Bill	Title	Total Funds*	FTE*	General Fund*	Cash Funds*	Cash Funds Exempt / RF*	Federal Funds*	Possible to repeal?	Notes
FY 2005-06									
HB 05-1015	Substance Abuse	$3,264,363	0.0	$1,621,070	$0	$0	$1,609,956	Yes	Repeal may result in increased utilization of higher cost care. Note, the original fiscal note assumed savings above program costs by FY 2007-08. Further, estimated utilization was much lower than originally estimated.
HB 05-1086	Services to Legal Immigrants	$8,365,325	0.0	($1,157,225)	$5,276,686	($266,519)	$4,512,383	No	Repeal would violate federal eligibility maintenace of effort requirements
HB 05-1243	Consumer Directed Care	($803,395)	0.5	($444,369)	$0	$0	($359,026)	Yes	
HB 05-1262	Tobacco Tax Implementation	$99,851,331	7.3	($5,211,733)	$85,486	$76,073,400	$28,904,178	No	Repeal would violate federal eligibility maintenace of effort requirements
	FY 2005-06 Total	$110,677,624	7.8	($5,192,257)	$5,362,172	$75,806,881	$34,667,491		
FY 2006-07									
	FY 2006-07 Total	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**		
FY 2007-08									
HB 07-1021	Prescription Drug Consumer Information and Technical Assistance Act	($545,281)	1.0	($276,877)	$0	$0	($268,404)	Yes	Repeal would result in the loss of savings associated with this initiative
HB 07-1301	Cervical Cancer Immunizations	$298,177	0.0	$0	$0	$104,362	$193,815	Yes	
SB 07-036	Mental Health Disorders - Mandatory Coverage	$42,470	0.0	$11,011	$0	$11,011	$20,448	Unknown	Repeal may violate provisions of the federal Affordable Care Act
SB 07-130	Medical Homes for Children	$118,128	1.0	$44,965	$0	$0	$73,163	Yes	Repeal would result in lack of sufficiently coordinated care and increased long-term costs for clients.
SB 07-211	Improvements to Health Care for Children	$161,427	1.3	$62,562	$0	$1,237	$97,628	No	Repeal would violate federal eligibility maintenace of effort requirements
	FY 2007-08 Total	**$74,921**	**3.3**	**($158,339)**	**$0**	**$116,610**	**$116,650**		
FY 2008-09									
SB 08-057	Insurance Coverage for Hearing Aids for Minors	$54,300	0.0	$0	$19,000	$0	$35,300	Yes	
SB 08-099	Extending Medicaid Eligibility for Foster Care	$1,428,800	0.0	$0	$714,400	$0	$714,400	No	Repeal would violate federal eligibility maintenace of effort requirements
	FY 2008-09 Total	**$1,483,100**	**0.0**	**$0**	**$733,400**	**$0**	**$749,700**		
FY 2009-10									
HB 09-1047	Alternative Therapies for Persons with Disabilities	$53,480	0.8	$0	$26,740	$0	$26,740	Yes	In order to gain waiver approval, services must be at least budget neutral. Repealing this program would not generate General Fund savings beyond the initial administrative expenditure.
	FY 2009-10 Total	**$53,480**	**0.8**	**$0**	**$26,740**	**$0**	**$26,740**		
FY 2010-11									
HB 10-1005	Home Health Care	$123,270	0.0	$0	$47,348	$0	$75,922	Yes	
HB 10-1033	Screening Brief Intervention Referral	$870,155	0.0	$334,227	$0	$0	$535,928	Yes	Repeal may result in increased utilization of higher cost care.
HB 10-1146	State-funded Public Assistance Programs	($520,034)	0.0	($778,408)	$818	$0	$257,556	Yes	
SB 10-061	Medicaid Hospice Room and Board Charges	$102,570	0.0	$0	$51,285	$0	$51,285	Yes	Services are required to be budget neutral, although after a waiver is approved, General Fund will be required for system changes.
SB 10-167	Medicaid Efficiency & False Claims	($1,062,209)	7.0	($414,513)	$0	$0	($647,696)	Yes	Repeal would result in the loss of savings associated with this initiative
	FY 2010-11 Total	**($486,248)**	**7.0**	**($858,694)**	**$99,451**	**$0**	**$272,995**		
Grand Total Special Bills		**$111,802,877**	**18.9**	**($6,209,290)**	**$6,221,763**	**$75,923,491**	**$35,833,576**		

*Funding amounts only include the original appropriation associated with the bill and do not account for any annualizations.

Benefits Collaborative Schedule

Policy	Public Meeting Date
Apnea Monitors	Wednesday, October 20th, 2010
Electrical Stimulation Devices	Wednesday, October 20th, 2010
Mattresses and Overlays	Friday, October 29th, 2010
Hospital / Specialty Beds	Friday, October 29th, 2010
Augmentative Communication Devices	Wednesday, November 12th, 2010
Lifts	Friday, November 17th, 2010
Power Operated Vehicles / Wheelchairs	Friday, November 17th, 2010
Diabetic Equipment and Supplies	Friday, December 10th, 2010
Radiology	Friday, January 7th, 2011
Angiography	Friday, January 7th, 2011
CAT Scans	Friday, January 21st, 2011
MRIs	Friday, January 21st, 2011
PET Scans	Friday, January 21st, 2011
Ultrasounds	Friday, February 4th, 2011
Laboratory & Pathology Services	Friday, February 4th, 2011
Anesthesia	Wednesday, January 12th, 2011
Transplants	Wednesday, January 12th, 2011
Breast Reconstruction	Wednesday, January 19th, 2011
Podiatry	Wednesday, January 19th, 2011
Physical and Occupational Therapy	Wednesday , January 26th, 2011
Prosthetics	Wednesday , January 26th, 2011
Office Visits	Wednesday, February 9th, 2011
Office Administered Drugs	Wednesday, February 9th, 2011

Attachment B- Benefits Collaborative Schedule

Policy	Public Meeting Date
Immunizations	Wednesday, February 9th, 2011
Health Care Provider Services: Inpatient and Surgery Services	Friday, February 18th, 2011
Health Care Provider Services: Outpatient (except surgery)	Friday, February 18th, 2011
Telemedicine	Friday, March 4th, 2011
Dialysis Centers	Friday, March 4th, 2011
Ambulatory Surgery Centers	Wednesday, March 9th, 2011
Public Health Clinics	Expedited – January 2011
School Based Health Services	Expedited – January 2011
Non-Emergent Medical Transportation	Wednesday, March 23rd, 2011
Emergent (Ambulance) Medical Transportation	Wednesday, March 23rd, 2011
Autism Treatment	Friday, April 1st, 2011
Traumatic Brain Injury Treatment	Friday, April 1st, 2011
Outpatient Substance Abuse	Wednesday, April 6th, 2011
Mental Health Services	Friday, April 16th, 2011
Case Management	Friday, April 16th, 2011
Hospice Services	Wednesday, April 20th, 2011
Home Health Services	Friday, April 29th, 2011
Private Duty Nursing	Friday, April 29th, 2011
Adult Daycare	Wednesday, May 4th, 2011
Personal Care Services	Friday, May 13th, 2011
Homemaker Services	Friday, May 13th, 2011

Medicaid Integrity Recovery Efforts

Safeguarding Federal and State Dollars Spent on the Colorado Medical Assistance Program

