



Department of Health Care Policy and Financing
Medical Services Premiums
and
Medicaid Mental Health Community Programs

FY 2009-10 and FY 2010-11 Budget Request

February 16, 2010

(2) MEDICAL SERVICES PREMIUMS	2
I. BACKGROUND	2
II. MEDICAID CASELOAD	3
III. BASIC APPROACH TO MEDICAL SERVICES PREMIUMS CALCULATIONS	3
IV. PROJECTION METHODOLOGY AND DESCRIPTION OF EXHIBITS	6
Exhibit A - Calculation of Total Request and Fund Splits	6
Summary of Request (Pages EA-1 through EA-3).....	6
Calculation of Fund Splits (pages EA-4 through EA-7).....	7
Exhibit B - Medicaid Caseload Projection	11
Exhibit C - History and Projections of Per Capita Costs	11
Exhibit D - Cash Funds Report	11
Exhibit E - Summary of Premium Request By Service Group	12
Exhibit F – Acute Care	12
Calculation of Acute Care Expenditure (Page EF-1)	12
Breast and Cervical Cancer Program Per Capita Detail and Fund Splits (Page EF-6)	20
Antipsychotic Drugs (Page EF-7)	21
State-Only Prenatal Care Costs for Non-Citizens (Page EF-9).....	22
Family Planning - Calculation of Enhanced Federal Match (Page EF-10)	23
Year-to-Date Expenditure (Page EF-11)	23
Exhibit G - Community Based Long Term Care	24
Prior Year Expenditure (Page EG-4).....	31
Exhibit H - Long Term Care And Insurance Services	31
Summary of Long Term Care and Insurance Request (Page EH-1)	31
Class I Nursing Facilities (Pages EH-2 and EH-3).....	31
Class I Nursing Facilities – Calculation of Nursing Facilities General Fund Cap (Page EH-9 and EH-10).....	51
Class I Nursing Facilities – Cash-Based Actuals and Projections by Aid Category (Page EH-11).....	51
Class II Nursing Facilities (Page EH-13).....	51
Program of All-Inclusive Care for the Elderly (PACE) (Page EH-14)	52
Supplemental Medicare Insurance Benefit (SMIB) (Page EH-18)	54
Health Insurance Buy-In (HIBI) (Page EH-20)	56
Exhibit I – Service Management	57

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

Summary of Service Management (Page EI-1).....	57
Single Entry Points (Page EI-2)	57
Disease Management (Page EI-4)	60
Prepaid Inpatient Health Plan Administration (Page EI-5).....	61
Exhibit J - Cash Funded Expansion Populations	63
Exhibit K - Upper Payment Limit Financing	71
Exhibit L - Appropriations and Expenditures.....	72
Exhibit M – Cash-Based Actuals.....	73
Exhibit N – Expenditure History by Service Category	74
Exhibit O – Comparison Of Budget Requests And Appropriations.....	74
Exhibit P – Global Reasonableness	75
Exhibit Q – Caseload Graphs.....	75
V. ADDITIONAL CALCULATION CONSIDERATIONS	75
(3) MEDICAID MENTAL HEALTH COMMUNITY PROGRAMS	90
(A) MENTAL HEALTH CAPITATION PAYMENTS	98
Exhibit AA - Calculation of Current Total Long Bill Group Impact	101
Exhibit BB - Calculation of Fund Splits	102
Exhibit CC - Medicaid Mental Health Community Programs Summary	103
Exhibit DD - Mental Health Caseload and Per Capita History and Projections, Expenditure History, and Calculations for Goebel Adjustments.....	104
Exhibit EE - Estimate and Request by Eligibility Category	105
Exhibit FF - Medicaid Mental Health Claims to Caseload Adjustment and Claims-Based Adjustment Multiplier	107
Exhibit HH - Forecast Model Comparisons	110
Exhibit II - Recoupment of Payments Made for Clients Found to be Ineligible for Medicaid	113
Exhibit JJ - Cash Funded Expansion Populations	114
(B) OTHER MEDICAID MENTAL HEALTH PAYMENTS	116
Exhibit KK - Medicaid Mental Health Fee-for-Service Payments	117
Exhibit LL - Global Reasonableness Test for Mental Health Capitation Payments.....	119

(2) MEDICAL SERVICES PREMIUMS

I. BACKGROUND

Medicaid was enacted by Title XIX of the Social Security Act as an entitlement program to provide health care services to eligible elders, the disabled, adults, and children. The Medicaid budget is constructed based on projected numbers of persons who will be eligible (caseload) and projected average costs per person/eligible (per capita cost). This Budget Request is a projection of services that entitled individuals will utilize during the year. The first section of the Medical Services Premiums Budget Narrative describes the Medicaid caseload projection. The second section describes the development of the per capita cost, the application of per capita caseload and bottom-line adjustments. A series of exhibits in this Budget Request support the Narrative.

Several key points should be made evident before further discussion. These change-producing issues cause this line item to be complicated to project. They are summarized as follows:

1. Because of the recent financial crisis, the Department has submitted a large number of Supplemental Requests and Budget Amendments which, if approved, will cause reductions to the Medical Services Premiums line item. Those requests with priority numbers starting with “ES” are incorporated in, and superseded by, this request (S-1), with the exception of the request ES-7, “Medicaid Payment Timing”. Other Supplemental Requests and Budget Amendments are not considered in this request. In places where the Department’s Request for Medical Services Premiums supersedes other budget actions, it will be noted in the narrative and/or the Exhibits.
2. Adjustments have been made to caseload and per capita costs for estimated impacts due to HB 05-1262, the Tobacco Tax Bill and HB 09-1293, the Health Care Affordability Act of 2009. The costs are calculated in various ways. Expenditure for the programs included in these two bills are from cash fund sources other than the General Fund. Adjustments to ensure that funding is requested from the Health Care Expansion Fund, for the Tobacco Tax funded programs, and from the Hospital Provider Fee Cash Fund are incorporated into Exhibit A, pages EJ-1 and EJ-2. Pages EJ-3 through EJ-8 provide detail on the components of the fund splits. Additional information is available in Exhibit J.
3. The implementation of the Medicare Modernization Act on January 1, 2006 impacts prescription drug totals in the FY 2005-06 and FY 2006-07 actuals. Cost savings estimates for prescription drugs have been accounted for in the per capita estimates.
4. The Department is currently contracting with several managed care plans as managed care organizations and with other health plans to provide services to clients as prepaid inpatient health plans. A prepaid inpatient health plan receives a monthly administrative fee per client and is not at risk for the cost of services. The Department did not renew its contract with one

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

administrative services organization in May 2006, and one managed care plan did not renew its contract with the Department in September 2006.

5. In February 2007, the Department re-titled the Qualified Medicare Beneficiaries/Special Low-Income Medicare Beneficiaries aid category to “Partial Dual Eligibles.” This more accurately reflects the benefit package afforded to these clients, who receive only coinsurance and the Supplemental Medicare Insurance Benefit. The title change does not imply any change to the services provided for these clients.
6. The Department implemented a policy of “Passive Enrollment” in May 2006, which requires most clients in Adams, Arapahoe, Denver, and Jefferson counties to choose between the fee-for-service program, primary care physician program, or managed-care program. Clients who do not make a selection are defaulted into the managed-care program.
7. Presumptive eligibility for Medicaid pregnant women was eliminated on September 1, 2004, and was reinstated by HB 05-1262, effective July 1, 2005. During the initial phase of the program, services were billed through a single contractor, which resulted in a “Presumptive Eligibility” service category in the Acute Care group. This arrangement ended January 1, 2008; therefore, expenditure in that service category has dropped to zero. Clients who are presumptively eligible receive services through fee-for-service, and expenditure is recorded in service-appropriate categories.
8. The Deficit Reduction Act of 2005 and HB 06S-1023 require individuals to provide documentary evidence of citizenship and identity prior to the receipt of public benefits.

The Department’s exhibits for Medical Services Premiums remain largely the same as previous Budget Requests. Minor differences are noted in the description of each exhibit in section IV.

II. MEDICAID CASELOAD

The Medicaid caseload analysis, including assumptions and calculations, are included in a separate section of this Request.

III. BASIC APPROACH TO MEDICAL SERVICES PREMIUMS CALCULATIONS

Once caseload is forecasted, the next step in the process is to forecast per capita costs. Per capita costs contain price, utilization, and Special Bill impacts. Inherent in the per capita cost is the differential “risk” of each eligibility category. The concept of “risk” can be roughly described as follows: due to the differences in health status (age, pre-existing condition, etc.), generally healthy clients are less costly to serve (lower “risk”) than clients with severe acute or chronic medical needs requiring medical intervention (higher “risk”). For example, on average, a categorically eligible low-income child is substantially less costly to serve than a disabled person each

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

year. Because Medicaid caseload is growing and receding at differing rates by individual eligibility categories, it is essential to determine the anticipated cost per capita for all types of eligibility categories that will be served. In very broad terms and for most services, the rate of change that was experienced across actual expenditure reference periods is applied to the future in order to estimate the premiums that will be needed for FY 2007-08 and FY 2008-09, the Base Request year. To that base, adjustments are made due to policy items or environmental changes (e.g., Change Requests and new legislation).

A detailed discussion of how the projection was prepared for this budget request follows.

Rationale for Grouping Services for Projection Purposes

The Medical Services Premiums calculations are grouped into like kinds of services and similar calculation considerations. Actual collection of data for expenditures is very detailed, but for purposes of preparing projections, premium calculations are clustered into several groupings. This is done to improve the reasonableness of the projections that result from the calculations. The objective is to cluster services that have like characteristics (e.g., community based long-term care services) or which demonstrate a high degree of relationship (e.g., the impact of health maintenance organization service utilization on inpatient hospital, outpatient, physician services, etc.). Adversely, the approach of projecting the budget by individual service category and applying historic rates generates a materially higher forecast.

Following are the service groupings used in computing the projections or summarizing individual service calculations in this Budget Request.

Acute Care:

- Physician Services and the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT)
- Emergency Transportation
- Non-emergency Medical Transportation
- Dental Services
- Family Planning
- Health Maintenance Organizations
- Inpatient Hospitals
- Outpatient Hospitals
- Lab & X-Ray
- Durable Medical Equipment
- Prescription Drugs
- Drug Rebate

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

- Rural Health Centers
- Federally Qualified Health Centers
- Co-Insurance (Title XVIII-Medicare)
- Breast and Cervical Cancer Treatment Program
- Prepaid Inpatient Health Plan Services
- Other Medical Services
- Home Health
- Presumptive Eligibility

Community Based Long Term Care:

- Home and Community Based Services: Elderly, Blind and Disabled
- Home and Community Based Services: Mental Illness
- Home and Community Based Services: Disabled Children
- Home and Community Based Services: Persons Living with AIDS
- Home and Community Based Services: Brain Injury
- Home and Community Based Services: Children with Autism
- Home and Community Based Services: Pediatric Hospice
- Private Duty Nursing
- Hospice

Long Term Care:

- Class I Nursing Facilities
- Class II Nursing Facilities
- Program of All-inclusive Care for the Elderly

Insurance:

- Supplemental Medicare Insurance Benefit
- Health Insurance Buy-In

Service Management:

- Single Entry Points
- Disease Management
- Prepaid Inpatient Health Plan Administration

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

Note that for services in the Long Term Care, Insurance, and Service Management categories, separate forecasts are performed. Only Acute Care and Community Based Long Term Care are forecast as a group.

IV. PROJECTION METHODOLOGY AND DESCRIPTION OF EXHIBITS

EXHIBIT A - CALCULATION OF TOTAL REQUEST AND FUND SPLITS

Summary of Request (Pages EA-1 through EA-3)

For the current year, the Department sums total spending authority by fund source, including the Long Bill and any special bills which have appropriations that affect the Department.¹ The total spending authority is compared to the total projected estimated current year expenditures from page EA-4. The difference between the two figures is the Department's request for the Medical Services Premiums line item for the current year, excluding the impact of the American Recovery and Reinvestment Act (ARRA). Both the total spending authority and total projected estimated current year expenditures are adjusted for the impact of ARRA. The incremental impact of ARRA on FY 2009-10 expenditures is from page EA-4. The difference between the two adjusted figures is the Department's request for the Medical Services Premiums Long Bill Group total adjustment.

For the request year, the Department starts with the prior year's appropriation including special bills, and adds in any required annualizations. This total is the Base Amount for the request year. The total Base Amount is compared to the total projected estimated request year expenditure from page EA-6. The difference between the two figures is the Department's request for the Medical Services Premiums line item for the request year, excluding the impact of ARRA. Both the total Base Amount and total projected estimated request year expenditure are adjusted for the impact of ARRA. The incremental impact of ARRA on FY 2010-11 expenditures is from page EA-7. The difference between the two adjusted figures is the Department's request for the Medical Services Premiums Long Bill Group total adjustment.

Totals for the base request on this page correspond with Columns 3, 5, and 8 on the Schedule 13, as appropriate. Totals for the ARRA adjustment are included in a separate budget request.

¹ For FY 2009-10, the Department's totals on this page differ from the actual spending authority due to the inclusion of the budget balancing items submitted and implemented (labeled with priority numbers beginning with "ES"). Page EA-3 shows the actual total spending authority. Annualizations of budget balancing items are included in the FY 2010-11 base request.

Calculation of Fund Splits (pages EA-4 through EA-7)

These pages have been reformatted effective with the November 1, 2007 Budget Request; some information has been relocated to page EA-1, as described above. These pages take the total estimated expenditure by service group and calculate the required source of funding for each. For each service category, the federal financial participation rate (FFP, also known as the federal match rate) is listed on the right-hand side of the table. The FFP calculations reflect the participation rate information provided from the federal Centers for Medicare and Medicaid Services, as reported through the Federal Register, or as specified in federal law and/or regulation. The FFP rate for Medicaid is recomputed by the Federal Funds Information Service each year and is based on a statewide per capita earnings formula that is set in federal law.

The FFP rate is impacted by the American Recovery and Reinvestment Act of 2009 (ARRA). One provision of ARRA is an enhanced federal medical assistance percentage (FMAP) for specified Medicaid programs; the effective period of this enhanced rate is October 1, 2008 through December 31, 2010. All states which meet general qualifying criteria receive a 6.2% increase in the FFP for eligible programs. Additional relief is available for states which experience increased unemployment; there are three defined tiers of the rate of increased unemployment percentage with respective increases to the enhanced FMAP. ARRA includes a ‘hold harmless period’; if the FFP for any calendar quarter from January 1, 2009 and ending before July 1, 2010 would be less than the FFP for the preceding quarter, the higher percent shall continue in effect for each subsequent calendar year ending before July 1, 2010. Below is a table detailing the Department’s FFP, as reported by federal Centers for Medicare and Medicaid Services, for FY 2008-09 through FY 2010-11.

FFP Rate		Effective Period	Fiscal Year Quarters
50.00%	Pre-ARRA	Through September 2008	Through first quarter of FY 2008-09
58.78%	Enhanced rate per ARRA	October 2008 through March 2009	Second and third quarters of FY 2008-09
61.59%	Enhanced rate per ARRA	April 2009 through December 2010	FY 2009-10, First and second quarters of FY 2010-11
50.00%	Post-ARRA	January 2011 forward	Third quarter of FY 2010-11 forward

The Department first calculates the appropriate fund splits, excluding the impact of ARRA. The pre-ARRA fund splits for FY 2009-10 are on page EA-3, and for FY 2010-11 are on page EA-5. In separate tables, the Department then calculates the incremental impact of the enhanced federal matching rate, per ARRA, on the fund splits. These incremental figures for FY 2009-10 are on page EA-4, and for FY 2010-11 are on page EA-6.

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

In order to calculate appropriate pre-ARRA fund splits, the Department selectively breaks out the large service groups (e.g. Acute Care) by programs which are funded with either a different state source or a different federal financial participation rate. The majority of programs in Medical Services Premiums are paid with 50% General Fund and 50% federal funds. However, the following programs are paid for using different funding mechanisms:

- Family Planning: There is 90% federal financial participation available for all documented family planning expenditures. This includes those services that are rendered through health maintenance organizations. Please see Exhibit F for calculations.
- Breast and Cervical Cancer Program: This program receives a 65% federal financial participation rate. To determine state funding, the population is separated into two groups: traditional clients, and expansion clients. Traditional clients, who gained eligibility through SB 01S2-012, have funding sources specified in statute, at 25.5-5-308 (9), C.R.S. (2009). For FY 2009-10 and FY 2010-11, 100% of state funding comes from the Breast and Cervical Cancer Prevention and Treatment Fund. Expansion clients, who gained eligibility through additional screenings funded in HB 05-1262, receive state funding through the Prevention, Early Detection, and Treatment fund. Please see Exhibit F for calculations.
- Prenatal Costs: A portion of Acute Care expenditure is for prenatal care for Non-Citizens. Through FY 2008-09, prenatal services were provided as a state-only option and therefore required to be funded through 100% General Fund with the exception that delivery costs qualify for the standard 50% federal financial participation rate. However, as part of ES-2, Medicaid Program Reductions, the Department granted full eligibility, subject to federal approval, to clients enrolled in its prenatal state-only program who meet all eligibility criteria except citizenship status retroactive back to July 2009; this allows the Department to receive federal financial participation for these clients without enrolling any new populations. This change was made possible due to new provisions in the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). Please see Exhibit F for calculations.
- Health Care Expansion Fund Programs: Expenditures for clients granted eligibility through HB 05-1262 are funded through the Health Care Expansion Fund. Separate adjustments are made to Acute Care, Community Based Long Term Care, Long Term Care and Insurance, and Service Management. In addition, in instances where the Department cannot isolate certain expenditures, the Department performs a bottom-line adjustment to allocate expenditure to the Health Care Expansion Fund. Please see Exhibit J for calculation of the fund splits for programs funded through the Health Care Expansion Fund.
- Nursing Facility Provider Fee and General Fund Cap: HB 08-1114 directs the Department to implement a new methodology for calculating nursing facility reimbursement rates, introduced a cap on General Fund growth for core components of the reimbursement rate and authorized the Department to collect a provider fee from nursing facilities statewide. SB 09-263 amends the new methodology. Any growth in the portion of the per diem reimbursement rate for core components beyond the General

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

Fund cap is paid from the Nursing Facility Provider Fee cash fund, as are all Supplemental Payments. Please refer to Exhibit H for calculations and additional details.

- Indian Health Services: The federal financial participation rate for this program is 100%. The total is a rough estimate based on the Department's most recent two years of paid expenditure.
- Tobacco Tax Funded Disease Management: The Department annually receives funding from the Department of Public Health and Environment for the operation of disease management programs that address cancer, heart disease, lung disease and the risk factors associated therewith. The funding for these programs is a constant \$2,000,000 allocation of tobacco tax cash funds from the Prevention, Early Detection, and Treatment Fund overseen by the Department of Public Health and Environment. The Department receives the standard 50% federal match on disease management expenditures, however the American Recovery and Reinvestment Act of 2009 has increased the federal matching percentage.
- Physician Supplemental Payments: The Department draws a federal financial match on uncompensated certified expenditures by Denver Health Medical Center on physician and other non-physician practitioner professional services. The state share of funding is through certification of public expenditure. In FY 2009-10, and FY 2010-11, SB 09-264 requires that the Department retain any ARRA enhanced federal contribution and transfer that to the State's General Fund, effectively moving the ARRA driven federal dollars from the cash fund into General Fund.
- Hospital Provider Fee Programs: HB 09-1293, the Health Care Affordability Act of 2009, authorizes the Department to collect hospital provider fees for the purpose of obtaining federal financial participation for the state's medical assistance programs and using the combined funds to: 1) increase reimbursement to hospitals for providing medical care under the medical assistance program and the Colorado Indigent Care Program; 2) increase the number of persons covered by public medical assistance; and 3) pay the administrative costs to the Department in implementing and administering the program. The expansion populations will be funded through revenue generating from federal funds and two State cash funds: the Hospital Provider Fee Fund and the Medicaid Buy-in Fund. Because these populations were not provided benefits prior to the passage of ARRA, they are not eligible to receive the enhanced federal match.
- Children with Autism Waiver Services: This program provides case management and behavioral therapy services to a limited number of children living with Autism. The available funding is a fixed allocation of Tobacco Master Settlement Funds equal to \$1,000,000 per year; the Department receives funding through the Colorado Autism Treatment Fund. Typically eligible for a FFP rate of 50%, the program is eligible for enhanced federal financial participation during the ARRA period.

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

- Supplemental Medicare Insurance Benefit: Medicare premiums are not federally matched for clients who exceed 134% of the federal poverty level. Premiums for clients between 120% and 134% of the federal poverty level receive a 100% federal financial participation rate. In aggregate, the Department estimates that approximately 80% of the total will receive federal financial participation, while 20% will be provided as a state-only option.
- Single Entry Point: A portion of this line item is for clients who do not receive Medicaid coverage (4%) and does not receive federal financial participation. Instead this portion must be funded through 100% General Fund.
- Coordinated Care for People with Disabilities Program: The Joint Budget Committee recommended and approved \$500,000 in additional appropriated total funds for the 2009 Long Bill to implement the coordinated care for people with disabilities pilot program as directed by SB 06-128, which authorizes the Department to pay per member per month administration fees to the Colorado Alliance for Health and Independence (CAHI).
- Upper Payment Limit Financing: The Upper Payment Limit financing offset to General Fund is a bottom-line adjustment to total expenditures.
- Denver Health Outstationing: Federal funds are drawn to reimburse Denver Health federally qualified health centers for the federal share of their actual expenditures in excess of the current reimbursement methodology. This reimbursement does not require any increase in General Fund. The FY 2009-10 and FY 2010-11 totals are based on the total amount Denver Health Medical Center was able to certify in FY 2008-09.
- Cash Funds Financing: This item includes the impact of legislation, SB 09-261 and SB 09-271, and five initiatives from Executive Order D 017 09, which reduce General Fund expenditure through cash fund transfers. Please refer to Section V for more detailed information. In addition, the item includes a \$2.0 million transfer of reappropriated funds, for FY 2009-10 only, from the Prevention, Early Detection and Treatment fund. These funds are transferred from the Department of Public Health and Environment for the Disease Management program, although the Department has statutory flexibility to use the funding for the treatment of the specified conditions. This program is detailed in the Exhibit I section.

The Department's February request corrects a significant error from its November request related to the "Health Care Expansion Fund Allocations Split Adjustment" on page EA-5 and EA-7, "Calculation of Fund Splits Due to the American Recovery and Reinvestment Act". As described above, in instances where the Department cannot isolate certain expenditures, the Department performs a bottom-line adjustment to allocate expenditure to the Health Care Expansion Fund. Using the FY 2009-10 calculations as an example, on page EA-4 of the February request, "Calculation of Fund Splits", this net-zero adjustment reallocates General Fund to Health Care Expansion Fund. The federal funds associated with these populations are accounted for in other areas on page EA-4 (at a 50%

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

FMAP), and the full amount of enhanced federal funds is calculated on EA-5; therefore, it was originally assumed that ARRA would have no further affect on fund splits. However, this is not the case.

For each population captured in the Health Care Expansion Fund Allocations Split Adjustment, the funding request is implicitly captured in the Department's base calculation as General Fund (in particular, in the lines "Base Acute", "Base Community Based Long Term Care," etc.). As a result, on page EA-5, when the calculation is adjusted on a line-by-line basis for the enhanced FMAP, the total amount of General Fund and federal funds are reduced to the appropriate level under ARRA. At this point, the Department must now reallocate the General Fund included in the calculation for these populations to Health Care Expansion Fund. On Page EA-4, this is accomplished by the net-zero Health Care Expansion Fund Allocations Split Adjustment. This calculation is at the base FMAP of 50%. In the November request, where there is no further adjustment, this created an inconsistency in the final aggregate request: General Fund calculated at the enhanced FMAP rate is replaced with Health Care Expansion Fund calculated at the base FMAP rate. In other words, General Fund was reduced by too much, while Health Care Expansion Fund was increased by too much.

To properly account for the state funds, on page EA-5 and EA-7, "Calculation of Fund Splits Due to the American Recovery and Reinvestment Act", the Department's February request adjusts the Health Care Expansion Fund Allocations Split Adjustment by increasing General Fund and reducing Health Care Expansion Fund to ensure that both funds are requested appropriately. In total, the FY 2009-10 adjustment on page EA-5 resulted in an increased General Fund request of \$14,709,432, and the FY 2010-11 adjustment on page EA-7 resulted in an increased General Fund request of \$8,149,586.

EXHIBIT B - MEDICAID CASELOAD PROJECTION

This exhibit is described in the Medicaid Caseload Budget Narrative section.

EXHIBIT C - HISTORY AND PROJECTIONS OF PER CAPITA COSTS

Medical Services Premiums per capita costs history (through FY 2008-09) and projections are included for historical reference and comparison, and are calculated on a cash-accounting basis.

EXHIBIT D - CASH FUNDS REPORT

Effective with the November 2009 Budget Request, this exhibit displays spending authority, total request, and incremental request for each source of cash funds in the Medical Services Premiums line item. This information is a summary of the information presented on Exhibit A. In addition, total spending authority is broken out between the Long Bill and other special bills; this information is used to calculate the revised letternote amount on the Schedule 13.

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

The information presented on the “Summary of Request by Eligibility Category” has been replaced with information shown in Exhibit E, page E-1, in the rows for “Total Per Capita.”

EXHIBIT E - SUMMARY OF PREMIUM REQUEST BY SERVICE GROUP

Page EE-1 of this exhibit is a summary of the requests by service group and by eligibility category for the current year and the request year.

Starting with page EE-2 of this exhibit contains a detailed summary of the Department’s Budget Request, by service category. In addition, this exhibit directly compares the Department’s Budget Request to the Department’s Long Bill plus Special Bills appropriation, as determined by the Department’s March 18, 2009 Figure Setting and subsequent actions by the Joint Budget Committee and the General Assembly. This exhibit includes all bottom-line impacts and financing, but does not break the request down by eligibility type or funding source. Totals on this portion of the exhibit match the totals on Exhibit A, and the Schedule 13.

EXHIBIT F – ACUTE CARE

Calculation of Acute Care Expenditure (Page EF-1)

Acute Care services expenditure is calculated in a series of steps. At the top of page EF-1, historical expenditures and the annual percent changes are provided. Historical per capita costs and the annual percent changes are also provided. The first step of the calculation is to select a historical per capita percent change rate, if possible, to trend the last actual per capita to the next year. Finally, bottom-line adjustments are made for legislation and other impacts not included in historical trends. Total expenditure after bottom-line adjustments is divided by the projected caseload to obtain a final per capita cost for the current year. To calculate the request year expenditure, the same methodology is applied to the projected request year per capita, including a per capita trend factor and bottom-line impacts. The total estimated expenditure for Acute Care is added to total estimated expenditure in other service groups and bottom-line impacts to generate the total request for Medical Services Premiums. There is no separate budget request for Acute Care.

In light of the Medicare Modernization Act of 2003, the Department has added a separate page of trends on page EF-2. On this page, expenditures for pharmacy and drug rebate recoveries have been removed from the historical expenditure. This page is particularly relevant, as per capita costs for eligibility categories with significant amounts of dual-eligibles are skewed by the new Part D benefit. In Adults 65 and Older (OAP-A), Disabled Adults 60 to 64 (OAP-B), and Disabled Individuals to 59 (AND/AB), the per capita costs experienced a significant downturn as Medicare became responsible for most pharmacy claims. Selecting trends that incorporate FY

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

2005-06 would incorporate the shift in expenditure and may not be appropriate. This portion of the exhibit enables the Department to analyze and select trends without the net cost of pharmaceuticals, which has historically been a significant cost driver.

Calculation of Per Capita Percent Change

The per capita percent change for several different years is computed for each eligibility category on a per capita cost basis. The period of time that was selected for computing the trend or annual rate of change was FY 2002-03 through FY 2008-09. Prior year information is provided for historical reference. This period was selected for two reasons: first, it is a recent period and second, because Medicaid benefits over this period have remained mostly the same. At the top of page EF-3, the Department has provided a list of historic trends. Included are 2-year, 3-year, 4-year, and 5-year trends, ending in FY 2006-07, FY 2007-08, and FY 2008-09. Typically, the same percentage selected to modify current year per capita costs were used to modify the request year per capita costs, although the Department makes adjustments to the selected trend where necessary.

Percentages selected to modify per capita costs are calculated to assess the percentages in light of any policy changes or one-time costs that may skew just one trend year. At the same time, per capita trend factors must not take into account changes in caseload, or changes that have been accounted for as bottom-line adjustments. Because the eligibility categories differ in eligibility requirements, demographics, and utilization, different trends are used for each eligibility category.

The table below describes the trend selections for FY 2009-10 and FY 2010-11. In some cases, though not all, the Department has held the trend constant between the two years. On Exhibit F, the selected trend factors have been bolded for clarification. By convention, any trend factor selected based on expenditure without prescription drugs and drug rebate is labeled “Without RX.”

For the supplemental request, particular weight is given to the year-to-date expenditures and selecting a trend that generates a likely final fiscal year expenditure total based upon that evidence.

As described in the Department’s caseload narrative, populations which are sensitive to economic conditions are growing at substantial rates. Historically, rapid caseload growth leads to per capita declines, due to several factors. First, clients may not receive services immediately upon receiving eligibility; there is typically a lag between when eligibility is determined to when clients receive services and when those services are billed. For this reason, under cash accounting, where services are accounted for in the period where the claim is paid, expenditure growth will typically lag caseload growth, causing a per capita decline. Additionally, new caseload for economically sensitive populations may previously have had health insurance, and may generally be healthier than populations who have not had access to care. These clients may require fewer services, further lowering the overall per capita cost.

The selected trend factors for FY 2009-10 and FY 2010-11 with the rationale for selection, are as follows:

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

Aid Category	FY 2009-10 Trend Selection	FY 2010-11 Trend Selection	Justification
Adults 65 and Older (OAP-A)	-1.42% Average of FY 2005-06 through FY 2007-08 (without Rx)	3.87% Average of FY 2004-05 through FY 2008-09 (without Rx)	Year-to-date expenditures are below previously estimated expenditure levels. The various budget cutting activities over the course of the fiscal year appear to have significantly impacted and driven total costs down even while caseload increases. The Department increases the trend in the out year, consistent with historical growth rates; it is likely that the decline in the current year per capita is a one-time level shift, and not reflective of a new underlying trend for this population.
Disabled Adults 60 to 64 (OAP-B)	0.98% Average of FY 2004-05 through FY 2008-09	3.17% Average of FY 2005-06 through FY 2008-09	Year-to-date expenditures are below previously estimated expenditure levels, however per capitas in some key service areas are still growing. Additionally, second half of the year expenditure traditionally is significantly greater than first half year expenditure. The Department increases the trend in the out year, consistent with historical growth rates; it is likely that the decline in the current year per capita is a one-time level shift, and not reflective of a new underlying trend for this population.
Disabled Individuals to 59 (AND/AB)	2.93% Average of FY 2003-04 through FY 2007-08 (without Rx)	3.91% Average of FY 2005-06 through FY 2008-09	Year-to-date expenditures are below previously estimated expenditure levels. The various budget cutting activities over the course of the fiscal year appear to have significantly impacted and driven total costs down even while caseload increases. However, caseload will continue to grow at an accelerated rate and drive up total expenditure. The Department increases the trend in the out year, consistent with historical growth rates; it is likely that the decline in the current year per capita is a one-time level shift, and not reflective of a new underlying trend for this population.

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

Aid Category	FY 2009-10 Trend Selection	FY 2010-11 Trend Selection	Justification
Categorically Eligible Low-Income Adults (AFDC-A)	-5.46% One third of the percent increase in FY 2004-05	-2.73% Half of estimated FY 2009-10 growth rate	Dramatically increasing caseload will continue to drive per capita costs downward, although the rate of caseload increase, however, will continue to drive total expenditure upwards. The out-year caseload growth will continue, but at a slower rate than the current year.
Expansion Adults	8.39% Half the percent increase in FY 2008-09	4.20% Half of estimated FY 2009-10 growth rate	The year-to-date expenditure is in line with the previously submitted forecast, and increasing caseload is estimated to pressure the out-year per capita trend downwards.
Breast & Cervical Cancer Program	-3.88% See page EF-6.	-3.88%	See the section in this Budget Narrative titled "Breast and Cervical Cancer Program Per Capita Detail and Fund Splits" for a description of this trend factor.
Eligible Children (AFDC-C/ BCKC-C)	-1.05% Half the percent increase in FY 2001-02	-1.05% Half the percent increase in FY 2001-02	The rapid caseload growth has dampened the effect of the various budget reduction initiatives when looking at total expenditure. Year-to-date expenditure suggests the forecast needs to be adjusted upwards from the previous estimate. This population, in particular, may have an inelastic return to rate reductions due to Department efforts related to, for example, medical home.
Foster Care	6.62% Average of FY 2005-06 through FY 2008-09	3.31% Half of estimated FY 2009-10 growth rate	The FY 2009-10 trend reflects that in recent years, overall, this aid category has seen steady per capita growth while year-to-year per capita changes have been moderately volatile. The out-year takes a conservative view of this volatility, moving away from the stronger 2009-10 trend. These are the same trend selections as the previous estimate, and year-to-date expenditure is tracking in line with that estimate.

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

Aid Category	FY 2009-10 Trend Selection	FY 2010-11 Trend Selection	Justification
Baby Care Program - Adults (BCKC-A)	3.74% Average of FY 2004-05 through FY 2008-09	3.74% Average of FY 2004-05 through FY 2008-09	The FY 2009-10 trend reflects that historical trends are limited in their predictive power for the future, as policy changes regarding presumptive eligibility have made the per capita unstable. These policy changes have now had time to find equilibrium, and the Department has selected a conservative long-term trend factor typical of Medicaid programs when caseload populations are stable. Year-to-date expenditure is tracking with previous forecasts, so those trend selections remain constant from the previous forecast. For the out-year, that trend is carried forward.
Non-Citizens	14.60% Average of FY 2005-06 through FY 2008-09	7.30% Half of estimated FY 2009-10 growth rate	Year-to-date expenditure is greater than previously anticipated. This population has seen significant per capita increases before and therefore it seems possible the increased per capita will continue through the fiscal year; for the out-year, the Department has selected a conservative long-term trend factor anticipating per capitas will decrease as the population stabilizes.
Partial Dual Eligibles	-7.10% Percent increase in FY 2004-05	4.35% Average of FY 2004-05 through FY 2008-09	Year-to-date expenditure is significantly less than previously forecasted. However, last fiscal year saw a 165% increase in expenditure from the first half to the second half of the year. That trend was selected with allows for that growth potential. The out-year anticipates continued long-term growth.

