY 2008-09 the Department projected expenditures for this population based on the estimate FY 2006-07 expenditures. However, the Department does not try to separately identify this caseload.

8. *Breast and Cervical Cancer Program*: This program receives ongoing Tobacco Tax funding to subcontract with clinics that provide screen for breast and cervical cancer. The Department does not forecast a specific caseload associated with the new screenings.

Table 6 breaks-out the Department's current caseload forecasts by the traditional Medicaid caseload and the Amendment 35 expansion populations (note staff has estimated a caseload for the asset test clients based on the Department's expenditure projections).

Table 6: Impact of the Medicaid Expansion Populations -- Department November 2007 Forecast

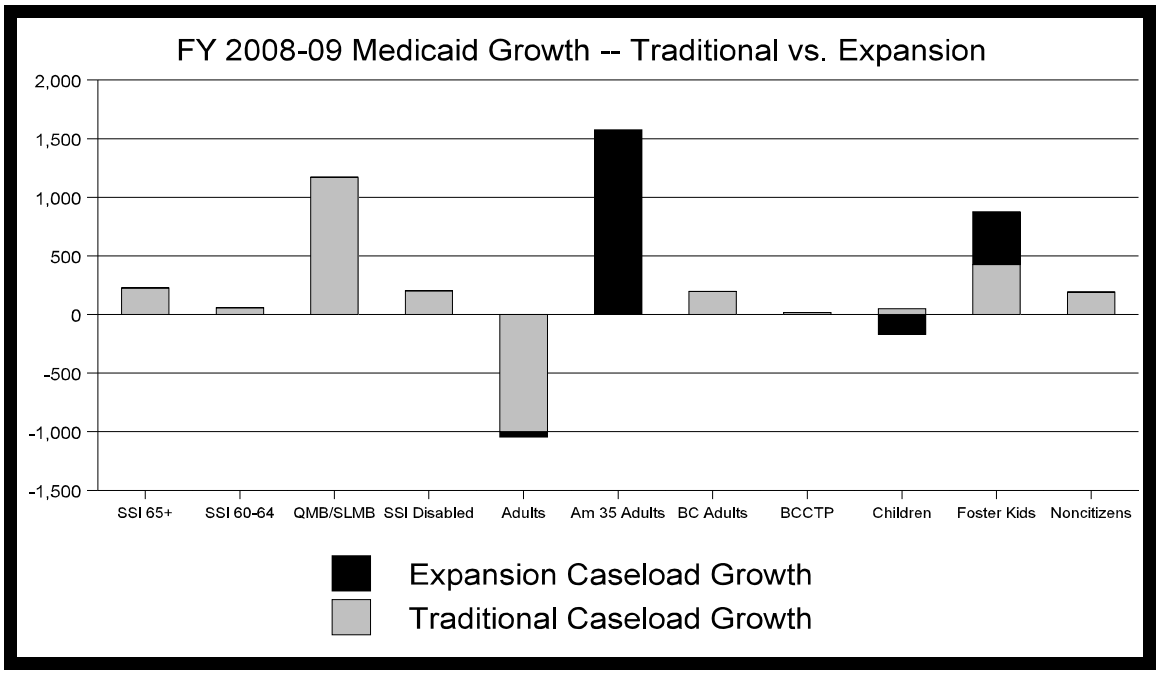
	FY 2007-08 Current App.	FY 2007-08 Dept. Forecast	FY 2008-09 Dept. Forecast	Difference	% Change
Traditional Medicaid Population	346,283	340,983	342,461	1,478	0.43%
Optional Legal Immigrants	3,512	3,512	3,512	0	0.00%
Expansion Low-Income Adults	10,377	7,886	9,462	1,576	16.66%
Expansion Foster Care/1	1,226	1,226	1,678	452	26.94%
HCBS Waiver Slot Expansion-- Children	652	678	678	0	0.00%
CES Waiver Slot Expansion	83	59	59	0	0.00%
Presumptive Eligibility Pregnant Women/2	0	1,649	1,708	59	3.45%
Breast Cervical Cancer Expansion Only	83	0	0	0	n/a
Medicaid Asset Test Removal -- Adults/3	4,946	5,156	5,110	(46)	-0.90%
Medicaid Asset Test Removal -- Children/3	17,848	18,566	18,399	(167)	-0.91%
Total Caseload	385,010	379,715	383,067	3,352	0.88%

/1 This is a slightly different caseload than indicate in the Fiscal Note for S.B. 07-002. The fiscal note indicate an anticipated number of individuals eligible which is not the same as average monthly caseload.

/2 Staff did not separate this caseload out from the Traditional caseload during figure setting but used a dollar allocation for the service cost instead. The Department does forecast this caseload separately from the Traditional caseload.

/3 The Department's request does not indicate a caseload figure for these populations. Staff backs into the caseload projection by using the Departments estimated expenditure allocation for eliminating the asset test divided by per capita costs for children and adults. Staff assumes a ratio of 3.6 children for every eligible adult (this is the ratio used for the current FY 2007-08 appropriation estimate).

The graph below shows in which aid categories the caseload growth is anticipated to occur in FY 2008-09 over the FY 2007-08 estimate based on the Department's current forecast.



The Department's Specific Cost - Per -Client Projections for FY 2007-08 & FY 2008-09

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 #3a, 6, 12, 14, BRI #1, or T #1 and 3. Therefore, the costs in these tables may not add to other tables throughout this briefing document showing the Department's total request for FY 2008-09.

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). Table 7 summarizes the Department's Medicaid medical service cost estimates by service area for FY 2007-08 and FY 2008-09.

Table 7: Department November Forecast by Service Category						
	FY 2006-07 Actual	**FY 2007-08 Cur. App.**	**FY 2007-08 Dept. Estimate**	**% Change to Cur. App.**	**FY 2008-09 Estimate**	**% Change to Dept. Est.**
Acute Care Services	$1,203,363,838	$1,222,505,559	$1,237,512,700	1.23%	$1,292,482,914	4.44%
Community Long-Term Care	$215,126,488	$229,567,136	$239,832,028	4.47%	$248,068,802	3.43%
Institutional Long-Term Care	$523,445,904	$563,977,939	$547,367,664	(2.95)%	$575,448,073	5.13%
Supplemental Insurance	$83,449,233	$89,164,779	$91,685,281	2.83%	$102,177,869	11.44%
Administrative Services	$23,051,952	$28,140,952	$31,747,323	12.82%	$29,347,503	(7.56)%
TOTAL	$2,048,437,415	$2,133,356,365	$2,148,144,996	0.69%	$2,247,525,161	4.63%
Increase from current FY 2007-08 App.			**$14,788,631**	**0.69%**	**$114,168,796**	**4.63%**
Bottom Line Financing	**$12,959,393**	**$14,502,543**	**$13,378,896**	**(7.75)%**	**$13,888,655**	**3.81%**
TOTAL BASE with Bottom Line Financing	**$2,061,396,808**	**$2,147,858,908**	**$2,161,523,892**	**0.64%**	**$2,261,413,816**	**4.62%**

*This is the base request for medical services. Does not reflect impact of decision items (other than decision item #1). A summary of the total request with all other decision items can be found on page 96 of this briefing packet).

As Table 7 above shows, the Department is forecasting higher expenditures in FY 2007-08 than the original appropriation estimate for acute care services, community long-term care services, supplemental insurance, and administrative fees. However, these increases are being partially offset with a decrease in the estimate for institutional long-term care and to the bottom line financing adjustment.

For FY 2008-09, the Department is forecasting an overall growth to the base Medical Services Premiums line item of 4.62 percent (the Department's change requests account for the other 1.6 percent increase to their revised FY 2007-08 estimate). The reason for the larger increase for supplemental insurance is due mainly to comparatively larger caseload growth anticipated for the QMB/SLIMB aid category as well as anticipated cost increases for the Medicare premiums. The reason for the anticipated decrease for administrative services is mainly due to the loss of $1.9 million in funding from the Department of Public Health and Environment for disease management programs pursuant to H.B. 05-1262 and S.B. 07-239.

Table 8 below provides an analysis of how much of the cost in the base Medical Services Premiums budget request is being driven by cost-per-client increases and how much is being driven by caseload increases.

Table 8: Analysis of Factors Driving the Services Cost Estimates

	FY 2007-08 Current Appropriation*	FY 2007-08 New Estimate Department's Request	FY 2008-09 Department Request	FY 2007-08 New Estimate Compared to Current App.	FY 2008-09 compared to FY 2007-08 Current App.	FY 2008-09 compared to FY 2007-08 Estimate
Total Cost Estimated	$2,147,858,908	$2,161,523,892	$2,261,413,816	$13,664,984	$113,554,908	$99,889,924
Caseload	385,010	379,715	383,067	(5,295)	(1,943)	3,352
$/Client*	$5,578.71	$5,692.49	$5,903.44	$113.78	$324.73	$210.95
Impact Associated with Caseload Change				($29,539,266)	($10,839,432)	$19,081,227
Impact Associated with Cost per Client Changes (includes compounding effect)				$43,204,250	$124,394,340	$80,808,697
Subtotal Acute Care Services Cost Increases				$13,664,984	$113,554,908	$99,889,924

* Based on estimate of acute care costs in original appropriation.

Questions for the Department

Staff Recommends the Committee discuss the following questions or issues with Department at their hearing:

1. Can the Department identify the specific caseload impact that resulted from the Deficit Reduction Act of 2005 requirement that low-income populations have their citizenship or legal status documented before they can receive eligibility?

2. Does the Department have any concerns that economic conditions could worsen in the near future causing a greater increase to the Medicaid caseload in FY 2008-09? How confident is the Department that caseload growth will remain below 1.0 percent for FY 2008-09?

3. Why is the CBMS system still unable to identify optional legal immigrants?

4. If a FY 2007-08 General Fund supplemental is needed for the Medical Services Premiums line item, does the Executive have suggestions on how the JBC can avoid being over the 6.0 percent appropriations limit?

FY 2008-09 Joint Budget Committee Staff Budget Briefing
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
Disease Management

ISSUE

Without a legislative change, the Department will lose $3.9 million to fund disease management programs in FY 2008-09.

SUMMARY

- House Bill 05-1262 provided that in FY 2005-06 and FY 2006-07, up to $2.0 million from the Prevention, Early Detection, and Treatment Fund be transferred from Department of Public Health and Environment to the Department of Health Care Policy and Financing for disease management programs that address heart disease, lung disease, and cancer. After FY 2006-07, this statutory transfer expired. The Department did not use this available funding in either FY 2005-06 or FY 2006-07 to establish disease management programs. During figure setting last year, the Committee approved rolling over any unexpended funding at the FY 2006-07 into FY 2007-08. Therefore, in FY 2007-08 the Department has a total of $3.9 million available for disease management programs ($1.9 million PEDT Fund and $1.9 million in matching federal funds). Without a statutory change, this funding will no longer be available in FY 2008-09.

RECOMMENDATION:

Staff recommends that the Joint Budget Committee amend current statute to allow up to $2.0 million to be transferred from the Department of Public Health and Environment's Prevention, Early Detection, and Treatment Fund to the Department of Health Care Policy and Financing in order to continue the availability of disease management funding for HCPF in FY 2008-09.

Staff recommends the Committee discuss the questions at the end of this issue with the Department at their hearing.

DISCUSSION:

Under the Department's new administration, the Quality Improvement Section at the Department has been exploring ways to improve the cost effectiveness and quality of services provided under the Medicaid program. As such, the Department has re-evaluated some of their goals and performance measures to place more emphasis on improving health conditions for Colorado citizens. When staff met with the Department in October 2007, the Department presented 6 specific disease management

programs that the Department is administering or planning to implement in the near future. These programs include the following:

Asthma: The Department has identified over 30,000 clients with a diagnosis of asthma, the majority are children. Total annual medical and pharmacy claims costs equal approximately $165 million. In October 2002, the Department implemented a pilot program to provide disease management services to 150 clients. Based on the initial results of the pilot program (2.84 return on investment), the Department implemented a broad base disease management program for asthma in November 2004. Clients eligible for the program have asthma as their primary or secondary diagnosis and have more than $800 in paid claims in the previous 12 months.

Telehealth Pilot Program for Chronic Conditions: Senate Bill 06-165 required the Department to implement a pilot program to investigate the feasibility of managing and treating clients with specific chronic medical conditions through telemedicine. This pilot program began in July 2007. Clients eligible for the program have congestive heart failure, chronic obstructive pulmonary disease and/or diabetes as their primary or secondary diagnosis and have been determined to be high cost or high risk. Once enrolled, the client is provided with in-home tele-monitoring equipment that allows for the use of multiple peripherals including Glucometer, weight scale, blood pressure, pulse oximeter, and spirometer, as appropriate for the condition being managed.

Congestive Heart Failure: Heart failure is the second most costly chronic diagnosis for inpatient costs, and has an annual total medical and pharmacy claims cost of approximately $43.0 million. In July 2007 the Department began a disease management program for this condition. Clients eligible for the program have congestive heart failure as their primary or secondary diagnosis. Once enrolled, high risk clients are provided a biometric home monitor with scale.

Chronic Obstructive Pulmonary Disease: Chronic Obstructive Pulmonary Disease is the third most common chronic diagnosis with an annual total medical and pharmacy claim cost to the Department of approximately $46.0 million. In October 2007 the Department began a disease management program for this disease. Clients enrolled in this program also receive a biometric home monitor.

High Risk Obstetrics: Fourteen of the top 15 diagnoses, ranked by dollars, were related to high-risk pregnancy, totaling $69 million in hospital claims paid by Colorado Medicaid in FY 2005. Annually, Medicaid pays for approximately 1/3 of all births in the state each year. In order to address the short and long-term health and monetary effect of pre-term births, low-birth weight babies and high risk pregnancies, the Department anticipates beginning a new disease management program in November 2007.

Weight Management: The Department believes that at least 10,000 Medicaid clients have a diagnosis of obesity with over 7,00 of these clients having a co-morbidity of hypertension, heart failure, and or diabetes as a result. The Department plans to begin a weight management program in February 2008 for Medicaid clients with body mass index greater than 25 percent.

While disease management programs are anticipated to improve health outcomes and reduce health care costs by proper management of the chronic conditions, there are additional costs associated with the program (including monitoring devices, case management, identification of clients, educational materials for the clients). For the programs that relate to heart disease, the Department is able to use approximately $3.9 million in roll-forward authority that the Committee provided in the FY 2007-08 budget from the Prevention, Early Detection, and Treatment Fund. Of this amount, $1.9 million is actual monies from the Prevention, Early Detection, and Treatment Fund, and $1.9 million is matching federal funds. After FY 2007-08, this funding will no longer be available without a statutory change.

Staff recommends that the Committee carry legislation to allow up to $2.0 million to be transferred annually from the Department of Public Health and Environment to the Department of Health Care Policy and Financing for disease management programs. Staff believes that the greatest potential savings to the state from the Prevention, Early Detection, and Treatment Fund would come from reducing the costs in the State Medicaid program. Therefore, having a dedicated funding source for the administrative costs of disease management programs would allow the Department to develop long-term programs that could be evaluated for cost-effectiveness as well as health quality improvements for the clients that participate in the program.

Questions for the Department

1. Please describe for the Committee how the Department plans to use the roll-forward authority for the H.B. 05-1262 disease management programs in FY 2007-08? Briefly elaborate on the quality improvement and disease management initiatives that the Department is administering or pursuing in the near future.

2. What is the Administration's position on allowing a permanent statutory annual transfer of $2.0 million from the Prevention, Early Detection, and Treatment Fund to the Department of Health Care Policy and Financing each year? Is there are drawbacks from such a statutory change?

FY 2008-09 Joint Budget Committee Staff Budget Briefing
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
Prescription Drugs Costs in the Medicaid Program

ISSUE

Continued cost-containment efforts for prescription drugs.

SUMMARY

- There are three recent events that impact prescription drugs: (1) passage of H.B. 07-1021 on medication management; (2) final rules for DRA 2005 prescription drug reimbursement; and (3) implementation of a preferred drug list for the Medicaid program.

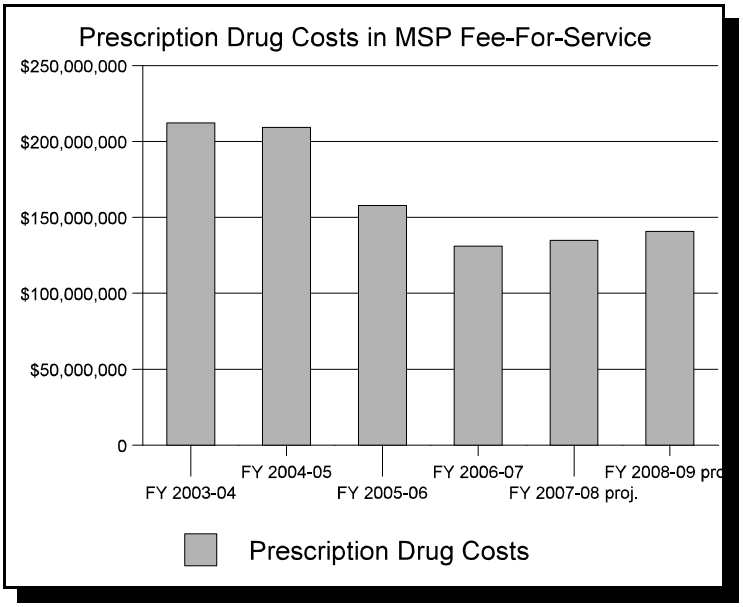
RECOMMENDATION:

Staff recommends the Committee discuss the questions at the end of this issue with the Department at their hearing.

DISCUSSION:

Prescription drugs remain one of the top five expenditures in the Medical Services Premiums line item despite the passage of the Medicare Modernization Act of 2003. In FY 2006-07, total expenditures for prescription drugs after rebates was $131.2 million.

For FY 2007-08, there are three new initiatives that will have impacts on prescription drugs.



(1) **House Bill 07-1021:** This bill created the Prescription Drug Information and Technical Assistance Program to provide advice about prescription drugs to Medicaid clients. The Department of Health Care Policy and Financing is required to administer the program and provide incentive payments to pharmacists and physicians who consult with Medicaid clients about how to avoid dangerous drug interactions, improve outcomes, and save money. Based on the provisions in this bill, total Medicaid prescription drug expenditures are anticipated

to decrease by decrease by $545,281 in FY 2007-08 and by $1,298,425 in FY 2008-09. These costs assumptions are build into the Department's base budget assumptions.

(2) **Final Rules for the DRA 2005 Were Adopted in July 2007:** On July 6, 2007 the Centers for Medicare and Medicaid Services published the final rule based on the Deficit Reduction Act of 2005 requirement that Medicaid reimburse prescription drugs using Average Manufacture Price (AMP) instead of Average Wholesale Price (AWP). Under the new rule, CMS will post AMPs on a Web site that the state and consumers could access. In addition, the rule would limit the federal share of the cost of prescription drugs when at least three generic alternatives are available. The final CMS rule excluded from the formula pharmacy benefit managers and pharmacies in nursing homes and assisted living facilities. CMS anticipates that the new rule would save states and the federal government $8.4 billion over the next five years.

(3) **Preferred Drug List:** Executive Order D 004-07 established a Preferred Drug List for the medicaid program. The Department anticipates that the Preferred Drug List will save $670,376 in prescription drug costs in FY 2007-08 and $1.3 million FY 2008-09.

Questions for the Department

1. Please provide the Committee with an undate on the implementation of H.B. 07-1021.

2. What savings impact, if any, does the Department anticipate from the CMS Final Rules for the DRA 2005 related to pharmacy reimbursement? What impact does the Department believe the rules will have on independent pharmacies participating in the Medicaid program?

3. Please update the Committee on the implementation on the preferred drug list.

FY 2008-09 Joint Budget Committee Staff Budget Briefing
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
Recovery Legislation

ISSUE

The Department has requested JBC sponsorship for three pieces of legislation related to trust, estate, and third-party recoveries.

SUMMARY

- ❑ The Department has brought to staff's attention three pieces of legislation that they request JBC sponsorship.

RECOMMENDATION:

Staff recommends that the Committee consider the Department's legislative package on estate, trust, and third-party recovery for JBC sponsorship. Staff recommends that the Committee discuss this issue with the Department at their hearing including the potential fiscal impacts for each proposal and potential controversy for each proposal.

DISCUSSION:

In January 2006, Congress passed the Deficit Reduction Act of 2005 which contained several provisions attempting to slow the growth in the Medicaid long-term care program. Namely, the DRA of 2005 increased penalties on individuals who transfer assets for less than fair market value in order to qualify for nursing home care under the Medicaid program by moving the start of the penalty period from the date of the asset transfer to the date of the application for Medicaid and by increasing the look-back period from three years to five years. The DRA also made individuals with home equity greater than $750,000 ineligible for Medicaid nursing home benefits. Finally, the DRA also counted certain assets that were previously exempt financial instruments (such as certain annuities, promissory notes, and mortgages). All of these changes were attempting to limiting the Medicaid long-term care benefits to those individuals who don't have the financial resources to help pay for their long-term care needs.

In their hearing responses last year on this issue, the Department stated that increasing the look back period from three to five years was anticipated to have very little impact during first three years after the DRA was passed. In addition, the Department noted that these law changes would not necessarily help to reduce the prevalence of asset transfers as a form of Medicaid planning. In the short term, the Department anticipated that changing the look back period would most likely result

in a shift in the types of strategies used for transferring assets to attain Medicaid eligibility (Department December 19 and 20, 2006 Hearing Responses, page 50). However, the Department does believe that there are some state law changes would help improve the state's ability to make sure Medicaid eligibility is reserved to those most in need of financial assistance. These law changes fall into three categories:

(1) ***Limit Pooled Trusts:*** The Department asks that the current statute allowing pooled trusts to be amended to contain a cap (the Department suggested $50,000 when talking to staff about this idea) on the amount of funds that the individual could place in the trust and still qualify for Medicaid. The Department also requests that the limitation on the source of funding for these trusts to personal injury settlements and certain retroactive Social Security payments.

Discussion: Current statute prohibits the establishing of trusts in order to establish or maintain Medicaid eligibility except for in three cases (Section 38-10-111.5):

a) Income trusts can be established when an individual's income from all sources is too high to qualify for Medicaid but is less than the average private pay rate for nursing home care in the geographic region in which the applicant lives. The income that can be placed in these trusts is limited to pension income, social security and other monthly income. The income trust must meet all of the following criteria: (1) the assets in the fund are limited to monthly unearned income (i.e. pension, social security, etc.); (2) the sole lifetime beneficiary of the trust are the person for whom the trust is established and the Department of Health Care Policy and Financing; (3) the entire corpus of the trust (expect for reasonable trust administrative fees) are for the nursing home or HCBS costs of the beneficiary; (4) allows for certain monthly deductions from the trust; (5) the Department of Health Care Policy and Financing receives all amounts remaining in the trust up to the total medical assistance paid on behalf of the client upon the client's death. (Section 15-14-412.7).

b) Disability trusts can be established for individuals under 65 years of age who are disabled. Disability trusts must meed these criteria: (1) the trust if funded by assets of an individual under age 65 but the individuals family, guardian or court; (2) upon the death of the individual the HCPF receives any amount remaining in the trust up to the total medical assistance paid on behalf of the individual; (3) the sole lifetime beneficiary of the trust are the individual for whom the trust is established and HCPF; (4) the trust can only be used to establish Medicaid eligibility but not any other public assistance program; and (5) HCPF must review the trust and determine the trust conforms to these statutory requirements.

c) Pooled trusts are trusts consisting of individual accounts established for individuals who are disabled and are established for maintaining or establishing Medicaid eligibility. These trusts must meet the following criteria: (1) but managed by a

nonprofit; (2) maintain separate accounts for each individual; (3) the sole lifetime beneficiary is the person for whom the trust is established and HCPF. Upon the death of the individual, HCPF must recover from the trust any payments made on behalf of the individual before any other person may recover from the trust; accounts in the trust are established solely for the benefit of in individual; (3) HCPF must review the trust.

Over the years, HCPF has become concerned that pooled trusts have been used to shield and transfer assets. Because the trust assets are not limited in amount or source, HCPF is aware of some instance where assets have been transferred to a pool trust so that the beneficiary can qualify for Medicaid and then the assets in the trust have been depleted by the guardian of the beneficiary before beneficiaries death. When discussing this issue with staff, the Department indicated that in the worst cases this scenario has involved over a million dollars in the trust. Therefore, in order to avoid this instrument being used by individuals (and their families) who can afford long-term care services, the Department would like to limit the assets in these trust to a specific amount (HCPF discussed $50,000 with staff) and limit the source of funding to tort and casualty award cases rather than any income or asset.

(2) ***Estate Recoveries***: The Department proposes several changes to the estate recovery statutes including the following: (1) Allow the Department to foreclose on TEFRA liens after the death of a Medicaid recipient;[1] (2) specify in statute that capitation payments made on behalf of Medicaid clients are considered medical assistance and are recoverable; and (3) allow the Department through the county human services departments to file for a request for notice of transfer of real property of a Medicaid recipient.

(3) ***Third Party Recovery:*** The Department seeks legislation to clarify who participates in data matching to allow discovery of potential third party insurance obligations and requires third

[1]The Tax Equity and Fiscal Responsibility Act (TEFRA 1982) allows states the option to place liens on Medicaid long-term client's assets while the client is still living in order to prevent these assets from being given away before the state can recover assistance payments made on behalf of the client. When states elect to use this option, the financial interests of Medicaid are given precedence over the interests of adult children or others who reside in or claim an interest in the homes of institutionalized Medicaid recipients who no longer live in them and may never do so again. TEFRA liens are the only type of lien that may be placed prior to the death of a Medicaid recipient whose benefits have been correctly paid. For this reason, they are also called “pre-death” liens. They only apply to permanently institutionalized individuals. While estate recovery does not begin until the Medicaid recipient dies, a TEFRA lien may be placed against the real property of a recipient of any age who is an inpatient of a nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if it has been determined that he or she cannot reasonably be expected to return home. States must afford the individual an opportunity for a hearing on that finding and are required to dissolve a TEFRA lien if the Medicaid recipient returns home.

party insurers to accept claims for recovery under certain guidelines. A similar bill was introduced last year but failed to make it through the process.

Questions for the Department

1. Please explain the Department's proposed legislation for limiting pooled trusts? Please explain the Department's estimated fiscal impact of the proposed legislation and any controversy that would be associated with the proposal.

2. Please explain the Department's proposed legislation for estate recovery? Please explain the Department's estimated fiscal impact of the proposed legislation and any controversy that would be associated with the proposal.

3. Please explain the Department's proposed legislation for third party recoveries. Please explain the Department's estimated fiscal impact of the proposed legislation any controversy that would be associated with the proposal.

FY 2008-09 Joint Budget Committee Staff Budget Briefing
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
Breast and Cervical Cancer Treatment Fund

ISSUE

The fund balance in the Breast and Cervical Cancer Treatment Fund is projected to be $9.1 million at the end of FY 2007-08 and $10.2 million at the end of FY 2008-09.

SUMMARY

- ❑ Current statute requires that in FY 2007-08, 75 percent of the state costs for the breast and cervical cancer treatment program be appropriated from the General Fund and that 25 percent be appropriated from the breast and cervical cancer prevention and treatment fund. In FY 2008-09, current state requires that 100 percent of the state costs shall be appropriated [implied from the General Fund].

RECOMMENDATION:

Staff recommends the statutory changes to the Breast and Cervical Cancer Treatment Fund and to the Coordinated Care for People with Disabilities Fund as discussed in this issue.

DISCUSSION:

The Breast and Cervical Cancer Treatment Fund (BCCT Fund) was created in S.B. 01S2-012, for the purpose of funding the state match for Medicaid services for women under age 65 year old, that have been diagnosed with breast or cervical cancer, and do not have any credible insurance coverage. The revenue source for the BCCT Fund is the interest earnings from the Tobacco Litigation Settlement Trust Fund. All moneys in the fund remain (including the unexpended fund balance) in the fund with the exception that interest earnings on this fund are transferred to the Coordinated Care for People with Disabilities Fund. Per current statute, the breast and cervical cancer treatment program must receive 100 percent state General Fund support beginning in FY 2008-09 and the BCCT Fund is repealed effective July 1, 2009 (FY 2009-10).

Based on the Department's November 1, 2007 budget request, the BCCT Fund should have a fund balance of $9,125,987 at the end of FY 2007-08 and $10,225,937 by the end of FY 2008-09. After the fund is repealed on July 1, 2009, then the Tobacco Litigation Settlement Trust Fund shall retain its interest earnings. The statute is unclear on what happens to moneys in the BCCT, in that the statute prohibits the funding from reverting to the General Fund and the Coordinated Care for People

Disabilities Fund is required to receive the interest earnings from the BCCT Fund until at least FY 2012-13 (five years after the pilot program for the CCPD program began).

Current Funding for the Breast and Cervical Cancer Treatment Program

The Breast and Cervical Cancer Treatment program is anticipated to have the following expenditures in FY 2007-08 and FY 2008-09.

Table 1: Breast and Cervical Cancer Treatment Program Expenditures - Department Request

	FY 2007-08	FY 2008-09	Comment
General Fund	$1,197,563	$1,711,756	
CFE - BCCT Fund	$399,188	$0	25% of state expenditures for original BCCT caseload in FY 2007-08. 0.0% of state expenditures for oiriginal BCCT program in FY 2008-09 pursuant to section 25.5-308 (9) (c).
CFE - Transfer from DPHE	$684,322	$728,567	State match for added BCCT clients added under H.B. 05-1262 (Tobacco Tax Funding)
Federal Funds	$4,236,277	$4,532,077	
Total Fund	$6,517,350	$6,972,400	

Table 2 shows the fund balance that the Department is projecting for the BCCT Fund by the end of FY 2008-09.

Table 2: Fund Balance for BCCT Fund

	FY 2005-06 Actual	FY 2006-07 Actual	FY 2007-08 Estimate	FY 2008-09 Estimate
Beginning Balance	$5,477,034	$7,007,157	$8,445,560	$9,125,937
Revenues	$1,883,505	$1,781,991	$1,500,000	$1,500,000
Expenditures for BCCT Program	($353,382)	($343,588)	($399,188)	$0
Expenditure Transfer to CCPD Fund	$0	$0	($420,435)	($400,000)
Ending Balance	$7,007,157	$8,445,560	$9,125,937	$10,225,937

The current statute is unclear on three points:

1) **Whether or not the General Assembly can appropriate money from the BCCT Fund in FY 2008-09 for the support of the BCCT program.** When S.B. 01S2-012 was passed the original statute for the BCCT program phased in the General Fund support for the program and the BCCT Fund was seen as a temporary funding source. However, the current statute reads:

> "Section 25.5-5-308 (9) (a) For the fiscal year 2005-06, the general assembly shall appropriate fifty percent of the state costs of the breast and cervical cancer prevention and treatment fund from the general fund and fifty percent from the moneys credited to the breast and cervical cancer prevention and treatment fund pursuant to section 24-22-115 (1), C.R.S., to such program.
>
> (b) For the fiscal years 2006-07 and 2007-08, the general assembly shall appropriate seventy-five percent of the state costs of the breast and cervical cancer treatment program from the general fund and twenty-five percent form the moneys credited to the breast and cervical cancer prevention and treatment fund pursuant to section 24-22-115 (1), C.R.S., to such program.
>
> *(c) For the fiscal year 2008-09 the general assembly shall appropriate one hundred percent of the state costs of the breast and cervical cancer prevention and treatment program to such program.*"

While staff believes it was the intent of the statute that in FY 2008-09, the entire state support for the original breast and cervical cancer treatment program (excluding the expansion under H.B. 05-1262) be funded from the General Fund, the statute does not actually explicit say that because the statute neglects to identify what fund source should be used for the 100% percent requirement.

2) **The statute repeals the BCCT Fund on July 1, 2009 but neglects to specify what happens to any unexpended and unencumbered fund balance.** Section 25.5-5-308 (10) repeals the fund on July 1, 2009. However, the statute is unclear on what happens to unexpended fund balance in the fund. In 25.5-5-308 (8) (a) the statute states that "all moneys credited to the fund and all interest and income earned on the moneys in the fund shall remain in the fund for the purposes set forth in this section. No moneys credited to the fund shall be transferred to or revert to the general fund of the state at the end of any fiscal year." Staff interprets the statute to mean that after July 1, 2009, no more interest earnings from the Tobacco Litigation Settlement Trust Fund should be credited to the fund (that is why the fund is repealed). However, that as long as money remained in the fund that it would continue to exist in the State Treasury. However, because the fund is limited to being used

for the BCCT program and statute requires (although doesn't specific state) that the state match for this program be funded from the General Fund, it appears that the unused balance in the fund is met to stay in the fund in perpetuity.

3) **The statute allows in another paragraph (Section 25.5-5-308 (8) (b)) for the interest earnings on this fund to be transferred to the Coordinated Care for People with Disabilities (CCPD) Fund.** The CCPD Fund receives the interest earnings from the BCCT Fund. The CCPD Fund can be used to pay for the direct and indirect costs associated with implementing a pilot program for the coordinated care for the disabled. The statute is effective for five years following the implementation of the pilot program and then is repealed. When this fund is repealed, the statute specifically states any unexpended and unencumbered moneys remaining in the fund shall be transferred to the general fund. The CCPD pilot program is being implemented in FY 2007-08. Therefore, it is assumed that the implementation costs for this program should be paid through FY 2012-13 from the CCPD Fund.

Staff recommends the following:

1) Transfer $2.0 million from the unexpended balance from the BCCT Fund to the CCPD Fund in FY 2007-08 and eliminating the requirement that it receive the interest earnings from the BCCT Fund. This ensure that there should be enough funding in the CCPD Fund for the five years of the pilot program. Change the CCPD Fund to statute that if any fund remain unexpended or unencumbered when the fund is repealed that it revert to a special purposes fund in the Department of Health Care Policy and Financing.

2) Allow the state General Fund portion of the BCCT program funding to be funded from the BCCT Fund in both FY 2007-08 and FY 2008-09. This will help create additional room ($1.2 million) under the General Fund 6.0 percent limit in case of a positive supplemental for the Medical Services Premiums line item. It will also give the Committee some extra "spending" room in FY 2008-09 if it is needed to balance the state budget. Please note that this is one-time savings, and that funding from the General Fund would be needed to make up this difference in FY 2009-10. Provide in the statute that any unexpended or unencumbered balance in the BCCT Fund when it is repealed on July 1, 2009, but transferred to a special purposes fund in the Department of Health Care Policy and Financing.

3) Create the "special purposes fund" in the Department of Health Care Policy and Financing. Allow this fund to receive any expended balances from the BCCT Fund or CCPD Fund when these funds are repealed. This will ensure that this revenue does not revert back to the General Fund where it would be counted under the 6.0 percent limit or revert to the Tobacco Litigation Trust Fund where it would become part of the distribution formula for those moneys. This fund could be used to help mitigate unanticipated expenditures in the MSP line item.

FY 2008-09 Joint Budget Committee Staff Budget Briefing
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
Department's Provider Rate Increase Plan

ISSUE

The Department's FY 2008-09 budget request includes an increases of $17.1 million total funds ($8.3 million General Fund) for provider rate increases.

SUMMARY

- ❑ The Medical Services Premiums *base* cost projections do not include provider rate increases for any Medicaid providers who have their rates set by Department rule or policy. Therefore, the Department has included a separate decision item to increase rates for targeted acute care Medicaid providers.

- ❑ The Department's budget does not include any rate adjustments for home-and-community-based service providers.

RECOMMENDATION:

Staff recommends that if the Committee adopts a formal common policy on provider rate increases that Medicaid home-and-community based services providers be considered for the same common policy rate increases. Staff recommends that any rate increases for Medicaid acute care providers be targeted to address specific rate problems.

Staff recommends that the Committee discuss the questions at the end of this issue with the Department at their hearing.

DISCUSSION:

The Department's *base* request for Medical Services Premiums includes only those cost increases to rates that occur outside of the Department's rate schedule.[1] Therefore, any Medicaid provider who is paid based on the Department's rate schedule does not receive an increase in reimbursement unless the Committee approves additional funding. During the last several years, the Committee has approved specific provider rate increases in order to restore previous rate cuts that occurred in FY 2001-02 through FY 2003-04 and to address major problem areas in the current rates (i.e. such as when the Medicaid rate doesn't pay for the actual cost of a device or product such as adult

[1]Appendix contains a table of which providers have rates set by federal or state statute and which providers have rates set by the Department's schedule.

immunization shots). For FY 2008-09 the Department is targeting nine rate areas and the corresponding increase to HMO capitation in their provider rate plan. Table 1 shows the estimated fiscal impacts of the Department's request.

Table 1: Department's FY 2008-09 Rate Plan

Provider Class	Total Funds	General Fund	Health Care Expansion Fund	Federal Funds	Comments
Inpatient Hospital	$4,679,688	$2,260,347	$79,497	$2,339,844	Reflects a 1.5 percent increase to all inpatient hospital rates.
E&M - Age Specific	1,514,747	731,642	25,732	757,373	Increase 12 specific preventative medicine evaluation and management codes to 90% of the Medicare rate. CPT codes 99381 through 99387 and 99391 through 99397.
E&M - Other	1,750,000	845,272	29,728	875,000	Raise other evaluation and management codes to 83.4 percent of Medicare rate.
Medical Home Pilot Program	222,255	107,352	3,776	111,127	Increase well child vist rate by $10.00 for children 0-4 and by $40.00 for children 5-20.
Substance Abuse	750,000	362,259	12,741	375,000	Adjust the rates in line with average commercial reimbursement.
Radiology	2,250,000	1,086,778	38,222	1,125,000	Increase current radiology rates by 17.7 percent.
Vision Benefits	500,000	241,506	8,494	250,000	Increases rates for frames and lenses by 33.45 percent.
Dental Services	3,500,000	1,690,543	59,457	1,750,000	Increases dental rates by 7.38 percent.
Prenatal Plus	500,000	250,000	0	250,000	Increase rates by approximately 51.5 percent.
Health Maintenance Organization	1,425,185	688,382	24,211	712,592	Estimated impact for the rate increases above to the HMO capitation rate.
TOTAL	$17,091,875	$8,264,081	$281,858	$8,545,936	

Inpatient Hospital: During the last several years, the JBC has improved rate increases for inpatient hospital in order to maintain the Medicaid rate at or above 90 percent of the Medicare rate (usually it has been between 90 to 92 percent of Medicare rates for the last three years). In August 2007, Medicare published new rate methodologies for inpatient rates. Because the Department's rate methodology is based on the old Medicare rates, they will no longer be directly comparable. For FY 2008-09, the Department merely requests applying a 1.5 percent increase to all inpatient hospital rates rather than trying to maintain a target of at least 90 percent of the Medicare rate.

Evaluation and Management - Age Specific: The Primary Care Provider Rate Task Force and Study noted how inadequate some of Medicaid rates are for primary care codes related to preventative pediatric and adult health supervision. In response to the Task Force's finding, the Department is recommending that the JBC increase the rates for 12 frequently used preventative medicine evaluation and management codes to 90 percent of the corresponding Medicare rate. Currently, these rates are between 36.5 percent and 58.5 percent of Medicare.

Evaluation and Management - Other: The Department also recommends increasing the rates for another 75 evaluation and management codes that have not had rate increases in recent years. The Department stated in their request that they would like to raise all of these codes to 90 percent of Medicare. However, due to fiscal constraints, the Department can only recommend an increase to 83.4 percent of Medicare at this time. Raising these codes to 83.4 percent of the Medicare code results, on average, of an increase of 17.65 percent to most of the codes.

Medical Homes: Last year the General Assembly passed S.B 07-130, which requires the Department to maximize the number of children in the Medicaid program who have a Medical Home. In attempting to implement this bill, the Department is proposing a pilot program that would increase reimbursement for well-child visits to provide an incentive for providers to accept Medicaid clients and coordinate their care. The Department's pilot program will involve 124 providers, serving approximately 10,000 children. The providers will be paid an additional $10.00 per annual well child visit for children 0-4 and an additional $40.00 for annual well child visits for children ages 5 to 20. The Department will evaluate the cost effectiveness of the program and any cost-savings that result from children having an assigned Medical Home.

Substance Abuse: H.B. 05-1015 created an out-patient substance abuse benefit in the Medicaid program. Prior to the passage of this bill, Medicaid did not pay for outpatient substance abuse treatment and Medicaid clients received such care through the Department of Human Services Drug and Alcohol Abuse Treatment programs. At the time this bill was passed, the fiscal note estimated that approximately 4,500 Medicaid clients would use these services with an average cost of $1,500. The outpatient substance abuse treatment program was originally assumed to be operation by January 1, 2006. However, the Department was not able to implement the program until July 1, 2006. For FY 2006-07, the bill was anticipated to have fiscal impact of $5.6 million. However, the actual fiscal impact for this program in FY 2006-07 was $349,054 with an average monthly enrollment of 203 clients.

When the rates for the substance abuse program were originally set, they were based on the Department of Human Services Special Connections program (however, these rates have not been adjusted since 1992). Providers have indicated that the Medicaid rates are set too low to encourage providers to accept Medicaid clients.

The Department's rate plan seeks to adjust rates in line with average commercial reimbursement. To that end, the Department intends to increase the hourly reimbursement rates for group sessions at an average of 23 percent and hourly reimbursement rates for individual sessions an average of 63

percent. The Department also adjusts cost based on higher utilization as a result of additional providers participating in the program.

Radiology Services: In FY 2002-03, radiology services received a 5.0 percent rate cut in order to help balance the state's budget. These rate cuts have never been restored. Currently, the Department is reimbursing at approximately 23 percent of the Medicare rate for these services on average. The Department is requesting an increase of 17.7 percent in order to help bring these rates back up.

Vision Benefits: Currently, the state Medicaid program pays for eyeglasses for children and for adult clients following eye surgery. The majority of the rates were set in 1987. The Department requests would increase reimbursement rates for these services by 33.45 on average in order to rebase the rates.

Dental Services: Dental services are required for children under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. In addition, emergency dental services can be provided for adults. While dental rates received a rate increase in FY 2006-07 of 3.25 percent, the rates still remain at between 33 percent to 50 percent of average commercial rates. The Department's request for FY 2008-09, includes a rate increase of 7.38 percent.