Type	From	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	Total	Comments
Recovery							
Estate, Tort/Casualty, Trusts	Estate Recovery	$4,656,903	$3,349,036	$3,555,977	$3,682,865	$15,244,781	Estate recovery is contingent on the market for real estate. Although any number of factors could have been involved in SFY 07/08, this period coincides with the collapse of the housing market.
Estate, Tort/Casualty, Trusts	Trusts/Repayment	$2,049,119	$1,801,392	$2,675,299	$2,800,403	$9,326,213	Trust repayment recoveries fluctuate from year-to-year and the number in FY 2007-08 reflects an expected variance from the average. The average over 10 years is $1.85M and the variance noted is 2.7% less than the average.
Estate, Tort/Casualty, Trusts	Tort/Casualty	$3,161,970	$3,045,847	$3,800,728	$4,030,094	$14,038,639	The average annual recovery for the last 10 years is $2.976M - FY 2007-08 reflects a variance of 2.3% greater than this average, which would be expected.
Estate, Tort/Casualty, Trusts	Postpayment	$15,933,332	$16,332,211	$14,013,844	$25,364,405	$71,643,792	The increase in FY 2009-10 included $3.8M in recoveries from the date of death project. There was also a $5.6M increase in recoveries from commercial insurance coverage and an increase of $1.5M in Medicare Part A recoveries.
Program Integrity	Provider Recoveries	$6,750,242	$3,624,367	$1,932,325	$2,068,301	$14,375,235	PI had one contingency contractor (HMS) from May 2002 through June 30, 2006 conducting Credit Balance Audits. PI had a second contingency contractor (HWT) from July 1, 2003 through June 30, 2007 conducting algorithm based reviews. A new contingency contract (HMS) started in Feb 1, 2007 through June 30, 2011. This has yielded increased recoveries. HWT HMS FY 2006-07 $4,560,350.18 $198,713.73 FY 2007-08 $2,297,563.89 $618,081.67 FY 2008-09 $176,383.41 $1,146,217.82 Recoveries from contractors demonstrate a drop in recoveries when the contracts ended. A run out period allowed the contractor to be paid for recoveries obtained for two years after the contract end for projects completed during the performance period of the contract. Much of the recoveries were geared toward cleaning up past billing issues. Once these issues were resolved, recoveries decreased. On May 30, 2007, new state legislation (HB-07-1319) became effective that doubled the timelines for providers to submit records to PI when requested (went from 21 days to 45 days), and implemented an informal reconsideration process which added 75 days into the timeline for completing review cases. Doubling timelines resulted in a notable drop in total recoveries.
Program Integrity	National Fraud Settlements	$1,307,102	$3,508,252	$5,266,665	$4,153,017	$14,235,036	National fraud settlements vary from year to year depending on the legal issue(s) and overpayments that have been identified.
CFMS/Client Fraud	CFMS/Client Fraud	$256,643	$267,291	$236,051	$321,529	$1,081,514	Client fraud is currently investigated and recovered by the county departments of human/social services and the Colorado Department of Human Services. The Department is actively investigating methods of improving detecting and recovering client fraud. The Department does not currently have any FTEs specifically allocated to this task and is currently utilizing internal audit staff. The Department believes that it would be beneficial to have additional staff that could utilize data mining and investigative techniques to deter client fraud.
Collections and System Generated AR's	Collections and System Generated AR's	$9,228,701	$12,217,259	$7,384,506	$12,708,529	$41,538,995	The Collections and System Generated AR's are the result of provider claim(s) adjustments within the Medicaid Management Information System (MMIS). Providers may adjust current claims in the MMIS based on the results of their own internal audit/review of their claims. These amounts will fluctuate with an increase/decrease in provider claim adjustments.

Medicaid Integrity Recovery Efforts
Safeguarding Federal and State Dollars Spent on the Colorado Medical Assistance Program

Type	From	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	Total	Comments
Reconciliation							
HMO/Pace Recoveries	HMO/PACE Recoveries	$2,273,142	$1,176,070	$2,495,396	$1,583,363	$7,527,971	HMO and PACE recovery totals are the outcome of provider recoupments for past fiscal years. Fluctuations in these amounts are the result of changes in managed care enrollment year over year as well as changes to rate methodologies which influence the need for reconciliation. The amount in FY 2008-09 reflects a one-time recoupment from Colorado Access due to a retroactive risk adjustment to account for the case mix of their newly enrolled population. The Department expects only to make retroactive rate adjustments when data on the population enrolled in a health plan is not available (such as when a health plan is new). Amounts in FY 2009-10 are reconciliations for dates of service in FY 2004-05. The Department has recently prioritized several processes to both make future managed care reconciliations more timely and smaller in magnitude.
Hospital Cost Settlements	Hospital Cost Settlements	$5,627,054	$8,679,512	$12,278,039	$34,146,385	$60,730,990	Outpatient hospital claims are paid at a percentage of costs; however, because actual cost is not known until after hospitals cost reports are audited, 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. Historically, the Department has had a series of technical difficulties that have prevented it from settling with all providers; this has created a backlog of financial audits which is currently being resolved. The Department became increasingly concerned over the growing backlog of financial audits and instituted a project plan to address both the technical issues and the workload necessary to become caught up.
							In FY 2008-09, the Department's contract auditor was able to complete only 77 audits due to issues with expenditure reports from the Department's fiscal agent. With these issues resolved, 136 audits were completed in FY 2009-10. The Department requested, and was appropriated, a $9,167,450 reduction in FY 2009-10 to account for the expected increase in outpatient cost settlements (S-1, "Request for Medical Services Premiums", Exhibit F, February 16, 2010). In total, the Department's appropriation assumed $21,918,565 in recoveries from cost settlements. However, actual cost settlements for FY 2009-10 totaled $34,146,385. Less cost settlement amounts paid to hospitals, the net cost settlement amount due the Department for FY 2009-10 totaled $31,976,927.
Mental Health Reconciliation	MH Reconciliations	$0	$0	$0	$3,252,765	$3,252,765	In FY 2009-10, the Department implemented a retrospective eligibility validation process, which allowed the Department to recoup mental health capitation payments made for clients determined to be retroactively ineligible. The Department was unable to recoup capitation payments during FY 2006-07 through FY 2008-09 because of complications verifying the historical eligibility information. In order to resolve the complications, the Department worked with the Centers for Medicare and Medicaid Services (CMS) to develop a process that would allow the Department to accurately capture the capitation payments made for ineligible clients. Once developed, the Department was able to resume the mental health reconciliations in FY 2009-10 and recovered capitations made for ineligible clients during three fiscal years: FY 2005-06, FY 2006-07, and FY 2007-08. For more information on the mental health reconciliations, please refer to page 113 of the FY 2009-10 and FY 2010-11 Budget Request submitted to the JBC on February 16, 2010.

Medicaid Integrity Recovery Efforts
Safeguarding Federal and State Dollars Spent on the Colorado Medical Assistance Program

Type	From	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	Total	Comments
Nursing Facility Recoveries	Nursing Facility Recoveries	$1,880,150	$2,527,840	$1,023,966	$762,202	$6,194,157	In FY 2007-08 two auditors completed 45 sample audits. In FY 2008-09, the Department changed auditing processes to be complaince with 25.5-4-301 C.R.S. This statute allows nursing facilities the option of a sample audit or a 100% audit. The 100% requires the auditor to look at each individual claim. Prior to this, all nursing facility audits were performed on a sample basis. Of the nursing facilities audited in FY 2008-09, 40% requested 100% audits. The 100% audits take one full month to complete. Sample audits take approximately 1.5-2 weeks. In FY 2008-09, two auditors completed ten 100% audits and 15 sample audits. In FY 2009-10, one auditor's duties changed from auditing nursing facilities to working with Senate Bill 09-263's newly mandated rate methodology for nursing facilities, pay-for-performance, and managing a certified public accounting firm to set per diem rates for billing reimbursement. The diverting of staff resources to maintain compliance with new mandates resulted in fewer recoveries.
TPL/ACS Recoveries	TPL/ACS Recoveries	$995,094	$1,298,538	$1,002,000	$2,780,176	$6,075,808	The TPL/ACS Recoveries (aka ACS Check Logs) are similar to the Collections and System Generated AR's. This however is a manual process that is in place for provider claim(s) adjustments that result from provider internal audit/review. This manual process is available to providers when the internal audit/review involves older claims that cannot be adjusted through the MMIS or when the provider lacks sufficient supporting documentation and therefore requires assistance from the Department's Fiscal Agent, Affiliated Computer Systems (ACS). These amounts will fluctuate with an increase/decrease in provider claims adjustments.
Total Recoveries		**$54,119,452**	**$57,827,615**	**$55,664,796**	**$97,654,033**	**$265,265,896**	
Rebates							
Pharmacy	Pharmacy/Drug Rebates	$55,465,088	$58,644,804	$91,818,104	$99,538,330	$305,466,326	
Total Recoveries With Drug Rebates		**$109,584,540**	**$116,472,420**	**$147,482,899**	**$197,192,363**	**$570,732,222**	

