Schedule 6
Change Request for FY 06-07

Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** November 15, 2005
Priority Number:	BRI - 1	**OSPB Approval:**		**Date:**
Program:	Information Technology Contract Monitoring	**Statutory Citation:**	26-4-104 (1), C.R.S. (2005); 26-4-106 (1) (a), C.R.S. (2005)	
Request Title:	Reduce Funding for Medical Identification Cards			

		1	2	3	4	5	6	7	8	9	10
	Fund	Prior-Year Actual FY 04-05	Appropriation FY 05-06	Supplemental Request FY 05-06	Total Revised Request FY 05-06	Base Request FY 06-07	Decision/ Base Reduction FY 06-07	November 15 Request FY 06-07	Budget Amendment FY 06-07	Total Revised Request FY 06-07	Change from Base in Out Year FY 07-08
Total of All Line Items	**Total**	54,483	383,716	0	383,716	383,123	(192,231)	190,892	0	190,892	(192,231)
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	26,902	180,534	0	180,534	180,534	(96,116)	84,418	0	84,418	(96,116)
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	679	1,517	0	1,517	1,517	0	1,517	0	1,517	0
	CFE	0	10,549	0	10,549	10,247	0	10,247	0	10,247	0
	FF	26,902	191,116	0	191,116	190,825	(96,115)	94,710	0	94,710	(96,115)
(1) Executive Director's Office, Medical Identification Cards	**Total**	54,483	383,716	0	383,716	383,123	(192,231)	190,892	0	190,892	(192,231)
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	26,902	180,534	0	180,534	180,534	(96,116)	84,418	0	84,418	(96,116)
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	679	1,517	0	1,517	1,517	0	1,517	0	1,517	0
	CFE	0	10,549	0	10,549	10,247	0	10,247	0	10,247	0
	FF	26,902	191,116	0	191,116	190,825	(96,115)	94,710	0	94,710	(96,115)

Letter Notation:	
Cash Fund name/number, Federal Fund Grant name:	FF: Title XIX, CF: Old Age Pension State Medical Fund, CFE: Health Care Expansion Fund and Department of Public Health and Environment
IT Request: Yes X No	(If yes and request includes more than 500 programming hours, attach IT Project Plan)
Request Affects Other Departments: X Yes No	Department of Personnel and Administration

CHANGE REQUEST for FY 06-07
EFFICIENCY AND EFFECTIVENESS ANALYSIS

SELECT ONE (click on box):
☐ Decision Item
☑ Base Reduction Item
☐ Supplemental Request Criterion:
☐ Budget Request Amendment Criterion:

Priority Number	BRI - 1
Change Request Title:	Reduce Funding for Medical Identification Cards
Long Bill Line Item(s)	(1) Executive Director's Office, Medical Identification Cards
State and Federal Statutory Authority:	26-4-104 (1), C.R.S. (2005); 26-4-106 (1) (a), C.R.S. (2005)

Summary of Request (Alternative A): This Base Reduction Request asks for a reduction in funding of $192,231 for the Medical Identification Cards due to projected volume in the current Long Bill line item of Medicaid Authorization Cards. The request is also to change the Long Bill line item name to Medical Identification Cards.

Alternative A {Recommended alternative}:

Problem or Opportunity Description: Prior to September 2003, Medicaid clients were provided a monthly paper card to show to medical providers as evidence that the clients qualified to receive medical services. The cards were printed and mailed by the General Government Computer Center.

Services of the General Government Computer Center ceased to be used for preparation and mailing of the cards after a new private contractor distributed plastic identification cards to all Medicaid clients occurred in September 2003. This action was a result of Change Request #BRI-2 in the November 1, 2002 Budget Request, page H.11-1. This action converted the monthly paper card system (called Medicaid Authorization Cards) to permanent plastic cards for Medicaid and the Old Age Pension State Medical Program

called Medical Identification Cards. In accordance with this change, the line item was changed to "Medicaid Authorization Cards and Medical Identification Cards" in SB 03-258 (FY 03-04 Long Bill). This name continued into FY 04-05, even though Medicaid Authorization Cards were gone at that time. In SB 05-209, the line item became "Medicaid Authorization Cards."

The private contractor, Integrated Printing Solutions, took over the responsibility for printing and mailing the plastic cards to new Medicaid clients and for replacement cards to any clients who lose their cards.

General Description of Alternative:

This Request accomplishes three needs: 1) to eliminate the General Government Computer Center payment, 2) to reproject the volume need based on experience, and 3) to rename the line item. The request reduces the appropriated funding for medical identification cards, to true up the appropriation with amounts that recent projections indicate as actually needed for the preparation and mailing of the cards. This Base Reduction Item requests $79,154 less for the contract with Integrated Printing Solutions, and removes $113,077 which is no longer needed to pay the General Government Computer Center for printing and mailing services, resulting in a reduction of $192,231 total funds.

1. Prior to the plastic cards, the charges to the Department of Health Care Policy and Financing for the services of the General Government Computer Center lagged two fiscal years behind. $113,077 for the General Government Computer Center was included in the FY 03-04 appropriation for the cards because old expenses were still being paid off. Since the plastic cards implementation, the General Government Computer Center electronically transmits a file of names and other related information to the private contractor. The costs to transmit electronic files are minimal. Consequently, costs to the General Government Computer Center have dwindled for the cards. However, the funding at $113,077 for the General Government Computer Center continues to be included in the appropriation.