Legislative Impacts and Bottom-line Adjustments

To account for programmatic changes which are not incorporated in the prior per capita or trend factors, the Department adds total-dollar bottom-line impacts to the projected expenditure. For complete information on legislative impacts, see section V, Additional Calculation Considerations:

- HB 08-1409 reduced the Department's appropriation for the estimated savings associated with enhanced requirements of third party insurers to accept the state's right of recovery of Medicaid payments.

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

- SB 08-090 reduced the Department's appropriation for the estimated savings associated with clients' increased access to mail-order pharmacies.
- BRI-1, Pharmacy Efficiencies, reduces expenditure as a result of implementing an automated prior authorization system in February 2010 and changing the reimbursement rates of drugs using a state maximum allowable cost structure in December 2009. Automating prior authorizations increases efficiency in managing current prior authorizations while decreasing the administrative burden on providers. The automated process makes it easier for providers to submit requests, in turn making it easier and faster for clients to obtain drugs with prior authorization restrictions.
- BRI-2, Medicaid Program Efficiencies: Fluoride Varnish, allows trained medical and dental professional to administer fluoride varnish treatments to children up to age 6, beginning in July 2009. Studies demonstrate that fluoride varnish is the safest and most effective form of topical fluoride for young children and helps reduce the need for more expensive dental care in the future.
- S-8, Physician Supplemental Payment to Denver Health, provided the Department with spending authority to draw a federal financial match on uncompensated certified expenditures by Denver Health Medical Center on physician and other non-physician practitioner professional services. Every year Denver Health Medical Center incurs uncompensated costs related to directly employing or contracting for physicians and non-physician practitioners who provide services to patients in inpatient and outpatient hospital settings. The costs for these physicians and practitioners are not included in inpatient or outpatient hospital costs.
- BA-24, Adjust Outpatient Hospital Cost to Charge Ratio, annualizes the Department's received authority to update its "cost-to-charge" ratios for outpatient hospitals, implemented in January 2009. Outpatient hospitals are paid at percentage of costs; however, actual costs are not known for several years, until the hospital is audited. To ensure that hospitals receive accurate and timely payments, claims paid are adjusted using a cost-to-charge ratio that adjusts billed charges to approximate costs using historical data. BA-24 adjusts and updates these cost-to-charge ratios to ensure that the Department is not overpaying hospitals only to recoup those funds several years later. In most cases, the updated cost-to-charge ratio for each hospital is lower than that which was currently in place. By resetting the ratio, the Department reduces its current year expenditure, but decreases the amount of recoupments it makes when final costs are audited, typically between 3 and 5 years after the fiscal year ends.
- BA-33, Promote Use of VA for Veterans, increases efforts to coordinate with the Department of Veterans Affairs (VA) to enroll eligible veterans in the VA health care system beginning in July 2009.
- BA-33, Prior Authorization of Anti-convulsant Drugs, adds anti-convulsant pharmaceuticals to prior authorization requirements and/or the preferred drug list for non-seizure uses of anti-convulsants in coordination with the BRI-1, Pharmacy Efficiencies (see above).
- BA-33, Correct Home Health Billing for Dual Eligibles, requires the Department, through more targeted enforcement beginning in July 2009, to avoid costs by ensuring providers have appropriately billed Medicaid for dual eligible clients only after receiving a Medicare denial for home health claims.

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

- BA-33, Restrict Inpatient Hospital Claims for Readmission with in 24 Hours, requires the Department, beginning in July 2009, to have its claims system to automatically deny a separate bill for clients readmitted to the same hospital for the same condition less than 24 hours after the initial discharge. Until system changes are complete, the Department, through its existing utilization review contracts, manually denies these claims. Exceptions are granted on an as-needed basis.
- BA-33, Reduce Selected Physician Codes to 100% of Medicare, annualizes the reduction of physician reimbursement for selected codes.
- BA-33, Rate Reductions, requires the Department to solicit ideas from provider groups on how to reduce unnecessary volume and create efficiencies in order to generate a 2.0% reduction in provider expenditure (excluding pharmacy) in FY 2009-10, effective July 1, 2009. The Department is required to reduce pharmacy expenditure by reducing pharmacy reimbursements to the average wholesale price (AWP) minus 14.0% for brand-name drugs, and AWP minus 40% for generic medications. The Department has taken steps to generate the 2.0% reduction for provider expenditures; those steps are described in Section V of this narrative.
- BA-37, HIBI Increase, is estimated to increase enrollment in the Department's Health Insurance Buy-In (HIBI) program by 100 clients. The Health Insurance Buy-In Program (HIBI) is a service in which the Department pays the health insurance premiums, deductibles, coinsurance, and/or co-pays for those Medicaid clients who have access to private health insurance or COBRA, when it is found to be cost effective for the State to do so. The estimated savings of this initiative is included in this section; the administrative cost is included in the HIBI section of this request.
- SB 09-259, Refinance Pediatric Specialty Hospital, shifting funding from Medical Services Premiums to the Pediatric Specialty Hospital line item, which exists to fund the Children's Hospital to offset the cost of providing care to large numbers of Medicaid and indigent care clients.
- ES-2, Provider Rate Reductions, included a permanent 1.5% reduction, effective September 1, 2009, in the reimbursement rate paid for most Acute Care services for FY 2009-10. The effective date for managed care provider payments is October 1, 2009, to allow time to actuarially certify rates.
- ES-2, FQHC Payment Methodology, requires the Department to reduce rates paid to federally qualified health centers (FQHC) by 50% of the difference between each provider's current rate and the minimum rate required under the Benefits Improvement and Protection Act of 2000 (BIPA), or an average of approximately 106% of the BIPA rate, beginning September 2009. Currently, the Department pays FQHCs above the minimum rate required under federal law, set in the BIPA. The Department estimates that the statewide average reimbursement for FQHCs was approximately 113% of BIPA at the beginning of FY 2009-10.
- ES-2, Prenatal State Only Benefits, grants full eligibility to clients enrolled in its prenatal state-only program who meet all eligibility criteria except citizenship status beginning July 2009; this allows the Department to receive federal financial participation for these clients without enrolling any new populations.
- ES-2, Pharmacy Reimbursements, directs the Department to reduce rates paid to pharmacies to average wholesale price (AWP) minus 14.5% for brand-name medications and AWP minus 45% for generic medication, beginning September 2009.

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

- ES-2, Expand PDL, the Department is expanding its preferred drug list (PDL) by subjecting approximately \$40,000,000 of gross pharmacy expenditure to new or additional restrictions under its PDL beginning March 2010, allowing the Department to receive an additional supplemental rebates back from manufacturers.
- ES-6, Provider Rate Reductions, included a permanent 1.0% reduction in the reimbursement rate paid to providers for Acute Care Services for the remainder of FY 2009-10, effective December 1, 2009.
- The Average Wholesale Pricing Reduction line accounts for a reduction in the average wholesale price (AWP) of certain drugs due to a lawsuit involving First DataBank, which provider the Department with AWP information used in the pricing of Medicaid pharmacy claims. See section V for more detail.
- The Reduction to Synagis Recommended Dosage line accounts for the impact of the change in recommended dosage protocol for administering Synagis by the American Academy of Pediatrics. Previously, recipients were to receive a six dose course of treatment; the new protocol recommends 3 to 4 doses per client.
- The Estimated Impact of PACE Enrollment line accounts for the Department's initiative to increase enrollment of new PACE providers. The Department anticipates that this increased enrollment will cause a shift in expenditure from the Acute Care and Community Based Long Term Care service groups to the PACE service category. The Department's calculations are contained in Section V of this part of the narrative.
- The Colorado Access contract for the Colorado Regional Integrated Care Collaborative (CRICC) was altered from a risk-based, capitated program to an Administrative Services Organization (ASO), generating a one-time cash-flow reduction as the Department ceased paying risk-based capitations.
- Remove Manual Pricing of Durable Medical Equipment (DME), Injectibles, and Medical Services sets reimbursement rates to a percentage of Medicare while ensuring that for goods and services where no Medicare rate information exists rates are set using the Department's average paid, other states' Medicaid average paid, or the commercial average paid rate.
- Benefits Limits on Echocardiograms limits the number of echocardiograms available without prior authorization as defined through the Department's community engaged Benefits Collaborative process.
- Hospital Cost Settlements identifies those recoupments from hospitals above the normal reconciliations made via the Department's cost-to-charge payment methodology. Hospitals are immediately paid after services based on the hospital's cost-to-charge ratio and later financial audits reclaim any expenditure that resulted in payments made above the actual cost of services rendered. The Department has dedicated resources addressing this reconciliation process that have allowed for multiple years to be reconciled above the standard practice.
- NEMT Supplemental Payments allows for additional funds to be expended on its fixed price contract to provide Non-Emergency Transportation Services in the 8 metro counties. The contractor had recently informed the Department that it would need to cease to provide services, as the fixed price contract did not accommodate the unprecedented caseload growth facing the Department and the provider. Through contract negotiations, the Department was able to adjust the fixed price on the contract in order to ensure vital services continued.

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

- SB 09-265 requires the Department to delay the last weekly provider payment cycle in FY 2009-10 to after July 1, 2010. This is a one-time shift which will be reversed with a corresponding increase in expenditure in FY 2010-11.
- SB 09-265 also requires the Department to begin paying its managed care payments in the month following service deliver, rather than during the month in which services are delivered, as is current practice. This action creates a permanent savings in the final month of the fiscal year, as those payments that were normally to be made in June 2010 will now be paid in July 2011, or the start of the next fiscal year.

Special bills which have caseload impacts are included as part of the Department's caseload projections, and no bottom-line expenditure adjustment is made. A bottom-line expenditure adjustment would double-count the impact of such a bill.

Breast and Cervical Cancer Program Per Capita Detail and Fund Splits (Page EF-6)

In 2001, the General Assembly passed SB 01S2-012, which established a breast and cervical cancer treatment program in the Department. In 2005, the General Assembly passed HB 05-1262, which provided additional funding to the Department of Public Health and Environment to increase the number of cancer screenings. HB 05-1262 also provided additional funding to the Department to pay for increased caseload as a result of increased screenings. The Department cannot identify which clients in the Breast and Cervical Cancer Treatment Program come into the program solely because of the increased screenings. In the Department's February 15, 2006 Budget Request, the Department stated that the Department of Public Health and Environment is funding approximately 30% of all screening with Amendment 35 monies. The Department suggested that the same allocation could be used for the treatment program. During Figure Setting, the Joint Budget Committee approved the Department's allocation plan (Figure Setting, March 13, 2006, page 104). Therefore, 30% of the total Breast and Cervical Cancer Treatment patients are allocated as Prevention, Early Detection and Treatment Fund patients and the other 70% of the total Breast and Cervical Cancer Treatment patients are considered "traditional" clients.

Per Capita Cost

In the Department's November 1, 2006 Budget Request, the Department observed that the expenditure and per capita costs in FY 2005-06 grew at an unexpected rate. The Department has investigated the issues involved, and determined that the total expenditure in FY 2005-06 contained a large amount of retroactive transactions, which caused the expenditure for FY 2005-06 to appear overstated. The residual effects of this experience continue, as the effected caseload is very small and changes to total expenditure, therefore, have a large impact on per capita calculations. Per capita expenditure has grown from year-to-year by as much as 26.55% and has been reduced by as much as -32.73%

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

As such, the Department uses only the most recent expenditure history to forecast the per capita for this program. The Department has used monthly program costs from October 2008 through December 2009 to estimate the per capita costs for eligible clients. All monthly costs are as reported in the Department's monthly report to the Joint Budget Committee on the Health Care Policy and Financing Medical Services Premiums Expenditures and Medicaid Caseload. The Department used the monthly caseload for the program (presented in Exhibit B) to calculate a monthly per capita, and calculated a trend factor by using the average percent change between the rolling 3-month averages. Because this factor is the average increase for each 3-month period, the Department adjusted the factor to obtain a full-year trend factor. The Department holds the per capita constant in the out-year; new caseload, which typically has higher costs within this eligibility category, should balance out any declines from longer-term caseload with lower treatment costs. These trend factors are applied to the base per capita on page EF-4.

Fund Splits

The second half of this exhibit calculates the portion of Breast and Cervical Cancer Program expenditure that will be allocated to the Prevention, Early Detection, and Treatment Fund, and the amount allocated to the Breast and Cervical Cancer Prevention and Treatment Program Fund.

Per 25.5-5-308 (9) (d) and (e), C.R.S. (2009), enacted in HB 08-1373, state funding for "traditional" Medicaid Breast and Cervical Program clients comes, in part, from the Breast and Cervical Cancer Prevention and Treatment Fund. According to the original legislation, beginning in FY 2009-10 and into the future, state funding would be split: 50% from General Fund and 50% from the Breast and Cervical Cancer Prevention and Treatment Fund.

SB 09-262 revised the statute, requiring that in FY 2009-10 and FY 2010-11, 100% of state funding for these clients comes from the Breast and Cervical Cancer Prevention and Treatment Fund. Per 24-22-117 (2) (d) (II), C.R.S. (2009), state funding for clients who have gained eligibility due to the Health Care Expansion Breast and Cervical Cancer Program comes from the Prevention, Early Detection, and Treatment Fund. Using the allocation methodology described above, 70% of clients are funded through the Breast and Cervical Cancer Prevention and Treatment Fund, while the remaining 30% of clients are funded through the Prevention, Early Detection, and Treatment Fund.

All Breast and Cervical Cancer Program expenditures have a 65% federal match rate.

Antipsychotic Drugs (Page EF-7)

Antipsychotic drugs were moved from the Department's premiums line to the Department of Human Services for FY 2001-02. For FY 2003-04, the General Assembly removed antipsychotic drugs from the Department of Human Services' portion of the budget and

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

located those costs within the Medical Services Premiums line item of the Department. These expenditures are now included in the Acute Care service group, within the Pharmaceutical Drug service category. Exhibit F, page EF-7 through EF-8, shows annual costs by aid category and per capita cost in two versions: with and without the estimated impact of drug rebate. The rebate calculation excludes supplemental rebates, as antipsychotic drugs are not including on the Department's preferred drug list. The Department has eliminated the projection of expenditure in this area due to the elimination of the informational only line-item in Long Bill group (3), effective with HB 08-1375.

State-Only Prenatal Care Costs for Non-Citizens (Page EF-9)

Pursuant to 25.5-5-103 (3), C.R.S. (2009), Colorado opted to provide prenatal care at its sole expense for certain non-citizens (legal immigrants not eligible for full Medicaid). SB 03-176 eliminated this service for legal immigrants, however due to legal challenges, there was no interruption in services. HB 05-1086 officially reinstated the services. The Department receives a 50% federal match for any emergency services provided for these clients, in particular, labor and delivery. Effective with the November 1, 2006 Budget Request, the Department has revised its reporting of expenditure. In Budget Requests prior to FY 2006-07, the Department's exhibit incorrectly listed the state-only portion of expenditure as the total amount spent on the program.

Upon federal approval in FY 2009-10, as per the Department's request ES-2, these clients began to receive full Medicaid benefits and therefore will receive a federal match on all Medicaid provided services. The total expenditure estimate remains part of the Department's request; however, the General Fund and federal fund estimates are presented for comparison purposes, only. The fund splits in Exhibit A of this request uses the estimated total expenditure from this exhibit on page EF-9, but accounts for receiving federal funds for all the expenditure. In the event that federal approval is not received, the Department's calculations on Exhibit A would be replaced by the ones on this exhibit.

Prior to FY 2009-10, expenditure for clients in the state-only prenatal care program was included in the Non-Citizens aid category. Upon receipt of federal approval, expenditure will be recorded in the Baby Care Adults column.

An analysis of monthly expenditure reveals that total expenditure for this population has relatively stable in recent months. The selected trend factor is the one month rolling average from the last three months of FY 2008-09, and results in a conservative estimate of changes in expenditure when compared to annual expenditure change in the last two fiscal years, based on the average percent change in expenditure over the most recent 6 months. The estimated state-only and federally matched portions are based on the FY 2008-09 experience but are not used, as described above, in Exhibit A.

Family Planning - Calculation of Enhanced Federal Match (Page EF-10)

Certain services that are family planning in nature are eligible for 90% federal financial participation. However, in order to claim the enhanced match, the State must be able to uniquely identify these services. The services are provided both through fee-for-service, and beginning in late FY 2001-02 the Department was able to identify those family planning services provided by health maintenance organizations. Therefore, the State receives the enhanced match on all family planning services provided to Medicaid clients. A portion of the payments, \$2,311,115, were disallowed due to family planning activities that did not qualify for enhanced federal financial participation, resulting in a repayment of federal funds to the federal government in FY 2004-05. Totals listed on page EF-10 are taken directly from the Department's requests from the Centers for Medicare and Medicaid Services for enhanced federal funds.

As of FY 2005-06, The Department no longer has any contingency-fee based contracts to calculate the managed care portion of the enhanced family planning match rate. This calculation is now done by the Department. Additionally, historically, calculations for fee-for-service and health maintenance organizations were done independently. However, due to changes in the Department's managed care program, the totals were combined beginning in FY 2008-09, and a single combined estimate is now produced.

The total estimate for FY 2009-10 and the out-year is based on the average yearly percentage change from FY 2005-06 to FY 2006-07, 2.00%. More recent family planning expenditure has increased as a result of the Departments considered effort to educate providers as to what services are billable as family planning services. Research by the Department had indicated that only a fraction of allowable services were being appropriately billed. The Department believes that the recent double-digit percentage increases in family planning expenditure are due to this education effort, and anticipates growth to now return to historical levels.

Year-to-Date Expenditure (Page EF-11)

As an additional reasonableness check, this section uses fiscal year-to-date actuals through December 31, 2009 to estimate a FY 2009-10 per capita. To avoid double counting, year-to-date expenditure is reduced by the estimated amount of bottom-line impacts that have affected the year-to-date expenditure total. Year-to-date average caseload for this exhibit has been taken from Exhibit B of this request. The calculated per capita is a rough estimate; the half-year per capita is calculated and doubled. Expenditure for the full year is estimated by taking the final projected caseload from Exhibit B and multiplying by the estimated full year per capita. The per capita figure calculated in this exhibit is compared to the FY 2008-09 per capita, to provide an estimate of how eligibility categories are trending over the course of the year.

The Department urges extreme caution when using the per capita costs calculated in this exhibit. This is a rough projection utilizing year-to-date expenditure patterns as a guide to predict future expenditures. The impact of one-time expenses, or considerations of

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

seasonality are not included. It is not meant to replace the extensive forecasting used in the official Budget Request and is not always a predictor of future expenditures.

EXHIBIT G - COMMUNITY BASED LONG TERM CARE

The increased emphasis on utilizing community based services has served to keep the census in Class I nursing facilities relatively flat. In FY 1981-82, with the implementation of the first wave of Home and Community Based Service (HCBS) waivers, Class I nursing facility census was over 12,500 clients. Almost immediately, the census dropped to just over 10,000 clients. The census has generally remained in this range despite a 15% increase in Medicaid caseload for Adults 65 and Older since FY 1997-98. In response to budget balancing in FY 2002-03, rules were passed by the Medical Services Board to improve utilization management, which resulted in a reduction of per capita spending. Among these changes, the Department clarified the requirements necessary to meet the level of care required to qualify for nursing facility care or Home and Community Based Services. In addition, a requirement was added that in order to be eligible for long term home health, a client 18 years and over had to meet the need for that level of care. Although home health costs are in the Acute Care portion of the Premiums calculation, long term home health costs do correlate to community based long term care costs. High cost clients in the community were reviewed by Single Entry Points and transitioned to less expensive alternatives if their care plans and services did not assure that all services being provided were required. The assessment, which was a functional assessment to determine whether a client meets the long term care level of care, was redone with the help of providers, Single Entry Points, and clients. Responsibilities were shifted to ensure that Single Entry Points are the primary entities through which clients access long term care. Additionally, responsibilities required Single Entry Points to have tools and the authority to act as gatekeepers for long term care benefits. Federal requirements were more completely enforced, ensuring that clients regularly receive Home and Community Based Services waiver services in order to retain eligibility for the waiver.

HB 05-1243 extends the option of receiving home and community-based services (HCBS) through the Consumer-Directed care service model to all Medicaid recipients who are enrolled in a home and community-based services waiver for which the Department has federal waiver authority. The bill specifies that an eligible person shall not be required to disenroll from the person's current home and community-based services waiver in order to receive services through the Consumer-Directed care service model. Additionally, the bill specifies that certain professional licensing requirements do not apply to a person who is directly employed by an individual participating in the Consumer-Directed care service model and who is acting within the scope and course of such employment. The restrictions that apply to this professional licensure exclusion and the circumstances under which the exclusion does not apply are noted in the bill. A consumer of attendant support is allowed to have an authorized representative who has the judgment and ability to assist the consumer in acquiring and using services under the program.

In 2005, the Centers for Medicare and Medicaid Services completely revised the home and community-based services waiver application forms, requiring additional components that needed to be researched and addressed by the Department prior to submission.

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

This caused a substantial extension to the timeframe required for the implementation of this bill. Approval by the Centers for Medicare and Medicaid Services for the implementation of Consumer Directed Care for the Elderly, Blind, and Disabled waiver and the Mental Illness waiver was granted in mid-2007. Services became available to clients in January 2008. The Department has incorporated the estimated costs and savings of this program in the base trends for Community-Based Long Term Care.

Calculation of Community Based Long Term Care Expenditure (Pages EG-1 through EG-3)

The per capita percent change for several different years is computed for each eligibility category on a per capita cost basis. The period of time that was selected for computing the trend or annual rate of change was FY 2001-02 through FY 2008-09. Prior year information is provided for historical reference. This period was selected for two reasons: first, it is a recent period and second, because Medicaid benefits over this period have remained mostly the same. At the top of page EG-2, the Department has provided a list of historic trends. Included are 2-year, 3-year, 4-year, and 5-year trends, ending in FY 2006-07, FY 2007-08, and FY 2008-09.

Percentages selected to modify per capita costs are calculated to assess the percentages in light of any policy changes or one-time costs that may skew just one trend year. At the same time, per capita trend factors must not take into account changes in caseload, or changes that have been accounted for as bottom-line adjustments. Because the eligibility categories differ in eligibility requirements, demographics, and utilization, different trends are used for each eligibility category.

The table below describes the trend selections for FY 2009-10 and FY 2010-11. On Exhibit G, the selected trend factors have been bolded for clarification.

The selected per capita trend factors for FY 2009-10 and FY 2010-11, with the rationale for selection, are as follows:

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

Aid Category	FY 2009-10 Trend Selection	FY 2010-11 Trend Selection	Justification
Adults 65 and Older (OAP-A)	7.07% Average of FY 2007-08 through FY 2008-09	3.54% Half of FY 2009-10 Trend Selection	The FY 2009-10 trend is based on the current expenditure and prior-year cash flow. The primary driver in this eligibility category is expenditure for Elderly, Blind and Disabled waiver clients with over 70% of expenditure; this growth rate of expenditure for these waiver services has dampened in FY 2008-09. Hospice services account for nearly a quarter of expenditure for this aid category, and expenditure growth stabilized from the first half to second half of FY 2008-09. The Department anticipates relatively stable expenditures overall through the end of the fiscal year, moderating in the next fiscal year. The FY 2010-11 trend factor is half of the FY 2009-10 selection.
Disabled Adults 60 to 64 (OAP-B)	11.92% Average of FY 2007-08 through FY 2008-09	5.96% Half of FY 2009-10 Trend Selection	Expenditure growth in this category in the first half of FY 2009-10 was primarily driven by growth in hospice expenditure, primarily due to federally mandated increases and retroactive adjustments. The selected trend factors in FY 2009-10 and FY 2010-11 account for the expenditure increase and one-time nature of the retroactive adjustments.

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

Aid Category	FY 2009-10 Trend Selection	FY 2010-11 Trend Selection	Justification
<p>Disabled Individuals to 59 (AND/AB)</p>	<p>8.93% Average of FY 2003-04 through FY 2006-07</p>	<p>4.47% Half of FY 2009-10 Trend Selection</p>	<p>The FY 2009-10 trend is based on the current expenditure, prior-year cash flow and historical growth rates. Expenditure for Elderly, Blind and Disabled waiver clients is over half of the expenditure for this aid category; the growth rate for expenditure for these waiver services dampened in FY 2008-09, but expenditure growth for disabled clients is still higher than for the Adults 65 and Older Category. Two other significant drivers of expenditure are the Mental Illness waiver client and Private Duty Nursing service categories; growth in FY 2008-09 was relatively stable for the Mental Illness clients and decreased for clients who received Private Duty Nursing services. The Department anticipates some overall moderating of recent trends. The FY 2009-10 trend is a long-term historical average which allows for growth, yet which dampens the recent trends. The Department halves the trend factor in FY 2010-11.</p>
<p>Categorically Eligible Low-Income Adults (AFDC-A)</p>	<p>10.00%</p>	<p>5.00% Half of FY 2009-10 Trend Selection</p>	<p>Clients in this eligibility category are not generally eligible for community based long term care benefits except hospice care, although there tends to be some expenditure in waiver services. This is due to clients incurring costs before their aid category changes to AND/AB. Because of the uncertain nature of expenditure in this aid category, per capita trends are unreliable. The FY 2009-10 trend factor is based on the year-to-date actuals, and the FY 2010-11 trend at half of the FY 2009-10 rate allows for a relatively slower rate of movement out of this aid category as the expenditure level decreases.</p>

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

Aid Category	FY 2009-10 Trend Selection	FY 2010-11 Trend Selection	Justification
Expansion Adults	10.00%	5.00% Half of FY 2009-10 Trend Selection	Similar to the low-income adults category, clients in this eligibility category are not generally eligible for community based long term care benefits except hospice care, although there tends to a relatively small level of expenditure in waiver services. This is due to clients incurring costs before their aid category changes to AND/AB. Because of the uncertain nature of expenditure in this aid category, per capita trends are unreliable. The FY 2009-10 trend factor is based on the year-to-date actuals, and the FY 2010-11 trend at half of the FY 2009-10 rate allows for a relatively slower rate of movement out of this aid category as the expenditure level decreases
Breast & Cervical Cancer Program	0.00%	0.00%	Clients in this eligibility category are not eligible for community based long term care benefits.
Eligible Children (AFDC-C/ BCKC-C)	11.71% Average of FY 2006-07 through FY 2008-09	5.86% Average of FY 2006-07 through FY 2008-09	The FY 2009-10 trend is based on the current expenditure, prior-year cash flow and historical growth rates. Eligible Children only receive private duty nursing and hospice care. Because a very small number of clients receive services, per capita trends are skewed by changes in caseload, and are unreliable. Most of the expenditure is driven by private duty nursing services. The FY 2009-10 selected trend is a two-year average growth rate which reflect prior periods of increasing costs. The Department halves the trend selection constant in FY 2010-11 based on historical experience.

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

Aid Category	FY 2009-10 Trend Selection	FY 2010-11 Trend Selection	Justification
Foster Care	15.00%	7.50% Half of FY 2009-10 Trend Selection	The FY 2009-10 trend is based on the current expenditure, prior-year cash flow and historical growth rates. Expenditure for Foster Care children is limited to private duty nursing services, which has dampened in FY 2008-09. The FY 2010-11 selected growth rate is consistent with historical trends which allows for growth yet which moderates the most recent trends.
Baby Care Program - Adults (BCKC-A)	-100.00%	0.00%	Clients in this eligibility category are not eligible for community based long term care benefits.
Non-Citizens	0.00%	0.00%	Clients in this eligibility category are not eligible for community based long term care benefits.
Partial Dual Eligibles	10.57% Half of Average of FY 2007-08 through FY 2008-09	5.28% Half of FY 2009-10 Trend Selection	Clients in this eligibility category are not eligible for community based long term care benefits. In some cases, however, clients who are eligible for these services are incorrectly being assigned to this aid category. This began in January 2007, and appears to be abating. Clients receiving these services are generally eligible for OAP-A. Based on expenditure to date, the Department anticipates a relatively slower increase of expenditure in this aid category in FY 2009-10 as compared to FY 2008-09, slowing further in FY 2010-11.

Legislative Impacts and Bottom-Line Adjustments

To account for programmatic changes which are not incorporated in the prior per capita or trend factors, the Department adds total-dollar bottom-line impacts to the projected expenditure. For complete information on legislative impacts, see section V, Additional Calculation Considerations. The following impacts have been included in the Request for Community Based Long Term Care:

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

- BA-15 Community Transitions Services for Mental Illness Waiver Clients, originally included a reduction of FY 2009-10 expenditure, and an annualized reduction in FY 2010-11 expenditure, due to clients utilizing the relatively less costly waiver services rather than residing in a facility. Due to program delays, the implementation of this initiative is expected to occur in FY 2010-11.
- BA-33 Provider Volume and Rate Reductions, included a reduction of FY 2009-10 expenditure due to a permanent 2% rate reduction in Community Based Long Term Care services, effective July 1, 2009. In addition, the proposal estimates the FY 2009-10 implementation of a reduction in expenditure by increasing efforts to coordinate with the Department of Veterans Affairs (VA) to enroll eligible veterans in the VA health care system. The request also originally estimated an additional reduction by implementing cost-sharing requirements for Home and Community Based Services programs for clients/families with incomes over \$250,000, however the Department is not implementing this initiative.
- ES-2, Medicaid Program Reductions, included a permanent 1.5% reduction in the reimbursement rate paid for Community Based Long Term Care for FY 2009-10, effective September 1, 2009.
- ES-2, Medicaid Program Reductions, included, a cap on the amount of non-medical transportation a client enrolled in a home and community based services waiver program can receive per week. Clients would be limited to 2 roundtrips per week. Trips to adult day programs will not be subject to the cap included limitations on the HCBS waiver transportation benefit.
- ES-2, Medicaid Program Reductions, included a cap on the amount of personal care and homemaker services a client enrolled in a home and community based services waiver program can receive each day. The Department would limit personal care expenditure to \$72.05 per day, which is 150% of the daily rate for a client living in an alternative care facility. The Department is currently seeking alternative options to achieve the cost savings from this initiative.
- Impact of Retroactive Increase of HB 08-1114 on FY 2008-09 Hospice Rates: Since hospice rates are a function of the reimbursement rate for Class I Nursing Facilities, the reimbursement methodology changes directed by HB 08-1114 have a fiscal impact on hospice expenditure. This impact was not anticipated and is included as a retroactive adjustment in FY 2009-10, annualized as a corresponding reduction in FY 2010-11.
- ES-6, Provider Rate Reductions, included a permanent 1.0% reduction in the reimbursement rate paid for Community Based Long Term Care for FY 2009-10, effective December 1, 2009.
- Estimated Impact of PACE Enrollment: The Department has reduced its projection under the assumption that increased enrollment in new PACE providers will cause a shift in expenditure from the CBLTC group to the PACE service category. The Department's calculations are contained in Section V of this part of the narrative.
- SB 09-265 required the Department to delay the last weekly provider payment cycle in FY 2009-10 to after July 1, 2010. This is a one-time shift which will reduce the total funds expended for CBLTC services in FY 2009-10 and which will be reversed with a corresponding increase in expenditure in FY 2010-11.

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

Prior Year Expenditure (Page EG-4)

As an additional reasonableness check, the Department has split FY 2008-09 actual expenditure into two half-year increments to analyze the changing rates of expenditure over time.

EXHIBIT H - LONG TERM CARE AND INSURANCE SERVICES

This section is for a series of services that, for a variety of reasons, are individually computed and then allocated to the eligibility categories based on experience. Those services are:

- Class I Nursing Facilities
- Class II Nursing Facilities
- Program of All-Inclusive Care for the Elderly (PACE)
- Supplemental Medicare Insurance Benefits
- Health Insurance Buy-In

Summary of Long Term Care and Insurance Request (Page EH-1)

This exhibit summarizes the total requests from the worksheets within Exhibit H.

Class I Nursing Facilities (Pages EH-2 and EH-3)

Class I nursing facility costs are essentially a function of the application and interpretation of rate reimbursement methodology specified in detail in State statutes, the utilization of the services by Medicaid clients, and the impact of the effect of cost offsets such as estate and income trust recoveries. The traditional strategy for estimating the cost of these services is to predict 1) the costs driven by the estimated Medicaid reimbursement methodology (the weighted average per diem allowable Medicaid rate and the estimated average patient payment), 2) the estimated utilization by clients (patient days without hospital backup and out of state placement), and 3) the estimated cost offsets from refunds and recoveries and the expected adjustments due to legislative impacts.

Overall, patient days have declined since FY 1999-00, although caseload in the Department's Adults 65 and Older, Disabled Adults 60 to 64, and Disabled Individuals to 59 eligibility categories has increased by approximately 12.8% (through the FY 2008-09 total) since FY 1999-00. This is due to efforts by the Department to place clients in Home and Community Based Services (HCBS), and in the Department's Program for All-Inclusive Care for the Elderly (PACE).

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

Patient payment is primarily a function of client income. As clients receive cost-of-living adjustments in their supplemental security income, their patient payment has increased accordingly.

HB 08-1114 directed the Department to change the existing method of reimbursing Class I Nursing Facilities. In addition, the legislation authorized a new quality assurance fee to be collected by the Department from certain Class I Nursing Facilities, including facilities which do not serve Medicaid clients. The fee can be used for administrative costs related to assessing the fee and to limit growth of General Fund expenditures to 3% annually. The Department received federal approval of both the nursing facility fee and the new rate reimbursement method from the federal Centers for Medicare and Medicaid Services (CMS) on March 26, 2009, effective retroactive to July 1, 2008.