FY 2011-12 Provider Rate Reductions

Service Category	FY 2011-12 Estimate (1), (2),(3)	FY 2011-12 Appropriation Available for Rate Cut(4),(5)	Cut Level	FY 2011-12 Total Funds Reduction	FY 2011-12 Estimated GF Reduction	FY 2011-12 Estimated CF/RF Reduction	FY 2011-12 Estimated FF Reduction
ACUTE CARE							
Physician Services & EPSDT	$303,458,907	$303,458,907	1.00%	($3,034,589)	($1,397,598)	($119,696)	($1,517,295)
Emergency Transportation	$6,534,982	$6,534,982	1.00%	($65,350)	($30,097)	($2,578)	($32,675)
Non-emergency Medical Transportation	$11,117,664	$11,117,664	1.00%	($111,177)	($51,204)	($4,385)	($55,588)
Dental Services	$111,398,899	$111,398,899	1.00%	($1,113,989)	($513,055)	($43,940)	($556,994)
Family Planning	$403,088	$403,088	0.00%	$0	$0	$0	$0
Health Maintenance Organizations	$141,599,801	$141,599,801	0.80%	($1,134,302)	($522,410)	($44,741)	($567,151)
Inpatient Hospitals	$423,420,433	$423,420,433	1.00%	($4,234,204)	($1,950,089)	($167,013)	($2,117,102)
Outpatient Hospitals	$183,731,375	$183,731,375	1.00%	($1,837,314)	($846,186)	($72,471)	($918,657)
Lab & X-Ray	$37,826,736	$37,826,736	1.00%	($378,267)	($174,213)	($14,920)	($189,134)
Durable Medical Equipment	$97,674,840	$97,674,840	1.00%	($976,748)	($449,847)	($38,527)	($488,374)
Prescription Drugs	$282,741,845	$282,741,845	0.00%	$0	$0	$0	$0
Drug Rebate	($120,180,912)	($120,180,912)	0.00%	$0	$0	$0	$0
Rural Health Centers	$9,982,463	$9,982,463	0.00%	$0	$0	$0	$0
Federally Qualified Health Centers	$95,105,530	$95,105,530	0.00%	$0	$0	$0	$0
Co-Insurance (Title XVIII-Medicare)	$26,714,054	$26,714,054	1.00%	($267,141)	($123,034)	($10,537)	($133,570)
Breast and Cervical Cancer Treatment Program	$10,838,927	$10,838,927	0.80%	($86,827)	($1)	($30,389)	($56,437)
Prepaid Inpatient Health Plan Services	$53,803,295	$53,803,295	0.80%	($430,998)	($198,499)	($17,000)	($215,499)
Other Medical Services	$59,142	$59,142	0.00%	$0	$0	$0	$0
Home Health	$193,049,555	$193,049,555	1.00%	($1,930,496)	($889,102)	($76,146)	($965,248)
Presumptive Eligibility	$0	$0	0.80%	$0	$0	$0	$0
Subtotal of Acute Care	$1,869,280,623	$1,869,280,623		($15,601,400)	($7,145,333)	($642,343)	($7,813,724)
COMMUNITY BASED LONG TERM CARE		$0					
HCBS - Elderly, Blind, and Disabled	$225,559,857	$225,559,857	1.00%	($2,255,599)	($1,122,163)	($5,637)	($1,127,799)
HCBS - Mental Illness	$27,339,031	$27,339,031	1.00%	($273,390)	($136,012)	($683)	($136,695)
HCBS - Disabled Children	$2,184,470	$2,184,470	1.00%	($21,845)	($10,868)	($55)	($10,922)
HCBS - Persons Living with AIDS	$710,205	$710,205	1.00%	($7,102)	($3,533)	($18)	($3,551)
HCBS - Consumer Directed Attendant Support	$4,173,027	$4,173,027	1.00%	($41,730)	($20,761)	($104)	($20,865)
HCBS - Brain Injury	$13,759,829	$13,759,829	1.00%	($137,598)	($68,455)	($344)	($68,799)
HCBS - Children with Autism	$1,892,245	$1,892,245	1.00%	($18,922)	($9,414)	($47)	($9,461)
HCBS - Pediatric Hospice	$121,278	$121,278	1.00%	($1,213)	($604)	($3)	($606)
Private Duty Nursing	$28,081,745	$28,081,745	1.00%	($280,817)	($139,706)	($702)	($140,409)
Hospice	$51,777,635	$38,833,226	1.00%	($388,332)	($193,196)	($970)	($194,166)
Subtotal of Community Based Long Term Care	$355,599,322	$342,654,913		($3,426,549)	($1,704,713)	($8,563)	($1,713,273)
LONG TERM CARE and INSURANCE		$0					
Class I Nursing Facilities	$551,945,698	$497,066,440	1.00%	($4,970,664)	($2,485,332)	$0	($2,485,332)
Class II Nursing Facilities	$2,259,189	$2,259,189	1.00%	($22,592)	($11,296)	$0	($11,296)
Program for All-Inclusive Care for the Elderly	$88,885,593	$88,885,593	0.88%	($782,193)	($391,096)	$0	($391,097)
Subtotal Long Term Care	$643,090,480	$588,211,222		($5,775,450)	($2,887,725)	$0	($2,887,725)
Supplemental Medicare Insurance Benefit	$133,070,746	$133,070,746	0.00%	$0	$0	$0	$0
Health Insurance Buy-In Program	$2,111,363	$2,111,363	0.00%	$0	$0	$0	$0
Subtotal Insurance	$135,182,109	$135,182,109		$0	$0	$0	$0
Subtotal of Long Term Care and Insurance	$778,272,589	$723,393,331		($5,775,450)	($2,887,725)	$0	($2,887,725)
SERVICE MANAGEMENT		$0					
Single Entry Points	$25,399,302	$25,399,302	1.00%	($253,993)	($132,076)	$0	($121,917)
Disease Management	$500,000	$500,000	0.00%	$0	$0	$0	$0
Prepaid Inpatient Health Plan Administration	$22,200,297	$22,200,297	0.00%	$0	$0	$0	$0
Subtotal Service Management	$48,099,599	$48,099,599		($253,993)	($132,076)	$0	($121,917)
Total	**$3,051,252,133**	**$2,983,428,466**		**($25,057,392)**	**($11,869,847)**	**($650,906)**	**($12,536,639)**

(1) Does not include any supplemental payment expenditure to either hospitals or nursing facilities

(2) Base is estimated in DI-1, and service category totals are estimated using FY 2008-09 expenditure patterns.

(3) This amount has been reduced for the Department's December 2009 reductions, and required annualizations.

(4) This amount has been reduced for other reductions in this proposal. If additional reductions are required, the figures in this calculation will change.

(5) Estimated implementation date: July 1, 2010 Only 11 months of savings are assumed in FY 2010-11 to account for cash accounting.