2. In addition to decreased preparation costs from the General Government Computer Center, card printing and postage costs are also less than was expected because clients are not requiring replacement cards as often as initially anticipated. Total production costs by the private contractor has been far below the amount in the appropriation for the private contractor. For this reason the Department has excess funding for the private contractor as well.

3. This request also is to change the Long Bill line item name to "Medical Identification Cards." The primary reason is because the cards are used in other programs besides Medicaid. The other reason is because the cards require the providers to check eligibility so the cards are not actually "authorization" cards. They are more like a health plan identification card.

Calculations for Alternative's Funding:

Summary of Request FY 06-07 and FY 07-08 Matches Schedule 6 and Recommended Request	**Total Funds**	**General Fund**	**Federal Funds**
Total Request for Medical Identification Card	($192,231)	($96,116)	($96,115)
Integrated Printing Solutions Reduction	($79,154)	($39,577)	($39,577)
General Government Computer Center Reduction	($113,077)	($56,539)	($56,538)

Table A: Reduce Funding for Medical Identification Cards					
	Total Funds	General Fund	Cash Funds	Cash Funds Exempt	Federal Funds
FY 06-07 Base Funding					
Total Appropriation	$383,123	$180,534	$1,517	$10,247	$190,825
Card Production Printing and Mailing by Vendor	$270,046	$123,995	$1,517	$10,247	$134,287
General Government Computer Center	$113,077	$56,539	$0	$0	$56,538

Table A: Reduce Funding for Medical Identification Cards					
	Total Funds	General Fund	Cash Funds	Cash Funds Exempt	Federal Funds
Needed Funding FY 06-07					
Total Need	$190,892	$84,418	$1,517	$10,247	$94,710
Card Production Printing and Mailing by Vendor	$190,892	$84,418	$1,517	$10,247	$94,710
Base Reduction in FY 06-07					
Total Reduction	($192,231)	($96,116)	$0	$0	($96,115)
Card Production Printing and Mailing by Vendor	($79,154)	($39,577)	$0	$0	($39,577)
General Government Computer Center	($113,077)	($56,539)	$0	$0	($56,538)

Table B: FY 04-05 Number of Medical Identification Cards Produced	
Month	**Total Number of Cards Produced**
July-04	22,598
Aug-04	26,040
Sep-04	5,477
Oct-04	10,309
Nov-04	11,708
Dec-04	15,307
Jan-05	16,080
Feb-05	15,679
Mar-05	21,013
Apr-05	16,701
May-05	19,462
Jun-05	20,031
Total	**200,405**

Table C: Projections for Expenditures and Number of Cards Issued Per Fiscal Year			
Fiscal Year	**Estimated Expenditures**	**Number of Cards Issued**	**Cost per Card Issued**
FY 05-06	$191,475	225,265	$0.85
FY 06-07	$190,892	234,567	$0.85

Impact on Other Areas of Government: The Department of Personnel and Administration would have less funding for the General Government Computer Center in the amount of $113,077 total funds as well as the same amount in Cash Funds Exempt.

Assumptions for Calculations: Table A shows the funding reduction for the medical identification cards as estimated by the Department. An allowance for growth has been included since reported caseload is still high.

Table B reports the total number of medical identification cards produced and mailed by the outside contractor in FY 04-05. The total number of cards reported as produced each month is listed on the contractor's billing invoice received and paid by the Department. FY 04-05 is the only fiscal year for which the numbers can be considered relevant. The plastic medical identification cards were implemented during FY 03-04 (September), but due to the mass mailing to every Medicaid client and due to re-mailings necessitated by initial transition problems, the number of cards mailed in FY 03-04 is not reliable as a base for any future estimates.

Table C shows expenditures related to the projected number of cards per fiscal year. The estimate for FY 05-06 assumes that churn in the clients enrolled in Medicaid will continue, with clients moving onto Medicaid being issued new cards while other clients who no longer qualify drop off, so the total caseload will not increase as much as the total number of cards issued. At the same time, the projected increase in new clients due to the removal of the asset test for categorically eligible low income children and families as

funded by the Health Care Expansion Fund (HB 05-1262) adds a need for new cards also. The Department assumes the churn in clients will also occur in FY 06-07. The projected number of cards to be issued assumes that at least the same number of cards issued in FY 04-05 will be issued again as part of the usual churn, plus additional cards will be issued as a result of increased clients from the HB 05-1262 provisions. Therefore, the projection is 225,265 cards issued in FY 05-06 (200,405 that is the same as FY 04-05 plus 24,860 for new clients under HB 05-1262). The projection for FY 06-07 is 224,567 cards to be issued (200,405 that is the same as FY 04-05 plus 24,162[1] cards for new clients under HB 05-1262).

The Department used $0.85 ($0.48 for production of each card plus $0.37 for postage), the amount currently in the contract with Integrated Printing Solutions, as the cost per card when only one card is mailed in each envelope, so the $0.85 cost applies to each card that is mailed individually to one person. Although cards mailed to family members at the same address are sent in the same envelope if possible and less postage is needed than if every family member received a card in a separate envelope, it is difficult to predict when the multiple card envelopes will go out.

The funding for the Old Age Pension State Medical Program clients has proved adequate in the amount of $1,517 Cash Funds, and this funding can continue at its current level.

Cash Funds Exempt in the amount of $10,247, appropriated through HB 05-1262 with $10,195 from the Health Care Expansion Fund and $52 from the Department of Public Health and Environment (funded by the Tobacco Tax), has not been revised from the fiscal note estimate since no history has accumulated yet for this fund source.