The new reimbursement methodology is further amended by SB 09-263, which specified the method for calculating the General Fund share of payments during the federal American Recovery and Reinvestment Act (ARRA) time period, adjusted the cap on General Fund growth, specified conditions for supplemental payments, created an upper limit on the nursing facility provider fee, replaced the 8% cap on the direct and indirect health care services component of the reimbursement rate, included a hold harmless provision for administration and general services under certain circumstances, and made changes to the method of implementing pay-for-performance payments. The Department received federal approval of the changes to the reimbursement methodology in December 2009, effective retroactive to July 1, 2009.

For complete information regarding specific calculations, the footnotes in pages EH-4 through EH-7 describe calculations of individual components. The methodology for the Class I request in Exhibit H is as follows²:

- Based on calculations provided by Myers and Stauffer, the Department's rate contractor, the estimate starts with the estimated per diem allowable Medicaid rate for core components in claims that will be incurred in FY 2009-10.
- Using historic claims data from the MMIS, the Department calculates the estimated patient payment for claims that will be incurred in FY 2009-10. The difference between the estimated per diem rate for core components and the estimated patient payment, is an estimate of the amount the Department will reimburse nursing facilities per day in FY 2009-10 for core components.
- Using the same data from above, the Department calculates the estimated number of patient days for FY 2009-10.
- The product of the estimated Medicaid reimbursement per day for core components and the estimated number of patient days yields the estimated total reimbursement for core components in claims incurred in FY 2009-10. Similarly, the estimated total reimbursement for add-on payments in FY 2009-10 is the product of the estimated Medicaid reimbursement per day for add-on payments and the estimated number of patient days.

² For clarity, FY 2009-10 is used as an example. The estimate for FY 2010-11 is based on the estimate for FY 2009-10, and follows the same methodology.

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

- Of the estimated total reimbursement for claims incurred in FY 2009-10, only a portion of those claims will be paid in FY 2009-10. The remainder is assumed to be paid in FY 2010-11. The Department estimates that 92.27% of claims incurred in FY 2009-10 will also be paid during FY 2009-10. Footnote 5 of Exhibit H, page EH-4, details the calculation of the percentage of claims that will be incurred and paid in FY 2009-10.
- During FY 2009-10, the Department will also pay for some claims incurred during FY 2008-09 (“prior year claims”). In Footnote 6 of Exhibit H, page EH-4, the Department applies the percentages calculated in Footnote 5 to claims incurred during FY 2008-09 to calculate an estimate of outstanding claims to be paid in FY 2009-10. The estimate is calculated separately for expenditures for core components and add-on payments. Note that, beginning in FY 2010-11, the calculation is only necessary for core components since the “add-on” payments become “Supplemental Payments” which are paid once annually and which are not subject to retroactive adjustments.
- The sum of the current year claims and the prior year claims is the estimated expenditures in FY 2009-10 prior to adjustments (“gross budget estimate”).
- Other non-rate factors are then added or subtracted from the gross budget estimate. These include the hospital backup program and out of state placements, estimated estate and income trust recoveries, recoveries from Department overpayment reviews, and program reductions. Information and calculations regarding these adjustments are contained in the footnotes for the Class I Nursing Facilities request, on pages EH-5 and EH-6.
- Legislative impacts are added as bottom-line adjustments. For FY 2009-10, this includes SB 09-265, which shifts the MMIS payment from the last week in FY 2009-10 into the first week of FY 2010-11.
- Once the “non-rate” factors are estimated, the sum of the gross budget estimate and the non-rate adjustments yields the total estimated FY 2009-10 expenditure.

For FY 2010-11, the same methodology is applied, taking into account the estimate for FY 2009-10.

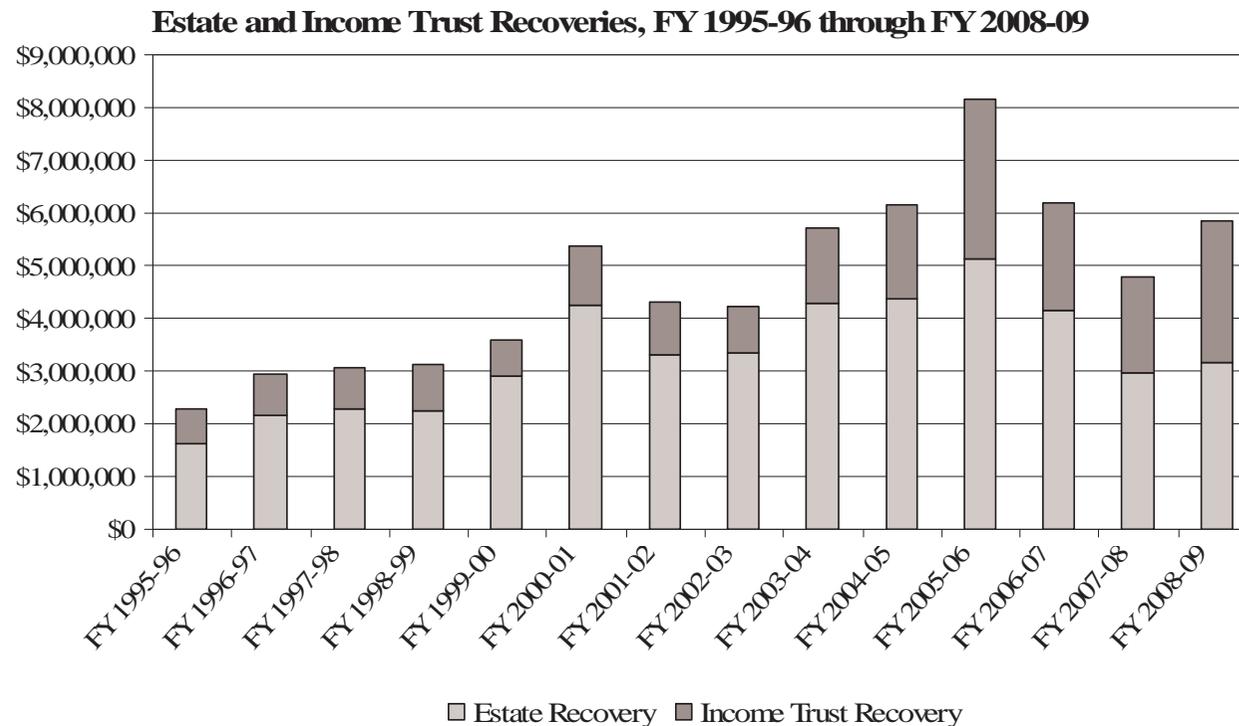
Legislative Impacts and Bottom-Line Adjustments

To account for programmatic changes which are not incorporated in the prior per capita or trend factors, the Department adds total-dollar bottom-line impacts to the projected expenditure. For complete information on legislative impacts, see section V, Additional Calculation Considerations. The following impacts have been included in the FY 2009-10 and FY 2010-11 calculations for Class I Nursing Facilities:

- Expenditures for the Hospital Backup Program are included as bottom line adjustments for FY 2009-10 and FY 2010-11. Please refer to footnote (7) on page EH-6 for more detail.

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

- The Department reduces the request by the expected amount to be received in estate and income trust recoveries in FY 2009-10 and FY 2010-11. The following chart illustrates the history of estate and income trust recoveries from FY 1995-96 through FY 2008-09. As described in footnote (8) on page EH-6, the Department had an unusual number of high dollar recoveries in FY 2005-06. The decline from FY 2005-06 represented a return to a normal level of dollars recovered. The further decline from FY 2006-07 to FY 2007-08 was primarily due to a weak housing market. The level of estate recoveries remained relatively flat from FY 2007-08 to FY 2008-09.



- The Budget Reduction Proposal, BA-36 Enhanced Estate and Income Trust Recoveries, estimated an additional reduction of expenditure due to estate and income trust recoveries in FY 2009-10 which would be the direct result of the enhanced recovery efforts. The Department intended to achieve the savings by amending one of its recovery contracts to explicitly enhance estate and income trust recovery efforts. However, this amendment did not occur, as the entire contract is under renegotiation. Any

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

enhanced recovery efforts are captured in the projected trends for estate and income trust recoveries. In the interim, the Department directed available resources to perform a related post-pay recoveries project. This project captured savings by recouping payments made for clients who have passed away. The Department realized \$1,292,410 in FY 2009-10 savings in Medical Services Premiums, and additional savings in the Medicaid Mental Health Community Programs Long Bill group. Because the recoupment was made by adjusting historical claims and is reflected in the year-to-date actuals, and because the recoupment was not specific to nursing facility claims, the Department makes no further adjustment in this section of the request.

- To meet budget balancing goals, the Department proposed a series of initiatives to reduce Medicaid expenditure through the ES-2: Medicaid Program Reductions budget request. The Executive Order included a 1.5% reduction in the reimbursement rate paid to Class I Nursing Facilities for FY 2009-10. This rate reduction has a delayed implementation date of March 1, 2010, due to the need for a statute change. In the event the statutory requirements are not changed, the Department cannot implement this rate reduction, and the including savings would not be achieved. The Department has included an increase to the supplemental payment as an offset to the rate reduction. It is not known at this time, however, if the nursing facility fee will be raised to backfill the rate cut.
- In addition to the estate and income trust recoveries, the Department receives recovery dollars from in-house audits of nursing facilities, and the estimated amount of recoveries is included as a bottom line impact for FY 2009-10 and FY 2010-11. Footnote (9) on page EH-7 contains additional detail about these recoveries.
- The Department has not implemented the expansion of the Hospital Back Up Program, as directed by BRI-2, Medicaid Program Efficiencies, due to program uncertainty. The Department continues to work with stakeholders to determine an appropriate methodology to implement this initiative.
- SB 09-265 allows the Department to delay the last weekly provider payment cycle in FY 2009-10 to after July 1, 2010. This delay will reduce the total funds expended for Class I Nursing Facilities in FY 2009-10, a one-time shift which will require a corresponding increase in expenditure in FY 2010-11. Footnote (11) on page EH-7 contains additional detail about this shift.

Incurred But Not Reported Adjustments

As part of the estimates for the allowable per diem rate, patient payment, and patient days, the Department utilizes the most recent four years of incurred claims to calculate estimates for the current year and the request year. However, because not all claims which have been incurred have been reported, the Department must adjust the incurred data for the expected incidence of claims which will be paid in the future for prior dates of service. Without such an adjustment, the claims data would appear to drop off at the end of the year, erroneously introducing a negative trend into the estimate.

The Department uses an extensive model which examines past claims by month of service and month of payment to estimate the amount of claims which will be paid in the future. This is known as an “Incurred But Not Reported” (IBNR) adjustment. The IBNR

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

adjustments analyze the prior pattern of expenditure (specifically, the lag between the time past claims were incurred and when they were paid), and applies that pattern to the data. This enables the Department to use its most recent data, where there is a significant volume of claims which have yet to be paid.

Separate IBNR adjustment factors are calculated for each month, based upon the number of months between the time claims in that month were incurred and the last month in the data set. These adjustments are applied to the collected data, and the Department calculates the estimate of nursing facility expenditure using the methodology described above. This adjustment is most apparent in the Department's estimate of claims paid in the current year for current year dates of service, particularly footnotes 5 and 6 of Exhibit H, page EH-4. In these footnotes, the Department uses the calculated monthly IBNR adjustment factors to estimate the percentage of claims in FY 2008-09 which will be paid in FY 2009-10, and the percentage of claims incurred in FY 2009-10 which will be paid in FY 2010-11.

The Department uses the IBNR adjustment calculation from the February 16, 2009 Budget Request, using paid claims data through December 2008. For reference, the following table lists IBNR factors calculated over the previous four Change Requests and compares them with the current IBNR factor. There is a slight increase in the factors over time, suggesting that there is a decreasing lag time between the date of service and the payment of a typical claim.

Date of Change Request:	IBNR Factor:
November 2006	91.54%
February 2007	91.82%
November 2007	91.78%
February 2008	91.94%
November 2008	92.75%
February 2009, November 2009, February 2010	92.27%

Because of erratic changes to the claims payment pattern related to large mass adjustment of claims when the nursing facility provider fee payments were implemented, the Department has held the IBNR factors constant through the February 2010 request. When better information is available, the Department will resume updating the factors biannually.

Patient Payment and Patient Days Forecasts Models

To forecast both patient days and patient payment rates, the Department selected a seasonal, auto-regressive model on time with a linear trend. This model was selected because both sets of data exhibit monthly seasonality and follow a trend over time. In addition, the value in a given month is partially a function of the value in the previous month; this is represented by an auto-regressive term in the forecasting model.

The Department presents two sets of statistical results supporting the selection of this forecasting model. First, the F-statistic from the analysis of variance test of the model represents the overall statistical significance of the model. Second, the stationarity of the model needs to be tested to determine the validity of the forecasts. The Department tested stationarity by performing a Dickey-Fuller unit root test. In this test, the first difference of the values predicted by the forecast model are a function of an auto-regressive term and a linear trend term. The resulting regression coefficient of the lagged term is the calculated d-statistic. This is compared against the Durbin-Watson d-statistic upper and lower bounds. If the absolute value of the calculated statistic is lower than the lower bound value, there is evidence of serial autocorrelation, and the model cannot be assumed stationary. If the absolute value of the calculated statistic is higher than the upper bound value, then there is no evidence of serial autocorrelation, and the model can be assumed stationary. If the value of the calculated statistic lies between the upper and lower bounds, then the evidence is inconclusive.

Testing the Overall Predictive Ability of the Model

The Department presents two sets of statistical results supporting the selection of this forecasting model. First, the F-statistic from the analysis of variance test of the model represents the overall statistical significance of the model. This test indicates how well the components of the model together generate valid forecasts. With a p-value of 0.0000, the model is statistically significant at the 99% confidence level.

Testing the Stationarity of the Model

The second set of statistics test the stationarity of the models. This is important, because if a model is not stationary, it cannot be used to predict values for time periods outside of the period represented by the actual data. The Department tested stationarity by performing a Dickey-Fuller unit root test. Theoretically, this test checks to see if the predictive components defined in the forecasting model are actually generating random predictions even though the overall model is statistically significant. With any model, a portion of the predicted value will be random. So, having a random element in the model is not in itself a problem; stationarity issues result from a model in which the components assumed to be generating defined results are actually generating random results.

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

Technically, the test is performed by creating a model where the first difference (the current month minus the previous month's value) of each value predicted by the forecast model is a function of an auto-regressive term and a linear trend term. The resulting regression coefficient of the auto-regressive term is the calculated "d-statistic." This is compared against the Durbin-Watson d-statistic upper and lower bounds. If the absolute value of the calculated statistic is lower than the lower bound value, there is evidence of serial autocorrelation (a unit root), and the model cannot be assumed stationary. If the absolute value of the calculated statistic is higher than the upper bound value, then there is no evidence of serial autocorrelation, and the model can be assumed stationary. If the value of the calculated statistic lies between the upper and lower bounds, then the evidence is inconclusive.

Ex Post/In-sample Forecasts

As an additional test of the reasonableness and robustness of the forecasts, the Department calculated in-sample forecasts and compared the results to actual data reported for July 2008 through October 2009.

Forecasting Patient Payment Rates

The table below includes the forecasted average annual patient payment rates for FY 2009-10 and FY 2010-11 resulting from the method defined in the previous section. The table also includes a base trend calculated as the expected increase if the patient payment rate was held at the June 2009 level.

The FY 2008-09 patient payment data was adjusted for use in calculating projections; mass adjustments to all claims caused a number of claims which were originally 100% patient paid to have a portion of the payment paid by the Department. Claims for which the Department does not make a Medicaid payment are not included in the calculation of the effective per diem rate. When the mass-adjusted claims which were originally excluded from the calculation became part of the data set, the effective per diem rates were skewed by claims for individuals who would have been responsible for 100% of the claim before the mass adjustment. However, these claims could not be retroactively billed to the client, so the Department paid a small share of the claim; this share was covered by the nursing facility provider fee. In order to obtain an appropriate patient payment per diem rate for FY 2008-09, the Department backed out any claims which were originally 100% patient paid.

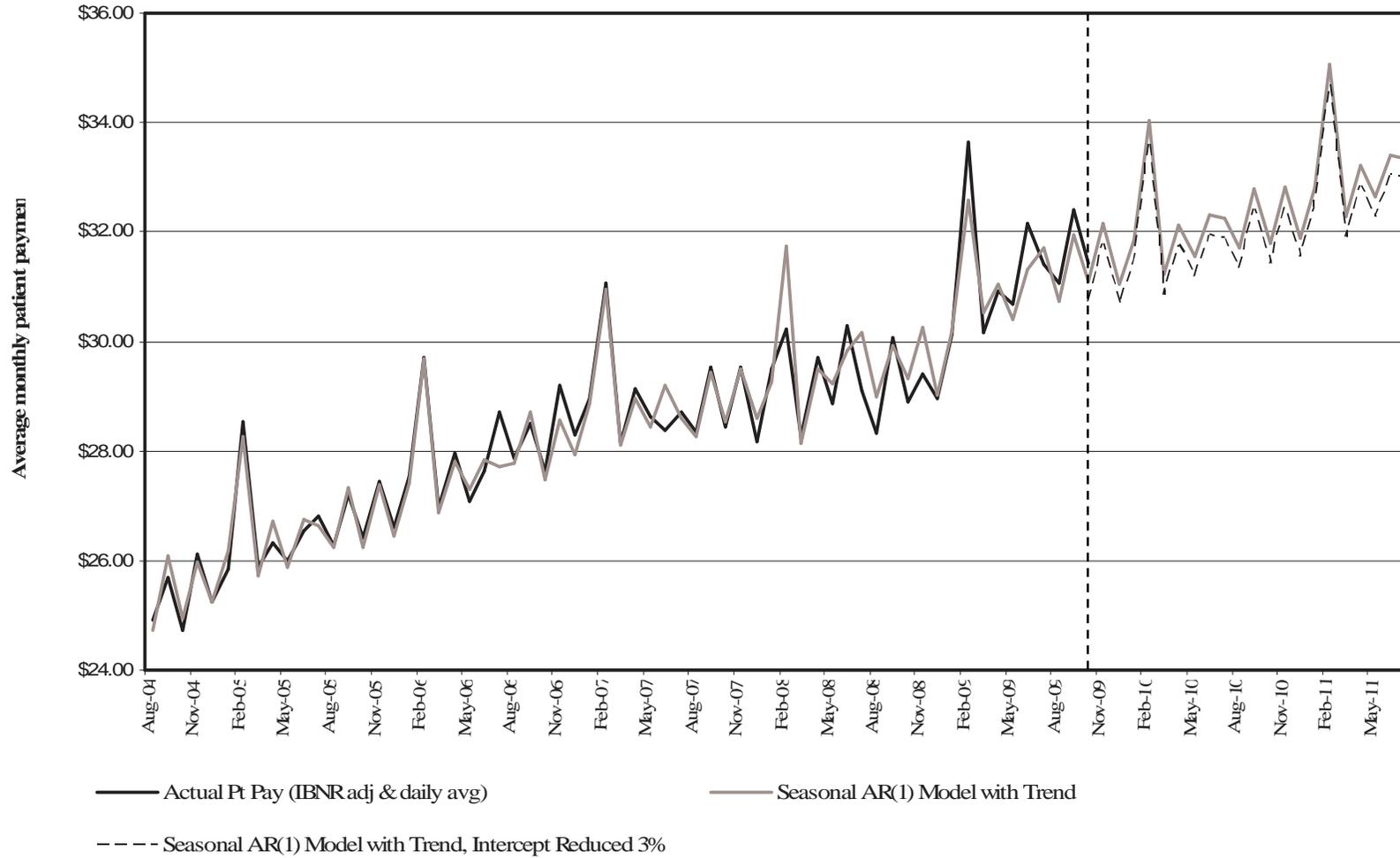
The forecasted 4.44% growth rate from FY 2008-09 to FY 2009-10 is slightly higher than long term growth rates; the average annual growth rate from FY 2005-06 to FY 2008-09 is 3.95%, and from FY 2000-01 to FY 2008-09 3.83%. The Department projects a lower growth rate, 2.76%, for FY 2010-11.

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

	Forecasted Annual Average Patient Payment Rate	Percent change from prior FY
FY 2009-10	\$31.55	4.44%
FY 2010-11	\$32.42	2.76%
Base trend at flat June 2009 level		
FY 2008-09	\$30.21	--
June 2009	\$32.16	6.46%

TESTING THE OVERALL GOODNESS OF FIT OF THE MODEL					
The predicted values are a function of seasonal indicators, one autoregressive AR(1) term, and a linear trend.					
F-statistic:	72.04	p-value:	0.0000	Confidence level:	99%
DICKEY-FULLER TEST OF STATIONARITY OF THE MODEL					
The first difference of the predicted values are a function of one autoregressive AR(1) term and a linear trend.					
Durbin-Watson d-statistic, lower bound:	1.441	Confidence level:	99%		
Durbin-Watson d-statistic, upper bound:	1.541	Calculated d-statistic:	-11.805		
Since the absolute value of the calculated d-statistic is greater than the upper bound, there is no evidence of serial autocorrelation in the model; it is assumed that the model is stationary.					

**Nursing Facilities Patient Payment Forecasts
FY 2009-10, and FY 2010-11
(Using IBNR-adjusted data from July 2004 through October 2009)**



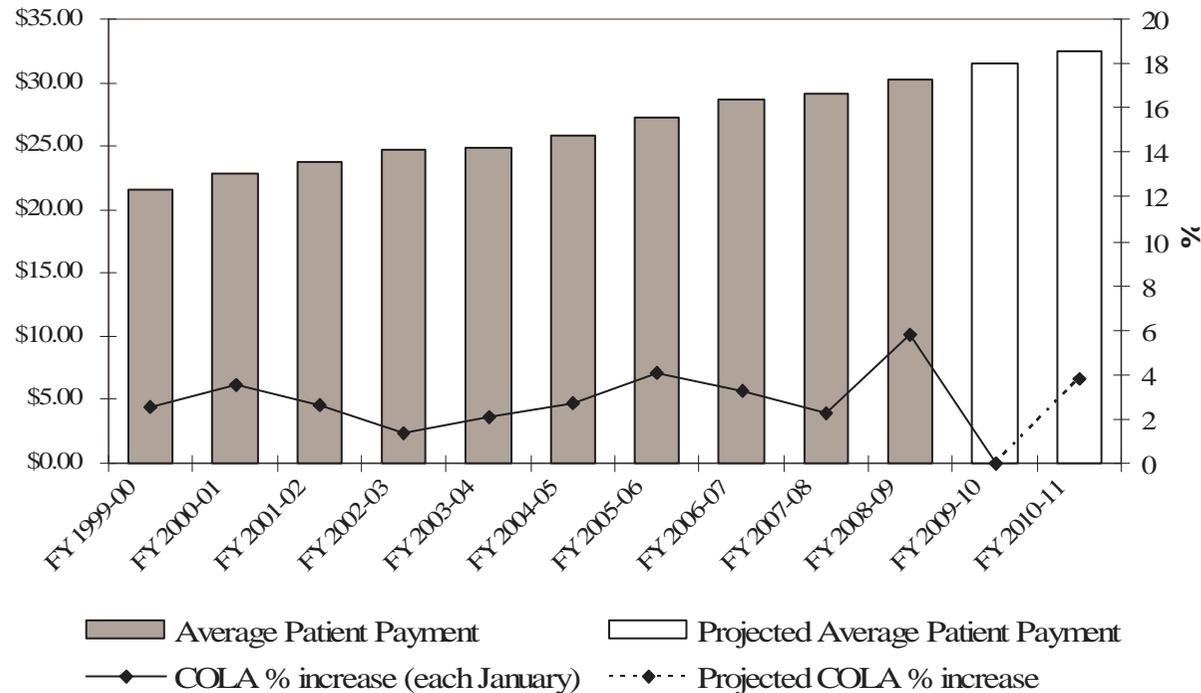
Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

The patient payment rate is a function of patient income. The spikes in each January are due to the annual SSI Cost of Living Adjustment; Social Security Income is a major component of patient income, so patient payment rates are influenced by this adjustment. As shown in the graph below, the average monthly patient payment rate does not exactly mirror the changes in the annual COLA rate. However, the flat patient payment rates from FY 2006-07 to FY 2007-08 corresponded to a relatively low COLA increase of 2.3%. The COLA calculations are based on Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W) figures. The 2008 COLA rate was significantly higher at 5.8% than the increases in previous years; the COLA rate was not increased in January 2009.³

³ Source for COLA data: Social Security Administration, <http://www.ssa.gov/OACT/COLA/colaseries.html>

FY 2009-10 and FY 2010-11 patient payment rates are estimated. Note that the annual COLA increase takes effect with the January SSI payments, changing at the mid-way point of the Department's fiscal year.

Average Patient Payment and Annual Social Security Income Cost of Living Adjustment (SSI COLA), FY 1999-00 through FY 2010-11



Ex Post Forecasts of Patient Payment Rates – Reported as Annual Average Rates by Fiscal Year

An additional step to compare data smoothing methods is to calculate ex post forecasts for each method and compare the results with actual data. This step should not be considered an absolute test, as the data smoothing method which produces the most accurate ex post forecast will not necessarily produce the best forecast using current data. However, this is a useful test of reasonableness and robustness. The data set used to forecast the patient payment rates for FY 2009-10 and FY 2010-11 is again utilized, however in this step, the forecasts are made for November 2008 through October 2009 and compared to the actual data for this period. The forecasted average patient payment rate is 1.8% less than the actual average rate. Note that the actual data did not have the significant spike in

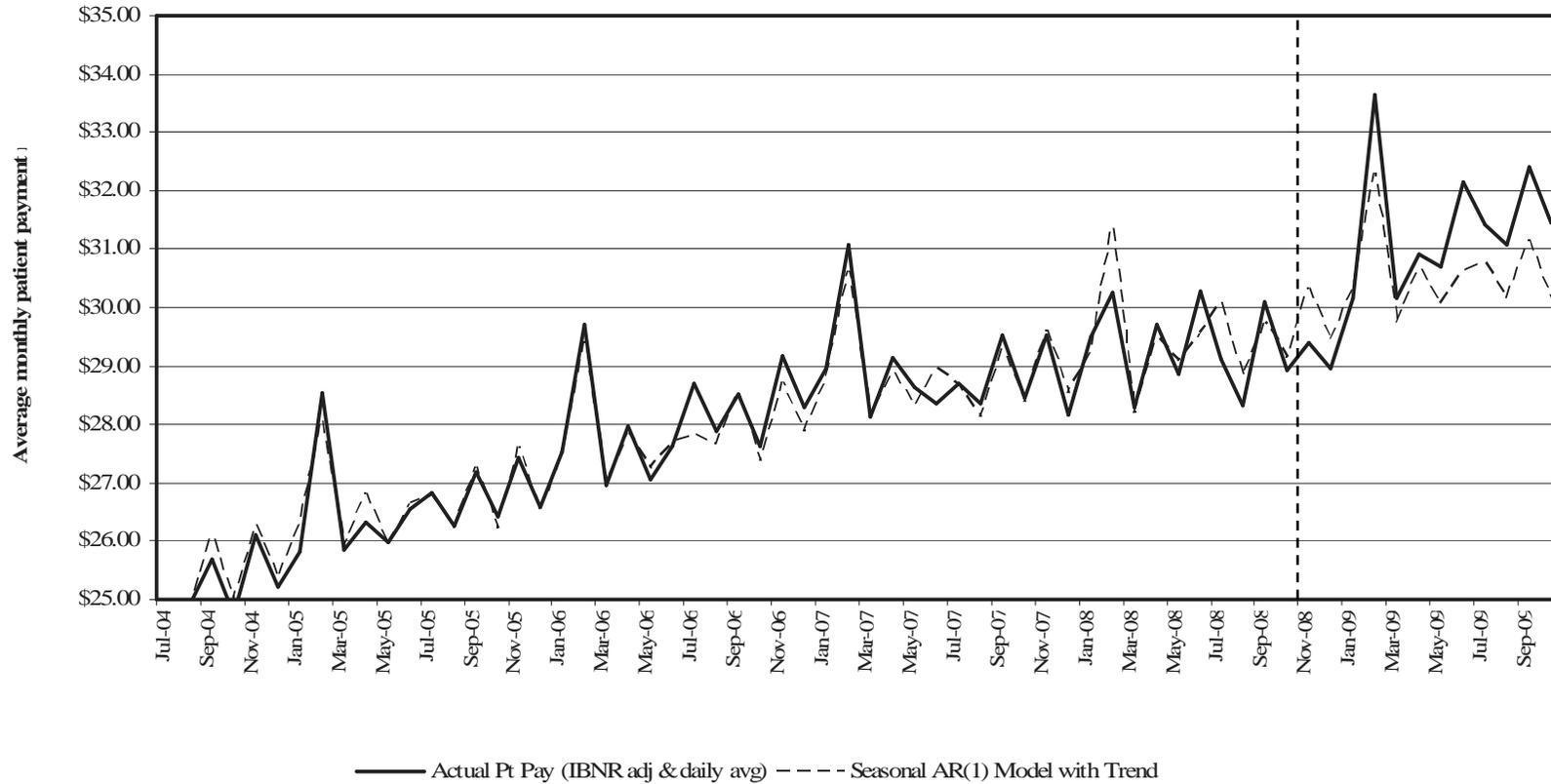
Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

January 2008 which is pronounced and recurring in previous fiscal years. This is likely due to a low COLA increase in 2007 (see discussion above).

Actual average (using IBNR-adjusted data)	Forecasted average	Percentage Difference
\$31.04	\$30.48	-1.8%

TESTING THE OVERALL GOODNESS OF FIT OF THE MODEL					
The predicted values are a function of seasonal indicators, one autoregressive AR(1) term, and a linear trend.					
F-statistic:	43.88	p-value:	0.0000	Confidence level:	99%
DICKEY-FULLER TEST OF STATIONARITY OF THE MODEL					
The first difference of the predicted values are a function of one autoregressive AR(1) term and a linear trend.					
Durbin-Watson d-statistic, lower bound:	1.350	Confidence level:	99%		
Durbin-Watson d-statistic, upper bound:	1.484	Calculated d-statistic:	-10.665		
Since the absolute value of the calculated d-statistic is greater than the upper bound, there is no evidence of serial autocorrelation in the model; it is assumed that the model is stationary.					

**Patient Payment Forecast Compared with Actual through October 2009
(Using IBNR adjusted data from July 2004)**



Forecasting Patient Days

Similar to the table for patient payment rates, the table below includes the estimated monthly patient days and FTEs for FY 2009-10 and FY 2010-11 resulting from the method defined in the previous section. The table also includes a base trend calculated as the expected increase if the number of patient days were held at the June 2009 level.

	Forecasted Annual Patient Days	Percent change from prior FY
FY 2009-10	3,378,386	-0.92%
FY 2010-11	3,367,575	-0.32%
Base trend if flat at June 2008 level		
FY 2008-09	3,409,701	--
June 2009	3,324,508	-2.50%

Since the number of monthly patient days is influenced by the number of days in each month, the data needs to be normalized before trending calculations are executed. The total number of days in each month is divided by the number of days in the month to create the number of FTEs, full time equivalent days. Trending is done using the FTEs, and then the total patient days are calculated by multiplying the FTE figures by the number of days in each month. A graph following the tables below illustrates forecasted trends of FTEs.

The declining trend in patient days is consistent with Department program policies; clients are enrolled in home care or alternative care facilities rather than nursing facilities, if appropriate. From FY 2005-06 to FY 2008-09, the average annual patient days decreased by 3.5%. From FY 2005-06 to FY 2008-09, home and community-based services average monthly paid enrollment was up approximately 22% (from 14,640). The number of clients in Alternative Care Facilities increased 5.4% from FY 2005-06 to FY 2007-08 (from 3,800).

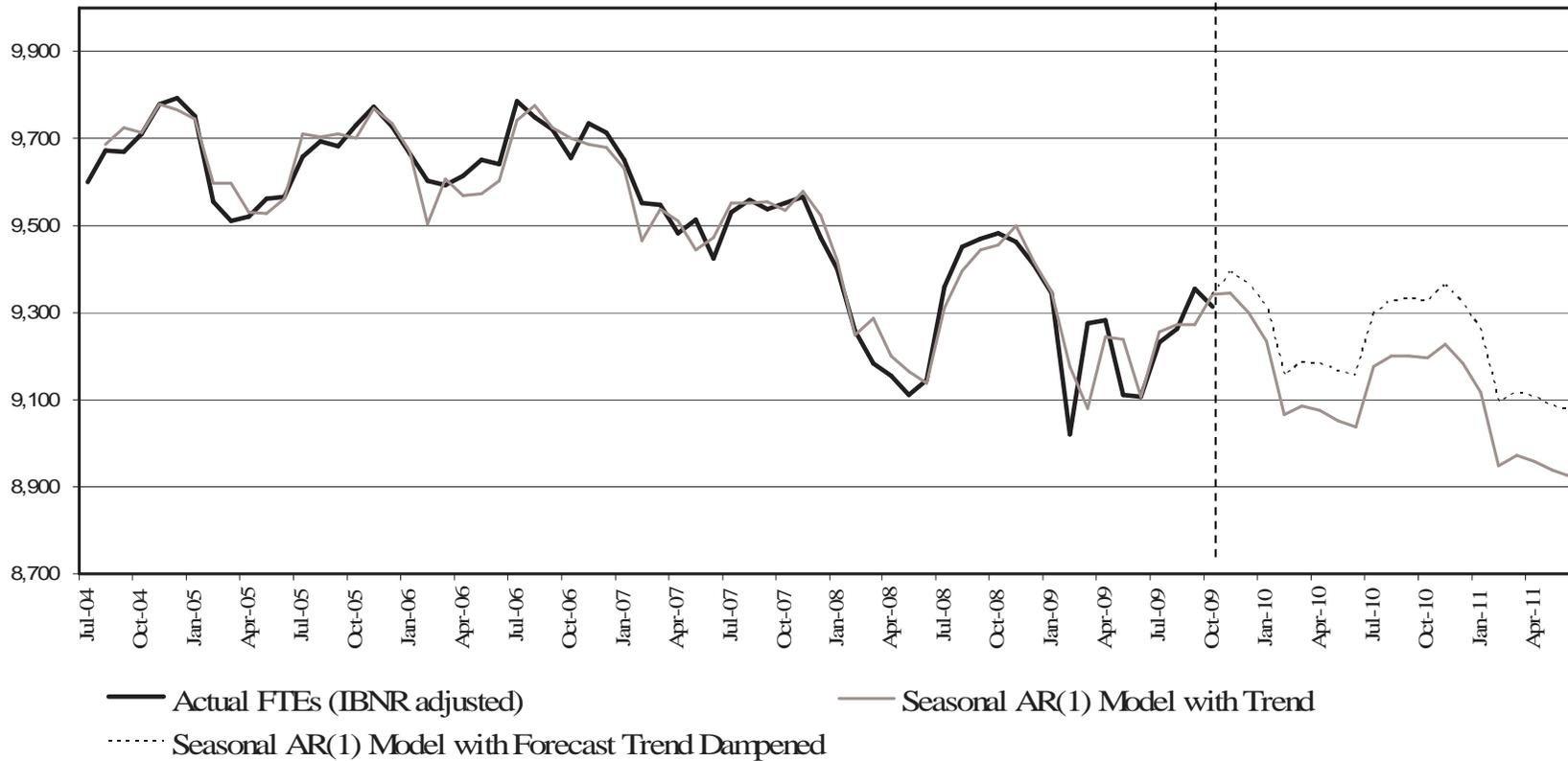
The Department believes that the pronounced negative trend observed in recent data will carry forward into FY 2009-10 and FY 2010-11, but at a dampened rate. Therefore, the Department utilizes the seasonal and autoregressive components of the forecast model, but dampens the trend component by 20%.

