

STATE OF COLORADO FY 2011-12 BUDGET REQUEST CYCLE: DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

Schedule 13 Change Request for FY 2011-12 Budget Request Cycle											
Decision Item FY 2011-12		Base Reduction Item FY 2011-12			Supplemental FY 2010-11			Budget Amendment FY 2011-12			
Request Title: Medicare Modernization Act State Contribution Payment		Department: Health Care Policy and Financing			Dept. Approval by: John Bartholomew <i>JB</i>			Date: November 1, 2010 <i>10/20</i>			
Priority Number: DI-4 S-4					OSPFB Approval: <i>Jelle</i>			Date: <i>10-21-10</i>			
	Fund	1 Prior Year Actual FY 2009-10	2 Appropriation FY 2010-11	3 Supplemental Request FY 2010-11	4 Total Revised Request FY 2010-11	5 Base Request FY 2011-12	6 Decision/ Base Reduction FY 2011-12	7 November 1 Request FY 2011-12	8 Budget Amendment FY 2011-12	9 Total Revised Request FY 2011-12	10 Change from Base (Column 5) FY 2012-13
Total of All Line Items	Total	57,624,126	70,700,172	(501,254)	70,198,918	89,106,681	2,231,489	91,338,170	0	91,338,170	2,231,489
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	57,624,126	70,700,172	(501,254)	70,198,918	89,106,681	2,231,489	91,338,170	0	91,338,170	2,231,489
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE:RF	0	0	0	0	0	0	0	0	0	0
	FF	0	0	0	0	0	0	0	0	0	0
(5) Other Medical Services: Medicaid Modernization Act of 2003 State Contribution Payment	Total	57,624,126	70,700,172	(501,254)	70,198,918	89,106,681	2,231,489	91,338,170	0	91,338,170	2,231,489
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	57,624,126	70,700,172	(501,254)	70,198,918	89,106,681	2,231,489	91,338,170	0	91,338,170	2,231,489
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE:RF	0	0	0	0	0	0	0	0	0	0
	FF	0	0	0	0	0	0	0	0	0	0
Non-Line Item Request: None											
Letternote Revised Text: None.											
Cash or Federal Fund Name and COFRS Fund Number:		None.									
Reappropriated Funds Source, by Department and Line Item Name:		None.									
Approval by OIT? Yes: No: N/A: <input checked="" type="checkbox"/>											
Schedule 13s from Affected Departments:		None.									

CHANGE REQUEST for FY 2011-12 BUDGET REQUEST CYCLE

Department:	Health Care Policy and Financing
Priority Number:	DI-4 S-4
Change Request Title:	Medicare Modernization Act State Contribution Payment

SELECT ONE (click on box):

- Decision Item FY 2011-12
- Base Reduction Item FY 2011-12
- Supplemental Request FY 2010-11
- Budget Request Amendment FY 2011-12

SELECT ONE (click on box):

Supplemental or Budget Request Amendment Criterion:

- Not a Supplemental or Budget Request Amendment
- An emergency
- A technical error which has a substantial effect on the operation of the program
- New data resulting in substantial changes in funding needs
- Unforeseen contingency such as a significant workload change

Short Summary of Request:

This Request is for an additional \$2,231,489 General Fund in FY 2011-12 for the “Other Medical Services; Medicare Modernization Act of 2003 State Contribution Payment” line item. This request is the result of a projected increase in the caseload of dual-eligible individuals in conjunction with a projected increase in the per-member per-month (PMPM) rate paid by the State as required by federal regulations.

General Description of Request:

On January 1, 2006, the federal Centers for Medicare and Medicaid Services (CMS) assumed responsibility for the Part D prescription-drug benefit that replaced the Medicaid prescription-drug coverage for dual-eligible clients (individuals eligible for both Medicare and Medicaid). In lieu of the states’ obligation to cover prescription drugs for this population, CMS began requiring states to pay a portion of what their anticipated dual-eligible drug cost would have been had this cost shift not occurred. In January 2006, states began to pay CMS these “Clawback” payments. The payments were calculated by taking 90% of the federal portion of each state’s average PMPM dual-eligible drug benefit from calendar year 2003, inflated to 2006 using the average growth rate from the National

Health Expenditure (NHE) per-capita drug expenditures. This inflated PMPM amount is then multiplied by the number of dual-eligible clients, including retroactive clients, back to January 2006. As each calendar year passes, the 90% factor is lowered by 1.67% each year – which is known as the phase-down percentage – until it reaches 75%, where it will remain beginning in 2015. In addition, CMS inflates each state’s PMPM rates based on either NHE growth or actual growth in Part D expenditures.