FY 2012-13 Provider Rate Reductions (Annualizations)							
Service Category	**FY 2011-12 Total Fund Reduction**	**Effective Months in FY 2011-12**	**Estimated Trend[1]**	**FY 2012-13 Total Funds Reduction**	**FY 2012-13 Estimated GF Reduction**	**FY 2012-13 Estimated CF/RF Reduction**	**FY 2012-13 Estimated FF Reduction**
ACUTE CARE							
Physician Services & EPSDT	($3,034,589)	12.00	9.71%	($3,329,096)	($1,533,235)	($131,312)	($1,664,549)
Emergency Transportation	($65,350)	12.00	9.71%	($71,692)	($33,018)	($2,828)	($35,846)
Non-emergency Medical Transportation	($111,177)	12.00	9.71%	($121,966)	($56,172)	($4,811)	($60,983)
Dental Services	($1,113,989)	12.00	9.71%	($1,222,102)	($562,848)	($48,204)	($611,050)
Family Planning	$0	12.00	9.71%	$0	$0	$0	$0
Health Maintenance Organizations	($1,134,302)	12.00	9.71%	($1,244,386)	($573,110)	($49,083)	($622,193)
Inpatient Hospitals	($4,234,204)	12.00	9.71%	($4,645,134)	($2,139,345)	($183,222)	($2,322,567)
Outpatient Hospitals	($1,837,314)	12.00	9.71%	($2,015,625)	($928,308)	($79,504)	($1,007,813)
Lab & X-Ray	($378,267)	12.00	9.71%	($414,978)	($191,121)	($16,368)	($207,489)
Durable Medical Equipment	($976,748)	12.00	9.71%	($1,071,542)	($493,505)	($42,266)	($535,771)
Prescription Drugs	$0	12.00	9.71%	$0	$0	$0	$0
Drug Rebate	$0	12.00	9.71%	$0	$0	$0	$0
Rural Health Centers	$0	12.00	9.71%	$0	$0	$0	$0
Federally Qualified Health Centers	$0	12.00	9.71%	$0	$0	$0	$0
Co-Insurance (Title XVIII-Medicare)	($267,141)	12.00	9.71%	($293,067)	($134,974)	($11,560)	($146,533)
Breast and Cervical Cancer Treatment Program	($86,827)	12.00	9.71%	($95,253)	($1)	($33,338)	($61,914)
Prepaid Inpatient Health Plan Services	($430,998)	12.00	9.71%	($472,826)	($217,763)	($18,650)	($236,413)
Other Medical Services	$0	12.00	9.71%	$0	$0	$0	$0
Home Health	($1,930,496)	12.00	9.71%	($2,117,850)	($975,389)	($83,536)	($1,058,925)
Presumptive Eligibility	$0	12.00	9.71%	$0	$0	$0	$0
Subtotal of Acute Care	($15,601,400)	12.00	9.71%	($17,115,517)	($7,838,789)	($704,682)	($8,572,046)
COMMUNITY BASED LONG TERM CARE							
HCBS - Elderly, Blind, and Disabled	($2,255,599)	12.00	8.94%	($2,457,136)	($1,222,427)	($6,141)	($1,228,568)
HCBS - Mental Illness	($273,390)	12.00	8.94%	($297,818)	($148,165)	($744)	($148,909)
HCBS - Disabled Children	($21,845)	12.00	8.94%	($23,797)	($11,839)	($60)	($11,898)
HCBS - Persons Living with AIDS	($7,102)	12.00	8.94%	($7,737)	($3,849)	($20)	($3,868)
HCBS - Consumer Directed Attendant Support	($41,730)	12.00	8.94%	($45,459)	($22,617)	($113)	($22,729)
HCBS - Brain Injury	($137,598)	12.00	8.94%	($149,893)	($74,572)	($375)	($74,946)
HCBS - Children with Autism	($18,922)	12.00	8.94%	($20,613)	($10,256)	($51)	($10,306)
HCBS - Pediatric Hospice	($1,213)	12.00	8.94%	($1,321)	($658)	($3)	($660)
Private Duty Nursing	($280,817)	12.00	8.94%	($305,908)	($152,189)	($765)	($152,954)
Hospice	($388,332)	12.00	8.94%	($423,030)	($210,458)	($1,057)	($211,515)
Subtotal of Community Based Long Term Care	($3,426,549)	12.00	8.94%	($3,732,712)	($1,857,030)	($9,329)	($1,866,353)
LONG TERM CARE and INSURANCE							
Class I Nursing Facilities	($4,970,664)	12.00	0.79%	($5,009,933)	($2,504,967)	$0	($2,504,966)
Class II Nursing Facilities	($22,592)	12.00	1.55%	($22,942)	($11,471)	$0	($11,471)
Program for All-Inclusive Care for the Elderly	($782,193)	12.00	13.31%	($886,303)	($443,151)	$0	($443,152)
Subtotal Long Term Care	($5,775,450)			($5,919,178)	($2,959,589)	$0	($2,959,589)
Supplemental Medicare Insurance Benefit	$0	12.00	13.65%	$0	$0	$0	$0
Health Insurance Buy-In Program	$0	12.00	8.26%	$0	$0	$0	$0
Subtotal Insurance	$0			$0	$0	$0	$0
Subtotal of Long Term Care and Insurance	($5,775,450)			($5,919,178)	($2,959,589)	$0	($2,959,589)
SERVICE MANAGEMENT							
Single Entry Points	($253,993)	12.00	-6.38%	($237,788)	($123,649)	$0	($114,139)
Disease Management	$0	12.00	0.00%	$0	$0	$0	$0
Prepaid Inpatient Health Plan Administration	$0	12.00	29.90%	$0	$0	$0	$0
Subtotal Service Management	($253,993)			($237,788)	($123,649)	$0	($114,139)
Total	**($25,057,392)**			**($27,005,195)**	**($12,779,057)**	**($714,011)**	**($13,512,127)**

(1) Trend is based on average estimated percent increase from FY 2008-09 to FY 2010-11. Aggregate trends for Acute Care and Community Based Long Term Care are used. Trends for PACE, Disease Management, and PIHP Admin are based on different figures due to programmatic changes

35. Please provide information on which hospitals are the winners and loser under the hospital provider fee program. Please explain the current Hospital Provider Fee model and why the FY 2010-11 models generates significantly higher revenues and expenditures then the model originally assumed in the current FY 2010-11 appropriations.

Hospital System	**Net Gain / Loss**
Banner	Net Gain
Centura Health-Adventists	Net Loss
Centura Health-Catholic Health Initiatives	Net Gain
Exempla	Net Gain
HealthOne	Net Gain
Poudre Valley	Net Gain

Net Loss Hospitals	**System**
Centura Health - Littleton Adventist Hospital	Centura Health-Adventists
Centura Health - Parker Adventist Hospital	Centura Health-Adventists
Centura Health - Porter Adventist Hospital	Centura Health-Adventists
Centura Health - Penrose -St. Francis Health Services	Centura Health-Catholic Health Initiatives
Exempla Good Samaritan Medical Center	Exempla
Exempla Lutheran Medical Center	Exempla
HealthOne Medical Center of Aurora	HealthOne
HealthOne Sky Ridge Medical Center	HealthOne
HealthOne Swedish Medical Center	HealthOne
Keefe Memorial Hospital	None
Kremmling Memorial Hospital	None
Boulder Community Hospital	None
Centura Health - Ortho Colorado	None
Community Hospital	None