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

	Forecasted FTEs	Percent change from prior FY
FY 2009-10	9,251	-0.68%
FY 2010-11	9,225	-0.28%
Base trend if flat at June 2009 level		
FY 2008-09	9,315	--
June 2009	9,108	-2.27%

TESTING THE OVERALL GOODNESS OF FIT OF THE MODEL					
The predicted values are a function of seasonal indicators, one autoregressive AR(1) term, and a linear trend dampened by 20%.					
F-statistic:	48.75	p-value:	0.0000	Confidence level:	99%
DICKEY-FULLER TEST OF STATIONARITY OF THE MODEL					
The first difference of the predicted values are a function of one autoregressive AR(1) term and a linear trend.					
Durbin-Watson d-statistic, lower bound:	1.441	Confidence level:	99%		
Durbin-Watson d-statistic, upper bound:	1.541	Calculated d-statistic:	-3.597		
Since the absolute value of the calculated d-statistic is greater than the upper bound, there is no evidence of serial autocorrelation in the model; it is assumed that the model is stationary.					

**Nursing Facilities FTE, Forecasted Series
FY 2009-10 and FY 2010-11
(Using IBNR-adjusted data from July 2004 through October 2009)**



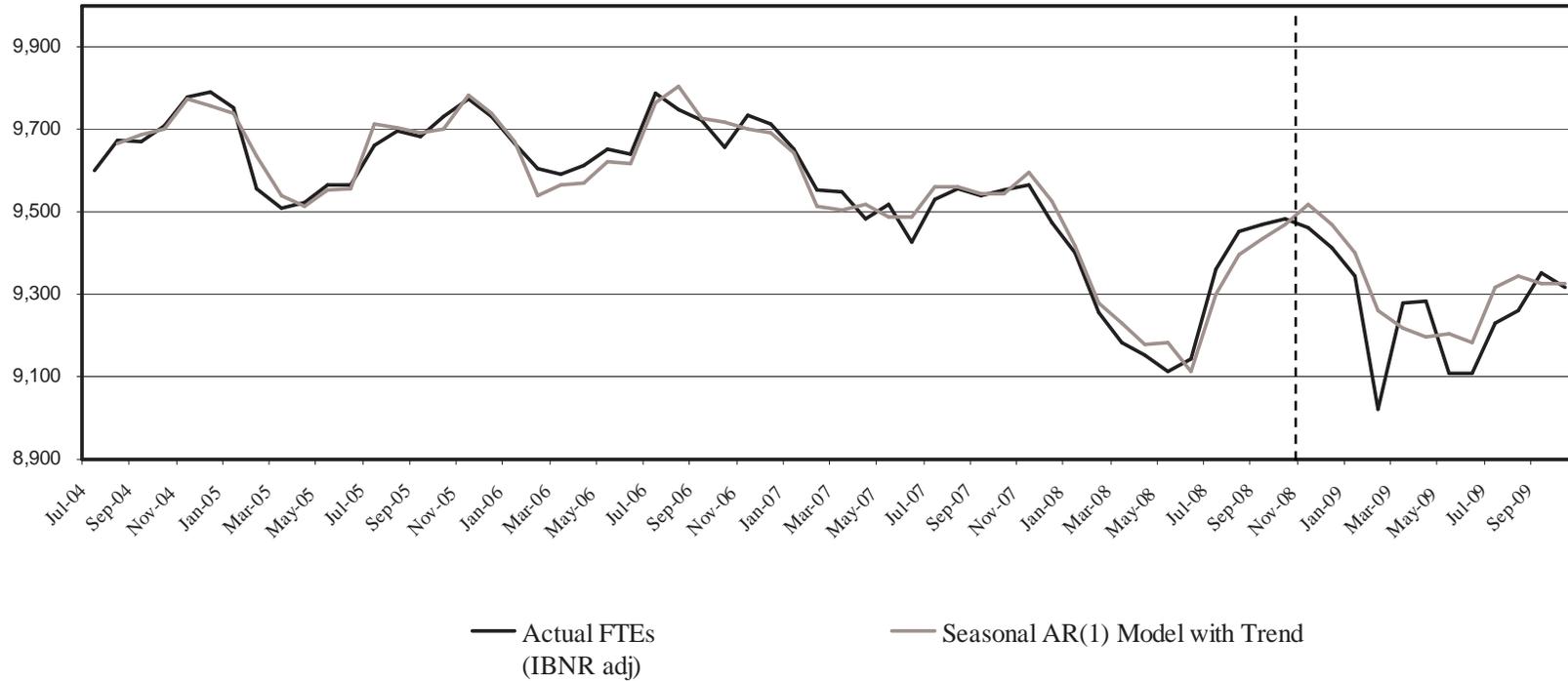
Ex Post (In-Sample) Forecasts of Patient Days

As described above for forecasting patient payment rates, the Department takes an additional step to compare data smoothing methods by calculating ex post (in-sample) forecasts for each method and comparing the results with actual data. As previously noted, the data smoothing method which produces the most accurate ex post forecast will not necessarily produce the best forecast using current data. The forecasted average FTEs for November 2008 through October 2009 are 0.5% higher than the actual average FTEs. In FY 2007-08, the patient days fell sharply for the first half of the fiscal year and rose sharply in the second half of the fiscal year, though not reaching the July 2007 level. The Department does not expect the pronounced negative trend to continue past FY 2008-09.

Actual FTEs (using IBNR-adjusted data)	Forecasted FTEs	Percentage Difference
9,265	9,314	0.5%

TESTING THE OVERALL GOODNESS OF FIT OF THE MODEL					
The predicted values are a function of seasonal indicators, one autoregressive AR(1) term, and a linear trend.					
F-statistic:	63.92	p-value:	0.0000	Confidence level:	99%
DICKEY-FULLER TEST OF STATIONARITY OF THE MODEL					
The first difference of the predicted values are a function of one autoregressive AR(1) term and a linear trend.					
Durbin-Watson d-statistic, lower bound:	1.350	Confidence level:	99%		
Durbin-Watson d-statistic, upper bound:	1.484	Calculated d-statistic:	-2.489		
Since the absolute value of the calculated d-statistic is greater than the upper bound, there is no evidence of serial autocorrelation in the model; it is assumed that the model is stationary.					

**Nursing Facilities FTE Forecast Compared with Actual, FY 2008-09
(Using IBNR-adjusted data from July 2004)**



Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

Nursing Facility Rate Methodology Changes

The following is a timeline of changes to Class I Nursing Facility policy:

- FY 1997-98 8% Health Care Cap and 6% Administrative Cap Implemented
- FY 1998-99 No change
- FY 1999-00 8% Health Care Cap temporarily removed and Case Mix Cap Implemented
- FY 2000-01 No change
- FY 2001-02 8% Health Care Cap permanently removed and Quality of Care Incentive Program / Resident Centered Quality Improvement Program discontinued
- FY 2002-03 Administrative Incentive Allowance removed for three months then reinstated
- FY 2004-05 8% Health Care Cap reinstated
- FY 2005-06 No change
- FY 2006-07 8% Health Care Cap removed for facilities with an average annual Medicaid resident census that exceeds 64% of the number of actual residents in that facility for that same period. Established a rate floor of 85% of the statewide average rate, or 110% of the facility's current year rate, whichever is lower (SB 06-131). Provisions from SB 06-131 are applicable for FY 2006-07 only.
- FY 2007-08 Established the Nursing Facility Grant Rate Program (HB 07-1183). Providers affected by the end of provisions implemented in SB 06-131 are given additional funding to mitigate the impact of the end of the rate floor.
- FY 2008-09 New methodology introduced for calculating nursing facility reimbursement rates (HB 08-1114): the 8% Health Care and 6% Administrative and General caps are removed, and an Administrative and General price is set based on 105% of the median cost for all facilities. Add-on rates are implemented for performance and for facilities with residents who have moderately to very severe mental health conditions, cognitive dementia, or acquired brain injury. The Department is authorized to collect a provider fee from nursing facilities statewide.
- FY 2009-10 The new methodology established in HB 08-1114 was further amended by SB 09-263 which specified the method for calculating the General Fund share of payments during the federal American Recovery and Reinvestment Act (ARRA) time period, adjusted the cap on General Fund growth, specified conditions for supplemental payments, created an upper limit on the nursing facility provider fee, replaced the 8% cap on the direct and indirect health care services component of the reimbursement rate, included a hold harmless provision for administration and general services under certain circumstances, and made changes to the method of implementing pay-for-performance payments.

Class I Nursing Facilities – Calculation of Nursing Facilities General Fund Cap (Page EH-9 and EH-10)

This exhibit calculates the cash funds needed from the Nursing Facility Cash Fund as directed by HB 08-1114 and SB 09-263 for 1) General Fund growth over the allowable per diem cap, and 2) Add-on or Supplemental Payments. Per SB 09-263, the state share of all growth in the General Fund portion of the per diem rate for core components is required to be funded by the cash fund. The state share of growth over 5% in this rate from FY 2009-10 to FY 2010-11 is funded by the cash fund. The state share of all Add-on or Supplemental Payments are funded by the cash fund. The exhibit incorporates the impact of the American Recovery and Reinvestment Act (ARRA).

Class I Nursing Facilities – Cash-Based Actuals and Projections by Aid Category (Page EH-11)

For comparison purposes to other service categories, this exhibit lists prior year expenditure along with the projected expenditure from page EH-2. Estimated totals by aid category are split proportionally to the most recent year of actual expenditure. Additionally, the Department calculates per capita costs for each year.

Totals for each aid category are used to calculate total expenditure by aid category in Exhibit E, and total per capita by aid category in Exhibit C.

Class II Nursing Facilities (Page EH-13)

This service category is for specialized private nursing facility care for developmentally disabled clients, which was the focus of the Department of Human Services' initiative to deinstitutionalize these clients by placing them in appropriate care settings. The deinstitutionalization strategy was completed in April of FY 1997-98. Beginning in FY 1998-99, the service category was limited to one facility, Good Shepherd Lutheran. There are no plans to eliminate this facility as it essentially functions more like a group home than an institutional facility.

At the end of FY 2005-06, Good Shepherd Lutheran increased its enrollment from 16 clients to 20 clients. During FY 2006-07, the census at this facility has remained constant, and there is no expectation that there will be a further change in enrollment at this facility. Additionally, this facility received an annual cost-based rate adjustment, similar to Class I nursing facilities. As a result, this service category has experienced expenditure growth that differs sharply from any recent year. The estimated growth rates for FY 2009-10 and FY 2010-11 are the average of overall growth in expenditures from FY 2007-08 to FY 2008-09. Because all clients are paid the same rate regardless of aid category, it is anticipated that change in expenditure per aid category will only change if enrollment varies by aid category. However, total expenditure would still remain the same; therefore, differences between aid categories are less relevant.

Program of All-Inclusive Care for the Elderly (PACE) (Page EH-14)

The Program of All-Inclusive Care for the Elderly (PACE) is a Medicare/Medicaid managed care system that provides health care and support services to persons 55 years of age and older. The goal of PACE is to assist frail individuals to live in their communities as independently as possible by providing comprehensive services depending on their needs. PACE is only used by Adults 65 and Older (OAP-B), Disabled Adults 50-59 (OAP-B), and Disabled Adults to 59 (AND/AB). PACE rates are adjusted once per year, generally on January 1 of each year.

Effective with the November 1, 2007 Budget Request, the Department has substantially revised the methodology used to calculate the projections for PACE expenditure. In prior years, the Department performed a per capita-based estimate, similar to the Acute Care and Community Based Long Term Care projections. However, enrollment trends in PACE are different from the overall Medicaid population. Therefore, the standard per capita measure is unreliable, in that it does not reflect the true cost of serving a client enrolled in PACE.

HB 08-1374 removed the requirement that the Department reimburse PACE providers at 95% of the equivalent fee-for-service cost, effective July 1, 2008. The Department now pays providers the lesser of the 100% rate or the federal upper payment limit.

To better forecast expenditure, the Department began providing two new metrics in FY 2008-09: average monthly enrollment, and average cost per enrollee. The average monthly enrollment is based on the number of distinct clients for whom capitations were paid to PACE providers in each fiscal year, as determined by claims information from the Medicaid Management Information System. The average cost per enrollee is the total expenditure divided by the average monthly enrollment for each fiscal year.

The FY 2009-10 projection for PACE is computed in several parts: First, the Department estimates the growth in the average enrollment, and applies the selected trend factor to the FY 2008-09 average enrollment. Estimated enrollment at new PACE providers, which are not reflected in historical trends, is added as a bottom-line adjustment. Second, the Department estimates the growth in the average cost per enrollee, and applies the selected trend factor to the FY 2008-09 average cost per enrollee. The estimated cost per enrollee and estimated enrollment are multiplied to calculate the estimated FY 2009-10 base expenditure. Then, the Department adjusts for any bottom-line impacts not incorporated in the trend (described below). The sum of the base expenditure and the bottom-line adjustments is the estimated FY 2009-10 total expenditure. FY 2010-11 is calculated in the same fashion.

To estimate the increase in enrollment in FY 2009-10, the Department selected half of the FY 2006-07 growth rate for Adults 65 and Older and Disabled Adults 60 to 64 categories, 2.72% and 2.60%, respectively. The trend for the Disabled Adults 60 to 64 category is applied to the Disabled Individuals to age 59 aid category. To estimate the increase in enrollment in FY 2010-11, the Department selected one half of these estimated FY 2009-10 trends.

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

To estimate the average increase in cost per enrollee in FY 2009-10, the Department selected the average percent increase in cost per enrollee between FY 2005-06 and FY 2007-08 for Adults 65 and Older. For the Disabled Adults 60 to 64 and Disabled Individuals to age 59 aid categories, the Department selected the average percent increase in cost per enrollee between FY 2004-05 and FY 2008-09. For FY 2010-11, the Department held the FY 2009-10 trend selections constant.

The Department has received applications for additional PACE providers. Senior Community Care of Colorado (Volunteers of America), a new provider, began serving clients on August 1, 2008, in Montrose and Delta counties. The organization originally planned to open a third facility in Grand Junction in Spring 2010, however this plan is on hold. Rocky Mountain Health Care began serving clients on December 1, 2008, in El Paso County. The Department anticipates that Total Longterm Care, the Department's oldest PACE organization, will open a facility in late 2009 to serve clients in Pueblo as well as facilities in Loveland and Englewood in Spring 2011. The organization also plans to expand the current facility in the Brighton area; this is planned for Spring 2011.

Legislative Impacts and Bottom-Line Adjustments

To account for programmatic changes which are not incorporated in the prior per capita or trend factors, the Department adds total-dollar bottom-line impacts to the projected expenditure. For complete information on legislative impacts, see section V, Additional Calculation Considerations. The following impacts have been included in the FY 2009-10 and FY 2010-11 calculations for the Program of All-Inclusive Care for the Elderly (PACE):

- HB 08-1114 directed the Department to change the method of reimbursement for Class I Nursing Facilities. Since the PACE reimbursement rate is a function of the nursing facility rate, this change in methodology will impact PACE expenditure. The fiscal note for HB 08-1114 included \$893,455 for increased PACE expenditures in FY 2009-10. The FY 2010-11 impact is assumed to be annualized into the base amount.
- To meet budget balancing goals, the ES-2: Medicaid Program Reductions budget request included a reduction in fee-for-service reimbursement rates. This indirectly reduced the reimbursement rate paid for PACE for FY 2009-10, as PACE rates are based on the Department's fee-for-service rates. This reduction is a bottom line adjustment for FY 2009-10, with an implementation date of October 1, 2009, and the annualized impact is a bottom line adjustment for FY 2010-11.
- To meet budget balancing goals, the ES-6: Medicaid Program Reductions budget request included a reduction in fee-for-service reimbursement rates. This indirectly reduced the reimbursement rate paid for PACE for FY 2009-10, as PACE rates are based on the Department's fee-for-service rates. This reduction is a bottom line adjustment for FY 2009-10, with an implementation date of December 1, 2009, and the annualized impact is a bottom line adjustment for FY 2010-11.
- SB 09-265 provides that managed care capitation payments shall not be made before the first day of the month following the enrollment of the recipients. This impacts payments for Program of All-Inclusive Care for the Elderly (PACE) by effectively shifting the last monthly payment in FY 2009-10 to FY 2010-11. This is a permanent shift with one-time savings in FY 2009-10.

Supplemental Medicare Insurance Benefit (SMIB) (Page EH-18)

The Supplemental Medicare Insurance Benefit (SMIB) consists of two parts: Medicare Part A, the insurance premium for hospital care and Medicare Part B, the insurance premium for Medicare-covered physician and ambulatory care services. Only premiums are paid in this service category; co-payments and deductibles are paid under Acute Care. Medicaid clients who are dual-eligible (clients have both Medicaid and Medicare coverage) or Partial Dual Eligibles receive payment for Medicare Part B, and in some cases, Medicare Part A. The Partial Dual Eligibles aid category has two distinct groups: Qualified Medicare Beneficiaries and Specified Low-Income Medicare Beneficiaries. The Part A premium payments are made for a small subset of the Qualified Medicare Beneficiary eligibility group only.⁴ The Supplemental Medicare Insurance Benefit service category includes the estimate of payments for both Part B for all Medicare beneficiary client types, and Part A payments for Qualified Medicare Beneficiary clients. Premium payments for Medicare clients who do not meet the Supplemental Security income limit do not receive a federal match.

The federal law that requires Medicaid to pay the Medicare Part B premium for qualifying individuals whose income is between 120% and 135% of the federal poverty level was scheduled to expire September 30, 2003. However, eligibility was extended. This population was referred to as “Medicare Qualified Individual (1).” Legislation for the second group, referred to as “Medicare Qualified Individual (2),” comprised of individuals whose income was between 135% and 175% of the federal poverty level and expired April 30, 2003. Formerly, Medicaid paid the portion of the increase in the Part B premium due to the shift of home health services from Medicare Part A to Part B insurance. Qualified Individuals are 100% federally funded, subject to an annual cap.

Supplemental Medicare Insurance Benefit (SMIB) expenditure is related to two primary factors: the number of dual-eligible clients, and the increase in the Medicare premiums. For reference, the historical increases in the Medicare premiums are listed in the table below:⁵

⁴ Most Medicare beneficiaries do not make a Part A payment, because they have contributed to Medicare for 40 or more quarters during their working life. The Department only subsidizes Part A payments for Qualified Medicare Beneficiaries who do not meet the 40 quarter requirement.

⁵ Premium information taken from the Centers for Medicare and Medicaid Services,
<http://www.medicare.gov/MedicareEligibility/Home.asp?dest=NAV|Home|GeneralEnrollment|PremiumCostInfo#TabTop>

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

Medicare Premiums				
Calendar Year	Part A	% Change	Part B	% Change
2003	\$316.00		\$58.70	
2004	\$343.00	8.54%	\$66.60	13.46%
2005	\$375.00	9.33%	\$78.20	17.42%
2006	\$393.00	4.80%	\$88.50	13.17%
2007	\$410.00	4.33%	\$93.50	5.65%
2008	\$423.00	3.17%	\$96.40	3.10%
2009	\$443.00	4.73%	\$96.40	0.00%
2010	\$461.00	4.06%	\$110.50	14.63%

These premiums reflect the standard Medicare premiums paid by most Medicare recipients, or by the Department on their behalf. Clients with between 30 and 39 work quarters of Medicare Covered Employment require a higher Part A premium. Additionally, some clients pay higher Part B premiums based on higher adjusted gross income, but it is assumed that clients meeting those requirements do not qualify for Medicaid.

During FY 2007-08, the Department made its July 2007 payment for Medicare premiums several days late. As a result, Medicare automatically deducted the balance from the Department's Medicaid grant. As a result, from the perspective of Medicare, the Department effectively double-paid July, and the difference became a credit against the September total. As a result, the total expenditure for this line does not reflect payment for one month, because the federal funds Medicare received directly from the Medicaid grant did not pass through the state's accounting system. Therefore, in order to accurately project expenditure, the Department uses the actual Medicare invoice totals for FY 2007-08 instead of the actual expenditure for FY 2007-08. This ensures that the projection base is not understated, which would lead to a material under-projection in the forecast.

To forecast FY 2009-10, the Department first inflates the actual expenditure from the first half of FY 2009-10 by the estimated caseload trend for the first to second half of FY 2009-10 from Exhibit B, page EB-1. Then, the Department inflates the estimated first half expenditure by the estimated increase in the Medicare premium, which is zero percent in 2009. The total estimated expenditure for FY 2009-10 is the sum of the first half actual expenditures and the second half estimated expenditures.

To forecast FY 2010-11, the Department first inflates the estimated expenditure from the first half of FY 2010-11 by the estimated caseload trend for FY 2010-11 from Exhibit B, page EB-1. This figure represents the approximate expenditure for the first half of FY

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

2010-11. Then, the Department inflates the estimated first half expenditure by the estimated increase in the Medicare premium to estimate the second half expenditure. The total estimated expenditure for FY 2010-11 is the sum of the first half and second half estimates.

Health Insurance Buy-In (HIBI) (Page EH-20)

The Medicaid program purchases the premiums for private health insurance for individuals eligible for Medicaid if it is cost effective. This is known as the Health Insurance Buy-In (HIBI) program, permitted under 25.5-4-210, C.R.S. (2009). In recent years, HIBI expenditure has fluctuated significantly due to numerous policy and administrative changes. In particular, during FY 2005-06, due to the implementation of the Medicare Modernization Act, many of the health plans that were previously cost effective became ineffective, since the costs of those health plans included a drug benefit. This caused a significant decrease in HIBI expenditure and enrollment in FY 2005-06. Additionally, the Department found that, with rare exceptions, it was no longer cost effective to purchase commercial insurance for clients in the Adults 65 and Older (OAP-A) aid category. Instead, the majority of expenditure was shifted to Disabled Individuals to 59 (AND/AB), for clients who do not qualify for the Medicare Part D benefit.

In FY 2006-07, the Department experienced significant growth in the program, although the cause appears to be related to administrative changes rather than other factors. For example, a single outside agency has referred approximately 50 new clients to the Department for enrollment in the program. Additionally, during FY 2006-07, the Department examined and upgraded the existing process to determine client eligibility for the program. This change enabled the Department to process clients more efficiently, resulting in an increase in caseload.

Because of the dramatic changes in the expenditure patterns in recent years, the Department does not believe that long term per capita trends are a good indicator for FY 2009-10 expenditure. Total growth in FY 2006-07 was 41.62%; growth in FY 2007-08 was 21.90%, yet growth in FY 2008-09 was only 4.11%. The Department selected the FY 2008-09 growth rate of expenditures for all categories to trend expenditure to FY 2009-10 and FY 2010-11 for the Disabled Adults 60 to 64 (OAP-B) and Disabled Individuals to 59 (AND/AB) aid categories. The Department selected the FY 2008-09 growth rate for the Eligible Children category, and this trend was applied to Categorically Eligible Low-Income Adults (AFDC-A). The Department selected a 10% growth rate for Baby Care Program Adults. All FY 2009-10 trend selections were held constant for FY 2010-11.

Legislative Impacts and Bottom-Line Adjustments

To account for programmatic changes which are not incorporated in the prior per capita or trend factors, the Department adds total-dollar bottom-line impacts to the projected expenditure. For complete information on legislative impacts, see section V, Additional

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

Calculation Considerations. The following impact has been included in the FY 2009-10 and FY 2010-11 calculations for the Health Insurance Buy-In (HIBI) program:

- The Budget Reduction Proposal, BA-37 Increased Enrollment in Health Insurance Buy-In Program, originally estimated an increase in enrollment of 100 new HIBI clients for FY 2009-10 by repurposing existing resources to process a current backlog of HIBI applications. This estimate is reduced to 50 new HIBI clients for the same period. The administrative cost of this initiative is included in this section; the savings amount is included in the Acute Care section of this request.

EXHIBIT I – SERVICE MANAGEMENT

This service group includes administrative-like contract services within the Medical Services Premiums budget. The group is comprised of Single Entry Point agencies, disease management, and administrative fees for prepaid inpatient health plans.

Summary of Service Management (Page EI-1)

This exhibit summarizes the total requests from the worksheets within Exhibit I.

Single Entry Points (Page EI-2)

Single Entry Point (SEP) agencies were authorized by HB 91-1287. Statewide implementation was achieved July 1, 1995. The single entry point system was established for the coordination of access to existing services and service delivery for all long-term care clients in order to provide utilization of more appropriate services by long-term care clients over time and better information on the unmet service needs of clients (25.5-6-105, C.R.S. (2009)). A single entry point agency is an agency in a local community through which persons eighteen years or older, who are in need of long-term care services, can access needed long-term care services (25.5-6-106 (3) (a), C.R.S. (2009)).

The single entry point agency is required to serve clients of publicly funded long-term care programs including nursing facility care, Home and Community Based Services (HCBS) for the elderly, blind and disabled, HCBS for persons living with acquired immune deficiency syndrome, HCBS for persons with brain injury, HCBS for persons with mental illness, long-term home health care, home care allowance, alternative care facilities, adult foster care, and certain in-home services available pursuant to the federal Older Americans Act of 1965 (section 25.5-6-106 (2) (b), C.R.S. (2009)).

The major functions of single entry point agencies include providing information, screening and referral, assessing clients' needs, developing plans of care, determining payment sources available, authorizing provision of long-term care services, determining eligibility for certain long-term care programs, delivering case management services, targeting outreach efforts to those most at risk of

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

institutionalization, identifying resource gaps, coordinating resource development, recovering overpayment of benefits and maintaining fiscal accountability (25.5-6-106 (2) (c), C.R.S. (2009)). Single entry point agencies also serve as the utilization review coordinator for all community based long term care services.

Single entry point agencies are paid a case management fee for each client admitted into a community based service program. Single entry point agencies also receive payment for services provided in connection with the development and management of long term home health prior authorization requests, for work associated with client appeals and for utilization review services related to home and community based services and nursing facilities.

On November 1, 2002, the Department submitted a report for Footnote 52 of HB 02-1420, describing the payment methodology for single entry point agencies. However, recently it has come to light that the process described in the footnote report is not being used. Instead, individual single entry point agency contract amounts are determined using data from each single entry point agency's previous year's history of client and activity counts. At the end of the contract year the actual client and activity counts are reconciled against the projected client and activity counts. This process results in either funds owed to single entry point agencies for services delivered in excess of funds received, or funds owed to the Department for payments made in excess of services delivered. The Department then issues a reconciliation statement to collect for overpayment or adjusts for underpayment up to the amount allocated. This payment methodology, combined with close Department oversight, encourages single entry point agencies to enroll only those clients who are appropriate for community based services.

Annual financial audits are conducted by the Department to verify expenditures were made according to the contract scope of work and that to assure single entry point agency compliance with general accounting principles and federal Office of Management and Budget (OMB) circulars. If the audit identifies misused funds, the amount misused is collected through a recovery order.

SB 04-206 directed the Department to implement a pediatric hospice program; the impact of this legislation is fully annualized in the budget request. Entry into the program must be approved by single entry point agencies. The Department received approval from the Centers for Medicare and Medicaid Services to add a pediatric hospice effective January 1, 2008.

Also fully annualized in the budget request is the impact of HB 05-1243, which allowed the Department to add consumer directed care to home and community based waiver services. These services must be approved by single entry point agencies. The Department received approval from the Centers for Medicare and Medicaid Services to add consumer directed care to the Elderly, Blind, and Disabled waiver and the Mental Illness waiver in 2007; the Department began to provide these services effective January 1, 2008.

Effective with the November 1, 2007 Budget Request, the Department has revised the methodology used to calculate this portion of the Request. Because of the administrative nature of the service, single entry points are generally paid a fixed fee for each year,

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

although this amount may be adjusted based on actual experience. In recent years, the number of clients processed by single entry points has increased at a much faster rate than overall Medicaid caseload. Without an increase to the fixed-price contracts, single entry points would be required to serve an increasing population with the same funding.

Therefore, the Department's request includes an increase to single entry point contracts. The requested increase is based on the expected increase in Home and Community Based Services (HCBS) utilization, as determined by average monthly paid enrollment in the Department's HCBS programs. These figures do not reflect the actual enrollment in HCBS programs, nor do they reflect actual single entry point caseload; rather, they are based on the number of clients for whom the Department has paid a related claim during each fiscal year. This figure is therefore consistent with the cash accounting basis of Medical Services Premiums. The Department believes that growth in paid enrollment is a good proxy for growth in single entry point caseload.

For FY 2009-10, the Department's projection uses the total base contracts amount, which is the current amount allocated to single entry points in the FY 2009-10 Long Bill appropriation (as determined by information provided by the Joint Budget Committee during Figure Setting), and adds two legislative impacts (see below). For FY 2010-11, the Department estimates the increase in HCBS utilization based on the average percent change in average monthly paid enrollment from FY 2005-06 through FY 2009-10 to date for the Adults 65 and Older, Disabled Adults 60 to 64, and Disabled Individuals to 59 aid categories. The overall average percent change in average monthly paid enrollment for all categories from FY 2005-06 through FY 2009-10 to date is applied to the remaining aid categories. The estimated FY 2009-10 total expenditure is inflated by this percentage, and legislative impacts are added to estimate the total FY 2010-11 expenditure.

Legislative Impacts and Bottom-Line Adjustments

To account for programmatic changes which are not incorporated in the prior per capita or trend factors, the Department adds total-dollar bottom-line impacts to the projected expenditure. For complete information on legislative impacts, see section V, Additional Calculation Considerations. The following impacts have been included in the FY 2009-10 and FY 2010-11 calculations for Single Entry Points:

- The Budget Reduction Proposal, BA-33 Provider Volume and Rate Reductions, decreases the amount paid to Single Entry Point providers by 2%, effective July 1, 2009.
- To meet budget balancing goals, the Department proposed a series of initiatives to reduce Medicaid expenditure through the ES-2: Medicaid Program Reductions budget request. The Executive Order included a 1.5% reduction in the reimbursement rate paid for Single Entry Points for FY 2009-10. This reduction is a bottom line adjustment for FY 2009-10, with an implementation date of September 1, 2009, and the annualized impact is a bottom line adjustment for FY 2010-11.

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

- To meet budget balancing goals, the Department proposed a series of initiatives to reduce Medicaid expenditure through the ES-2: Medicaid Program Reductions budget request. The Executive Order included a 1.0% reduction in the reimbursement rate paid for Single Entry Points for FY 2009-10. This reduction is a bottom line adjustment for FY 2009-10, with an implementation date of December 1, 2009, and the annualized impact is a bottom line adjustment for FY 2010-11.

Disease Management (Page EI-4)

Beginning in July 2002 the Department implemented several targeted disease management pilot programs, as permitted by HB 02-1003. Specifically, the Department was authorized “to address over- or under-utilization or the inappropriate use of services or prescription drugs, and that may affect the total cost of health care utilization by a particular Medicaid recipient with a particular disease or combination of diseases” (25.5-5-316, C.R.S. (2009)). Initially, pilot programs were funded solely by pharmaceutical companies; the programs began and ended at different times between July 2002 and December 2004.

During the pilot program, the Department initiated seven disease management programs to identify the most appropriate strategies to contain rising health care costs, improve access to services and improve the quality of care for the fee-for-service Medicaid clients. The targeted disease conditions included high-risk infants, clients with asthma, clients with diabetes, clients with schizophrenia, female clients with breast and cervical cancer, and clients with chronic obstructive pulmonary disease. Additionally, the Care Management Organization pilot was established to coordinate all of the disease management programs and to establish a means for additional fee-for-service clients to obtain intensive case management or health counseling.

The pilot programs revolved around three key managed care principles: appropriate and timely access to health care services, evaluation and support for adherence to appropriate medical regimens/treatments and provision of nationally recommended practice guidelines for each chronic disease. The pilot programs enabled the Department to obtain actual Colorado Medicaid disease management data and experience to be utilized for future program development.

As a result of the pilot programs, the Department entered into permanent contracts with two disease management companies for two health conditions: clients with asthma, and clients with diabetes. In order to provide appropriate management to achieve cost-savings, reducing hospitalizations and emergency room visits, the Department contracted with Alere Medical Incorporated for clients with asthma, and with McKesson Health Solutions for clients with diabetes. Over time, the Department has added and changed contracts as appropriate to ensure that Medicaid clients continue to receive quality care.