In 2007, SB 07-133 changed the accounting for the payment from accrual to cash, which resulted in the May and June payments billed in one fiscal year to not be paid until the next fiscal year. This delay in payment allowed a one-time savings the year it was implemented. In addition, SB 09-265 “Medicaid CHP+ Payment Timing” made clear that the Department must make Clawback payments in compliance with the Federal rules, which allow the Department to make the May payment as late as July 25 of the same year, but that the Department is not required to make the Clawback payments before such date. As such, Clawback payments are paid two (2) months after the end of the month that the payment is for.

On February 18, 2010, the U.S. Department of Health and Human Services (HHS) determined that payments for Part D prescription-drug dual-eligible members should be calculated in accordance with the American Recovery and Reinvestment Act of 2009 (ARRA) using the enhanced Federal Medical Assistance Percentage (FMAP). The State contribution, funded entirely by General Fund, is normally 50% of the total prescription drug cost. Under the ARRA FMAP, the state contribution percentage is currently 38.41%, significantly reducing the state contribution payment. CMS applied the adjustment retroactively to payments going back to the original implementation of ARRA in October 2008 and the retroactive amount to be credited to Colorado was \$22,115,248 through December 2009. In addition to the retroactive credit, the federal government applied the ARRA-enhanced FMAP rate to monthly billing for January 2010 through June 2010.

During the FY 2010-11 Figure Setting process, the Joint Budget Committee adjusted the Department’s appropriation to account for the enhanced FMAP specified in ARRA,

section 5001(h)(3). The enhanced FMAP was set to expire December 31, 2010; however, Congress passed HR 1586, which signed by the President on August 10, 2010, and contains an extension of enhanced FMAP provisions for six months to June 30, 2011 (the end of FY 2010-11), albeit at a lower rate. The extension contains a phase-down of the FMAP rate, and the Department anticipates that the FMAP rate for the 3rd quarter of FY 2010-11 will be 58.77%, and that the FMAP rate for the 4th quarter will be 56.88%. As a result of this extension, the Department requested that its appropriations be adjusted to reflect the current expiration date of the enhanced FMAP in its FY 2010-11 ES-1 “Decrease Amount for Extended Enhanced Federal Medical Assistance Percentage.” The FY 2010-11 estimates included in this request to build to the FY 2011-12 requested increase incorporates this change.

The Department currently estimates the total FY 2011-12 MMA Clawback payment will equal \$91,338,170, which is \$2,231,489 more than the base request for FY 2011-12. This difference between the current FY 2010-11 appropriation and this FY 2011-12 request is primarily a result of the phased-down expiration of ARRA. The updated estimates are based on revised projections of the PMPM rate, dual-eligible caseload, and the anticipated level of retroactivity.

To estimate the PMPM rate for CY 2011, the Department followed the procedure outlined by the Office of the Actuary at CMS, which are detailed in the “Assumptions for Calculations” section of this request. The Department forecasts that the PMPM rate for CY 2011 will be \$127.32 and \$129.40 in CY 2012 (see Table 4).

The dual-eligible caseload is comprised of a subset of Medicaid eligibility categories Adults 65 and Older (OAP-A), Disabled Adults 60 to 64 (OAP-B), and Disabled Individuals to 59 (AND/AB) and is obtained through the Medicaid Management Information System, which processes all Medicaid claims for the State. To estimate dual-eligible caseload, the Department analyzed data from January 2006 through June 2010 and concluded a 3% historical over-the-year trend is the most reasonably accurate method to forecast dual-eligible caseload, excluding retroactivity (i.e., non-retroactive caseload). This forecasting method calculates the non-retroactive caseload by increasing the non-

retroactive caseload from the same month from the previous year by 3%. For example, the forecasted non-retroactive caseload for January 2011 of 55,184 is equal to the non-retroactive caseload from January 2010 of 53,577 increased by 3% ($53,577 * (100\% + 3\%) = 55,184$). See Table 5 for monthly non-retroactive actual caseload and projections.