Prenatal Plus: The Prenatal Plus program is a program administered in partnership with the Department of Public Health Environment to identify and provide services to women at high risk of pre-term (low-birth weight) births. The program enhances prenatal programs to assist women with nutritional and social services assistance, including discouraging the use of tobacco, alcohol and illicit drugs.

Based on a study by the two Departments, an analysis showed that on average providers were being reimbursed at 45 percent of the cost of the program. Overall the average cost per client in 2005 was $1,054 and Medicaid reimbursed at an average rate of $479 per client. The low Medicaid reimbursement creates more pressure on the Maternal Child Health (MCH) Block Grant and local funds and limits the number of women who can be served. In addition, according to the Department's request, since 2004 five Prenatal Plus programs have been discontinued due to the financial hardship by the agency providing the program. The Department's request would bring rates up to covering approximately 69 percent of the provider costs.

Adjustment to HMO capitation: Whenever, provider rate increases are provided in the fee-for-service Medicaid program, a corresponding increase is made to the capitation rates for HMOs.

Staff Comment

The Department's rate plan addresses the Joint Budget Committee's desire over the last several years to target appropriations to areas of the greatest need rather than just provide across the board rate adjustments for certain providers. Due to the fiscal constraints that State budgets under, it is

unrealistic to anticipate that the Department could immediately move all Medicaid rates up to 80 percent or more of Medicare rates. It has taken years for the Medicaid rates to decline to where they are and it will take years (if ever) for all rates to be adjusted to more sound and reasonable levels. Staff believes that the Department's submitted rate plan is a good place to start the discussion this year for provider rate changes.

One area that the Department's provider rate increases do not address is Home and Community-Based Services. As the Committee is aware, in FY 2005-06 and FY 2006-07 the Committee approved substantial rate increases for these provider groups in order to bring these rates 90.0 percent of Medicare rates. In FY 2007-08, this provider group was given the same common policy rate increase that other community providers received. Staff estimates that in order to provide a 1.0 percent COLA for this provider group that it would cost approximately $3.5 million.

Last year the Committee asked the Governor's Office to draft a report concerning the common policy for provider rates. The report was to consider the following factors: (1) distinguish which provider serve Colorado's most vulnerable population; (2) salaries and benefits; and (3) turn-over rates and attrition among staff. The Governor vetoed this footnote and at the time this issue was written, has not yet responded to this request.

Questions for the Department at Their Hearing

1. Please provide an update on the implementation of S.B. 07-130.

2. If Medicaid rates for the Prenatal Plus program actually covered cost of the program, would additional women be able to be served using funding from the Maternal Block Grant or local funds? If more women were served under this program, would the state anticipate greater savings in the Medicaid program?

3. When the substance abuse outpatient benefit was initially added, it was assumed that there would be some offsetting savings in the Medical Services Premiums line item. Does the Department anticipate that higher rates, an corresponding forecasted increase in utilization, will result in savings elsewhere in the Medical Services Premium. If so, how much savings does the Department anticipate.

FY 2008-09 Joint Budget Committee Staff Budget Briefing
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
Health Care Maintenance Organization Rates

ISSUE

Managed care rates at 100 percent of fee-for-service rates.

SUMMARY

- ❑ Last year, the JBC sponsored H.B. 07-1346 which made several changes to the managed care statutes for the Medicaid program including eliminating the statutory provisions that prohibited managed care rates from exceeding 95 percent of fee-for-service costs. Under H.B. 07-1356, MCO rates can not exceed 100 percent of fee-for-service costs.

- ❑ At the time H.B. 07-1346 was passed, it was assumed that the one MCO providing services in the Medicaid medical program would attempt to certify additional public funds in order to draw down additional federal funds in FY 2007-08. Therefore, H.B. 07-1346 did not contain an appropriation clause in FY 2007-08 to adjust rates up to 100 percent of fee-for-service. After the 2007 Session ended, Denver Health informed the Department that unless capitation rates were increased to 100 percent of fee-for-service, they would leave the Medicaid managed care program. In June 2007, the Committee gave approval to the Department to negotiate rates up to 100 percent but instructed the Department to delay implementation of the quality incentive grant program in order to help defray the costs of negotiating rates at a higher level than originally anticipated.

RECOMMENDATION:

Staff recommends that the Committee ask the Department to respond on the feasibility of implementing the quality incentive grant program before December 31, 2007.

DISCUSSION:

The Department's FY 2008-09 budget request includes an increase of $4.3 million total funds ($2.2 million General Fund) to increase rates for managed care providers up to 100 percent of fee-for-service. Once the FY 2007-08 appropriation has been adjusted to reflect the approval of the Department's June 1331 Emergency supplemental, the majority of the FY 2008-09 adjustment will be included in the FY 2007-08 base. Therefore, the FY 2008-09 decision item will be reduced to reflect only the incremental funding needed on the base funding to retain MCO rates at 100 percent of fee-for-service in FY 2008-09.

Background on Managed Care and Review of June 2007 1331 Supplemental

The Colorado Medicaid Managed Care Program has had many stumbling blocks over the last several years. In 1997 the General Assembly passed S.B. 97-005 which placed an emphasis on building an at-risk capitation model for managed care. In July 1997, the Department was contracting with 10 different HMO plans with risk-based capitation contracts (Antero Health Plans, Colorado Access - NUT, Community Health Plan of the Rockies, Foundation Health, Frontier Community Health Plans, HMO Colorado, Kaiser Foundation Health Plan, Rocky Mountain HMO (Metro/WS), Total Longterm Care & United Health Care). In July 1997, the total Medicaid enrollment in the HMO plans was 70,026 or 30 percent of the total Medicaid caseload (another 56,068 or 24 percent was enrolled in the PCPP program). At the height of the risk-based capitation program in October 2002, the Department was contracting with 6 different HMO plans (Total Longterm Care, Rocky Mountain HMO (F & A), Kaiser Foundation Health Plan, Colorado Access, United Health Care, and Community Health Plan of the Rockies). At that time, the total caseload in the MCOs was 155,576 clients or 51 percent of the total Medicaid caseload (another 56,547 or 18% were enrolled in the PCCM program).

Shortly after October 2002, most of the private MCOs did not renew their contracts with Department (i.e. Rocky, Kaiser, United Health Care and CHPR all left the Medicaid program during FY 2002-03). By June 2003, the Medicaid caseload enrolled in risk-based capitation MCO contracts was 91,459 or only 28.1 percent of the total Medicaid caseload (however, growth in the PCCM program occurred during this time to around 80,852 or 24.8% of the Medicaid caseload). Beginning in FY 2003-04, only Colorado Access remained serving the Medicaid medical program on a risk-based capitation model (Total Long-Term Care remained as the PACE provider) while Rocky Mountain HMO entered into a contract as a Prepaid Inpatient Health Plan (PIHP). In FY 2004-05, Denver Health, as Denver Health Medicaid Choice, entered a contract as a risk-based provider bringing the total at-risk capitation plans to two providers.

As the Committee is aware, in September 2006, Colorado Access ended their contract with the Department as a MCO in the medical program. As of November 2007, Denver Health Medicaid Choice remains the only MCO provider with an at-risk capitation contract for the Medicaid medical program. Based on the November 2007 caseload report, approximately 36,248 Medicaid clients are now being served by an MCOs (approximately 9.5 percent of the Medicaid population).

During the 2007 session, the Joint Budget Committee carried H.B. 07-1346 to reform the Medicaid managed care program. As the Committee is aware, H.B. 07-1346 allowed (but did not mandate) the Department to pursue additional PIHP agreements. In addition, H.B. 07-1346 allowed (but did not mandate) that managed care rates could increase from the previous ceiling of 95 percent of fee-for-service to 100 percent of fee-for-service for direct health care.

The FY 2007-08 fiscal impact of H.B. 07-1346 was assessed at $75,000 total funds. This appropriation was for a study regarding the feasibility of entering into additional PIHP agreements. The Legislative Council Staff Fiscal Note (latest version is May 30, 2007) assumed that if the study

should reveal additional administrative or system costs associated with entering into more PIHP agreements, that the annual budget process would address those costs (i.e. decision items would be submitted for FY 2008-09 for any new contracts). The Legislative Council Staff Fiscal Note (dated May 30, 2007) also assumed that MCO rates would not change as a result of this bill. The fiscal note specifically stated, "Should the DHCPF implement a new managed care capitation rate methodology, any increase in costs would be addressed through the budget process."

When the bill was going through the House Appropriation process, JBC staff noted the following:

> The bill [H.B. 07-1346] eliminates the cap on capitation payments to Managed Care Organizations (MCOs) to not exceed 95 percent of the costs for an equivalent Medicaid population in the fee-for-service or Primary Care Physician Program (PCPP). The House Health and Human Services Committee Report will ***allow*** the Department to pay MCO rates that equal up to but not to exceed 100 percent of the costs for an equivalent Medicaid population in the fee-for-service or PCPP. The Revised Legislative Council Staff Fiscal Note, dated April 4, 2007, does not identify any additional cost for these provisions because the language is permissive (i.e. the Department can negotiate rates any level as long as the rates do not exceed 100 percent of the fee-for-service and PCPP costs). Furthermore, if an appropriation was provided in the bill for this provision, the appropriation clause itself would weaken the Department's negotiating power. Staff raises this point only to alert the [Appropriation] Committee that additional costs other than those noted in the fiscal note ***could*** occur if Denver Health attempts to renegotiate their current rates to a level higher than the current 95 percent cap and succeeds. (JBC Staff Analysis dated April 10, 2007).

However, amendments in Senate provided that government-owned MCOs (which Denver Health is) the ability to seek certified public expenditure or other federally recognized financing mechanisms to provide the state share for the federal match to enhance capitation payments up to or above the one hundred percent limit (Section 25.5-5-408 (12)). When this amendment adopted, staff assumed that Denver Health was pursuing other means to enhance their reimbursement in order to avoid a fiscal impact in FY 2007-08 for H.B. 07-1346. Therefore, staff dropped the above "point to consider" from the Senate Appropriation analysis on the bill.

In June 2007, the Department was informed by Denver Health Medicaid Choice that unless capitation rates were increased above the 95 percent level, it would no longer be feasible to remain an MCO provider. Based on this communication, the Department submitted a 1331 emergency supplemental requesting that an additional $4,178,940 in total funds in order to increase rates up to 100 percent of fee-for-service. In June 2007, the Committee sent a letter to the Department approving their request to negotiate up to 100 percent of fee-for-service rates in order to retain Denver Health as a provider. The Committee gave this approval based on the following reasons:

1) The Committee carried H.B. 07-1346 in attempt to bring managed care back as viable delivery option in the Medicaid program. Losing another MCO provider would further weaken the Department's attempt to move more clients back into managed care

2) If Denver Health no longer participated as an MCO in the Medicaid medical program, the Medicaid program would have once again experienced the upheaval associated with moving clients from the managed care provider to the fee-for-service. Quality and consistency of care could have been lost for approximately 36,000 Medicaid clients.

However, because the FY 2007-08 appropriation level was already at the 6.0 percent limit, the Committee also requested that the Department delay the implementation of a quality incentive program in order to offset some of the costs associated with moving to 100 percent of fee-for-service. Based on this recommendation, in June 2007 the Committee assumed that the fiscal impact of approving the Department's request to negotiate rates up to 100 percent of the fee-for-service rates was as follows:

Table 1: 1331 Emergency Supplemental Cost Estimates from June 2007

	Incremental Cost to Increase Rates to 100% Fee-for-Service	Currently Approved Incentive Payment Offset	Total Fiscal Impact (Potential Appropriation Change)/2
General Fund	$1,984,996	($379,234)	$1,605,762
Cash Funds Exempt/1	104,474	0	104,474
Federal Funds	2,089,470	(379,233)	1,710,237
Total Funds	$4,178,940	($758,467)	$3,420,473

/1 Staff's estimate of the impact to the Health Care Expansion Fund.

At the time the Committee approved the 1331 supplemental, staff recommended against sending a formal letter to the State Controller changing the current FY 2007-08 appropriation. Staff believed the Medical Services Premiums line item had sufficient funding to avoid an over expenditure before January 2008 when the adjustment could be made during the regular supplemental process. Also delaying the formal appropriation adjustment would allow for a better estimate of actual costs based on the actual rates negotiated and more current estimates for caseload and costs in the Medical Services Premiums line item. Because the 1331 emergency supplemental has not yet been appropriated into the base funding for FY 2007-08, the Department includes the full impact in their decision item for FY 2008-09. Once the 1331 emergency supplemental is added to the FY 2007-08 appropriation base, the impact in FY 2008-09 will be as follows.

Table 2: New Cost Estimates for June 1331 Supplemental Based on Actual Negotiated Rates and Estimated Incremental Cost in FY 2008-09 for Rates Up to 100% Fee-For-Service			
	FY 2007-08 Staff Estimated Impact Incremental Adjustment to Current Appropriation	**FY 2008-09 Department Estimated Impact**	**Incremental Cost for D.I. # 12 (FY 2008-09 costs minus base costs to be included in FY 2007-08)**
Costs to Adjust Rates to Negotiated Amount or Up to 100%	$3,343,152	$4,372,996	$1,029,844
Offset by Incentive Grant Program (Per JBC instructions)	($758,467)	$0	n/a
Total Incremental Change to Base Appropriation	$2,584,685	$4,372,996	n/a

As table 2 shows (and page 59 of the footnote reports), the rates actually negotiated with Denver Health were actually approximately 99.0 percent of the fee-for-service rates rather than at 100 percent. Therefore, staff anticipates that the supplemental adjustment will be lower than originally assumed in June 2007. Based on staff's new assumptions, the Committee could instruct the Department to reinstate the incentive grant program and still have a lower cost estimate than staff assumed in June 2007. The reasons for doing so would as follows:

Financial position of Denver Health in 2007: Denver Health was counting on the incentive grant program to help mitigate their losses in 2007. Denver Health's fiscal year is on a calendar basis. Originally, Denver Health had assumed that the incentive grant program payment would have been paid to them in calendar year 2007. This would help them mitigate their losses for in the Medicaid managed care program in 2007.

Reasons Not to Reinstate the Incentive Grant Program include:

Anticipated Supplemental in Medical Services Premiums Line Item: Based on the higher than appropriated rate of 99 percent rather than 95 percent, Denver Health will receive approximately $1.7 million more from July through December 2007 than they would have if the rates had not been negotiated higher. This is $1.0 million higher than the JBC originally assumed when the Committee approved the incentive grant program. Both staff and the Department are currently forecasting that there will be a positive General Fund supplemental in Medical Services Premiums (see issue beginning on page 92). Therefore, this increase can not be absorbed within the current Medical Services Premiums line item and must come at the expense of other state programs.

The Quality Incentive Program Was Approved Before H.B. 07-1346 Passed: When the quality incentive program was approved in last year's budget, it was assumed that it was the only way under

current statute to provide an increase above the current rate structure to Denver Health. With the passage of H.B. 07-1346, the Department can now negotiate rates higher. Staff is no recommends a grant program that would allow the Department to exceed the costs in manage care over the costs in fee-for-service.

Questions for the Department

1. Please update the Committee on the implementation of H.B. 07-1346 and attracting new managed care providers to the state Medicaid program.

2. If the Committee rescinded its request for the Department to not implement the quality incentive grant program for Denver Health, would the Department be able to make the payment before the end of 2007? In the Department's opinion what would be the advantageous or disadvantageous for making these quality incentive payments?

FY 2008-09 Joint Budget Committee Staff Budget Briefing
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
Nursing Home Costs and Rates

ISSUE

Medicaid reimbursement for class 1 nursing homes

SUMMARY

- Class 1 nursing facilities account for approximately 22.4 percent of the Department's FY 2008-09 request for Medical Services Premiums. Based on current law, the statewide average nursing home per day effective rate is anticipated to increase by 4.58 percent (from $141.10 to $147.57). However, estimated patient days are anticipated to decrease by 0.44 percent (from 9,681 average daily census to 9,639 average daily census). The Department's FY 2008-09 budget request reflects an increase in nursing home costs of $19.3 million.

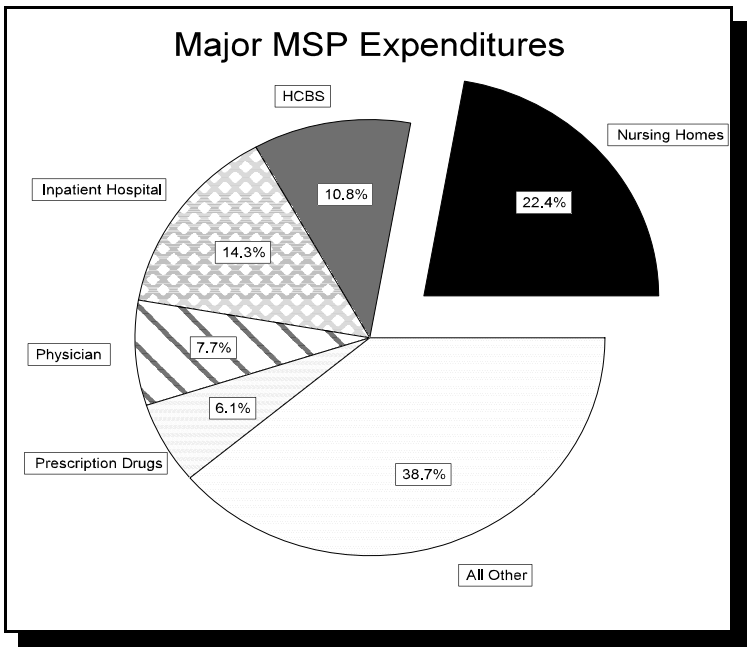
- The H.B. 07-1183 final report on nursing home reimbursement recommends an additional rate increase of $11.9 million total funds in FY 2008-09.

RECOMMENDATION:

Staff recommends the Committee discuss the H.B. 07-1183 rate methodology proposal with the Department at their hearing.

DISCUSSION:

The Department forecasts that class 1 nursing facilities expenditures will equal $515.0 million total funds in FY 2008-09. This equals approximately 22.4 percent of the total expenditure forecasted for the Medical Services Premiums line item. As in past years, class 1 nursing facilities remain the single largest expenditure for a single medical service within the Medical Services Premiums Line item.



Class 1 nursing facility costs result essentially from multiplying the rate determined for each facility based on the

statutory formula by the average daily census in nursing facilities offset by any estate or income trust recoveries. The current statutory reimbursement methodology is facility specific, based on the facility's actual costs adjusted for resident acuity. Because the system is cost-based, statutory caps on reimbursement were established in order to contain costs and to narrow the range of rates paid. In FY 2007-08, nursing home rates (all cost components) are anticipated to range from approximately $132.56 to $226.77 with the average rate for all facilities being approximately $171.39 per day. In FY 2008-09 the average rate for all facilities is anticipated to increase to $179.37 (an increase of 4.65 percent). These rates are partially offset by the patient payment. After the patient payment is deducted, the average facility rate in be approximately $141.10 in FY 2007-08 and $147.57 in FY 2008-09 (a 4.59 percent increase).

Table 1: Medicaid Nursing Facility Rates

Year	Average Total State Per Diem Rate	Estimated Patient Payment Per Day	Estimated Medicaid Rate	Percent Difference
FY 2002-03	$131.06	$24.75	$106.31	
FY 2003-04	$143.49	$24.93	$118.56	11.52%
FY 2004-05	$149.98	$25.88	$124.10	4.67%
FY 2005-06	$157.16	$27.29	$129.87	4.65%
FY 2006-07	$165.91	$28.85	$137.06	5.54%
FY 2007-08 est.	$171.39	$30.29	$141.10	2.95%
FY 2008-09 forecast	$179.37	$31.80	$147.57	4.59%

The average daily census in the nursing homes has remained fairly constant. In FY 2002-03 the average Medicaid daily census in nursing facilities was 9,830 clients. In FY 2008-09, the Department is forecasting a Medicaid daily census in nursing facilities of 9,638 clients.

Table 2: Average Medicaid Daily Census in Nursing Facilities

Year	Patient Days	Daily Census	Percent Change
FY 2002-03	3,588,003	9,830	
FY 2003-04	3,502,943	9,597	-2.37%
FY 2004-05	3,519,435	9,642	0.47%
FY 2005-06	3,532,119	9,677	0.36%
FY 2006-07	3,533,475	9,681	0.04%
FY 2007-08 est.	3,533,475	9,681	0.00%
FY 2008-09 forecast	3,518,088	9,639	-0.44%

In addition to the rate and census, the Department estimates other cost adjustments in their budget request. These cost adjustments include any additional reimbursement provided (such as the grant program under H.B. 07-1183 in FY 2007-08), the hospital backup program costs (a program that pays higher per diem for specialized clients), estate and trust recoveries, and recoupments for any Department overpayments. After all of these adjustments are factored in, nursing home expenses are projected to increase by 3.8 percent in FY 2008-09 over the current estimate for FY 2007-08 under current law.

Table 3: Class 1 Nursing Facility Expenditures

Year	Expenditures	Percent Change
FY 2002-03	$380,354,855	
FY 2003-04	$416,011,012	9.37%
FY 2004-05	$423,878,333	1.89%
FY 2005-06	$456,520,328	7.70%
FY 2006-07	$478,303,487	4.77%
FY 2007-08 est.	$495,684,624	3.63%
FY 2008-09 forecast	$514,997,462	3.90%

Current Rate Methodology

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 reimbursement rates in order to control the growth of costs.

Component	Description	Floor, Ceilings, Caps
Direct Health Care Services	All costs related to the direct care of patients, including food, nursing, therapies, prescription drugs, and health equipment.	Cap: Lower of actual cost of a 8.0 percent increase. Ceiling: Limited to a ceiling of 125% of the state-wide weighted average cost for DHC.
Administration and General	Facility administration costs including advertising, recruitment, travel, and all other costs that are not health care services, food costs, or capital-related services.	Cap: Lower of actual cost of a 6.0 percent increase. Ceiling: Limited to a ceiling of 120% of the state-wide weighted average cost for A&G
Fair Rental Value	The value of capital assets based on a depreciated cost value. This value is used to calculate a Fair Rental Value component of the rate.	Return on 10-year treasury bonds plus two percent; except that the rental rate shall not exceed 10.75% nor fall below 8.25%.

S.B. 06-131 and H.B. 07-1183 Report

In 2006, the General Assembly passed S.B. 06-131 which required the Department to conduct a feasibility study for a new methodology to reimburse class 1 nursing facilities. Initially the Department was to report back on November 1, 2006 with recommendations on either a pricing model or pay-for-performance model of nursing home reimbursement. House Bill 07-1183 extended the time for this report until November 1, 2007. Based on the outcome of their study, the H.B. 07-1183 work group on nursing home rates made the following recommendations:

1. ***Administrative and General (A&G) Component of the Rate:*** The work group recommends that a pricing model should be established for the A&G rate. Under the pricing model, the Department would set the rate at 105% of the un-imputed median cost for all facilities with over 60 beds. For facilities with 60 or less beds, the rate would be set at 110% of the unimputed median. For the purpose of updating the original set price, costs will be re-based every four years. During the years when there is no rebasing, the price will be adjusted by the Consumer Price Index on July 1 of each year.

This methodology change will create "winners" and "losers" in that facilities with costs above the median will be reimbursed only at the median while facilities with lower costs reimbursement will be brought up to the medium. In order to avoid creating "losers", the work group recommended freezing their A&G rate for four years or until the A&G price reaches their current rate through inflation adjustments. In order to mitigate the fiscal impact of this change, the work group recommended that the rate increases for A&G be phased in by not more than 25 percent of the net change in the first year, 50 percent in the second year, 75 percent in the third year, and fully converted to the new system in four years.

There was not unanimous agreement on this recommendation. The Colorado Association of Home and Services for the Aging (CAHSA) disagreed with this recommendation because of the creation of "winners" and "losers". CAHSA's position was rather than reset rates for all nursing facilities, to allow rates to be rebased for the current 120 facilities whose costs exceed the 6.0 percent cap and continue to fall further behind each year.

2. ***Health Component:*** The work group recommends that the health care component of the rate remain relatively the same in that it would continue to be reimbursed on a cost-based manner. However, the work group recommended removing the 8.0 percent cap on annual growth. The work group recommends retaining the 125 percent of weighted average cost ceiling.

3. ***Fair Rental Value:*** The work group recommends that this component of the rate remain the same.

4. ***Acuity Mix Adjustment:*** The work group recommends additional reimbursement for two behavior health conditions that require additional staff resources and training: (1) severe mental health diagnosis, and (2) Cognitive Loss/Dementia. For the severe mental health diagnosis, the work group recommended that for residents that score as a Level II on the PASRR screening receive an additional rate of $3.58 a day.[1] For cognitive loss/dementia the work group recommended that for groups that scored between 4 to 6 (moderate to severe impairment) on the Cognitive Performance Scale (CPS) receive additional reimbursements between $1.00 to $3.00 per day.

5. ***Pay-for-Performance:*** The work group recommended that a pay-for-performance component be included to reward facilities that provide services that result in better care and higher

[1] The current PASRR evaluations recognize severe mental illness and require nursing facilities to provide the mental health services required in order to prevent long-term placements in institutionalized care settings. Currently, there are approximately 1,828 individuals in nursing homes with PASRR Level II mental health designations. The work group's recommendation would be to create a two-tiered system that recognizes Level II designation (where the mental health diagnosis is no longer the primary diagnosis) for nursing home care for mentally ill. The current case mix index (CMI) does not recognize this designation. This recommendation is based on a Wisconsin model that recognizes three options for individuals with SMIs requiring long-term care services.

quality of life for the residents. The system would be based on point system evaluation of three components: (1) quality of life; (2) quality of care; and (3) facility management.

Based on these recommendations, the Committee estimated the fiscal cost to be as follows.

Table 4: S.B. 06-131 & H.B. 07-1183 Final Committee Report -- Nursing Home Reimbursement

	FY 08-09 Year One Incremental Costs	FY 09-10 Year Two Incremental Costs	FY 10-11 Year Three Incremental Costs	FY 11-12 Year Four Incremental Costs	Total Additional Incremental Costs over 4 years
A&G Pricing Model	$5,297,946	$5,552,247	$5,818,755	$5,621,558	$22,290,506
Life 8% Cap on Health Care Rate	$4,314,313	$4,521,400	$4,738,427	$4,965,872	$18,540,013
Pay for Performance	$0	$4,168,421	$4,168,421	$4,168,421	$12,505,263
Cognitive Performance	$971,630	$971,630	$971,630	$971,630	$3,886,520
PASRR Level II - Individual	$2,421,315	$2,421,315	$2,421,315	$2,421,315	$9,685,260
PASRR Level II - Facility	$1,006,159	$1,006,159	$1,006,159	$1,006,159	$4,024,636
Total Cost	$14,011,363	$18,641,173	$19,124,708	$19,154,954	$70,932,198
Estimated Patient Pay	($2,101,704)	($2,796,176)	($2,868,706)	($2,873,243)	($10,639,830)
Medicaid Payment	**$11,909,659**	**$15,844,997**	**$16,256,002**	**$16,281,711**	**$60,292,368**
General Fund	**$5,954,829**	**$7,922,498**	**$8,128,001**	**$8,140,856**	**$30,146,184**
Federal Funds	**$5,954,829**	**$7,922,498**	**$8,128,001**	**$8,140,856**	**$30,146,184**

*Note: This table reflects the work group's analysis -- not an official staff or Legislative Council Staff Fiscal Note. At this time staff does not agree that the estimated patient payment offset is correct (this is amount is based on patient's ability to pay not a percent of rates charged). Without the patient pay offset, the General Fund impact in FY 2008-09 would be $7.0 million -- not $5.9 million.

As table 4 above shows, the work group's recommendations would result in an increase of $11.9 million over the ***BASE*** nursing home costs in FY 2008-09. Because these rate changes would involve statutory changes (legislation), these costs are not included in the Department's FY 2008-09 budget request.

Questions for the Department at Their Hearing

1. The Department states that it supports the recommendations of the S.B. 06-131/H.B. 07-1183 work group on nursing home reimbursement changes. However, staff is unaware of any place in the Executive's budget that sets aside the necessary funding for the legislative changes involved. Please clarify if funding exists in the Executive's budget for this proposal.

2. Given the costs of the proposal, does the Department have any priorities on the components of the plan that the Department believes should be addressed first? Please discuss the specific components of the proposal and why the Department supports the changes proposed.

3. Given the past history of discontinuing other programs that tried to reimburse nursing homes for quality, what challenges does the Department believe exists in developing a "pay-for-performance" reimbursement methodology for nursing homes?

4. Please provide the Committee with a list of the facilities that would have their nursing home rate for A&G frozen for the next several years due to being above 105% or 110% of the medium costs for A&G. Please provide the Committee with a list of the facilities that would have their nursing home rates increased as a result of the A&G changes proposed.

FY 2008-09 Joint Budget Committee Staff Budget Briefing
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
Program For All Inclusive Care for the Elderly (PACE)

ISSUE

The Centers for Medicare and Medicaid Services (CMS) have not approved rates for the PACE program for FY 2007-08.

SUMMARY

- The Centers for Medicare and Medicaid Services (CMS) has not yet approved the PACE rates proposed by the Department for FY 2007-08. Currently, the CMS Regional Office has indicated that they do not approve of the current frailty factor used in the rates and have indicated the possibility of deferring federal funding from the PACE program if the Department continues to use this factor. At this point, CMS has indicated to the Department that they are, at a minimum, several months away from approval of the PACE rates that were effective July 1, 2007.

- Based on an analysis by Total Long Term Care's contract actuary, if the frailty factor was changed immediately in FY 2007-08, the PACE rates would still increase by 1.6 percent.

RECOMMENDATION:

Staff recommends that the Committee consider approving funding in the Department for a study to determine the frailty of PACE clients compared to clients in the fee-for-service population. Staff also recommends the Committee discuss the questions listed at the end of this issue with the Department at their hearing.

DISCUSSION:

The Program of All-Inclusive Care for the Elderly (PACE) is a Medicare/Medicaid managed care system to provide health care and support services to individuals 55 years and older at risk of institutional care. The PACE program is a fully capitated program in that the contractor assumes full risk for the medical costs and long-term care needs of their clients for the contracted rate. Under PACE programs, the contractor receives both a Medicare rate (for Medicare eligible services) and a Medicaid rate (for Medicaid eligible services). Currently, Colorado has one PACE provider, Total Long-Term Care (TLC) serving clients in the Denver metro area. As of September 2007, enrollment in TLC's PACE program was approximately 1,210 clients.

Growth in the PACE program expenditures have resulted both from increases in their rates plus caseload growth. The table below shows a five-year history for PACE program expenditures.

Table 1: Five Year History PACE Program Expenditures					
	FY 2002-03	FY 2003-04	FY 2004-05	FY 2005-06	FY 2006-07
Total Expenditures*	$20,366,142	$27,029,169	$35,160,005	$40,470,490	$42,872,281
Average Monthly Paid Enrollment	554	790	946	1,048	1,129
Annual Per Capita Cost for Medicaid	$36,761.99	$34,214.14	$37,167.02	$38,616.88	$37,973.68

The Department's November 1, 2007 budget request estimates that PACE expenditures will grow to $49,325,276 in FY 2007-08 and $58,001,837 in FY 2008-09 as shown in Table 2 below.

Table 2: Department's November 1, 2007 Budget Request for PACE				
	FY 2007-08 Estimate	% Change from Prior Year	FY 2008-09 Forecast	% Change from Prior Year
Total Expenditures*	$49,325,276	15.05%	$58,001,837	17.59%
Average Monthly Paid Enrollment	1,231	17.46%	1,400	13.73%
Annual Per Capita Cost for Medicaid	$40,069.27	3.76%	$41,429.88	3.40%

Current Rate Methodology

The PACE provider is paid a monthly capitation rate for each enrolled client. The PACE capitation rate is based on the costs for nursing home, home-and-community based (HCBS) services, and other medical costs not covered under Medicare in the Department's fee-for-service caseload. While the fee-for-service claims and cost data serves as the foundation for the PACE rates, the PACE rates have historically been adjusted by a "frailty factor" as allowed under 42 CFR Section 460.182 (b) (2). The current frailty factor was based on a study, conducted by the Colorado Foundation of Medical Care in 2004, that concluded absent the PACE program, a greater proportion of the client served by TLC would need nursing home placements compared to the Department's fee-for-service long-term care clients (those qualifying for either HCBS or nursing home services). Since 2004, the Department has used this frailty adjustment which results in the PACE rate being more heavily weighted towards the cost of nursing home services rather than HCBS services. The weight that was used in calendar year was 75.84 percent nursing home costs and 24.16 percent HCBS costs for PACE clients.

CMS Scrutiny of Colorado's PACE Rates

Federal regulations require that the PACE capitation rates must be less than the amount that would otherwise have been paid under the State plan if the participants were not enrolled in the PACE program (42 CFR Section 460.182 (b) (1)). During the last year, CMS has questioned where the Colorado frailty factor is consistent with the fee-for-service experience in Colorado and other states in the region. Based on other state PACE programs, CMS began to believe that the Colorado PACE rates should be weighted with a higher emphasis on HCBS services than they are currently. In the summer of 2007, the Department commissioned a study that seemed to support these results (TLC disagrees with outcome and methodology for this study).

Frailty Study Phase Out - 2 Year			
Frailty Designation	**Year 0 (CY06)**	**Year 1 (FY08)**	**Year 2 FY09)**
HCBS	24.16%	34.01%	43.87%
NF	75.84%	65.99%	56.13%
Total	**100.00%**	**100.00%**	**100.00%**

Based on the discussion with CMS and the results of their initial study (June 2007), the Department began negotiating a rate with TLC for FY 2007-08 that would help phase their rates over a two-year period to a frailty factor based on 56.13 percent nursing facility costs and 43.87 percent HCBS costs. Based on these negotiations, the contracted actuary for TLC (Milliman) projected the following impact to their rates.

Table 3: TLC Estimated Impact to Their Rates

	Third Party Liability		Medicaid Only			
	SSI 65+	SSI Disabled	SSI 65+	SSI Disabled	Pace Composite	Rate Change from 2006
TLC Membership	1,078	78	19	35	1,210	
CY 2006 Rates	$3,186.41	$3,748.69	$4,322.73	$5,172.29	$3,297.94	
FY 07-08						
1st Scenario -- 24.16% HCBS	$3,987.28	$3,738.46	$3,987.28	$5,282.85	$4,008.72	21.55%
2nd Scenario -- 34.01% HCBS	$3,654.46	$3,449.34	$3,654.46	$4,999.60	$3,680.15	11.59%
3rd Scenario-- 43.87% HCBS	$3,321.64	$3,160.22	$3,321.64	$4,716.35	$3,351.58	1.63%
FY 08-09						
43.87% HCBS/1	$3,460.02	$3,226.05	$346.02	$4,814.59	$3,484.12	

/1 FY 2008-09 rate would be a decrease of 5.3% from the 2nd Scenario FY 2007-08 rate.

The second scenario in the table above is the rate that Department proposed to TLC for FY 2007-08. The reason for the increase over the calendar year 2006 is partly explained because pasted rate adjustments for HCBS and NF were not included in the 2006 rate. Thus, even though their frailty factor is being adjusted to more heavily weight HCBS costs, TLC was still anticipated to see a 11.59 percent increase to their overall rate. This is the rate plan that the Department submitted to CMS. The rates were to be effective July 1, 2007.

As of the time this issue was written, CMS has not approved this rate plan. Therefore, TLC is still being paid their calendar 2006 rate (it is assumed that if CMS approves this rate that it will be retroactive back to July 1, 2007). Because the Department did not entirely move away from the previous frailty factor (i.e. they proposed a two-year phase down to the new frailty factor), CMS has indicated to the Department the possibility of a deferral of federal funding for the PACE program. This would result in the loss of federal funds of approximately $24.6 million.

Rather than risk the loss of federal funding, the Department may need to renegotiate the PACE rate down to the 3rd scenario shown in Table 3 above. TLC has mentioned to staff that it would be hard for them to adjust to such a drastic change in their rate methodology. Total Long-Term Care also disagrees with the underlying assumption that their clients are not as frail as previously stated. Total Long Term Care supports commissioning a new study, which would considers the morbidity rates of their clients (PACE clients on average are in the last 30 months of their life) as well as the end of life costs of their population. Until such a study is complete, TLC has told staff that they support the concept of phasing their frailty factor down over a two-to-three year period. Currently, based on conversations with the Department, staff is very uncertain that CMS would approve such a plan.

Staff recommends that a study an independent study be commissioned to determine the correct frailty factor for PACE clients. Until the study can be completed, staff recommends that the Department continue to negotiate with TLC to determine if there are other methodologies that could be used to bring the frailty factor into line with what CMS currently believes is appropriate while mitigating some (not all) of the initial impact.

Questions for the Department

1. What would be the costs for an independent commissioned study on the frailty of PACE client compared to the fee-for-service population?

2. What is the current status of the Department's negotiations with CMS on the PACE rates for FY 2007-08? How long can the Department continue to operate without a signed contract and receive federal match?

3. Please discuss any issues the Department believes the Committee should understand in order to try to find a solution to the PACE rate dispute with CMS and the provider.

FY 2008-09 Joint Budget Committee Staff Budget Briefing
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
Preliminary Medicaid Health Budget Outlook
for FY 2007-08 and FY 2008-09

ISSUE:

Preliminary forecasts for the FY 2007-08 and FY 2008-09 mental health expenditures.

SUMMARY:

- The Department's budget request shows a ***preliminary*** FY 2007-08 negative supplemental of $32.3 million total funds for the Medicaid mental health program line items administered by HCPF. This decrease is mainly related to eliminating the "informational-only" appropriation of $32.3 million for anti-psychotic drugs.
- The Department's FY 2008-09 budget request for the Medicaid Mental Health Division is an increase of $12.3 million total funds (6.2 percent) over the Department's current FY 2007-08 estimate. This increase is mainly related to Medicaid caseload growth and increases to the capitation rates for the mental health managed care program.

RECOMMENDATION:

Staff recommends that the Committee consider the Department's request to eliminate the "informational-only" appropriation for anti-psychotic drugs. This appropriation create's a double count in the Department's budget and therefore, distorts the Department's actual expenditure authority. Rather than containing the estimated costs for these drugs as an "informational-only" appropriation, the Committee could note the estimated cost as a footnote to the Medical Services Premiums line item (where the real expenditure authority is provided for this cost) or transfer this expenditure from the MSP line item to the MH Division.

Staff recommends that the Committee discuss the questions at the end of this briefing with the Department at their hearing.

DISCUSSION:

Preliminary Budget Calculations for the Medicaid Mental Health Division

The Medicaid Mental Health Division in the Department's budget is comprised of three budget line item:

✓ ***Mental Health Capitation for Medicaid Clients:*** This line item provides the appropriation for the contracted managed care providers (Behavioral Health Organizations -- BHOs) that provide mental health services for Medicaid clients throughout Colorado. The BHOs are responsible for providing or arranging all medically necessary mental health services to Medicaid eligible clients within specific geographical areas for a pre-determined capitation rate. Per federal regulation, the capitation rate must be actuarially sound. Calculating the appropriation for this line is basically multiplying the number of eligible clients in each category by the contracted capitation rate for the clients aid category adjusted by any recoupment amounts.

✓ ***Medicaid Mental Health Fee-for-Service Payments:*** This line item contains the appropriation for mental health services provided to Medicaid clients who are not enrolled in a behavioral health organization to receive mental health services or are for mental health services outside the scope of the behavioral health organization contract. Medicare cross-over claims are included in this line item.

✓ ***Mental Health Anti-Psychotic Pharmaceuticals:*** This line item is an "informational-only" appropriation estimating the amount of funding for anti-psychotic pharmaceuticals. Anti-psychotic pharmaceuticals are actually included in the appropriation for the Medical Services Premiums line item.

Please note that these line items do not contain all the mental or behavioral health expenditures that receive Title XIX (Medicaid) funding. As stated above, the Medical Services Premiums line item includes all prescription drugs appropriations, including anti-psychotic prescription drugs (estimated at $32.3 million). The Medical Services Premiums line item also contains the appropriation for out-patient substance abuse treatment for Medicaid clients (included as a net savings of $41,500 in the original FY 2007-08 appropriation), as well as community-long term care waiver services for mentally ill clients (approximately $15.0 million in actual expenditures in FY 2006-07). In addition, the Department of Human Services administers mental health services programs that qualify for Medicaid funding ($4.8 million total funds in FY 2007-08) as well as their state-only programs for non-Medicaid clients.[1]

Table 1 summarizes the Department's FY 2008-09 expenditure estimate and FY 2008-09 budget request for the Medicaid Mental Health Division (all line items).

[1]Department of Human Services receives some Medicaid funding for MH Administration, Residential Treatment for Youth, Mental Health Institute, Alcohol and Drug Abuse Division, and for Alcohol and Drug Abuse for High Risk Pregnant Women.

Table 1: FY 2007-08 Estimate & FY 2008-09 Budget Request

Funds	**Current** *FY 2007-08* Appropriation	Department's **Estimated** *FY 2007-08* Expenditure	**Difference Possible Supplemental Amount**	**Department's** *FY 2008-09* **Budget Request**	*FY 2008-09* Increase Compared to Current FY 2007-08 Appropriation	*FY 2008-09* Increase Compared to Estimated FY 2007-08 Expenditure
GF/GFE	$92,060,148	$91,706,890	**($353,258)**	$96,568,457	$4,508,309	$4,861,567
CFE	39,151,106	7,216,576	**(31,934,530)**	8,503,229	(30,647,877)	1,286,653
FF	98,902,995	98,938,827	**35,832**	105,088,749	6,185,754	6,149,922
Total	$230,114,249	$197,862,293	**($32,251,956)**	$210,160,435	($19,953,814)	$12,298,142
Percent (Decrease) / Increase			**-14.02%**	n/a	-8.67%	6.22%

Department's Preliminary Expenditure Estimate for FY 2007-08

Table 2 shows the reasons for the anticipated decrease in Medicaid Mental Health Division for FY 2007-08.