At the start of FY 2008-09, the Department had five disease management contracts covering specific conditions. Those conditions were: asthma; congestive heart failure (CHF); chronic obstructive pulmonary disease (COPD); high risk obstetrics; and weight management. The Department also employed a contractor to do more general disease management via telemedicine. The

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

Department's funding for these contracts was a combination of General Fund, Prevention Early Detection and Treatment Fund, and federal funds. Certain restrictions, specified in section 24-22-117 (2) (d) (IV.5), C.R.S. (2009), limit the use of Prevention Early Detection and Treatment Fund. Therefore, the Department separated the amount of base funding (contracts financed with General Fund) and the amount of expansion funding (contracts financed with Prevention Early Detection and Treatment Fund) in order to ensure that its request reflects the correct amount from each funding source. For FY 2008-09 only, this separation was reflected as a bottom-line impact.

The Department's disease management contractors operated on a fixed budget (specified in the contract), and client enrollment could not exceed a fixed number of clients that the Department has determined shall be managed on that budget. Contractors accepted new clients only up to the enrollee limit as specified in the contract.

Effective June 30, 2009, the Department discontinued the five specific Disease Management programs. The remaining funds were used toward services related to the treatment of the health conditions specified in HB 02-1003. The Department's telemedicine program has two months of expenditures encumbered for FY 2009-10; the encumbered amount of \$63,488 is included in the FY 2009-10 request. The Department does not plan to renew the telemedicine contract when it expires on September 30, 2009. The amount included in FY 2010-11 is the total amount of funds from the Prevention Early Detection and Treatment Fund which is reappropriated from the Department of Public Health and Environment.

Prepaid Inpatient Health Plan Administration (Page EI-5)

Prepaid inpatient health plans (formerly known as Administrative Service Organizations) are an alternative to traditional health maintenance organizations. They offer the case management and care coordination services of a health maintenance organization for a fixed fee. The organizations do this by not taking on the risk traditionally assumed by health maintenance organizations. The Department began using this type of organization to deliver health care to Medicaid clients during FY 2003-04. The Department currently contracts with one prepaid inpatient health plan, Rocky Mountain Health Plans. In FY 2005-06, the Department ended its contract with Management Team Solutions. Prepaid inpatient health plans receive a fixed amount administrative fee per client. Exhibit EI-6 depicts only the administrative fee expenditures for the Department's current contractor, including estimated cost avoidance payments. The service costs for these organizations are included in Acute Care. Because the administrative fee remains the same in FY 2009-10 and FY 2010-11, the Department has used actual enrollment in its current administrative service organization to forecast expenditure in FY 2009-10 and FY 2010-11.

In addition to an estimate for the amount of administrative fees, the Department has added bottom-line impacts for the estimated contracted cost avoidance payments to Rocky Mountain Health Plans for cost avoidance in FY 2005-06 through FY 2008-09. During FY 2007-08, the Department and Rocky Mountain Health Plans were unable to come to an agreement on the correct amount of cost

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

avoidance for the contract year FY 2005-06, and no payment was paid. At that time, the Department anticipated that it may make a combined payment for FY 2005-06 and FY 2006-07 in FY 2008-09, with existing funding. In addition, the Department anticipated making a single contracted payment in FY 2009-10 for services rendered in FY 2007-08. The FY 2009-10 figure was estimated based on the percentage enrollment increase of 1.37% in FY 2007-08. However, since that time, federal Centers for Medicare and Medicaid Services (CMS) directed the Department to cease making any cost avoidance payments until all historical encounter data for prepaid inpatient health plan claims is integrated into the Medicaid Management Information System (MMIS) system.

Concurrent with the project to include all encounter data in the MMIS system, the Department has adopted a new payment methodology effective FY 2009-10. This change is directed by HB 07-1346. Under the new methodology, the annual cost avoidance payments will no longer be made, and there will likely be an acceleration of payments due to cash accounting. The impact is indeterminate at the time of preparing this budget request, and the Department will adjust for any fiscal impact through the normal budget process.

The Department holds the estimated amount of cost avoidance for the contract years FY 2005-06 and FY 2006-07 constant from the February 16, 2009 Budget Request. This bottom line adjustment of \$943,802 is projected to impact FY 2009-10. The estimated amount of cost avoidance for the contract years FY 2007-08 and FY 2008-09 is estimated as the amount originally estimated for FY 2007-08 in the February Request. Since there may or may not be cost avoidance savings realized for these years, the Department holds the FY 2007-08 figure constant at \$956,606, though now as an estimate of the cost avoidance amount both years, and projects a FY 2010-11 impact.

The final payments will differ from the budgeted amount, as the Department will calculate the actual amount of cost avoidance, which may be higher or lower than the estimated levels.

Legislative Impacts and Bottom-Line Adjustments

To account for programmatic changes which are not incorporated in the prior per capita or trend factors, the Department adds total-dollar bottom-line impacts to the projected expenditure. For complete information on legislative impacts, see section V, Additional Calculation Considerations. The following impacts have been included in the FY 2009-10 and FY 2010-11 calculations for Prepaid Inpatient Health Plan Administration:

- In addition to an estimate for the amount of administrative fees, the Department has added bottom-line impacts for the estimated contracted cost avoidance payments to Rocky Mountain Health Plans, as detailed above.
- The Joint Budget Committee recommended and approved \$500,000 in additional appropriated total funds for the 2009 Long Bill to implement the coordinated care for people with disabilities pilot program as directed by SB 06-128.

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

- SB 09-265 provides that managed care capitation payments shall not be made before the first day of the month following the enrollment of the recipients. This impacts payments for Prepaid Inpatient Health Plan Administration by effectively shifting the last monthly payment in FY 2009-10 to FY 2010-11. This is a permanent shift with one-time savings in FY 2009-10.
- The FY 2010-11 request includes funding for the Department's Medicaid Value-Based Care Coordination Initiative, and for the administrative cost of a Colorado Regional Integrated Care Collaborative study related to the initiative.
- To meet budget balancing goals, the Department proposed a series of initiatives to reduce Medicaid expenditure through the ES-2: Medicaid Program Reductions budget request. The Executive Order included a 1.5% reduction in the reimbursement rate paid for Prepaid Inpatient Health Plan Administration for FY 2009-10. This reduction is a bottom line adjustment for FY 2009-10, with an implementation date of September 1, 2009, and the annualized impact is a bottom line adjustment for FY 2010-11.

EXHIBIT J - CASH FUNDED EXPANSION POPULATIONS

Summary of Cash Funded Expansion Populations (Pages EJ-1 and EJ-2)

These exhibits summarize the source of funding for Health Care Affordability Act of 2009 and Tobacco Tax cash funded expansion populations.

Health Care Expansion Fund Populations (Pages EJ-3 through EJ-6)

The caseload impacts of the Health Care Expansion Fund from HB 05-1262 are already included in the Medicaid caseload projections. The Medical Services Premiums request is based on these caseload projections and per capita costs. The overall request for each service category (Acute Care, Community Based Long Term Care, Long Term Care and Insurance, and Service Management) is divided out in the Federal Match Calculation, Exhibit A, pages EA-3 through EA-6 splitting the request by General Fund, Cash Funds, and federal funds accordingly. To isolate certain expenditures, the Department performs bottom-line adjustments to allocate expenditure to the Health Care Expansion Fund. For simplicity, pages EJ-3 through EJ-6 show the fund split adjustments that need to be made to the General Fund amounts shown in each section of the Calculation of Federal Match exhibits (page EA-3 through EA-6).

The Health Care Expansion Fund is administered by the Department. Items funded include 1) the additional Categorically Eligible Low-Income Adults and Eligible Children estimated to become eligible for Medicaid due to the removal of the Medicaid asset test, 2) expansion of child enrollment under the Children's Home and Community Based Services Waiver and the Children's Extensive Support Waiver programs, 3) Medicaid for legal immigrants, 4) increased Eligible Children due to the impact from marketing the Children's Basic Health, 5) providing presumptive eligibility to pregnant women in Medicaid, 6) parents of children enrolled in Medicaid or the Children's Basic Health Plan from 36% to least 60% of the federal poverty level, and 7) additional foster care clients between 18 and 21 years of age eligible for Medicaid immediately prior to their 18th birthday. The request differs from the analysis in

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

the fiscal note due to updating the per capita costs and caseload estimates to those in the request. The total for each program is listed in the table below. Following the tables are short descriptions for each of the programs.

Health Care Expansion Fund Programs	FY 2009-10		FY 2010-11	
	Total Funds	Health Care Expansion Fund	Total Funds	Health Care Expansion Fund
Expansion Adults	\$43,016,134	\$21,508,068	\$52,499,637	\$26,249,819
Expansion Foster Care	\$2,223,974	\$1,111,987	\$2,848,573	\$1,424,287
Presumptive Eligibility	\$2,868,270	\$1,434,135	\$3,076,475	\$1,538,238
Legal Immigrants	\$33,070,058	\$16,535,029	\$37,224,679	\$18,612,340
Removal of Medicaid Asset Test	\$69,988,186	\$34,994,093	\$78,103,937	\$39,051,969
Children's Home and Community Based Services	\$20,668,579	\$10,334,290	\$21,921,543	\$10,960,772
Children's Extensive Support	\$3,187,964	\$1,593,982	\$3,381,224	\$1,690,612
Total*	\$175,023,165	\$87,511,584	\$199,056,068	\$99,528,037

* Figures presented are not adjusted for the impact of the American Recovery and Reinvestment Act (ARRA).

The Department's projections for presumptive eligibility, legal immigrants, the removal of the Medicaid asset test (adult and children expansion), Children's Home and Community Based Services, and Children's Extensive Support are typically described in detail in the Tobacco Tax Update included with of this Budget Request. However, due to the impact of state mandated furlough days, the narrative for the Tobacco Tax Update has been omitted from this budget request. Please refer to the Department's February 2009 Supplemental Request for Medical Services Premiums and Tobacco Tax Update for a description of the Department's forecast methodologies, where appropriate.

Expansion Adults

Eligibility for low-income adults was expanded via HB 05-1262. Clients who do not qualify as Categorically Eligible Low Income Adults (AFDC-A), have income less than 60% of the federal poverty level, and have children who are Medicaid eligible. Foster care eligibility for some clients was extended to children up to age 21 via SB 07-002. These populations receive the full family-Medicaid benefits package, and are forecast as part of the standard per capita development in Exhibits F, G, H, and I.

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

Expansion Foster Care

Foster care eligibility for some clients was extended to children up to age 21 via SB 07-002. The Department began forecasting costs for these clients separately from the traditional Foster Care population as of this Budget Request due to substantial differences in the service utilization patterns between the two populations. In forecasting caseload and per capita costs for this population using historical expenditure data and enrollment levels, the Department assumes that this population is still in the ramp-up phase of program implementation. Therefore, per capita cost and caseload growth rates are expected to exceed those projected for the traditional Foster Care population until FY 2010-11. However, per capita cost growth for this population has stabilized over the past year, and is expected to grow by 3.14% in FY 2010-11.

Presumptive Eligibility

The Department discontinued Medicaid presumptive eligibility on September 1, 2004. Pursuant to HB 05-1262 the Department reinstated the presumptive eligibility process, effective July 1, 2005. Similar to the Children's Basic Health Plan, presumptive eligibility for Medicaid was handled through the Anthem network through December 2007. To be eligible for presumptive eligibility, a woman shall have a verified pregnancy, declare that her household's income shall not exceed 133% of federal poverty level and declare that she is a United States citizen or a documented immigrant. Eligibility for Medicaid must be determined by the county within 45 days of application. Once eligibility is determined, the client will be taken off presumptive eligibility and may go to fee-for-service or another Medicaid health maintenance organization. Previously, the Department made payments to Anthem based on the estimated cost per client per month, and checks for duplicates to assure that payments are not also made through the Medicaid Management Information System for these clients. Effective January 2008, clients who receive presumptive eligibility are being accounted for through the Medicaid Management Information System.

Using the normalized data, the Department has projected caseload for FY 2009-10 and FY 2010-11 using historical enrollment figures. Expenditure is projected using the current average monthly cost multiplied by the monthly caseload. The Department has forecasted expenditure based on historical monthly expenditure and caseload.

Optional Legal Immigrants

SB 03-176 eliminated Medicaid coverage to legal immigrants. However, implementation of the bill was delayed. During the delay Tobacco Tax funds funded the expenditures for these clients resulting in continuous coverage for this population. HB 05-1086 reinstated Medicaid coverage for legal immigrants and a provision was added to HB 05-1262 to provide funding from the Health Care Expansion Fund on an ongoing basis.

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

Citizenship status is collected to determine which applicants are categorized as legal immigrants versus illegal immigrants in the Colorado Benefits Management System. Illegal immigrants have no documentation and are eligible for emergency services only. Legal immigrants with 5 or more years of residency and 40 or more work quarters are categorized as a mandatory Medicaid population and receive full benefits, provided they meet the eligibility requirements other than citizenship status. Optional Medicaid legal immigrants (those who have 5 years of residency but less than 40 work quarters) also receive full medical benefits. When SB 03-176 passed, it was intended to eliminate full Medicaid benefits for optional legal immigrants and provide emergency services only. However, SB 03-176 was never implemented and these clients did not lose their full Medicaid benefits. HB 05-1086 reinstated the benefits for these optional legal immigrants. The Department identified system changes that can be made within the Colorado Benefits Management System that has enabled the Department to track this expansion population. Effective August 2007, the Department implemented system changes enabling it to track actual expenditures and monthly enrollment levels for the Optional Legal Immigrants population.

Due to the reinstatement of services to legal immigrants granted by HB 05-1086, \$2,638,343 was funded through the Health Care Expansion Fund for FY 2004-05. In FY 2007-08, the Department was appropriated \$11,596,517 for legal immigrants; the amount funded by the Health Care Expansion Fund was \$6,216,752 (Figure Setting, March 8, 2007, Appendix B, page 11). The Department's projections have been revised to include the actual projected expenditure for this population beginning with FY 2008-09.

Removal of the Medicaid Asset Test

Effective July 1, 2006, the asset test no longer applies to children and adults. As a result, clients who were previously ineligible for Medicaid became Medicaid eligible. Additionally, clients who were eligible for only the Children's Basic Health Plan now qualify for Medicaid. During FY 2006-07, the Department began to receive data on clients who are affected by the removal of the asset test. Currently, however, the Department's reporting only identifies total expenditure and not expenditure by eligibility category. The Department has forecasted expenditure based on historical monthly expenditure and known caseload.

Because the Department is no longer able to request asset test information for individuals who are not applying for Medicaid and other financial assistance programs, the asset test removal population has been difficult to track. Changes to the Colorado Benefits Management System allow for all individuals applying for Medicaid benefits to be marked with a flag that reports the following: whether the client would have been eligible for Medicaid regardless of the asset test removal; if the client would not qualify for Medicaid if the asset test was still in place; or, if it is unknown whether the client's assets are a factor in determining eligibility. Circumstances where this information may not be known include: existing clients who have not gone through a yearly re-determination, or clients who are not required to provide asset information as a result of not applying for other public assistance programs.

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

For clients who have not provided asset test information, the Department transfers funds from the Health Care Expansion Fund under the assumption that a number of clients who have not reported asset information would not have qualified for Medicaid prior to the rule change. In previous years the Department assumed that of the clients who had not reported asset information, the proportion of these clients who would not have qualified prior to the change was the same as the proportion of clients who had reported asset information and would not have qualified. However, based on analysis performed in FY 2007-08, the number of clients who have reported asset information is well below the original levels anticipated. Therefore, starting in FY 2007-08, the Department has revised the methodology used to allocate expenditure for clients who have not reported asset information. The Department's preliminary research indicates that clients who gained eligibility because of the removal of the asset test have significantly higher income on average than clients who would have qualified regardless of the change. Further, clients who have not reported asset information have significantly higher income than those clients who have reported asset information. Based on this information, the Department believes that there is a significant under-reporting bias in the eligibility data, in that clients who have higher income are less likely to provide asset information.

Given the under-reporting bias, the Department does not believe that it is appropriate to use the strict ratio of clients who would not have qualified to the total population who have reported asset information. Rather, the Department has used that ratio as a base, and inflated it by 100%. This figure is a rough estimate, based on the average difference in incomes between clients who have reported asset information but would not have previously qualified for Medicaid and those that have not provided asset information. Because the results are preliminary, the Department has made a number of assumptions to ensure that the estimate is conservative and reasonable, and has rounded the figure because of the inherent uncertainty of this projection. The Department continues to research this issue, and anticipates that a more comprehensive and permanent framework will be available in a future Budget Request.

The methodology used to forecast costs for these clients assumes that similar patterns of caseload and per capita cost growth exist within eligibility types. The Department uses the executive forecasts of caseload and per capita growth rates amongst the eligibility types potentially affected by the removal of the asset test, weighted by the relative size of those populations, to project total expenditures for the removal of the asset test into future budget years.

Children's Home and Community Based Services and the Children's Extensive Support Waiver Program Expansion

The Children's Home and Community Based Services (CHCBS) and the Children's Extensive Support (CES) waiver programs are programs that use Medicaid funds to serve children that would not qualify for Medicaid under standard eligibility criteria. The waiver programs relax eligibility requirements for certain populations and apply to receive federal matching funds for the program. Upon approval, the waiver programs are eligible to receive federal matching funds at the Medicaid defined rates for state expenditures. Once a child is on the waiver, he/she must receive at least one state-paid waiver service per month to remain on either of the Waiver programs.

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

In order to calculate the impact to the Health Care Expansion Fund, the Department calculates the estimated total cost per waiver slot for each program, and multiplies that cost by the total number of slots. The CHCBS waiver has 678 waiver slots, and the CES waiver has 79 slots which are funded via the Health Care Expansion Fund. For the CES waiver, waiver costs are not charged against the Medical Services Premiums Long Bill group; rather, those costs are borne by the Department of Human Services.

In FY 2007-08, the Department changed the methodology to account for the CHCBS waiver slots. In previous years, the Department considered each waiver slot as numbered sequentially; that is, the “last” 678 slots were considered expansion slots. This had the result of effectively reducing the total number of waiver slots eligible for Tobacco Tax funding, as there are delays in filling waiver slots when those slots become available. In its February 15, 2008 Budget Request, the Department requested to move to an “average slot” methodology, where the average per capita cost per slot was used to determine the total expenditure. The Joint Budget Committee approved the Department’s methodology during Figure Setting in March 2008. Effective with FY 2008-09, the Department is requesting to apply this methodology to the CES waiver program as well. This has the effect of increasing the effective number of slots from 59 to 79, the total amount of expansion slots added.

Hospital Provider Fee Funded Populations (Pages EJ-7 and EJ-8)

HB 09-1293, the Health Care Affordability Act of 2009, authorizes the Department to collect hospital provider fees for the purpose of obtaining federal financial participation for the state’s medical assistance programs and using the combined funds to: (I) increase reimbursement to hospitals for providing medical care under the medical assistance program and the Colorado Indigent Care Program; (II) increase the number of persons covered by public medical assistance; and (III) pay the administrative costs to the Department in implementing and administering the program. This bill has a FY 2010-11 impact on the Medical Services Premiums budget request and would similarly have an impact on FY 2009-10 should the program receive federal approval in time for current year implementation. The Department is presenting the updated figures for FY 2009-10 (page EJ-7) for informational purposes. Because the Department’s appropriations are conditional upon federal approval, the estimated impact on FY 2009-10 is removed from the Department’s official request in Exhibit A.

The Department anticipates enrolling new clients into the Medicaid system beginning in April 2010. The populations, described, below, will be funded through revenue generating from federal funds and two State cash funds: the Hospital Provider Fee Fund and the Medicaid Buy-in Fund.

Hospital Provider Fee Fund

HB 09-1293 establishes this fund provides for costs of administering Medicaid programs to three of the four HB 09-1293 expansion populations that impact the Medical Services Premiums budget (a fifth expansion population impacts the CHP+ program):

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

Expansion Adults to 100%

While the Health Care Expansion Fund provides funding for parents of children enrolled in Medicaid or the Children's Basic Health Plan from 36% to least 60% of the federal poverty level (see above), the Hospital Provider Fee Fund covers expenditures for parents from over 60% to 100% of the federal poverty level. Subject to federal approval, this expansion population would receive the same benefits as parents currently eligible under Medicaid. The Department estimated that rules and a state plan amendment would be approved by March 2010, with an effective date of April 1, 2010.

The Department's estimated caseload for this expansion are based on data provided by The Lewin Group. This data is described in the Department's February 16, 2008 Budget Request, S-3, "Children's Basic Health Plan Medical Premium and Dental Benefit Costs." For this expansion, the Department has assumed phase-in rates of 30% in FY 2009-10, 70% in FY 2010-11, and 90% in FY 2011-12. The Department will update these caseload estimates through the normal budget process when more recent data become available.

The Department assumes that the medical and mental health per capita costs for this expansion group will be the same as those for the Medicaid Expansion Adults population. The Department will update these per capita estimates through the normal budget process when more recent data become available.

Continuously Eligible Children: Family Medical Program and Foster Care

The Department anticipates providing 12 months of guaranteed eligibility to children in Medicaid beginning in February 2012. The Department assumes that it would be necessary to revise its State Medical Services Board rules as well as submit a state plan amendment.

The Department assumes that with 12-month guaranteed eligibility in Medicaid as described above, the average length of stay in Medicaid and the Children's Basic Health Plan would equalize at a lower level than experienced by children currently in Children's Basic Health Plan. This is due to children being able to move between the programs within the same 12-month guaranteed period, which would result in a slightly lower average length of stay in both programs.

The Department assumes that fee-for-service costs for these additional months of service would be lower than the current Medical Services Premiums per capitas. The current per capitas do not assume 12-months of guaranteed eligibility. Low-income clients are assumed to have a pent up demand for services, which drives higher per capita costs. For the additional months created by 12-month guaranteed eligibility, these higher cost services are assumed to be resolved, and the per capita should decline.

Adults Without Dependant Children to 100% FPL

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

The Department assumes that it would be necessary to revise its State Medical Services Board rules, submit a state plan amendment, as well as receive a federal waiver to establish the proposed Adults Without Dependant Children (AWDC) program (previously known as Childless Adults), effective January 2012. The Department assumes that the new AWDC program would require an 1115 demonstration waiver from CMS. Section 1115 of the Social Security Act provides CMS broad authority to authorize experimental, pilot, or demonstration projects likely to assist in promoting the objectives of the Medicaid statute. Flexibility under Section 1115 is sufficiently broad to allow states to test substantially new ideas of policy merit. Some states expand eligibility with 1115 waivers to individuals not otherwise eligible under the Medicaid program, provide services that are not typically covered, or use innovative service delivery systems.

The number of uninsured individuals assumed to participate in the program is based on data provided by income date and analysis supplied by The Lewin Group.

The assumed medical per capita for the AWDC program is based on the actuarially developed rate for the basic benefit package outlined in the 'Better Health Care For Colorado' proposal from the Blue Ribbon Commission for Healthcare Reform, trended forward by projected medical inflation. The Department assumes that these individuals would also be eligible for mental health benefits and has assumed the per capita cost for Medicaid low-income adults.

Medicaid Buy-in Fund

This fund is administered by the Department to support expenditure for the Buy-in for Individuals with Disabilities expansion population, as authorized by HB 09-1293.

Buy-in for Individuals with Disabilities

Disabled individuals with income up to 450% of the federal poverty level would become eligible for Medicaid benefits beginning in July 2011. The Department assumes that it would be necessary to revise its State Medical Services Board rules, and seek appropriate federal approval in order to establish the proposed Medicaid Disabled Buy-in program.

The Department's estimated caseload for this expansion are based on data provided by The Lewin Group. This data is described in the Department's February 16, 2009 Budget Request, S-3, "Children's Basic Health Plan Medical Premium and Dental Benefit Costs," and will be updated with more recent data as it becomes available.

The Department assumes that the Medical Services Premiums and Medicaid Mental Health per capita costs for the Disabled Buy-In program will be comparable to those for the current Medicaid Disabled Individuals to 59 (AND/AB). The Department assumes that

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

the Mental Health per capita for the Buy-In program would be equivalent to that for Medicaid Disabled Individuals to 59, and the Medical Services Premiums per capita is adjusted based on the following assumptions:

- The Department assumes that there would be proportionally fewer children in the Buy-In program than in the current Medicaid Disabled Individuals to 59 (AND/AB) population. Parental income is not included in the determination of eligibility for children’s waivers, so there should be few high income children that would not already be eligible. On average, children exhibit higher costs than adults, so the per capita is decreased based on the costs of adults in Disabled Individuals to 59 compared to the total per capita.
- The Department assumes that most clients in the Buy-In program will have little utilization of many Home and Community Based Services waivers and other Long Term Care services. The Department assumes that few individuals with the ability to work would meet the level of care for either a waiver or nursing facility, decreasing the per capita costs.

Hospital Provider Fee Programs	FY 2009-10		FY 2010-11	
	Total Funds	Cash Fund	Total Funds	Cash Fund
Expansion Adults to 100%	\$1,912,910	\$956,455	\$32,938,535	\$16,469,268
Continuously Eligible Children: Family Medical Program	\$0	\$0	\$0	\$0
Continuously Eligible Children: Foster Care	\$0	\$0	\$0	\$0
Buy-in for Individuals with Disabilities	\$0	\$0	\$0	\$0
Adults without Dependant Children to 100% FPL	\$0	\$0	\$0	\$0
Total	\$1,912,910	\$956,455	\$32,938,535	\$16,469,268

EXHIBIT K - UPPER PAYMENT LIMIT FINANCING

The Upper Payment Limit financing methodology accomplishes the following:

- Increases the Medicaid payment up to the federally allowable percentage for all public government owned or operated home health agencies, outpatient hospitals, and nursing facilities without an increase in General Fund.
- Maximizes the use of federal funds available to the State under the Medicare upper payment limit through the use of certification of public expenditures.

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

- Reduces the necessary General Fund cost by using the federal funds for a portion of the State's share of the expenditures.

The basic calculation for Upper Payment Limit financing incorporates the difference between Medicare and Medicaid reimbursement amounts, with slight adjustments made to account for different types of services and facilities. Because actual Medicare and Medicaid reimbursement amounts are not yet known for the current fiscal year, prior year's data for discharges, claims, and charges are incorporated into the current year calculation.

Funds received through the Upper Payment Limit for outpatient hospital services are used to offset General Fund expenditures. These offsets started in FY 2001-02. Similar methodologies are used for home health and nursing home premiums. While outpatient hospital services and nursing facilities account for a large portion of Upper Payment Limit funding, home health has expenditures that are relatively small by comparison, and will experience little impact related to changes in reimbursement rates.

In FY 2005-06, the Department only certified expenditure for a half year due to a federal audit requiring the Department to certify expenditure on a calendar year basis. During Figure Setting in March 2006, the Department's FY 2006-07 Base Reduction Item 2 (November 15, 2005) was approved; starting in FY 2006-07, the Department will record exactly the certified amount as Cash Funds Exempt.

During FY 2007-08, the Department was informed by the Centers for Medicare and Medicaid Services (CMS) that it would no longer be permitted to certify public expenditure for nursing facilities. However, in FY 2008-09, CMS and the Department came to an agreement which allowed for a certification process as long as it included a reconciliation process to provider cost. Therefore, the Department has included expenditure for certification of public nursing facility expenditure. Where applicable, the Department's estimates will be adjusted for any reconciliation performed.

Projections for all provider types are provided in Exhibit K.

EXHIBIT L - APPROPRIATIONS AND EXPENDITURES

This exhibit displays the FY 2008-09 final actual total expenditures for the Medical Services Premiums, including fund splits, the remaining balance of the FY 2008-09 appropriation, and the per capita cost per client. The per capita cost in this exhibit includes Upper Payment Limit and financing bills. This exhibit will not match Exhibit C due to these inclusions.

EXHIBIT M – CASH-BASED ACTUALS

Actual final expenditure data by service category for the past eleven years are included for historical purpose and comparison. This history is built around cash-based accounting, with a 12 month period for each fiscal year, based on paid date. This exhibit displays the estimated distribution of final service category expenditures by aid category from the estimated final expenditures by service categories. This is a necessary step because expenditures in the Colorado Financial Reporting System (COFRS) are not allocated to eligibility categories. The basis for this allocation is the Medicaid Management Information System, Management and Administrative Reporting Subsystem report named the “REX01/COLD (MARS) 464600.” This report provides detailed monthly data by eligibility category and by service category, as defined by a general ledger code structure. From that step, the percent of the total represented by service-specific eligibility categories was computed and then applied to the final estimate of expenditures for each service category within each major service grouping: Acute Care, Community Based Long Term Care, Long Term Care and Insurance (including subtotals for long term care and insurance pieces separately), and Service Management.

For the February 2010 request, Exhibit M also includes the year-to-date FY 2009-10 expenditure.

Effective with the November 1, 2007 Budget Request, the Department has made several labeling changes to this exhibit:

Service Group	Old Title	New Title
Acute Care	Administrative Service Organizations - Services	Prepaid Inpatient Health Plan Services
Community Based Long Term Care	Home and Community Based Services - Case Management	HCBS - Elderly, Blind, and Disabled
Community Based Long Term Care	Home and Community Based Services - Mentally Ill	HCBS - Mental Illness
Community Based Long Term Care	Home and Community Based Services-Children	HCBS - Disabled Children
Community Based Long Term Care	Home and Community Based Services - People Living with AIDS	HCBS - Persons Living with AIDS
Community Based Long Term Care	Consumer Directed Attendant Support	HCBS - Consumer Directed Attendant Support
Community Based Long Term Care	Brain Injury	HCBS - Brain Injury

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

Service Group	Old Title	New Title
Service Management	Administrative Service Organizations Administrative Fee	Prepaid Inpatient Health Plan Administration

Effective with the February 15, 2008 Budget Request, the Department has restated actuals for the Prepaid Inpatient Health Plan Services service category for FY 2006-07. The Department has adjusted the allocation to exclude categories that did not utilize this service category. The total amount in aggregate remains the same.

Effective with the November 3, 2008 Budget Request, the Department has restated actuals for Single Entry Points from, by using HCBS utilization rates as opposed to total expenditure in Community Based Long Term Care and Long Term Care service categories.

While trying to recreate the past history of expenditures in a cash-based environment, some documents and spreadsheets with the history of adjustments were no longer available. There is a greater opportunity for manual adjustments in the Colorado Financial Reporting System that do not get recorded in the Medicaid Management Information System (MMIS) during the accounts payable period. This can skew the reconciliation between the Computer Output to Laser Disk (COLD) storage of Medicaid Management Information System report and the Colorado Financial Reporting System (COFRS).

EXHIBIT N – EXPENDITURE HISTORY BY SERVICE CATEGORY

Annual rates of change in medical services by service group from FY 1995-96 through FY 2008-09 final actual expenditures are included in this Budget Request for historical purpose and comparison. This exhibit has been revised to list more recent years first.

EXHIBIT O – COMPARISON OF BUDGET REQUESTS AND APPROPRIATIONS

This exhibit compares the Department’s Budget Requests by broad service category to the Department’s Long Bill and special bills appropriations, for FY 2007-08, FY 2008-09, and FY 2009-10 in the chronological order of the events. Shaded areas indicate that the Request or appropriation has not yet taken place.

For FY 2007-08, this exhibit compares the Department’s November 1, 2006, February 15, 2007, November 1, 2007, and February 15, 2008 Budget Requests to the final FY 2007-08 appropriation and actuals.

For FY 2008-09, this exhibit lists the Department’s November 1, 2007, February 15, 2008, November 3, 2008, and February 16, 2009 Budget Requests to the FY 2008-09 appropriation including special bills, and the placeholder used by the Joint Budget Committee during the Department’s Supplemental briefing.

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

For FY 2009-10, this exhibit compares the Department's November 3, 2008, February 16, 2009, and November 6, 2009 Budget Requests.

EXHIBIT P – GLOBAL REASONABLENESS

This exhibit displays several global reasonableness tests as a comparison to the projection in this Budget Request. In addition, on page EP-3, this exhibit displays the FY 2009-10 year-to-date expenditures through September 2009 and the cash flow pattern of actual expenditures for the first quarter of FY 2008-09 to determine a rough estimate of FY 2009-10 expenditures, with certain exceptions. This exhibit is a rough projection utilizing past expenditure patterns as a guide to future expenditures. The Cash Flow Pattern is one forecasting tool used to estimate final expenditures on a monthly basis. It is not meant to replace the extensive forecasting used in the official Budget Request and is not always a predictor of future expenditures.

In places where the Department does not expect the prior year cash flow pattern to be relevant to the current year, the Department has made adjustments based on knowledge of current program trends. Exceptions to the cash flow pattern are noted in footnotes on page EP-3.

EXHIBIT Q – CASELOAD GRAPHS

This exhibit is described in the Caseload Narrative.

V. ADDITIONAL CALCULATION CONSIDERATIONS

Several bills passed during the 2008 and 2009 legislative sessions affect the Department's Request for Medical Services Premiums. Additionally, the Department has added several bottom-line impacts for factors which are not reflected in historical trends. This section details the adjustments the Department has made to the Request for Medical Services Premiums.

HB 08-1373 – Concerning the Breast and Cervical Cancer Prevention and Treatment Fund

HB 08-1373 altered the funding source for the Breast and Cervical Cancer Program for FY 2007-08 through FY 2013-14. For FY 2007-08 and FY 2008-09, 100% of the state funding is provided from the Breast and Cervical Cancer Prevention and Treatment Fund. For FY 2009-10 through FY 2013-14, 50% of the state funding is provided from the Breast and Cervical Cancer Prevention and Treatment Fund, and the remainder is provided from the General Fund. This bill did not impact the expansion clients who are funded through the Prevention, Early Detection, and Treatment Fund. This bill was amended by SB 09-262, which is described below.