[1] The number of cards for new clients under HB 05-1262 is based on total funds of $21,131 for FY 05-06 and $20,537 for FY 06-07 found in Table 1 and Table 4 respectively in the Department's 1331 Supplemental Request (Technical correction to adjust appropriations for HB 05-1262) heard by the Joint Budget Committee on June 21, 2005. The total funds are divided by $0.85 per card to arrive at the number of cards. For FY 05-06, $21,131/$0.85 = 24,860. For FY 06-07, $20,537/$0.85 = 24,162.

Concerns or Uncertainties of Alternative: If caseload and, thus, the need for identification cards, changed significantly either upward or downward, the Department would need to reconsider how much total funding would be required to produce and mail the cards. If new special legislation were passed in the future that resulted in a need for more identification cards, total funding for the cards would have to be reconsidered.

Alternative B {Status quo; no change in funding; not recommended}:

General Description of Alternative: Continue with the current level of appropriation from FY 05-06.

Calculations for Alternative's Funding: No change in funding with this alternative.

Concerns or Uncertainties of Alternative: Not all funding will be necessary, and a large amount of funding would revert at fiscal year end.

Supporting Documentation

Analytical Technique: The analytical technique used to evaluate this request is a Cost Effectiveness Analysis. The results are shown in the chart below. After review of the expenditures for each of the fiscal years, it becomes obvious that reducing the appropriated amounts is the most effective use of funding for medical identification cards by freeing up extra unneeded funding for other State projects. The financial advantages of reducing the total funding can be clearly seen.

Cost Effectiveness of Appropriation Request			
Fiscal Year	**Total Appropriation/Base Request**	**Annual Expenditures***	**Potentially Revertible Funding***
FY 03-04	$846,041	$511,165	$334,876
FY 04-05	$355,601	$102,618	$252,983
FY 05-06	$383,716	Estimated $191,475	$192,241
FY 06-07	$383,123	Estimated $190,892	$192,231
*Actual reversions for prior years may be slightly different in the Colorado Financial Reporting System (COFRS) than shown in this chart because spending history has been adjusted for when expenditures occurred rather than when reported in COFRS.			

Quantitative Evaluation of Performance - Compare all Alternatives:

The Annual Expenditures column in the above chart represents Alternative A. The Total Appropriation column represents Alternative B. It is easy to see that following Alternative B would result in the situation enumerated in the Potentially Revertible Funding column. In FY 06-07, Alternative A would not use $192,231 in total funding with $96,116 of that unused funding being General Fund. Therefore, Alternative A, based on the Annual Expenditure amounts, is clearly preferred.

Statutory and Federal Authority:

26-4-104 (1), C.R.S. (2005) *The state department, by rules and regulations, shall establish a program, of medical assistance to provide necessary medical care for the categorically needy. The state department is hereby designated as the single state agency to administer such program in accordance with Title XIX and this article…*

26-4-106 (1) (a) C.R.S. (2005) Application – verification of eligibility
(1) (a) …Any person who is determined to be eligible pursuant to the requirements of this article shall be eligible for benefits until such person is determined to be ineligible.

Department Objectives Met if Approved:

1.2 To support timely and accurate client eligibility determination.

1.4 To assure delivery of appropriate, high quality care. To design programs that result in improved health status for clients served and to improve health outcomes. To ensure

that the Department's programs are responsive to the service needs of enrolled clients in a cost-effective manner.

Schedule 6
Change Request for FY 06-07

Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** November 15, 2005
Priority Number:	BRI - 2	**OSPB Approval:**		**Date:**
Program:	Medical Assistance Office	**Statutory Citation:**	26-4-104, C.R.S. (2005)	
Request Title:	Adjust Cash Funds Exempt in Medical Services Premiums Upper Payment Limit			

		1	2	3	4	5	6	7	8	9	10
	Fund	Prior-Year Actual FY 04-05	Appropriation FY 05-06	Supplemental Request FY 05-06	Total Revised Request FY 05-06	Base Request FY 06-07	Decision/ Base Reduction FY 06-07	November 15 Request FY 06-07	Budget Amendment FY 06-07	Total Revised Request FY 06-07	Change from Base in Out Year FY 07-08
Total of All Line Items	**Total**	1,920,474,771	2,178,221,370	0	2,178,221,370	2,177,202,148	(13,299,304)	2,163,902,844	0	2,163,902,844	(13,299,304)
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	935,078,890	1,042,362,634	0	1,042,362,634	1,038,134,760	0	1,038,134,760	0	1,038,134,760	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	76,512	0	76,512	76,512	0	76,512	0	76,512	0
	CFE	30,699,080	66,065,603	0	66,065,603	85,146,310	(13,299,304)	71,847,006	0	71,847,006	(13,299,304)
	FF	954,696,801	1,069,716,621	0	1,069,716,621	1,053,844,566	0	1,053,844,566	0	1,053,844,566	0
(2) Medical Services Premiums	**Total**	1,920,474,771	2,178,221,370	0	2,178,221,370	2,177,202,148	(13,299,304)	2,163,902,844	0	2,163,902,844	(13,299,304)
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	935,078,890	1,042,362,634	0	1,042,362,634	1,038,134,760	0	1,038,134,760	0	1,038,134,760	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	76,512	0	76,512	76,512	0	76,512	0	76,512	0
	CFE	30,699,080	66,065,603	0	66,065,603	85,146,310	(13,299,304)	71,847,006	0	71,847,006	(13,299,304)
	FF	954,696,801	1,069,716,621	0	1,069,716,621	1,053,844,566	0	1,053,844,566	0	1,053,844,566	0