Attachment E- Hospital Provider Fee Model FFY 2010-11

Name	Oct 1, 2010 Model Net New Funds
Colorado Mental Health Institute-Ft Logan	$0
Colorado Mental Health Institute-Pueblo	$0
University of Colorado Hospital	$7,043,000
Arkansas Valley Regional Medical Center	$1,581,000
Aspen Valley Hospital	$318,000
Delta County Memorial Hospital	$509,000
Denver Health Medical Center	$24,379,000
East Morgan County Hospital	$1,013,000
Estes Park Medical Center	$740,000
Grand River Medical Center	$684,000
Gunnison Valley Hospital	$259,000
Haxtun Hospital	$27,000
Heart of the Rockies Regional Medical Center	$758,000
Keefe Memorial Hospital	($20,000)
Kit Carson County Memorial Hospital	$360,000
Kremmling Memorial Hospital	($219,000)
Lincoln Community Hospital and Nursing Home	$393,000
Melissa Memorial Hospital	$428,000
The Memorial Hosptial	$1,146,000
Memorial Hospital	$9,109,000
Montrose Memorial Hospital	$1,740,000
North Colorado Medical Center	$7,676,000
Pagosa Mountain Hospital	$597,000
Pioneers Hospital	$138,000
Poudre Valley Hospital	$3,142,000
Prowers Medical Center	$1,814,000
Rangely District Hospital	$62,000
Sedgwick County Memorial Hospital	$105,000
Southeast Colorado Hospital	$299,000
Southwest Memorial Hospital	$666,000
Spanish Peaks Regional Health Center	$786,000
St. Vincent General Hospital District	$175,000
Weisbrod Memorial County Hospital	$193,000
Wray Community District Hospital	$121,000
Yuma District Hospital	$716,000
Animas Surgical Hospital	$319,000
Boulder Community Hospital	($1,063,000)

Attachment E- Hospital Provider Fee Model FFY 2010-11

Name	Oct 1, 2010 Model Net New Funds
Cedar Springs Behavior Health System	$0
Centennial Peaks Hospital	$0
Centura Health - Avista Adventist Hospital	$3,355,000
Centura Health - Littleton Adventist Hospital	($3,128,000)
Centura Health - Parker Adventist Hospital	($51,000)
Centura Health - Penrose -St. Francis Health Services	($5,993,000)
Centura Health - Porter Adventist Hospital	($2,284,000)
Centura Health - Saint Anthony Central Hospital	$5,387,000
Centura Health - Saint Anthony North Hospital	$4,522,000
Centura Health - Saint Anthony Summit Hospital	$1,111,000
Centura Health - St. Mary-Corwin Medical Center	$9,733,000
Centura Health - St. Thomas More Hospital	$2,327,000
Centura Health - Ortho Colorado	($2,096,000)
Colorado Acute Long Term Hospital	$27,000
Colorado Plains Medical Center	$1,103,000
HealthOne Medical Center of Aurora	($1,170,000)
HealthOne North Suburban Medical Center	$2,832,000
HealthOne Presbyterian/St. Luke's Medical Center	$11,525,000
HealthOne Rose Medical Center	$1,761,000
HealthOne Sky Ridge Medical Center	($4,536,000)
HealthOne Spalding Rehabilitation Hospital	$162,000
HealthOne Swedish Medical Center	($1,774,000)
Community Hospital	($356,000)
Conejos County Hospital	$1,236,000
Eating Recovery Center	$0
Craig Hospital	$1,399,000
Exempla Good Samaritan Medical Center	($1,892,000)
Exempla Lutheran Medical Center	($932,000)
Exempla Saint Joseph Hospital	$7,371,000
Family Health West Hospital	$60,000
Haven Behavioral Senior Care at St. Mary-Corwin	$0
Highlands Behavioral Health System	$0
HealthSouth Rehabilitation Hospital	$236,000
Kindred Hospital	$52,000
Longmont United Hospital	$4,427,000
McKee Medical Center	$4,586,000
Medical Center of the Rockies	$1,289,000

Attachment E- Hospital Provider Fee Model FFY 2010-11

Name	Oct 1, 2010 Model Net New Funds
Mercy Medical Center	$1,492,000
Mount San Rafael Hospital	$893,000
National Jewish Health	$3,564,000
Haven Behavioral Health at North Denver	$0
Vibra Long Term Acute Care Hospital	$82,000
Northern Colorado Rehabilitation Hospital	$166,000
Parkview Medical Center	$10,190,000
Peak View Behavioral Health	$0
Pikes Peak Regional Hospital	$906,000
Platte Valley Medical Center	$5,235,000
Rio Grande Hospital	$492,000
San Luis Valley Regional Medical Center	$4,117,000
Select Long Term Care Hospital	$0
Select Specialty Hospital - Denver	$0
Select Specialty Hospital - Denver South Campus	$0
St. Mary's Hospital and Medical Center	$986,000
Sterling Regional MedCenter	$1,326,000
The Children's Hospital	$17,820,000
Triumph Hospital	$8,000
Vail Valley Medical Center	$118,000
Valley View Hospital	$4,465,000
West slope Mental Health Stabilization Center	$0
Yampa Valley Medical Center	$1,307,000
Total	**$159,450,000**

2010-11 Hospital Provider Fee Model Overview

PROVIDER FEES

Totals

- Total fees: $474,000,000
- Fees for expansions: $61,000,000

Inpatient Hospital Fee

- $83.46 per day for Managed Care Days
- $374.85 per day for non-Managed Care Days

  Managed Care Days are Medicaid HMO, Medicare HMO, and any Commercial PPO/HMO days. Non-Managed Care Days are all other days (i.e., fee for service, normal DRG or indemnity plan days).

Outpatient Hospital Fee

- 0.484% of total outpatient charges

Hospitals Exempt from Inpatient and Outpatient Hospital Fees

- State Licensed Psychiatric Hospitals
- Medicare Certified Long Term Care (LTC) Hospitals
- State Licensed and Medicare Certified Rehabilitation Hospitals

  The policy reasons for these exemptions are that the hospital fee is used as an incentive to reduce uncompensated costs and increase access for Medicaid and uninsured clients. State mental hospitals and private stand alone psychiatric facilities meet the definition of Institutions for Mental Diseases (IMDs) under 42 CFR 435.1010. Federal financial participation (FFP) is not available for Medicaid clients from age 22 through age 64 who are patients in an IMD, as noted under 42 CFR 435.1009(a)(2). Long Term Care and Rehabilitation facilities will not pay the hospital fee, but will receive an increased Medicaid Inpatient Hospital payment if they choose to participate in Medicaid. The intention of this policy is to increase access to these specialty hospitals for Medicaid clients.

Hospitals Assessed Discounted Fees

- The inpatient fee calculation for High Volume Medicaid and CICP providers is discounted by 47.79%, for a fee rate of $43.57 per day for Managed Care Days and $195.71 per day for Non-Managed Care Days.
    - High Volume Medicaid and CICP providers are those providers with at least 35,000 Medicaid days per year that provide over 30% of their total days to Medicaid and CICP clients.
- Managed care days (amounts described in the "Inpatient Hospital Fee" section above) receive a discount to recognize the effectiveness of a medical home or managed care-based health model.
- Essential Access providers are those providers are Critical Access Hospitals and other rural hospitals with 25 or fewer beds.
    - The inpatient fee calculation for Essential Access providers is discounted by 60%, or $33.38 per day for Managed Care Days and $149.94 per day for Non-Managed Care Days.
    - The policy reason for this discount is to protect the critical access and small rural hospitals of Colorado
- The outpatient fee for High Volume Medicaid and CICP providers is discounted by 0.84%.
    - This ensures that hospitals who serve the largest numbers of Medicaid and low-income clients will be assessed lower fees. Also, since Psychiatric, Long Term Care and Rehabilitation Hospitals have been excluded from the provider fee and managed care inpatient days are assessed a discounted fee, the B1/B2 test is required to be passed by 42 CFR 433.68(e)(2). In order to meet this requirement and policy goals, high volume Medicaid and CICP providers will pay a discounted fee.