Table 2: Mental Health Division FY 2007-08 Estimated Expenditures Detail

Item	**Total Funds**	**GF / GFE**	**Cash Fund Exempt**	**Federal Funds**
Current FY 2007-08 Appropriation	$230,114,249	$92,060,148	$39,151,106	$98,902,995
Department's Estimated Changes for FY 2007-08 (Nov 1, 2007 Request)				
Eliminate the "informational-only" anti-psychotic prescription drugs appropriation	(32,321,595)	0	(32,321,595)	0
Caseload and per-capita cost updated estimates for the MH capitation program	242,857	(266,649)	387,065	122,441
Medicaid Mental Health Fee-for-Service Payments	(173,218)	(86,609)	0	(86,609)
Department's New Estimate for FY 2007-08 (Nov 1, 2007)	**$197,862,293**	**$91,706,890**	**$7,216,576**	**$98,938,827**
(Decrease)/Increase from current FY 2007-08 appropriation	($32,251,956)	($353,258)	($31,934,530)	$35,832

Eliminate the "informational-only anti-psychotic prescription drug appropriation: The Department's request indicates a supplemental request to eliminate the "informational-only" appropriation for anti-

psychotic prescription drugs (please note that this not an official supplemental request until after January 1, 2008). Currently, all prescription drug costs are appropriated in the Medical Services Premiums line item in the Department's budget. Anti-psychotic prescription drugs currently are not part of the capitation contracts with the Behavioral Health Organizations (BHOs). Since FY 1999-00, the Long Bill has contained a double-counted appropriation for anti-psychotic drugs. As stated earlier, the actual expenditure authority for anti-psychotic drugs is currently contained in the Medical Services Premiums line item. However, when the Department of Human Services administered all mental health programs, a transfer appropriation from HCPF to DHS for the estimated cost of anti-psychotic drugs was included in the Long Bill. Once HCPF began administering the Medicaid MH capitation program, an "informational-only" appropriation for prescription drugs was contained in the Medicaid Mental Health Division.

The reason for including the "informational-only" appropriation in the Long Bill was to show the General Assembly (and interested parties) the total estimated costs for most mental health Medicaid programs. In addition, for the last ten years there has been discussion on whether or not anti-psychotic prescription drug costs should be fully incorporated into the capitation program. Therefore, the Joint Budget Committee has included the "informational-only" appropriation as a means to ensure that the Department reported on the costs of this service each year.

In FY 2005-06, the Department submitted a decision item to eliminate this "informational-only" appropriation for anti-psychotic drugs by stating: "The Department believes that the same information could be provided in a footnote or a report. Removing [this appropriation] would eliminate some double-counting of funds in the Long Bill. These funds are not needed in this line in order to complete any administrative activity." However, the JBC rejected this decision item based on the JBC staff recommendation that stated: "Because this sum represents funding in the mental health system and because ultimately there are plans to wrap the management for these drugs into the mental health capitation contract, staff recommends that the JBC not approve the Department's request to eliminate the reflection of the expenditure for informational purposes and that the estimate of the anti-psychotic pharmaceutical expenditure be maintained in the Mental Health Community Programs budget." The Department has resubmitted its request to eliminate this appropriation.

Staff agrees with the Department that this "informational-only" appropriation distorts the actual size of the state budget by double-counting spending for anti-psychotic drugs (once in the Medical Services Premiums line item and again in the Medicaid Mental Health Division). Also, the accuracy of this line item's appropriation has not been very good in the recent past as shown below.

	Final Appropriation	Actual	Difference	% Difference
FY 2004-05	$42,991,058	$45,954,548	$2,963,490	6.89%
FY 2005-06	$33,102,281	$27,105,418	($5,996,863)	-18.12%
FY 2006-07	$32,682,434	$34,294,729	$1,612,295	4.93%

Staff recommends that the Committee consider the Department's request to eliminate the double-count by either: (1) eliminate the "informational-only" appropriation in the Division of Mental Health; or (2) eliminate this cost in the Medical Services Premiums line item and officially move it to the Division of Mental Health. If the Committee accepts the first option, then staff would recommend that a footnote be included in the supplemental bill or next year's Long Bill to request a report on actual anti-psychotic expenditures within the Medical Services Premiums line item. Action on this staff recommendation can be considered during the supplemental and figure setting process.

Caseload and per-capita cost updated estimates for the MH capitation program: The Department's budget request also indicates a possible total fund supplemental of $242,857 for the MH capitation line item. This estimate is based on the Department's new Medicaid caseload projections for FY 2007-08 and adjustments to the estimated per-capita cost for each aid category as shown below in the Table 2a below.

Table 2a: FY 2007-08 Appropriation Compared to Department's FY 2007-08 Expenditure Estimate

Eligible MH Medicaid Caseload	Original Caseload Projection	Est. Capitation Rate for Aid Category	Cost Estimate	New Caseload Projection	Est. Capitation Rate for Aid Category	New Cost Estimate	Cost Difference
SSI 65+	36,703	$167.98	$6,165,370	35,272	$170.29	$6,006,469	($158,901)
SSI 60-64	6,252	$1,387.23	$8,672,962	6,050	$1,381.32	$8,356,986	($315,976)
SSI Disabled	48,942	$1,387.23	$67,893,811	49,354	$1,381.32	$68,173,667	$279,857
LI Adults	46,708	$210.39	$9,826,896	45,228	$217.46	$9,835,281	$8,385
Ex LI Adults	10,377	$210.39	$2,183,217	7,886	$217.46	$1,714,890	($468,327)
BC Adults	5,264	$210.39	$1,107,493	5,453	$217.46	$1,185,809	$78,316
BCCTP	277	$160.32	$44,409	260	$197.88	$51,449	$7,040
Children	193,981	$172.33	$33,428,746	192,834	$177.86	$34,297,455	$868,710
Foster Children	17,295	$3,602.19	$62,299,876	17,202	$3,685.94	$63,405,540	$1,105,664
Subtotal	365,799	n/a	$191,622,780	359,539	n/a	$193,027,546	$1,404,766
Recoupment Adjustment	n/a	n/a	$300,000	n/a	n/a	($1,000,000)	($1,300,000)
S.B. 07-02 Adj not included above	1,226	$3,573.30	4,380,871	1,226	$3,685.94	$4,518,962	$138,091
Total	367,025	n/a	$196,303,651	359,539	n/a	$196,546,508	$242,857

As Table 2a shows, the Department forecasts a decrease of 6,260 (1.71 percent) in the overall Medicaid caseload eligible for mental health services. However, the Department has adjusted most per-capita cost estimates upward based on the FY 2006-07 actual costs (the FY 2006-07 actual costs are inflated by 3.76% based on the actuarial certification letter for MH capitation). The Department also adjusts their recoupment estimate based on the FY 2006-07 actual recoupments. Based on all of these adjustments, the new estimate for FY 2007-08 in only $242,857 higher than the current appropriation. The Department's request also adjusts the fund splits for the program as shown in Table 2b.

Table 2b: FY 2007-08 Fund Splits for Mental Health Capitation Program

	Current FY 2007-08 Appropriation	Department Revised FY 2007-08 Estimate	Difference (Est - App)
General Fund	$91,315,646	$91,048,997	($266,649)
CFE -- Health Care Expansion Fund	$6,822,128	$7,208,074	$385,946
CFE -- BCCTP Program	$0	$3,141	$3,141
CFE -- DPHE Transfer for BCCTP Program	$7,383	$5,361	($2,022)
Federal Funds	$98,158,494	$98,280,935	$122,441
Total Funds	$196,303,651	$196,546,508	$242,857

Medicaid Mental Health Fee-for-Service Payments: The Department's revised FY 2007-08 estimate also indicates a negative total fund supplemental of $173,218 ($86,609 General Fund) for the Fee-for-Service payments. The Department's current FY 2007-08 estimate is based on FY 2006-07 actual expenditures, decreased by 3.81 percent due to decreased caseload.

Staff Comment on Request: The current FY 2007-08 appropriation for MH capitation is $196,303,651. At this appropriation level, average monthly expenditures should equal approximately $16.3 million per month. However, if the appropriation for S.B. 07-002 is excluded, the current MH capitation would support monthly expenditures of approximately $16.0 million per month. The current average monthly expenditures for the first four months of year have been $16.2 month. Based on this information, current monthly expenditures seem to be running slightly higher than currently anticipated.

Current caseload reports indicate two things: (1) The caseload impact from S.B. 07-002 has not yet occurred; and (2) excluding S.B. 07-002, the base caseload is running approximately 5,095 higher than the Department revised FY 2007-08 caseload forecast (and approximately 1,165 lower than current appropriation). If the Department's capitation rate estimates are accurate and caseload continues to be higher than their request indicates, then the Department most likely will be submitting a higher supplemental request in February 2008 for FY 2007-08. This would also most likely increase their projection for FY 2008-09 as well.

Department's Preliminary Request for FY 2008-09

After the Department adjusts the FY 2007-08 base they then calculate their estimate for FY 2008-09. The Department's current FY 2008-09 budget forecast for the Medicaid Mental Health Division is $210,160,435 total funds. This request is a decrease in total funds of approximately $20.0 million from the current FY 2007-08 appropriation but is an increase of $12.3 million total funds from the Department's revised expenditure estimates from FY 2007-08. Table 3 shows the components of the Department's FY 2008-09 budget request.

Table 3: Mental Health Division FY 2008-09 Estimated Expenditures Detail

Item	Total Funds	GF / GFE	Cash Fund Exempt	Federal Funds
Current FY 2007-08 Appropriation	$230,114,249	$92,060,148	$39,151,106	$98,902,995
Department's Estimated Changes for FY 2007-08 (Nov 1, 2007 Request)				
FY 2007-08 Preliminary Supplemental Request	(32,251,983)	(353,285)	(31,934,530)	35,832
Department's Estimated Changes for FY 2008-09 (Nov 1, 2007 Request)				
Caseload and per-capita cost updated estimates for the MH capitation program (DI #2 & T#3)	11,555,674	4,490,347	1,286,653	5,778,674
Additional caseload due to CBHP marketing (DI #3)	735,240	367,620	0	367,620
Medicaid Mental Health Fee-for-Service Payments Estimated Increase (DI #2)	7,255	3,627	0	3,628
Department's New Estimate for FY 2008-09 (Nov 1, 2007)	**$210,160,435**	**$96,568,457**	**$8,503,229**	**$105,088,749**

The Department's preliminary supplemental request for FY 2007-08 was discussed on the previous pages. Following is a brief discussion on the three change requests for the Department's FY 2008-09 request.

Caseload and per-capita cost updated estimates for the MH capitation program: The Department FY 2008-09 request includes a total fund increase of $11.6 million ($4.5 million General Fund) for increases related to Medicaid caseload growth and capitation contract rate increases. The overall Medicaid caseload eligible for Mental Health Services is forecasted to increase by 1,989 (or 0.55 percent) over the Department's revised caseload forecast for FY 2007-08. In addition, the Department is forecasting a 3.62 percent increase in FY 2008-09 to the capitation rates over their revised FY 2007-08 capitation rate estimates. Table 3a shows the impacts of the Department's estimates by aid category plus the impact of the estimated recoupments which are anticipated to decline by $500,000 in FY 2008-09 from the FY 2007-08 estimate.

Table 3a: FY 2008-09 Caseload and Capitation Rates compared to FY 2007-08 Revised Estimate							
Aid Category	FY 2007-08 Revised Estimate			FY 2008-09 Department Request			Cost Difference
	Caseload	Capitation	State Cost	Caseload	Capitation	State Cost	
SSI 65+	35,272	$170.29	$6,006,469	35,498	$176.45	$6,263,622	$257,153
SSI 60-64	6,050	$1,381.32	$8,356,986	6,106	$1,431.32	$8,739,640	$382,654
SSI Disabled	49,354	$1,381.32	$68,173,667	49,556	$1,431.32	$70,930,494	$2,756,827
LI Adults	45,228	$217.46	$9,835,281	44,183	$225.33	$9,955,755	$120,475
Ex LI Adults	7,886	$217.46	$1,714,890	9,462	$225.33	$2,132,072	$417,183
BC Adults	5,453	$217.46	$1,185,809	5,649	$225.33	$1,272,889	$87,080
BCCTP	260	$197.88	$51,449	278	$205.04	$57,001	$5,552
Children	192,834	$177.86	$34,297,455	192,717	$184.30	$35,517,743	$1,220,288
Foster Children	18,428	$3,685.94	$67,924,502	19,305	$3,819.37	$73,732,938	$5,808,436
Subtotal	360,765	n/a	$197,546,508	362,754	n/a	$208,602,155	$11,055,647
Recoupment	n/a	n/a	($1,000,000)	n/a	n/a	($500,000)	$500,000
Total	360,765	n/a	$196,546,508	362,754	n/a	$208,102,155	$11,555,647

Table 3b shows how much of the above budget impact is related to caseload increase and how much is caused from the increase in the overall capitation rate increases for MH services.

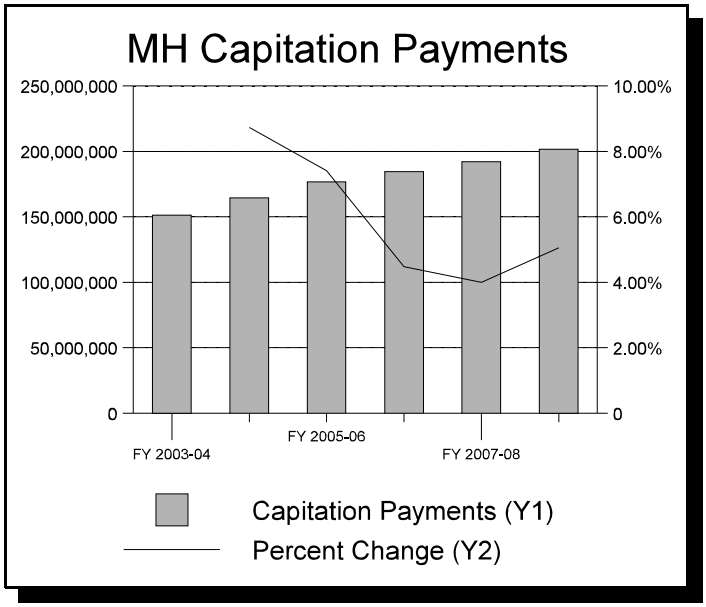
Table 3b: Analysis of Factors Driving the MH Cost Estimates for FY 2008-09			
	FY 2007-08 New Estimate Department's Request	FY 2008-09 Department Request	FY 2008-09 Request compared to FY 2007-08 Estimate
Total Cost Estimated	$197,546,508	$208,602,155	$11,055,647
Caseload	360,765	362,754	1,989
$/Client*	$547.58	$575.05	$27.47
Impact Associated with Caseload Change			$1,089,130
Impact Associated with Cost per Client Changes, including Compounding Impact			$9,966,517
Total Cost Increase for Services			$11,055,647
Recoupment Costs			$500,000
TOTAL CHANGE Cost Increase in FY 2008-09 for Caseload and Capitation			$11,555,647

Additional caseload due to CBHP marketing: In addition to the base caseload projections above, the Department also anticipates another 4,000 children eligible for Medicaid will sign-up due to increased marketing of the CBHP program. Medicaid eligibility screenings are performed on all application applying for the CBHP program. If a child is Medicaid eligible, they must be enrolled in Medicaid and not CBHP. The additional costs resulting from finding these eligible, but not enrolled, Medicaid children is estimated by the Department at $735,240 total funds ($367,620 General Fund). The Department's decision item to expand marketing is discussed in greater detail in a later issue.

Medicaid Mental Health Fee-for-Service Payments Estimated Increase: The Department's request also includes an increase of $7,255 for the MH fee-for-service payments. The FY 2008-09 increase is based on the Department's revised FY 2007-08 estimate multiplied by 0.55 percent to adjust for Department's FY 2008-09 caseload forecast.

Staff Comment on Budget Request: As discussed in Footnote 25, the Department already has contracted rates with each BHO for the first half of FY 2008-09 (July 1, 2008 through December 31, 2008). However, the Department's methodology for calculating the per capita rates are based on trending their FY 2007-08 estimate forward using a three year average increase of 3.62 percent.

The advantage of a capitation program is that the state has moved the risk of the program to the BHOs and budget predictability should improve based on having contracted rates in place. However, the Department's budget request still uses methodologies that don't take advantage of knowing the contracted rate (at least for the current budget year). This mainly due to the fact that caseload is not separately forecasted for each BHO region (the caseload forecast a statewide forecast only). Therefore, the Department must use an estimated "blended per capita rate" instead of using the actual contracted capitation rates. Staff believes this is somewhat of a weakness, in that, when over-expenditures or reversions occur, it is difficult for the Department to pin-point the exact reason. However, staff is unsure if greater detail would result in greater accuracy (i.e. forecast errors could be exacerbated with greater detail).



Because the Medicaid caseload has declined for the last three year, the percent increase in the Mental Health Capitation program has not been as high as it was in previous years. The Department's request indicates increases of only 4.0 percent to 5.0 percent for the base caseload (excludes S.B. 07-002). With a small risk pool, the BHOs may experience more financial difficulties managing the risk in the current capitation rates.

Questions for the Department

1. The current contracts with the Behavior Health Organizations (BHOs) will expire at the end of FY 2008-09. In the rebid of the BHO contracts, does the Department anticipate adding anti-psychotic prescription drugs as a required service for the new contracts? What would be the advantageous of doing so? What would be the disadvantageous? If moved into the capitation program, how would the Department ensure the savings from the drug rebate program are not loss?

2. Please comment on staff's recommendation to either: (1) move the actual expenditure authority for anti-psychotic prescription drugs from the Medical Services Premiums line item to the Mental Health Division; or (2) eliminate the "informational-only" appropriation for anti-psychotic drugs in the MH Division with the requirement that the Department continue to report on these expenditures. Which would the Department prefer and why?

3. Because early caseload reports do not indicate the decline in caseload that the Department's request indicates, does the Department anticipate that both the FY 2007-08 and FY 2008-09 estimates will be revised upward in February 2008? If not, why not?

4. What is the implementation status of S.B. 07-002? Will the Department be able to track this caseload separately from the rest of the foster children caseload? Does the Department have any expenditure data for this population yet? Does the Department believe that the capitation rate for foster children under 18 should be the same rate applied to young adults over 18? Will the service needs and delivery be the same for this population?

5. Does the Department believe forecast accuracy for the MH capitation program would improve if caseload was forecasted for each BHO multiplied by the contract rate in place for that BHO for the current FY and estimated contract rate for the next budget year?

6. Does the Department have any concerns about the level of service the BHOs are providing to Medicaid clients under the current capitation rates? Does the Department have any concerns on whether falling caseloads have put any BHO's at risk of financial loss during FY 2007-08 or FY 2008-09?.

FY 2008-09 Joint Budget Committee Staff Budget Briefing
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
Colorado's Children's Basic Health Plan *Preliminary* Base Budget Outlook

ISSUE:

The Department is currently forecasting an increase of $38.9 million total funds for the Children's Basic Health Plan (CBHP) for ***base*** caseload and cost-per-client increases in FY 2008-09 above the current FY 2007-08 appropriation. Of this amount, $2.4 million is from the General Fund.

SUMMARY:

- ❑ Last year, the Joint Budget Committee (JBC) sponsored S.B. 07-133 which moved the CBHP program to a cash based method of accounting instead of an accrual based method. As a result, caseload will no longer be adjusted for retroactivity and will instead be a snapshot of enrollment as of the end of the month (similar to the Medicaid caseload). The Department has adjusted past reported caseload back to FY 2001-02 in order to provide comparable history.
- ❑ In June 2007, the JBC approved a 1331 supplemental of $8.8 million total funds ($0.0 General Fund) due to higher than anticipated expenses for the CBHP program in FY 2006-07. At that time the FY 2007-08 appropriation was not adjusted to reflect the higher than anticipated expenses. Due to this fact and the other expenditure estimates contained in the Department's budget, staff anticipates that there will be a FY 2007-08 supplemental request of at least $19.6 million total funds for the CBHP program.
- ❑ The Department's FY 2008-09 budget request for the ***base*** CBHP program is $38.9 million total funds higher than the current FY 2007-08 appropriation. However, this request is only $19.3 million higher than the Department's revised FY 2007-08 estimate.

RECOMMENDATION:

Staff recommends that the Department discuss the questions at the end of this issue with the Department at their hearing.

DISCUSSION

Background

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 205 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 205 percent of the federal poverty level.

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

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

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

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

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

Funding

The state match for the program is provided from four sources: (1) the CBHP Trust Fund (Fund); (2) the Supplemental Tobacco Litigation Settlement Moneys Account of the CBHP Trust Fund (Account); (3) the Health Care Expansion Fund; and (4) the Colorado immunization program. The revenue sources for the CBHP Trust Fund include 24 percent of the funding received annually from the Master Tobacco Settlement Agreement, any General Fund appropriations into the Fund, interest and investment earnings, and enrollment fees charged to program participants. The revenue sources for the CBHP Trust Fund Account include 5.0 percent of Tobacco Master Settlement Agreement that was not previously allocated before S.B. 07-097 to other programs and other transfers specified in statute from the Innovative Health Program Grant Fund. Any expended funds and interest earnings from this account must be swept at the end of each fiscal year into the Short-term Innovative Health Program Grant Fund. The revenue sources for the Health Care Expansion Fund include 46 percent of the revenues collected from the increase to the Tobacco taxes approved by the voters in November 2004 and any interest and investment earnings to the fund. The state constitution limits the use of this fund to certain eligibility caseloads within the Medicaid and CBHP programs.

CBHP Population State Funding Source

CBHP Trust Fund

Children

– Ineligible for Medicaid to 185% FPL up to a total caseload of 41,786 (adj. by S.B. 07-033).

Adult Pregnant Women

–Ineligible for Medicaid to 185% FPL up to a total caseload of 101 (adj. by S.B. 07-033).

Health Care Expansion Fund

Children

– Ineligible for Medicaid to 185% FPL, any caseload above 41,786

– 186% to 200% FPL

Adult Pregnant Women

– Ineligible for Medicaid to 185% FPL, any caseload

CBHP Trust Fund Account

Children

– 200% FPL to 205% FPL

Adult Pregnant Women

--200% FPL to 205% FPL

Immunization Fund

HPV Vaccinations for CBHP Children

Table 1 below summarizes the Department's FY 2007-08 expenditure estimate and FY 2008-09 budget request for the four CBHP program line items.

Table 1: FY 2007-08 Estimate & FY 2008-09 Budget Request -- CBHP Program Line Items*

Funds	**Current** *FY 2007-08* Appropriation	Department's **Estimated** *FY 2007-08* Expenditure	**Difference Possible Supplemental Amount**	**Department's** *FY 2008-09* **Budget Request**	*FY 2008-09* Increase Compared to Current FY 2007-08 Appropriation	*FY 2008-09* Increase Compared to Estimated FY 2007-08 Expenditure
GF/GFE	$11,011	$11,011	**$0**	$2,405,185	$2,394,174	$2,394,174
CF	246,943	277,672	**30,729**	308,656	61,713	30,984
CFE	35,293,457	42,179,152	**6,885,695**	48,100,027	12,806,570	5,920,875
FF	63,560,051	76,287,957	**12,727,906**	87,226,421	23,666,370	10,938,464
Total	$99,111,462	$118,755,792	**$19,644,330**	$138,040,289	$38,928,827	$19,284,497
Percent (Decrease) / Increase			**19.82%**	n/a	39.28%	16.24%

* Does not include Decision Item #3a.

FY 2007-08 Estimated Supplemental Request

Table 2 shows the reasons for the anticipated increases in the CBHP program line items for FY 2007-08.

Table 2: CBHP Program Line Items FY 2007-08 Estimated Expenditure Detail*

Item	Total Funds	GF / GFE	Cash Funds	Cash Fund Exempt	Federal Funds
Current FY 2007-08 Appropriation	$99,111,462	$11,011	$246,943	$35,293,457	$63,560,051
Department's Estimated Changes for FY 2007-08 (Nov 1, 2007 Request)					
Adjustments for FY 2006-07 1331 Supplemental Caseload growth issue	4,147,496	0	10,567	1,447,923	2,689,006
Caseload and per-capita cost updated estimates for the CBHP program	15,496,834	0	20,162	5,437,772	10,038,900
Department's New Estimate for FY 2007-08 (Nov 1, 2007)	**$118,755,792**	**$11,011**	**$277,672**	**$42,179,152**	**$76,287,957**
(Decrease)/Increase from current FY 2007-08 appropriation	$19,644,330	$0	$30,729	$6,885,695	$12,727,906

* Includes changes to CBHP Trust Fund, CBHP Administration, CBHP Premium Costs, and CBHP Dental Benefit Costs.

Adjustments for FY 2006-07 1331 Supplemental: In June 2007, the JBC approved a 1331 emergency supplemental for the CBHP program based on higher than anticipated caseload in FY 2006-07. The JBC first adjusted for the higher than anticipated caseload in their March 2007 supplemental. However, the March supplemental was only based on initial caseload reports through January 2007. Once the Department had a nine months of data, it became apparent that the March 2007 supplemental would not be sufficient to meet the costs of the program due to higher than anticipated caseload. Because the General Assembly was out of session, the Department submitted an emergency 1331 supplemental and the JBC approved it. Based on higher than anticipated caseload and costs in FY 2006-07, the FY 2007-08 appropriation must be adjusted to reflect this higher base.

Staff Comment: With the move to cash accounting, staff believes that greater budget accuracy for this program will be achieved in the future. Under the accrual method of accounting, the Department revised caseload and expenditure data for up to six months after the fact for retroactivity. This made the monthly caseload and expenditure reports difficult to use because they were always changing (it would take six months before the number didn't change anymore). However, under the cash basis of accounting, the monthly caseload and expenditure data will reflect actual costs for the reporting period and will be a better tool for monitoring the appropriation.

Caseload and per-capita cost updated estimates for the CBHP program: Even with the base adjustment for the FY 2006-07 emergency supplemental, the Department still anticipates that FY 2007-08 appropriation is underfunded by $15.5 million total funds. This is mainly due to the Department's

new estimate for caseload growth and higher than anticipated increases to the per-capita rates based on the actuarial analysis of the program. The Department's new caseload and per-capita costs are not directly comparable to the current appropriation because the current appropriation caseload and per-capita cost were not adjusted to remove the retroactivity under cash accounting (however, a total bottom line estimate of the effect of cash accounting was made to the appropriation). These changes are discussed in greater detail below.

FY 2008-09 CBHP Base Request

Table 3 shows the reasons for the anticipated increases in the CBHP program line items for FY 2008-09.

Table 2: CBHP Program Line Items FY 2008-09 Base Request Detail*

Item	Total Funds	GF / GFE	Cash Funds	Cash Fund Exempt	Federal Funds
Current FY 2007-08 Appropriation	$99,111,462	$11,011	$246,943	$35,293,457	$63,560,051
Department's Estimated Changes for FY 2007-08 (Nov 1, 2007 Request)					
CBHP ***BASE*** Caseload and Per-Capita Cost increases for medical and dental benefits	36,476,461	0	(1,479)	12,808,354	23,669,586
CBHP External Administration	(5,000)		0	(1,784)	(3,216)
CBHP Trust Fund Solvency	2,457,366	2,394,174	63,192	0	0
Department's New Estimate for FY 2008-09 (Nov 1, 2007)	**$138,040,289**	**$2,405,185**	**$308,656**	**$48,100,027**	**$87,226,421**
(Decrease)/Increase from current FY 2007-08 appropriation	$38,928,827	$2,394,174	$61,713	$12,806,570	$23,666,370

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

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

- ✓ The children's base caseload is anticipated to increase from 56,323 in FY 2007-08 to 62,481 in FY 2008-09 (an increase of 6,158 or 10.9 percent).
- ✓ The per capita costs for the children's medical program is anticipated to increase from $1,581.01 in FY 2007-08 to $1,611.05 in FY 2008-09 (an increase of $30.04 or 1.9 percent).
- ✓ The per capita costs for the children's dental program is anticipated to increase from $152.36 in FY 2007-08 to $161.38 in FY 2008-09 (an increase of $9.02 or 5.9 percent).

- ✓ The adult pregnant women caseload is anticipated to increase from 1,297 in FY 2007-08 to 1,497 in FY 2008-09 (an increase of 200 or 15.4 percent).

- ✓ The per capita medical cost for the adult pregnant women are anticipated to increase from $11,933.24 in FY 2007-08 to $12,723.22 (an increase of $789.98 or 6.6 percent).

Table 2a summarizes the caseload changes for FY 2007-08 and FY 2008-09 in the Department's request.

Table 2a: Department's CBHP Caseload Projections FY 2007-08 & FY 2008-09

	CBHP Trust Fund up to 185%	HCE Fund up to 185%	HCE Fund from 185% to 200%	CBHP Trust Account from 200% to 205%	Total
Current FY 2007-08 Appropriation*					
Children	46,694	2,670	4,352	109	53,825
Adult Pregnant Women	119	1,056	482	8	1,664
Department's Revised FY 2007-08 Estimates					
Children	41,786	10,938	3,491	108	56,323
Adult Pregnant Women	101	977	212	7	1,297
Department's FY 2008-09 Forecast					
Children	41,786	16,596	3,864	235	62,481
Adult Pregnant Women	101	1,113	264	19	1,497

*includes retroactivity and thus, is not comparable to new caseload estimates.

Staff comment: The current FY 2007-08 appropriation was based on caseload projections before the 1331 Emergency Supplemental for FY 2006-07 was submitted. In addition, this caseload estimate is not adjusted to remove the retroactivity count from it. When S.B. 07-133 passed, it changed the method of accounting to a cash basis. Therefore, in order to better align caseload reports to monthly expenditure data, the Department has removed the retroactivity adjustment from the caseload figures back to FY 2000-01. This means that the FY 2003-04 caseload that is eligible for funding from the Health Care Expansion Fund has been revised to any caseload over 41,786 instead of any caseload over 46,694 for children and 101 instead of 119 for pregnant women. In all subsequent staff documents, staff will restate past year caseload to reflect the Department's non-retroactive caseload estimates.

Table 2b shows the impact of caseload growth and per-capita cost changes on the overall program expenditures for the CBHP program.

Table 2b: Department's CBHP Expenditure Projections FY 2007-08 & FY 2008-09					
	CBHP Trust Fund up to 185%	HCE Fund up to 185%	HCE Fund from 185% to 200%	CBHP Trust Account from 200% to 205%	Total
Current FY 2007-08 Appropriation*					
Children (medical)	**$63,488,366**	**$3,609,590**	**$5,923,363**	**$49,128**	**$73,070,448**
Children medical per capita costs	$1,359.67	$1,351.91	$1,361.07	$450.72	$1,357.56
Children (dental)	**$6,176,120**	**$353,130**	**$575,590**	**$4,806**	**$7,109,646**
Children dental per capita costs	$132.27	$132.26	$132.26	$44.09	$132.09
Adult Pregnant Women	**$1,235,363**	**$10,957,202**	**$5,001,298**	**$27,683**	**$17,221,547**
APW per capita costs	$10,381.20	$10,376.14	$10,376.14	$3,460.38	$10,349.49
TOTAL COSTS	$70,899,849	$14,919,923	$11,500,252	$81,617	$97,401,640
Adust for S.B. 07-133					($4,088,243)
Total Premium & Dental Costs -- Current FY 2007-08 Appropriation					$93,313,397
Department's Revised FY 2007-08 Estimates					
Children (medical)	**$66,064,084**	**$17,293,087**	**$5,519,306**	**$56,916**	**$88,933,393**
Children medical per capita costs	$1,581.01	$1,581.01	$1,581.01	$527.00	$1,578.99
Children (dental)	**$6,366,515**	**$1,666,514**	**$531,889**	**$5,485**	**$8,570,403**
Children dental per capita costs	$152.36	$152.36	$152.36	$50.79	$152.17
Adult Pregnant Women	**$1,205,257**	**$11,658,775**	**$2,529,847**	**$27,844**	**$15,421,723**
APW per capita costs	$11,933.24	$11,933.24	$11,933.24	$3,977.71	$11,890.30
TOTAL COSTS	**$73,635,856**	**$30,618,376**	**$8,581,042**	**$90,245**	**$112,925,519**
Department's FY 2008-09 Forecast					
Children (medical)	**$67,319,335**	**$26,736,986**	**$6,225,097**	**$378,597**	**$100,660,015**
Children medical per capita costs	$1,611.05	$1,611.05	$1,611.05	$1,611.05	$1,611.05
Children (dental)	**$6,743,425**	**$2,678,262**	**$623,572**	**$37,924**	**$10,083,183**
Children dental per capita costs	$161.38	$161.38	$161.38	$161.38	$161.38
Adult Pregnant Women	**$1,285,045**	**$14,160,944**	**$3,358,930**	**$241,741**	**$19,046,660**
APW per capita costs	$12,723.22	$12,723.22	$12,723.22	$12,723.21	$12,723.22
TOTAL COSTS	**$75,347,805**	**$43,576,192**	**$10,207,599**	**$658,262**	**$129,789,858**

Staff Comment: The current FY 2007-08 per-capita costs are not totally comparable to the Department's revised estimates because of the new estimates show the impact of the cash basis of accounting. However, the Department's budget request indicates that the FY 2007-08 rates for children are higher than previously reported (growth of 7.0 percent in the self-funded network and 12.9 percent in the HMO network). *"This is higher than that previously reported in the Department's [original FY 2007-08 budget request] as an income rating category was omitted from the original actuarial rates in anticipation that the removal of the Medicaid asset test would eliminate all clients under 100 percent of the federal poverty level.* (Department budget request page G-12)."

Thus far, through October 2007, the average non-retroactive monthly caseload for children has average 54,693 children. The adult prenatal program has average 1,337 women. The current appropriation supports average monthly expenditures of $7,776,116. Current monthly average expenditures (through October) have been $7,909,582. Based on the Department's request and the monthly reports, staff agrees that a FY 2007-08 supplemental will be necessary for this program. The exact amount will be determine during figure setting in March. This will mark the second year in a row where a significant positive supplemental was needed for this program.

The FY 2008-09 children medical rates reflect an increase of 5.9 percent for the self-funded network and increased of 6.9 percent for the HMOs. However, the blended rate between the self-funded network and HMOs (based on the case mix between the two services) results in an increase of only 1.9 percent to the overall per capita rate. For the FY 2008-09 children's dental rate, the Department is anticipated an increase to the rate of 5.9 percent over the FY 2007-08 rate. Finally, the FY 2008-09 rate for the adult prenatal program assumed an increase of 6.6 percent. All of these rates are developed with the assistance of a contracted actuary.

Even though actuaries help develop the rates for this program, during the last several years the forecast accuracy for this program has not been where it needs to be. Table 3c provides a five year history of the forecast accuracy for the CBHP Premium and Dental line items.

Table 3c: Accuracy of Total Fund Expenditures for CBHP Premiums and Dental Benefit

Total Medicaid Medical Expenditures	FY 2002-03	FY 2003-04	FY 2004-05	FY 2005-06	FY 2006-07[/1]
Original Total Fund App.	$70,825,105	$70,592,359	$64,670,544	$78,234,696	$76,284,836
Final Total Fund App.	$59,970,836	$70,592,359	$64,175,842	$71,383,683	$96,605,972
Actual Total Fund	**$57,197,837**	**$57,423,192**	**$57,084,990**	**$71,288,812**	**$96,492,276**
% Actual Different from Org App.	(19.24)%	(18.66)%	(11.73)%	(8.88)%	26.49%
% Actual Different from Final App.	(4.62)%	(18.66)%	(11.05)%	(0.13)%	(0.12)%

/1 Includes 1331 Supplemental that was approved.

CBHP External Administration: The Department's FY 2008-09 request reflects a technical adjustment to the CBHP External Administration line item in order to remove one-time costs from implementing S.B. 07-004 and S.B. 07-097.

CBHP Trust Fund Solvency: As stated earlier, the majority of the CBHP Trust Fund revenues come from transferring 24 percent of the total amount of money that the State receives annually from the Tobacco Master Settlement Agreement (Section 25.5-8-105, C.R.S.). The CBHP Trust Fund also receives revenue from the enrollment fee charged to clients and interest earnings. If necessary, the CBHP Trust Fund may also receive General Fund appropriations in order to maintain a positive fund balance 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. Table 3d shows the impact of the Department's caseload and cost estimates on the CBHP Trust Fund.

Table 1: CBHP Trust Fund Anticipated Revenues and Expenditure Needs

	FY 2005-06 Actual	FY 2006-07 Actual	FY 2008-09 Dept. Estimate	FY 2008-09 Dept. Request
Beginning Balance	$9,025,270	$4,411,882	$7,776,123	$1,788,804
General App.	2,000,000	11,243,215	0	2,382,423
Transfer by State Controller	900,000	0	0	0
Tobacco Settlement App.	20,927,529	19,214,822	21,612,590	23,972,821
Other Revenue	990,140	610,607	1,713,736	2,031,948
HCE Fund State Match Earnings	5,108,706	9,557,980	14,037,434	19,032,763
Federal Match Earnings	50,509,127	65,616,702	78,458,803	89,279,905
SUBTOTAL REVENUE	**$89,460,772**	**$110,655,208**	**$123,598,686**	**$138,488,664**
State Match for Traditional Caseload	$20,944,551	$26,824,625	$27,233,716	$27,850,430
State Match for Expansion Caseload	5,108,706	9,557,980	14,037,434	19,032,763
Supplemental Tobacco Tax Account & Immunization Fund	0	0	908,002	1,216,834
Federal Match for Traditional Caseload	50,509,127	65,616,702	78,458,803	89,279,905
Other Trust Fund Expenditures	386,506	879,778	1,171,927	1,108,732
SB 05-211 Transfer	8,100,000	0	0	0
SUBTOTAL EXPENDITURES	**$85,048,890**	**$102,879,085**	**$121,809,882**	**$138,488,664**
REMAINING BALANCE	**$4,411,882**	**$7,776,123**	**$1,788,804**	**$0**

Questions for Department

1. Please describe any difficulties that the Department will experience in tracking actual expenditures from the CBHP Trust Fund Account in order to know how much should be swept back into the Innovative Health Care Grant Fund at the end of each fiscal year?

2. Please describe why there are still children with family incomes under 100% FPL on the CBHP program.

3. The Department's budget request indicates a large supplemental for the CBHP program in FY 2007-08. While some of this increase is related to higher than projected caseload, the request also reflects substantial changes for PMPM rates than originally requested by the Department in November 1, 2006. Please describe in detail why these rates have increased over the original Department estimate.

4. Please explain why the FY 2008-09 per capita costs for the CBHP Adult Prenatal program are higher than the estimated FY 2008-09 acute care per capita costs for the Medicaid Baby Care pregnant women.

FY 2008-09 Joint Budget Committee Staff Budget Briefing
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
Colorado's Children's Basic Health Plan Outreach Increase

ISSUE:

The Department requests a total of $23.9 million in additional funds for expanded outreach efforts to find and enroll existing eligible but uninsured children in the CBHP and Medicaid programs. This issue is one of the Governor's highlighted priorities.

SUMMARY:

- The Department anticipates that an increase of $1.4 million total funds for increased outreach in the CBHP program will result in the enrollment of an additional 8,000 children in the CBHP program and 4,000 children in the Medicaid program. This enrollment is in addition to the ***base*** enrollment forecasts that were discussed earlier for the Medicaid and CBHP programs.

RECOMMENDATION:

Staff recommends that the Department discuss the questions at the end of this issue with the Department at their hearing.

DISCUSSION:

Estimates for the number of uninsured children in Colorado eligible for Medicaid or CBHP range from 70,000 to 110,000.

The 208 Commission on Health Care Reform contracted with the Lewin Group to perform initial data analysis of the characteristics of the uninsured population in Colorado, baseline spending on health care, and initial cost estimates for all proposals from the Commission. The Lewin Group estimated that there are approximately 85,000 uninsured that are *eligible* for either Medicaid or CBHP. Of this amount, approximately 70,125 are children under age 19.[1]

[1]Characteristics of the Uninsured in Colorado, Draft, Lewin Group, July 12, 2007, p. 10. Please note that this is a preliminary estimate subject to change. In modeling the different proposals, the Lewin Group used an uninsured number 791,800 total uninsured compared to the earlier estimate of 785,200 (of which, they estimated 10.82 were eligible for Medicaid or CBHP).

In their budget request, the Department estimates that there are approximately 44,000 uninsured children eligible for CBHP and 65,000 uninsured children within the Medicaid income guidelines (November 1, 2007 HCPF Budget Request, page G-4). The Department's estimate is based on the Current Population Survey (CPS) data from the U.S. Bureau of Census. The ***main*** reason for the difference is the Lewin Group attempts to eliminate the under count in the CPS data for people covered by the Medicaid program. The Lewin Group estimates this undercount at 30 percent. The Department's estimate is the CPS number without an adjustment for the Medicaid undercount.

In order to pursue Governor Ritter's "Colorado Promise", the Department is requesting funding to expand outreach efforts to help find and enroll children who may be eligible for the CBHP program. Because all CBHP children must be screened for Medicaid eligibility first, this decision item will also increase the enrollment for children in the Medicaid program.

Currently, the Department spends $1.3 million to market the CBHP program. Under the Department's proposal, the Department would continue to spend $1.3 million to market the CBHP program through radio and television advertising. However, the Department requests an additional $1.4 million total funds for direct outreach efforts. The Department would use this funding for the following:

-- Increase the availability of applications at hospitals, pharmacies, and clinics;

-- Send direct mailings to families with children that qualify for free or reduced price lunches in their schools;

-- Expand community and local outreach throughout the State by increasing the number of regional outreach coordinators, and;

-- Coordinate and promote community enrollment events where families can receive application assistance.

The Department anticipates that an additional 8,000 children could be enrolled in CBHP through this effort and another 4,000 children would be enrolled in the Medicaid program. Table 1 below shows the costs estimates for the Department's request.