Letter Notation:	
Cash Fund name/number, Federal Fund Grant name:	FF: Title XIX, CFE: Breast and Cervical Cancer Prevention Fund, Autism Treatment Fund, Health Care Expansion Fund, Transfer from Department of Public Health and Environment, and Certification of Public Expenditures
IT Request: ☐ Yes ☑ No	(If yes and request includes more than 500 programming hours, attach IT Project Plan)
Request Affects Other Departments: ☐ Yes ☑ No	(If Yes, List Other Departments Here:)

CHANGE REQUEST for FY 06-07
EFFICIENCY AND EFFECTIVENESS ANALYSIS

SELECT ONE (click on box):
☐ Decision Item
☑ Base Reduction Item
☐ Supplemental Request Criterion:
☐ Budget Request Amendment Criterion:

Priority Number:	BRI - 2
Change Request Title:	Adjust Cash Funds Exempt in Medical Services Premiums Upper Payment Limit
Long Bill Line Item(s)	(2) Medical Services Premiums
State and Federal Statutory Authority:	26-4-104, C.R.S. (2005), 42 CFR 447.272, 42 CFR 447.321, 42 CFR 433.51.

Summary of Request (Alternative A): The Request seeks to achieve consistency in the accounting for the "Medicare Upper Payment Limit" and certification of public expenditures in the two Long Bill appropriations that contain this financing mechanism. The Request is for a reduction of $13,299,304 in total funds, all of which is Cash Funds Exempt funding for the Medical Services Premiums Long Bill group.

Alternative A {Recommended alternative}:

Problem or Opportunity Description: The purposes of Base Reduction Item #1 and #3 proposed in the Department's FY 02-03 Budget Request submitted November 1, 2001, were to: 1) reduce the amount of General Fund required to be appropriated for the State share of expenditures for client services provided in the Medical Services Premiums line item and, 2) increase federal revenue to the State. These goals were achieved through the application of Medicaid federal regulations regarding the maximum reimbursement of health care facilities and the use of public funds as the State's share in claiming federal funds participation for Medicaid expenditures for public owned nursing facilities and hospitals.

Under Medicaid federal regulations, payments by State Medicaid agencies to health care facilities cannot exceed the amount that would be paid under Medicare payment principles. This Medicare Upper Payment Limit is the maximum amount Medicaid can reimburse providers and still receive the maximum federal match (also known as federal financial participation) for the payments. As Colorado's Medicaid reimbursement rates for these providers were below these limits, there was an opportunity to earn additional federal revenue by recording and claiming expenditures up to the maximum allowable under federal regulations.

However, the additional expenditures require the State to share in the costs. In order to avoid using General Fund as the State share, the proposals utilized another Medicaid federal regulation that allows public funds certified by public agencies as representing expenditures eligible for federal financial participation as the State share. This "certification of public funds" is appropriated and recorded as Cash Funds Exempt funds and offsets the need for General Fund. As the additional federal revenue earned is retained by the State, the General Fund appropriation required to support Medical Services Premiums expenditures to provide services to eligible clients could be reduced. These base reduction items implemented in FY 02-03 helped avoid the need for additional Medicaid budget cuts during a period of declining State revenues.

The Medicare Upper Payment Limit financing mechanism is utilized in two departmental appropriations: Medical Services Premiums, and Safety-Net Provider Payments. However, unlike the Safety-Net Provider Payments appropriation, the intent of this financing in the Medical Services Premiums appropriation is to lessen the amount of General Fund requested. However, in order to display the full impact this financing, the Department requested that twice the amount of Cash Funds Exempt be appropriated; and thus, offset the General Fund reduction, leaving the remaining Cash Funds Exempt and federal funds equal the total fund impact.

General Description of Alternative: This alternative requests a reduction in the total funds and Cash Funds Exempt appropriated to the Medical Services Premiums line item to reflect the actual amount of State match required to draw the current level of federal funds. This change will result in

a consistent recording of Cash Funds Exempt revenue for the two line items that utilize the Medicare Upper Payment Limit reimbursement and Certification of Public Expenditures State matching financing mechanism. This change will have no impact on the amount of additional federal funds earned and no impact on the resulting reduction in General Fund required.

When the original financing using the certified public expenditures was initially implemented, the Cash Funds Exempt amount equaled the total amount of certified expenditures rather than only the State match. While this was an appropriate procedure under accounting rules, it created confusion and it exaggerated total funds in the State budget. To provide clarity in the Medical Services Premiums line item, to provide consistency with the financing methodology in the Safety Net Provider Payments line item, and to more accurately reflect total funds in the statewide budget, this alternative is requested.

Under the new methodology, the Cash Funds Exempt will reflect the state match (50% of the total expenditure), and the federal funds will reflect 50% of the expenditure. This will match to the typical Medicaid federal financial participation of 50%. This Cash Funds Exempt then "replaces" the General Fund as the State match, causing a General Fund savings. The General Fund savings is not changed in either methodology but the new methodology is more transparent. See Table 1.