SUPPLEMENTAL HOSPITAL PAYMENTS

Outpatient Hospital Supplemental Medicaid Payment

- For qualified hospitals, this payment equals Medicaid outpatient billed costs, adjusted for utilization, and inflation, multiplied by 30.70% for most hospitals (for Urban Safety Net Hospitals this percentage is 25.00%).
- Medicaid outpatient billed costs equal outpatient billed charges from the Medicaid Management Information System (MMIS), multiplied by the most recent outpatient cost-to-charge ratio as reported by CMS.
- The policy reason for this payment is to reimburse approximately 100% of Medicaid costs for Outpatient Hospital services to reduce uncompensated Medicaid costs and increase access for Medicaid clients.
- State Licensed Psychiatric Hospitals, Long Term Care (LTC) Hospitals, and State Licensed and Rehabilitation Hospitals are not qualified for this payment.

Outpatient High-Volume Small Rural Hospital Supplemental Medicaid Payment

- For qualified hospitals, this payment equals Medicaid outpatient billed costs, adjusted for utilization, and inflation, multiplied by 50%.
- Medicaid outpatient billed costs are calculated in the same manner as described above for the Supplemental Outpatient Medicaid Hospital Payment.
- The policy reason for this payment is to support providers of outpatient services of Medicaid clients at small rural hospitals
- Acute care hospitals located in a rural area whose outpatient Medicaid payments equal 80% or more of their total Medicaid payments with 20 or fewer beds are qualified for this payment.

Colorado Indigent Care Program (CICP) Disproportionate Share Hospital (DSH) Payment *and* CICP Supplemental Medicaid Payment

- For qualified hospitals, the sum of these payments will equal CICP write-off costs multiplied by 75% for most hospitals (for High Volume Medicaid and CICP Hospitals this percentage equals 64%; for rural and Critical Access Hospitals this percentage equals 100%).
- CICP write-off costs equal CICP write-off charges as published in the most recent CICP Annual Report, multiplied by the cost-to-charge ratio calculated from the most recently filed CMS 2552-96 Cost Report, adjusted for inflation.
- The policy reason for this payment is to reduce uncompensated uninsured costs and increase access for uninsured clients. The increased payments will improve access for uninsured clients at rural and non-Denver metro hospitals. Providers with high CICP costs are large metro area hospitals that can more efficiently manage uninsured costs, such as by utilizing an integrated primary care system.

- General acute care and Critical Access Hospitals that participate in the CICP are qualified for this payment. State Licensed Psychiatric Hospitals, LTC Hospitals, and State Licensed and Rehabilitation Hospitals are not qualified for this payment.

Uninsured (Charity Care) DSH Payment

- For qualified hospitals, this payment will equal its uncompensated charity care costs multiplied by 50%.
- Uncompensated charity care costs equal charity care charges as reported on the hospital survey, multiplied by the most recently audited cost-to-charge ratio.
- The policy reason for this payment is to reimburse approximately 50% of uncompensated charity care costs at acute care hospital providers to reduce uncompensated charity care costs and increase access for uninsured clients.
- Hospitals that do not participate in the CICP are qualified for this payment. State Licensed Psychiatric Hospitals, LTC Hospitals, and State Licensed and Rehabilitation Hospitals are not qualified for this payment.

Inpatient Hospital Base Rate Supplemental Medicaid Payment

- For qualified hospitals, this payment equals Medicaid estimated discharges, multiplied by average Medicaid case mix, multiplied by the Medicaid base rate, multiplied by 35.0% for most hospitals (for Pediatric Specialty Hospitals the percentage is 16.8%; for Urban Center Safety Net Specialty Hospitals the percentage is 16.0%.)
- The policy reason for this payment is to reimburse approximately 100% of Medicare Inpatient Hospital Base Rate to reduce uncompensated Medicaid costs and increase access for Medicaid clients.
- State Licensed Psychiatric Hospitals are not qualified for this payment.

High Level Neonatal Intensive Care Unit (NICU) Supplemental Medicaid Payment

- For qualified hospitals, this payment will equal Medicaid NICU days paid for CY 2008 under DRG 801 (neonates < 1,000 grams; 2 lb and 3.27 oz) and capped at the average length of stay for the DRG, multiplied by $2100.
- The policy reason for this payment is to reimburse the high costs of providing highest level of NICU services to Medicaid clients.
- The policy reason for capping the Medicaid NICU days at the average length of stay is to avoid incentivizing longer than necessary stays in the NICU.
- Hospitals with certified level IIIb or IIIc NICUs according to American Academy of Pediatrics guidelines by the Colorado Perinatal Care Council are qualified for this payment. High Volume Medicaid and CICP Hospitals, State Licensed Psychiatric Hospitals, LTC Hospitals, and State Licensed and Rehabilitation Hospitals are not qualified for this payment.

State Teaching Hospital Supplemental Medicaid Payment

- For qualified hospitals, this payment will equal total Medicaid Days multiplied by $125.
- The policy reason for this payment is to support those hospitals which provide supervised teaching experiences in a hospital setting in Colorado.
- High Volume Medicaid and CICP Hospitals which provide supervised teaching experiences to graduate medical school interns and residents enrolled in a state institution of higher education, and in which more than fifty percent (50%) of their credentialed physicians are members of the faculty at a state institution of higher education, are qualified for this payment.

Large Rural Hospital Supplemental Medicaid Payment

- For qualified hospitals, this payment equals total Medicaid Days multiplied by $600.
- The policy reason for this payment is to reduce uncompensated Medicaid costs and increase access for Medicaid clients at rural hospital providers who did not receive a discounted fee as an "essential access" provider as described above.
- Hospitals located in a rural area outside a federally-designated Metropolitan Statistical Area with more than 25 licensed beds are qualified for this payment. State Licensed Psychiatric Hospitals, LTC Hospitals, and State Licensed and Rehabilitation Hospitals are not qualified for this payment.

Denver Metro Supplemental Medicaid Payment

- For qualified hospitals located in Adams or Arapahoe county, this payment equals total Medicaid Days multiplied by $675.
- For qualified hospitals located in Denver, Jefferson, Douglas, Boulder, or Broomfield county, this payment equals total Medicaid Days multiplied by $700.
- The policy reason for this payment is to increase access for Medicaid clients in the Denver Metro Area, while focusing increased payments to those areas where the Medicaid population has limited access to providers.

  The enhanced payment to hospitals in Denver County is to ensure that adequate access to hospital care is available for Medicaid clients who reside there. Denver County has the highest number of Medicaid clients of all counties in Colorado with approximately 95,000 clients (over 15% of the population in the county and over 17% percent of all Medicaid clients in the state). In recent years, two large hospitals relocated their main facilities from Denver County to Adams County to the east, decreasing the number of hospital beds in Denver County. The enhanced access payment will decrease the uncompensated care costs for the remaining Denver hospitals and ensure that adequate capacity is available for Denver Medicaid clients near their homes.

  The purpose of the enhanced payment for hospitals in Boulder, Broomfield, Douglas, and Jefferson Counties is to improve access to hospital services for Medicaid clients in the county in which they reside. Analysis of inpatient hospital utilization during SFY 2008-09 demonstrates that over 40% of Medicaid clients who reside in the western Denver

Metro Area (Boulder, Douglas, and Jefferson Counties) receive inpatient care at hospitals located in eastern counties, namely Adams, Arapahoe, Denver, and Weld Counties. Conversely, the majority of Medicaid clients who reside in one of these eastern counties receive services near their homes.

- Hospitals located in Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, or Jefferson county are qualified for this payment. High Volume Medicaid and CICP Hospitals, State Licensed Psychiatric Hospitals, LTC Hospitals, and State Licensed and Rehabilitation Hospitals are not qualified for this payment.

Metropolitan Statistical Area Supplemental Medicaid Payment

- For qualified hospitals located in El Paso, Larimer, Mesa, Pueblo, or Weld county this payment equals total Medicaid Days multiplied by $600.
- The policy reason for this payment is to reduce uncompensated Medicaid costs and increase access for Medicaid clients at hospitals in metropolitan areas other than the Denver metropolitan area.
- Hospitals located in El Paso, Larimer, Mesa, Pueblo, or Weld county are qualified for this payment. High Volume Medicaid and CICP Hospitals, State Licensed Psychiatric Hospitals, LTC Hospitals, and State Licensed and Rehabilitation Hospitals are not qualified for this payment.