Table 1: Costs for Increasing Outreach

	Outreach Expense	Medicaid Impact	CBHP Impact	Total
Caseload Impact	**0**	**4,000**	**8,000**	**12,000**
Premium Costs[/1]	$0	$7,063,080	$12,888,400	$19,951,480
Medicaid MH Costs	0	735,240	0	735,240
CBHP Dental	0	0	1,291,040	1,291,040

Table 1: Costs for Increasing Outreach				
	Outreach Expense	**Medicaid Impact**	**CBHP Impact**	**Total**
CBHP Administration	1,400,000	0	0	1,400,000
CBHP Trust Fund	0	0	555,735	555,735
TOTAL	**$1,400,000**	**$7,798,320**	**$14,735,175**	**$23,933,495**
General Fund	$0	$3,899,160	$516,215	$4,415,375
CBHP Enrollment Fees	0	0	39,520	39,520
CBHP Trust Fund	516,215	0	39,520	555,735
CBHP Trust Account	0	0	62,605	62,605
Immunization Fund	0	0	65,327	65,327
Health Care Expansion	21,455	0	4,821,040	4,842,495
Federal Funds	862,330	3,899,160	9,190,948	13,952,438
TOTAL FUNDS	**$1,400,000**	**$7,798,320**	**$14,735,175**	**$23,933,495**

Based on the Department's estimate, the additional $1.4 million would reduce the number of uninsured children eligible for Medicaid or CBHP by approximately 10.9 percent. However, if using the Lewin Group's estimate, the Department's request would reduce the number of uninsured children eligible for Medicaid or CBHP by approximately 17.1 percent.

Staff Comment: With the passage of H.B. 05-1262, the Department has had a dedicated funding source of approximately $1.3 million to market the CBHP program. Beginning in January 2006, the Department entered a contract with Maximus and new marketing campaign began on April 1, 2006. The new administration also began a new radio and television campaign on January 29, 2007 that specifically targeted low-income and Hispanic populations. As was stated earlier in this briefing packet, the caseload in FY 2006-07 was much higher than was originally anticipated. The Department believes that part of the reason for this was because of the successful launch of these marketing campaigns. However, the Department states in their budget request that they "do not currently have the resources to directly measure the effect marketing has had on caseload in either the [Medicaid or CBHP] program.".

The Department's request would continue the base funding for marketing the CBHP program but would also focus on more "outreach" activities. While marketing activities may increase public awareness about the program, outreach activities usually provide actual assistance in gaining access to and filling out applications for eligible families.

During the last five years there have been a lot of changes that have affected the marketing of CBHP program (and indirectly Medicaid), including the following:

1) In early 2003, the Department ceased all marketing of the CBHP program due to the state's budget problems;

2) In November 2003 the children's program was capped pursuant to S.B. 03-291 and was uncapped beginning again in July 1, 2004;

3) House Bill 04-1058 allowed the Department to authorize other entities beside the county departments of social services to accept Medicaid applications and to determine Medicaid eligibility;

4) House Bill 05-1262 expanded eligibility to 200% FPL and appropriated approximately $1.3 million for marketing. This marketing campaign began in April 2006;

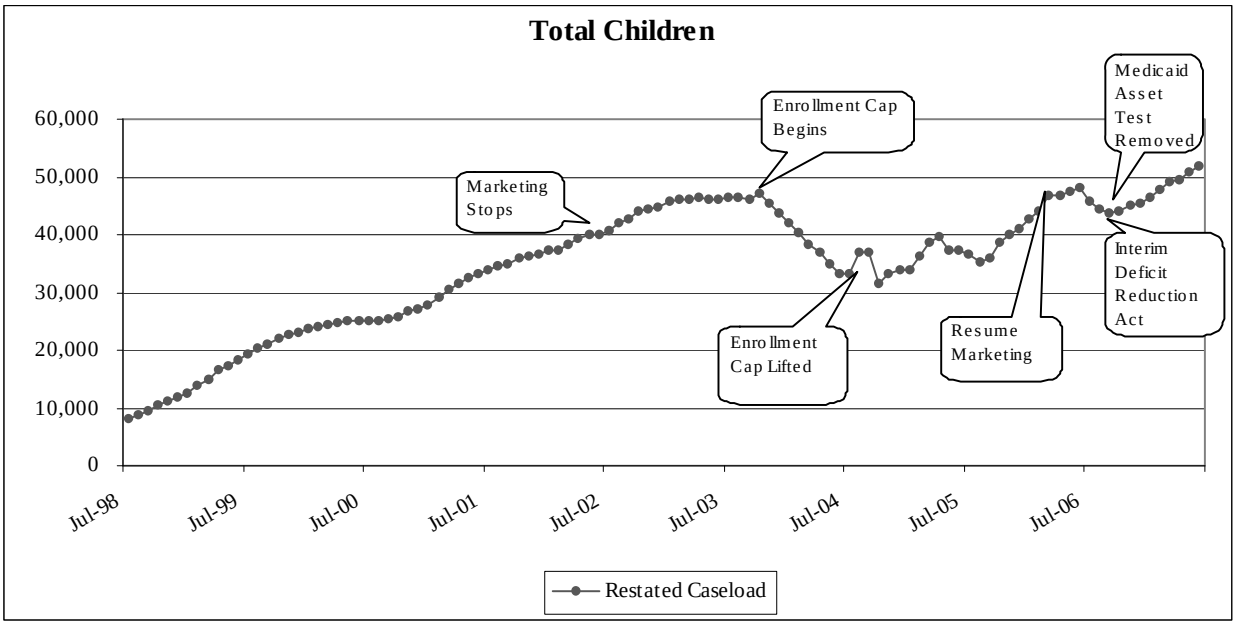
5) In July 2006, the Medicaid asset test was eliminated and the Deficit Reduction Act of 2005 legal status verification requirements for the Medicaid program began;

6) In January 2007 the Department began a new marketing campaign;

7) In July 2007, a pilot program to allow school districts to determine eligibility began pursuant to H.B. 06-1270; and

8) In January 1, 2008, children will be presumptively eligible for Medicaid or CBHP if they meet the income criteria pursuant to S.B. 07-211.

The following chart shows how some of these policy changes have impacted the enrollment in the CBHP children's program.



The Department states in their request that: "the Department has no way to directly measure the effect marketing has had on caseload in either program....the Department does not know at this time the actual expected impacts from additional outreach. The Department will be able to refine estimates once the outreach plan is solidified with a selected contractor.". Right now the Department's request does not fully support their assumption that they will be able to enroll another 12.000 children with additional outreach. Staff believes that this decision item was included in the Department's request in order to begin a discussion with the Joint Budget Committee on the most effective way to enroll currently eligible children in the Medicaid and CBHP program. Therefore, staff recommends that the Committee discuss the following questions with the Department at their hearing:

1. Please provide the Committee with an update of the school districts selected to participate in the H.B. 06-1270 pilot program. What is the initial feedback on the effect this program has had on CBHP and Medicaid enrollment.

2. Will the Department be ready to implement presumptive eligibility for children in the CBHP and Medicaid on January 1, 2008? The Department's budget request does not include any specific additional caseload or cost adjustments for presumptive eligibility.

3. Is additional outreach funding the most cost-effective means for reducing the number of eligible uninsured children? Would providing 12 months of continuous Medicaid eligibility for ***children*** have a greater impact? How would this impact the number of uninsured?

4. Why doesn't the Department's request include an increase for adults on Medicaid for this decision item? Wouldn't it be safe to assume that there would be additional eligible adults that would be enrolled if more eligible children are found?

5. Please describe the most recent federal guidelines for screening for Medicaid eligibility before a child can be determined CBHP eligible. Can a child be CBHP eligible without the necessary Medicaid citizenship or legal status documentation?

6. The S.B. 07-211 Advisory Committee made several preliminary recommendations regarding data collection within the Department regarding the number of children eligible for these programs but not enrolled. What is the status of the Department's response to the S.B. 07-211 Advisory Committee's initial recommendations.

FY 2008-09 Joint Budget Committee Staff Budget Briefing
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
SCHIP Federal Reauthorization

ISSUE:

As of the writing of this issue, Congress and the President have not yet agreed on a bill to reauthorize the SCHIP program (CBHP in Colorado).

SUMMARY:

- The Balanced Budget Act of 1997, which established SCHIP, required that the SCHIP program be reauthorized after a 10 year period -- September 2007. As of November 27, 2007, a bill has not passed to reauthorize SCHIP. However, the program currently operates under a continuing resolution until December 14, 2007.

RECOMMENDATION:

This is an informational issue. Staff makes no recommendation regarding this issue.

DISCUSSION:

The Balanced Budget Act of 1997, which established SCHIP, required that the SCHIP program be reauthorized after a 10-year period. The date for the program to expire was September 30, 2007. Because a bill was not made law by this deadline, the SCHIP program is currently operating under a continuing resolution until December 14, 2007.

On September 27, 2007, Congress passed H.R. 976 which reauthorized the SCHIP program as well as made other SCHIP program changes and expansions. This bill was vetoed by President Bush on October 3, 2007. On October 18, 2007 the House of Representatives attempted to override the veto but fell short of the 2/3 majority to do so with a vote of 273 - 156 (the House of Representatives needs 287 votes to override a Presidential veto). On October 24, 2007, Congress introduced a new bill, H.R. 3963 that reauthorized the SCHIP program as well as made other program changes. This bill passed the House of Representatives on October 25, 2007 (265 - 142). The bill passed the Senate without amendment on November 1, 2007 (64-30). However, the bill was never sent to the President (President Bush had stated he would veto this bill also). Congress recessed for two weeks and anticipated revisiting the issue in December.

As the Committee is aware, the reauthorization of the SCHIP program is caught up in the political debates for the 2008 election. At this time, staff is uncertain on what the final outcome will be for SCHIP. Staff will continue to monitor the bills and debate before Congress and inform the Committee if anything new happens.

Issues that would of interest to Colorado in the debate include, but are not limited to the following.

Table 1: Major CBHP and Medicaid Issues in the Most Recent Congressional Bill (HR 3963) Compared to Current Law			
	Current Federal Law	**HR 3963**	**Staff Comment**
Financing			
CHIP Appropriations	Original Bill specified in law the federal appropriations for the program through FFY 2007. After FFY 2007 no appropriations are authorized.	Contains specific federal appropriations through FFY 2012 (a five year time period).	According to CMS calculations, Colorado would receive approximately a 8.0 percent increase over the baseline projection for FFY 2008.
Allotment of federal CHIP funds to states	Current allotments are based on the number of children who are low income and are uninsured. States have up to 3 years to spend their annual allotments.	Based primarily on actual and projected spending plus inflation for population growth and health care costs. Contingency fund for spending in excess fo allotments. States allowed 2 years to spend annual allotment.	According to the Department's estimates, without a change in federal allotment from 2007, the Department will spend all of the allotment plus previous year balances beginning in FY 2007-08.
Financing		61 cent increase in per pack cigarette tax. $35 billion over 5 years.	This may impact revenue projections for 208 Commission and existing tobacco tax programs.
Eligibility			
Optional State Plan Amendment coverage for pregnant women	Currently, states can cover pregnant women ages 19 and older through waiver authority or by providing coverage to unborn children.	Would allow states to cover pregnant women as a state plan option. Expands medical coverage to beyond prenatal, delivery, and post-partum care.	Colorado already covers adult pregnant women through a waiver.

Table 1: Major CBHP and Medicaid Issues in the Most Recent Congressional Bill (HR 3963) Compared to Current Law			
	Current Federal Law	**HR 3963**	**Staff Comment**
Non-pregnant childless adults	Section 1115 waivers allowed coverage for some childless adults.	Prohibits new 1115 demonstration waivers to cover childless adults. Allows a one year transition period for the six states with such waivers to move these populations to Medicaid.	Colorado doesn't currently cover nor have plans to cover non-pregnant childless adults in the CBHP program.
Parents of Enrolled Children	Section 1115 waivers allowed coverage of parents.	No new waivers. Move to cap funds for parents on the program as of October 2007.	Colorado doesn't currently cover parents of children on the program.
Children	Original legislation assumed 200% of FPL but income disregards have allowed some states to cover up to 350% FPL.	No SCHIP coverage > 300% FPL (exception New Jersey).	Colorado currently covers up to 205% of FPL.
Enrollment			
Enrollment Outreach	Administrative costs can not exceed 10 percent of program costs.	Performance bonuses to states that enroll more Medicaid eligible children. A $100 million grant program for out reach activities.	Colorado could benefit from the federal grant funding more outreach activities. Grant program would specifically target cultural and linguistic barriers to enrollment and activities that address these issues would receive an enhance federal match rate.
Citizenship Documentation	The DRA 2005 citizenship/ legal status Medicaid documentation currently does not apply to SCHIP.	New legal status documentation applied to SCHIP. Allows social security cards to be sufficient proof of legal status.	Children are excluded from citizenship verification under 06S-1023. However, this provision would require that the Department verify legal status for CBHP applicants if this provision passed.

Table 1: Major CBHP and Medicaid Issues in the Most Recent Congressional Bill (HR 3963) Compared to Current Law			
	Current Federal Law	**HR 3963**	**Staff Comment**
Premium Assistance / Crowd-Out			
Premium assistance programs	Under Medicaid, states may pay a Medicaid beneficiaries share of employer based health coverage.	Allows premium assistance programs for qualified sponsored coverage to all targeted low-income children.	Colorado just began an employer-based premium assistance program in CBHP.
Crowd-out	Existing regulations at 42 C.F.R. 457.805 provide that States must have "reasonable procedures" to prevent substitution of public SCHIP coverage for private coverage.	All states must implement best practices on crowd-out provisions.	Currently, children can not enroll in CBHP for 3 months if they had previous insurance coverage except in cases of loss of coverage or unemployment.
Benefits			
Dental Services	Stand alone SCHIP programs do not have to offer dental benefits.	Dental services required.	Colorado currently provides dental services.
Mental Health Services	Stand alone SCHIP programs do not have to offer mental health services if not included in their benchmark-equivalent plan.	Mental health parity required if states offer mental health services.	Colorado currently covers mental health services in CBHP.

Should Colorado Be In Panic Mode Because Reauthorization Has Not Yet Passed?

Currently, some states are releasing press statements on how to cap their SCHIP programs if federal authorization is not passed soon. Fortunately, Colorado is in a better position in that our program has not and is not projected to exceed our federal allotment plus carry forward balance for FY 2007-08. Staff anticipates that even if a comprehensive SCHIP reauthorization bill does not pass before the 2008 elections, that Congress will pass another continuing resolution extending the program beyond December 14, 2007. At this point in time, staff recommends continuing monitoring of the federal action but ***no*** specific JBC action. Come March 2008, if a compromise has not been reached at the national level then staff will recommend specific contingency plans to the JBC.

FY 2008-09 Joint Budget Committee Staff Budget Briefing
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
Health Care Expansion Fund Solvency

ISSUE:

The Health Care Expansion Fund will remain solvent through FY 2012-13 based on the Department's FY 2008-09 budget request.

SUMMARY:

- ❑ The Health Care Expansion Fund had a FY 2006-07 ending balance of $130.7 million. Based on the Department's November 1, 2007 Budget Request, the Health Care Expansion Fund will have a fund balance of $129.5 million in FY 2007-08 and $117.7 million in FY 2008-09.

- ❑ Beginning in FY 2007-08, the Department forecasts that annual expenditures from the fund will begin exceeding annual revenues into the fund.

RECOMMENDATION:

This is an informational only issue. Staff makes no recommendations for this issue.

DISCUSSION:

The Health Care Expansion fund receives 46 percent of the total tobacco taxes collected pursuant Article X, Section 21 of the Colorado Constitution (Amendment 35). The Health Care Expansion fund can be used for three purposes: (1) expand enrollment in CBHP above FY 2003-04 enrollment; (2) add parents or enrolled children; and (3) expand eligibility of low income adults and children in either CBHP or Medicaid. The General Assembly has passed H.B. 05-1086, H.B. 05-1262, and S.B. 07-002 to expand CBHP and Medicaid in order to use these funds.

During the first three years after Amendment 35 passed, revenues into the fund exceeded expenditures. This was mainly due to revenues collecting in the fund before legislation could be passed on how to spend the moneys and during the enrollment ramp up phase for the new expansion programs. Thus, the Health Care Expansion Fund balance at the end FY 2006-07 was $130.7 million. However, beginning in FY 2007-08, Department projects that annual expenditures from the fund will begin to exceed annual revenues into the fund. Table 1 shows the Department's estimated Health Care Expansion Fund balance projected through FY 2009-10 based on their November 1, 2007 budget request.

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**
Fund Balance	$28,095,163	$94,635,520	$130,653,131	$129,514,449	$117,675,388
New Revenues (includes interest earnings)	80,434,243	83,242,586	75,900,000	81,552,299	81,149,771
Total Funds Available	$108,529,406	$177,878,106	$206,553,131	$211,066,748	$198,825,159
Total Expenditures (Department's Request)	$13,893,886	$47,224,975	$77,038,682	$93,391,360	$96,841,317
Health Care Expansion Fund Balance (total funds available - total expenditures)	$94,635,520	$130,653,131	$129,514,449	$117,675,388	$101,983,842
Decrease/Increase in Fund Balance	n/a	$36,017,611	($1,138,682)	($11,839,061)	($15,691,546)

Revenues from the Amendment 35 tobacco taxes are assumed to be relatively flat. However, health care expenditures from the fund are anticipated to grow based on both caseload and cost increases. Under a scenario where revenues remain flat and costs grow by 6.0 percent each year, the fund balance would be depleted by FY 2013-14 (five years out from the current request year of FY 2008-09).

Table 2: Staff Scenario 1 -- Flat Revenues and 6.0% Growth For Expenditures				
State Fiscal Year	**FY 2010-11**	**FY 2011-12**	**FY 2012-13**	**FY 2013-14**
Fund Balance	$101,983,842	$80,481,817	$52,820,684	$18,630,897
New Revenues (assume constant revenues)	81,149,771	81,149,771	81,149,771	81,149,771
Total Funds Available	$183,133,613	$161,631,588	$133,970,455	$99,780,668
Total Expenditures (6% Growth)	$102,651,796	$108,810,904	$115,339,558	$122,259,931
Health Care Expansion Fund Balance (total funds available - total expenditures)	$80,481,817	$52,820,684	$18,630,897	($22,479,263)
Decrease/Increase in Fund Balance	($21,502,025)	($27,661,133)	($34,189,787)	($41,110,160)

FY 2008-09 Joint Budget Committee Staff Budget Briefing
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
Uninsured Assistance Programs in Colorado

ISSUE

The Department's FY 2008-09 budget request includes approximately $370.0 million total funds for programs devoted to covering a portion of the health care costs of the uninsured.

SUMMARY

- In 2005, the Lewin Group estimates that there were 785,200 average monthly uninsured in Colorado. Of this amount, 51.3 percent had incomes under 200 percent of the federal poverty level.

- The Department has six programs that provide coverage to the uninsured. The total funds appropriated are $370.0 million. This includes $135.0 million in certified public expenditures from public hospitals.

RECOMMENDATION:

Staff recommends that the Committee discuss with the Department what contingency plans the State pursue should the CMS rule, "Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership" ever go into effect.

DISCUSSION:

The 208 Commission contracted with the Lewin Group to provide estimates of the number of uninsured in Colorado. Their preliminary draft report indicated that there were 785,200 average monthly uninsured in Colorado during 2005.[1] Of this amount, the Lewin Group estimated that approximately 402,800 (51.3 percent) were individuals or children in families with incomes under 200 percent of the federal poverty level. The Lewin Group estimates that only 85,000 (10.8 percent) of the uninsured are actually currently eligible for Medicaid or CBHP. The other uninsured, at or near poverty, are ineligible for these public insurance programs because they do not fit into a Medicaid/CBHP covered eligible group (i.e. they are childless non-disabled adults, aren't pregnant, have too high of income, or are non-citizens).

[1] Please note that future fiscal notes may use a higher number based on trending this data forward to the current year.

Current Funding Devoted to the Uninsured

The Department has six major programs devoted to covering a portion of the health care costs for the uninsured. Two of the programs can be categorized as "care reimbursement" programs in that eligible individual receive discounted health care services from providers that participate in the programs. The other three programs are "enhanced reimbursement or grant programs" that provide direct aid to those health care providers serving a large number of uninsured or underinsured clients. Providers, not individuals, qualify for these programs.

Care Reimbursement Programs
Colorado Indigent Care Program (CICP) Provides partial reimbursement to hospitals and clinics participating in the program for providing services to uninsured or underinsured individuals with incomes up to 250 percent of the federal poverty level. In FY 2005-06, 180,411 unique individuals were able to receive discounted services through this program. It is important to note that program is not an insurance program Rather, it is a way for providers to recoup some of their costs for the uninsured or underinsured. Funding for this program come from the state, public hospitals, and federal sources.
Old Age Medical Program This program serves individuals older than 60 years of age with incomes at or below 76.2 percent of FPL who are not eligible for Medicaid. The number clients served in FY 2006-07 was 5,103. This program operates more lie a regular Government medical program in that clients receive an eligibility card and have a defined set of services that are covered. Funding for this program is entirely state funds.
Enhanced Reimbursement & Grant Programs
Pediatric Speciality Hospital Provides enhanced Medicaid reimbursement for pediatric hospitals that serve a high volumn of Medicaid and uninsured children. Funding for this program is state and federal funds.
Primary Care Fund Program Provides grants to providers serving indigent care. Each provider must apply for this program. Grant awards are distributed based on the portion of medically indigent or uninsured patients each provider serves relative to the total amount of medically indigent or uninsured clients served by all qualified providers. This is a state-only funded program.
Health Care Services Fund Provides funding to providers providing primary care services to uninsured or underinsured adults. Currently, this is state-only funded program but the Department is directed to seek federal matching funds if available.
Comprehensive Primary and Preventative Grants This program provides grant funding to providers to expand services to indigent Colorado residents. This funding is used mainly to increase the infrastructure to serve indigent clients. This is a state-only funded program.

For the most part, current programs for the uninsured indigent population tend to provide financial aid to the providers serving these clients rather than a direct benefit to the individual. These programs also allow a wider catchment of individuals to receive services than do Medicaid or CBHP. Therefore, even if Medicaid or CBHP eligibility was expanded to cover a larger number of the uninsured, continued funding for these programs may still be necessary.

The current FY 2007-08 appropriation for these programs is $360.6 million total funds. However of this amount, $135.0 million is certified local funds from qualifying public hospitals. Certified expenditures are specific expenditures by local entities used as the "state" match to draw down the federal match through the Disproportionate Share Program and Medicare Upper Payment limit programs within Title XIX of the Social Security Act. For FY 2008-09, 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 1 provides a five-year history of the funding available for these programs and line items.

Table 1 -- Funding History for Programs for the Uninsured

	FY 2004-05 Actual	FY 2005-06 Actual	FY 2006-07 Actual	FY 2007-08 App.	FY 2008-09 Request
Safety Net Provider Payments (CICP)	$264,013,206	$287,296,074	$279,933,040	$296,188,630	$296,188,630
Clinic Based Indigent Care (CICP)/1	6,119,760	6,119,760	6,119,760	6,119,760	6,119,760
Old Age Pension Program	9,999,321	14,426,967	12,578,662	13,293,672	13,181,483
Pediatric Specialty Hospital	0	5,452,134	7,732,072	8,499,289	8,728,000
Primary Care Program	0	44,041,879	31,980,929	32,365,298	30,818,000
Health Care Service Fund/1	0	0	14,962,408	15,000,000	15,000,000
CPC Grant Program	2,566,401	2,604,927	2,310,510	4,138,070	5,997,000
Total Funding	**$282,698,688**	**$359,941,741**	**$355,617,381**	**$375,604,719**	**$376,032,873**
GF/GFE/1	$12,492,364	$18,362,593	$34,979,106	$35,385,951	$35,614,662
CFE - Certified	$122,574,119	$131,071,391	$126,875,738	$135,003,533	$135,003,533
CFE - State	$12,565,722	$61,073,773	$46,870,101	$49,797,040	$49,996,483
FF	$135,066,483	$149,433,984	$146,892,436	$155,418,195	$155,418,195

/1 All expenditures for the Health Care Services Fund are represented here in the year that services were provided from the fund. No double-counted appropriations are shown in this table.

As Table 1 shows, funding for the indigent care program is forecasted to increase by only $428,154 (1.1 percent) in FY 2008-09 over the current FY 2007-08 appropriation. These is amount reflects an increase of $1,858,930 for the Comprehensive Primary and Preventive Care Grant Program and an increase of $228,711 for the Pediatric Speciality Hospital line item. These funding increases are both related to increases in Tobacco Settlement funds pursuant to S.B. 07-097 and H.B. 07-1359. These increases are offset by a decrease of $1,547,298 for the Primary Care Fund and a decrease of $112,189 to the Old Age Pension Fund. These program decreases both relate to lower revenue forecasts for the Amendment 35 Tobacco Tax funds.

Uncertainty About Funding Stability in the Future

Through the use of new financing mechanism and funding sources, the state has been able to increase the amount of funding available of the uninsured population during the last several years. However, there are several issues that threaten funding stability or growth for these programs.

1) ***Primary Care Fund:*** This program receives19 percent of the tax revenues collected pursuant to Article X, Section 21, of the State Constitution (Amendment 35 Tobacco Tax revenues). Legislative Council forecasts (September 2007) that this revenue stream will decrease from approximately $31.5 million in FY 2007-08 to $30.0 million by FY 2011-12.

2) ***Health Care Services Fund***: Pursuant to S.B. 06-044, this fund receives $15.0 million from the additional General Fund revenues retained under Referendum C. Under current law, this funding is eliminated beginning in FY 2010-11.

3) ***Safety Net Provider Payment:*** The federal match for this program comes mainly through two sources: (1) the Disproportionate Share Hospital (DSH) payments under Title XIX of the Social Security Act and (2) the Medicare Upper Payment Limit (UPL). Colorado's federal DSH allotment is currently $87.1 million and should remain at this level through at least FY 2009-10. It is possible that additional federal legislation could be implemented to change current or future allotments. Currently, the state match for the federal DSH dollars is mainly from certified public expenditures at public hospitals and some General Fund ($13.1 million).

   The Medicare Upper Payment Limit (UPL) is the maximum amount Medicaid can reimburse a provider and still receive federal matching funds. Currently, the state reimburses providers below the UPL. However, publicly-owned providers certify public expenditures up to the UPL, which allows the state to generate a federal match without a state fund expenditure for the difference.

   On January 18, 2007, CMS published a proposed rule, "Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-state Financial Partnership" that redefined "a unit of government" to those local governmental entities that have "generally applicable taxing authority." Under this proposed

rule, the ability for public hospitals in Colorado to certify public expenditures would have been eliminated. Originally, this rule was to be effective on September 1, 2007. The Joint Budget Committee Co-Sponsored SJM 07-004 requesting that Congress enact legislation to prevent the CMS from adopting or enforcing their proposed rule. On May 25, 2007, President Bush signed H.B. 2206 ("U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act, 2007) which contained an amendment to impose a one-year moratorium on the CMS proposed rule. Therefore, under current law, the rule can not take effect before September 1, 2008.

There remain three other bills introduced in this Congress (Senate Bill 787, House Bill 1480 and House Bill 1741 [Rep. Salazar is a co-sponsor on this bill]) that would impose a two-year moratorium on implementing the CMS rule. At this point, these bills have been introduced but have not yet been scheduled for Committee Action.

Issues to Discuss with Department at their Hearing

1. What contingency plans should the State pursue if the CMS rule, "Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership" should become effective on September 1, 2008?

FY 2008-09 Joint Budget Committee Staff Budget Briefing
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
208 Commission on Health Care Reform

ISSUE:

The 208 Blue Ribbon Commission on Health Care Reform must present their recommendations to the Senate and House of Representative Health and Human Services Committees by January 31, 2008.

SUMMARY:

- ❑ The 208 Blue Ribbon Commission on Health Care Reform considered five proposals to reform health care delivery in Colorado. Their final recommendations are due to the Senate and House of Representatives Health and Human Services Committee by January 31, 2008.

- ❑ Because of the large funding requirements of all of the proposals under consideration, continued technical assistance may be necessary for developing fiscal note impacts on any one proposal.

- ❑ Funding sources for any proposal put forward should sustain the expansion programs without needing any General Fund support under the current six percent limit.

RECOMMENDATION:

Staff makes the following recommendations:

1. The Joint Budget Committee should invite the 208 Commission to do a formal presentation of their recommendations to the JBC in February 2008 or attend their presentation to the HHS Committees.

2. The General Assembly and/or Executive Branch should consider whether or not to contract with the 208 Commission contractor, Lewin Group, to assist in forecasting the enrollment impacts of any proposed legislation that modifies eligibility for Medicaid or CBHP.

3. The Committee should ensure that any proposal to expand Medicaid or CBHP have a reliable and sustainable funding source and that reserves can be accumulate until the program has reached a reasonable penetration rate.

4. The Committee should ask the Department to respond to the questions at the end of this issue.

DISCUSSION:

Background

Senate Bill 06-208 established the Blue Ribbon Commission for Health Care Reform (Commission) for the purpose of studying and establishing health care reform models to expand health care coverage and to decrease health care costs for Colorado residents. The Commission was charged with selecting between three to five specific health care reform models to ensure access to affordable health care coverage for all Colorado residents. Initially, the Commission was to report their findings to the General Assembly by November 1, 2007. However, the reporting requirements were changed to reporting to the Senate and House Health and Humans Services Committee by January 31, 2008.

The Commission began meeting in November 2006. The Commission hired Lewin Group, a health and human services consulting group, to provide technical assistance in determining the number of uninsured in Colorado and for pricing the costs of proposals. During the 2007 interim, the Commission considered five different proposals. The costs for the proposals considered ranged from $980 million to $26,578 billion. The table below provides ***brief*** summary of ***selected*** highlights of the plans considered by the 208 Commission (staff does not cover all aspects of each plan -- only those pertinent to this briefing -- mainly Medicaid, CBHP, and CICP impacts).

	Better Health Care Colorado	**Solutions for Healthy Colorado**	**A Plan for Covering Coloradans**	**Colorado Health Services Plan**	**Commission Proposal**
New Program Spending	$980 million	$1,366 Billion	$3,146 Billion	$26,578 Billion	$2,365 Billion
Percent of Uninsured Who Become Covered	41.0%	82.5%	86.3%	100.0%	87.6%
Medicaid/CHP+ Expansion	Kids living below 300%	Kids and PG Women <250% Other Adults <100%	Kids < 300% Parents < 300% Other Adults <100%	All residents 3+ months in state	Kids 250% FPL Adults < 205% Medical Needy Disabled Buy-in
Premium Subsidies	Sliding scale voucher < 300%	Sliding scale tax credit for adults < 250%	Sliding scale voucher <400%	No premiums	Sliding scale subside for all below <400% FPL
New STATE tax revenues proposed	$336 million TT and AT	$858 million TT, AT, LNF	$2,014 Billion TT, AT ,PT, PRT, SIT, EA	$15,036 Billion TT, AT, EPT, SIT	$1,138 Billion TT, AT, LNF, SIT

Source: Lewin Group draft presentation presented to Commission on November 15, 2007.
TT -- Tobacco Tax; AT -- Alcohol Tax; LNF -- Low-Nutrition Foods; PT -- Premium Tax; PRT -- Provider Tax; EPT--Employer Payroll Tax; SIT -- State Income Tax; EA -- Employer Assessment.

Highlighted Preliminary Commission Recommendations

On November 19, 2007 the Commission released a summary of approved recommendations. The rationale behind their recommendations will be presented when the Commission releases their final report to the Senate and House Health and Human Services Committees on January 31, 2008. Staff recommends that the Committee schedule time to either attend the HHS Committee or to invite the Commission to present their recommendations to the JBC. Staff ***highlights a few*** of the recommendations related to the Medicaid, CBHP, and CICP programs below:

1. The Commission's first recommendation is that all recommendations from the Blue Ribbon Commission on Health Care Reform be viewed as a comprehensive, integrated package.

2. The Commission supports Medicaid rate increases in order to reduce the cost-shift to private insurance (at least CHBP rates or 75% of Medicare).

3. The Commission supports subsidies for uninsured low-income workers below 300% FPL to purchase their employer's plan, or, for workers not offered coverage by their employer, provide subsidies up to 400% FPL for private coverage.

4. The Commission supports providing a medical home for all Coloradans, reimburse Medicaid/CHP+ and Cover Colorado programs for care coordination and case management.

5. The Commission supports restructuring and combining public health benefits programs (Medicaid, CBHP, etc) by:

    a) Merging Medicaid and CHBP into one program for all parents, childless adults and children (excluding the aged, disabled, and foster care eligibles);
    b) Provide CBHP benefits in new program with access to EPSDT services for children who need these additional Medicaid services.
    c) Require enrollment in managed care, where available.

6. The Commission supports improved benefits and case management for the disabled and elderly in Medicaid and improved delivery of services to vulnerable populations.

7. The Commission supports expanding eligibility for Medicaid/CBHP to cover more of the uninsured as follows:

    a) Expand Medicaid/CBHP to cover all uninsured legal residents of Colorado under 205% of poverty.
    b) Use auto enrollment strategies to increase enrollment and pursue presumptive eligibility where possible.
    c) Provide one-year continuous eligibility to childless adults, parents, and children.

Staff Comment

Staff comment focuses on the uninsured and public expansion portions of the Commission's recommendations (staff does not comment on the service delivery, adequacy of rates, etc).

1. ***A standard estimate of the uninsured currently eligible or potentially eligible under expansion of Medicaid or CBHP should be used.*** Costs for any proposals that attempt to expand Medicaid/CBHP in order to reduce the number of uninsured will vary greatly depending on how many eligibles are estimated. As discussed in an earlier issue, the Lewin Group adjusts the number of uninsured reported in the Current Population Survey to reflect an undercount of Medicaid recipients in the survey. However, the Department in the past has used the CPS estimates, without any adjustments, in their cost estimates. Staff recommends that for any proposals that come forward that the Lewin Groups estimate of the number of uninsured be used for costing out proposals. Because the recommendations and proposals under consideration have very large impacts, it may be advantageous for the General Assembly to consider contracting with the Lewin Group to provide technical assistance for fiscal note development.

2. ***Uncertainty At the National Level for Health Care Reform.*** Until SCHIP is reauthorized it will be difficult to estimate how much federal matching funds will be available for certain aspects of any expansion programs for Medicaid or CBHP. The last bill considered, H.R. 3963, prohibited new Section 1115 waivers in the CBHP program to cover childless adults or expand the number of parents eligible. Therefore, receiving federal match for ***all*** childless adults or parents of enrolled children up to 205% may be difficult. Depending on the outcome of the SCHIP debate, it could also be possible to cover children in CBHP up to, but not exceeding 300% FPL. Lastly, all of the candidates running for President have different health care reform proposals that could impact reforms in Colorado.

3. ***The JBC Should Scrutinize Revenue Sources to Ensure Growth in Funding Can Match Growth in Health Care Spending:*** Increased taxes on tobacco products are a suggested as a possible revenue source for expansion programs. Staff has a couple of concerns about this revenue source: (1) as an excise tax it will only increase with increase consumption; (2) the last federal SCHIP bill (H.R. 3963) also proposed increases on tobacco taxes in order to fund the additional federal costs; (3) additional tax burden should eventually decrease demand and therefore, decrease revenues; (4) not all taxpayers share the tax burden. Staff is pleased that the 208 proposals considered a variety of taxes as revenue sources beyond just the tobacco taxes. As proposals come forward, staff recommends that the JBC scrutinize all revenue sources proposed to ensure that the revenues can sustain future growth to any expansion program proposed.

4. ***The General Assembly Has Partially Addressed Some of Commission's Recommendations:*** Last year, the General Assembly passed S.B. 07-130 which required the Department to maximize the number of children with a "medical home" and S.B. 07-211

which requires presumptive eligibility for children on the Medicaid or CBHP who meet the current income standards for those programs.

Questions for the Department at Their Hearing

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

1. Does the Department support using the Lewin Group's estimate of the number of uninsured in Colorado? If not, why not?

2. What concerns, if any, would the Department have with merging the Medicaid and CBHP programs into one program for all parents, childless adults and children (excluding the aged, disabled, and foster care eligibles) with the appropriate EPSDT services maintained (see 208 Commission recommendations).

3. What are the Department's cost estimates if ***all*** currently eligible children and adults were enrolled in Medicaid/CBHP?

4. How much does the Department estimate it would cost if Medicaid clients were provided one-year continuous eligibility.

5. How much would it cost to expand coverage for low-income adults on Medicaid to 100 percent of poverty?

6. How much does the Department estimate it would cost to expand Medicaid/CBHP to cover all uninsured legal residents of Colorado up to 205 percent of FPL (Please breakdown this estimate into Children, Parents of Eligible Children, Adults without Dependent Children).

7. Does the Department believe that CMS would grant the necessary waivers to cover all uninsured legal residents of Colorado up to 205 percent of FPL?

8. What concerns, if any, does the Department have with the 208 Commission's health care reform recommendations as they relate to the Medicaid/CBHP program?