HB 08-1409 - Concerning Recovery of Payments under Medicaid

HB 08-1409 authorizes the Department to take all reasonable measures to determine the legal liability of third parties to pay for services provided to Medicaid clients and to pursue claims against liable parties. As a condition of doing business in the state, third parties such as health insurance carriers and managed care organizations are required to do the following: provide monthly eligibility records identifying everyone to whom they provide benefits; accept the state's right of recovery of Medicaid payments; and respond to inquiries by the state regarding claims for payment that are within 3 years of the date of service. This bill also aligns Colorado law with federal requirements established in the Deficit Reduction Act of 2005. The bill reduced the Department's appropriation in FY 2008-09 by \$300,000, annualizing to \$400,000 in FY 2009-10.

SB 08-090 - Concerning Mail-Order Prescription Drugs under the State Medical Assistance Program

SB 08-090 makes the following two changes regarding mail-order prescription drugs under Medicaid: it allows Medicaid clients to use a mail-order pharmacy if they have third-party insurance and require maintenance medications, and it authorizes a mail-order pharmacy to bill Medicaid for the difference between the Medicaid co-payment and a third-party insurer's co-payment or deductible. Because Medicaid is the payer of last resort, when Medicaid clients also have third-party insurance, pharmacies are required to bill the insurer prior to billing Medicaid. However, when a local pharmacy bills a third-party insurer that requires the use of mail-order for maintenance medications, the insurance claim is denied. Because current law disallows mail-order pharmacies from billing Medicaid for the client's co-payment, either the client pays the co-payment required by the insurer, or Medicaid is billed for the entire claim. SB 08-090 allows Medicaid to pay the difference between the Medicaid co-payment (paid by the client) and the insurance co-payment.

The bill reduced the Department's appropriation in FY 2008-09 by \$279,272 in FY 2008-09, annualizing to \$478,752 in FY 2009-10.

SB 08-099 – Concerning Extending Medicaid Eligibility for Persons Who Are in the Foster Care System Immediately Prior to Emancipation

SB 08-099 expands Medicaid eligibility to young adults, under age 21, for whom the state made subsidized adoption or foster care payments immediately prior to the client turning age 18. These young adults were not eligible for Title IV-E federal funds while in foster care, but received state benefits. SB 07-002 expanded Medicaid eligibility to young adults, ages 18 to 21, who qualified for federal benefits through Title IV-E and aged-out of foster care or subsidized adoption programs. Anticipated caseload was based on the automatic enrollment of all young adults meeting the eligibility requirements. However, implementation of SB 07-002 has not progressed as anticipated.

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

Enrollment of these young adults has not approached the estimates provided. Only a small fraction of the estimated eligible clients have enrolled. Low enrollment is due to several factors, most notably the delay in computerized enrollment. Low enrollment can also be attributed to clients moving out of state, lack of knowledge about the expanded eligibility, lack of interest in receiving Medicaid benefits, and availability of employer-sponsored coverage. With the expansion in SB 08-099, the Department anticipates much stronger growth in the caseload for this population than occurred in FY 2007-08.

As with SB 07-002, clients who gain eligibility under the provisions of SB 08-099 are funded via the Health Care Expansion Fund. For FY 2008-09, the Department received an appropriation of \$692,121, annualizing to \$1,086,735 in FY 2009-10. The Department has updated the estimated cost of the program (including the effects of SB 07-002 and SB 08-099) in Exhibit A, starting on page EA-4. The Department's Request includes the most current estimates for caseload and per capita cost for these clients.

SB 09-259 – FY 2009-10 Long Bill

The FY 2009-10 Long Bill contained funding for a number of initiatives the Department proposed as Change Requests as well as Joint Budget Committee actions during the 2009 Legislative Session which impact the Medical Services Premiums budget request. Except where noted, the Department uses the appropriated value as the bottom-line impact. All figures listed are total funds.

- *Pharmacy Technical and Pricing Efficiencies (BRI-1)*: This Budget Reduction Item reduces FY 2009-10 expenditure by an estimated \$1,022,887, with an additional \$1,110,999 reduction in FY 2010-11, as the result of an automated prior authorization system for pharmacy claims as well as through changing the reimbursement rates for drugs using a state maximum allowable cost structure.
- *Medicaid Program Efficiencies (BRI-2)*: This Budget Reduction Item increases FY 2009-10 expenditure by an estimated \$141,964, with an additional \$464,864 increase in FY 2010-11. The Department will begin allowing trained medical and dental professional to administer fluoride varnish treatments to children up to age 6.
- *Community Transitions Services for Mental Illness Waiver Clients (BA-15)*: This Budget Reduction Proposal estimates a reduction of \$373,390 in FY 2009-10 expenditure due to clients utilizing the relatively less costly waiver services rather than residing in a facility. The savings annualizes to \$388,324 in FY 2010-11.
- *Additional Certification for Outpatient Charges (BA-24)*: This Budget Amendment annualizes the Department's updating of its "cost-to-charge" ratios for outpatient hospitals. The Department estimates a reduction of \$4,897,557 in FY 2009-10.
- *Provider Volume and Rate Reductions (BA-33)*: This Budget Reduction Proposal includes several initiatives to reduce Medicaid expenditure. The proposal includes some direct rate reductions, however, where possible, the Department presented ideas on how to reduce avoidable, inappropriate, duplicative or unnecessary volume and create efficiencies. Together, the following initiatives reduced the Medical Services Premiums budget request by \$54,027,098 total funds:

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

- Enroll Eligible Veterans in VA Health Care System: The Department estimates a reduction of \$10,826,952 by increasing efforts to coordinate with the Department of Veterans Affairs (VA) to enroll eligible veterans in the VA health care system. Of the total fund savings, \$9,129,991 is a reduction of expenditure for Acute Care services, and \$1,696,961 is a reduction to Community Based Long Term Care services expenditure.
- Prior Authorization of Anti-convulsant Drugs: The Department estimates a reduction of \$960,000 in expenditures for Acute Care services by adding anti-convulsant pharmaceuticals to prior authorization requirements and/or the preferred drug list for non-seizure uses of anti-convulsants, excluding treatment for seizures.
- Correct Home Health billing for Dual Eligibles: The Department estimates a reduction of \$500,000 in Acute Care expenditure for home health services by implementing enhanced requirements to ensure that clients are fully exhausting their Medicare home health benefit or have Medicare determine the care is not a covered benefit before receiving the full Medicaid benefit. The savings is achieved by reducing the total claims which are inappropriately billed by providers and paid by Medicaid.
- Restrict Inpatient Hospital Claims for Readmission with in 24 Hours: The Department estimates a \$1,400,000 reduction in Acute Care expenditure by altering its claims system to automatically deny a separate bill for clients who are readmitted to the same hospital for the same condition less than 24 hours after the initial discharge. Until system changes are complete, the Department, through its existing utilization review contracts, manually denies these claims.
- HCBS Cost Sharing for High Income Families: The Department estimates a reduction of \$22,383 in Community Based Long Term Care services by implementing cost-sharing requirements for Home and Community Based Services programs for clients/families with incomes over \$250,000.
- Reduce Pharmacy Reimbursement: The Department estimates a reduction of \$3,489,218 in FY 2009-10 by reducing the reimbursement rates paid for pharmacies to the average wholesale price (AWP) minus 14.5% for brand-name drugs, and AWP minus 45% for generic medications.
- Reduce Selected Physician Codes to 100% of Medicare: The Department estimates a \$5,432,902 reduction to Acute Care expenditure by reducing selected physician codes below 100% of the Medicare rate.
- Rate and Volume Reductions: The Department estimates a reduction of \$30,833,418, in total Medical Services Premiums expenditure, equivalent to approximately 2% of Acute Care expenditure, is due to provider rate and volume reductions. An estimated reduction of over \$20,300,000 is due to rate reductions effective July 1, 2009; these include fee-for-service Acute Care reductions as well as a reduction of \$1,107,125 for HMO payments, \$4,660,232 in Community Based Long Term Care services, and \$505,223 for payments to Single Entry Points. The balance of savings is produced through volume reductions for programs, including:
 - Dental services
 - Durable Medical Equipment (DME)
 - Practitioner Services including Imaging, Physician Services (E&M), NEMT, and others

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

- Home Health and HCBS Elderly Blind & Disabled Waiver, Persons with Mental Illness Waiver, and Persons Living with AIDS Waiver
- Hospital Services
- *Enhanced Estate and Income Trust Recoveries (BA-36)*: This Budget Reduction Proposal estimates that an additional \$1,116,721 in estate and income trust recoveries in FY 2009-10 would be the direct result of the enhanced recovery efforts. The Department is in process of amending the contract with HMS, a contractor, to explicitly enhance estate and income trust recovery efforts. The Department estimates a reduction of \$1,116,721 in FY 2009-10.
- *Increased Enrollment in Health Insurance Buy-In Program (BA-37)*: This Budget Reduction Proposal estimates an increase in enrollment of 100 new HIBI clients for FY 2009-10 by repurposing existing resources to process a current backlog of HIBI applications. The administrative cost of this initiative is \$336,538 in FY 2009-10, and the estimated savings in Acute Care services in the same fiscal year is \$961,538. The Department estimates that the initiative will result in an estimated overall savings of \$625,000 in FY 2009-10.
- *Administrative costs for Colorado Alliance for Health and Independence (CAHI) Prepaid Inpatient Health Plan*: The Joint Budget Committee recommended and approved \$500,000 in additional appropriated total funds for the 2009 Long Bill to implement the coordinated care for people with disabilities pilot program as directed by SB 06-128, which authorizes the Department to pay a per member per month administration fee.
- *Transfer of Funds to Pediatric Specialty Hospital Line Item (Joint Budget Conference Committee Amendment)*: The Joint Budget Committee recommended and approved a transfer of \$2,211,994 from the Pediatric Specialty Hospital Fund for use for general state expenditure.

SB 09-261 – Concerning the Use of Moneys in the Supplemental Old Age Pension Health and Medical Care Fund to Pay for Services Received by Certain Persons in the State Medicaid Program

This bill authorizes the use of the Supplemental Old Age Pension Health and Medical Care Fund for persons age 65 or older who are served through the state Medicaid program; the fund is used to cover Medicaid costs associated with clients age 65 and older who would have otherwise been eligible for the OAP Medical program. Moneys in the fund can be applied toward Medicaid expenditures for FY 2008-09 and FY 2009-10 only. General Fund expenditures for FY 2008-09 were reduced by a \$3.0 million offset from the fund, and FY 2009-10 expenditures were reduced by a \$6.0 million offset from the same fund.

SB 09-262 – Concerning the Funding Source for State Costs of the Breast and Cervical Cancer Prevention and Treatment Program

This bill amends HB 08-1373. The state cost for the Medicaid Breast and Cervical Cancer Prevention and Treatment Program was fully funded through the Breast and Cervical Cancer Prevention and Treatment (BCCPT) Fund for FY 2008-09, and the state funding sources was due to change in FY 2009-10 to 50 percent from the General Fund and 50 percent from the BCCPT Fund. SB 09-262 specifies that 100 percent of the state funding for the program is from the BCCPT Fund for FY 2009-10 through 2011-12. Then, for FY 2012-13 and FY 2013-14, the formula returns to 50 percent General Fund and 50 percent BCCPT Fund. After FY 2013-14, the state cost for the program is paid 100 percent from the General Fund. This change impacted Medical Services Premiums expenditures in FY 2009-10 by reducing the needed General Fund expenditure by \$874,603, with a corresponding increase from the BCCPT Fund.

SB 09-263 – Concerning Payments to Medicaid Nursing Facility Providers

SB 09-263 makes changes in the calculation of Medicaid nursing facility reimbursement rates. The bill specifies the method to calculate the General Fund share of payments to Medicaid nursing facilities during the federal American Recovery and Reinvestment Act (ARRA) time period; reduces the growth rate for the General Fund share from 3 to 0 percent in FY 2009-10, allows for 5 percent growth in FY 2010-11, and reinstates the current 3 percent cap in future fiscal years; specifies that payments made to nursing facilities as a result of provider fees and matching federal funds are supplemental payments instead of an additional per diem rate, and allows payments to be reduced by the Department of Health Care Policy and Financing based on available funding; limits the nursing facility provider fee to \$7.50 per non-Medicare-resident day in FY 2009-10, and allows the fee to increase by inflation in future years; limits the increase in the reimbursement of direct and indirect health care services and raw food to 8 percent per year, determined and indexed from the health care portion of rates effective on July 1, 2009; includes a hold-harmless provision for administration and general services under certain circumstances; and makes certain changes to the pay-for-performance payments for nursing facilities. The effect of SB 09-263 is discussed in detail in the section for Exhibit H in this narrative.

SB 09-265 – Concerning the Timing of Payments Made Under Public Medical Assistance Programs

SB 09-265 provides that, 1) the Medicare Modernization Act State Contribution Payment does not have to be paid before the date it is due, 2) managed care capitation payments shall not be made before the first day of the month following the enrollment of the recipients, and 3) the Department of Health Care Policy and Financing has the authority to delay the last weekly provider payment cycles in FY 2009-10 to after July 1, 2010. These provisions impact the Medical Services Premiums budget request as follows:

- The Department will delay the last weekly provider payment cycle in FY 2009-10 to after July 1, 2010. This delay will reduce the total funds expended for Medical Services Premiums in FY 2009-10, including: a \$29,127,184 reduction in Acute Care

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

expenditures, a \$5,793,280 reduction in Community Based Long Term Care services, and the reimbursement for Class I Nursing Facilities will be reduced by \$10,129,504. This is a one-time shift which will require corresponding increases in expenditure for each respective service category in FY 2010-11

- The Department will not make managed care capitation payments before the first day of the month following the enrollment of the recipients. This impacts the total funds expended for Medical Services Premiums in FY 2009-10 by effectively shifting the last monthly payment in FY 2009-10 to FY 2010-11 for the following service categories: payments for Acute Care services will be reduced by \$11,850,594, Program of All-Inclusive Care for the Elderly (PACE) will be reduced by \$6,427,375, and payments for Prepaid Inpatient Health Plans will be reduced by \$380,781.

The Department's estimates in this request replace the estimates from the original fiscal note for SB 09-265.

SB 09-271 – Concerning the Use of Tobacco Revenues Generated Under Section 21 of Article X of the State Constitution in a State Fiscal Emergency

Pursuant to declaration of a state fiscal emergency in SJR09-35, for FY 2009-10 only, the bill expands the purposes for use of tobacco tax revenue (Amendment 35 moneys) in the Tobacco Education Programs Fund and the Prevention, Early Detection, and Treatment Fund. Specifically, moneys in these funds may be used for any health-related purpose and to serve persons enrolled in both the Children's Basic Health Plan and Medicaid. This change impacted Medical Services Premiums expenditures in FY 2009-10 by reducing the needed General Fund expenditure by \$27,400,000, with corresponding offsets from the following funds: \$8.0 million from the Tobacco Education Programs Fund, \$12.0 million from the Prevention, Early Detection, and Treatment Fund, and \$ 7.4 million from the Primary Care Fund.

Executive Order D 017 09 – Declaring Insufficient Revenues Available for Expenditures and Ordering Suspension of Certain State Programs and Services in order to Meet a Revenue Shortfall in Fiscal Year 2009-10

Executive Order D 017 09 included a series of initiatives presented by the Department to meet budget balancing goals. The budget request and/or spending authority for Medical Services Premiums was impacted by the following initiatives:

- ES-1, Enhanced Federal Funding Adjustments, is a net zero total funds request which reduces the General Fund by using the incremental savings to the Hospital Provider Fee Cash Fund due to the enhanced federal funds per the American Recovery and Reinvestment Act (ARRA) to offset General Fund expenditure. The savings is annualized in FY 2010-11.
- ES-2, Medicaid Program Reductions, reduces expenditure through combination of rate reductions, service restrictions, elimination of certain programs, increased cost-sharing, and financial efficiencies. Included in the request are seven initiatives which impact the Medical Services Premiums request:

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

- Provider Rate Reductions: A 1.5% reduction in the reimbursement rate paid for providers of Acute Care and Community Based Long Term Care services as well as payments to Single Entry Points for FY 2009-10. The effective date is September 1, 2009. Rates paid to managed care organizations, including PACE, will have corresponding decreases totaling approximately 1.2%; effective date October 1, 2009, with the extra month to allow for actuarial rate certification. In addition, the reimbursement rate for Class I nursing facilities is reduced by 1.5%; the effective date is March 1, 2010, since a statute changes is necessary. These reductions are bottom line adjustments for FY 2009-10, and the respective annualized impacts are bottom line adjustments for FY 2010-11.
- FQHC Payment Methodology: the Department reduced rates paid to federally qualified health centers (FQHC) by 50% of the difference between each provider's current rate and the minimum rate required under the Benefits Improvement and Protection Act of 2000 (BIPA), or an average of approximately 106% of BIPA, beginning September 2009. Currently, the Department pays FQHCs above the minimum rate required under federal law, set in the Benefits Improvement and Protection Act of 2000 (BIPA). The Department estimates that the statewide average reimbursement for FQHCs is currently 113% of BIPA.
- Prenatal State Only Benefits: the Department granted full eligibility to clients enrolled in its prenatal state-only program who meet all eligibility criteria except citizenship status retroactive back to July 2009; this allows the Department to receive federal financial participation for these clients without enrolling any new populations. This change was made possible due to new provisions in the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA).
- Pharmacy Reimbursements: the Department reduced rates paid to pharmacies to average wholesale price (AWP) minus 14.5% for brand-name medications and AWP minus 45% for generic medication, beginning September 2009.
- Expand PDL: the Department is expanding its preferred drug list (PDL) by subjecting approximately \$40,000,000 of gross pharmacy expenditure to new or additional restrictions under its PDL beginning March 2010, allowing the Department to receive an additional supplemental rebates back from manufacturers.
- Non-Medical Transportation Cap: the Department imposed a cap on the amount of non-medical transportation a client enrolled in a home and community based services waiver program can receive per week. Clients would be limited to two roundtrips per week. Trips to adult day programs are not be subject to the cap included limitations on the HCBS waiver transportation benefit.
- Personal Care Cap: the Department intended to impose a cap on the amount of personal care and homemaker services a client enrolled in a home and community based services waiver program can receive each day, effective January 1, 2010. Under the proposal, the Department would limit personal care expenditure to \$72.05 per day, which is 150% of the daily rate for a client living in an alternative care facility. The Department is currently seeking alternative options to achieve the cost savings from this initiative.

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

- ES-4, Safety Net Grant Reductions, eliminates certain supplemental payments made to providers participating in the Colorado Indigent Care Program (CICP) and the associated administrative expenses. These reductions to supplemental payments would be cash fund reductions to CICP line items that would be used to offset General Fund in the Medical Services Premiums line item.
- ES-6, Provider Rate Reductions, included a permanent 1.0% reduction in the reimbursement rate paid to providers for Acute Care Services and Community Based Long Term Care for the remainder of FY 2009-10, effective December 1, 2009.
- NP-ES#5, a Department of Human Services budget reduction initiative, closes 59 beds at the Colorado Mental Health Institute at Fort Logan. This impacts Medicaid as former residents of the Fort Logan institute relocate to an appropriate nursing facility.
- NP-ES#8, a Department of Human Services budget reduction initiative, closes a 32-bed Nursing Facility at Grand Junction Regional Center. This impacts Medicaid as former residents at the Regional Center relocate to an appropriate nursing facility.
- NP-ES#16 is a Department of Public Health and Environment budget reduction initiative which utilizes cash funds from the Tobacco Education Program Fund 18M to offset General Fund expenditure.
- NP-ES#17 is a Department of Public Health and Environment budget reduction initiative which utilizes cash funds from the Health Disparities Grant Program Fund 19F 18M to offset General Fund expenditure.
- NP-ES#18 is a Department of Public Health and Environment budget reduction initiative which utilizes cash funds from the Prevention, Detection and Treatment Fund 18N to offset General Fund expenditure.

S-8 Physician Supplemental Payment to Denver Health

S-8, Physician Supplemental Payment to Denver Health, provided the Department with spending authority to draw a federal financial match on uncompensated certified expenditures by Denver Health Medical Center on physician and other non-physician practitioner professional services. The Department estimates an expenditure reduction of \$14,569,507 in FY 2009-10, with an annualized impact of a \$3,160,385 in FY 2010-11.

The Department has been working with Denver Health to calculate these supplemental payments. That calculation has been evolving based upon changes in assumptions in which state fiscal year the payments would be made (or issues of payment timing), changes in the data used for the calculations, and changes in the methodology used to calculate the payments.

Regarding payment timing, the original calculations submitted via S-8 in February 2008, assumed Centers for Medicare and Medicaid Services (CMS) approval for the necessary State Plan Amendment would occur in state FY 2008-09 and payments would be made in that same fiscal year. At the time of the budget submission in November 2009, CMS approval had not occurred and subsequently

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

supplemental payment amounts for previous years were rolled into the request calculation for FY 2009-10. Additionally, a new calculation for supplemental payments from calendar year 2010 was added for the FY 2010-11 request year.

Regarding changes in data, between the November 2009 request and the February 2010 request, data was updated to include the most recently available data and Medicaid Management Information System (MMIS) claims data was replaced by Denver Health cost data.

Finally, regarding changes in methodology, between February 2009 and November 2009 requests, “Other Professional Services” billing was removed from the calculations in order to comply with CMS guidance.

The primary goals of the calculation process for supplemental payments for hospital-based physician services are to: secure approval of the methodology by CMS, ensure the data used to calculate the payments is logical, verifiable and auditable, and to ensure fair treatment of the Department’s providers and clients. The methodology has been evolving as a result of a better understanding of the data, especially regarding billed charges, which the Department has received from Denver Health. The Department has requested and received much more information from Denver Health and source data to support and verify the summary data used for the calculations. The Department continues to work with Denver Health develop the best sustainable methodology possible for this State Plan Amendment. It is possible additional changes to the calculation methodology may be required to secure approval by CMS.

Average Wholesale Pricing Reduction

The Average Wholesale Pricing Reduction results from the impact of the settlement of providers with First Databank, which effectively reduces the average wholesale price (AWP) of certain drugs. First DataBank has agreed to a settlement with plaintiffs in a lawsuit that alleges the company colluded with prescription drug wholesaler McKesson to raise the average wholesale prices of prescription drugs. Effective in late September 2009, First DataBank agreed to reduce the AWP’s for many drugs by five percentage points. Further, First DataBank will cease to publish the AWP’s two years after the settlement is final. The estimated expenditure reduction is \$5,058,978 in FY 2009-10, annualizing to and \$6,812,036 in FY 2010-11.

Reduction to Synagis Recommended Dosage

The American Academy of Pediatrics altered its recommendation for the appropriate use of Synagis for client care. Synagis is the only Food and Drug Administration (FDA) approved medication to mitigate the risk of newborns and infants contracting respiratory syncytial virus (RSV). Previously, recommended courses of treatment required 6 doses of the medication. The new recommendations call for 3-4 doses given approximately a month apart. The Department estimates a decrease in expenditure of \$1,259,131 in FY 2009-10.

Estimated Impact of Increasing PACE Enrollment

As described in the narrative for Exhibits F and H, the Department is currently in the process of adding several new Program of All-Inclusive Care for the Elderly (PACE) providers to the Medicaid program. Like other risk-based managed care organizations (including the Department’s health maintenance organizations and behavioral health organizations), the monthly payment to the provider covers all services provided by the provider – the in instance of a PACE provider, the payment covers acute care and long term care. While the Department does not adjust its request for each additional client enrolled in PACE – enrollments in existing providers are considered part of the base trend – the addition of new providers will cause an expenditure shift from fee-for-service categories to the PACE service category.

The impact to acute care and CBLTC is not “dollar-for-dollar.” The PACE program is designed to keep clients who have high community-based long term care needs out of nursing facilities. The clients who move into the PACE program typically are those clients whose needs are no longer met by an HCBS program. Thus, clients are moving from a lower-cost option (HCBS) to a higher-cost option (PACE). However, the Department still anticipates that the move is at least budget neutral in the long-term; clients who do not move to a PACE program will typically require nursing facility coverage, which is more expensive than PACE coverage.

The impact to acute care and CBLTC is calculated as the percentage of the PACE cost-per-enrollee attributable to those services (based on the actuarially-certified capitation rates), adjusted for the cash-flow issues related to transitioning a client from fee-for-service to managed care under cash accounting. The cash-flow impact is calculated as 1/12th of the total enrollment impact, and distributed proportionally to the acute care and HCBS reductions.

Estimated Savings due to PACE Enrollments				
FY 2009-10	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Total
Acute Care	(\$328,935)	(\$74,763)	(\$38,364)	(\$442,062)
CBLTC	(\$566,493)	(\$97,870)	(\$50,219)	(\$714,582)
Total	(\$895,428)	(\$172,633)	(\$88,583)	(\$1,156,644)

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

Estimated Savings due to PACE Enrollments				
FY 2010-11	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Total
Acute Care	(\$357,713)	(\$74,284)	(\$42,014)	(\$474,011)
CBLTC	(\$616,054)	(\$97,243)	(\$54,999)	(\$768,296)
Total	(\$973,767)	(\$171,527)	(\$97,013)	(\$1,242,307)

Colorado Access Contract for CRICC

The Colorado Access Contract for the Colorado Regional Integrated Care Collaborative (CRICC) was altered from a risk-based, capitated program to an Administrative Services Organization (ASO) after the provider informed the Department that the risk-based model would no longer be sustainable. The Department and the provider negotiated an alternative that would allow for continuity of services while altering the reimbursement structure to a more sustainable model. The reimbursement rates for the ASO have been set such that the ASO reimbursement for the expected life of the program (through June 2011) do not exceed the estimate cash flow savings from shifting clients from risk-based managed care to non-risk based care. The Department has accounted for this change with bottom line impacts in Acute Care and PIHP Administration.

Remove Manual Pricing of DME, Injectibles, and Medical Services

In an effort to continuously find efficiencies within the Medicaid programs, the Department identified a number of antiquated, manual price setting methodologies around Durable Medical Equipment (DME), injectibles, and medical services. The Department initiated adjustments to these methodologies so that reimbursement rates would automatically be set to a percentage of Medicare while ensuring that for goods and services where no Medicare rate information exists, rates were set using the Department's average paid, other states' Medicaid average paid, or the commercial average paid rate.

This effort ensures that rates will be adjusted on medical goods and services are prices fluctuate, often downwards, over time.

Benefits Limits on Echocardiograms

Through the Department’s community-involved Benefits Collaborative, the Department and its stakeholders identified appropriate limits to set on the use of echocardiograms. The Benefits Limits on Echocardiograms limits the number of echocardiograms taken and the number of echocardiogram readings available without prior authorization. The Department set these policies in consultation with physicians and clients, and adhered to best practices in diagnosis requirements. The limitations should reduce the number of unnecessary echocardiograms received, and in greater volume, the number of unnecessary readings when readings by certified professionals are already available and recorded in patient records.

Hospital Cost Settlements

Hospital Cost Settlements identifies those recoupments from hospitals above the normal reconciliations made via the Department’s cost-to-charge payment methodology. Hospitals are immediately paid following the delivery of services based on the hospital’s cost-to-charge ratio. Later, a financial audit process reclaims any expenditure that resulted in payments made above the actual cost of services rendered.

Previous budget requests have provided new, dedicated resources to address this reconciliation process. This effort has allowed for multiple years to be reconciled within the current fiscal year, and should generate similar additional savings in the next fiscal year before the Department has caught up to the most recently available data. These reconciliations result in reclamations above the standard practice and are therefore not represented in the base budget.

NEMT Supplemental Payments

The Department provided additional funds to be expended on its fixed price contract to provide Non-Emergency Transportation Services in the 8 metro counties. The contractor had recently informed the Department that it would need to cease to provide services, as the fixed price contract did not accommodate the unprecedented caseload growth facing the Department and the provider. Through contract negotiations, the Department was able to adjust the fixed price on the contract in order to ensure vital services continued.

In the long-term, the Department is actively exploring altering the contract from a fixed-price to a Per-Member-Per-Month (PMPM) structure to avoid any similar problems in the future while simultaneously ensuring the Department does not pay an inflated rate when caseload ceases to grow.

Physician and Hospital Drug Rebates

In the Deficit Reduction Act of 2005, the federal government required that all provider claims provide information sufficient for states to obtain rebates by January 1, 2006 for single source physician administered drugs. For multiple source drugs, the federal government would publish the list of the top 20 physician administered drugs based on the highest dollar volume no later than January 1, 2007. All physicians and hospitals must provide information sufficient to obtain rebates for only these drugs by January 1, 2008. The top 20 list would be modified annually to reflect changes in highest dollar volume.

The Department already had a system in place to collect rebates from single source physician administered drugs prior to January 1, 2006. Beginning in September 2003 the Department contracted with Health Watch Technologies to identify single source drugs in the physician claims data and invoice pharmaceutical companies. This contract ended in June 2007 and was not renewed. The Department began performing these services in-house. The contract and in-house services only include physician administered drugs outside a hospital.

The Department did not collect rebates for single source hospital drug claims through Health Watch Technologies or through the in-house system. Hospitals use revenue codes rather than procedure codes to bill claims. This billing method does not provide the level of detail necessary to meet rebate requirements.

Uncertainty existed as to whether hospitals were required to meet the federal requirements identified in the Deficit Reduction Act of 2005. The Centers for Medicare and Medicaid Services clarified that hospitals are required to be in compliance with this law. This ruling required major systems changes to capture national drug code (NDC) information. Colorado, along with many other states, requested an extension to implement the top 20 physician administered drugs within hospitals. As a result, the Department was given until July 1, 2008 to collect refunds for claims linked to the top 20 multiple source drugs within hospitals. Due to the required systems changes and clarification of requirements, the Department is now able to seek rebates on claims for single source hospital administered drugs in addition to the claims for the top 20 multiple source drugs. The Department was able to begin submitting rebate invoices for the claims for top 20 multiple source drugs administered by physicians on the January 1, 2008 deadline.

Impacts of Physician and Hospital Drug Rebates

Changes in physician and hospital drug rebates require no additional appropriations. All changes in claims processing and reporting were absorbed within the Department using funding previously paid for the contractor to collect single source drug rebates from physician claims, Health Watch Technologies.

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

Physician and Hospital Drug Rebate Estimates

As a result of the Deficit Reduction Act of 2005, the Department is now able to collect drug rebates on drugs administered directly by physicians and hospitals. Previously, the Department was unable to invoice for these rebates due to the lack of information provided in the billing of these claims. The new regulations in place require physicians and hospitals to provide national drug code information for all single source drugs and the top 20 multiple source drugs.

The Department was able to make systems changes necessary to be in compliance with federal requirements resulting from the Deficit Reduction Act related to drug rebates in physician and hospital claims. As these changes were made and as the Department began tracking rebate revenue, rebate impact has been built into the Department's base budget. Throughout the budget process, as new information becomes available, new estimates are wrapped into the Department's standard budget requests. Currently, the Department estimates almost \$2,092,551 in additional rebate from hospital administered drugs in FY 2009-10.

(3) MEDICAID MENTAL HEALTH COMMUNITY PROGRAMS

The following is a description of the budget projection for the Medicaid Mental Health Community Programs.

In 1993, under Section 1915 (b) and Section 1902 (a) of Title XIX of the Social Security Act, the Centers for Medicare and Medicaid Services granted the State waivers that allowed the State to implement a pilot managed care mental health program. The pilot program operated until 1995. In 1995, SB 95-078 directed the Department and the Department of Human Services to implement a statewide capitated mental health managed care program. In 1997, SB 97-005 authorized the Department to provide mental health services through a managed care program.

The structure of managed care has changed over time. In 1995, implementation of the Medicaid Mental Health Capitation Program in fifty-one counties of the State was complete, with the remaining twelve counties added in 1998. A sixty-fourth county was added when Broomfield became a county in November 2001. Through a competitive bid process, eight mental health assessment and service agencies were awarded contracts to be service providers in the program. Again through competitive procurement, the Department reduced the number of regions from eight to five and awarded managed care contracts to five behavioral health organizations effective January 1, 2005. The five behavioral health organizations were reprocured through a competitive bid process effective July 1, 2009. As a result of the reprocurement, the same five organizations won their respective contract bids, leaving the program unchanged.

Each behavioral health organization is responsible for providing or arranging medically necessary mental health services to Medicaid-eligible Adults 65 and Older, Disabled Adults 60-64 and Disabled Individuals to 59, Categorically Eligible Low-Income Adults, Health Care Expansion Fund Low-Income Adults, and Baby Care Program - Adults, Eligible Children, Foster Care children, and Breast and Cervical Cancer Program Adults enrolled with a behavioral health organization. Services provided by those organizations include, but are not limited to, inpatient hospitalization, psychiatric care, rehabilitation and outpatient care; clinic services, case management, medication management and physician care; and non-hospital residential care as it pertains to mental health. The capitation program also includes alternatives to institutionalization. The Department is required to make monthly capitation payments to contracted behavioral health organizations for services for each eligible Medicaid recipient. Payments vary across each behavioral health organization, as well as each eligibility category.

Since the inception of the Medicaid Mental Health Community Programs, the Department has been responsible for oversight and contracting with the managed care organizations. The budget projections, day-to-day operations and administration of the program were the responsibility of the Department of Human Services. In 2004, the administration and programmatic duties were transferred from the Department of Human Services to the Department. These duties include budget projections and accounting for the program, site reviews of the institutions, and contract negotiations. The transfer resulted in a new Long Bill group for the Department in the FY

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

2004-05 Long Bill (HB 04-1422). Subsequently, SB 05-112 transferred: (1) the Mental Health Administration appropriation for Personal Services, Operating Expenses, and External Quality Review Organization Mental Health from Medicaid Mental Health Community Programs – Program Administration to the Executive Director’s Office Long Bill group, (2) Single Entry Point case management services from Medicaid Mental Health Fee-for-Service Payments to Medical Services Premiums, and (3) services for the developmentally disabled from the Colorado Department of Human Services for People with Disabilities – Community Services and Regional Centers to Non-Emergency Medical Transportation, Medical Services Premiums, and Mental Health Fee-for-Service appropriations within the Department. As a result, only the Medicaid Mental Health Community Programs expenditures are addressed in this section.