In addition to the non-retroactive payments for the dual-eligibles in a given month, the State is required to make payments for individuals found to be retroactively eligible for up to two years prior (which is offset by credits to the State for individuals retroactively disenrolled). Based on data from January 2006 forward, the Department determined that the retroactive caseload figure has historically represented roughly 5% of the non-retroactive (non-retroactive) caseload paid in a given month. As such, the Department forecasts the retroactive caseload to be paid in any given month to be 5% of the non-retroactive projected caseload. For example, the Department estimates that in addition to the January 2011 non-retroactive caseload of 55,184, an additional 2,759 individuals will be retroactively enrolled in January 2011 for the prior two years ($55,184 * 5\% = 2,759$).

Based upon the caseload forecast, the Department anticipates that non-retroactive dual-eligible caseload will increase in FY 2011-12 from 55,505 in July 2011 to 57,667 in June 2012, and caseload with retroactivity for the same period will increase from 58,283 to 60,552 (see Tables 5 and 6). Further, the Department assumes this caseload category will continue to increase for the foreseeable future due to the continuing retirement of the “baby boomer” generation.

Consequences if Not Funded:

If the Department does not receive the requested additional appropriation and subsequently cannot make the required federal payment, the Department is at risk of having the amount due for the Clawback payment – plus interest – deducted from the federal funds received for the Medicaid program. Such a deduction could cause the Department to be under-funded to provide services in FY 2011-12 and would necessitate a General Fund appropriation or program cuts to make up the difference, as Medicaid is an entitlement program in which the Department cannot cap enrollment.

Calculations for Request:

Summary of Request FY 2010-11: Other Medical Services; Medicare Modernization Act of 2003 State Contribution Payment	Total Funds	General Fund
FY 2009-10 Final Appropriation	\$88,808,586	\$88,808,586
FY 2010-11 BRI-2: "Coordinated Payment and Payment Reform"	\$792,720	\$792,720
FY 2010-11 DI-4: "MMA State Contribution Payment"	\$1,727,607	\$1,727,607
FY 2010-11 S-4, BA-4: "MMA State Contribution Payment"	\$596,989	\$596,989
FY 2010-11 BA-25: "ARRA FMAP Adjustment to MMA"	(\$21,225,730)	(\$21,225,730)
FY 2010-11 Long Bill Appropriation	\$70,700,172	\$70,700,172
FY 2010-11 ES-1: "Decrease Amount for Extended Enhanced FMAP"	\$2,067,630	\$2,067,630
FY 2010-11 S-4: "MMA State Contribution Payment" Placeholder	(\$501,254)	(\$501,254)
FY 2010-11 Revised Request	\$72,266,548	\$72,266,548

Summary of Request FY 2011-12: Other Medical Services; Medicare Modernization Act of 2003 State Contribution Payment	Total Funds	General Fund
FY 2010-11 Long Bill Appropriation	\$70,700,172	\$70,700,172
Annualization of FY 2010-11 BRI-2: "Coordinated Payment and Payment Reform"	\$842,040	\$842,040
Annualization of FY 2010-11 BA-25: "ARRA FMAP Adjustment to MMA"	\$17,564,469	\$17,564,469
FY 2011-12 Base Request	\$89,106,681	\$89,106,681
FY 2011-12 DI-4: "MMA State Contribution Payment"	\$2,231,489	\$2,231,489
FY 2011-12 Revised Request	\$91,338,170	\$91,338,170

Summary of Request FY 2012-13: Other Medical Services; Medicare Modernization Act of 2003 State Contribution Payment	Total Funds	General Fund
FY 2011-12 Base Request	\$89,106,681	\$89,106,681
FY 2011-12 DI-4: "MMA State Contribution Payment"	\$2,231,489	\$2,231,489
FY 2012-13 Change From Base	\$2,231,489	\$2,231,489

Table 1: National Health Expenditures 2009-2019 Prescription Drug Expenditures			
	Year	Per Capita	Percent Change
Historical Estimate	CY 2004	\$644	-
	CY 2005	\$675	4.81%
	CY 2006	\$726	7.56%
	CY 2007	\$752	3.58%
	CY 2008	\$769	2.26%
Projected	CY 2009	\$802	4.29%
	CY 2010	\$839	4.61%
	CY 2011	\$878	4.65%
	CY 2012	\$911	3.76%

Source: Centers for Medicare & Medicaid Services, NHE Projections 2009-2019, Table 11.