Appendix A

Medicaid Caseload and Expenditure Data and Charts

Caseload and Cost Histroy -- JBC Document

Total Caseload (Both Traditional and Expansion)

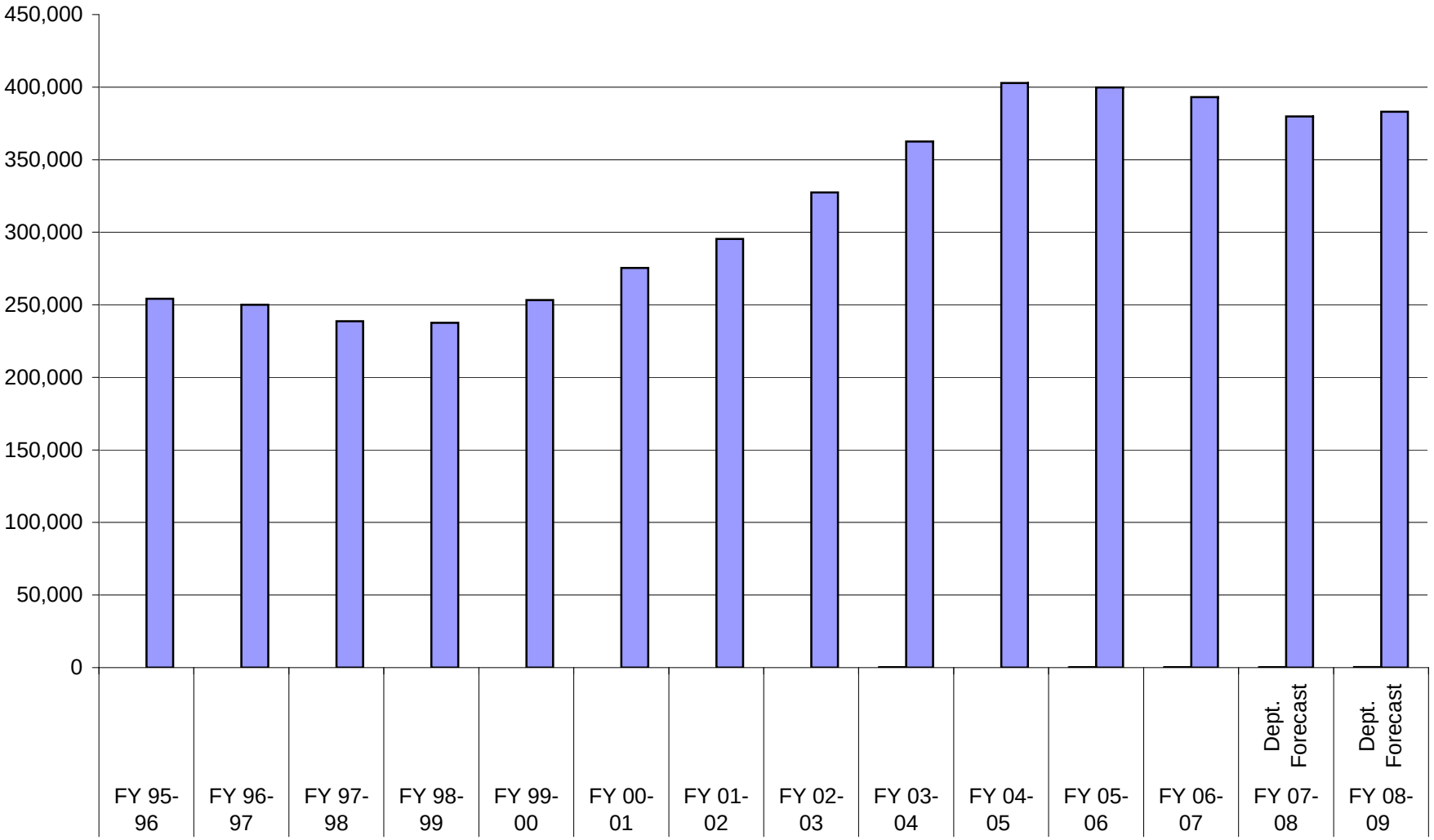
		SSI 65	SSI 60-64	QMB/SLIMB	SSI Disabled	Low Income Adults	BC Adults	BCCTP	Exp. Adults	Eligible Children	Foster Care	Non-Citizens	Total
FY 95-96		31,321	4,261	3,937	44,736	36,690	7,223	0	0	113,439	8,376	4,100	254,083
FY 96-97		32,080	4,429	4,316	46,090	33,250	5,476	0	0	110,586	9,261	4,610	250,098
FY 97-98		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		35,977	6,042	12,818	48,567	51,361	5,123	230	4,974	206,170	16,601	5,214	393,077
FY 07-08	Dept. Forecast	35,272	6,050	14,188	49,354	45,228	5,453	260	7,886	192,834	18,428	4,762	379,715
FY 08-09	Dept. Forecast	35,498	6,106	15,360	49,556	44,183	5,649	278	9,462	192,717	19,305	4,953	383,067
Acute Care Services													
FY 95-96		$65,490,832	$20,813,888	$1,498,645	$215,076,923	$95,568,690	$42,767,829	$0	$0	$142,105,656	$20,002,990	$13,792,970	$617,118,423
FY 96-97		$86,555,911	$23,425,875	$1,768,008	$258,031,934	$105,465,599	$37,543,774	$0	$0	$136,318,983	$21,784,915	$17,851,756	$688,746,755
FY 97-98		$90,855,859	$24,711,381	$1,405,971	$258,958,421	$82,369,107	$28,942,845	$0	$0	$142,788,816	$22,102,057	$18,549,901	$670,684,358
FY 98-99		$99,611,066	$31,780,339	$1,429,623	$275,661,117	$71,396,513	$31,462,780	$0	$0	$149,529,580	$22,448,268	$20,732,564	$704,051,850
FY 99-00		$109,773,578	$36,614,227	$1,899,206	$316,945,087	$80,784,239	$33,518,472	$0	$0	$169,546,536	$27,431,418	$29,667,057	$806,179,820
FY 00-01		$126,369,794	$38,727,163	$2,302,841	$345,853,758	$88,491,965	$31,496,405	$0	$0	$192,833,114	$30,660,294	$36,924,837	$893,660,171
FY 01-02		$131,835,670	$37,856,289	$2,145,037	$349,368,303	$104,039,520	$33,937,796	$0	$0	$220,491,735	$33,156,728	$39,367,016	$952,198,094
FY 02-03		$127,969,752	$39,813,094	$1,897,397	$385,226,750	$139,553,510	$42,510,204	$1,428,780	$0	$227,550,173	$34,701,970	$48,724,102	$1,049,375,732
FY 03-04		$135,135,551	$46,255,115	$2,089,094	$414,667,649	$182,959,373	$63,256,861	$2,668,858	$0	$231,893,695	$41,981,745	$55,128,970	$1,176,036,911
FY 04-05		$144,236,013	$46,693,685	$1,893,876	$397,728,916	$183,416,905	$38,545,344	$2,490,150	$0	$289,270,930	$42,142,755	$44,696,253	$1,191,114,827
FY 05-06		$119,353,131	$45,562,871	$2,068,100	$395,096,174	$194,256,325	$39,291,425	$6,809,762	$0	$304,607,787	$44,535,020	$55,307,090	$1,206,887,685
FY 06-07		$83,069,760	$44,002,744	$2,845,609	$382,381,966	$197,984,589	$47,585,089	$5,712,309	$7,353,407	$327,049,562	$49,389,806	$55,988,997	$1,203,363,838
FY 07-08	Dept. Forecast	$84,435,539	$45,361,481	$3,395,703	$409,310,450	$185,037,842	$53,627,955	$6,517,350	$12,313,072	$323,377,167	$58,346,220	$55,789,921	$1,237,512,700
FY 08-09	Dept. Forecast	$86,365,366	$46,427,857	$3,918,197	$425,694,687	$189,659,518	$56,928,724	$6,972,425	$15,504,766	$336,845,012	$64,194,369	$59,971,993	$1,292,482,914
Community Based Long-Term Care													
FY 95-96		$23,914,044	$2,421,317	$28,593	$15,693,871	$169,696	$0	$0	$0	$13,802	$2,051	$0	$42,243,374
FY 96-97		$33,196,634	$2,819,452	$17,406	$19,888,727	$7,414	$0	$0	$0	$132,517	$444,840	$0	$56,506,990
FY 97-98		$37,156,766	$3,246,682	$21,537	$23,055,275	$15,700	$14,436	$0	$0	$135,551	$649,676	$0	$64,295,623
FY 98-99		$46,152,127	$4,563,159	$47,186	$30,523,406	$47,389	$68	$0	$0	$79,498	$871,837	$0	$82,284,670
FY 99-00		$59,932,681	$5,511,069	$115	$29,301,508	$29,479	$0	$0	$0	$21,258	$21,723	$0	$94,817,833
FY 00-01		$61,569,418	$9,013,673	$217	$39,811,298	$163,996	$0	$0	$0	$679,864	$43,938	$0	$111,282,404
FY 01-02		$85,928,541	$7,399,415	$44	$42,961,368	$84,265	$0	$0	$0	$21,694	$36,905	$0	$136,432,232
FY 02-03		$78,719,107	$7,549,034	$0	$56,806,389	$70,931	$109	$0	$0	$389,329	$2,854,975	$0	$146,389,874
FY 03-04		$85,726,658	$8,298,496	$1	$61,272,991	$167,620	$0	$0	$0	$213,385	$3,044,165	$0	$158,723,316
FY 04-05		$86,505,276	$8,689,937	$224	$61,264,884	$126,591	$2,461	$0	$0	$689,933	$3,665,603	$0	$160,944,909
FY 05-06		$95,295,727	$12,130,404	$41,208	$71,302,410	$150,551	$0	$0	$0	$529,206	$4,121,260	$0	$183,570,766
FY 06-07		$112,939,443	$14,106,731	$395,653	$82,896,656	$88,469	$0	$0	$5,134	$704,094	$3,990,308	$0	$215,126,488
FY 07-08	Dept. Forecast	$122,542,353	$15,144,129	$481,910	$96,107,486	$82,697	$0	$0	$8,408	$744,807	$4,720,238	$0	$239,832,028
FY 08-09	Dept. Forecast	$128,246,416	$15,381,936	$543,449	$98,074,231	$79,862	$0	$0	$10,066	$755,254	$4,977,588	$0	$248,068,802
Long Term Care and Insurance													
FY 95-96		$265,378,874	$10,954,225	$4,496,634	$48,395,635	$895,294	*$333,694*	$0	$0	$1,136,055	$179,036	*$104,233*	$331,873,680
FY 96-97		$314,390,400	$10,909,968	$4,778,071	$52,329,969	$110,037	*$5,162*	$0	$0	$18,773	$121,330	*$2,331*	$382,666,041
FY 97-98		$301,838,995	$10,146,682	$4,743,369	$50,362,296	$886,773	*$275,566*	$0	$0	$1,328,171	$229,016	*$180,144*	$369,991,012
FY 98-99		$316,477,042	$11,814,875	$4,743,222	$53,765,594	$785,668	*$328,015*	$0	$0	$1,516,010	$250,598	*$215,866*	$389,896,890
FY 99-00		$332,816,267	$12,277,622	$5,069,564	$57,069,162	$90,884	*$12,253*	$0	$0	$48,750	$29,080	*$8,866*	$407,422,448
FY 00-01		$331,336,749	$12,824,839	$5,523,571	$61,708,777	$102,744	*$7,417*	$0	$0	$41,469	$41,752	*$5,514*	$411,592,832
FY 01-02		$357,382,766	$15,509,568	$5,972,427	$69,135,778	$104,381	*$9,031*	$0	$0	$43,497	$11,168	*$5,747*	$448,174,363
FY 02-03		$362,124,520	$16,815,129	$6,037,874	$70,719,059	$121,987	$11,580	$0	$0	$55,287	$9,301	*$10,530*	$455,905,267
FY 03-04		$398,213,039	$20,698,583	$7,379,512	$80,411,131	$147,275	$17,982	$0	$0	$85,666	$14,361	*$11,145*	$506,978,694
FY 04-05		$404,700,124	$24,095,846	$9,029,704	$81,341,062	$202,034	$15,329	$0	$0	$73,026	$12,242	*$9,501*	$519,478,868
FY 05-06		$444,232,144	$27,813,673	$11,243,514	$86,190,316	$150,982	$13,231	$0	$0	$64,840	$10,566	*$8,200*	$569,727,466
FY 06-07		$466,369,276	$29,974,318	$13,749,798	$96,639,946	$148,220	$3,133	$0	$0	$9,795	$651	*$0*	$606,895,137
FY 07-08	Dept. Forecast	$488,976,274	$31,512,926	$16,370,562	$102,034,348	$142,431	$3,785	$0	$0	$11,833	$786	*$0*	$639,052,945
FY 08-09	Dept. Forecast	$517,020,060	$33,342,213	$19,241,816	$107,851,473	$152,269	$4,179	$0	$0	$13,064	$868	*$0*	$677,625,942

Caseload and Cost Histroy -- JBC Document

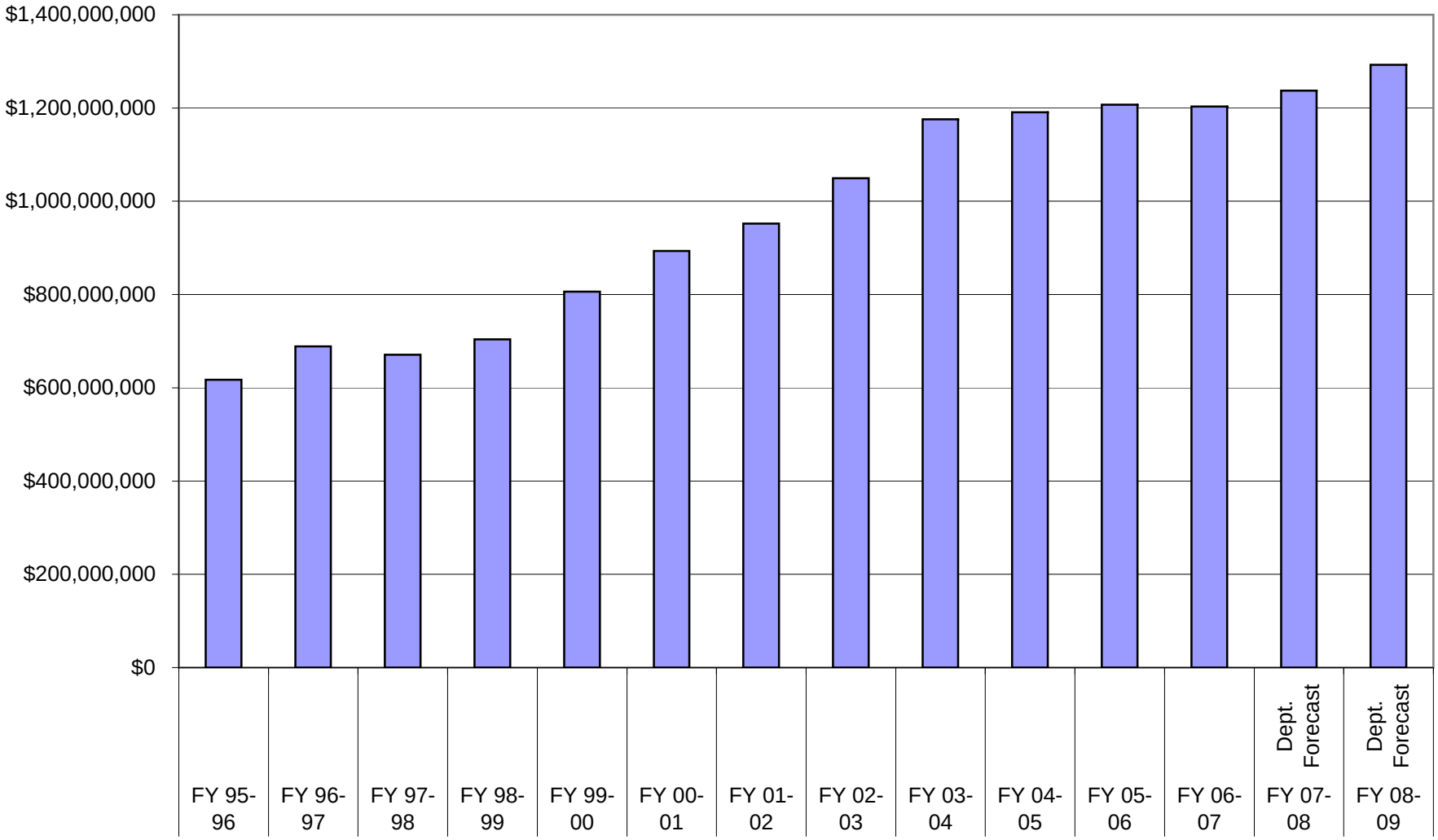
Total Caseload (Both Traditional and Expansion)

		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		$15,044,147	$1,061,392	$33,778	$3,437,617	$595,410	$100,020	$2,053	$1,000	$2,533,150	$243,385	*$0*	$23,051,952
FY 07-08	Dept. Forecast	$18,738,927	$1,459,988	$41,651	$5,559,084	$1,408,586	$249,641	$23,686	$2,000	$3,813,056	$450,704	*$0*	$31,747,323
FY 08-09	Dept. Forecast	$19,570,270	$1,433,759	$44,924	$4,499,253	$701,695	$121,823	$4,827	$4,204	$2,680,005	$286,743	*$0*	$29,347,503
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		$677,422,626	$89,145,185	$17,024,838	$565,356,185	$198,816,688	$47,688,242	$5,714,362	$7,359,541	$330,296,601	$53,624,150	$55,988,997	$2,048,437,415
FY 07-08	Dept. Forecast	$714,693,093	$93,478,524	$20,289,826	$613,011,368	$186,671,556	$53,881,381	$6,541,036	$12,323,480	$327,946,863	$63,517,948	$55,789,921	$2,148,144,996
FY 08-09	Dept. Forecast	$751,202,112	$96,585,765	$23,748,386	$636,119,644	$190,593,344	$57,054,726	$6,977,252	$15,519,036	$340,293,335	$69,459,568	$59,971,993	$2,247,525,161
Cost Per Client (without bottom line financing -- service costs only)													
FY 95-96		$11,327.34	$8,023.80	$1,530.07	$6,240.31	$2,633.79	$5,967.26	$0.00	$0.00	$1,262.84	$2,409.75	$3,389.56	$3,901.23
FY 96-97		$13,533.13	$8,389.09	$1,520.73	$7,165.34	$3,175.43	$6,857.00	$0.00	$0.00	$1,234.06	$2,413.46	$3,872.90	$4,509.91
FY 97-98		$13,159.80	$8,475.25	$1,353.26	$7,225.09	$3,063.82	$6,806.25	$0.00	$0.00	$1,388.22	$2,198.48	$3,722.19	$4,631.18
FY 98-99		$14,004.31	$9,810.22	$1,019.01	$7,772.62	$3,160.75	$6,336.63	$0.00	$0.00	$1,480.54	$2,045.00	$3,612.42	$4,950.52
FY 99-00		$15,165.91	$10,684.00	$917.32	$8,694.77	$3,440.55	$5,430.96	$0.00	$0.00	$1,544.55	$2,203.16	$3,273.68	$5,166.43
FY 00-01		$15,432.14	$11,744.36	$959.50	$9,715.80	$3,277.53	$4,801.68	$0.00	$0.00	$1,570.79	$2,351.33	$2,966.06	$5,143.57
FY 01-02		$16,957.98	$11,721.70	$963.16	$9,956.32	$3,125.56	$4,760.46	$0.00	$0.00	$1,532.61	$2,530.66	$9,774.77	$5,202.22
FY 02-03		$16,494.52	$11,762.69	$886.72	$11,055.94	$3,491.83	$5,610.49	$31,060.43	$0.00	$1,369.03	$2,713.74	$11,883.60	$5,044.89
FY 03-04		$18,128.65	$13,612.91	$967.47	$11,947.85	$3,919.97	$7,713.62	$25,911.24	$0.00	$1,209.03	$3,045.32	$11,976.57	$5,080.22
FY 04-05		$18,267.34	$13,193.89	$1,141.31	$11,443.76	$3,257.87	$6,315.54	$28,960.13	$0.00	$1,317.39	$2,930.06	$8,985.99	$4,700.29
FY 05-06		$18,579.44	$14,299.69	$1,213.53	$11,684.92	$3,380.32	$7,801.14	$36,225.53	$0.00	$1,442.86	$2,996.87	$9,282.65	$4,959.65
FY 06-07		$18,829.33	$14,754.25	$1,328.20	$11,640.75	$3,870.97	$9,308.66	$24,845.05	$1,479.60	$1,602.06	$3,230.18	$10,738.20	$5,211.29
FY 07-08	Dept. Forecast	$20,262.34	$15,451.00	$1,430.07	$12,420.70	$4,127.34	$9,881.05	$25,157.83	$1,562.70	$1,700.67	$3,446.82	$11,715.65	$5,657.26
FY 08-09	Dept. Forecast	$21,161.82	$15,818.17	$1,546.12	$12,836.38	$4,313.73	$10,099.97	$25,098.03	$1,640.14	$1,765.77	$3,598.01	$12,108.22	$5,867.19

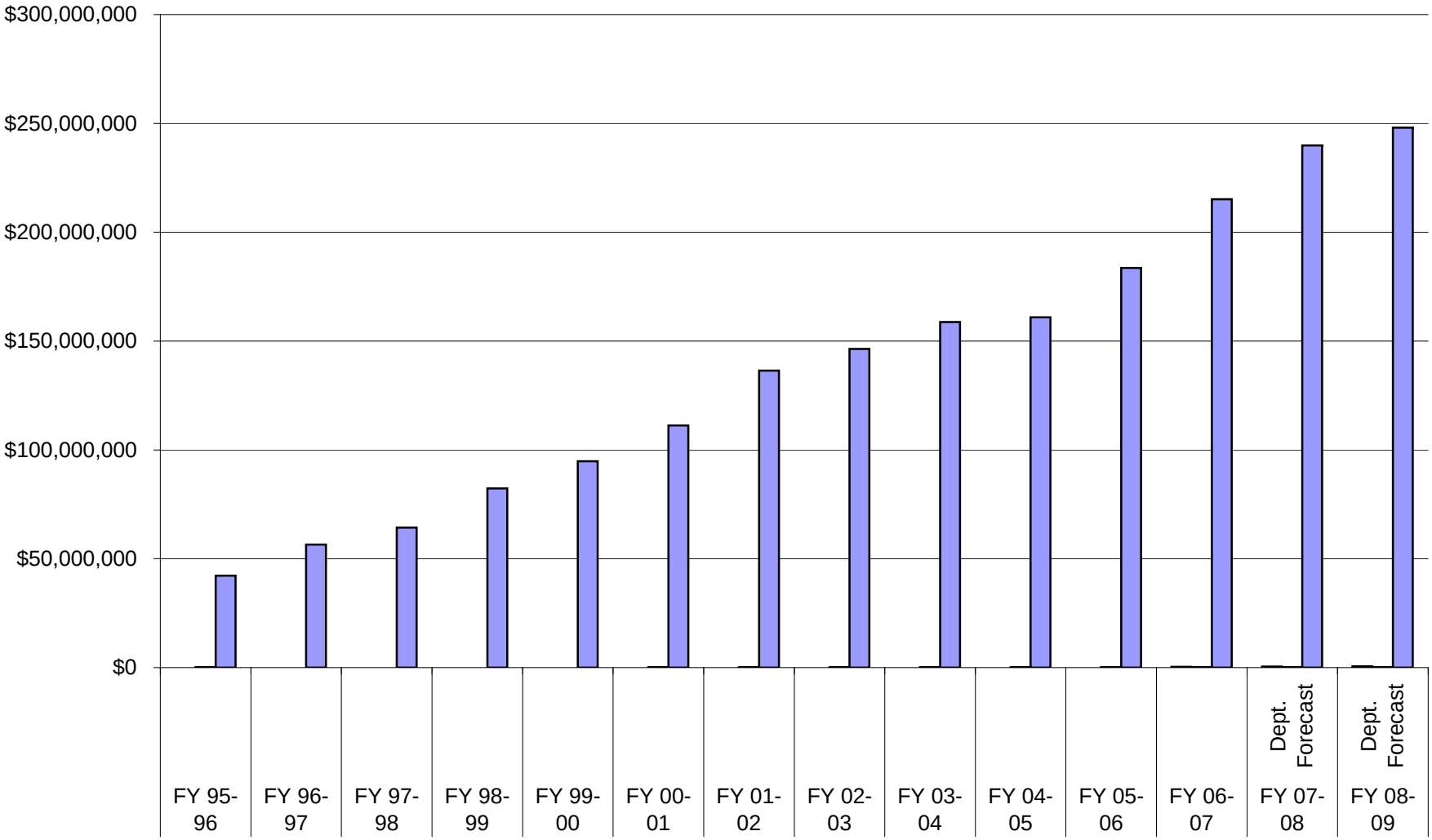
Average Yearly Medicaid Caseload



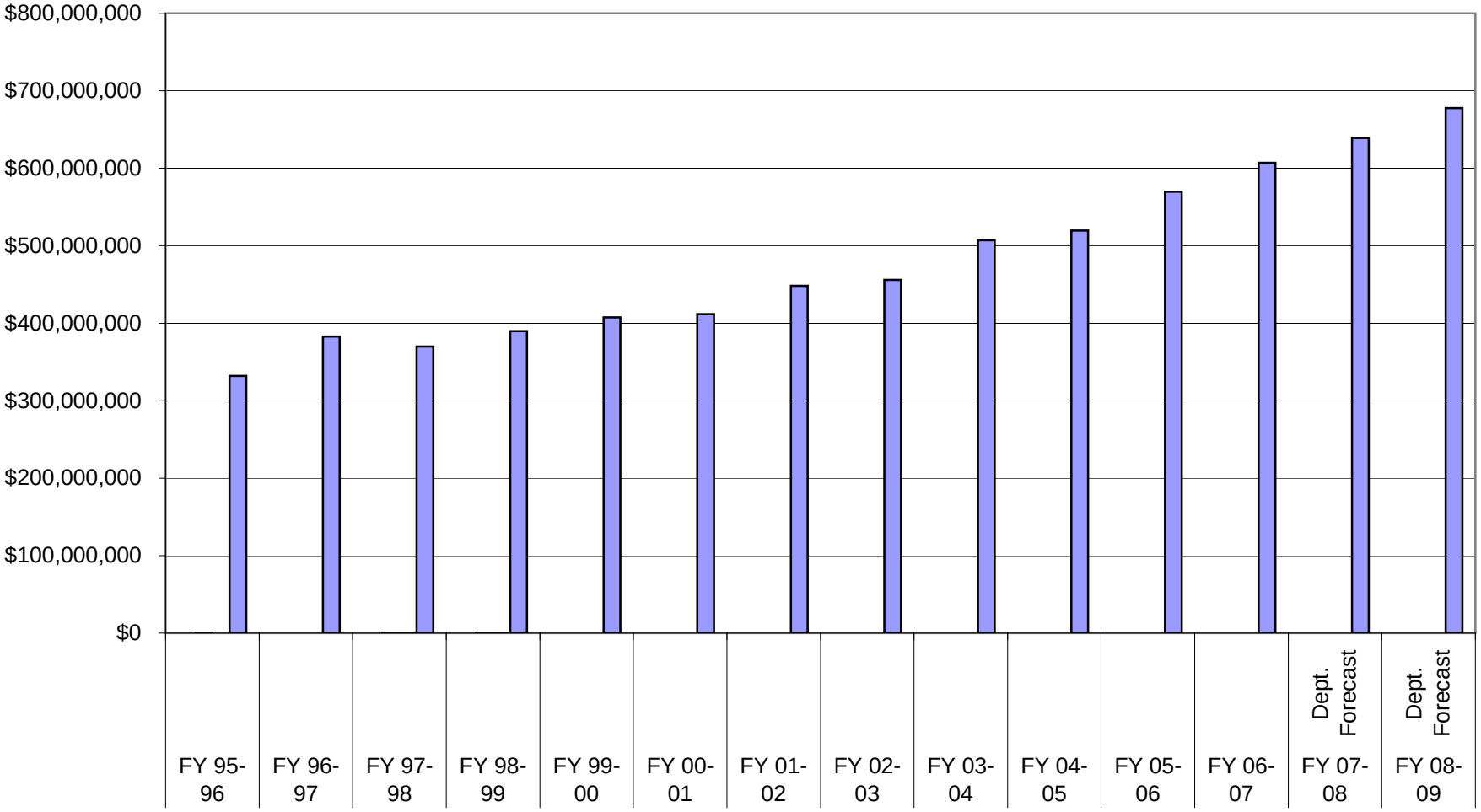
Acute Care Services Expenditure History



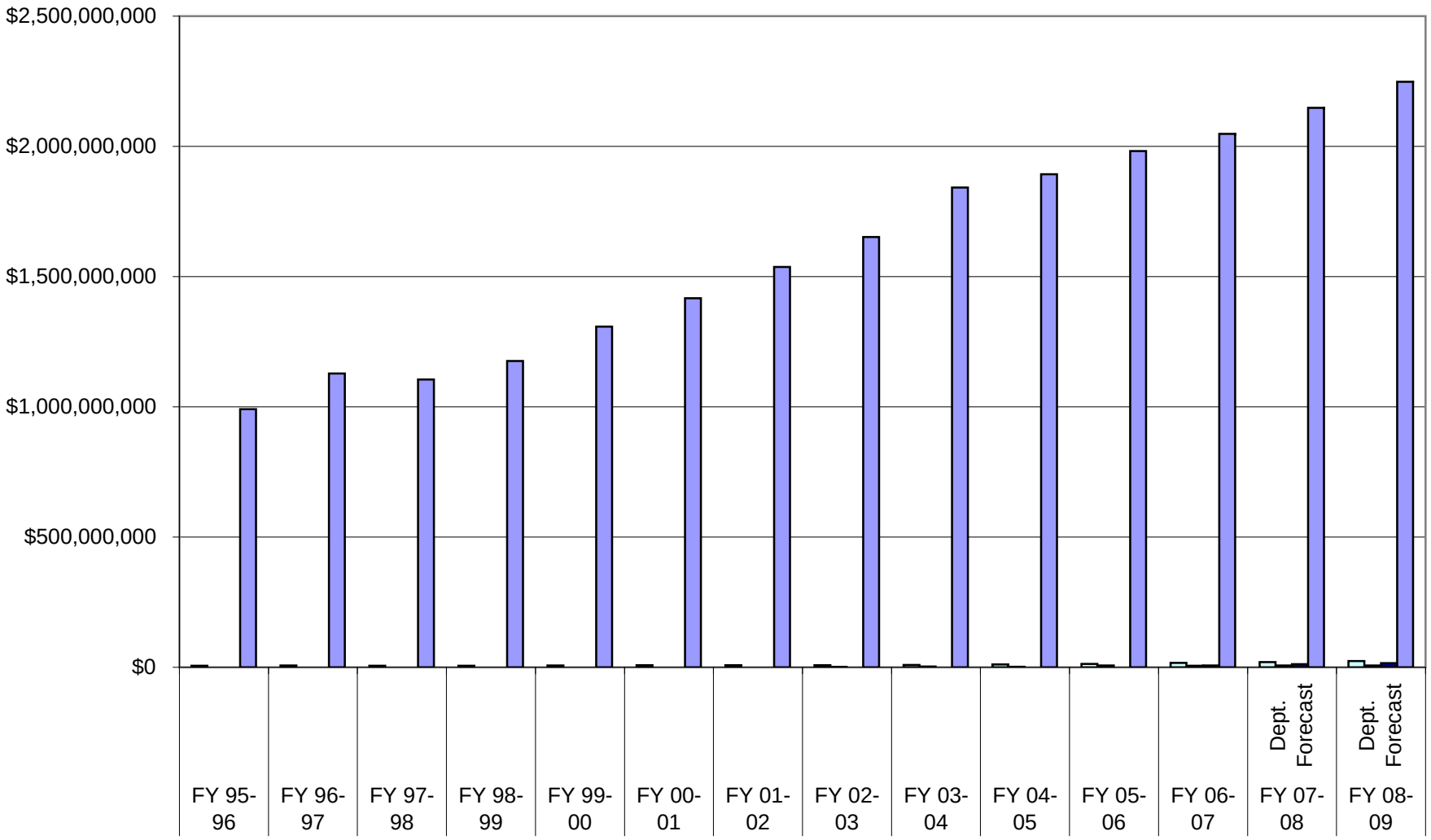
Community Based Long-Term Care Expenditure History



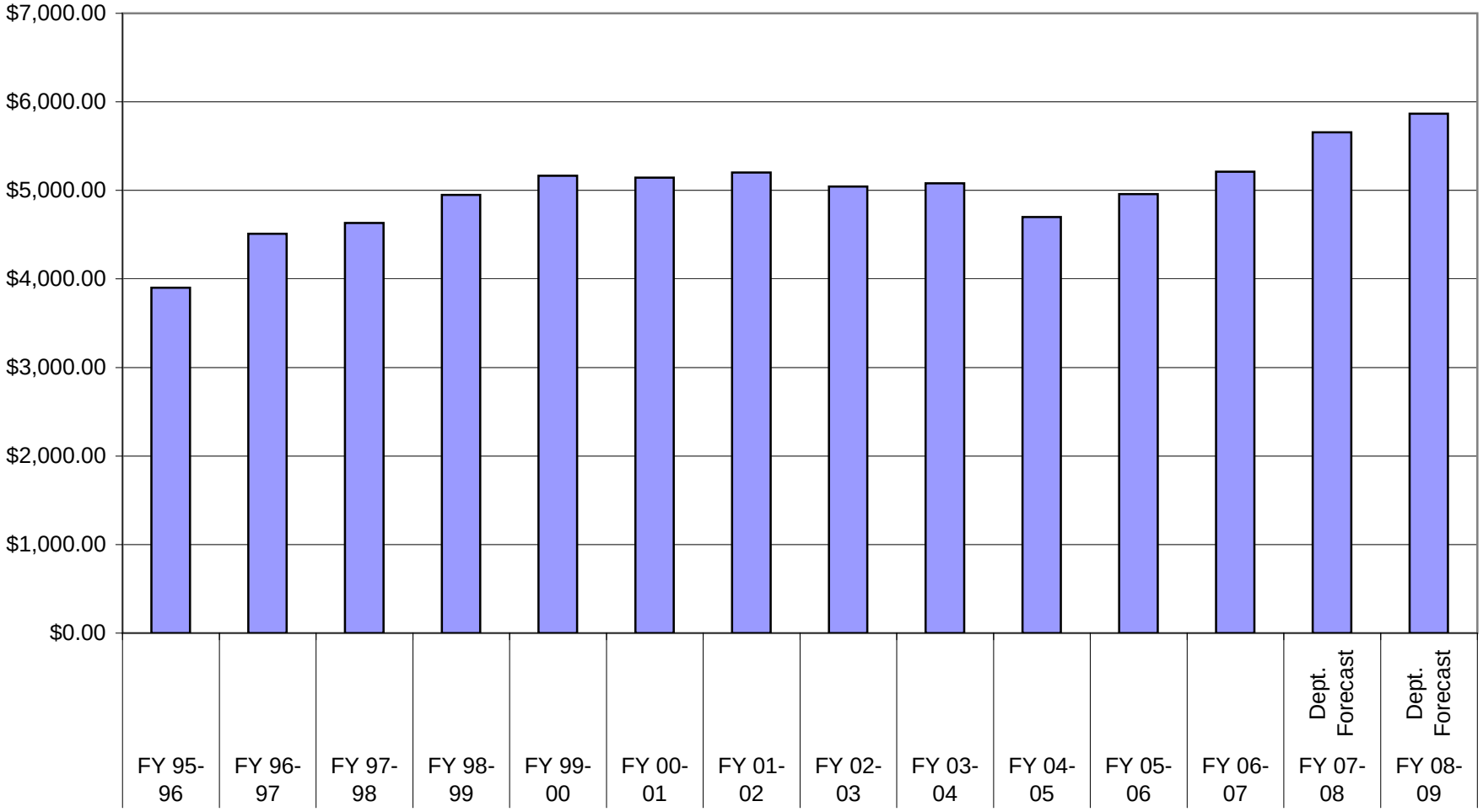
Institution Long-Term Care & Insurance Expenditure History



Total Medical Services Expenditure History



Medical Services Premiums Overall
Cost-Per-Client History



Appendix B

Medicaid Medical Services Premiums Detail

Department of Health Care Policy and Financing -- Medical Services Premiums Cost by Aid Category and Service Area -- FY 2006-07 Actuals

FY 2006-07 Actual Percentages

	SSI 65	SSI 60-64	QMB/SLIMB	SSI Disabled	Low Income Adults	Pregnant Adults	BCCTP	Expansion Adults	Eligible Children	Foster Care	Non-Citizens
Acute Care											
Physician Services & EPSDT	2,557,590	4,913,899	2,652	32,157,433	38,985,126	9,019,205	0	1,224,479	61,863,460	6,843,560	6,665,024
% of Service	1.56%	2.99%	0.00%	19.58%	23.74%	5.49%	0.00%	0.75%	37.67%	4.17%	4.06%
% of Total	0.12%	0.24%	0.00%	1.57%	1.90%	0.44%	0.00%	0.06%	3.02%	0.33%	0.33%
Emergency Transportation	75,398	169,825	0	1,386,996	922,395	129,933	0	33,151	1,313,302	139,118	114,504
% of Service	1.76%	3.96%	0.00%	32.37%	21.53%	3.03%	0.00%	0.77%	30.65%	3.25%	2.67%
% of Total	0.00%	0.01%	0.00%	0.07%	0.05%	0.01%	0.00%	0.00%	0.06%	0.01%	0.01%
County Transportation	-18,672	-8,454	-2	-25,794	-1,823	-176	0	0	-4,150	-1,652	-17
% of Service	30.74%	13.92%	0.00%	42.47%	3.00%	0.29%	0.00%	0.00%	6.83%	2.72%	0.03%
% of Total	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Dental Services	662,760	164,830	0	2,924,310	2,681,114	239,992	0	152,231	38,168,661	4,365,105	8,130
% of Service	1.34%	0.33%	0.00%	5.92%	5.43%	0.49%	0.00%	0.31%	77.32%	8.84%	0.02%
% of Total	0.03%	0.01%	0.00%	0.14%	0.13%	0.01%	0.00%	0.01%	1.86%	0.21%	0.00%
Family Planning	0	0	0	464	-1,854	422	0	8,904	7,323	3,119	55
% of Service	0.00%	0.00%	0.00%	2.52%	-10.06%	2.29%	0.00%	48.30%	39.73%	16.92%	0.30%
% of Total	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Health Maintenance Organization	9,906,026	5,316,092	0	44,014,281	18,339,469	1,093,523	0	832,261	28,259,688	667,693	0
% of Service	9.14%	4.90%	0.00%	40.59%	16.91%	1.01%	0.00%	0.77%	26.06%	0.62%	0.00%
% of Total	0.48%	0.26%	0.00%	2.15%	0.90%	0.05%	0.00%	0.04%	1.38%	0.03%	0.00%
Inpatient Hospitals	12,785,899	10,333,981	0	77,352,935	59,552,000	19,508,543	0	1,558,745	74,070,764	5,149,408	44,375,127
% of Service	4.20%	3.39%	0.00%	25.39%	19.55%	6.40%	0.00%	0.51%	24.31%	1.69%	14.56%
% of Total	0.62%	0.50%	0.00%	3.78%	2.91%	0.95%	0.00%	0.08%	3.62%	0.25%	2.17%
Outpatient	1,996,199	3,500,504	217	31,579,126	30,497,019	2,972,677	0	1,404,553	38,657,701	3,944,746	1,214,531
% of Service	1.72%	3.02%	0.00%	27.28%	26.34%	2.57%	0.00%	1.21%	33.39%	3.41%	1.05%
% of Total	0.10%	0.17%	0.00%	1.54%	1.49%	0.15%	0.00%	0.07%	1.89%	0.19%	0.06%
Lab & X-Ray	336,966	575,229	91	4,080,667	7,613,932	1,552,063	-112	294,448	4,565,655	1,172,479	255,725
% of Service	1.65%	2.81%	0.00%	19.96%	37.24%	7.59%	0.00%	1.44%	22.33%	5.73%	1.25%
% of Total	0.02%	0.03%	0.00%	0.20%	0.37%	0.08%	0.00%	0.01%	0.22%	0.06%	0.01%
Durable Medical Equipment	17,788,206	3,417,083	21,364	34,532,449	1,944,867	114,018	0	77,764	5,382,698	3,535,980	7,737
% of Service	26.62%	5.11%	0.03%	51.68%	2.91%	0.17%	0.00%	0.12%	8.06%	5.29%	0.01%
% of Total	0.87%	0.17%	0.00%	1.69%	0.09%	0.01%	0.00%	0.00%	0.26%	0.17%	0.00%
Prescription Drugs	6,520,078	10,234,109	174	88,778,681	29,066,476	1,277,899	1,088	1,602,085	33,279,711	19,027,403	45,745
% of Service	3.43%	5.39%	0.00%	46.77%	15.31%	0.67%	0.00%	0.84%	17.53%	10.02%	0.02%
% of Total	0.32%	0.50%	0.00%	4.33%	1.42%	0.06%	0.00%	0.08%	1.62%	0.93%	0.00%
Drug Rebate	-2,014,232	-3,161,599	-54	-27,426,192	-8,979,439	-394,778	-336	-494,928	-10,281,023	-5,878,091	-14,132
% of Service	3.43%	5.39%	0.00%	46.77%	15.31%	0.67%	0.00%	0.84%	17.53%	10.02%	0.02%
% of Total	-0.10%	-0.15%	0.00%	-1.34%	-0.44%	-0.02%	0.00%	-0.02%	-0.50%	-0.29%	0.00%
Rural Health Centers	33,187	105,329	0	792,378	1,019,191	212,217	0	68,417	3,407,281	221,847	20,555
% of Service	0.56%	1.79%	0.00%	13.47%	17.33%	3.61%	0.00%	1.16%	57.94%	3.77%	0.35%
% of Total	0.00%	0.01%	0.00%	0.04%	0.05%	0.01%	0.00%	0.00%	0.17%	0.01%	0.00%
Federally Qualified Health Centers	603,731	558,662	0	4,565,903	9,985,268	2,874,034	0	495,431	36,599,910	1,514,903	1,762,260
% of Service	1.02%	0.95%	0.00%	7.74%	16.94%	4.87%	0.00%	0.84%	62.08%	2.57%	2.99%
% of Total	0.03%	0.03%	0.00%	0.22%	0.49%	0.14%	0.00%	0.02%	1.79%	0.07%	0.09%
Co-Insurance (Title XVIII-Medicare)	9,351,692	1,308,275	2,440,303	5,742,590	28,897	17,869	0	71,544	6,279	8,956	0
% of Service	49.28%	6.89%	12.86%	30.26%	0.15%	0.09%	0.00%	0.38%	0.03%	0.05%	0.00%
% of Total	0.46%	0.06%	0.12%	0.28%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Breast and Cervical Cancer Program	0	0	0	0	0	0	5,554,934	0	0	0	0
% of Service	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%	0.00%	0.00%	0.00%	0.00%
% of Total	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.27%	0.00%	0.00%	0.00%	0.00%
ASO	1,834,684	1,142,134	97,491	9,134,946	5,838,253	1,099,079	156,613	11,261	9,123,059	1,316,246	1,531,550
% of Service	5.86%	3.65%	0.31%	29.20%	18.66%	3.51%	0.50%	0.04%	29.16%	4.21%	4.90%
% of Total	0.09%	0.06%	0.00%	0.45%	0.29%	0.05%	0.01%	0.00%	0.45%	0.06%	0.07%
Other Medical Services	1,879	1,007	82	8,697	4,562	855	122	0	7,155	1,185	1,192
% of Service	7.03%	3.77%	0.31%	32.53%	17.06%	3.20%	0.46%	0.00%	26.76%	4.43%	4.46%
% of Total	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Home Health	20,648,369	5,431,838	283,291	72,782,096	489,136	18,370	0	13,061	2,622,088	7,357,801	1,011
% of Service	18.83%	4.95%	0.26%	66.38%	0.45%	0.02%	0.00%	0.01%	2.39%	6.71%	0.00%
% of Total	1.01%	0.27%	0.01%	3.55%	0.02%	0.00%	0.00%	0.00%	0.13%	0.36%	0.00%
Presumptive Eligibility	0	0	0	0	0	7,849,344	0	0	0	0	0
% of Service	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%	0.00%	0.00%	0.00%	0.00%	0.00%
% of Total	0.00%	0.00%	0.00%	0.00%	0.00%	0.38%	0.00%	0.00%	0.00%	0.00%	0.00%
Acute Care Subtotal	83,069,760	44,002,744	2,845,609	382,381,966	197,984,589	47,585,089	5,712,309	7,353,407	327,049,562	49,389,806	55,988,997
% of Service	6.90%	3.66%	0.24%	31.78%	16.45%	3.95%	0.47%	0.61%	27.18%	4.10%	4.65%
% of Total	4.06%	2.15%	0.14%	18.67%	9.67%	2.32%	0.28%	0.36%	15.97%	2.41%	2.73%

Department of Health Care Policy and Financing -- Medical Services Premiums Cost by Aid Category and Service Area -- FY 2006-07 Actuals