The recent history of the Medicaid Mental Health Community Programs is summarized as follows:

- HB 02-1420 also provided funding for three alternative programs in the Medicaid Mental Health Community Programs: Alternatives to Inpatient Hospitalization at the Mental Health Institute at Pueblo, Alternatives to Inpatient Hospitalization at the Mental Health Institute at Fort Logan, and Alternatives to the Fort Logan Aftercare Program. Each of these programs was the result of reductions in institutional care. Contracting through mental health assessment and service agencies, community mental health centers offered to provide services through managed care at a much lower cost. Initially part of the Mental Health Capitation Payments line, separate appropriations were made in the FY 2004-05 Long Bill (HB 04-1422) and the FY 2004-05 Long Bill Add-On (SB 05-209). Funding for Alternatives to Inpatient Hospitalization at the Mental Health Institute at Pueblo, Alternatives to Inpatient Hospitalization at the Mental Health Institute at Fort Logan, and Alternatives to the Fort Logan Aftercare Program was incorporated into the capitation base during the request for proposal process for contracts effective January 1, 2005. Due to this new contractual provision with behavioral health organizations, separate appropriations were no longer needed as of FY 2005-06.
- In FY 2002-03, budget reductions were implemented and capitation payments were reduced significantly for FY 2002-03 through FY 2003-04. This led to a reduction of services provided by the behavioral health organizations. Increasing caseload for Medicaid Mental Health Community Programs and incorporating funding for alternative programs to inpatient hospitalization tempered the effect reductions had on the capitation budget.
- Due to a temporary federal change, the Medicaid federal financial participation match was enhanced for the last quarter of FY 2002-03 and the entire FY 2003-04 to 52.95% (up from 50%), while the State’s share was reduced to 47.05%. The federal financial participation match rate returned to 50% for FY 2004-05.

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

- SB 03-196 mandated the Department to move from accrual-based accounting to cash-based accounting for the Medical Services Premiums and the Medicaid-funded services in the Department of Human Services' budget. This resulted in a one-time savings of approximately \$70 million in Medical Services Premiums and \$7 million in the Department of Human Services' Medicaid-funded services during FY 2002-03. With cash-based accounting, all expenditures became based on the date of payment, regardless of when the date of service occurred, thus eliminating the six-month accounts payable period maintained under accrual-based accounting. Ideally, all prior expenditure history for mental health services would have been rebuilt on a cash basis for historical comparison purposes, using both the Colorado Financial Reporting System and the Medicaid Management Information System data. However, the Department's prospective per capita budget methodology did not require the use of historical data prior to FY 2002-03.
- SB 03-282 gave the Department and the Department of Human Services' Medicaid-funded programs a one-time appropriation of \$1,000,000 in FY 2003-04, wherein \$500,000 was from the Tobacco Litigation Settlement Cash Fund pursuant to section 24-75-1104, C.R.S. (2005) and the remaining \$500,000 was from federal funds for mental health capitation and performance incentive awards.
- Within the appropriation for Medicaid Mental Health Community Programs, the FY 2004-05 Long Bill (HB 04-1422) provided funding for the Mental Health Institute Rate Refinance Adjustment. This funding was necessary because in 2001 it was discovered that the capitation-based payment for Medicaid clients did not cover bed costs at mental health institutes. Separate appropriations for the Mental Health Institutional Rate Refinance Adjustment were made in the FY 2004-05 Long Bill (HB 04-1422) and the FY 2004-05 Long Bill Add-on (SB 05-209). New contracts with behavioral health organizations effective January 1, 2005 began fully covering the negotiated bed cost at the mental health institutes in new capitation rates via payments withheld from behavioral health organizations and made directly to the Mental Health Institute. Therefore, a separate appropriation for the Mental Health Institute Rate Refinance Adjustment was no longer needed as of FY 2005-06.
- HB 04-1422 reorganized the Medicaid Mental Health Community Programs Long Bill group into the following sections:
 1. Mental Health Capitation Payments, which included Capitation Base Payments, Mental Health Services for Breast and Cervical Cancer Patients, Mental Health Institute Rate Refinance Adjustment, Alternatives to Inpatient Hospitalization at the Mental Health Institute at Pueblo and the Mental Health Institute at Fort Logan and Alternatives to the Fort Logan Aftercare Program. SB 05-209 consolidated these line items into one Mental Health Capitation Payments line item in FY 2005-06.
 2. Other Medicaid Mental Health Payments, which included Medicaid Mental Health Fee-for-Service Payments, Child Placement Agency and Anti-Psychotic Pharmaceuticals. Child Placement Agency and Anti-Psychotic Pharmaceuticals were listed under Other Medicaid Mental Health Payments for informational purposes only. Detailed explanations of the Child Placement Agency and Anti-Psychotic Pharmaceuticals programs and appropriations can be found in the Department of Human Services

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

Child Welfare section and the Department's Medical Services Premiums section, respectively. SB 05-209 did not change these line items. However, in November 2004, the Department received an order from the Centers for Medicare and Medicaid Services to cease making Child Placement Agency payments since they were considered supplemental payments outside the scope of the existing waiver. Payments were discontinued in December and the line item has been removed from the Department budget.

- HB 05-1262, known as the Tobacco Tax bill, established two funds that provide capitated mental health benefits to an increasing population of Medicaid clients. Increased caseload funded by the Health Care Expansion Fund, administered by the Department, and the Prevention, Early Detection and Treatment Fund, administered by the Department of Public Health and Environment, are included in both the FY 2008-09 Estimate and the FY 2009-10 Budget Request and are elaborated below.
- The Joint Budget Committee approved the Department's September 20, 2006 1331 Supplemental Request to transfer funding from the Department of Human Services to the Department. This transfer allowed for the inclusion of the Goebel enhanced services in the Medicaid Mental Health Capitation rates and eliminated the need to classify and track them separately. The Goebel Lawsuit Settlement line item was created in FY 2003-04 to fund specialized and enhanced mental health services for approximately 1,600 Medicaid and non-Medicaid clients with mental illness in northwest Denver. The Goebel lawsuit claimed that residents of northwest Denver with chronic mental illness were being denied services. The FY 2003-04 Supplemental Bill (HB 04-1320) established the Goebel Lawsuit Settlement as a separate line item in the Department's Department of Human Services Medicaid-Funded Programs Long Bill group and paid it separately from Medicaid Mental Health Community Programs payments.

On March 31, 2006, the Goebel lawsuit was dismissed. After consultation with the Department's contracted actuary and review of the Goebel-specific encounter and eligibility data, it was determined that an actuarially certified payment would become part of the Mental Health Capitation Payments line item. An adjustment was made for the inclusion and it began being included in the FY 2006-07 capitations.

- SB 07-002 and SB 08-099 expanded Medicaid eligibility for foster care children up to age 21.
- HB 08-1320 designated Cash Funds Exempt as cash funds and Reappropriated Funds, in effect moving the Health Care Expansion Fund from Cash Funds Exempt to cash funds, and clearly distinguishing transfers from the Department of Human Services to the Department as Reappropriated Funds.

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

- HB 08-1373 continued and extended the Breast and Cervical Cancer Treatment Program to July 1, 2014. The bill designates funding sources for the program: a) for FY 2008-09, 100% of the State costs for the Program shall be appropriated from the Breast and Cervical Cancer Prevention and Treatment Fund; b) for FY 2009-10 through FY 2013-14, 50% of State costs for the Program shall be appropriated from the Breast and Cervical Cancer Prevention and Treatment Fund and 50% shall be from the General Fund.
- SB 09-262 shifted state funding for the Breast and Cervical Cancer Program from 50% General Fund and 50% Breast and Cervical Cancer Prevention and Treatment Fund to 100% Breast and Cervical Cancer Prevention and Treatment Fund.
- SB 09-265 delayed various Medicaid payments. The payments for the final week of FY 2009-10 for mental health fee-for-service was delayed until the beginning of FY 2010-11, thus reducing the FY 2009-10 expenditure and increasing the FY 2010-11 expenditure by the same amount. The bill also altered the timing of payments for the capitated mental health program. Beginning in the final month of FY 2009-10, capitation payments are paid in the month following rather than prospectively in the beginning of the month. This will produce a one-time savings as FY 2009-10 expenditure will only include eleven months of capitation payments.
- Effective January 1, 2009, the Department issued, and the Behavioral Health Organizations (BHOs) actuarially certified, a new set of rates. Rates are set using a combination of historical rate experience and recent encounter data. Under direction from the Centers for Medicare and Medicaid Services, the Department has gradually put more weight on the encounter data PMPM. FY 2005-06 was the first year of rate setting that used a combination of historical rate experience and recent encounter data. These capitation rates were calculated using 5% encounter data and 95% of the historical rate experience. During the rate setting process resulting in the January 2009 rates, the Department altered the weight to 35% encounter and 65% historical. However, the Department found that the estimated service expenditures were generally valued at an amount less than expected, relative to the BHO's audited financial statements. The Department believes that there are two primary reasons for this discrepancy. First, the non-traditional, federally waived (b)(3) service data was newly included in the FY 2006-07 encounter data used for rate setting and appeared to not be completely reported. Additionally, inconsistencies in coding and accounting practices cause some difficulties in the encounter pricing methodology. To offset the discrepancy the Department paid its mental health rates at 3% above the actuarial midpoint. See description of Exhibit GG for additional information.
- The June 22, 2009 General Revenue forecast indicated that additional General Fund cuts would be necessary in FY 2009-10. On August 24, 2009, the Department released a series of early supplemental requests (ES), which affected the Department's mental health programs in the following ways:

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

1. As a part of ES-2 “Medicaid Program Reductions” the Department reduced the reimbursement rate for the mental health capitation program by 2.5%, effective September 1, 2009, and accounted for the recoupment of net overpayments on prior years’ mental health capitation payments. This was estimated to result in a total fund reduction of \$8,520,268 and a General Fund reduction of \$4,259,696 to this line in FY 2009-10. The Department’s FY 2010-11 base request includes an annualized total fund increase of \$1,660,475 and a General Fund increase of \$890,761 in FY 2010-11 (note, the incremental increase estimated for FY 2010-11 is due to the nature of the one time recoupment being built back into the out-year base budget).
 2. As a part of NP-ES-5 “Close Beds at the Mental Health Institutes” the Department of Human Services proposed that specific beds at the mental health institutes be closed as of January 1, 2010. These bed closures impacted the Department by immediately making those displaced from the mental health institutes clients of the capitated mental health program. While treated at the institutes, Department of Human Services funding preempted Medicaid payment, with Medicaid being the “payer of last resort.” Displacing these clients would allow them to be eligible to receive Medicaid funded benefits. This resulted in an estimated total fund increase of \$582,420 and a General Fund reduction of \$291,210 to this line in FY 2009-10. The Department’s FY 2010-11 base request includes an annualized total fund increase of \$582,419 and a General Fund increase of \$291,210 in FY 2010-11.
- Effective January 1, 2010, the Department calculated a new set of mental health rates. Two of the contracted Behavioral Health Organizations (BHOs) were unable to actuarially certify that they could operate at the new payment schedule. In January 2010, the Joint Budget Committee voted to appropriate funds to continue paying these two BHOs at the previously set rates (the rates from the last rate setting process, with the 2.5% cut from September 2009). See description of Exhibit GG for additional information.
 - HB 09-1293, the “Colorado Health Care Affordability Act” provided health care coverage for more than 100,000 uninsured Coloradans. Implementation of the bill for FY 2009-10 is contingent upon Centers for Medicare and Medicaid Services (CMS) approval. For FY 2010-11, the law results in a total fund increase of \$8,062,050 and a Hospital Provider Fee Cash Fund increase of \$4,031,025.

Potential Impact of Further Reductions to BHO Rates

The Department has proposed further reductions to the behavioral health program beginning July 1, 2010. Given the difficulties of two BHOs to actuarially certify rates prior to this proposed cut, the Department is working to anticipate and mitigate potential difficulties the BHOs may have with certifying these rate reductions. The Department and the BHOs are developing and modeling ways to cut costs to the Medicaid mental health program, in preparation for the proposed July 1, 2010 rate cut (see Base Reduction

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

Item 6, “Medicaid Program Reductions”, November 2, 2009). As described above, two of the five BHOs could not certify the CY2010 rates as actuarially sound. With further rate cuts, it is unclear how much further the remaining three BHOs can move within the actuarially sound rate range before they can no longer certify the rates as well. While the Department intends to pursue further rate cuts to the BHOs that can continue to move within the range, the Department cannot require services be delivered beyond those that are actuarially sound within the limits of available funding for each individual BHO. Therefore, the Department has entered into negotiations regarding service responsibilities of the BHOs.

The Department and the BHOs have determined that they can reduce costs in several ways. First, the BHOs’ administrative responsibilities can be reduced. While the administrative responsibilities do not provide direct benefit to the clients, they do allow the Department and the BHOs to monitor the care of the clients. The potential limitations will need careful consideration in order to determine where the least amount of impact to the clients’ care will occur. The BHOs and the Department are discussing the following limitations, and the BHOs will provide the cost of reducing these responsibilities at a later date.

- Limit the 23 total performance measures in the current contract to 18 measures.
- Reduce or eliminate the reporting requirements of the Evidence-Based and Promising Practices (EBP/PPs). The BHOs are required to implement at least four adult and four child practices that are either proven to be successful through research (EBPs), or are anecdotally sound and need confirmation through research (PPs).
- Modify the service access standards. The Department and BHOs are considering changing the time standards for access to emergency services in person to 95% within one hour and 100% within two hours for urban areas, and to 95% within two hours and 100% within three hours for rural/frontier areas. Additionally, the Department is considering a change in access to routine appointments to 95% within seven days and 100% within ten days.
- Consider BHO proposals to close treatment sites with very low client volume on a case-by-case basis, with the requirement that an adequate plan to support client access to services is in place.

Secondly, the Department and the BHOs determined that various service reductions would also reduce costs. The Department modeled the following service cuts and calculated a range of savings for each service. Listed below are the minimum and maximum cost savings. It is important to note that this savings estimate is preliminary, and has not been adjusted by the Department’s actuaries, in accordance to the federal and state regulations of setting actuarially sound rates. This estimate reflects what the Department would have saved in prior years, but has not been trended forward to the current year.

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

- Reduce the annual adult inpatient hospital days per client.
Savings: Minimum savings of \$24,629 to a maximum savings of \$465,075, depending on reduction in days.
- Reduce clubhouse allowable cost for each BHO by a certain percent.
Savings: Minimum savings of \$340,048 to a maximum savings of \$2,040,288, depending on the percent reduction.
- Cap the allowable number of encounters per adult client for case management.
Savings: Minimum savings of \$264,497 to a maximum savings of \$3,582,164, depending on reduction in encounters.
- Reduce annual number of adult outpatient individual therapy sessions per client.
Savings: Minimum savings of \$1,846 to a maximum savings of \$2,965, depending on reduction in sessions.

While a dramatic service reduction can achieve the desired savings, before the Department can propose any cuts, the Department will need input from stakeholders about which cuts will provide the least amount of impact to the client's care. The stakeholders' input will inform the Department whether deep cuts or cuts across several services will be more beneficial to the clients. Additionally, the Centers for Medicare and Medicaid Services (CMS) have not been notified of the potential service or access reductions, and have not provided final approval of the potential reductions. CMS may have an opinion on which of the services can and cannot be reduced.

The BHOs believe that imposing caps on the amount of service provided to clients, such as those modeled by the Department would limit the desired flexibility under a managed care model. As a third alternative, the BHOs are researching whether efficiencies in reducing the average cost per client served could substitute for service caps. The BHOs envision these efficiencies being reflected in reductions to the PMPM capitation calculation through reform to the rate setting methodology.

While these discussions are preliminary, the Department is very interested in continuing to collaborate with the BHOs to find a feasible mechanism to reduce mental health expenditures while limiting the adverse impacts to the clients served by the BHOs and will continue to work with stakeholders and CMS to develop a proposal of cuts that will best serve the needs of the program.

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

Program Administration

In FY 2005-06, SB 05-112 transferred all of Medicaid Mental Health Community Programs - Program Administration expenditures into the Executive Director's Office Long Bill group, and is reflected in the lines for Personal Services, Operating Expenses, and Mental Health External Quality Review Organization. The FY 2009-10 Estimate and the FY 2010-11 Budget Request for Program Administration are included in the Executive Director's Office Long Bill group.

Medicaid Anti-Psychotic Pharmaceuticals

Prior to FY 2008-09, as part of the Long Bill, estimated expenditures for anti-psychotic pharmaceuticals were appropriated to this Long Bill group as Cash Funds Exempt. This was an informational-only line item: the costs for these drugs were and are paid in the Department's Medical Services Premiums Long Bill group, and no actual transfer took place. Because there was no corresponding decrease to the Medical Services Premiums Long Bill group, this double counted the funding for these drugs.

In its November 1, 2007 Budget Request, the Department officially requested the removal of the Medicaid Anti-Psychotic Pharmaceuticals line item and subsequently received approval. The Department continues to report expenditure for anti-psychotics in its Budget Request (such as in Exhibit F of the exhibits for Medical Services Premiums, and/or the Strategic Plan).

(A) MENTAL HEALTH CAPITATION PAYMENTS

The Mental Health Capitation Payments line item reflects the appropriation that funds Medicaid mental health services throughout Colorado through managed care providers contracted by the Department. As a result of competitive procurement, five behavioral health organizations were awarded contracts with updated capitation rates and services effective January 1, 2005. Payments for Mental Health Institute Rate Refinance Adjustment, Alternatives to Inpatient Hospitalization at the Mental Health Institute at Pueblo, Alternatives to Inpatient Hospitalization at the Mental Health Institute at Fort Logan, and Alternatives to the Fort Logan Aftercare Program were separate payments prior to FY 2005-06, and incorporated into the Mental Health Capitation Payments line item in FY 2005-06. Effective July 1, 2009, the five behavioral health organizations were reprocured through a competitive bid process. As a result of the reprocurement, the same five organizations won their respective contract bids, leaving the program unchanged.

The behavioral health organizations are responsible for providing or arranging all medically necessary mental health services to Medicaid-eligible clients within a specified geographic location for a pre-determined capitation rate. The Department pays actuarially certified rates to each behavioral health organization for each Medicaid client in each Medicaid eligibility category. Amounts are prorated for partial months of service and retroactive eligibility is covered. Payments vary across behavioral health organizations, as well as eligibility categories.

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

The Medicaid populations that are eligible for mental health services covered by capitation rates are combined into six categories, as indicated in the table below. Partial Dual Eligibles and Non-citizens are ineligible for Medicaid mental health services.

Eligible Medicaid Mental Health Populations

Adults 65 and Older (OAP-A)
Disabled Adults 60 to 64 (OAP-B) and Disabled Individuals to 59 (AND/AB)
Categorically Eligible Low-Income Adults (AFDC-A), Expansion Adults, and Baby Care Program – Adults
Eligible Children (AFDC-C/BC)
Foster Care
Breast and Cervical Cancer

Analysis of Historical Expenditure Allocations across Eligibility Categories:

At the beginning of a contract cycle, behavioral health organization capitation rates were entered in the Medicaid Management Information System. Monthly payments were paid based on eligibility categories. The Medicaid Management Information System provided detailed expenditures by behavioral health organization and eligibility category but did not include offline transactions and accounting adjustments. The only source that included all actual expenditure activity is the Colorado Financial Reporting System. The drawback was the Colorado Financial Reporting System provided total expenditures, but not by eligibility category. The exception was the Breast and Cervical Cancer Treatment Program eligibility category, which was reported separately in the Colorado Financial Reporting System. Since an allocation had to be calculated to determine the amount of actual expenditures across the other eligibility categories, a ratio was calculated for each eligibility category by dividing the Medicaid Management Information System eligibility category expenditures (less the Breast and Cervical Cancer Treatment Program eligibility category) by the total Medicaid Management Information System expenditures (less the Breast and Cervical Cancer Treatment Program eligibility category). The ratio for each category was multiplied by the total expenditures (less the Breast and Cervical Cancer Treatment Program eligibility category) from the Colorado Financial Reporting System. This calculation estimated actual Colorado Financial Reporting System expenditures across each eligibility category. Variance between the two systems was less than 0.3%.

Description of Transition to New Methodology:

Member month methodology was used prior to 2005 when the administration of Medicaid Mental Health Community Programs was transferred from the Department of Human Services to the Department. Historical expenditures were divided by the capitation rates for the region served by each mental health assessment and service agency (now known as behavioral health organizations) to estimate the number of member months for which capitation payments were made. Mental health caseload growth rates were applied to these member months to calculate projected member months. Member months were multiplied by the capitation rates for the upcoming year to determine the projected capitation base payments. The problem with this system was that member months, which reflected the impact of retroactive payments, were not equivalent to the Medicaid caseloads used in Medical Services Premiums, which did not include retroactivity. This methodology was used until February 15, 2005.

From February 2005 until the present Request, the Department had been transitioning towards a per capita methodology. Previous year actual amounts were trended forward by eligibility category, generating an estimated per capita. Prior to this Request, the Joint Budget Committee had asked the Department to explore the possibility of projecting budgets by behavioral health organization as well as by eligibility category. The Department has determined that such a projection is not yet possible due to the following: a) the recent (FY 2005-06) consolidation of eight mental health assessment and service agencies into five behavioral health organizations, b) the disproportionate impact of Goebel driven expenditures into one behavioral health organization's capitation rate, and c) the volatile nature of specific capitation rates as compared to the overall trend of capitation rate increases within respective eligibility categories. However, the Department will continue to explore this methodology as new data becomes available.

As part of its ongoing efforts to continuously improve the projections, as well as to provide access to information more specific than overall per capita rates, the Department moved to a capitation trend forecast model for the FY 2008-09 Estimate and FY 2009-10 Request. In short, the methodology examines the trend in capitation rates across each eligibility category and applies that trend to the average per-claim, incurred expense rate. By examining the capitation rate trends directly, rather than through a per capita methodology, future expenditures are forecasted directly through the primary cost drivers: the actuarially agreed upon capitation rate and caseload. By tying forecasts directly to capitation rates, the methodology may provide more accurate estimates of expenditures by eligibility category, rather than simply in aggregate, as well as provide an additional window of transparency into the forecasting process by presenting a clear link between total expenditure and the rates being paid to behavioral health organizations.

Additionally, the Department has incorporated an incurred but not reported methodology similar to other portions of this Request submitted by the Department (e.g. Nursing Facilities; see Section E, Exhibit H). The Department is adjusting its request to capture the reality that some mental health claims incurred in any one fiscal year may not be paid during that same fiscal year. Similarly, some portion of expenditure in any fiscal year will be payments on claims incurred in prior fiscal years.

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

The following narrative describes in greater detail the assumptions and calculations used in developing the FY 2009-10 Estimate and the FY 2010-11 Budget Request for Medicaid Mental Health Community Programs. It should be noted that the data and values in many of the exhibits are contained and/or calculated in one or more other exhibits which may come before or after the exhibit being described. When this occurs, the source exhibit will be noted. The exhibits being referenced can be found in the Department's February 16, 2010 Budget Request, Section F.

EXHIBIT AA - CALCULATION OF CURRENT TOTAL LONG BILL GROUP IMPACT

Effective with the November 2, 2009 Budget Request, in this exhibit the Department sums the total spending authority by fund source, including the Long Bill and any special bills which have appropriations that affect the Department. The total spending authority is compared to the total projected estimated current year expenditures from Exhibit BB. The difference between the two figures is the Department's Supplemental Request for the current fiscal year.⁶

Exhibit AA now presents a concise summary of spending authority affecting the Medicaid Mental Health Programs. In previous budget requests, the Department has presented historical expenditure and caseload figures in graphical form. This information can be found in table form in Exhibit DD (see below).

For the request year, the Department starts with the prior year's appropriation including special bills, and adds in any required annualizations. This total is the Base Amount for the Request year. The total Base Amount is compared to the total projected estimated request year expenditure from page Exhibit BB. The difference between the two figures is the Department's Decision/Base Reduction Item in the November Budget Request, and the Department's Budget Amendment in the February Supplemental Budget Request.

Of particular note is that the Department's ES-2 budget action of July 2009, which requires the Department to pay its Behavioral Healthcare Organizations at a rate -2.5% from the actuarially set rate midpoint (see above), is replaced by this Request. This request accounts for the impact of ES-2 as that impact changes due to changing caseload and actuarially set capitation rates.

For this budget cycle, the Department has also presented in this exhibit the incremental impact created by the American Recovery and Reinvestment Act (ARRA). See the description of ARRA impacts at the opening of "(2) Medical Services Premiums," in this document.

⁶ For FY 2009-10, the Department's totals on this page differ from the actual spending authority due to the inclusion of the budget balancing items submitted and implemented (labeled with priority numbers beginning with "ES"). Page EA-3 shows the actual total spending authority. Annualizations of budget balancing items are included in the FY 2010-11 base request.

EXHIBIT BB - CALCULATION OF FUND SPLITS

Exhibit BB details fund splits for all Mental Health Community Programs budget lines for the current fiscal year Supplemental and the out-year Budget Request. For all of the capitation payments except the Breast and Cervical Cancer Program, the funding is 50% state funds and 50% federal funds (prior to ARRA impacts, see the description of Exhibit AA, above). Payments for clients in the Breast and Cervical Cancer Program receive a 65% federal match rate and are described separately, below. Capitation expenditures have been split between traditional clients and expansion clients funded from Tobacco Tax Funds or from Hospital Provider Fee funds. For FY 2009-10, implementation of the Hospital Provider Fee is contingent upon CMS approval. The numbers are presented for informational purposes and then removed from the build to the total estimated capitation expenditure (see exhibit JJ for tax and fee impacts on mental health expenditure). Finally, the recoupments from prior years for mental health capitation overpayments and retractions for capitations paid for clients later determined to be deceased are also presented (see Exhibit II for recoupment calculations).

In the capitation base for both years, most clients are paid for with 50% General Fund and 50% federal funds. Health Care Expansion Fund clients are paid for with 50% cash funds from the Health Care Expansion Fund and 50% federal funds. Clients enrolled in the Breast and Cervical Cancer Prevention and Treatment Program (BCCP) are paid for with 35% state funds and 65% federal funds. State funding for 70% of the BCCP program comes from the Breast and Cervical Cancer Prevention and Treatment fund, and the remaining 30% of state funding comes from the Prevention, Early Detection, and Treatment fund (as reappropriated funds from the Department of Public Health and Environment). Expansion clients funded through HB 09-1293 receive state share funding from either the Hospital Provider Fee Cash Fund or (in future years) the Medicaid Buy-in Fund, and are discussed in more detail, below. These clients also receive a 50% federal match.

Medicaid Mental Health Fee-for-Service Payments also receive 50% General Fund and 50% federal funds. The sum of the capitations and the fee-for-service payments comprise the Department's Request.

An additional page has been added to Exhibit BB for the purpose of presenting ARRA impacts to funding. For FY 2009-10, those populations of clients not already receiving an enhanced federal match (e.g. Breast and Cervical Cancer Clients) received an increased federal match of 61.59% (from the established 50% match). For FY 2010-11, the increase in match is assumed to be the same, but is in place for only the first six months of that fiscal year. Therefore, the effective increase in match is half of the incremental increase of 11.59%, or 5.795%. ARRA has the effect of decreasing state-share responsibility for the entirety of the Medicaid Mental Health Programs, shifting expenditure from General Fund or various cash funds to federal funds.

Mental Health Services for Breast and Cervical Cancer Program Adults:

SB 01S2-012 created the Breast and Cervical Cancer Prevention and Treatment Program. SB 05-209 and HB 08-1373 incorporated funding for the Breast and Cervical Cancer Patients into the appropriation for Medicaid Mental Health Community Programs Capitation Payments, effective with the FY 2005-06 budget. Mental health care for clients in the Breast and Cervical Cancer Program is managed through the capitation contracts with the behavioral health organizations. Therefore, the budget is based on the mental health caseload that includes the Breast and Cervical Cancer Program Adults eligibility category. For this reason, they are shown as a separate eligibility category where appropriate.

Annual designations of General Fund contributions to program costs are specified in Section 25.5-5-308 (8), (9), and (10) C.R.S. (2009). Exhibit BB details funds splits for Mental Health Community Programs Capitations lines. In addition to clients already enrolled in the program, also called “traditional clients”, the Department received funding from the Tobacco Tax Bill (HB 05-1262) to enroll more clients in the Breast and Cervical Cancer Program. These clients, called the “expansion clients”, are funded by the Prevention, Early Detection and Treatment Fund administered by the Department of Public Health and Environment and the Tobacco Tax Bill (see the explanation below and Exhibit JJ, which shows all Tobacco Tax impacts, for a full explanation). The funding for the expansion clients is 35% cash funds and 65% federal funds. For traditional clients, the source for cash funds is the Breast and Cervical Cancer Prevention and Treatment Fund; for expansion clients, the Department receives a transfer from the Department of Public Health and Environment from the Prevention, Early Detection and Treatment Fund.

Mental Health Services for Hospital Provider Fee Expansion Clients:

HB 09-1293 established a funding mechanism for a series of expansion clients. The first set of expansion clients to be funded is parents with income up to 100% of the Federal Poverty Limit (FPL). Services for these clients will be funded through the Hospital Provider Fee Cash Fund. These clients are assumed to be similar to other adult expansion clients, and expenditure for these clients are therefore calculated using the same per capita rate as other adult clients (see exhibit JJ). In future years, additional expansion populations will receive funding through the Hospital Provider Fee Cash Fund as well as through the Medicaid Buy-in Fund. Currently, the Medicaid Buy-in Fund line is provided as a place-holder to ensure continuity of exhibits in future years.

EXHIBIT CC - MEDICAID MENTAL HEALTH COMMUNITY PROGRAMS SUMMARY

Exhibit CC presents a summary of mental health caseload and capitation expenditures itemized by eligibility category as well as a summary of the rest of the Mental Health Community Programs. The net capitation payments include the impacts of actions with perpetual effect, such as the decrease in payment rates by 2.5%, as well as caseload driven impacts such as the various recoupments

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

and retractions for clients determined to be ineligible. Exhibit EE illustrates the build to the final expenditure estimates presented in this exhibit.

EXHIBIT DD - MENTAL HEALTH CASELOAD AND PER CAPITA HISTORY AND PROJECTIONS, EXPENDITURE HISTORY, AND CALCULATIONS FOR GOEBEL ADJUSTMENTS

Exhibit DD contains per capita history and projections provide information on each of the nine eligibility categories. The same is true for per capita projections and historical expenditures. The calculations include the Goebel lawsuit expenditures as incorporated into the expenditure history for FY 2003-04 through FY 2005-06. Each of the tables that comprise Exhibit DD is described below.

Medicaid Mental Health Community Programs Caseload

Medicaid Mental Health Community Programs caseload is displayed in two tables. The first table shows total caseload for the combined disabled categories as well as the combined Adult categories. The second table displays caseload by all Mental Health eligibility categories. Figures for fiscal years up to the present fiscal year are actual caseloads, while the current fiscal year and the request year caseloads are estimates. The mental health caseload excludes the caseload for Partial Dual Eligibles and Non-Citizens and ties to the caseload presented in the Request for Medical Services Premiums, Section E, Exhibit B. Please see the Medicaid Caseload section of the Medical Services Premiums narrative for further discussion of Medicaid Caseload projections. The caseload numbers and are used in numerous exhibits throughout the Medicaid Mental Health Community Programs Exhibits and narrative.

Medicaid Mental Health Community Programs Per Capita Historical Summary

As with caseload, Medicaid Mental Health Community Programs per capita is displayed in two tables. The first table sets forth total per capita for the combined disabled categories as well as the combined Adult categories. The second table displays per capita by all Mental Health eligibility categories. However, since the actual per capita from the first table is the same for both disabled categories, and the three Adult categories have a single per capita, the true per capita is shown in those categories and will not mathematically be the same as dividing each individual category expenditure by the caseload. Figures for fiscal years up to the present fiscal year are actual caseloads, while the current fiscal year and the request year caseloads are estimates.

Medicaid Mental Health Community Programs Expenditures Historical Summary

The history of expenditures includes combined category and expanded category tables as well as total expenditures for both capitation and fee-for-service expenditures. For fee-for-service expenditure, service categories are listed separately.

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

Actual expenditures are only available from the Colorado Financial Reporting System. Expenditures by eligibility category, other than the Breast and Cervical Cancer Treatment Program, are not available from the Colorado Financial Reporting System. The Medicaid Management Information System does provide expenditures by eligibility category, but does not include offline transactions and accounting adjustments. The two systems typically have minor discrepancies in reported expenditure, often due to accounting adjustments made to the Colorado Financial Reporting System as fiscal periods close. Because the variance is minor, data from the Medicaid Management Information System can be used to distribute total expenditures from the Colorado Financial Reporting System across eligibility categories.

A ratio is calculated for each eligibility category by dividing the Medicaid Management Information System eligibility category expenditures by the total Medicaid Management Information System expenditures. The ratio is multiplied by the total expenditures from the Colorado Financial Reporting System. This calculation estimates actual Colorado Financial Reporting System expenditures across each eligibility category. The Breast and Cervical Cancer Treatment Program expenditures are carved out of both totals before the calculations are done, since this is the only category that does not need to be estimated. Once the overall expenditures by eligibility category are determined, they may be divided by the actual average monthly caseload for each eligibility category to determine the actual per capita for each eligibility category.

Adjustments to Medicaid Mental Health Community Programs Expenditures for Inclusion of Goebel Expenditures

For comparative purposes, expenditures for all years must contain the same primary components. However, expenditures for Goebel enhanced services were not included in the capitation payments for the years shown prior to FY 2006-07. Therefore, an adjustment was made for those years. The table sets forth actual expenditures including the Goebel expenditures. Actual expenditures were distributed by an average percentage from available years since actual percentages were not available for every year. These are the capitation expenditures used in the previous sections of this exhibit.