Calculations for Alternative's Funding:

Summary of Request FY 06-07 Medical Services Premiums (Matches Schedule 6)	Total Funds	General Fund	Cash Funds	Cash Funds Exempt	Federal Funds
FY 06-07 Total Request (column 7)	$2,177,202,148	$1,038,134,760	$76,512	$85,146,310	$1,053,844,566
FY 06-07 Change Request (column 6)	($13,299,304)	$0	$0	($13,299,304)	$0
FY 06-07 Base Request (column 5)	$2,163,902,844	$1,038,134,760	$76,512	$71,847,006	$1,053,844,566
FY 07-08 Change From Base (column 10)	($13,299,304)	$0	$0	($13,299,304)	$0

Table 1
Impact of Change Request on Medical Services Premiums By Service Area

	FY 05-06 Appropriation	FY 06-07 Base Request*	FY 06-07 Change Request	FY 06-07 Total Request
Outpatient Hospital				
Total Funds	$24,601,363	$23,331,453	($11,665,726)	$11,665,727
General Fund	($12,300,682)	($11,665,727)	$0	($11,665,727)
Cash Funds Exempt	$24,601,363	$23,331,453	($11,665,726)	$11,665,727
Federal Funds	$12,300,682	$11,665,727	$0	$11,665,727
Nursing Facilities				
Total Funds	$2,949,261	$2,949,261	($1,474,630)	$1,474,631
General Fund	($1,474,631)	($1,474,631)	$0	($1,474,631)
Cash Funds Exempt	$2,949,261	$2,949,261	($1,474,630)	$1,474,631
Federal Funds	$1,474,631	$1,474,631	$0	$1,474,631
Home Health				
Total Funds	$317,896	$317,896	($158,948)	$158,948
General Fund	($158,948)	($158,948)	$0	($158,948)
Cash Funds Exempt	$317,896	$317,896	($158,948)	$158,948
Federal Funds	$158,948	$158,948	$0	$158,948
Total Upper Payment Limit				
Total Funds	$27,868,260	$26,598,610	($13,299,304)	$13,299,306
General Fund	($13,934,260)	($13,299,306)	$0	($13,299,306)
Cash Funds Exempt	$27,868,260	$26,598,610	($13,299,304)	$13,299,306
Federal Funds	$13,934,260	$13,299,306	$0	$13,299,306

Impact on Other Areas of Government: There are no impacts on other areas of government.

Assumptions for Calculations: Table 1 illustrates the impact that Alternative A will have on the Medical Services Premiums line item.

The FY 05-06 Appropriation matches Exhibit Q from the Department's February 15, 2005 Budget Request. The FY 06-07 Base Request matches Exhibit K in the November 15, 2005 Budget Request. The requested reduction in Cash Funds Exempt is equal to half of the Cash Funds Exempt in the Base Request.

Concerns or Uncertainties of Alternative: This new method will result in a difference between the total expenditures claimed on the CMS-64 federal report "Quarterly Statement of Medicaid Expenditures" and the total expenditures recorded in the Colorado Financial Reporting System (COFRS.) In the event that future auditors would attempt to reconcile the two reporting systems, documentation of the reasons for the differences should be included in each federal report. However, no problems with this reconciliation are expected.

Alternative B {Status quo; no change in funding; not recommended}:

General Description of Alternative: The calculations of amounts requested for the Medicare Upper Payment Limit financing within the Medical Services Premiums will continue to reflect the Cash Funds Exempt as the total expenditures certified as public expenditures rather the amount required as the State match for drawing the Medicaid federal funds.

Calculations for Alternative's Funding: No change in funding with this alternative.

Concerns or Uncertainties of Alternative: The status quo methodology is confusing and inconsistent with how Cash Funds Exempt is reported in the Safety Net Provider Payments line item. If the current appropriation remains unchanged, the Department essentially double counts the amount of funding within Medical Services Premiums for this purpose. This causes an inflation to total funds in the State budget that is misleading.

Supporting Documentation

Analytical Technique: Benefit-Cost Analysis

The benefit of choosing alternative A is that Cash Funds Exempt will be recorded in a consistent manner in both the Safety-Net Provider Payments and the Medical Services Premiums line. There are no additional costs or savings associated with implementing this change.

Statutory and Federal Authority:

26-4-104, C.R.S. (2005), et seq. Program of medical assistance – single state agency. *The state department, by rules and regulations, shall establish a program of medical assistance to provide necessary medical care for the categorically needy. The state department is hereby designated as the single state agency to administer such program in accordance with Title XIX and this article.*

42 CFR 447.272. Inpatient Services (Hospitals, Nursing Facilities and Intermediate Care Facility Services for the Mentally Retarded): Application of Upper Payment Limits
(b) General rules. (1) Upper payment limit refers to a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles in subchapter B of this chapter. (2) Except as provided in paragraph (c) of this section, aggregate Medicaid payments to a group of facilities within one of the categories described in paragraph (a) of this section may not exceed the upper payment limit described in paragraph (b)(1) of this section.

42 CFR 447.321. Outpatient Hospital and Clinic Services: Application of Upper Payment Limits *(a) Scope. This section applies to rates set by the agency to pay for outpatient services furnished by hospitals and clinics within one of the following categories: (1) State government-owned or operated facilities (that is, all facilities that are either owned or operated by the State). (2) Non-State government-owned or operated facilities (that is, all government facilities that are neither owned nor operated by the State). (3) Privately-owned and operated facilities. (b) General rules. (1) Upper payment limit refers to a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles in subchapter B of this chapter.*

42 CFR 433.51. Public funds as the State share of financial participation.

(a) Public funds may be considered as the State's share in claiming FFP if they meet the conditions specified in paragraphs (b) and (c) of this section. (b) The public funds are appropriated directly to the State or local Medicaid agency, or transferred from other public agencies (including Indian tribes) to the State or local agency and under its administrative control, or certified by the contributing public agency as representing expenditures eligible for FFP under this section.