FY 2006-07 Actual Percentages

	SSI 65	SSI 60-64	QMB/SLIMB	SSI Disabled	Low Income Adults	Pregnant Adults	BCCTP	Expansion Adults	Eligible Children	Foster Care	Non-Citizens
Community Based Long-Term Care											
Home and Community Based Services-Case Ma	77,897,470	9,019,369	211,964	36,497,817	37,957	0	0	2,506	0	5,953	0
% of Service	62.99%	7.29%	0.17%	29.51%	0.03%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
% of Total	4.72%	0.55%	0.01%	2.21%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Home and Community Based Services - Mental	2,759,506	1,696,177	35,513	12,752,277	4	0	0	2,373	0	470	0
% of Service	16.00%	9.84%	0.21%	73.94%	0.00%	0.00%	0.00%	0.01%	0.00%	0.00%	0.00%
% of Total	0.17%	0.10%	0.00%	0.77%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Home and Community Based Services - Model	0	0	75	904,544	0	0	0	0	264	0	0
% of Service	0.00%	0.00%	0.01%	99.96%	0.00%	0.00%	0.00%	0.00%	0.03%	0.00%	0.00%
% of Total	0.00%	0.00%	0.00%	0.05%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Home and Community Based Services - AIDS	16,836	17,189	704	468,801	0	0	0	0	0	0	0
% of Service	3.34%	3.41%	0.14%	93.10%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
% of Total	0.00%	0.00%	0.00%	0.03%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Consumer Directed Attendant Support	7,923,897	917,469	21,561	3,712,636	3,861	0	0	255	0	606	0
% of Service	62.99%	7.29%	0.17%	29.51%	0.03%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
% of Total	0.48%	0.06%	0.00%	0.22%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Children With Autism	0	0	0	18,801	0	0	0	0	0	0	0
% of Service	0.00%	0.00%	0.00%	100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
% of Total	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Private Duty Nursing	354,877	155,949	37,261	12,205,851	0	0	0	0	562,535	3,983,279	0
% of Service	2.05%	0.90%	0.22%	70.56%	0.00%	0.00%	0.00%	0.00%	3.25%	23.03%	0.00%
% of Total	0.02%	0.01%	0.00%	0.74%	0.00%	0.00%	0.00%	0.00%	0.03%	0.24%	0.00%
Hospice	23,913,108	1,986,641	88,575	5,611,231	46,496	0	0	0	141,295	0	0
% of Service	75.23%	6.25%	0.28%	17.65%	0.15%	0.00%	0.00%	0.00%	0.44%	0.00%	0.00%
% of Total	1.45%	0.12%	0.01%	0.34%	0.00%	0.00%	0.00%	0.00%	0.01%	0.00%	0.00%
Brain Injury	73,747	313,937	0	10,724,693	151	0	0	0	0	0	0
% of Service	0.66%	2.83%	0.00%	96.51%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
% of Total	0.00%	0.02%	0.00%	0.65%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Community Based Long-Term Care Subtotal	112,939,443	14,106,731	395,653	82,896,656	88,469	0	0	5,134	704,094	3,990,308	-1
% of Service	52.50%	6.56%	0.18%	38.53%	0.04%	0.00%	0.00%	0.00%	0.33%	1.85%	0.00%
% of Total	6.84%	0.85%	0.02%	5.02%	0.01%	0.00%	0.00%	0.00%	0.04%	0.24%	0.00%
Long Term Care and Insurance											
Class I Nursing Facilities	384,275,629	24,171,304	951,138	68,903,820	1,596	0	0	0	0	0	0
% of Service	80.34%	5.05%	0.20%	14.41%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
% of Total	23.26%	1.46%	0.06%	4.17%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Class II Nursing Facilities	106,064	27,660	35,710	2,100,702	0	0	0	0	0	0	0
% of Service	4.67%	1.22%	1.57%	92.54%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
% of Total	0.01%	0.00%	0.00%	0.13%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Program for All-Inclusive Care for the Elderly	37,878,793	3,182,900	0	1,810,588	0	0	0	0	0	0	0
% of Service	88.35%	7.42%	0.00%	4.22%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
% of Total	2.29%	0.19%	0.00%	0.11%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Specialized Medicare Insurance Beneficiaries	44,106,993	2,572,065	12,762,950	23,120,257	144,616	0	0	0	0	0	0
% of Service	53.33%	3.11%	15.43%	27.95%	0.17%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
% of Total	2.67%	0.16%	0.77%	1.40%	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Health Insurance Buy-In Program	1,797	20,389	0	704,579	2,008	3,133	0	0	9,795	651	0
% of Service	0.24%	2.75%	0.00%	94.91%	0.27%	0.42%	0.00%	0.00%	1.32%	0.09%	0.00%
% of Total	0.00%	0.00%	0.00%	0.03%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Subtotal of Long Term Care and Insurance	466,369,279	29,974,318	13,749,798	96,639,947	148,220	3,133	0	0	9,795	651	0
% of Service	76.85%	4.94%	2.27%	15.92%	0.02%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
% of Total	28.23%	1.81%	0.83%	5.85%	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Service Management											
Single Entry Points	14,507,449	942,285	33,778	2,518,446	122	105	0	0	329	22	0
% of Service	80.59%	5.23%	0.19%	13.99%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
% of Total	0.88%	0.06%	0.00%	0.15%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Disease Management	31,652	16,971	0	146,541	76,859	14,413	2,053	0	120,548	19,962	0
% of Service	7.38%	3.96%	0.00%	34.16%	17.92%	3.36%	0.48%	0.00%	28.10%	4.65%	0.00%
% of Total	0.00%	0.00%	0.00%	0.01%	0.00%	0.00%	0.00%	0.00%	0.01%	0.00%	0.00%
ASO Administrative Fee	505,046	102,136	0	772,630	518,429	85,502	0	1,000	2,412,273	223,401	0
% of Service	10.93%	2.21%	0.00%	16.72%	11.22%	1.85%	0.00%	0.02%	52.21%	4.84%	0.00%
% of Total	0.03%	0.01%	0.00%	0.05%	0.03%	0.01%	0.00%	0.00%	0.15%	0.01%	0.00%
Subtotal of Service Management	15,044,147	1,061,392	33,778	3,437,617	595,410	100,020	2,053	1,000	2,533,150	243,385	0
% of Service	65.26%	4.60%	0.15%	14.91%	2.58%	0.43%	0.01%	0.00%	10.99%	1.06%	0.00%
% of Total	0.73%	0.05%	0.00%	0.17%	0.03%	0.00%	0.00%	0.00%	0.12%	0.01%	0.00%
TOTAL	677,422,629	89,145,186	17,024,838	565,356,187	198,816,688	47,688,242	5,714,362	7,359,541	330,296,601	53,624,150	55,988,996

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	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 & 2007 Session												
Caseload Forecast Appropriations												
FINAL FY 2006-07 Forecast	36,218	6,068	12,706	48,489	52,115	5,018	233	5,292	205,213	16,580	5,248	393,180
Actual FY 2006-07 Caseload	35,977	6,042	12,818	48,567	51,361	5,123	230	4,974	206,170	16,601	5,214	393,077
Difference	241	26	(112)	(78)	754	(105)	3	318	(957)	(21)	34	103
% Error	0.67%	0.43%	-0.88%	-0.16%	1.45%	-2.09%	1.29%	0.00%	-0.47%	-0.13%	0.65%	0.03%
Appropriation by Bill Source												
06-1385 -- Long Bill	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**
06-131	1,928,835	117,808	1,659	328,149	(55)	0	0	0	9	0	0	2,376,406
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
07-239 Supplemental	(15,976,523)	7,319,721	3,787,871	11,285,374	(51,581,563)	5,011,755	509,492	1,045,408	(5,097,121)	(4,108,954)	(5,681,807)	(53,486,347)
TOTAL FY 2006-07 APPROPRIATION	686,906,866	90,397,797	15,759,558	576,658,757	184,927,744	42,969,697	5,619,235	13,196,189	331,401,686	53,782,835	56,180,847	2,057,801,212
FINAL APPROPRIATION BY SERVICE AREA AND BOTTOM OF THE LINE FINANCING												
ACUTE CARE SERVICES	81,201,775	43,818,479	2,246,941	388,840,368	182,253,712	42,464,202	5,562,341	13,196,189	324,961,011	48,974,431	55,782,284	1,189,301,733
COMMUNITY LONG TERM CARE SERVICES	112,942,832	14,141,608	53,549	84,688,358	88,314	0	0	0	595,183	4,055,419	0	216,565,263
LONG-TERM CARE SERVICES AND INSURANCE	472,489,762	30,621,662	12,821,651	94,709,815	188,189	15,824	0	0	75,402	12,638	9,808	610,944,751
SERVICE MANAGEMENT	15,543,162	1,208,236	543,499	4,514,106	1,025,474	212,798	9,031	0	3,604,096	396,805	0	27,057,207
Subtotal for Services w/o Bottom of Line Financing	682,177,531	89,789,985	15,665,640	572,752,647	183,555,689	42,692,824	5,571,372	13,196,189	329,235,692	53,439,293	55,792,092	2,043,868,954
BOTTOM LINE FINANCING FINAL ESTIMATE	4,729,335	607,812	93,918	3,906,110	1,372,055	276,873	47,863	0	2,165,994	343,542	388,756	13,932,258
FINAL APPROPRIATION BY SERVICE AREA & BLF	686,906,866	90,397,797	15,759,558	576,658,757	184,927,744	42,969,697	5,619,235	13,196,189	331,401,686	53,782,835	56,180,848	2,057,801,212
ACTUAL FY 2006-07 EXPENDITURES BY SERVICE AREA												
ACUTE CARE SERVICES ESTIMATE	83,069,760	44,002,744	2,845,609	382,381,966	197,984,589	47,585,089	5,712,309	7,353,407	327,049,562	49,389,806	55,988,997	1,203,363,838
COMMUNITY BASED SERVICES	112,939,443	14,106,731	395,653	82,896,656	88,469	0	0	5,134	704,094	3,990,308	0	215,126,488
LONG TERM SERVICES	466,369,276	29,974,318	13,749,798	96,639,946	148,220	3,133	0	0	9,795	651	0	606,895,137
SERVICE MANAGEMENT	15,044,147	1,061,392	33,778	3,437,617	595,410	100,020	2,053	1,000	2,533,150	243,385	0	23,051,952
Subtotal for Services	677,422,626	89,145,185	17,024,838	565,356,185	198,816,688	47,688,242	5,714,362	7,359,541	330,296,601	53,624,150	55,988,997	2,048,437,415
Percent Difference from Forecast	-0.70%	-0.72%	8.68%	-1.29%	8.31%	11.70%	2.57%	0.00%	0.32%	0.35%	0.35%	0.22%
BOTTOM LINE FINANCING ESTIMATE	$4,285,699	$563,975	$107,707	$3,576,713	$1,257,809	$301,699	$36,152	$46,560	$2,089,614	$339,252	$354,213	$12,959,393
TOTAL EXPENDITURES (Service Area & BLF)	681,708,325	89,709,160	17,132,545	568,932,898	200,074,497	47,989,941	5,750,514	7,406,101	332,386,215	53,963,402	56,343,210	2,061,396,808
Difference from Appropriation	(5,198,541)	(688,637)	1,372,987	(7,725,859)	15,146,753	5,020,244	131,279	(5,790,088)	984,529	180,567	162,362	3,595,596
% Difference	-0.76%	-0.76%	8.71%	-1.34%	8.19%	11.68%	2.34%	0.00%	0.30%	0.34%	0.29%	0.17%

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	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 2007-08 Appropriation -- 2007 Session												
Caseload -- H.B. 06-1385	**36,703**	**6,252**	**13,294**	**48,942**	**46,708**	**5,264**	**277**	**10,377**	**193,981**	**17,295**	**4,691**	**383,784**
Traditional Medicaid Caseload (can be funded with GF)	35,891	6,136	13,294	47,507	41,086	5,004	194	0	175,277	17,203	4,691	346,283
Expansion Medicaid Caseload (can be funded with Tobacco Tax)	812	116	0	1,435	5,622	260	83	10,377	18,704	92	0	37,501
Expansion Medicaid Caseload (based on S.B. 07-002).	0	0	0	0	0	0	0	0	0	1,226	0	1,226
TOTAL CASELOAD	**36,703**	**6,252**	**13,294**	**48,942**	**46,708**	**5,264**	**277**	**10,377**	**193,981**	**18,521**	**4,691**	**385,010**
Current FY 2007-08 Appropriation for Medical Service Premiums												
S.B. 07-239 -- Long Bill	730,737,943	99,834,628	16,999,041	604,734,235	172,642,107	47,270,186	7,096,877	25,530,366	331,956,019	60,417,309	46,967,141	2,144,185,852
S.B. 07-002 -- Foster Children to Age 21	0	0	0	0	0	0	0	0	0	3,900,859	0	3,900,859
H.B. 07-1021 -- Pharmacy Medication Review	(132,176)	(33,929)	(69)	(275,464)	(65,470)	(2,903)	(6)	0	(69,466)	(45,198)	(122)	(624,803)
H.B. 07-1183 -- Nursing Home Grant Program	322,229	19,681	277	54,820	(9)	0	0	0	2	0	0	397,000
	730,927,996	99,820,380	16,999,249	604,513,591	172,576,628	47,267,283	7,096,871	25,530,366	331,886,554	64,272,970	46,967,019	2,147,858,908
Current FY 2007-08 App. By Service Area												
Acute Care Services	82,027,893	48,592,841	2,265,663	407,517,761	170,584,537	46,822,209	7,046,965	25,355,828	326,483,959	59,167,170	46,640,735	1,222,505,559
Community Care Services	120,837,107	15,039,662	75,041	88,548,527	78,284	0	0	0	603,194	4,385,321	0	229,567,136
Long Term Care Services & Insurance	504,000,224	34,202,371	14,390,642	100,261,432	171,763	16,256	0	0	75,766	14,155	10,109	653,142,718
Administrative Services	19,097,598	1,309,767	151,917	4,103,203	579,870	109,171	1,994	0	2,489,389	298,043	0	28,140,952
SUBTOTAL SERVICE COSTS	725,962,821	99,144,640	16,883,264	600,430,924	171,414,453	46,947,636	7,048,959	25,355,828	329,652,307	63,864,689	46,650,844	2,133,356,365
Bottom of the Line Financing -- UPL	4,751,856	646,708	111,003	3,907,264	1,112,243	305,914	45,854	167,039	2,138,257	390,740	302,592	13,879,470
Bottom of the Line Financing -- Denver Health Outstationing	213,319	29,032	4,983	175,404	49,930	13,733	2,058	7,499	95,990	17,541	13,584	623,073
TOTAL BY SERVICE AREA	**730,927,996**	**99,820,380**	**16,999,250**	**604,513,591**	**172,576,627**	**47,267,282**	**7,096,872**	**25,530,366**	**331,886,554**	**64,272,970**	**46,967,020**	**2,147,858,908**
Average Per Capita -- Services Only	$19,779.39	$15,858.07	$1,269.99	$12,268.21	$3,669.92	$8,918.62	$25,447.50	$2,443.46	$1,699.41	$3,448.23	$9,944.75	$5,541.04
Average Per Capita -- Total Appropriation	$19,914.67	$15,966.15	$1,278.72	$12,351.63	$3,694.80	$8,979.35	$25,620.47	$2,460.28	$1,710.92	$3,470.28	$10,012.16	$5,578.71
Per Capita Costs by Service Area												
Acute Care	$2,234.91	$7,772.37	$170.43	$8,326.54	$3,652.15	$8,894.80	$25,440.31	$2,443.46	$1,683.07	$3,194.60	$9,942.60	
Community Care	$3,292.30	$2,405.58	$5.64	$1,809.25	$1.68	$0.00	$0.00	$0.00	$3.11	$236.78	$0.00	
Long Term Care and Insurance	$13,731.85	$5,470.63	$1,082.49	$2,048.58	$3.68	$3.09	$0.00	$0.00	$0.39	$0.76	$2.15	
Administrative Services	$520.33	$209.50	$11.43	$83.84	$12.41	$20.74	$7.20	$0.00	$12.83	$16.09	$0.00	

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	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 Estimate (Original Relook at FY 2007-08 Appropriation)												
CASELOAD FORECAST												
Current Appropriated Caseload	36,703	6,252	13,294	48,942	46,708	5,264	277	10,377	193,981	18,521	4,691	385,010
Department FY 2007-08 Caseload Forecast -- November 2007	35,272	6,050	14,188	49,354	45,228	5,453	260	7,886	192,834	18,428	4,762	379,715
Difference	(1,431)	(202)	894	412	(1,480)	189	(17)	(2,491)	(1,147)	(93)	71	(5,295)
% Difference	-3.90%	-3.23%	6.72%	0.84%	-3.17%	3.59%	-6.14%	0.00%	-0.59%	-0.50%	1.51%	-1.38%
Department's Estimate By Funding Category												
Traditional Medicaid Caseload (includes LI & PE -- fund splits take care of)												
Expansion Medicaid Caseload (w/o LI or PE -- see fund splits)												
Total	0	0	0	0	0	0	0	0	0	0	0	0
Staff's October 5-year Forecast (PRELIMINARY)												
General Fund / Traditional Caseload (can be funded with GF)	35,647	6,026	14,302	48,118	40,661	5,157	194	0	178,228	16,844	4,153	349,330
Expansion Fund Caseload	812	116	0	1,435	5,622	260	83	7,245	18,704	705	0	34,982
TOTAL	36,459	6,142	14,302	49,553	46,283	5,417	277	7,245	196,932	17,549	4,153	384,312
(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	1,187	92	114	199	1,055	(36)	17	(641)	4,098	(879)	(609)	4,597
% Difference	3.37%	1.52%	0.80%	0.40%	2.33%	-0.66%	6.54%	0.00%	2.13%	-4.77%	-12.79%	1.21%
Difference Current Appropriation	(244)	(110)	1,008	611	(425)	153	0	(3,132)	2,951	(972)	(538)	(698)
	-0.66%	-1.76%	7.58%	1.25%	-0.91%	2.91%	0.00%	0.00%	1.52%	-5.25%	-11.47%	-0.18%
Department 11/1/07 Client Forecast	35,272	6,050	14,188	49,354	45,228	5,453	260	7,886	192,834	18,428	4,762	379,715
Increase/(Decrease) from FY 2007-08 current appropriation	(1,431)	(202)	894	412	(1,480)	189	(17)	(2,491)	(1,147)	(93)	71	(5,295)
Increase/(Decrease) from FY 2006-07 Actual	(705)	8	1,370	787	(6,133)	330	30	2,912	(13,336)	1,827	(452)	(13,362)
% difference from current appropriation	-3.90%	-3.23%	6.72%	0.84%	-3.17%	3.59%	-6.14%	0.00%	-0.59%	-0.50%	1.51%	-1.38%
% difference from FY 2006-07 Actual	-1.96%	0.13%	10.69%	1.62%	-11.94%	6.44%	13.04%	n/a	-6.47%	11.01%	-8.67%	-3.40%
% of Total Caseload	9.29%	1.59%	3.74%	13.00%	11.91%	1.44%	0.07%	2.08%	50.78%	4.85%	1.25%	100.00%
Department's Current FY 2007-08 Service Cost Estimates												
ACUTE CARE SERVICES ESTIMATE	84,435,539	45,361,481	3,395,703	409,310,450	185,037,842	53,627,955	6,517,350	12,313,072	323,377,167	58,346,220	55,789,921	1,237,512,700
COMMUNITY BASED SERVICES	122,542,353	15,144,129	481,910	96,107,486	82,697	0	0	8,408	744,807	4,720,238	0	239,832,028
LONG TERM SERVICES	488,976,274	31,512,926	16,370,562	102,034,348	142,431	3,785	0	0	11,833	786	0	639,052,945
SERVICE MANAGEMENT	18,738,927	1,459,988	41,651	5,559,084	1,408,586	249,641	23,686	2,000	3,813,056	450,704	0	31,747,323
BOTTOM OF THE LINE FINANCING (not spread across aid categories)	0	0	0	0	0	0	0	0	0	0	0	13,378,896
TOTAL PREMIUM	714,693,093	93,478,524	20,289,826	613,011,368	186,671,556	53,881,381	6,541,036	12,323,480	327,946,863	63,517,948	55,789,921	2,161,523,892
Cost Per Client												
ACUTE CARE	$2,393.84	$7,497.77	$239.34	$8,293.36	$4,091.22	$9,834.58	$25,066.73	$1,561.38	$1,676.97	$3,166.17	$11,715.65	$3,259.06
COMMUNITY BASED SERVICES	$3,474.21	$2,503.16	$33.97	$1,947.31	$1.83	$0.00	$0.00	$1.07	$3.86	$256.14	$0.00	$631.61
LONG TERM SERVICES	$13,863.02	$5,208.75	$1,153.83	$2,067.40	$3.15	$0.69	$0.00	$0.00	$0.06	$0.04	$0.00	$1,682.98
SERVICE MANAGEMENT	$531.27	$241.32	$2.94	$112.64	$31.14	$45.78	$91.10	$0.25	$19.77	$24.46	$0.00	$83.61
Total Medical Services Cost-per-Client	$20,262.34	$15,451.00	$1,430.07	$12,420.70	$4,127.34	$9,881.05	$25,157.83	$1,562.70	$1,700.67	$3,446.82	$11,715.65	$5,657.26
Percent Change from Current App./Cost Per Client												
ACUTE CARE	7.11%	-3.53%	40.43%	-0.40%	12.02%	10.57%	-1.47%	-36.10%	-0.36%	-0.89%	17.83%	
COMMUNITY BASED SERVICES	5.53%	4.06%	501.73%	7.63%	9.09%	n/a	n/a	n/a	24.21%	8.18%	n/a	
LONG TERM SERVICES	0.96%	-4.79%	6.59%	0.92%	-14.36%	-77.52%	n/a	n/a	-84.29%	-94.42%	-100.00%	
SERVICE MANAGEMENT	2.10%	15.19%	-74.31%	34.35%	150.86%	120.74%	1165.53%	n/a	54.08%	51.98%	n/a	
Total Medical Service Request Change Over Current App.	(11,269,728)	(5,666,116)	3,406,562	12,580,444	15,257,103	6,933,745	(507,923)	(13,032,348)	(1,705,444)	(346,741)	9,139,077	14,788,631
Total Bottom Line Financing Request	0	0	0	0	0	0	0	0	0	0	0	(1,123,647)
Change	(11,269,728)	(5,666,116)	3,406,562	12,580,444	15,257,103	6,933,745	(507,923)	(13,032,348)	(1,705,444)	(346,741)	9,139,077	13,664,984
Cost Associated with New Caseload	(28,304,302)	(3,203,330)	1,135,372	5,054,504	(5,431,476)	1,685,620	(432,608)	(6,086,669)	(1,949,218)	(320,685)	706,078	(37,146,714)
Service Cost Increase	17,725,674	(2,545,015)	2,128,080	7,463,115	21,365,573	5,066,226	(80,240)	(9,139,653)	245,223	(26,187)	8,307,266	50,510,062
Compounding Effect	(691,100)	82,229	143,110	62,825	(676,994)	181,899	4,924	2,193,975	(1,450)	131	125,734	1,425,283
Total	(11,269,728)	(5,666,116)	3,406,562	12,580,444	15,257,103	6,933,745	(507,923)	(13,032,348)	(1,705,444)	(346,741)	9,139,077	14,788,631
Total Medical Service Request Change Over App. (check)	(11,269,728)	(5,666,116)	3,406,562	12,580,444	15,257,103	6,933,745	(507,923)	(13,032,348)	(1,705,444)	(346,741)	9,139,077	14,788,631

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 2008-09 Request												
CASELOAD FORECAST												
Caseload Forecast	35,498	6,106	15,360	49,556	44,183	5,649	278	9,462	192,717	19,305	4,953	383,067
Department's Estimate By Funding Category												
Traditional Medicaid including legal immigrants (includes LI & PE)												
Expansion Medicaid												
Total Caseload Forecast	0	0	0	0	0	0	0	0	0	0	0	0
Staff's October 5-year Forecast (PRELIMINARY)												
Traditional Medicaid (excluding legal immigrants)	35,887	6,237	15,477	48,697	42,762	5,235	227	0	182,202	17,469	4,352	358,545
Expansion Medicaid (including legal immigrants)	812	116	0	1,477	5,622	260	98	7,535	18,704	1,350	0	35,974
TOTAL	36,699	6,353	15,477	50,174	48,384	5,495	325	7,535	200,906	18,819	4,352	394,519
(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	1,201	247	117	618	4,201	(154)	47	(1,927)	8,189	(486)	(601)	11,452
% Difference	3.38%	4.05%	0.76%	1.25%	9.51%	-2.73%	16.91%	0.00%	4.25%	-2.52%	-12.13%	2.99%
Department 11/1/07 Client Forecast	35,498	6,106	15,360	49,556	44,183	5,649	278	9,462	192,717	19,305	4,953	383,067
Increase/(Decrease) from FY 2007-08 appropriation	(1,205)	(146)	2,066	614	(2,525)	385	1	(915)	(1,264)	784	262	(1,943)
Increase/(Decrease) from FY 2007-08 Dept estimate	226	56	1,172	202	(1,045)	196	18	1,576	(117)	877	191	3,352
% difference from FY 2006-07 current appropriation	-3.28%	-2.34%	15.54%	1.25%	-5.41%	7.31%	0.36%	-8.82%	-0.65%	4.23%	5.59%	-0.50%
% difference from FY 2006-07 Dept Estimate	0.64%	0.93%	8.26%	0.41%	-2.31%	3.59%	6.92%	19.98%	-0.06%	4.76%	4.01%	0.88%
% of Total Caseload	9.27%	1.59%	4.01%	12.94%	11.53%	1.47%	0.07%	2.47%	50.31%	5.04%	1.29%	100.00%
Department's Nov FY 2008-09 Service Cost Estimates												
ACUTE CARE SERVICES ESTIMATE	86,365,366	46,427,857	3,918,197	425,694,687	189,659,518	56,928,724	6,972,425	15,504,766	336,845,012	64,194,369	59,971,993	1,292,482,914
COMMUNITY BASED SERVICES	128,246,416	15,381,936	543,449	98,074,231	79,862	0	0	10,066	755,254	4,977,588	0	248,068,802
LONG TERM SERVICES	517,020,060	33,342,213	19,241,816	107,851,473	152,269	4,179	0	0	13,064	868	0	677,625,942
SERVICE MANAGEMENT	19,570,270	1,433,759	44,924	4,499,253	701,695	121,823	4,827	4,204	2,680,005	286,743	0	29,347,503
BOTTOM OF THE LINE FINANCING (Not Spread)	0	0	0	0	0	0	0	0	0	0	0	13,265,582
DENVER HEALTH OUTSTATIONING (Not Spread)	0	0	0	0	0	0	0	0	0	0	0	623,073
TOTAL PREMIUM	751,202,112	96,585,765	23,748,386	636,119,644	190,593,344	57,054,726	6,977,252	15,519,036	340,293,335	69,459,568	59,971,993	2,261,413,816
Cost Compared to Current FY 2007-08 Appropriation	25,239,291	(2,558,875)	6,865,122	35,688,720	19,178,891	10,107,090	(71,707)	(9,836,792)	10,641,028	5,594,879	13,321,149	113,554,908 *include BLF
% increase from Current FY 2007-08 Appropriation	3.48%	-2.58%	40.66%	5.94%	11.19%	21.53%	-1.02%	-38.79%	3.23%	8.76%	28.56%	5.29%
Cost Compared to Dept. FY 2007-08 Estimate	36,509,019	3,107,241	3,458,560	23,108,276	3,921,788	3,173,345	436,216	3,195,556	12,346,472	5,941,620	4,182,072	99,889,924
% increase from New Department FY 2006-07 Estimate	5.11%	3.32%	17.05%	3.77%	2.10%	5.89%	6.67%	25.93%	3.76%	9.35%	7.50%	4.62%
Department's Estimated Per-Capita's for Base W/O Bottom Line Financing	$21,161.82	$15,818.17	$1,546.12	$12,836.38	$4,313.73	$10,099.97	$25,098.03	$1,640.14	$1,765.77	$3,598.01	$12,108.22	
Decision Items (Other Than Base Adjustments -- DI #1)												
BRI #1 -- Implement Preferred Drug List	(27,240)	(42,756)	(1)	(370,902)	(121,435)	(5,339)	(5)	(6,693)	(139,037)	(79,493)	(191)	(793,092)
DI # 3A -- CBHP Marketing Activities	0	0	0	0	0	0	0	0	7,063,080	0	0	7,063,080
DI #6 --Provider Rate Increases	1,179,874	624,989	40,417	5,431,129	2,812,057	675,871	81,134	104,443	4,645,220	701,504	795,235	17,091,875
DI #12 --HMO Up to 100%	399,515	214,401	0	1,775,118	739,640	44,102	0	33,565	1,139,727	26,928	0	4,372,996
DI #14 -- Transfer Non-Emergency Transportation	2,243,869	1,015,942	240	3,099,740	219,075	21,150	0	0	498,718	198,526	2,043	7,299,303
TOTAL FY 2008-09 REQUEST (MATCHES SCHEDULE 3)	754,998,130	98,398,340	23,789,043	646,054,729	194,242,681	57,790,511	7,058,382	15,650,352	353,501,043	70,307,033	60,769,080	2,296,447,978 includes BTL not spread

Fund Splits for FY 2006-07 Appropriation

	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: Autism Fund	Federal Funds	TOTAL FUNDS
ACUTE CARE									
Base Acute	575,721,308							575,721,307	1,151,442,615
Family Planning	850,830	0	0	0	0	0	0	7,657,470	8,508,300
Estimated Prenatal Costs	3,088,434	0	0	0	0	0	0	1,298,400	4,386,834
Health Care Expansion Fund Split Adjustment	0	0	0	9,261,623	0	0	0	9,261,621	18,523,244
Breast and Cervical Cancer Program	1,021,479	0	0	0	584,848	340,493	0	3,615,520	5,562,340
Indian Health Services	0	0	0	0	0	0	0	878,400	878,400
SUBTOTAL ACUTE	**580,682,051**	**0**	**0**	**9,261,623**	**584,848**	**340,493**	**0**	**598,432,718**	**1,189,301,733**
Base Community Care	108,125,944	0	0	0	0	0	0	108,125,944	216,251,888
Autism Waiver	0	0	0	0	0	0	156,688	156,687	313,375
SUBTOTAL COMMUNITY CARE	108,125,944	0	0	0	0	0	156,688	108,282,631	216,565,263
Base Long-Term Care & Insurance	264,549,046	0	0	0	0	0	0	264,549,045	529,098,091
SMIB	49,107,996	0	0	0	0	0	0	32,738,664	81,846,660
SUBTOTAL OTHER LTC & INSURANCE	313,657,042	0	0	0	0	0	0	297,287,709	610,944,751
Service Management									
Base Service Management	2,637,361	0	0	0	0	0	0	2,637,360	5,274,721
Single Entry Point	9,277,689	0	0	0	0	0	0	8,564,020	17,841,709
Disease Management	0	0	0	0	1,970,388	0	0	1,970,389	3,940,777
SUBTOTAL ADMINSTRATION SERVICES	11,915,050	0	0	0	1,970,388	0	0	13,171,769	27,057,207
TOTAL MEDICAL SERVICES	**1,014,380,087**	**0**	**0**	**9,261,623**	**2,555,236**	**340,493**	**156,688**	**1,017,174,827**	**2,043,868,954**
Estimated Health Care Expansion Offset	**(26,434,003)**	**0**	**0**	**26,434,003**	**0**	**0**	**0**	**0**	**0**
	987,946,084	**0**	**0**	**35,695,626**	**2,555,236**	**340,493**	**156,688**	**1,017,174,827**	**2,043,868,954**
Bottom Line Financing									
ICFMR Fee	(38,256)	38,256	0	0	0	0	0	38,256	38,256
UPL Financing	(13,270,929)	0	13,270,929	0	0	0	0	13,270,929	13,270,929
Denver Health UPL Adjustments	0	0	311,537	0	0	0	0	311,536	623,073
TOTAL BOTTOM LINE FINANCING	**(13,309,185)**	**38,256**	**13,582,466**	**0**	**0**	**0**	**0**	**13,620,721**	**13,932,258**
TOTAL FY 2006-07 Final Appropriation	**974,636,899**	**38,256**	**13,582,466**	**35,695,626**	**2,555,236**	**340,493**	**156,688**	**1,030,795,548**	**2,057,801,212**
Total Final Expenditures	976,477,714	0	13,582,466	34,342,955	585,848	340,493	8,444	1,036,058,888	2,061,396,808
Over-expenditure/ (Reversion)	1,840,815	(38,256)	0	(1,352,671)	(1,969,388)	0	(148,244)	5,263,340	3,595,596

Unspent DPHE Transfer was allowed to roll forward to next year in the amount of $1,970,388

FY 2007-08 Original Appropriation Fund Split Allocation

	General Fund & GFE	Cash Funds	Cash Funds Exempt					Federal Funds	Total Funds
			Certified Funds	Health Care Expansion	Transfer from DPHE	BCCTP Fund	Autism		
Expansion Medicaid (Health Care Expansion)									
Legal Immigrant Offset	$0	$0	$0	$6,216,752	$0	$0	$0	$5,379,765	$11,596,517
Breast and Cervical Caner Expansion	$0	$0	$0	$0	$735,600	$0	$0	$1,366,114	$2,101,714
Asset Test Elimination	$0	$0	$0	$28,401,835	$0	$0	$0	$28,401,835	$56,803,670
Up to 60% FPL Adults	$0	$0	$0	$12,684,961	$0	$0	$0	$12,684,961	$25,369,922
Waiver Expansion	$0	$0	$0	$7,906,256	$0	$0	$0	$7,906,256	$15,812,512
TOTAL	**$0**	**$0**	**$0**	**$55,209,804**	**$735,600**	**$0**	**$0**	**$55,738,931**	**$111,684,335**
Traditional Medicaid									
Base Acute	$593,977,832	$0	$0	$0	$0	$0	$0	$593,977,832	$1,187,955,664
Minus Breast and Cervical Cancer Expansion	($735,600)	$0	$0	$0	$0	$0	$0	($1,366,114)	($2,101,714)
Minus Legal Immigrant Acute	($4,987,699)	$0	$0	$0	$0	$0	$0	($4,150,712)	($9,138,411)
Minus Increased Children Waiver Expansion	($7,906,256)	$0	$0	$0	$0	$0	$0	($7,906,256)	($15,812,512)
Minus Asset Test Elimination	($28,401,835)	$0	$0	$0	$0	$0	$0	($28,401,835)	($56,803,670)
Minus 60% FPL	($12,684,961)	$0	$0	$0	$0	$0	$0	($12,684,961)	($25,369,922)
Family Planning	$876,364	$0	$0	$0	$0	$0	$0	$7,887,279	$8,763,643
Estimated Prenatal Costs	$2,979,285	$0	$0	$0	$0	$0	$0	$1,252,513	$4,231,798
Breast and Cervical Cancer Treatment Program	$1,289,515	$0	$0	$0	$0	$429,838	$0	$3,193,085	$4,912,438
Indian Health Services	$0	$0	$0	$0	$0	$0	$0	$878,400	$878,400
Presumptive Eligibility Fund Transfer	($2,719,827)	$0	$0	$2,719,827	$0	$0	$0	$0	$0
SUBTOTAL ACUTE CARE	**$541,686,818**	**$0**	**$0**	**$2,719,827**	**$0**	**$429,838**	**$0**	**$552,679,231**	**$1,097,515,715**
Base Community Care	$111,484,231	$0	$0	$0	$0	$0	$626,750	$112,110,981	$224,221,962
Minus Legal Immigrants Estimate for CC	($272,242)	$0	$0	$0	$0	$0	$0	($272,242)	($544,484)
SUBTOTAL COMMUNITY CARE	**$111,211,989**	**$0**	**$0**	**$0**	**$0**	**$0**	**$626,750**	**$111,838,739**	**$223,677,478**
Nursing Facility I	$252,161,698	$0	$0	$0	$0	$0	$0	$252,161,698	$504,323,396
Minus Legal Immigrants Estimate for NF I	($956,811)	$0	$0	$0	$0	$0	$0	($956,811)	($1,913,622)
SUBTOTAL NURSING FACILTIES	**$251,204,887**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$251,204,887**	**$502,409,774**
Nursing Facility II	$1,103,234	$0	$0	$0	$0	$0	$0	$1,103,234	$2,206,468
PACE	$28,525,101	$0	$0	$0	$0	$0	$0	$28,525,101	$57,050,202
SMIB	$53,111,027	$0	$0	$0	$0	$0	$0	$35,407,352	$88,518,379
HIBI	$323,200	$0	$0	$0	$0	$0	$0	$323,200	$646,400
SUBTOTAL OTHER LTC & INSURANCE	**$83,062,562**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$65,358,887**	**$148,421,449**
Single Entry Point (with March 15, 2007 vote)	$9,781,885	$0	$0	$0	$0	$0	$0	$9,068,217	$18,850,102
ASO Service	$2,203,438	$0	$0	$0	$0	$0	$0	$2,203,438	$4,406,876
Disease Management	$504,353	$0	$0	$0	$0	$0	$0	$504,353	$1,008,706
SUBTOTAL ADMINSTRATION SERVICES	**$12,489,676**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$11,776,008**	**$24,265,684**
TOTAL MEDICAL SERVICES									

FY 2007-08 Original Appropriation Fund Split Allocation

	General Fund & GFE	Cash Funds	Cash Funds Exempt					Federal Funds	Total Funds
			Certified Funds	Health Care Expansion	Transfer from DPHE	BCCTP Fund	Autism		
Bottom Line Financing									
ICFMR Fee	($38,256)	$38,256	$0	$0	$0	$0	$0	$38,256	$38,256
UPL Financing	($13,879,470)	$0	$13,879,470	$0	$0	$0	$0	$13,879,470	$13,879,470
Denver Health UPL Adjustments	$0	$0	$311,537	$0	$0	$0	$0	$311,537	$623,074
TOTAL BOTTOM LINE FINANCING	**($13,917,726)**	**$38,256**	**$14,191,007**	**$0**	**$0**	**$0**	**$0**	**$14,229,263**	**$14,540,800**
TOTAL FY 2007-08 Before Change / SL	**$985,738,206**	**$38,256**	**$14,191,007**	**$57,929,631**	**$735,600**	**$429,838**	**$626,750**	**$1,062,825,946**	**$2,122,515,235**
Change Requests									
DI #4	$0	$0	$0	$0	$0	$0	$0	$0	$0
DI #6 With March 21, 2007 Vote	$7,855,812	$0	$0	$138,111	$0	$0	$0	$7,993,929	$15,987,852
DI #10 -- Staff Doesn't Recommend	$0	$0	$0	$0	$0	$0	$0	$0	$0
BRI #1	($248,573)	$0	$0	$0	$0	$0	$0	($248,573)	($497,146)
BA #4	$379,234	$0	$0	$0	$0	$0	$0	$379,234	$758,468
Executive Order Preferred Drug List	($335,188)	$0	$0	$0	$0	$0	$0	($335,189)	($670,377)
HPV Vaccines For Children Under 20	$505,042	$0	$0	$0	$0	$0	$0	$505,042	$1,010,084
JBC 1.5 Provider Rate Increase for HCBS & HH	$2,540,868	$0	$0	$0	$0	$0	$0	$2,540,868	$5,081,736
S.B. 07-002	$0	$0	$0	$1,950,430	$0	$0	$0	$1,950,429	$3,900,859
H.B. 07-1021	($312,401)	$0	$0	$0	$0	$0	$0	($312,402)	($624,803)
H.B. 07-1183	$198,500	$0	$0	$0	$0	$0	$0	$198,500	$397,000
Total FY 2007-08 Original Appropriation	**$996,321,500**	**$38,256**	**$14,191,007**	**$60,018,172**	**$735,600**	**$429,838**	**$626,750**	**$1,075,497,784**	**$2,147,858,908**

Department's FY 2007-08 -- Revised Fund Split Estimates

				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	$597,383,045	$0	$0	$0	$0	$0	$0	$0	$597,383,045	$1,194,766,090
Estimated Family Planning	$851,019	$0	$0	$0	$0	$0	$0	$0	$7,659,173	$8,510,192
Estimated Prenatal State-Only Program Costs	$3,068,101	$0	$0	$0	$0	$0	$0	$0	$1,306,361	$4,374,462
Health Care Expansion Fund Split Adjustment	$0	$0	$0	$0	$11,229,148	$0	$0	$0	$11,229,147	$22,458,295
Estimated Breast and Cervical Cancer Program (BCCP) [Change in funding via HB 04-1416 and HB 05-1262]	$1,197,563	$0	$0	$0	$0	$0	$1,083,510	$0	$4,236,277	$6,517,350
Estimated Indian Health Service (IHS) (Advisory Only)	$0	$0	$0	$0	$0	$0	$0	$0	$886,311	$886,311
Acute Care Services Sub-Total	**$602,499,728**	**$0**	**$0**	**$0**	**$11,229,148**	**$0**	**$1,083,510**	**$0**	**$622,700,314**	**$1,237,512,700**
Community Based Long Term Care Services										$0
Base Community Based Long Term Care	$119,128,043	$0	$0	$0	$0	$0	$0	$0	$119,128,043	$238,256,086
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	$161,221	$0	$0	$0	$161,221	$322,442
Community Based Long Term Care Sub-Total	**$119,128,043**	**$0**	**$0**	**$0**	**$161,221**	**$0**	**$0**	**$626,750**	**$119,916,014**	**$239,832,028**
Long Term Care and Insurance										
Base Long Term Care	$274,132,224	$0	$0	$0	$0	$0	$0	$0	$274,132,223	$548,264,447
Specialized Medicare Insurance Beneficiaries (SMIB)	$54,473,068	$0	$0	$0	$0	$0	$0	$0	$36,315,378	$90,788,446
Health Care Expansion Fund Split Adjustment	$0	$0	$0	$0	$26	$0	$0	$0	$26	$52
Long Term Care and Insurance Sub-total	**$328,605,292**	**$0**	**$0**	**$0**	**$26**	**$0**	**$0**	**$0**	**$310,447,627**	**$639,052,945**
Service Management										
Base Service Management	$2,787,889	$0	$0	$0	$0	$0	$0	$0	$2,787,889	$5,575,778
Single Entry Point	$11,543,368	$0	$0	$0	$0	$0	$0	$0	$10,655,416	$22,198,784
Tobacco Tax Funded Disease Management Adjustment	$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	$15,993	$0	$0	$0	$15,992	$31,985
Service Management Sub-total	**$14,331,257**	**$0**	**$0**	**$0**	**$15,993**	**$1,970,388**	**$0**	**$0**	**$15,429,685**	**$31,747,323**
Health Care Expansion Fund Allocations Split Adjustment	**($43,190,173)**	**$0**	**$0**	**$0**	**$43,190,173**	**$0**	**$0**	**$0**	**$0**	**$0**
FY 07-08 Estimate of Total Expenditures for Medical Services to Clients	**$1,021,374,147**	**$0**	**$0**	**$0**	**$54,596,561**	**$1,970,388**	**$1,083,510**	**$626,750**	**$1,068,493,640**	**$2,148,144,996**
Impact of Upper Payment Limit Financing (Estimated)	($12,755,822)	$0	$0	$12,755,823	$0	$0	$0	$0	$12,755,822	$12,755,823
Denver Health Outstationing	$0	$0	$0	$311,537	$0	$0	$0	$0	$311,536	$623,073
Referendum C Funding	($343,900,000)	$343,900,000	$0	$0	$0	$0	$0	$0	$0	$0
Total Projected FY 07-08 Expenditures	**$664,718,325**	**$343,900,000**	**$0**	**$13,067,360**	**$54,596,561**	**$1,970,388**	**$1,083,510**	**$626,750**	**$1,081,560,998**	**$2,161,523,892**
TOTAL FY 2007-08 REQUEST	**$664,718,325**	**$343,900,000**	**$0**	**$13,067,360**	**$54,596,561**	**$1,970,388**	**$1,083,510**	**$626,750**	**$1,081,560,998**	**$2,161,523,892**