<https://www.cms.gov/NationalHealthExpendData/downloads/proj2009.pdf>

Table 2: Phase-down Percentage from the Medicare Modernization Act of 2003	
Phase-down Percent Per Year:	Percentage
CY 2006	90.00%
CY 2007	88.33%
CY 2008	86.67%
CY 2009	85.00%
CY 2010	83.33%
CY 2011	81.67%
CY 2012	80.00%
CY 2013	78.33%
CY 2014	76.67%
CY 2015 and thereafter	75.00%

Source: Centers for Medicare & Medicaid Services, CMS Legislative Summary, April 2004, page 23.

<https://www.cms.gov/MMAUpdate/downloads/PL108-173summary.pdf>

Table 3: Calculation of Rate Increase Prior to Applying Phase-down			
Row	Source	Amount	Description
From "National Health Expenditure Projections 2008-2018"			
A	Estimated 2004 Per Capita Prescription Drug Expenditures	\$643	From: Table 11: Prescription Drug Expenditures; Aggregate and per Capita Amounts, Percent Distribution and Annual Percent Change by Source of Funds: Calendar Years 2003-2018
B	Estimated 2007 Per Capita Prescription Drug Expenditures	\$753	From: Table 11: Prescription Drug Expenditures; Aggregate and per Capita Amounts, Percent Distribution and Annual Percent Change by Source of Funds: Calendar Years 2003-2018
C	Percentage Growth	17.11%	(Row A / Row B) - 1
From "National Health Expenditure Projections 2009-2019"			
D	Estimated 2004 Per Capita Prescription Drug Expenditures	\$644	From: Table 11: Prescription Drug Expenditures; Aggregate and per Capita Amounts, Percent Distribution and Annual Percent Change by Source of Funds: Calendar Years 2004-2019
E	Estimated 2007 Per Capita Prescription Drug Expenditures	\$752	From: Table 11: Prescription Drug Expenditures; Aggregate and per Capita Amounts, Percent Distribution and Annual Percent Change by Source of Funds: Calendar Years 2004-2019
F	Percentage Growth	16.77%	(Row E / Row D) - 1
G	Change in the Percentage Growth	-1.99%	(Row F / Row C) - 1
H	Annual Percentage increase in average per capita aggregate Part D expenditures for 2010	0.31%	Source: "Announcement of Calendar Year (CY) 2011 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies" from CMS. Attachment II.
I	Final Percentage Change in Rate Prior to Applying Phase-down	-1.68%	Row G + Row H

Sources: Centers for Medicare & Medicaid Services, NHE Projections 2008-2018, Table 11.

<https://www.cms.gov/NationalHealthExpendData/downloads/proj2008.pdf>

Centers for Medicare & Medicaid Services, NHE Projections 2009-2019, Table 11.