Department Objectives Met if Approved: 1.5 To accurately project, report, and manage budgetary requirements to effect executive and legislative intent with program and budget development and operations. To accurately record and monitor expenditures for programs managed by the Department so there may be accurate financial reporting at all times.

Schedule 6
Change Request for FY 06-07

Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** November 15, 2005
Priority Number:	BRI - 3	**OSPB Approval:**		**Date:**
Program:	Office of Medical Assistance, Office of Operations and Finance	**Statutory Citation:**	26-4-406.5, C.R.S. (2005)	
Request Title:	Revision to the Medicare Modernization Act Implementation			

	Fund	1 Prior-Year Actual FY 04-05	2 Appropriation FY 05-06	3 Supplemental Request FY 05-06	4 Total Revised Request FY 05-06	5 Base Request FY 06-07	6 Decision/ Base Reduction FY 06-07	7 November 15 Request FY 06-07	8 Budget Amendment FY 06-07	9 Total Revised Request FY 06-07	10 Change from Base in Out Year FY 07-08
Total of All Line Items	**Total**	1,921,084,414	2,178,896,301	196,300	2,179,092,601	2,177,719,356	(6,012,966)	2,171,706,390	0	2,171,706,390	(7,700,939)
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	935,383,712	1,042,700,100	98,150	1,042,798,250	1,038,393,364	3,802,704	1,042,196,068	0	1,042,196,068	5,870,495
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	76,512	0	76,512	76,512	0	76,512	0	76,512	0
	CFE	30,699,080	66,065,603	0	66,065,603	85,146,310	0	85,146,310	0	85,146,310	0
	FF	955,001,622	1,070,054,086	98,150	1,070,152,236	1,054,103,170	(9,815,670)	1,044,287,500	0	1,044,287,500	(13,571,434)
(1) Executive Director's Office Administrative Law Judge Services	**Total**	609,643	674,931	0	674,931	517,208	43,449	560,657	0	560,657	43,449
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	304,822	337,466	0	337,466	258,604	21,725	280,329	0	280,329	21,725
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	0	0	0	0	0	0	0	0	0
	FF	304,821	337,465	0	337,465	258,604	21,724	280,328	0	280,328	21,724
(2) Medical Services Premiums	**Total**	1,920,474,771	2,178,221,370	0	2,178,221,370	2,177,202,148	(81,841,050)	2,095,361,098	0	2,095,361,098	(89,352,581)
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	935,078,890	1,042,362,634	0	1,042,362,634	1,038,134,760	(71,905,506)	966,229,254	0	966,229,254	(75,661,273)
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	76,512	0	76,512	76,512	0	76,512	0	76,512	0
	CFE	30,699,080	66,065,603	0	66,065,603	85,146,310	0	85,146,310	0	85,146,310	0
	FF	954,696,801	1,069,716,621	0	1,069,716,621	1,053,844,566	(9,935,544)	1,043,909,022	0	1,043,909,022	(13,691,308)
(5) Other Medical Services Medicare Modernization Act of 2003 Maintenance of Effort Payment (new)	**Total**	0	0	0	0	0	75,588,335	75,588,335	0	75,588,335	81,411,893
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	0	0	0	0	0	75,588,335	75,588,335	0	75,588,335	81,411,893
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	0	0	0	0	0	0	0	0	0
	FF	0	0	0	0	0	0	0	0	0	0
(6) Department of Human Services - Medicaid-Funded Programs, (D) Medicare Modernization Act County Administration	**Total**	0	0	196,300	196,300	0	196,300	196,300	0	196,300	196,300
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	0	0	98,150	98,150	0	98,150	98,150	0	98,150	98,150
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	0	0	0	0	0	0	0	0	0
	FF	0	0	98,150	98,150	0	98,150	98,150	0	98,150	98,150

Letter Notation:	
Cash Fund name/number, Federal Fund Grant name:	CF: Provider Fees and Service Fees. CFE: Certified Public Expenditures, Children's Basic Health Plan Trust Fund, Breast and Cervical Cancer Prevention and Treatment Fund, Autism Treatment Fund, Health Care Expansion Fund. FF: Title XIX and Title XXI
IT Request: ☐ Yes ☑ No	(If yes and request includes more than 500 programming hours, attach IT Project Plan)
Request Affects Other Departments: ☑ Yes ☐ No	(If Yes, List Other Departments Here: Department of Human Services, Department of Personnel and Administration)

CHANGE REQUEST for FY 06-07
EFFICIENCY AND EFFECTIVENESS ANALYSIS

SELECT ONE (click on box):
☐ Decision Item
☑ Base Reduction Item
☐ Supplemental Request Criterion:
☐ Budget Request Amendment Criterion:

Priority Number:	BRI – 3
Change Request Title:	Revision to the Medicare Modernization Act Implementation
Long Bill Line Item(s)	(1) Executive Director's Office, Administrative Law Judge Services; (2) Medical Services Premiums; (5) Other Medical Services, Medicare Modernization Act of 2003 Maintenance of Effort Payment (new line); (6) DHS Medicaid-Funded Programs, County Administration – Medicaid Funding
State and Federal Statutory Authority:	26-4-406.5, C.R.S (2005), 42 CFR Parts 400, 403, 417, and 423

Summary of Request (Alternative A): On January 1, 2006, the federal Centers for Medicare and Medicaid Services (CMS) implemented the Medicare Part D prescription drug benefit that replaced Medicaid prescription drug coverage for dual eligibles. This Request is to cover the cost of additional administrative responsibilities the State will now assume, and to update the cost of the implementation of the Medicare Modernization Act of 2003 ("the Act"). The net impact of these changes is a reduction in total funds of $6,012,966. Final rules for the Act were published on January 28, 2005.