Department's FY 2008-09 -- 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	$621,663,213	$0	$0	$0	$0	$0	$0	$0	$621,663,213	$1,243,326,426
Estimated Family Planning	$868,054	$0	$0	$0	$0	$0	$0	$0	$7,812,485	$8,680,539
Estimated Prenatal State-Only Program Costs	$3,198,739	$0	$0	$0	$0	$0	$0	$0	$1,361,984	$4,560,723
Health Care Expansion Fund Split Adjustment	$0	$0	$0	$0	$14,028,244	$0	$0	$0	$14,028,244	$28,056,488
Estimated Breast and Cervical Cancer Program (BCCP) [Change in funding via HB 04-1416 and HB 05-1262]	$1,711,756	$0	$0	$0	$0	$0	$728,594	$0	$4,532,077	$6,972,427
Estimated Indian Health Service (IHS) (Advisory Only)	$0	$0	$0	$0	$0	$0	$0	$0	$886,311	$886,311
Acute Care Services Sub-Total	**$627,441,762**	**$0**	**$0**	**$0**	**$14,028,244**	**$0**	**$728,594**	**$0**	**$650,284,314**	**$1,292,482,914**
Community Based Long Term Care Services										$0
Base Community Based Long Term Care	$123,186,291	$0	$0	$0	$0	$0	$0	$0	$123,186,291	$246,372,582
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	$221,360	$0	$0	$0	$221,360	$442,720
Community Based Long Term Care Sub-Total	**$123,186,291**	**$0**	**$0**	**$0**	**$221,360**	**$0**	**$0**	**$626,750**	**$124,034,401**	**$248,068,802**
Long Term Care and Insurance										
Base Long Term Care	$293,418,711	$0	$0	$0	$0	$0	$0	$0	$293,418,710	$586,837,421
Specialized Medicare Insurance Beneficiaries (SMIB)	$54,473,068	$0	$0	$0	$0	$0	$0	$0	$36,315,378	$90,788,446
Health Care Expansion Fund Split Adjustment	$0	$0	$0	$0	$38	$0	$0	$0	$37	$75
Long Term Care and Insurance Sub-total	**$347,891,779**	**$0**	**$0**	**$0**	**$38**	**$0**	**$0**	**$0**	**$329,734,125**	**$677,625,942**
Service Management										
Base Service Management	$2,790,123	$0	$0	$0	$0	$0	$0	$0	$2,790,122	$5,580,245
Single Entry Point	$12,343,828	$0	$0	$0	$0	$0	$0	$0	$11,394,302	$23,738,130
Tobacco Tax Funded Disease Management Adjustment	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Health Care Expansion Fund Split Adjustment	$0	$0	$0	$0	$14,564	$0	$0	$0	$14,564	$29,128
Service Management Sub-total	**$15,133,951**	**$0**	**$0**	**$0**	**$14,564**	**$0**	**$0**	**$0**	**$14,198,988**	**$29,347,503**
Health Care Expansion Fund Allocations Split Adjustment	**($44,708,978)**	**$0**	**$0**	**$0**	**$44,708,978**	**$0**	**$0**	**$0**	**$0**	**$0**
FY 08-09 Estimate of Total Expenditures for Medical Services to Clients	**$1,068,944,805**	**$0**	**$0**	**$0**	**$58,973,184**	**$0**	**$728,594**	**$626,750**	**$1,118,251,828**	**$2,247,525,161**
Impact of Upper Payment Limit Financing (Estimated)	($13,265,580)	$0	$0	$13,265,582	$0	$0	$0	$0	$13,265,580	$13,265,582
Denver Health Outstationing	$0	$0	$0	$311,537	$0	$0	$0	$0	$311,536	$623,073
Referendum C Funding	($343,900,000)	$343,900,000	$0	$0	$0	$0	$0	$0	$0	$0
Total Projected FY 08-09 Expenditures	**$711,779,225**	**$343,900,000**	**$0**	**$13,577,119**	**$58,973,184**	**$0**	**$728,594**	**$626,750**	**$1,131,828,944**	**$2,261,413,816**
Decision Items (Other Than Base Adjustments -- DI #1)										
BRI #1 -- Implement Preferred Drug List	($396,546)	$0	$0	$0	$0	$0	$0	$0	($396,546)	($793,092)
DI # 3A -- CBHP Marketing Activities	$3,531,540	$0	$0	$0	$0	$0	$0	$0	$3,531,540	$7,063,080
DI #6 --Provider Rate Increases	$8,264,081	$0	$0	$0	$281,858	$0	$0	$0	$8,545,936	$17,091,875
DI #12 --HMO Up to 100%	$2,186,498	$0	$0	$0	$0	$0	$0	$0	$2,186,498	$4,372,996
DI #14 -- Transfer Non-Emergency Transportation	$3,649,651	$0	$0	$0	$0	$0	$0	$0	$3,649,652	$7,299,303
TOTAL FY 2008-09 REQUEST	**$729,014,449**	**$343,900,000**	**$0**	**$13,577,119**	**$59,255,042**	**$0**	**$728,594**	**$626,750**	**$1,149,346,024**	**$2,296,447,978**

Appendix C

Medicaid Medical Services Monthly Reports

JBC Staff

Monthly Caseload Reports -- FY 2003-04 Through FY 2007-08 Caseload Reports

		SSI 65+	SSI 60-64	QMB/SL MB	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%	

/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)

JBC Staff

Monthly Caseload Reports -- FY 2003-04 Through FY 2007-08 Caseload Reports

		SSI 65+	SSI 60-64	QMB/SL MB	SSI Disabled	Adults	Exp. Adults	BCP Adults	BCCTC	Children	Foster Children	Non-Citizens	Total	Growth
FY 2006-07	July	36,033	5,953	12,050	47,946	56,253	971	5,152	203	214,085	16,332	6,514	401,492	(208)
	Aug	36,190	5,985	12,250	48,192	56,565	1,976	4,990	213	214,766	16,492	6,248	403,867	2,375
	Sept	36,258	5,990	12,349	48,320	55,341	2,940	4,926	222	212,808	16,430	6,103	401,687	(2,180)
	Oct	36,233	6,040	12,438	48,611	53,950	4,452	5,026	231	211,000	16,461	5,849	400,291	(1,396)
	Nov	36,105	6,070	12,594	48,503	51,838	5,131	4,927	236	207,366	16,387	5,306	394,463	(5,828)
	Dec	36,029	6,098	12,837	48,363	50,857	5,388	4,948	237	204,273	16,512	4,978	390,520	(3,943)
	Jan	36,182	6,074	12,833	48,576	50,395	5,901	5,042	232	204,363	16,565	4,888	391,051	531
	Feb	36,095	6,088	12,958	48,714	50,058	6,162	5,133	229	204,054	16,587	4,762	390,840	(211)
	Mar	36,028	6,107	13,109	48,785	49,325	6,366	5,252	233	202,939	16,754	4,649	389,547	(1,293)
	Apr	35,758	6,059	13,453	48,766	48,513	6,774	5,347	239	202,831	16,791	4,480	389,011	(536)
	May	35,545	6,024	13,387	48,975	47,016	6,786	5,356	242	198,384	16,922	4,424	383,061	(5,950)
	Jun	35,272	6,020	13,562	49,057	46,219	6,846	5,381	248	197,166	16,981	4,361	381,113	(1,948)
YTD		35,977	6,042	12,818	48,567	51,361	4,974	5,123	230	206,170	16,601	5,214	393,079	
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.		36,218	6,068	12,706	48,489	52,115	5,292	5,018	233	205,213	16,580	5,248	393,180	
Difference		241	26	(112)	(78)	754	318	(105)	3	(957)	(21)	35	101	
% Difference		0.67%	0.42%	-0.88%	-0.16%	1.47%	6.38%	-2.06%	1.12%	-0.46%	-0.13%	0.66%	0.0258%	
FY 2007-08	July	35,303	6,046	13,744	49,353	46,376	7,009	5,468	258	198,772	16,885	4,349	383,563	2,450
	Aug	35,397	6,062	13,891	49,402	46,119	6,926	5,507	266	198,677	16,797	4,208	383,252	(311)
	Sept	35,557	6,081	13,958	49,348	45,434	6,900	5,366	273	196,285	16,707	4,035	379,944	(3,308)
	Oct	35,916	6,117	14,059	49,714	45,837	7,021	5,347	280	198,859	16,871	3,996	384,017	4,073
	Nov													
	Dec													
	Jan													
	Feb													
	Mar													
	Apr													
	May													
	Jun													
YTD		35,543	6,077	13,913	49,454	45,942	6,964	5,422	269	198,148	16,815	4,147	382,694	
Original FY 2007-08 App.		36,703	6,252	13,294	48,942	46,708	10,377	5,264	277	193,981	17,295	4,691	383,784	
Supplemental App.													0	
Difference		1,160	176	(619)	(512)	767	3,413	(158)	8	(4,167)	480	544	1,090	
% Difference		3.26%	2.89%	-4.45%	-1.04%	1.67%	49.01%	-2.91%	2.88%	-2.10%	2.85%	13.12%	0.2848%	

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**
Autism													
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**

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SERVICES	FY 2005-06 July	FY 2005-06 August	FY 2005-06 Sept	FY 2005-06 Oct	FY 2005-06 Nov	FY 2005-06 Dec	FY 2005-06 Jan	FY 2005-06 Feb	FY 2005-06 March	FY 2005-06 April	FY 2005-06 May	FY 2005-06 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
Autism														
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**

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SERVICES	FY 2006-07 July	FY 2006-07 August	FY 2006-07 Sept	FY 2006-07 Oct	FY 2006-07 Nov	FY 2006-07 Dec	FY 2006-07 Jan	FY 2006-07 Feb	FY 2006-07 March	FY 2006-07 April	FY 2006-07 May	FY 2006-07 June	FY 2006-07 YTD Total	YTD Average
Acute Care Services														
Physician Services & EPSDT	13,096,524	9,331,900	11,794,023	15,654,622	12,502,978	14,905,323	13,542,144	13,451,244	14,277,380	18,303,052	13,479,501	13,915,835	164,254,526	13,687,877
Emergency Transportation	587,121	305,440	300,154	348,367	248,772	439,598	304,773	317,287	333,692	432,512	318,961	347,945	4,284,622	357,052
County Transportation	(1,176)	(1,784)	(789)	(2,226)	(4,823)	(556)	8,782	(928)	(5,283)	(1,239)	(2,527)	(47,689)	(60,239)	(5,020)
Dental Services	4,449,960	4,048,371	3,577,164	4,808,906	3,653,739	5,943,192	3,697,195	3,329,753	4,787,073	5,427,171	3,649,883	3,977,967	51,350,373	4,279,198
Family Planning	17,775	21,024	3,479	25,369	16,459	13,068	12,007	12,427	12,990	13,763	(24,478)	(105,451)	18,431	1,536
Health Maintenance Organization	19,374,317	19,323,753	7,265,540	7,656,083	6,628,130	7,857,511	7,191,765	6,510,408	7,465,702	6,353,287	6,977,879	5,824,659	108,429,033	9,035,753
Inpatient Hospitals	28,775,244	20,325,085	21,469,520	28,020,128	22,099,750	26,813,091	23,408,629	26,539,964	27,863,768	32,967,233	23,110,917	23,332,249	304,725,578	25,393,798
Outpatient	10,264,962	8,545,968	7,377,202	11,616,209	7,287,958	10,602,914	8,824,299	7,865,387	10,304,090	12,527,699	8,815,060	11,780,165	115,811,913	9,650,993
Lab & X-Ray	1,727,142	1,362,504	1,393,816	2,042,667	1,573,678	1,799,829	1,541,143	1,753,201	1,738,067	2,176,326	1,677,833	1,660,949	20,447,154	1,703,930
Durable Medical Equipment	5,472,881	4,389,957	4,553,251	6,236,213	5,061,899	3,959,953	5,579,600	5,365,634	6,200,921	6,527,679	5,746,148	5,745,450	64,839,585	5,403,299
Prescription Drugs	14,181,448	11,860,212	14,138,941	18,094,048	14,686,216	18,680,495	16,173,456	16,264,696	16,857,657	18,765,686	14,533,362	15,670,821	189,907,037	15,825,586
Drug Rebate (OAP State Only & Medicaid)	0	(9,701,086)	(2,985,719)	(13,057)	(9,752,067)	(1,618,271)	(4,752,493)	(5,503,684)	(900,050)	(3,942,565)	(7,024,897)	(10,152,789)	(56,346,678)	(4,695,557)
Rural Health Centers	402,643	310,711	445,966	447,377	394,973	434,463	802,782	556,511	613,439	605,425	332,566	533,546	5,880,401	490,033
Federally Qualified Health Centers	4,881,716	3,776,863	4,076,518	5,837,252	4,760,262	5,799,049	4,188,939	5,131,740	5,313,297	6,306,231	4,247,488	4,640,746	58,960,103	4,913,342
Co-Insurance (Title XVIII-Medicare)	2,294,663	(244,849)	551,124	1,362,062	1,335,989	1,966,603	1,739,636	1,512,630	2,297,256	2,814,905	1,266,800	2,114,388	19,011,206	1,584,267
Breast and Cervical Cancer Program	529,135	405,702	430,312	625,421	379,978	411,703	433,699	403,288	370,059	574,681	526,225	464,731	5,554,935	462,911
Other Medical Services (Medicaid Refugee & ASO & DM)	1,793,651	1,498,277	3,975,721	3,801,798	2,379,182	3,451,770	5,905,193	2,995,965	1,456,276	4,693,705	7,143,176	4,910,338	44,005,052	3,667,088
Home Health	9,793,068	7,970,876	8,235,047	10,354,530	8,441,701	9,753,415	8,413,171	8,479,147	8,759,682	10,674,643	8,907,290	9,849,536	109,632,106	9,136,009
Acute Care Subtotal	117,641,074	83,528,924	86,601,270	116,915,769	81,694,774	111,213,150	97,014,718	94,984,670	107,746,014	125,220,193	93,681,187	94,463,396	1,210,705,138	100,892,095
Community Based Long-Term Care														
Home and Community Based Services-Case Management	11,285,212	9,474,676	9,597,881	11,304,202	9,742,370	11,050,695	9,875,025	9,812,811	9,857,633	11,836,973	9,456,455	10,372,593	123,666,525	10,305,544
Home and Community Based Services - Mentally Ill	1,481,598	1,356,247	1,374,443	1,504,021	1,350,786	1,448,771	1,347,769	1,376,698	1,410,084	1,591,189	1,485,099	1,519,341	17,246,046	1,437,171
Home and Community Based Services - Model 200	69,227	57,762	49,425	96,416	62,692	82,353	73,120	87,151	66,946	102,485	69,540	87,768	904,884	75,407
Home and Community Based Services - AIDS	38,403	40,915	34,841	41,807	35,041	53,798	38,692	38,573	38,967	60,309	37,723	44,461	503,531	41,961
Autism											75	18,726	18,801	9,401
Consumer Directed Attendant Support	1,211,454	843,779	463,576	700,629	503,871	1,936,024	493,096	1,109,241	611,569	1,066,658	1,667,135	1,973,254	12,580,285	1,048,357
Private Duty Nursing	1,556,734	1,276,455	1,360,897	1,517,607	1,098,335	1,449,823	1,358,492	1,469,730	1,294,007	1,872,585	1,438,885	1,606,208	17,299,757	1,441,646
Hospice	2,377,904	2,716,788	2,621,885	2,919,441	2,622,576	2,621,729	2,611,561	2,823,115	2,530,017	2,920,682	2,519,994	2,501,654	31,787,347	2,648,946
Brain Injury	834,171	776,300	1,113,170	1,006,507	845,742	1,027,003	885,305	990,762	848,336	1,037,190	853,972	894,072	11,112,529	926,044
Community Based Long-Term Care Subtotal	18,854,703	16,542,922	16,616,118	19,090,630	16,261,413	19,670,196	16,683,060	17,708,081	16,657,558	20,488,069	17,528,878	19,018,078	215,119,706	17,926,642
Long Term Care and Insurance														
Class I Nursing Facilities	39,533,059	37,269,789	38,691,319	45,408,807	37,734,217	43,394,132	40,341,963	37,631,954	37,935,104	43,979,711	36,466,571	40,074,614	478,461,240	39,871,770
Class II Nursing Facilities	160,698	161,430	133,825	228,846	168,510	217,825	244,734	198,047	177,607	190,908	189,271	198,436	2,270,136	189,178
Single Entry Points	2,164,062	1,861,788	836,921	1,371,282	1,460,027	1,502,022	1,054,024	1,465,702	1,675,606	894,222	2,173,098	1,543,782	18,002,536	1,500,211
Program for All-Inclusive Care for the Elderly	3,548,486	3,224,784	4,016,293	3,821,693	3,863,991	3,838,334	2,701,763	2,379,333	3,913,457	3,866,911	3,798,744	3,898,492	42,872,281	3,572,690
Supplemental Medicare Insurance Beneficiaries	7,664,770	6,412,882	6,511,703	6,336,646	6,590,346	6,282,716	6,719,350	7,216,079	7,650,659	6,893,677	7,213,839	7,214,215	82,706,881	6,892,240
Health Insurance Buy-In Program	50,624	66,267	48,298	68,588	55,758	47,515	83,110	60,704	58,939	60,864	71,670	70,026	742,363	61,864
Subtotal of Long Term Care and Insurance	53,121,699	48,996,940	50,238,359	57,235,862	49,872,849	55,282,544	51,144,944	48,951,819	51,411,372	55,886,292	49,913,193	52,999,565	625,055,438	52,087,953
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	147,829,036	186,165,890	164,842,722	161,644,570	175,814,944	201,594,554	161,123,258	166,481,038	2,050,880,282	170,906,690
Bottom Line Financings														
Prior Fiscal Year Accounts Payable	0	205,405	0	0	0								205,405	41,081
Nursing Facility Upper Payment Limit	0	0	0	0	0							997,088	997,088	166,181
Inpatient Upper Payment Limit	0	0	0	0	0								0	0
Outpatient Upper Payment Limit	0	0	0	0	1,566,491							10,107,022	11,673,513	1,945,585
Home Health Upper Payment Limit	0	0	0	0	0							288,792	288,792	48,132
Total Bottom Line Financings	0	205,405	0	0	1,566,491	0	0	0				11,392,902	13,164,798	1,462,755
Grand Total	**189,617,476**	**149,274,191**	**153,455,747**	**193,242,261**	**149,395,527**	**186,165,890**	**164,842,722**	**161,644,570**	**175,814,944**	**201,594,554**	**161,123,258**	**177,873,940**	**2,064,045,079**	**172,003,757**

Monthly Reports Expenditu

SERVICES	FY 2007-08 July	FY 2007-08 August	FY 2007-08 Sept	FY 2007-08 Oct	FY 2007-08 Nov	FY 2007-08 Dec	FY 2007-08 Jan	FY 2007-08 Feb	FY 2007-08 March	FY 2007-08 April	FY 2007-08 May	FY 2007-08 June	YTD Total	YTD Average
Acute Care Services														
Physician Services & EPSDT	15,064,797	16,351,086	10,820,122	18,421,183										15,164,297
Emergency Transportation	420,993	393,370	250,220	418,608										370,798
County Transportation	(1,255)	(1,848)	(15,154)	(10,043)										(7,075)
Dental Services	4,766,284	5,208,617	3,012,662	5,132,523										4,530,022
Family Planning	25,869	13,699	9,279	22,239										17,772
Health Maintenance Organization	10,827,163	6,556,174	8,793,755	8,226,635										8,600,932
Inpatient Hospitals	31,789,080	28,721,133	17,990,384	29,759,491										27,065,022
Outpatient	11,904,235	7,038,152	8,613,756	10,907,881										9,616,006
Lab & X-Ray	1,987,490	1,964,292	1,236,529	2,047,321										1,808,908
Durable Medical Equipment	6,879,525	7,202,184	4,760,774	7,038,128										6,470,153
Prescription Drugs	18,376,504	18,107,201	11,645,567	19,670,243										16,949,879
Drug Rebate (OAP State Only & Medicaid)	0	(3,068,956)	(1,905,157)	(5,781,589)										(2,688,926)
Rural Health Centers	528,146	603,905	352,982	555,859										510,223
Federally Qualified Health Centers	5,087,627	5,010,190	3,665,002	6,125,498										4,972,079
Co-Insurance (Title XVIII-Medicare)	1,814,817	1,312,575	460,439	3,474,229										1,765,515
Breast and Cervical Cancer Program	641,641	529,173	422,682	604,539										549,509
Other Medical Services (Medicaid Refugee & ASO & DM)	3,412,156	3,650,324	833,706	7,048,757										3,736,236
Home Health	11,635,717	11,530,176	6,686,343	11,697,315										10,387,388
Acute Care Subtotal	125,160,789	111,121,447	77,633,891	125,358,817	0	0	0	0	0	0	0	0	439,274,944	36,606,245
Community Based Long-Term Care														
Home and Community Based Services-Case Management	11,538,447	11,777,044	9,078,170	12,098,984									44,492,645	11,123,161
Home and Community Based Services - Mentally Ill	1,661,254	1,720,328	1,462,361	1,769,617									6,613,560	1,653,390
Home and Community Based Services - Model 200	97,035	86,317	69,356	148,181									400,889	100,222
Home and Community Based Services - AIDS	48,670	57,516	38,133	56,279									200,598	50,150
Autism	14,247	23,570	14,636	52,384									104,837	26,209
Consumer Directed Attendant Support	1,484,342	686,264	1,591,476	1,768,589									5,530,671	1,382,668
Private Duty Nursing	1,924,829	1,860,683	1,154,844	1,788,149									6,728,505	1,682,126
Hospice	2,291,827	2,381,357	2,199,405	2,607,733									9,480,322	2,370,081
Brain Injury	877,854	974,276	731,817	1,079,123									3,663,070	915,768
Community Based Long-Term Care Subtotal	19,938,505	19,567,355	16,340,198	21,369,039	0	0	0	0	0	0	0	0	77,215,097	6,434,591
Long Term Care and Insurance														
Class I Nursing Facilities	42,415,295	44,418,445	34,592,584	44,186,115									165,612,439	41,403,110
Class II Nursing Facilities	182,255	144,118	185,459	207,954									719,786	179,947
Single Entry Points	3,528,367	1,793,832	1,774,066	0									7,096,265	1,774,066
Program for All-Inclusive Care for the Elderly	4,126,470	4,005,657	3,979,939	3,906,140									16,018,206	4,004,552
Supplemental Medicare Insurance Beneficiaries	(17)	14,007,951	307,461	7,169,192									21,484,587	5,371,147
Health Insurance Buy-In Program	76,940	67,511	72,609	69,792									286,852	71,713
Subtotal of Long Term Care and Insurance	50,329,310	64,437,514	40,912,118	55,539,193	0	0	0	0	0	0	0	0	211,218,135	17,601,511
Service Management (new in FY 2005-06)														
Single Entry Points														
Disease Management														
ASO Administrative Fee														
Subtotal of Service Management														
TOTAL	195,428,604	195,126,316	134,886,207	202,267,049	0	0	0	0	0	0	0	0	727,708,176	60,642,348
Bottom Line Financings														
Prior Fiscal Year Accounts Payable	0												0	0
Nursing Facility Upper Payment Limit	0	(13,181)											(13,181)	(6,591)
Inpatient Upper Payment Limit	0												0	0
Outpatient Upper Payment Limit	0												0	0
Home Health Upper Payment Limit	0												0	0
Total Bottom Line Financings	0	(13,181)	0	0	0	0	0	0				0	(13,181)	(1,465)
Grand Total	**195,428,604**	**195,113,135**	**134,886,207**	**202,267,049**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**727,694,995**	**60,641,250**

Appendix D

Staff Five Year Forecast

Health Care Policy and Financing
5-Year Forecast -- October 2007

Source: JBC Staff Working Paper/MJB

	FY 2007-08 Appropriation	FY 2007-08 New Estimate	FY 2008-09 Forecast	Growth Over App.	FY 2009-10 Forecast	Growth Prior Year	FY 2010-11 Forecast	Growth Prior Year	FY 2011-12 Forecast	Growth Prior Year	FY 2012-13 Forecast	Growth Prior Year
Executive Director's	**97,363,795**	**97,363,795**	**97,363,795**	**0**	**97,363,795**	**0**	**97,363,795**	**0**	**97,363,795**	**0**	**97,363,795**	**0**
FTE	**245.3**	**245.3**	**245.3**	**0**	**245.30**	**0.0**	**245.30**	**0.0**	**245.30**	**0.0**	**245.30**	**0.0**
General Fund	32,971,841	32,971,841	32,971,841	0	32,971,841	0	32,971,841	0	32,971,841	0	32,971,841	0
Cash Funds	2,680,877	2,680,877	2,680,877	0	2,680,877	0	2,680,877	0	2,680,877	0	2,680,877	0
Cash Funds Exempt	6,289,822	6,289,822	6,289,822	0	6,289,822	0	6,289,822	0	6,289,822	0	6,289,822	0
Federal Funds	55,421,255	55,421,255	55,421,255	0	55,421,255	0	55,421,255	0	55,421,255	0	55,421,255	0
Medical Services Premiums	**2,147,858,908**	**2,138,778,011**	**2,244,798,998**	**96,940,090**	**2,397,813,661**	**153,014,663**	**2,527,828,851**	**130,015,190**	**2,663,573,412**	**135,744,562**	**2,803,810,376**	**140,236,964**
General Fund	996,321,500	997,943,423	1,047,988,569	51,667,069	1,121,165,120	73,176,550	1,183,485,515	62,320,395	1,249,955,063	66,469,548	1,316,078,771	66,123,708
Cash Funds	38,256	76,512	76,512	38,256	76,512	0	76,512	0	76,512	0	76,512	0
Cash Funds Exempt	76,001,368	70,460,308	73,047,950	(2,953,418)	76,148,512	3,100,563	78,592,838	2,444,326	81,755,131	3,162,293	83,673,795	1,918,663
Federal Funds	1,075,497,784	1,070,297,768	1,123,685,967	48,188,183	1,200,423,517	76,737,550	1,265,673,985	65,250,469	1,331,786,706	66,112,721	1,403,981,298	72,194,592
Medicaid Mental Health	**230,114,249**	**227,056,466**	**241,026,640**	**10,912,391**	**255,623,166**	**14,596,526**	**269,189,061**	**13,565,895**	**283,342,007**	**14,152,947**	**298,046,514**	**14,704,507**
General Fund	92,060,148	91,941,507	97,015,768	4,955,620	102,785,536	5,769,768	108,815,076	6,029,540	115,124,141	6,309,065	121,694,168	6,570,027
Cash Funds	0	0	0	0	0	0	0	0	0	0	0	0
Cash Funds Exempt	39,151,106	37,740,856	40,135,116	984,010	42,151,743	2,016,627	43,389,214	1,237,471	44,646,956	1,257,743	45,907,504	1,260,548
Federal Funds	98,902,995	97,374,103	103,875,756	4,972,761	110,685,887	6,810,131	116,984,771	6,298,884	123,570,910	6,586,139	130,444,842	6,873,932
Indigent Care Program	**477,448,509**	**477,448,509**	**489,350,353**	**11,901,844**	**498,395,125**	**9,044,772**	**478,105,914**	**(20,289,211)**	**488,533,910**	**10,427,996**	**499,734,344**	**10,034,592**
General Fund	35,225,673	35,225,673	37,924,380	2,698,707	38,960,809	1,036,429	25,038,695	(13,922,114)	26,159,696	1,121,001	27,325,538	1,165,842
Cash Funds	246,943	246,943	255,283	8,340	265,494	10,211	276,114	10,620	287,158	11,044	298,644	11,486
Cash Funds Exempt	222,997,647	222,997,647	224,788,069	1,790,422	227,587,415	2,799,346	215,605,214	(11,982,201)	218,858,797	3,253,583	222,366,883	3,508,086
Federal Funds	218,978,246	218,978,246	226,382,621	7,404,375	231,581,407	5,198,786	237,185,891	5,604,484	243,228,259	6,042,368	249,743,279	6,515,020
Other Medical Services	**121,690,995**	**121,690,995**	**130,839,530**	**9,148,535**	**132,827,407**	**1,987,877**	**134,825,334**	**1,997,927**	**136,830,393**	**134,842,516**	**138,839,392**	**2,008,999**
General Fund	70,552,732	70,552,732	79,701,267	9,148,535	81,689,144	1,987,877	83,687,071	1,997,927	85,692,130	2,005,059	87,701,129	2,008,999
Cash Funds	0	0	0	0	0	0	0	0	0	0	0	0
Cash Funds Exempt	33,306,193	33,306,193	33,306,193	0	33,306,193	0	33,306,193	0	33,306,193	0	33,306,193	0
Federal Funds	17,832,070	17,832,070	17,832,070	0	17,832,070	0	17,832,070	0	17,832,070	0	17,832,070	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	**3,074,476,456**	**3,062,337,776**	**3,203,379,316**	**128,902,860**	**3,382,023,154**	**178,643,838**	**3,507,312,954**	**125,289,801**	**3,669,643,518**	**162,330,564**	**3,837,794,421**	**168,150,903**
FTE	**245.30**	**245.30**	**245.30**	**0.0**	**245.3**	**0.0**	**245.3**	**0.0**	**245.3**	**0.0**	**245.3**	**0.0**
General Fund	1,227,131,894	1,228,635,176	1,295,601,825	68,469,931	1,377,572,450	81,970,624	1,433,998,198	56,425,748	1,509,902,871	75,904,673	1,585,771,447	75,868,576
Cash Funds	2,966,076	3,004,332	3,012,672	46,596	3,022,883	10,211	3,033,503	10,620	3,044,547	11,044	3,056,033	11,486
Cash Funds Exempt	377,746,136	370,794,826	377,567,150	(178,986)	385,483,685	7,916,536	377,183,281	(8,300,404)	384,856,900	7,673,619	391,544,197	6,687,297
Federal Funds	1,466,632,350	1,459,903,442	1,527,197,669	60,565,319	1,615,944,136	88,746,467	1,693,097,972	77,153,837	1,771,839,200	78,741,228	1,857,422,744	85,583,544

October 2007 -- 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 2006-07 Actual	35,977	6,042	12,818	48,567	51,361	4,974	5,123	230	206,170	16,601	5,214	393,077	
Current FY 2007-08 Appropriation													
Traditional Medicaid	35,891	6,136	13,294	47,507	41,086	0	5,004	194	175,277	17,203	4,691	346,283	
Expansion Medicaid (Legal Immigrants)	812	116	0	700	676	0	260	0	856	92	0	3,512	
Expansion Medicaid (1262) & (S.B. 07-02)	0	0	0	735	4,946	10,377	0	83	17,848	1,226	0	35,215	
TOTAL CASELOAD	36,703	6,252	13,294	48,942	46,708	10,377	5,264	277	193,981	18,521	4,691	385,010	
Year-to-Date FY 2006-07 Caseload (through September)													
TOTAL CASELOAD	35,419	6,063	13,864	49,368	45,976	6,945	5,447	266	197,911	16,796	4,197	382,253	
Preliminary FY 2007-08 Reforecast													
Traditional Medicaid (General Fund)	35,647	6,026	14,302	48,118	40,661	0	5,157	194	178,228	16,844	4,153	349,330	
Caseload that Can Be Funded with HCF	812	116	0	1,435	5,622	7,245	260	83	18,704	705	0	34,982	
TOTAL CASELOAD	**36,459**	**6,142**	**14,302**	**49,553**	**46,283**	**7,245**	**5,417**	**277**	**196,932**	**17,549**	**4,153**	**384,312**	**-2.23%**
Preliminary FY 2008-09													
Traditional Medicaid (General Fund)	35,887	6,237	15,477	48,697	42,762	0	5,235	227	182,202	17,469	4,354	358,547	2.64%
Caseload that Can Be Funded with HCF	812	116	0	1,477	5,622	7,535	260	98	18,704	1,351	0	35,975	2.84%
TOTAL CASELOAD	**36,699**	**6,353**	**15,477**	**50,174**	**48,384**	**7,535**	**5,495**	**325**	**200,906**	**18,820**	**4,354**	**394,522**	2.66%
Preliminary FY 2009-10													
Traditional Medicaid (General Fund)	36,329	6,447	16,652	49,336	45,045	0	5,334	260	189,670	18,130	7,490	374,693	4.50%
Caseload that Can Be Funded with HCF	812	116	0	1,477	5,622	7,836	260	112	18,704	1,773	0	36,712	2.05%
TOTAL CASELOAD	**37,141**	**6,563**	**16,652**	**50,813**	**50,667**	**7,836**	**5,594**	**372**	**208,374**	**19,903**	**7,490**	**411,405**	4.28%
Preliminary FY 2010-11													
Traditional Medicaid (General Fund)	36,771	6,657	17,828	49,975	47,329	0	5,434	293	197,138	18,791	8,012	388,228	3.61%
Caseload that Can Be Funded with HCF	812	116	0	1,477	5,622	8,150	260	126	18,704	1,770	0	37,037	0.89%
TOTAL CASELOAD	**37,583**	**6,773**	**17,828**	**51,452**	**52,951**	**8,150**	**5,694**	**419**	**215,842**	**20,561**	**8,012**	**425,265**	3.37%
Preliminary FY 2011-12													
Traditional Medicaid (General Fund)	37,214	6,868	19,004	50,614	49,613	0	5,533	326	204,606	19,452	8,535	401,765	3.49%
Caseload that Can Be Funded with HCF	812	116	0	1,477	5,622	8,476	260	140	18,704	1,770	0	37,377	0.92%
TOTAL CASELOAD	**38,026**	**6,984**	**19,004**	**52,091**	**55,235**	**8,476**	**5,793**	**466**	**223,310**	**21,222**	**8,535**	**439,142**	3.26%
Preliminary FY 2012-13													
Traditional Medicaid (General Fund)	37,656	7,078	20,179	51,254	51,897	0	5,633	326	212,074	20,113	9,058	415,268	3.36%
Caseload that Can Be Funded with HCF	812	116	0	1,477	5,622	8,815	260	140	18,704	1,770	0	37,716	0.91%
TOTAL CASELOAD	**38,468**	**7,194**	**20,179**	**52,731**	**57,519**	**8,815**	**5,893**	**466**	**230,778**	**21,883**	**9,058**	**452,984**	3.15%

Appendix E

Budget Detail by Line Item for Department's FY 2008-09 Request

Department of Health Care Policy and Financing
FY 2007-08 and FY 2008-09 Long Bill Line Item Detail Changes

Department Request

Line Item	FTE	General Fund	GFE	Cash Fund	Cash Fund Exempt	Federal Funds	Total Funds
Executive Director's Office							
Personal Services							
Current Appropriation	**245.3**	**7,261,822**	**0**	**140,495**	**592,486**	**8,720,787**	**16,715,590**
Current Appropriation With Sup.	**245.3**	**7,261,822**	**0**	**140,495**	**592,486**	**8,720,787**	**16,715,590**
T-1 Annualize Prior Year Budget Adj -- PBP	0.0	74,180	0	0	5,187	85,838	165,205
T-1 Annualize Prior Year Budget Adj -- SS	0.0	217,149	0	0	15,225	248,549	480,923
T-1 Annualize Prior Year Budget Adj--AED	0.0	13,722	0	0	1,220	20,008	34,950
T-2 Annualize 1331 Supplemental	12.0	(91,502)	0	0	1,534,751	(91,501)	1,351,748
T-3 Annualize Prior Year Bills -- S.B. 07-001	1.5	0	0	72,612	0	0	72,612
T-3 Annualize Prior Year Bills -- S.B. 07-196	0.5	79,029	0	0	0	79,028	158,057
T-3 Annualize Prior Year Bills -- S.B. 07-211	0.2	7,328	0	0	0	7,327	14,655
T-4 Remove One-time Funding--Interal Audit	0.0	0	0	0	(75,200)	0	(75,200)
T-4 Remove One-time Funding--Incntv Pymnt	0.0	(10,000)	0	0	0	(10,000)	(20,000)
T-5 Fund S;pit Issues -- BCCTP Fund	0.0	9,155	0	0	(9,155)	0	0
T-5 Fund S;pit Issues -- Indirect Cost Recovery	0.0	223,338	0	0	60,932	(284,270)	0
T-6 Common Policy Issue -- Base Reduction	0.0	(15,568)	0	(426)	(4,251)	(17,552)	(37,797)
DI # 7 Addition FTE for Productivity Gains	7.3	230,263	0	0	(46,670)	230,262	413,855
DI # 9 Restore IT Funding	0.0	13,750	0	0	0	13,750	27,500
DI #10 Funding for Additional Lease Space	0.0	5,250	0	0	0	5,250	10,500
New Fiscal Year Appropriation	**266.8**	**8,017,916**	**0**	**212,681**	**2,074,525**	**9,007,476**	**19,312,598**
Health, Life, and Dental							
Current Appropriation	**0.0**	**414,460**	**0**	**0**	**37,568**	**477,265**	**929,293**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**414,460**	**0**	**0**	**37,568**	**477,265**	**929,293**
T-6 Common Policy Issue -- HLD	0.0	41,897	0	0	33,803	46,429	122,129
Proposed New Fiscal Year App.	**0.0**	**456,357**	**0**	**0**	**71,371**	**523,694**	**1,051,422**
Short-Term Disability							
Current Appropriation	**0.0**	**8,509**	**0**	**0**	**635**	**10,404**	**19,548**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**8,509**	**0**	**0**	**635**	**10,404**	**19,548**
T-6 Common Policy Issue -- STD	0.0	275	0	0	346	(408)	213
Proposed New Fiscal Year App.	**0.0**	**8,784**	**0**	**0**	**981**	**9,996**	**19,761**
Amortizaton Equalization Disb.							
Current Appropriation	**0.0**	**76,448**	**0**	**0**	**5,855**	**96,036**	**178,339**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**76,448**	**0**	**0**	**5,855**	**96,036**	**178,339**
T-6 Common Policy Issue AED	0.0	31,662	0	0	6,215	26,990	64,867
Proposed New Fiscal Year App.	**0.0**	**108,110**	**0**	**0**	**12,070**	**123,026**	**243,206**
Supple Amortizaton Equalization Disb.							
Current Appropriation	**0.0**	**13,722**	**0**	**0**	**1,220**	**20,008**	**34,950**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**13,722**	**0**	**0**	**1,220**	**20,008**	**34,950**
T-6 Common Policy Issue AED	0.0	20,893	0	0	2,646	19,383	42,922
Proposed New Fiscal Year App.	**0.0**	**34,615**	**0**	**0**	**3,866**	**39,391**	**77,872**

Department of Health Care Policy and Financing
FY 2007-08 and FY 2008-09 Long Bill Line Item Detail Changes

Department Request

Line Item	FTE	General Fund	GFE	Cash Fund	Cash Fund Exempt	Federal Funds	Total Funds
Salary Survey and SES							
Current Appropriation	**0.0**	**217,149**	**0**	**0**	**15,225**	**248,549**	**480,923**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**217,149**	**0**	**0**	**15,225**	**248,549**	**480,923**
T-1 Annualize Prior Year Budget Adj -- SS	**0.0**	(217,149)	0	0	(15,225)	(248,549)	(480,923)
T-6 Common Policy Issue SS	0.0	266,581	0	0	30,417	303,472	600,470
Proposed New Fiscal Year App.	**0.0**	**266,581**	**0**	**0**	**30,417**	**303,472**	**600,470**
Performance Based Pay							
Current Appropriation	**0.0**	**92,725**	**0**	**0**	**6,484**	**107,297**	**206,506**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**92,725**	**0**	**0**	**6,484**	**107,297**	**206,506**
T-1 Annualize Prior Year Budget Adj -- PBP	0.0	(92,725)	0	0	(6,484)	(107,297)	(206,506)
T-6 Common Policy Issue PBP	0.0	104,107	0	0	11,625	118,471	234,203
Proposed New Fiscal Year App.	**0.0**	**104,107**	**0**	**0**	**11,625**	**118,471**	**234,203**
Worker's Compensation							
Current Appropriation	**0.0**	**12,124**	**0**	**0**	**0**	**12,123**	**24,247**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**12,124**	**0**	**0**	**0**	**12,123**	**24,247**
T-6 Common Policy Issue -- WC	0.0	4,308	0	0	0	4,308	8,616
NP DI #11 -- C-SEAP Program Staffing	0.0	174	0	0	0	174	348
Proposed New Fiscal Year App.	**0.0**	**16,606**	**0**	**0**	**0**	**16,605**	**33,211**
Operating Expenses							
Current Appropriation	**0.0**	**494,229**	**0**	**14,395**	**14,546**	**516,295**	**1,039,465**
	0.0	0	0	0	0	0	0
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**494,229**	**0**	**14,395**	**14,546**	**516,295**	**1,039,465**
T-3 Annualize Prior Year Bills -- H.B. 07-1021	0.0	(1,503)	0	0	0	(1,503)	(3,006)
T-3 Annualize Prior Year Bills -- S.B. 07-001	0.0	0	0	(10,595)	0	0	(10,595)
T-3 Annualize Prior Year Bills -- S.B. 07-004	0.0	0	0	0	(1,640)	(1,640)	(3,280)
T-3 Annualize Prior Year Bills -- S.B. 07-130	0.0	(1,503)	0	0	0	(1,502)	(3,005)
T-3 Annualize Prior Year Bills -- S.B. 07-196	0.0	(1,265)	0	0	0	(1,265)	(2,530)
T-3 Annualize Prior Year Bills -- S.B. 07-211	0.0	(2,254)	0	0	0	(2,255)	(4,509)
T-2 Annualize 1331 Supplemental	0.0	(1,362)	0	0	14,187	(1,425)	11,400
DI #7 -- Additional FTE for Productivity Gains	0.0	39,472	0	0	(4,750)	39,471	74,193
DI #8 -- Training for Department Staff	0.0	50,000	0	0	0	50,000	100,000
DI #9 -- Restor IT Funding	0.0	33,419	0	0	0	33,418	66,837
DI #10 Funding for Additional Lease Space	0.0	106,006	0	0	0	106,007	212,013
DI #11 Restore Enrollment Broker Contract	0.0	(48,924)	0	0	0	(48,924)	(97,848)
Proposed New Fiscal Year App.	**0.0**	**666,315**	**0**	**3,800**	**22,343**	**686,677**	**1,379,135**
Legal Services & Third Pary Recov.							
Current Appropriation	**0.0**	**370,501**	**0**	**76,924**	**6,319**	**459,885**	**913,629**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**370,501**	**0**	**76,924**	**6,319**	**459,885**	**913,629**
No Change Requested	0.0	0	0	0	0	0	0
Proposed New Fiscal Year App.	**0.0**	**370,501**	**0**	**76,924**	**6,319**	**459,885**	**913,629**