<https://www.cms.gov/NationalHealthExpendData/downloads/proj2009.pdf>

Table 4: Per-Client Per-Month (PCPM) Rate History and Estimates			
		Non-ARRA Rate	ARRA Rate
CY 2008 PMPM Rate	Q1	\$120.03	-
	Q2		-
	Q3		-
	Q4		\$98.95
CY 2009 PMPM Rate	Q1	\$128.62	\$106.03
	Q2		\$98.81
	Q3		\$98.81
	Q4		\$98.81
CY 2010 PMPM Rate	Q1	\$132.12	\$101.49
	Q2		\$101.49
	Q3		\$101.49
	Q4		\$101.49
CY 2010 Phase-down Percentage (Table 2)			83.33%
CY 2010 PCPM Rate prior to Phase-down (\$132.12 / 83.33%)			\$158.55
Final Percentage Increase in Rate prior to applying Phase-down for CY 2011 (Table 3, Row I)			-1.68%
Projected CY 2011 PCPM Rate Prior to Phase-down (\$158.55 * (1 - 1.68%))			\$155.89
CY 2011 Phase-down Percentage (Table 2)			81.67%
Projected CY 2011 PCPM Rate (\$155.81 * 81.67%)			\$127.32
		Non-ARRA Rate	ARRA Rate
CY 2011 PMPM Rate	Q1	\$127.32	\$104.98
	Q2		\$109.80
	Q3		-
	Q4		-
Annual Percentage Increase for 2012 from NHE (Table 1)			3.76%
Projected CY 2012 PCPM Rate Prior to Phase-down (\$155.89 * 1.0376)			\$161.75
CY 2012 Phase-down Percentage (Table 2)			80.00%
Projected CY 2012 PCPM Rate (\$159.53 * .80)			\$129.40

Table 5: Non-retroactive Dual-Eligible Caseload History and Projections (without retroactivity)			
	FY 2009-10	FY 2010-11	FY 2011-12
July	52,319	53,889	55,505
August	52,812	54,396	56,028
September	52,965	54,554	56,191
October	53,154	54,749	56,391
November	53,108	54,701	56,342
December	53,150	54,745	56,387
January	53,577	55,184	56,840
February	53,453	55,057	56,708
March	53,508	55,113	56,767
April	53,718	55,330	56,989
May	54,018	55,639	57,308
June	54,357	55,988	57,667

Italicized font denotes projected figures.

Table 6: Dual-Eligible Caseload Projections (with retroactivity)			
	FY 2009-10	FY 2010-11	FY 2011-12
July	54,935	56,583	58,283
August	55,453	57,114	58,829
September	55,613	57,282	59,000
October	55,812	57,483	59,211
November	55,763	57,434	59,160
December	55,808	57,479	59,207
January	56,256	57,946	59,682
February	56,126	57,812	59,543
March	56,183	57,871	59,606
April	56,404	58,098	59,838
May	56,719	58,423	60,175
June	57,075	58,789	60,552

	CY 2009	CY 2010	CY 2011	FY 2010-11 TOTAL
July 2010	350	56,233	0	56,583
August 2010	270	56,844	0	57,114
September 2010	217	57,065	0	57,282
October 2010	162	57,321	0	57,483
November 2010	118	57,316	0	57,434
December 2010	91	57,388	0	57,479
January 2011	68	2,694	55,184	57,946
February 2011	46	1,746	56,020	57,812
March 2011	29	1,214	56,628	57,871
April 2011	18	897	57,183	58,098
May 2011	12	630	57,781	58,423
June 2011	6	471	58,312	58,789
CY Total Member Months	1,387	349,819	341,108	
CY Q1 Rate	\$98.81	\$101.49	Varies (see Table 7a)	
Expenditures	\$137,049	\$35,503,130	\$36,626,368	\$72,266,548

The vertical columns depict the CY of service, while the horizontal rows depict the FY of billing.

FY 2010-11	Member Months	Rate	Total Cost
Q1	0	\$101.49	\$0
Q2	0	\$101.49	\$0
Q3	171,637	\$104.98	\$18,018,452
Q4	169,471	\$109.80	\$18,607,916
Total	341,108		\$36,626,368

	CY 2010	CY 2011	CY 2012	FY 2011-12 TOTAL
July 2011	363	57,921	0	58,284
August 2011	281	58,548	0	58,829
September 2011	225	58,775	0	59,000
October 2011	170	59,041	0	59,211
November 2011	125	59,035	0	59,160
December 2011	97	59,110	0	59,207
January 2012	69	2,773	56,840	59,682
February 2012	46	1,797	57,700	59,543
March 2012	29	1,249	58,328	59,606
April 2012	18	922	58,898	59,838
May 2012	12	648	59,515	60,175
June 2012	6	486	60,060	60,552
CY Total Member Months	1,441	360,305	351,341	
CY Rate	\$101.49	Varies (see Table 8a)	\$129.40	
Expenditures	\$146,247	\$45,728,398	\$45,463,525	\$91,338,170

The vertical columns depict the CY of service, while the horizontal rows depict the FY of billing.