Alternative A {Recommended alternative}:

Problem or Opportunity Description: The Medicare Prescription Drug, Improvement and Modernization Act ("the Act"), signed into law in December 2003, created a new drug benefit known as Part D of Medicare. All Medicare beneficiaries are eligible for this benefit which began January 1, 2006, including all dual eligible Medicaid beneficiaries (those individuals that are both

Medicare and Medicaid eligible). For the dual eligible population, this is the only coverage for all Part D covered drugs, as states are no longer able to receive a federal match for these prescription drugs for dual eligibles. In addition, with the passage of SB 05-162 on April 5, 2005, Colorado amended its Medical Assistance Act to prohibit dual eligibles from these federally covered drugs; however, this legislation still allows the State to cover non-Part D drugs for dual eligibles, as long as these drugs will receive federal financial participation. The Department submitted a letter to the Joint Budget Committee on September 6, 2005 requesting direction regarding the coverage of non-Part D drugs. The Joint Budget Committee has not yet responded to this letter, and is expected to do so in November. Therefore, these costs are not included in this request. If the Committee decided to cover these non-Part D drugs, the Department will submit a Supplemental and Budget Request Amendment to add this cost. If the Committee decides to not cover these drugs, then the Department would have to terminate coverage of non-Part D drugs for all Medicaid clients, as recently required by the federal government. The Department would submit a corresponding Supplemental and Budget Request Amendment reflecting the savings.

Enrollment

The Part D drug benefit will be administered by private health plans, called prescription drug plans. Eligible individuals can obtain drug coverage through a stand-alone prescription drug plan, or can enroll in a Medicare Advantage-prescription drug plan. During the first half of calendar year 2005, CMS worked with states to identify all current dual eligible beneficiaries for enrollment in the Low Income Subsidy. As of October 2005, Medicare has notified current dual eligibles of the upcoming transition and informed them of the specific prescription drug plan in which they were automatically enrolled, as well as their ability to opt-out of that plan and enroll in another. Costs for the auto-enrollment process will be borne by CMS.

Low Income Subsidies

Low-income Medicare beneficiaries are eligible to participate in the new drug benefit's low-income subsidy program. Although subsidies are available based on certain federal poverty level incomes, the Medicaid dual eligibles, such as the following, were automatically deemed eligible for low-income subsidies:

- Full benefit dual eligibles (on both Medicare and full Medicaid);
- Qualified Medicare Beneficiaries, those entitled to Medicaid coverage of the Part B premium and all Medicare cost-sharing;
- Specified Low-income Medicare Beneficiaries, those entitled to Medicaid payment of their Part B premium (but not Medicare cost-sharing); and
- "Qualifying individuals," for whom states receive a 100% federally matched grant to pay the Part B premium.

Eligibility for low-income subsidies are determined by Medicaid eligibility sites or by the Social Security Administration (SSA). States are required to process subsidy applications for clients that request a "state determination," and to make determinations and redeterminations on those cases and process appeals.

The Clawback

States are required to provide a "phased-down contribution" payment to the federal government to defray a portion of Medicare drug expenditures for clients whose projected Medicaid drug coverage is assumed by Medicare Part D. This payment is also known as the Clawback. The specific amount each state will pay is based on a formula set forth in federal rules. The calculation uses calendar year 2003 data, and requires that each state pay 90% of the calculation in the first year (January 2006 - December 2006), with this percentage decreasing from 90% to 75% over a ten-year period. After the tenth year, the states will continue to pay 75% as long as Part D exists. For FY 06-07, the 90% factor changes to 88.33%, on January 1, 2007, and continues for the next twelve months.

The Clawback estimates the per capita drug costs for the average dual eligible during calendar year 2003. This per capita is a weighted average of managed care clients and fee-for-service clients. The per capita is then multiplied by current monthly dual eligible counts to estimate the monthly cost of Part D prescription drugs for this population. The amount is inflated for national medical cost growth between 2003 and 2006 and is adjusted by the state's Federal Medical Assistance Percentage (50% for Colorado).

On October 1, 2004 and on July 1, 2005, the Department submitted its concerns to the Centers for Medicare and Medicaid Services about the Clawback calculation. The primary concern is that one of four quarters of rebate were not reflected in calendar year 2003 for Colorado. This inflates the average expenditures used to calculate the Clawback. On October 14, 2005, the Centers for Medicare and Medicaid Services provided its calculation of Colorado's Clawback to the Department.

General Description of Alternative:

During the Department's FY 05-06 Figure Setting, although the Department did not submit a Change Request, the Joint Budget Committee approved a number of adjustments to the Department's Budget to account for these additional administrative responsibilities required of the State. However, a few additional changes are necessary that were overlooked at that time.

This Request is for:

- Funding the additional cost for counties and eligibility sites to process subsidy applications.
- Funding the additional costs anticipated to affect Administrative Law Judge Services due to increased appeals.
- Requesting that the appropriation for the Clawback be relocated to the Other Medical Services Long Bill group, and also updates the projected Clawback amount for FY 06-07.
- Updating the Medical Services Premiums line item for prescription drug savings.