EXHIBIT EE - ESTIMATE AND REQUEST BY ELIGIBILITY CATEGORY

Exhibit EE provides capitation expenditure calculations for the current fiscal year and the request year.

The Department has adopted a methodology based on forecasting a capitation rate, multiplying that rate by monthly caseload, multiplying again by the number of months that the forecasted rate will be in effect, and then adjusting for incurred claims that will be paid in subsequent years as well as for claims from former years that will be paid in the year of the request. The methodology is a zero-based budget tool that allows the Department to examine projected expenditures each year without building in inappropriate assumptions, estimates, or calculations from preceding years.

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

The forecasted capitation rate is derived from exhibits FF through HH, and will be presented in more detail, below. The caseload is the same as presented in Medicaid Medical Services Premiums, Section E, Exhibit B (excepting Partial Dual Eligibles and Non-Citizens, as discussed, above).

The Department has broken down the current fiscal year and the request year in a two ways: first and second quarter estimate (Q1 and Q2), and a third and fourth quarter estimate (Q3 and Q4); The Department typically makes rate adjustments on a calendar year basis. As such, the Q1 and Q2 capitation rate is known and is the actuarial midpoint of the rate from the previous two quarters (the first two quarters of the calendar year). For the Department's November requests, the current year's Q1 and Q2 rates are known and the remaining rates are estimated. In the February supplemental, the rates for FY 2009-10 and the first half of FY 2010-11 are known and only the final two quarters of the out-year request are estimated. By the time February numbers are presented, the Department has completed its most recent rate setting process, adding to the known set of data. As presented in Exhibit EE, the estimated capitation rate is multiplied by the monthly caseload and then multiplied by the number of months the rate will be in effect.

In order to adjust the calculations to cash-accounting, the Department makes two adjustments to the calculation: first, the Department subtracts the incurred amount estimated to be paid in subsequent periods; then, the Department adds the claims incurred in prior periods expected to be paid in the forecast period. These adjustments transform the estimated incurred expenditure to a cash-based figure. The basis for these adjustments is described in this narrative below and is shown starting on page EE-3.

Incurred but not Reported Estimates (Exhibit EE, pages EE-3 through EE-6)

In order to estimate the necessary adjustments to convert the projection to a cash basis, the Department estimates monthly incurred but not reported (IBNR) adjustments based on historical data. Monthly adjustments are required because, for example, claims incurred in July of the current fiscal year have eleven more months of the fiscal year in which the claims can be paid; however, claims incurred in June of the fiscal year only have the remainder of that month in which to be paid before the payment becomes part of the next fiscal year's expenditure.

The Department examined historical data from the last five fiscal years, and determined that the prior fiscal years would provide a representative model for the likelihood of claims being paid in the year in which they are incurred. Page F.EE-3 presents the percentage of claims paid in a six month period that come from that same period and those which come from previous periods. The previous four years of expenditure experience were examined and the average was applied to the forecast.

Historically, for each eligibility category except Disabled Adults 60 to 64 and Disabled Individuals to 59, over 99% of incurred claims are paid by the end of the fiscal year in which the claims were incurred. For the Disabled Adults and Individuals, it has taken approximately three years for 99% of claims to be paid. This is likely due to the relative difficulty in determining and documenting

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

disability as opposed to criteria such as age or income. Hence, a larger percentage of claims from previous periods exists for this category of clients.

It is of note that beginning November 1, 2009, the Department instituted a policy of denying retroactive capitation claims that are from a period beyond 18 months prior to the payment month. For those clients with retroactive claims beyond 18 months who are found to have received services, the Department will reimburse the BHOs through a fee-for-service payment. Since capitations are calculated to pay for actual services delivered by spreading that cost to caseload regardless of whether services are received, the net effect of eliminating cap payments and reimbursing for services may be cost neutral. The Department will monitor this policy change, and should there be any expenditure fluctuations, the Department will seek to adjust through future budget requests.

SB 09-265 also impacts the IBNR calculations (see the History and Background Information section of this narrative, above). Beginning in June 2010 and carrying forward into the future of the program, no claims will be paid in the month in which expenses were incurred. By switching managed care payments from the month in which services are delivered to the month following delivery of services, the IBNR factor changes drastically beginning in the second half of FY 2009-10.

On pages F.EE-4 through F.EE-6, the Department calculates the estimated outstanding expenditure from claims remaining from previous period by aid category. The sums are then carried forward to the calculations on pages EE-1 and EE-2.

Actuarially Certified Capitation Rates

Capitated rates for the behavioral health organizations are required to be actuarially certified and approved by the Centers for Medicare and Medicaid Services, thus actuarially certified rate increases could reasonably be expected to be good predictors of future costs. As such, the Department used trends on the historically certified capitation rates to derive the capitation rate presented in Exhibit EE. The methodology for determining the forecasted capitation rate is the subject of Exhibits FF through HH.

EXHIBIT FF - MEDICAID MENTAL HEALTH CLAIMS TO CASELOAD ADJUSTMENT AND CLAIMS-BASED ADJUSTMENT MULTIPLIER

Capitations are paid for clients from the date that client's eligibility is effective, resulting in claims paid retroactively. As such, any projection which derives expenditure by using non-retroactive caseload must take into account these retroactive claims. Since expenditures are calculated as the estimated capitation rate multiplied by the non-retroactive caseload, an adjustment for retroactivity can be applied to either the forecasted capitation rate or the caseload figure. In order to maintain the uniform presentation of caseload across all Departmental Estimates and Requests, the Department chose to make its retroactivity adjustment to the forecasted capitation rate itself.

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

Additionally, claims-based data (as it is derived from literally the money spent on each claim) is the actual driver of expenditure. Examining the capitation rate for forecasting allows the Department and policy makers to see the relationship of the capitation payments paid to the behavioral health organizations to total expenditure. Forecasting based on trends in the capitation rate will only be as accurate as the relationship between that capitation trend and any trends in the rates of per-claim expenditure. These two rates can (and indeed do) trend similarly, but any difference in trends needs to be captured in order to ensure the accuracy of the forecast. The different trends are usually related to the incidence of payments for partial months of eligibility, which fluctuate for reasons unrelated to the Mental Health Capitation program. This difference is captured through a claims-based adjustment multiplier.

Claims to Caseload Adjustment:

For the purpose of adjusting the forecasted capitation rate to capture the omission of retroactivity from caseload, the Department analyzed the last five years of claims and caseload data. Page F.FF-1 presents the average monthly claims as compared to the average monthly caseload for those years across eligibility categories. The relatively steady percentage values across each respective eligibility category suggest that the ratio is indeed systemic (as created by retroactivity) rather than a unique circumstance. The most recent data, however, does not fully account for the fact that there are retroactive claims that have not been paid. It is the case, then, that a period removed from the most recent will be the most predictive of future experience (being the most recently available data that does not suffer from this problem of retroactivity). Therefore, the average of the percentages across each eligibility category is weighted, pulling 70% of that weight from two prior-periods ago, 10% from the most recent period, and 20% from the average of the remaining historical periods.

Claims-Based Adjustment Multiplier:

To derive the claims-based adjustment multiplier for the purpose of capturing any difference in trends between the capitation rate trends and the trends on per-claim expenditure, the last three years of data were examined. Prior to FY 2006-07, capitation rates were radically adjusted to capture systemic changes including, but not limited to, shifting to the Department the bulk of Medicaid program responsibility from the Department of Human Services, the consolidation to five behavioral health organizations from eight, and program and financing adjustments resulting from the Goebel lawsuit. Due to these adjustments, the volatility of capitation rates prior to FY 2006-07 would not be a quality indicator of any future comparisons to claims paid.

As presented on page F.FF-2, for each eligibility category, the weighted average claims-based rate (weighted by proportion of total claims within an eligibility category covered by an individual behavioral health organization) was compared to the weighted capitation rate (similarly weighted). Then, the claims-based rate as a percentage of the capitation rate was calculated providing a simple comparison of any trend in claims-based rates as compared to capitation rates. As the percentage is similar across years, it is a good

indicator the claims-based trends are matching capitation trends. In order to capture any potential variance between the trends, the forecasted capitation rate was multiplied by the difference of the average relationship percentage, from 100%.

Medicaid Mental Health Capitation Rate Trends and Forecasts (Exhibit GG):

As presented, above, the expenditure forecast was derived by examining the trend on the capitation rate and then applying that trend to the monthly cost per client (i.e. the claims-based rate). For the purpose of trend analysis, the weighted capitation rate (weighted by proportion of total claims within an eligibility category covered by an individual behavioral health organization) was examined. Exhibit GG presents historical data as well as the forecasted weighted rates.

Beginning in January of 2009, the Department switched its rate setting cycle from a state fiscal year cycle to a calendar year cycle. Capitation rates are now effective from January 1 through December 31. Therefore, the Department now presents its forecasted rates in six month blocks to account for the rate change occurring in the middle of a state fiscal year.

The weighted rate is presented along with the percentage change from the previous six months as well as from the average rate of the entire previous fiscal year. The multiple forecast trend models and the criteria for selecting the forecasted capitation rate point estimate are presented in Exhibit HH.

Based on the Department's calculations and rate setting process, and input from the behavioral health organizations, the Department's actuaries certify a capitation rate range for each BHO and eligibility type; the Department is permitted to pay any rate within this range and maintain an actuarially sound capitation payment. To develop the range, the actuaries calculate a single rate (the "midpoint rate"), and add or subtract 5% from that rate to develop the upper and lower bounds for actuarial soundness.

It is important to note that the overall weighted midpoint rate presented in the exhibit is weighted across two factors. First, the rate is weighted within an eligibility category (that is, weighted by the behavioral health organizations' proportion of claims processed within that eligibility category). Second, that rate is then weighted across all eligibility categories (with the weight derived from the total number of claims processed within an eligibility category as a percentage of total claims processed across all eligibility categories). Because caseload can be increasing or decreasing independently of any one capitation rate, the Weighted Mental Health Total rate may not be a clear indicator of the rate trends across all eligibility categories.

As stated, Exhibit GG presents the weighted midpoint rates, and the trend of those rates is used for forecasting. From January 1, 2009 to June 30, 2009, the Department paid rates 3% above the actuarial midpoint; subsequently, budget cutting requirements reduced that rates paid within that rate range (see below). However, these rates are not presented in Exhibit GG, in order to allow for comparison across years and so as to not artificially inflate or deflate the rate trend and bias the estimated rate in future years.

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

Similarly, beginning September 1, 2009, in accordance with budget action ES-2, beginning September 1, 2009, the Department paid rates that are 2.5% below the actuarial midpoint. Beginning January 1, 2010, the Department paid two of the BHOs at the September 1, 2009 rates while three BHOs received new rates (still at minus 2.5% of that new midpoint). The Department's rate setting process and federal regulation require that the BHOs actuarially certify that they will be able to operate at the proposed paid rates. With the January 1, 2010 rates, two BHOs were unable to certify. The Joint Budget Committee voted to appropriate funding to continue those two BHOs at a continuation of their most recent previously certified rates, the September 1, 2009 rates.

The following table presents the estimated paid rates (as opposed to midpoint rates) across eligibility categories beginning with the January 1, 2009 rates with their plus 3% adjustment.

Paid Capitation Rates by Eligibility Category					
Fiscal Year	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B) and Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low Income Adults (AFDC-A), Expansion Adults, and Baby Care Program-Adults ⁽¹⁾	Eligible Children (AFDC-C/BC)	Foster Care
January 1, 2009 Midpoint Rate	\$13.38	\$126.75	\$18.56	\$14.50	\$236.61
% Change in the rate range	3.00%	3.00%	3.00%	3.00%	3.00%
Paid Rate, January 1, 2009 to June 30, 2009	\$13.78	\$130.55	\$19.12	\$14.94	\$243.71
July 1, 2009 Midpoint Rate	\$13.38	\$126.75	\$18.56	\$14.50	\$236.61
% Change in the rate range	0.00%	0.00%	0.00%	0.00%	0.00%
Paid Rate, July 1, 2009 to August 31, 2009	\$13.38	\$126.75	\$18.56	\$14.50	\$236.61
September 1, 2009 Midpoint Rate	\$13.38	\$126.75	\$18.56	\$14.50	\$236.61
% Change in the rate range	-2.50%	-2.50%	-2.50%	-2.50%	-2.50%
Paid Rate, September 1, 2009 to December 31, 2009	\$13.05	\$123.58	\$18.10	\$14.14	\$230.69
January 1, 2010 Midpoint Rate	\$13.44	\$136.31	\$19.99	\$14.89	\$203.16
% Change in the rate range	0.07%	-4.21%	-3.50%	-3.96%	8.38%
Paid Rate, January 1, 2010 to June 30, 2010	\$13.45	\$130.57	\$19.29	\$14.30	\$220.19

Note: Rates for each eligibility category are weighted by the proportion of claims incurred by each BHO within that category. The Paid Rate from January 1, 2010 to June 30, 2010 is the result of two of the BHOs having their previous rate carried forward; the blend of those rates with the new rates for three BHOs yields unique weighted average rates, as presented.

EXHIBIT HH - FORECAST MODEL COMPARISONS

Exhibit HH produces the final capitation rate estimates that are used as the source of the expenditure calculations provided in Exhibit EE. Page F.HH-2 presents the final rate estimates in their entirety. The final rate estimates are a product of model selection (discussed below) and the necessary adjustments as presented in Exhibit FF.

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

On page F.HH-2, a series of differing forecast models are presented for each eligibility category. From the differing models or from historical changes, a point estimate is selected as an input into page F.HH-1. Based on the point estimates, the adjustments presented in Exhibit FF are then applied and the final, adjusted point estimate is then used in the expenditure calculations of Exhibit EE.

Final Forecasts:

Page F.HH-1 begins by presenting the known rates from those already set through the actuarial process and the remaining point estimates of each eligibility category's rate as selected on page F.HH-2 (see below). For Decision Items, the first rate applied to the first six months of the current year is known due to the calendar year rate setting cycle (see the description of Exhibit GG, above). The rate applied to the next six months of the current year is then estimated from a series of trend models and historical changes (see below). That same rate is then carried forward into the first six months of the request year, due to the calendar year rate setting cycle. Finally, the rate for the last six months of the request year is estimated by taking the percent change in rates from the last known rate to the first forecasted rate and carrying that percentage change forward.

For Supplemental Requests, the rate for the entirety of the current year and the first six months of the request year are known due to the calendar year rate setting cycle. The rate for the final six months of the request year is estimated using the various trend models and historical information described, below.

The projected rate is then adjusted by any policy impacts. In accordance with budget action ES-2, beginning September 1, 2009, the Department has paid rates that are 2.5% below the actuarial midpoint. For the first six months forecast, this equated to two-thirds of that period being paid at a reduced rate. This is an effective cut of two-thirds of -2.5%, or -1.67%. For the first half of FY 2009-10, the rates shown reflect actual experience.

Beginning with January 1, 2010, the JBC voted to appropriate funding to carry the rates forward for two of the BHOs who were unable to certify the new rates (see the History and Background Information section of this narrative). The cumulative effect of this action is presented in HH as the "Capitation Rate Range Adjustment" for this period.

For the remaining forecast periods, the full 2.5% reduction is presented. (This request replaces the ES-2 submission, with that action's provider rate decreases accounted for, here, and with ES-2's recoupment of overexpenditure accounted for in Exhibit II.)

The forecasted rate is also adjusted by the claims-based adjustment multiplier, calculated on page F.FF-2. The multiplier is applied to adjust for the fact that the full capitation rate is not paid for every member month. The rate for paid claims are impacted by payments made for partial months of eligibility as well as payments made for clients determined to be eligible, retroactively; neither of these

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

types of payments will be for a “whole” capitation payment at the current fiscal period’s capitation rate. Therefore, the multiplier is applied to convert capitation rates to a figure which is more likely to reflect actual expenditure.

Finally the adjusted claims-based rate is adjusted a third time, this time by the claims-to-caseload adjustment. From Exhibit FF, page F.FF-1, this second adjustment is made to capture the retroactivity not captured by the caseload figures. As described in the narrative for Exhibit FF, since caseload does not capture retroactivity, and since projected total expenditure is equal to caseload times the projected rate, either the rate or the caseload must be adjusted to capture retroactivity. To keep mental health caseload matched to other caseload figures presented by the Department, the adjustment is made to the projected rate yielding the final forecasted rate, which is the rate used to drive the expenditure calculation presented in Exhibit EE. A similar methodology is applied to the rates in each eligibility category, and for each fiscal period.

Capitation Trend Models:

The forecasted capitation rates are the result of a point estimate selection from among several forecast trend models and historical information. These models are presented on page F.HH-2 and historical midpoint rates are presented in Exhibit GG.

For each eligibility category, four different trend model forecasts were performed: an average growth model; a two-period moving average model; an exponential growth model; and, a linear growth model. The average growth model examines the rate of change in the capitation rate and applies the average rate of change to the forecast period. The two-period moving average model projects that the forecast period will see a change in the capitation rate that is the average of the last two changes in the capitation rate. The exponential growth model assumes that the capitation rate is increasing faster as time moves forward (a best-fit exponential equation is applied to the historical data and trended into the future). The linear growth model is an autoregression model on time, fitting a linear equation line to the historical data and forecasting that line into the future. Each model in the exhibit also shows what the percent change would be from the prior period.

The Department’s decisions for trend factors are informed, in part, by preliminary calculations from the actual rate setting process. Because those calculations remain preliminary, the Department does not explicitly use them in estimating trend factors.

Capitation rates are required to be actuarially sound and are built from a blend of historical rates and recent year encounter data (provider expenditure on services). The trends models, as presented in this exhibit, are an attempt to predict the final outcome of this rate setting process. However, the use of historical, final rates as data points for predicting future rates is limited when future periods are likely to be fundamentally different than historical periods. Beginning with FY 2008-09 the Department has experienced unusual trends for the mental health capitation program. This program, in its present state, has never existed in an economic climate like the one currently being experienced. As such, the various rate estimating models’ reliance on historical performance for predicting future

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

performance is limited. The Department has used the trend models to establish a range of reasonable rate values and has selected trends by considering the various factors that impact the respective eligibility populations as well as the impact that encounter data will have on the rate setting process. As such, the Department believes that the previous year's experience is the most predictive of the likely current year and future year experiences.

For Q3 and Q4 of FY 2010-11:

- The rate of change from the last rate setting process (the change from Q1 and Q2 of FY 2009-10 to Q3 and Q4 of that year) was applied forward for 1) Adults 65 and Older, 2) Categorically Eligible Low Income Adults, and 3) Eligible Children;
- The linear growth model was selected for the Disabled Adults 60 to 64 (OAP-B) and Disabled Individuals to 59 (AND/AB) populations; the rate for the disabled population has seen a steady year-to-year increase, from 6.39% to 7.79% annually, but for the Goebel settlement year (see the "History and Background" section of this narrative). The Department anticipates this linear growth to continue.
- For Foster Care clients, the average of the FY 2009-10 Q1 and Q2 midpoint rate along with the Q3 and Q4 midpoint rate of that year was selected; this population's declining rate contributed significantly to the inability of two BHOs to certify the last rate change; therefore, an average of the rate from the time prior to that non-certification and the time following that non-certification was selected.

The selected point estimates of the capitation rates are adjusted on page F.HH-1, as described above, for use in the expenditure calculations presented in Exhibit EE.

EXHIBIT II - RECOUPMENT OF PAYMENTS MADE FOR CLIENTS FOUND TO BE INELIGIBLE FOR MEDICAID

Capitation payments are made on a monthly basis throughout the year in the Medicaid Management Information System. When clients are determined to be eligible for benefits retroactively, retroactive capitation payments are made to the behavioral health organizations through the Medicaid Management Information System. When clients are determined to be ineligible for Medicaid benefits retroactively, a recoupment of the capitation payments is completed separately. The Department's ES-2 budget action of July 2009, presented these recoupments for budget savings purposes. This portion of this Request replaces that component of ES-2. Exhibit II summarizes the expected fiscal impacts.

The Department has worked to reduce the payments to the behavioral health organizations for clients later deemed ineligible for Medicaid. Historically, monthly capitation payments were made on a prospective basis. In February 2004, the Department converted

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

to concurrent capitation payments. FY 2004-05 was the first full year for monthly capitation payments on a concurrent basis. SB 09-265 requires that, beginning with FY 2010-11, payments for a monthly capitation will be made in the month immediately following the incurred month. Because the Department will have an additional month to determine eligibility before processing payment, eligibility determination may be more accurately adjudicated prior to payments being made; this, in turn, may reduce the total amount of recoupments required at the end of each fiscal year.

No recoupments were made during FY 2005-06 due to a computer programming change, and this has delayed the recoupment process. In FY 2006-07, recoupments from FY 2003-04 were processed. In FY 2007-08, no recoupments were processed as the Department sought to verify eligibility information provided by the behavioral health organizations. This process has proven to be complicated by the various reporting practices of the community mental health centers that provide services to clients. The Department is currently working with the Centers for Medicare and Medicaid Services (CMS) to develop a retrospective eligibility validation process which the Department anticipates implementing in FY 2009-10. Therefore, recoupment collection is anticipated to resume during FY 2009-10, and to be accelerated in its processing. Recoupments from FY 2004-05 through FY 2006-07 should be processed in the later half of FY 2009-10. FY 2010-11 recoupment collections should cover FYs 2007-08 and 2008-09. The recoupments in FY 2010-11 from incurred expenses in FY 2008-09 will be altered in their federal fund split due to the impact of the American Recovery and Reinvestment Act. Since those expenditures were made with enhanced federal funds, any recoupments will also see a disproportionate share of federal funds retrieved.

EXHIBIT JJ - CASH FUNDED EXPANSION POPULATIONS

Exhibit JJ is a stand-alone exhibit designed to show the effect of the Tobacco Tax Bill (HB 05-1262) and related bills as well as the Colorado Health Care Affordability Act (HB 09-1293) to the Medicaid Mental Health Community Programs. This exhibit presents projected caseload and costs itemized by eligibility category for the current year and the request year. Note that the caseloads shown are the average monthly number over each year and will fluctuate throughout the year.

Tobacco Tax Bill:

HB 05-1262 established a number of funds, two of which provide funding to the Medicaid Mental Health Community Programs line: the Health Care Expansion Fund administered by the Department; and the Prevention, Early Detection, and Treatment Fund administered by the Department of Public Health and Environment. The Health Care Expansion Fund provides capitated mental health funding for expansion adults, individuals eligible as a result of the removal of the Medicaid asset test, the expansions of the Children's Extensive Support and Children's Home and Community Based Services waiver programs, Optional Legal Immigrants eligible for services as a result of HB 05-1086, and Foster Care clients eligible for services up to the age of 21 as a result of beginning

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

SB 07-002. The Prevention, Early Detection, and Treatment Fund provides funding for cancer treatment through its Breast and Cervical Cancer Treatment program. 30% of the Breast and Cervical Cancer Program caseload is paid for out of this Fund.

With the passage of HB 05-1262, the Department received funding to provide services to the 478 individuals on the Children's Home and Community Based Services waiver program waiting list. In addition, the Joint Budget Committee decided to add an additional 200 expansion slots during FY 2006-07 Figure Setting (see the March 13, 2006 Figure Setting Document, page 145). In total, there are 678 expansion slots in the Children's Home and Community Based Services waiver program FY 2008-09 and subsequent fiscal years. Please see Exhibit JJ for the Department's projected Health Care Expansion Fund expenditures for the Children's Home and Community Based Services.

HB 05-1262 also provided additional funding to pay for 148 individuals on the Children's Extensive Support wait list. However, since 99 of these clients were already Medicaid eligible, expenditures associated with these clients cannot be billed to the Health Care Expansion Fund. Therefore, only 49 of the original 148 expansion slots are funded with Health Care Expansion Fund money. During FY 2006-07 Figure Setting, the Joint Budget Committee approved an additional 30 expansion slots (March 13, 2006 Figure Setting Document, page 145), of which 10 were paid for through the Health Care Expansion Fund due to the other 20 clients not being Medicaid eligible at the time these slots were approved. Based on the consistently increasing number of individuals on the waitlist for the Children's Extensive Support waiver, the Department requested that the remaining 20 slots approved for FY 2006-07 be paid out of the Health Care Expansion Fund as well. In total, the Department expects to pay for 79 Children's Extensive Support expansion slots. Exhibit JJ provides additional detail regarding the Department's projections of expenditures for the Children's Extensive Support expansion population.

The Health Care Expansion Fund also provides funding for capitated mental health services to Expansion Adults. This population consists of individuals that meet the following requirements: 1) they are parents of children that are eligible for either Medicaid or the Children's Basic Health Plan, 2) their income is less than 60% of the federal poverty level, and 3) they are not otherwise eligible for Medicaid. The estimated caseloads were taken from the Department's caseload projections provided in this Budget Request (see Exhibit B in Medical Services Premiums). Costs for each expansion population are assumed to be the same as for the traditional populations as the vast majority of mental health services payments are made via the capitation, and do not change based on client utilization.

SB 07-002 and SB 08-099 provided for appropriations to support Medicaid clients from the Foster Care system who are between the ages of 18 and 21. The Department's caseload projections are provided in this Budget Request (see Exhibit B in Medical Services Premiums). As with Expansion Adults, the rate of per capita growth for this expanded Foster Care population is assumed to be the same as for the traditional Foster Care population. However, unlike the Expansion Adults, the individually identified costs of the

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

expansion foster care clients are used as the base upon which the per capita cost growth rates in the larger Foster Care population are applied.

The Health Care Expansion Fund also pays for individuals that are eligible for Medicaid as a result of the removal of the asset test, as required by HB 05-1262. Due to the fact that many Medicaid recipients are no longer required to submit information for the asset test, the Department has found it difficult to track expenditures for this population. Based on a review of the asset test population in FY 2008-09, it was concluded that approximately 70.1% of the total asset test removal population has an asset test flag that allows the Department to discern whether or not they are eligible as a result of the removal of the asset test. To project expenditures in the Medicaid Mental Health Community Programs line for the asset test removal population, the Department has built its estimated caseload and per capita growth rates from the last completed fiscal year by applying the last known changes to the current year as well as the growth rates from the estimated current year to the request year.

The Optional Legal Immigrants program is also funded out of the Health Care Expansion Fund. The caseload for this program is spread across all of the eligibility categories, and funds are matched by the federal government at 50% to the State's 50% contribution. See the Tobacco Tax Report in this Budget Request for the Department's caseload projections for this group.

Colorado Health Care Affordability Act:

HB 09-1293, the "Colorado Health Care Affordability Act" provided health care coverage for more than 100,000 uninsured Coloradans in FY 2009-10 and beyond. Implementation of the bill for FY 2009-10 is contingent upon Centers for Medicare and Medicaid Services (CMS) approval

The first expansion population to be affected by HB 09-1293 is the expansion adult population described, above, but now with income limits up to 100% of the federal poverty level. The Department has presented caseload calculations in this Request (see Exhibit B in Medical Services Premiums) for this population. The Department also anticipates that the costs for this population will be the same as for the traditional populations, as the vast majority of mental health services payments are made via the capitation, and do not change based on client utilization.

(B) OTHER MEDICAID MENTAL HEALTH PAYMENTS

All Medicaid Mental Health Community Programs payments which are not part of the capitation payments are under this Long Bill group as Mental Health Fee-For-Service Payments.

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

EXHIBIT KK - MEDICAID MENTAL HEALTH FEE-FOR-SERVICE PAYMENTS

Medicaid Mental Health Fee-for-Service Payments is a separate budget line item in Medicaid Mental Health Community Programs. Expenditures for this line are shown in Exhibit KK. The data from Exhibit KK also appears in Exhibits AA, BB, and CC as well as the Schedule 13.

The Medicaid Mental Health Fee-for-Service Payments appropriation allows Medicaid clients not enrolled in a behavioral health organization to receive mental health services or enrolled Medicaid clients to receive mental health services not covered by the behavioral health organizations. The services are not covered either because the client is not enrolled in a behavioral health organization or the services are outside the scope of the behavioral health organization contract. Medicare crossover claims are included in the fee-for-service category; these are behavioral health organization covered services for clients enrolled in a behavioral health organization who are eligible for both Medicare and Medicaid.

Fee-for-service providers include, but are not limited to hospitals, psychiatrists, psychologists, primary care physicians, and mental health centers. The State also reimburses providers through fee-for-service if either the diagnosis or the procedure is not included in the behavioral health organization contract or the patient is not enrolled in a behavioral health organization.

History and Background Information

The nature of Medicaid Mental Health Fee-for-Service Payments has changed in recent years. Prior to FY 2002-03, Fee-for-Service Payments were included in the Medicaid Mental Health Capitation base appropriation. During FY 2002-03, case management services provided by community mental health centers were included in the Mental Health Fee-for-Service Payments appropriation. During FY 2003-04, case management services were provided by Single Entry Point agencies and were still part of the Mental Health Fee-for-Service Payments appropriation, but they were moved to the Medical Services Premiums appropriation in FY 2004-05. Also during FY 2004-05, fee-for-service mental health care for developmentally disabled clients living in Regional Centers was transferred from the Department of Human Services to the Department's Mental Health Fee-for-Service Payments appropriation. The changes to case management services and mental health care for developmentally disabled clients are discussed below.

Historically, community mental health centers provided case management services to the Children's Home and Community Based Services for the Mentally Ill waiver clients on a fee-for-service basis. Effective July 1, 2003, the Department began utilizing contracted Single Entry Point agencies for these services instead of the community mental health centers. Funding for these case management services remained in the fee-for-service payments appropriation for FY 2003-04. However, since Single Entry Point contracts are customarily paid from the Medical Services Premiums, the Department requested that these services be transferred to the Medical Services Premiums Long Bill group. The supplemental appropriation to the Department (SB 05-112) moved Single Entry

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

Point case management from the Mental Health Fee-for-Service Payments line item to the Medical Services Premiums line item in FY 2004-05 and was effective July 1, 2004.

The supplemental appropriation to the Department (SB 05-112) also authorized the transfer of the fee-for-service mental health care for developmentally disabled clients living in Regional Centers from the Department of Human Services to the Department. This followed a September 3, 2004 1331 Supplemental which was approved by the Joint Budget Committee on September 21, 2004 for the transfer of funds from the Department of Human Services for Developmental Disability State Plan services. This action funded State Plan services provided to clients in the Developmentally Disabled waiver for Children's Home and Community Based Services as required by the Centers for Medicare and Medicaid Services, effective October 1, 2004.

In FY 2005-06 there was a one-time recoupment of \$303,492 in the inpatient services area for disallowed payments going back to FY 2001-02. The recoupment was added back to get an accurate base for trending forward. The recoupment was then deducted to arrive at a bottom-line expenditure which matches data from the Colorado Financial Reporting System. The expenditures in Exhibit KK are broken out into the three major categories which make up Medicaid Mental Health Fee-for-Service: inpatient services, outpatient services, and physician services.

Current Calculations

The current fiscal year's total estimated expenditure is based on the first half of the year's actual expenditures, trended forward based upon the expected change in caseload. Similarly, the request year estimate is the result of a forward trend of the current year estimate by the factor of the anticipated change in caseload.

No rate or utilization increases are forecast, although the Department is currently investigating the feasibility and necessity of incorporating such adjustments. The first half of FY 2009-10 has seen significant increases in Fee-for-Service expenditure. The Department is currently performing data analysis using fee-for-service claims in an attempt to determine if this increase in expenditure reflects a permanent shift in expenditure patterns or if the last six months are an anomaly. The Department will continue to monitor the situation. In the interim and until data analysis can prove or disprove any theories, the Department takes the conservative view for forecasting purposes, assuming the increase fee-for-service expenditure will continue into the foreseeable future.

Mental Health Anti-Psychotic Pharmaceuticals:

This line was included in the Other Medicaid Mental Health Payments appropriation section within the Long Bill for informational purposes only. Original funding is in the Medical Services Premiums Long Bill group of the Department's budget. For calculations of the requested amount, see Calculation of Anti-psychotic Drugs under the Medical Services Premiums section, Exhibit F. Through

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

implementation of the Medicare Modernization Act, the costs to the State for providing prescription drugs, including anti-psychotic medications, were expected to decline. However, the rate of increase for anti-psychotic medications has been approximately the same, and is projected to continue.

For FY 2008-09, the Department requested and received approval on the removal of the Medicaid Anti-Psychotic Pharmaceuticals line item. This change did not impact the Department's ability to pay for these drugs, as they are still part of the Medicaid physical health benefit (as are all other pharmaceuticals related to the treatment of mental health conditions, such as anti-depressants). The Department will continue to report expenditure for anti-psychotics in its Budget Request in future years (such as in Exhibit F of the exhibits for Medical Services Premiums), and so no information will be lost from the Budget Request.

By removing the double-count, the Department's Budget more accurately reflects the total funds appropriated to the Department, and the actual expenditure for Medicaid services.

EXHIBIT LL - GLOBAL REASONABLENESS TEST FOR MENTAL HEALTH CAPITATION PAYMENTS

The Global Reasonableness Test presented in Exhibit LL compares the percent change between mental health capitation expenditures as reported in Exhibit DD and forecasted in Exhibit EE. The FY 2009-10 appropriation is 4.83% lower than FY 2008-09 actual expenditures, primarily due to the various expenditure cutting initiatives implemented in light of the state budget shortfall. The FY 2009-10 estimate incorporates increased caseload projections along with various rate adjustments for budget cutting initiatives and results in a 4.99% decrease from FY 2008-09 actual expenditures and a 0.17% decrease from the current appropriation. The FY 2010-11 Budget Request is built on the FY 2009-10 estimate, and presents a 20.10% expenditure increase. This increase is primarily due to 1) increased caseload projections for traditional clients, 2) increased caseload due to the Colorado Health Care Affordability Act expansion populations, and 3) adjustments to the base budget to replace one-time savings measures from FY 2009-10 (such as the MMIS payment delay and the change in capitation payment methodologies from concurrent payment to payment in the month following services as required by SB 09-265). The FY 2010-11 Request represents a 19.90% increase over the current FY 2009-10 appropriation.