FY 2010-11	Member Months	Rate	Total Cost
Q1	2,012	\$104.98	\$211,220
Q2	5,747	\$109.80	\$631,021
Q3	175,796	\$127.32	\$22,382,347
Q4	176,750	\$127.32	\$22,503,810
Total	360,305		\$45,728,398

Cash Funds Projections:

Not Applicable.

Assumptions for Calculations:

The Department assumes the changes in the PMPM rate paid by the Department will be based on the growth in the 2009 NHE prescription-drug per-capita estimates, as shown in Table 1, and offset by the phase-down percent shown in Table 2. Per 42 CFR 423.902 (4), the growth factor for 2007 and succeeding years will equal the annual percentage increase in average per-capita aggregate expenditures for covered Part D drugs in the United States for Part D-eligible individuals for the 12-month period ending in July of the previous year. Since the Department does not have the data to project the Part D drug expenditures, the Department has used the 2009 NHE forecasts for years beyond CY 2009 as a proxy for the annual growth in the per-capita rate.

Tables 1 through 4 provide relevant information for calculating the PMPM rates for CY 2011 and CY 2012. In order to estimate the 2011 PMPM rate, which the Department estimates will be \$127.32, the Department followed the procedure outlined by the Office of the Actuary at CMS using the latest available NHE estimates of per-capita drug expenditures growth for the period 2004 to 2007 listed in CMS's NHE Projections from 2008 and 2009, combined with the 2010 annual percentage increase in the average per-capita aggregate Part D expenditures from CMS. To estimate the PMPM rate for calendar year 2011 and beyond, the Department used the annual percentage increase in prescription drug expenditures from the NHE shown in Table 1. In addition, the projection is also based on the phase-down percentage detailed in 42 CFR 423.908 and shown in Table 2.

The Department notes that the projection of PMPM rates is based on the growth in the NHE drug expenditures; however, federal law states the growth factor for 2007 and succeeding years will equal the annual percentage increase in average per-capita aggregate expenditures for covered Part D drugs in the United States for Part D-eligible individuals during the 12-month period ending in July of the previous year. Since actual expenditure data is not available for 2011 and beyond at the time of this request, the actual per capita rate growth may differ from the Department's projection. Table 3 shows the derivation of

the projected PMPM rate increase for 2011. The full derivation of the 2011 estimated rate is shown in Table 4.

Tables 5 and 6 depict the Department's estimates for non-retroactive and total (including retroactivity) dual-eligible caseload. The Department assumes that the average growth rate in non-retroactive caseload through FY 2011-12 will remain relatively unchanged from that experienced between January 2006 and June 2010. As such, the Department assumes that the dual-eligible caseload will grow at monthly rate of approximately 0.25%, or an annual growth rate of approximately 3%. The Department also assumes the proportion of retroactive caseload to non-retroactive caseload in any given month of payment of 5% will remain relatively unchanged through FY 2011-12. The Department has allocated the estimated retroactive caseload among the prior 23 month based on the average distribution experienced between October 2007 and June 2010.

Impact on Other Government Agencies: Not Applicable.

Cost Benefit Analysis:

FY 2010-11 Cost Benefit Analysis	Costs	Benefits
Request	The cost of this request includes \$2,231,489 in General Fund in FY 2011-12 to pay for the increase in the projected caseload of dual-eligible individuals and a projected increase in the PMPM rate paid by the State per federal regulations.	This request would allow the Department to meet its obligations to the federal government and ensure the Department would not have the amount of payment plus interest deducted from the federal funds received for the Medicaid program.
Consequences if not Funded	The cost of not funding the request would be the potential deduction in federal funds received by the Medicaid program equal to the amount owed for the payment plus interest. This would equal an amount greater than \$2,231,489.	There are no benefits to the Department because the savings of General Fund would be offset by greater loss of federal funds that would need to be backfilled with General Fund for the Medicaid program.

Implementation Schedule:

Not Applicable.