Pediatric Specialty Hospital Provider Fee Payment

- For qualified hospitals, this payment will equal $3 million.
- The policy reason for this payment is to reduce uncompensated Medicaid costs and increase access for Medicaid clients at pediatric specialty hospitals.
- Hospitals which provide care exclusively to pediatric populations are qualified for this payment.

Medicaid Psychiatric Inpatient Payment

- For qualified hospitals, this payment equals Medicaid Psychiatric Days as reported on the hospitals survey multiplied by $150.
- The policy reason for this payment is to reduce uncompensated Medicaid costs and increase access for Medicaid clients in need of inpatient psychiatric care.
- State Licensed Psychiatric Hospitals, LTC Hospitals, and Rehabilitation Hospitals are not qualified for this payment.

Medicaid Expansion Population Service Costs (in millions)

Summary of CHAA Expansion Population Costs by Year (in millions)

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
CHP+ to 250% FPL (July 2010)	$1.3	$24.9	$51.0	$62.0	$65.6	$69.4	$73.5	$77.9	$82.6	$87.5	$92.6
Medicaid Parents to 100% FPL (July 2010)	$2.1	$36.5	$77.9	$161.8	$170.5	$179.5	$189.3	$199.6	$210.5	$222.1	$234.3
Continuous Eligibility for Medicaid Children (January 2012)	-	-	$32.7	$104.1	$147.5	$156.8	$167.0	$177.9	$189.4	$201.5	$213.8
Disabled Buy-In to 450% FPL (July 2011)	-	-	$41.5	$78.6	$78.2	$82.4	$86.8	$91.6	$96.6	$101.9	$107.5
Childless Adults to 100% FPL (July 2012)	-	-	-	$187.1	$354.9	$415.1	$437.7	$461.5	$486.8	$513.6	$542.0
Total Expansion Populations	**$3.4**	**$61.4**	**$203.0**	**$593.7**	**$816.6**	**$903.2**	**$954.3**	**$1,008.5**	**$1,065.8**	**$1,126.6**	**$1,190.3**
Enrollment Fees	$0.0	$0.1	$0.2	$0.2	$0.2	$0.2	$0.2	$0.2	$0.2	$0.2	$0.2
Medicaid Disabled Buy-In Cash Fund	-	-	$8.9	$16.8	$19.6	$20.7	$21.8	$23.0	$24.2	$25.6	$27.0
State Share (Provider Fee)	$1.5	$26.9	$89.4	$279.1	$126.0	$117.7	$124.9	$165.8	$182.7	$201.1	$236.1
Federal Funds	$1.9	$34.4	$104.6	$297.6	$670.8	$764.6	$807.4	$819.5	$858.6	$899.7	$926.9

Summary of Federal Reform Expansion Population Costs by Year (in millions)

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Medicaid Children to 133% FPL	-	-	-	-	$63.9	$135.9	$181.0	$192.8	$205.3	$218.4	$231.7
Medicaid Parents to 133% FPL	-	-	-	-	$30.5	$64.1	$84.5	$89.1	$94.0	$99.2	$104.7
Disabled Individuals to 133% FPL	-	-	-	-	$78.5	$164.1	$214.3	$224.2	$234.9	$245.8	$257.2
Childless Adults to 133% FPL	-	-	-	-	$38.3	$80.7	$106.3	$112.1	$118.2	$124.8	$131.7
Total Expansion Populations	**-**	**-**	**-**	**-**	**$211.2**	**$444.8**	**$586.1**	**$618.3**	**$652.4**	**$688.1**	**$725.2**
State Share (Other)	-	-	-	-	-	-	-	$30.9	$39.1	$48.2	$72.5
Federal Funds	-	-	-	-	$211.2	$444.8	$586.1	$587.4	$613.2	$640.0	$652.7

Total by Expansion Population (in millions)

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
CHP+ to 250% FPL	$1.3	$24.9	$51.0	$62.0	$65.6	$69.4	$73.5	$77.9	$82.6	$87.5	$92.6
Medicaid Children to 133% FPL	-	-	-	-	$63.9	$135.9	$181.0	$192.8	$205.3	$218.4	$231.7
Medicaid Parents to 133% FPL	$2.1	$36.5	$77.9	$161.8	$200.9	$243.6	$273.8	$288.7	$304.5	$321.2	$339.0
Disabled Individuals to 450% FPL	-	-	$41.5	$78.6	$156.7	$246.5	$301.2	$315.8	$331.4	$347.7	$364.7
Childless Adults to 133% FPL	-	-	-	$187.1	$393.2	$495.8	$544.1	$573.7	$605.0	$638.3	$673.7
Continuous Eligibility for Medicaid Children	-	-	$32.7	$104.1	$147.5	$156.8	$167.0	$177.9	$189.4	$201.5	$213.8
Total All Expansion Populations (in millions)	**$3.4**	**$61.4**	**$203.0**	**$593.7**	**$1,027.8**	**$1,348.0**	**$1,540.5**	**$1,626.8**	**$1,718.2**	**$1,814.7**	**$1,915.5**
Client Fees	$0.0	$0.1	$9.1	$17.0	$19.9	$20.9	$22.0	$23.2	$24.5	$25.8	$27.2
Hospital Provider Fee	$1.5	$26.9	$89.4	$279.1	$126.0	$117.7	$124.9	$165.8	$182.7	$201.1	$236.1
State Funds	-	-	-	-	-	-	-	$30.9	$39.1	$48.2	$72.5
Federal Funds	$1.9	$34.4	$104.6	$297.6	$882.0	$1,209.4	$1,393.5	$1,406.9	$1,471.8	$1,539.6	$1,579.7
Increase Physician Rates to 100% Medicare [2]	-	-	-	TBD	TBD	-	-	-	-	-	-
Pharmacy Rebates [3]	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
Other [4]	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
Administration [5]	-	-	-	-	$6.3	$13.3	$17.6	$18.5	$19.6	$20.6	$21.8

[1] This document will be updated regularly as the Department receives guidance from the Centers for Medicare and Medicaid Services on implementation of federal reform, as the Department finalizes estimates of costs not associated with expansion populations, and as the Department adds specificity to the "Other" category. The costs shown for expansion populations will most likely not be updated.

[2] Section 1202 of the Health Care and Education Reconciliation Act of 2010 requires physician rates to be increased to 100% of Medicare in FFY 2013 and FFY 2014. The increase from the State's payment rate as of July 1, 2009 to 100% Medicare is funded at 100% FMAP.

[3] Section 2501 of the Patient Protection and Affordable Care Act and Section 1206 of the Health Care and Education Reconciliation Act of 2010 increases select prescription drug rebates, with all additional revenues obtained through these increases to the retained by the federal government.

[4] Includes costs associated with unpriced requirements or options such as required Medicaid coverage for Foster Care Children up to are 26 (Section 2004), coverage of freestanding birth center services (Section 2301), Community First Choice option, Health Homes for enrollees with chronic conditions option (Section 2703) , and various demonstration projects (Sections 2705 through 2707).

[5] Administration is estimated as a flat 3% of total services costs. Includes estimated external administration (contracted services), internal administration, and systems costs. Though not included in the table, funding for implementation will be needed in FY 2011-12 through FY 2013-14, and will be addressed through the normal budgetary process.