Department of Health Care Policy and Financing
FY 2007-08 and FY 2008-09 Long Bill Line Item Detail Changes

Department Request

Line Item	FTE	General Fund	GFE	Cash Fund	Cash Fund Exempt	Federal Funds	Total Funds
Administrative Law Judges							
Current Appropriation	**0.0**	**203,755**	**0**	**0**	**0**	**203,754**	**407,509**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**203,755**	**0**	**0**	**0**	**203,754**	**407,509**
T-7 Common Policy -- ALJ	0.0	22,849	0	0	0	22,849	45,698
Proposed New Fiscal Year App.	**0.0**	**226,604**	**0**	**0**	**0**	**226,603**	**453,207**
Purchases of Computer Services							
Current Appropriation	**0.0**	**7,590**	**0**	**0**	**3,337**	**7,589**	**18,516**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**7,590**	**0**	**0**	**3,337**	**7,589**	**18,516**
T-7 Common Policy -- PCS	0.0	(633)	0	0	0	(633)	(1,266)
Proposed New Fiscal Year App.	**0.0**	**6,957**	**0**	**0**	**3,337**	**6,956**	**17,250**
Risk Management & Property Funds							
Current Appropriation	**0.0**	**45,864**	**0**	**0**	**0**	**45,863**	**91,727**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**45,864**	**0**	**0**	**0**	**45,863**	**91,727**
T-7 Common Policy -- RM & PF	0.0	(9,680)	0	0	0	(9,680)	(19,360)
Proposed New Fiscal Year App.	**0.0**	**36,184**	**0**	**0**	**0**	**36,183**	**72,367**
Capitol Complex Lease Space							
Current Appropriation	**0.0**	**195,540**	**0**	**0**	**0**	**195,539**	**391,079**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**195,540**	**0**	**0**	**0**	**195,539**	**391,079**
T-7 Common Policy -- RM & PF	0.0	1,646	0	0	0	1,647	3,293
Proposed New Fiscal Year App.	**0.0**	**197,186**	**0**	**0**	**0**	**197,186**	**394,372**
Commercial Lease Space							
Current Appropriation	**0.0**	**130,659**	**0**	**0**	**5,500**	**136,159**	**272,318**
	0.0	0	0	0	0	0	0
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**130,659**	**0**	**0**	**5,500**	**136,159**	**272,318**
DI #10 Funding for Additional Lease Space	0.0	32,011	0	0	0	32,010	64,021
Proposed New Fiscal Year App.	**0.0**	**162,670**	**0**	**0**	**5,500**	**168,169**	**336,339**
Transfer to DHS							
Current Appropriation	**0.0**	**37,282**	**0**	**0**	**0**	**37,282**	**74,564**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**37,282**	**0**	**0**	**0**	**37,282**	**74,564**
No Change Requested	0.0	0	0	0	0	0	0
Proposed New Fiscal Year App.	**0.0**	**37,282**	**0**	**0**	**0**	**37,282**	**74,564**
MMIS Contract							
Current Appropriation	**0.0**	**5,265,858**	**0**	**368,971**	**706,330**	**15,965,050**	**22,306,209**
	0.0	0	0	0		0	0
Appropriation with Sup	**0.0**	**5,265,858**	**0**	**368,971**	**706,330**	**15,965,050**	**22,306,209**
T-3 Annualize Prior Year Bills -- S.B. 07-001	0.0	0	0	934,778	0	0	934,778
T-3 Annualize Prior Year Bills -- S.B. 07-097	0.0	0	0	0	(32,193)	(59,787)	(91,980)
T-3 Annualize Prior Year Bills -- S.B. 07-130	0.0	(14,100)	0	0	0	(42,300)	(56,400)
T-3 Annualize Prior Year Bills -- S.B. 07-196	0.0	(23,625)			0	(70,875)	(94,500)
T-1 Annualize Prior Budget -- CBHPPremiums	0.0	0	0	0	(63,195)	(117,363)	(180,558)
T-5 Fund Split Issue	0.0	133	0	0	(133)	0	0
DI # 5 -- MMIS Contract	0.0	75,905	0	0	3,287	233,818	313,010
Proposed New Fiscal Year App.	**0.0**	**5,304,171**	**0**	**1,303,749**	**614,096**	**15,908,543**	**23,130,559**

Department of Health Care Policy and Financing
FY 2007-08 and FY 2008-09 Long Bill Line Item Detail Changes

Department Request

Line Item	FTE	General Fund	GFE	Cash Fund	Cash Fund Exempt	Federal Funds	Total Funds
HIPAA Web Portal Maintenance							
Current Appropriation	**0.0**	**78,225**	**0**	**0**	**0**	**234,675**	**312,900**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**78,225**	**0**	**0**	**0**	**234,675**	**312,900**
DI #13 -- Web Portal Adjustment	0.0	29,458	0	0	0	88,375	117,833
Proposed New Fiscal Year App.	**0.0**	**107,683**	**0**	**0**	**0**	**323,050**	**430,733**
Medical ID Cards							
Current Appropriation	**0.0**	**48,444**	**0**	**0**	**12,352**	**59,204**	**120,000**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**48,444**	**0**	**0**	**12,352**	**59,204**	**120,000**
	0.0	0	0	0	0	0	0
Proposed New Fiscal Year App.	**0.0**	**48,444**	**0**	**0**	**12,352**	**59,204**	**120,000**
DPHE Facility Survey & Certification							
Current Appropriation	**0.0**	**1,346,102**	**0**	**0**	**0**	**3,192,936**	**4,539,038**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**1,346,102**	**0**	**0**	**0**	**3,192,936**	**4,539,038**
T-3 Annualize Prior Year Bill -- S.B. 07-196	0.0	13,553	0	0	0	24,147	37,700
T-1 Annualize Prior Budget - POTS Adj.	0.0	(69,148)	0	0	0	334,037	264,889
NP DI #4 DHS Regional Centers ICF/MR Conv	0.0	10,098	0	0	0	80,302	90,400
Proposed New Fiscal Year App.	**0.0**	**1,300,605**	**0**	**0**	**0**	**3,631,422**	**4,932,027**
Acute Care Utilization Review							
Current Appropriation	**0.0**	**344,703**	**0**	**0**	**17,245**	**1,013,958**	**1,375,906**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**344,703**	**0**	**0**	**17,245**	**1,013,958**	**1,375,906**
T-5 Fund Split Issue	0.0	725	0	0	(725)	0	0
Proposed New Fiscal Year App.	**0.0**	**345,428**	**0**	**0**	**16,520**	**1,013,958**	**1,375,906**
Long Term Care Utilization Review							
Current Appropriation	**0.0**	**598,813**	**0**	**0**	**38,429**	**1,107,724**	**1,744,966**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**598,813**	**0**	**0**	**38,429**	**1,107,724**	**1,744,966**
No Change Requested (Need a letternote chn)	0.0	0	0	0	0	0	0
Proposed New Fiscal Year App.	**0.0**	**598,813**	**0**	**0**	**38,429**	**1,107,724**	**1,744,966**
External Quality Review							
Current Appropriation	**0.0**	**220,548**	**0**	**0**	**0**	**661,645**	**882,193**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**220,548**	**0**	**0**	**0**	**661,645**	**882,193**
T-3 Annualize Prior Year Bill -- S.B. 07-211	0.0	(17,500)	0	0	0	(52,500)	(70,000)
Proposed New Fiscal Year App.	**0.0**	**203,048**	**0**	**0**	**0**	**609,145**	**812,193**
Drug Utilization Review							
Current Appropriation	**0.0**	**76,036**	**0**	**0**	**0**	**228,107**	**304,143**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**76,036**	**0**	**0**	**0**	**228,107**	**304,143**
BRI # 2 -- Implement Preferred Drug List	0.0	76,036	0	0	0	(76,036)	0
Proposed New Fiscal Year App.	**0.0**	**152,072**	**0**	**0**	**0**	**152,071**	**304,143**
MH External Quality Review							
Current Appropriation	**0.0**	**88,202**	**0**	**0**	**0**	**264,605**	**352,807**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**88,202**	**0**	**0**	**0**	**264,605**	**352,807**
No Change Requested	0.0	0	0	0	0	0	0
Proposed New Fiscal Year App.	**0.0**	**88,202**	**0**	**0**	**0**	**264,605**	**352,807**

Department of Health Care Policy and Financing
FY 2007-08 and FY 2008-09 Long Bill Line Item Detail Changes

Department Request

Line Item	FTE	General Fund	GFE	Cash Fund	Cash Fund Exempt	Federal Funds	Total Funds
EPSDT Program							
Current Appropriation	**0.0**	**1,234,192**	**0**	**0**	**0**	**1,234,191**	**2,468,383**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**1,234,192**	**0**	**0**	**0**	**1,234,191**	**2,468,383**
No Change Requested	0.0	0	0	0	0	0	0
Proposed New Fiscal Year App.	**0.0**	**1,234,192**	**0**	**0**	**0**	**1,234,191**	**2,468,383**
Nursing Facility Audits							
Current Appropriation	**0.0**	**548,750**	**0**	**0**	**0**	**548,750**	**1,097,500**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**548,750**	**0**	**0**	**0**	**548,750**	**1,097,500**
No Change Requested	0.0	0	0	0	0	0	0
Proposed New Fiscal Year App.	**0.0**	**548,750**	**0**	**0**	**0**	**548,750**	**1,097,500**
Hospital and FQHC Audits							
Current Appropriation	**0.0**	**249,600**	**0**	**0**	**0**	**249,600**	**499,200**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**249,600**	**0**	**0**	**0**	**249,600**	**499,200**
No Change Requested	0.0	0	0	0	0	0	0
Proposed New Fiscal Year App.	**0.0**	**249,600**	**0**	**0**	**0**	**249,600**	**499,200**
Disability Determination Services							
Current Appropriation	**0.0**	**581,831**	**0**	**0**	**5,000**	**586,831**	**1,173,662**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**581,831**	**0**	**0**	**5,000**	**586,831**	**1,173,662**
No Change Requested	0.0	0	0	0	0	0	0
Proposed New Fiscal Year App.	**0.0**	**581,831**	**0**	**0**	**5,000**	**586,831**	**1,173,662**
NH Preadmission and Risk Asstmnt							
Current Appropriation	**0.0**	**252,510**	**0**	**0**	**0**	**757,530**	**1,010,040**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**252,510**	**0**	**0**	**0**	**757,530**	**1,010,040**
No Change Requested	0.0	0	0	0	0	0	0
Proposed New Fiscal Year App.	**0.0**	**252,510**	**0**	**0**	**0**	**757,530**	**1,010,040**
Nurse Aid Certification							
Current Appropriation	**0.0**	**148,020**	**0**	**0**	**14,652**	**162,671**	**325,343**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**148,020**	**0**	**0**	**14,652**	**162,671**	**325,343**
	0.0	0	0	0	0	0	0
Proposed New Fiscal Year App.	**0.0**	**148,020**	**0**	**0**	**14,652**	**162,671**	**325,343**
DORA In-Home Support Review							
Current Appropriation	**0.0**	**2,000**	**0**	**0**	**0**	**2,000**	**4,000**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**2,000**	**0**	**0**	**0**	**2,000**	**4,000**
T-1 Annualize Prior Budget - Eliminate Fndng	0.0	(2,000)	0	0	0	(2,000)	(4,000)
Proposed New Fiscal Year App.	**0.0**	**0**	**0**	**0**	**0**	**0**	**0**
PCP Rate Task Force & Study							
Current Appropriation	**0.0**	**9,667**	**0**	**0**	**0**	**9,667**	**19,334**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**9,667**	**0**	**0**	**0**	**9,667**	**19,334**
T-1 Annualize Prior Budget -- Eliminate Fndng	0.0	(9,667)	0	0	0	(9,667)	(19,334)
Proposed New Fiscal Year App.	**0.0**	**0**	**0**	**0**	**0**	**0**	**0**

Department of Health Care Policy and Financing
FY 2007-08 and FY 2008-09 Long Bill Line Item Detail Changes

Department Request

Line Item	FTE	General Fund	GFE	Cash Fund	Cash Fund Exempt	Federal Funds	Total Funds
Estate Recovery							
Current Appropriation	**0.0**	**0**	**0**	**350,000**	**0**	**350,000**	**700,000**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**0**	**0**	**350,000**	**0**	**350,000**	**700,000**
No Change Requested	0.0	0	0	0	0	0	0
Proposed New Fiscal Year App.	**0.0**	**0**	**0**	**350,000**	**0**	**350,000**	**700,000**
Single Entry Point Administration							
Current Appropriation	**0.0**	**26,500**	**0**	**0**	**0**	**26,500**	**53,000**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**26,500**	**0**	**0**	**0**	**26,500**	**53,000**
No Change Requested	0.0	0	0	0	0	0	0
Proposed New Fiscal Year App.	**0.0**	**26,500**	**0**	**0**	**0**	**26,500**	**53,000**
Single Entry Point Audits							
Current Appropriation	**0.0**	**56,000**	**0**	**0**	**0**	**56,000**	**112,000**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**56,000**	**0**	**0**	**0**	**56,000**	**112,000**
No Change Requested	0.0	0	0	0	0	0	0
Proposed New Fiscal Year App.	**0.0**	**56,000**	**0**	**0**	**0**	**56,000**	**112,000**
S.B. 97-05 Enrollment Broker							
Current Appropriation	**0.0**	**316,486**	**0**	**0**	**33,514**	**350,000**	**700,000**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**316,486**	**0**	**0**	**33,514**	**350,000**	**700,000**
DI #11 Restore Enrollment Broker Contract	0.0	128,709	0	0	0	128,709	257,418
Proposed New Fiscal Year App.	**0.0**	**445,195**	**0**	**0**	**33,514**	**478,709**	**957,418**
Non-Emergency Transportation Srv.							
Current Appropriation	**0.0**	**3,649,651**	**0**	**0**	**0**	**3,649,651**	**7,299,302**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**3,649,651**	**0**	**0**	**0**	**3,649,651**	**7,299,302**
DI # 14 -- Transfer to MSP Division	0.0	(3,649,651)	0	0	0	(3,649,651)	(7,299,302)
Proposed New Fiscal Year App.	**0.0**	**0**	**0**	**0**	**0**	**0**	**0**
County Administration							
Current Appropriation	**0.0**	**7,248,943**	**0**	**73,526**	**4,632,531**	**11,801,209**	**23,756,209**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**7,248,943**	**0**	**73,526**	**4,632,531**	**11,801,209**	**23,756,209**
T #3 -- Annualize Prior Year Bills--S.B. 07-001	0.0	0	0	46,924	0	0	46,924
Proposed New Fiscal Year App.	**0.0**	**7,248,943**	**0**	**120,450**	**4,632,531**	**11,801,209**	**23,803,133**
Administrative Case Management							
Current Appropriation	**0.0**	**808,764**	**0**	**0**	**0**	**808,764**	**1,617,528**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**808,764**	**0**	**0**	**0**	**808,764**	**1,617,528**
DI #15 -- Accuracy in Budgeting	0.0	650,000	0	0	0	650,000	1,300,000
Proposed New Fiscal Year App.	**0.0**	**1,458,764**	**0**	**0**	**0**	**1,458,764**	**2,917,528**
PERM Contract							
Current Appropriation	**0.0**	**110,348**	**0**	**0**	**77,240**	**253,787**	**441,375**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**110,348**	**0**	**0**	**77,240**	**253,787**	**441,375**
T-1 Annualize Prior Year Budget	0.0	(110,348)	0	0	(77,240)	(253,787)	(441,375)
Proposed New Fiscal Year App.	**0.0**	**0**	**0**	**0**	**0**	**0**	**0**

Department of Health Care Policy and Financing
FY 2007-08 and FY 2008-09 Long Bill Line Item Detail Changes

Department Request

Line Item	FTE	General Fund	GFE	Cash Fund	Cash Fund Exempt	Federal Funds	Total Funds
Public School Administration							
Current Appropriation	**0.0**	**0**	**0**	**0**	**0**	**391,696**	**391,696**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**0**	**0**	**0**	**0**	**391,696**	**391,696**
T-1 Annualize Prior Year Budget - Pots Adj.	0.0	0	0	0	0	4,865	4,865
Proposed New Fiscal Year App.	**0.0**	**0**	**0**	**0**	**0**	**396,561**	**396,561**
School District Eligibility Determinations							
Current Appropriation	**0.0**	**79,269**	**0**	**0**	**25,854**	**122,169**	**227,292**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**79,269**	**0**	**0**	**25,854**	**122,169**	**227,292**
No Change Requested	0.0	0	0	0	0	0	0
Proposed New Fiscal Year App.	**0.0**	**79,269**	**0**	**0**	**25,854**	**122,169**	**227,292**
CBMS & Program Contractor CO RX							
Current Appropriation	**0.0**	**0**	**0**	**1,656,566**	**0**	**0**	**1,656,566**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**0**	**0**	**1,656,566**	**0**	**0**	**1,656,566**
T-3 Annualize CBMS Costs -- S.B. 07-001	0.0	0	0	59,147	0	0	59,147
T-3 Annualize Contractor Costs -- S.B. 07-001	0.0	0	0	562,665	0	0	562,665
Proposed New Fiscal Year App.	**0.0**	**0**	**0**	**2,278,378**	**0**	**0**	**2,278,378**
ASO Study							
Current Appropriation	**0.0**	**0**	**0**	**0**	**37,500**	**37,500**	**75,000**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**0**	**0**	**0**	**37,500**	**37,500**	**75,000**
T-3 Annualize Prior Year Bill -- H.B. 01346	0.0	0	0	0	(37,500)	(37,500)	(75,000)
Proposed New Fiscal Year App.	**0.0**	**0**	**0**	**0**	**0**	**0**	**0**
Executive Director's Office Summary							
Current FY 2007-08 Appropriation	245.3	**32,971,841**	**0**	**2,680,877**	**6,289,822**	**55,421,255**	**97,363,795**
1331 Supplementals	0.0	0	0	0	0	0	0
January Supplementals	0.0	0	0	0	0	0	0
Revised FY 2007-08 Appropriation	**245.3**	**32,971,841**	**0**	**2,680,877**	**6,289,822**	**55,421,255**	**97,363,795**
T-1 Annualize Prior Year Budget Adj -- PBP	0.0	(18,545)	0	0	(1,297)	(21,459)	(41,301)
T-1 Annualize Prior Year Budget Adj -- SS	0.0	0	0	0	0	0	0
T-1 Annualize Prior Year Budget Adj--AED	0.0	13,722	0	0	1,220	20,008	34,950
T-1 Annualize Prior Year Budget Adj -- CHBP	0.0	0	0	0	(63,195)	(117,363)	(180,558)
T-1 Annualize Prior Year Budget Adj- DPHE	0.0	(69,148)	0	0	0	334,037	264,889
T-1 Annualize Prior Year Budget Adj -- DORA	0.0	(2,000)	0	0	0	(2,000)	(4,000)
T-1 Annualize Prior Year Budget Adj-- PCP Std	0.0	(9,667)	0	0	0	(9,667)	(19,334)
T-1 Annualize Prior Year Budget Adj -- Ed.	0.0	0	0	0	0	4,865	4,865
T-1 Annualize Prior Year Budget Adj- PERM	0.0	(110,348)	0	0	(77,240)	(253,787)	(441,375)
T-2 Annualize 1331 Supplemental	12.0	(92,864)	0	0	1,548,938	(92,926)	1,363,148
T-3 Annualize Prior Year Bills -- H.B. 07-1021	0.0	(1,503)	0	0	0	(1,503)	(3,006)
T-3 Annualize Prior Year Bill -- H.B. 07-1346	0.0	0	0	0	(37,500)	(37,500)	(75,000)
T-3 Annualize Prior Year Bills -- S.B. 07-001	1.5	0	0	1,665,531	0	0	1,665,531
T-3 Annualize Prior Year Bills -- S.B. 07-004	0.0	0	0	0	(1,640)	(1,640)	(3,280)
T-3 Annualize Prior Year Bills -- S.B. 07-097	0.0	0	0	0	(32,193)	(59,787)	(91,980)
T-3 Annualize Prior Year Bills -- S.B. 07-130	0.0	(15,603)	0	0	0	(43,802)	(59,405)
T-3 Annualize Prior Year Bills -- S.B. 07-196	0.5	67,692	0	0	0	31,035	98,727
T-3 Annualize Prior Year Bills -- S.B. 07-211	0.2	(12,426)	0	0	0	(47,428)	(59,854)

Department of Health Care Policy and Financing
FY 2007-08 and FY 2008-09 Long Bill Line Item Detail Changes

Department Request

Line Item	FTE	General Fund	GFE	Cash Fund	Cash Fund Exempt	Federal Funds	Total Funds
T-4 Remove One-time Funding--Interal Audit	0.0	0	0	0	(75,200)	0	(75,200)
T-4 Remove One-time Funding--Incntv Pymnt	0.0	(10,000)	0	0	0	(10,000)	(20,000)
T-5 Fund Slpit Issues -- all other fund split adj.	0.0	10,013	0	0	(10,013)	0	0
T-5 Fund Slpit Issues -- Indirect Cost Recovery	0.0	223,338	0	0	60,932	(284,270)	0
T-6 Common Policy Issue -- PS / Benefits	0.0	454,155	0	(426)	80,801	501,093	1,035,623
T-7 Common Policy Issues - Operating	0.0	14,182	0	0	0	14,183	28,365
DI #5 MMIS Contract Adjustment	0.0	75,905	0	0	3,287	233,818	313,010
DI # 7 Addition FTE for Productivity Gains	7.3	269,735	0	0	(51,420)	269,733	488,048
DI #8 -- Training for Department Staff	0.0	50,000	0	0	0	50,000	100,000
DI # 9 Restore IT Funding	0.0	47,169	0	0	0	47,168	94,337
DI #10 Funding for Additional Lease Space	0.0	143,267	0	0	0	143,267	286,534
DI #11 Restore Enrollment Broker Contract	0.0	79,785	0	0	0	79,785	159,570
DI #13 -- Web Portal Adjustment	0.0	29,458	0	0	0	88,375	117,833
DI #14 -- Transfer Non-Emergency Trans.	0.0	(3,649,651)	0	0	0	(3,649,651)	(7,299,302)
DI #15 -- Accuracy in Budgeting	0.0	650,000	0	0	0	650,000	1,300,000
BRI #1 -- Implement Preferred Drug List	0.0	76,036	0	0	0	(76,036)	0
NP DI #4 DHS Regional Centers ICF/MR Conv	0.0	10,098	0	0	0	80,302	90,400
NP DI #11 -- C-SEAP Program Staffing	0.0	174	0	0	0	174	348
FY 2008-09 Budget Request	266.8	**31,194,815**	**0**	**4,345,982**	**7,635,302**	**53,260,279**	**96,436,378**
(check)		31,194,815	0	4,345,982	7,635,302	53,260,279	96,436,378

Medical Services Premiums							
Current Appropriation	**0.0**	**652,421,500**	**343,900,000**	**38,256**	**76,001,368**	**1,075,497,784**	**2,147,858,908**
	0.0	0	0	0	0	0	0
Appropriation with Sup	0.0	**652,421,500**	**343,900,000**	**38,256**	**76,001,368**	**1,075,497,784**	**2,147,858,908**
T-1 Annualize Prior Year Budget Adjustments	0.0	(335,188)	0	0	0	(335,188)	(670,376)
T-3 Annualize Prior Year Legislation -- HB 07-1021	0.0	(375,070)	0	0	0	(375,069)	(750,139)
T-3 Annualize Prior Year Legislation -- HB 07-1183	0.0	(198,500)	0	0	0	(198,500)	(397,000)
T-3 Annualize Prior Year Legislation -- SB 07-002	0.0	0	0	0	792,799	792,798	1,585,597
DI #1 Base Adjustments to MSP	0.0	60,266,483	0	(38,256)	(2,888,520)	56,447,119	113,786,826
DI #3A CBHP Child Outreach	0.0	3,531,540	0	0	0	3,531,540	7,063,080
DI #6 Provider Rate Increase	0.0	8,264,081	0	0	281,858	8,545,936	17,091,875
DI #12 Increase HMO Rates to 100%	0.0	2,186,498	0	0	0	2,186,498	4,372,996
DI #14 Transfer Non-Emergency Transportation	0.0	3,649,651	0	0	0	3,649,651	7,299,302
BRI #2 Implement Preferred Drug List	0.0	(396,546)	0	0	0	(396,545)	(793,091)
Proposed New Fiscal Year App.	0.0	**729,014,449**	**343,900,000**	**0**	**74,187,505**	**1,149,346,024**	**2,296,447,978**

Mental Health Division (all line items)							
Current Appropriation	**0.0**	**92,060,148**	**0**	**0**	**39,151,106**	**98,902,995**	**230,114,249**
	0.0	0	0	0	0	0	0
Appropriation with Sup	0.0	**92,060,148**	**0**	**0**	**39,151,106**	**98,902,995**	**230,114,249**
T-3 Annualize Prior Year Legislation -- SB 07-002	0.0	0	0	0	920,711	920,711	1,841,422
DI #2 -- Base Adjustments for Mental Health	0.0	4,140,689	0	0	(31,568,588)	4,897,423	(22,530,476)
DI #3A -- CBHP Outreach	0.0	367,620	0	0	0	367,620	735,240
Proposed New Fiscal Year App.	0.0	**96,568,457**	**0**	**0**	**8,503,229**	**105,088,749**	**210,160,435**

Department of Health Care Policy and Financing
FY 2007-08 and FY 2008-09 Long Bill Line Item Detail Changes

Department Request

Line Item	FTE	General Fund	GFE	Cash Fund	Cash Fund Exempt	Federal Funds	Total Funds
Indigent Care Division							
Safety Net Provider Payments							
Current Appropriation	**0.0**	**13,090,782**	**0**	**0**	**135,003,533**	**148,094,315**	**296,188,630**
	0.0	0	0	0		0	0
Appropriation with Sup	**0.0**	**13,090,782**	**0**	**0**	**135,003,533**	**148,094,315**	**296,188,630**
No Change Requested	0.0	0	0	0	0	0	0
Proposed New Fiscal Year App.	**0.0**	**13,090,782**	**0**	**0**	**135,003,533**	**148,094,315**	**296,188,630**
Colorado Health Care Services Fund							
Current Appropriation	**0.0**	**15,000,000**	**0**	**0**	**0**	**0**	**15,000,000**
	0.0	0	0	0		0	0
Appropriation with Sup	**0.0**	**15,000,000**	**0**	**0**	**0**	**0**	**15,000,000**
No Change Requested	0.0	0	0	0	0	0	0
Proposed New Fiscal Year App.	**0.0**	**15,000,000**	**0**	**0**	**0**	**0**	**15,000,000**
The Children's Hospital, Indigent Care							
Current Appropriation	**0.0**	**3,059,880**	**0**	**0**	**10,086,000**	**3,059,880**	**16,205,760**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**3,059,880**	**0**	**0**	**10,086,000**	**3,059,880**	**16,205,760**
No Change Requested	0.0	0	0	0	0	0	0
Proposed New Fiscal Year App.	**0.0**	**3,059,880**	**0**	**0**	**10,086,000**	**3,059,880**	**16,205,760**
Health Care Services Fund Programs							
Current Appropriation	**0.0**	**0**	**0**	**0**	**4,914,000**	**0**	**4,914,000**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**0**	**0**	**0**	**4,914,000**	**0**	**4,914,000**
No Change Requested	0.0	0	0	0	0	0	0
Proposed New Fiscal Year App.	**0.0**	**0**	**0**	**0**	**4,914,000**	**0**	**4,914,000**
Pediatric Speciality Hospital							
Current Appropriation	**0.0**	**3,551,000**	**0**	**0**	**684,289**	**4,264,000**	**8,499,289**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**3,551,000**	**0**	**0**	**684,289**	**4,264,000**	**8,499,289**
T-3 Prior Year Legislation (1359 & 097)	0.0	0	0	0	228,711	0	228,711
Proposed New Fiscal Year App.	**0.0**	**3,551,000**	**0**	**0**	**913,000**	**4,264,000**	**8,728,000**
GF App. To Pediatric Hosp. Fund							
Current Appropriation	**0.0**	**0**	**513,000**	**0**	**0**	**0**	**513,000**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**0**	**513,000**	**0**	**0**	**0**	**513,000**
T-8 Revenue Reduction Forecasted	0.0	0	(26,400)	0	0	0	(26,400)
Proposed New Fiscal Year App.	**0.0**	**0**	**486,600**	**0**	**0**	**0**	**486,600**
App from Tobacco Tax Fund to GF							
Current Appropriation	**0.0**	**0**	**0**	**0**	**513,000**	**0**	**513,000**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**0**	**0**	**0**	**513,000**	**0**	**513,000**
T-8 Revenue Reduction Forecasted	0.0	0	0	0	(26,400)	0	(26,400)
Proposed New Fiscal Year App.	**0.0**	**0**	**0**	**0**	**486,600**	**0**	**486,600**
Primary Care Program							
Current Appropriation	**0.0**	**0**	**0**	**0**	**32,365,298**	**0**	**32,365,298**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**0**	**0**	**0**	**32,365,298**	**0**	**32,365,298**
T-1 Annualize Prior Year Budget Adjustments	0.0	0	0	0	75,200	0	75,200
T-8 Revenue Reduction Forecasted	0.0	0	0	0	(1,622,498)	0	(1,622,498)
Proposed New Fiscal Year App.	**0.0**	**0**	**0**	**0**	**30,818,000**	**0**	**30,818,000**

Department of Health Care Policy and Financing
FY 2007-08 and FY 2008-09 Long Bill Line Item Detail Changes

Department Request

Line Item	FTE	General Fund	GFE	Cash Fund	Cash Fund Exempt	Federal Funds	Total Funds
CBHP Trust Fund							
Current Appropriation	**0.0**	**11,011**	**0**	**245,464**	**0**	**0**	**256,475**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**11,011**	**0**	**245,464**	**0**	**0**	**256,475**
T-3 Prior Year Legislation (036)	0.0	11,751	0	0	0	0	11,751
T-3 Prior Year Legislation (097)	0.0	0	0	3,230	0	0	3,230
DI #3 -- CBHP Premium & Dental Costs	0.0	2,382,423	0	59,962	0	0	2,442,385
DI #3A -- Additional CBHP Outreach	0.0	516,215	0	39,520	0	0	555,735
Proposed New Fiscal Year App.	**0.0**	**2,921,400**	**0**	**348,176**	**0**	**0**	**3,269,576**
CBHP Administration							
Current Appropriation	**0.0**	**0**	**0**	**0**	**2,474,735**	**3,066,855**	**5,541,590**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**0**	**0**	**0**	**2,474,735**	**3,066,855**	**5,541,590**
T-3 Prior Year Legislation (004)	0.0	0	0	0	(1,400)	(2,600)	(4,000)
T-3 Prior Year Legislation (097)	0.0	0	0	0	(384)	(616)	(1,000)
DI #3A -- Additional CBHP Outreach	0.0	0	0	0	537,670	862,330	1,400,000
Proposed New Fiscal Year App.	**0.0**	**0**	**0**	**0**	**3,010,621**	**3,925,969**	**6,936,590**
CBHP Premium Costs							
Current Appropriation	**0.0**	**0**	**0**	**1,479**	**30,408,342**	**56,016,777**	**86,426,598**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**0**	**0**	**1,479**	**30,408,342**	**56,016,777**	**86,426,598**
T-3 Prior Year Legislation (1301)	0.0	0	0	0	92,478	171,746	264,224
T-3 Prior Year Legislation (004)	0.0	0	0	0	8,609	15,987	24,596
T-3 Prior Year Legislation (036)	0.0	0	0	0	11,751	21,825	33,576
T-3 Prior Year Legislation (097)	0.0	0	0	(1,479)	170,994	314,813	484,328
T-3 Prior Year Legislation (07-133)	0.0	0	0	0	1,352,889	2,512,507	3,865,396
DI #3 -- CBHP Premium & Dental Costs	0.0	0	0	0	10,052,899	18,555,058	28,607,957
DI #3A -- Additional CBHP Outreach	0.0	0	0	0	4,536,628	8,351,772	12,888,400
Proposed New Fiscal Year App.	**0.0**	**0**	**0**	**0**	**46,634,590**	**85,960,485**	**132,595,075**
CBHP Dental Costs							
Current Appropriation	**0.0**	**0**	**0**	**0**	**2,410,380**	**4,476,419**	**6,886,799**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**0**	**0**	**0**	**2,410,380**	**4,476,419**	**6,886,799**
T-3 Prior Year Legislation (097)	0.0	0	0	0	9,783	18,168	27,951
T-3 Prior Year Legislation (07-133)	0.0	0	0	0	77,996	144,851	222,847
DI #3 -- CBHP Premium & Dental Costs	0.0	0	0	0	1,030,955	1,914,631	2,945,586
DI #3A -- Additional CBHP Outreach	0.0	0	0	0	451,864	839,176	1,291,040
Proposed New Fiscal Year App.	**0.0**	**0**	**0**	**0**	**3,980,978**	**7,393,245**	**11,374,223**
Comprehensive PC Grant Program							
Current Appropriation	**0.0**	**0**	**0**	**0**	**4,138,070**	**0**	**4,138,070**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**0**	**0**	**0**	**4,138,070**	**0**	**4,138,070**
T-3 Prior Year Legislation (1359)	0.0	0	0	0	328,582	0	328,582
T-3 Prior year Legislation (097)	0.0	0	0	0	1,000,000	0	1,000,000
T-1 Annualize Prior Year Budget Adjustments	0.0	0	0	0	530,348	0	530,348
Proposed New Fiscal Year App.	**0.0**	**0**	**0**	**0**	**5,997,000**	**0**	**5,997,000**

Department of Health Care Policy and Financing
FY 2007-08 and FY 2008-09 Long Bill Line Item Detail Changes

Department Request

Line Item	FTE	General Fund	GFE	Cash Fund	Cash Fund Exempt	Federal Funds	Total Funds
Indigent Care Program Division Totals							
Current FY 2007-08 Appropriation	0.0	**34,712,673**	**513,000**	**246,943**	**222,997,647**	**218,978,246**	**477,448,509**
January Supplementals	0.0	0	0	0	0	0	0
Revised FY 2007-08 Appropriation	**0.0**	**34,712,673**	**513,000**	**246,943**	**222,997,647**	**218,978,246**	**477,448,509**
T-1 Annualize Prior Year Budget Adjustments	0.0	0	0	0	605,548	0	605,548
T-3 Prior Year Legislation	0.0	11,751	0	1,751	3,280,009	3,196,681	6,261,481
T-8 Revenue Adjustments	0.0	0	(26,400)	0	(1,648,898)	0	(1,675,298)
DI #3 CBHP Premium and Dental Forecast	0.0	2,382,423	0	59,962	11,083,854	20,469,689	33,995,928
DI #3a -- CHBP Outreach	0.0	516,215	0	39,520	5,526,162	10,053,278	16,135,175
FY 2008-09 Budget Request	0.0	**37,623,062**	**486,600**	**348,176**	**241,844,322**	**252,697,894**	**532,771,343**
(check)		37,623,062	486,600	348,176	241,844,322	252,697,894	533,000,054
Other Medical Programs Division							
Old Age Pension State Med Prgm							
Current Appropriation	**0.0**	**0**	**0**	**0**	**13,293,672**	**0**	**13,293,672**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**0**	**0**	**0**	**13,293,672**	**0**	**13,293,672**
T-3 Annualize Prior Year Legislation - 133	0.0	0	0	0	680,779	0	680,779
T-1 Prior Year Budget Adjustment Annualization	0.0	0	0	0	(725,468)	0	(725,468)
T-1 Prior Year Budget Adjustment Annualization	0.0	0	0	0	(67,500)	0	(67,500)
Proposed New Fiscal Year App.	**0.0**	**0**	**0**	**0**	**13,181,483**	**0**	**13,181,483**
Tobacco Tax Transfer to OAP Fund							
Current Appropriation	**0.0**	**0**	**0**	**0**	**2,500,500**	**0**	**2,500,500**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**0**	**0**	**0**	**2,500,500**	**0**	**2,500,500**
T-8 Revenue Adjustments	0.0	0	0	0	(67,500)	0	(67,500)
Proposed New Fiscal Year App.	**0.0**	**0**	**0**	**0**	**2,433,000**	**0**	**2,433,000**
University of CO Family Medicine							
Current Appropriation	**0.0**	**951,779**	**0**	**0**	**0**	**951,779**	**1,903,558**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**951,779**	**0**	**0**	**0**	**951,779**	**1,903,558**
NP DI #2	0.0	135,000	0	0	0	135,000	270,000
Proposed New Fiscal Year App.	**0.0**	**1,086,779**	**0**	**0**	**0**	**1,086,779**	**2,173,558**
Enhanced Prenatal							
Current Appropriation	**0.0**	**54,500**	**0**	**0**	**0**	**54,499**	**108,999**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**54,500**	**0**	**0**	**0**	**54,499**	**108,999**
T-1 Prior Year Budget Adjustments--POTS	0.0	4,206	0	0	0	4,206	8,412
Proposed New Fiscal Year App.	**0.0**	**58,706**	**0**	**0**	**0**	**58,705**	**117,411**
NH Visitor Program							
Current Appropriation	**0.0**	**0**	**0**	**0**	**1,505,000**	**1,505,000**	**3,010,000**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**0**	**0**	**0**	**1,505,000**	**1,505,000**	**3,010,000**
No Change	0.0	0	0	0	0	0	0
Proposed New Fiscal Year App.	**0.0**	**0**	**0**	**0**	**1,505,000**	**1,505,000**	**3,010,000**

Department of Health Care Policy and Financing
FY 2007-08 and FY 2008-09 Long Bill Line Item Detail Changes

Department Request

Line Item	FTE	General Fund	GFE	Cash Fund	Cash Fund Exempt	Federal Funds	Total Funds
MMA State Contribution Payment							
Current Appropriation	**0.0**	**69,546,453**	**0**	**0**	**0**	**0**	**69,546,453**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**69,546,453**	**0**	**0**	**0**	**0**	**69,546,453**
T-3 Annualize Prior Year Legislation - 133	0.0	7,173,368	0	0	0	0	7,173,368
DI #4 State Contribution Caseload Cost Increase	0.0	2,854,636	0	0	0	0	2,854,636
Proposed New Fiscal Year App.	**0.0**	**79,574,457**	**0**	**0**	**0**	**0**	**79,574,457**
Public School Health Services							
Current Appropriation	**0.0**	**0**	**0**	**0**	**16,007,021**	**15,320,792**	**31,327,813**
	0.0	0	0	0	0	0	0
Appropriation with Sup	**0.0**	**0**	**0**	**0**	**16,007,021**	**15,320,792**	**31,327,813**
T-1 Prior Year Budget Adjustments--POTS	0.0	0	0	0	0	(4,865)	(4,865)
Proposed New Fiscal Year App.	**0.0**	**0**	**0**	**0**	**16,007,021**	**15,315,927**	**31,322,948**
Other Medical Services Division							
Current FY 2006-07 Appropriation	0.0	**70,552,732**	**0**	**0**	**33,306,193**	**17,832,070**	**121,690,995**
January Supplementals	0.0	0	0	0	0	0	0
Revised FY 2006-07 Appropriation	**0.0**	**70,552,732**	**0**	**0**	**33,306,193**	**17,832,070**	**121,690,995**
T-1 Annualizations Prior Year Budget Adj.	0.0	4,206	0	0	(792,968)	(659)	(789,421)
T-3 Annualize Prior Year Legislation	0.0	7,173,368	0	0	680,779	0	7,854,147
T-8 Revenue Adjustments	0.0	0	0	0	(67,500)	0	(67,500)
DI #4 State Contribution Caseload Cost Increase	0.0	2,854,636	0	0	0	0	2,854,636
NP DI #2 Commission on Family Medicine	0.0	135,000	0	0	0	135,000	270,000
FY 2007-08 Budget Request	0.0	**80,719,942**	**0**	**0**	**33,126,504**	**17,966,411**	**131,812,857**
(check)		80,719,942	0	0	33,126,504	17,966,411	131,812,857

Appendix F

List of Legislative Proposals Mentioned in Briefing

1. Require monthly reports in statute (only if necessary).

2. Require in statute that MCO rates contracted for each fiscal year be forwarded to the JBC.

3. Increase the funding in the OAP Supplemental Medical Fund from $750,000 to $1.0 million annually.

4. OAP Medical Program Constitutional Fix if Health Care Reform goes to the ballot.

5. Provide the Department with $1.0 million General Fund transfer authority at the end of the fiscal year to avoid over-expenditures and reversions.

6. Require a $2.0 million transfer of Prevention Early Detection Dollars from the Department of Public Health and Environment to the Department of Health Care Policy and Financing.

7. Limit the amount and source of funding that can be placed in Disability Pool Trusts.

8. Enhance Estate Recovery efforts (see Department proposal).

9. Enhance Third Party Recovery

10. Nursing Home Rate adjustment to a cost-based approach for A&G expenses. Staff doesn't recommend or not recommend this issue -- however, if the Committee wants to do anything with nursing home rates then we will need to plan for the bill in our budget calculations.

Appendix G

Federal Poverty Levels

Family Size	1	2	3	4	5	6	7	8
100%	$10,210	$13,690	$17,170	$20,650	$24,130	$27,610	$31,090	$34,570
120%	$12,252	$16,428	$20,604	$24,780	$28,956	$33,132	$37,308	$41,484
133%	$13,579	$18,208	$22,836	$27,465	$32,093	$36,721	$41,350	$45,978
135%	$13,784	$18,482	$23,180	$27,878	$32,576	$37,274	$41,972	$46,670
150%	$15,315	$20,535	$25,755	$30,975	$36,195	$41,415	$46,635	$51,855
175%	$17,868	$23,958	$30,048	$36,138	$42,228	$48,318	$54,408	$60,498
185%	$18,889	$25,327	$31,765	$38,203	$44,641	$51,079	$57,517	$63,955
200%	$20,420	$27,380	$34,340	$41,300	$48,260	$55,220	$62,180	$69,140
250%	$25,525	$34,225	$42,925	$51,625	$60,325	$69,025	$77,725	$86,425