Statutory and Federal Authority:

42 C.F.R. §423.908 (2010) *Phased-down State contribution to drug benefit costs assumed by Medicare. This subpart sets forth the requirements for State contributions for Part D drug benefits based on full-benefit dual eligible individual drug expenditures.*

42 C.F.R. §423.910 (a) (2010) General rule: *Each of the 50 States and the District of Columbia is required to provide for payment to CMS a phased-down contribution to defray a portion of the Medicare drug expenditures for individuals whose projected Medicaid drug coverage is assumed by Medicare Part D.*

42 C.F.R. §423.910 (b) (2) (2010) Method of payment: *Payments for the phased down State contribution begins in January 2006, and are made on a monthly basis for each subsequent month. State payment must be made in a manner specified by CMS that is similar to the manner in which State payments are made under the State Buy-in Program except that all payments must be deposited into the Medicare Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund. The policy on collection of the Phased-down State contribution payment is the same as the policy that governs collection of Part A and Part B Medicare premiums for State Buy-in.*

42 C.F.R. §423.910 (g) (2010) Annual per capita drug expenditures. *CMS notifies each State no later than October 15 before each calendar year, beginning October 15, 2005, of their annual per capita drug payment expenditure amount for the next year.*

24-75-109, C.R.S. (2010). *Controller may allow expenditures in excess of appropriations - limitations - appropriations for subsequent fiscal year restricted - repeal. (1) For the purpose of closing the state's books, and subject to the provisions of this section, the controller may, on or after May 1 of any fiscal year and before the forty-fifth day after the close thereof, upon approval of the governor, allow any department, institution, or*

agency of the state, including any institution of higher education, to make an expenditure in excess of the amount authorized by an item of appropriation for such fiscal year if:

(a.6) The overexpenditure is by the department of health care policy and financing for the required state contribution payment pursuant to the federal "medicare modernization act of 2003", pub.l. 108-173;

(6) The controller may allow overexpenditures pursuant to this section only for the fiscal years beginning July 1, 1998, July 1, 1999, July 1, 2000, July 1, 2001, July 1, 2002, July 1, 2003, July 1, 2004, July 1, 2005, July 1, 2006, July 1, 2007, and July 1, 2008, July 1, 2009, July 1, 2010, July 1, 2011, July 1, 2012, and July 1, 2013, and this section is repealed, effective September 1, 2014.

25.5-4-105, C.R.S. (2010) *Nothing in this article or articles 5 and 6 of this title shall prevent the state department from complying with federal requirements for a program of medical assistance in order for the state of Colorado to qualify for federal funds under Title XIX of the social security act and to maintain a program within the limits of available appropriations.*

25.5-4-201, C.R.S. (2010) *Cash system of accounting - financial administration of medical services premiums - medical programs administered by department of human services - federal contributions - rules. (1.5) (a) The state department shall utilize the cash system of accounting, as enunciated by the governmental accounting standards board, for the contributions required by 42 U.S.C. sec. 1396u-5 (c).*

(b) The contributions required by 42 U.S.C. sec. 1396u-5 (c) shall be made in the manner required by the federal centers for medicare and medicaid services, or any successor agency. Nothing in this paragraph (b) shall require the state department to make the contribution before the contribution is due.

25.5-5-503, C.R.S. (2010) *(1) The state department is authorized to ensure the participation of Colorado medical assistance recipients, who are also eligible for*

medicare, in any federal prescription drug benefit enacted for medicare recipients. (2) Prescribed drugs shall not be a covered benefit under the medical assistance program for a recipient who is eligible for a prescription drug benefit program under medicare; except that, if a prescribed drug is not a covered Part D drug as defined in the “Medicare Prescription Drug, Improvement, and Modernization Act of 2003”, Pub.L. 108-173, the prescribed drug may be a covered benefit if it is otherwise covered under the medical assistance program and federal financial participation is available.

Performance Measures:

If the Department does not receive an additional appropriation, and subsequently cannot make the required payment, the Department is at risk of having the amount due for the Clawback payment plus interest deducted from the federal funds received for the Medicaid program. This deduction would hinder the Department’s ability to achieve all performance measures requiring State and matching federal funding. Funding this request would assist the Department in achieving many of its performance measures, including the following:

- Increase the number of clients served through targeted, integrated care management programs.
- Increase the number of children served through a dedicated medical home service delivery model.
- Maintain or reduce the difference between the Department’s spending authority and actual expenditures for Medicaid services.