Medicaid Expansion Population Caseload [1]

CHAA Expansion Population Summaries	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
CHP+ to 250% FPL (July 2010)											
CHP+ Children to 250% Projected Caseload	420	6,860	13,125	12,500	12,700	12,900	13,200	13,400	13,700	14,000	14,200
CHP+ Prenatal to 250% Projected Caseload	53	858	1,750	2,600	2,600	2,600	2,700	2,700	2,700	2,700	2,800
Medicaid Parents to 100% FPL (July 2010)											
Medicaid Parents to 100% Projected Caseload	750	12,250	25,000	49,700	50,200	50,600	51,000	51,500	52,000	52,600	53,100
Disabled Buy-In to 450% FPL (July 2011)											
Disabled Buy-In to 450% FPL Projected Caseload	-	-	2,400	4,400	4,900	5,000	5,000	5,100	5,100	5,200	5,200
Childless Adults to 100% FPL (July 2012)											
Childless Adults to 100% FPL Projected Caseload	-	-	-	55,700	101,200	113,300	114,400	115,400	116,600	117,800	119,000
Continuous Eligibility for Medicaid Children (January 2012)											
Projected Eligible Children Caseload Impact	-	-	18,500	56,300	76,400	77,700	79,300	80,900	82,400	83,900	85,300
Projected Foster Care Caseload Impact	-	-	800	2,300	3,200	3,200	3,300	3,300	3,400	3,500	3,500
Projected CHP+ Children Caseload Impact	-	-	0	(100)	(100)	(100)	(100)	(100)	(100)	(100)	(200)
Total CHAA Expansion Population (Including Continuous Eligibility) [2]	**1,223**	**19,968**	**61,575**	**183,400**	**251,100**	**265,200**	**268,800**	**272,200**	**275,800**	**279,600**	**282,900**

Federal Reform Expansion Population Summaries	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Medicaid Children to 133% FPL											
Medicaid Children to 133% FPL- Projected Caseload	-	-	-	-	29,300	59,600	75,900	77,400	78,900	80,400	81,700
Medicaid Parents to 133% FPL											
Medicaid Parents to 133% FPL- Projected Caseload	-	-	-	-	9,000	18,100	22,800	23,000	23,200	23,500	23,700
Disabled to 133% FPL											
Disabled Buy-In to 133% FPL- Projected Caseload	-	-	-	-	4,200	8,400	10,500	10,600	10,600	10,600	10,600
Childless Adults to 133% FPL											
Childless Adults to 133% FPL- Projected Caseload	-	-	-	-	10,900	22,000	27,800	28,000	28,300	28,600	28,900
Total Federal Reform Expansion Population	**-**	**-**	**-**	**-**	**53,400**	**108,100**	**137,000**	**139,000**	**141,000**	**143,100**	**144,900**

Caseload by Expansion Population	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
CHP+ to 250% FPL	473	7,718	14,875	15,100	15,300	15,500	15,900	16,100	16,400	16,700	17,000
Medicaid Children to 133% FPL	-	-	-	-	29,300	59,600	75,900	77,400	78,900	80,400	81,700
Medicaid Parents to 133% FPL	750	12,250	25,000	49,700	59,200	68,700	73,800	74,500	75,200	76,100	76,800
Disabled Individuals to 450% FPL	-	-	2,400	4,400	9,100	13,400	15,500	15,700	15,700	15,800	15,800
Childless Adults to 133% FPL	-	-	-	55,700	112,100	135,300	142,200	143,400	144,900	146,400	147,900
Total New Expansion Caseload (Without Continuous Eligibility) [2]	**1,223**	**19,968**	**42,275**	**124,900**	**225,000**	**292,500**	**323,300**	**327,100**	**331,100**	**335,400**	**339,200**

[1] All caseload estimates represent a full time equivalent, or an average monthly count. For example, the Medicaid Parents to 100% caseload estimate in 2010 is 750. This assumes that the expansion would start April 1, 2010, with approximately 1,500 new enrollees per month through June 2010. Thus the estimated number of unique new enrollees by the end of the fiscal year is 4,500. The 2010 caseload estimate is then calculated as the average of the entire year, including the months before implementation with no enrollment and monthly estimates of 1,500 in April 2010, 3,000 in May 2010, and 4,500 in June 2010.

[2] The subtotal for the CHAA Expansion populations includes the estimated caseload impact for Continuous Eligibility for Medicaid Children. Total New Expansion Caseload does not include the additional caseload from continuous eligibility as these are not new clients, but rather additional months of eligibility for existing clients.

Provider Payment Delays

- Proposed Permanent 3-week Payment Delay
  - Causes a provider cash flow concern, but all providers will be paid
- Phased Implementation to Minimize Impact
  - Friday, April 15 - No Deposit, 1st week delay
  - Friday, May 13 - No Deposit, 2nd week delay
  - Friday, June 17 - No Deposit, 3rd week delay
- March 24th Deadline for the Department to Implement or not Implement the 1st week in April Payment Delay
  - Providers need enough advanced notice so a decision in early March is necessary
- One month payment delay for MCO capitations in June
  - Includes BHO and CHP+
  - Excludes PACE and ACC until FY 2011-12

Competing MMIS Priorities

- Department Initiatives
  - Accountable Care Collaborative
  - Budget Reductions Actions
    - Payment Delays
    - Readmissions within 48 Hours
  - Health Care Affordability Act
    - Expansions
    - Inpatient Hospital Payments: APR-DRG
- Federal Objectives
  - HIPAA 5010 & ICD-10
  - National Correct Coding Initiative (NCCI)
  - National Health Care Reform
    - Provider Enrollment Regulation
  - EHR Provider Incentive Payments

- Programming Code Contention
  - MMIS pipeline is very full already
  - Partial code freeze for HIPAA 5010 and ICD-10
  - General code freeze to implement the New MMIS
  - Fiscal Note and New Program Implementation
    - Additional money won't solve the code contention concern
    - Early 2013 is opportunity to implement New Legislation from 2011 Session that has a MMIS Impact

MMIS Reprocurement

- Why
  - Current MMIS is a mainframe design from 1970's and is specifically designed to process fee-for-service claims
  - Older systems has larger operational costs from outdated technology and have a higher risk of failure
  - Expected performance is for the MMIS to be modular, flexible approach to systems development
    - Medicaid Information Technology Architecture (MITA)
    - Decrease paper and human interaction
  - Increased benefit packages and provider payment flexibility
  - Additional analytics and detailed client reporting
- Timing
  - Department is not the first mover, can learn from other states
  - Expected higher cost to develop new system

MMIS Planning Timeline

December 2010 through March 2011

- Implement Current Top Tier Projects

Early 2012 through Early 2013

- Develop and Implement Projects Designed prior to January 2012

Completed by March 2011

- ACC
- HIPAA 5010 Assessment
- NCCI Interim
- Hospital Readmissions
- Telemedicine Claims
- Present on Admission
- CLIA Certification
- Payment Delays

Completed in Summer/Fall 2011

- NCCI Bloodhound Solution
- Medicaid Buy-In Expansion
- Client Over Utilization Program Adjustments
- EHR Incentive Payments
- Pharmacy: 3rd Party Payments, Outlier Pricing, SMAC, Smart PA

Implemented in January 2012

- HIPAA 5010

Completed in Early 2012

- APR-DRG Pricing
- AwDC Expansion
- CHP+ Enrollment Spans
- Outpatient Radiology PARs

Early 2013 through October 2013

- Partial Code Freeze to Implement ICD-10
- Requirements and Design for New Projects

October 2013 through Early 2014

- Develop, Test and Implement Projects Designed prior to October 2013

Early 2014 through July 2015

- General Code Freeze to Design and Develop New MMIS
- From this Point Forward New Projects will be Designed and Developed into New MMIS

Completed by Early 2013

- Opportunity to Implement New Legislation from 2011 Session that has a MMIS Impact
- Develop and Implement Projects Designed prior to January 2012

Implemented in October 2013

- ICD-10

Completed in Early 2014

- Opportunity to Implement New Legislation from 2012 and 2013 Sessions that has a MMIS Impact

Beginning in July 2015

- Begin Implementation of New MMIS