Costs for Counties and Eligibility Sites to Process Subsidy Applications

One ongoing cost overlooked during the Department's FY 05-06 Figure Setting was funding for the counties and their increased workload. States are required to check eligibility for any client applying for the low-income subsidy for applicable Medicaid and other State assistance programs. This will increase costs at Medicaid eligibility sites. Funding of $1,356,340 for FY 05-06 was requested as a Supplemental Request to the Joint Budget Committee on September 19, 2005. On September 20, 2005, the Joint Budget Committee approved $196,300. This request for FY 06-07 is for the continuation amount approved for FY 05-06. Since this funding is for county relief, it is requested at 50% General Fund and 50% federal funds, and in a separate line item.

The Department recommends that as counties gain experience in this program, that the funding methodology be re-evaluated.

Appeals - Costs for Administrative Law Judges

The Department assumed that 1,000 individuals will insist that the State must process their low income subsidy applications and that 10% of those will appeal the eligibility determination to the Administrative Law Judge. However, these numbers are unknown. The Department based the time needed for the average appeal to be equal to the total FY 03-04 hours of utilization divided by number of appeals, or 3.81 hours per case (5,579 hours divided by 1,465 cases).

The FY 05-06 Legislative Council Common Policy cost per Administrative Law Judge hour is $114.04. Therefore, the FY 06-07 estimate is (1,000 * 0.10) * 3.81 * $114.04 = $43,449.

Clawback Payment

The first actual Clawback payment was not to be made until January 2006. The Joint Budget Committee recommended an appropriation within the Medical Services

Premiums line item of $30,984,982 in FY 05-06 (Department's March 15, 2005 Figure Setting document, page 118). Using the methodology outlined by federal regulations 42 CFR Part 423, the Department estimates the FY 06-07 Clawback will cost the State $75,588,335, or $38,147,393 for the six months beginning July 2006, and $37,440,942 for the six months beginning January 2007. This estimate incorporates the inflated per capita drug expenditures for full benefit dual eligibles in calendar year 2003 provided by the Centers for Medicare and Medicaid Services to the Department on October 14, 2005.

In addition, the Department has incorporated its most recent estimate for the number of full benefit dual eligibles anticipated in December 2005 (as December's full-benefit dual eligible caseload will be used in calculation of the January 2006 Clawback payment). Since Colorado's dual eligible population is comprised predominately of three stable eligibility types (Supplemental Security Income Clients Age 65 and Older, Supplemental Security Income Clients Age 60 to 64, and Supplemental Security Income for Disabled Individuals), the Department has not grown this December 2005 caseload going forward.

These figures are further detailed in the Assumptions for Calculations section of this Request.

While these Clawback payments are directly tied to prescription drug expenditures for Medicare clients, the Department would request that this funding be relocated to the Other Medical Services Long Bill group, with the other State-only funded programs, as this is a General Fund only payment. The Clawback is not a Medicaid payment, or a Medicaid service, and is not subject to the overexpenditure authority that the remainder of the Medical Services Premiums line has.

<u>Medical Services Premiums Prescription Drug Savings</u>

The Department would like to update the estimates of savings for the Medical Services Premiums. Using estimates according to the federal Centers for Medicare and Medicaid Services' Clawback methodology does not result in the same estimate of savings that the Department concludes using traditional budget methods. The Department has completed

a very detailed estimate of the savings using the typical method and this can be found at attachment 2.

Joint Budget Committee staff estimated the Medicaid prescription drug savings as $62,394,408 in FY 05-06 (FY 05-06 Figure Setting, March 15, 2005, page 118), which is only 81% of the estimated dual eligible prescription drug costs of $77,233,957 at attachment 1 ($34,755,276 x 2 / 0.9). However, there could be increases in medical costs that could reduce savings if clients cannot easily access their effective medications under Part D. Recent attempts by the Centers for Medicare and Medicaid Services, such as requiring coverage of all drugs in 6 sensitive categories[1], indicate that transition issues may be minimized.

The Department also estimates that additional costs due to increased caseload caused by the mandatory screening of low-income subsidy clients may be higher than estimated by JBC staff, using information provided by the Centers for Medicare and Medicaid Services. This impact is not reflected here, but rather in the Medical Services Premiums as a caseload adjustment.

[1] Antipsychotics, antidepressants, anticonvulsants, HIV/AIDS drugs, immunosuppressants, anti-cancer drugs.

Calculations for Alternative's Funding:

Summary Request for FY 06-07 Matches Schedule 6, Column 6	**Total Funds**	**General Fund**	**Cash Funds Exempt**	**Federal Funds**
(1) Executive Director's Office, Administrative Law Judge Services	$43,449	$21,725	$0	$21,724
(2) Medical Service Premiums (move Clawback)	($61,969,964)	($61,969,964)	$0	$0
(2) Medical Service Premiums (Adjust Prescription Drug Savings)	($19,871,086)	($9,935,542)	$0	($9,935,544)
(5) Other Medical Services, Medicare Modernization Act of 2003 Maintenance of Effort Payment (new line)	$75,588,335	$75,588,335	$0	$0
(6) Department of Human Services Medicaid Funded Programs, MMA County Administration (new line item)	$196,300	$98,150	$0	$98,150
Total FY 06-07 Request	**($6,012,966)**	**$3,802,704**	**$0**	**($9,815,670)**

*This total does not include an increase to the Medical Services Premiums due to the "woodwork effect" of screening clients for low income subsidy. This cost is represented in DI-1 of the November 15, 2005 Budget Request for Medical Services Premiums. This cost offsets the savings.

Summary Request for FY 07-08 Matches Schedule 6, Column 10	**Total Funds**	**General Fund**	**Cash Funds Exempt**	**Federal Funds**
(1) Executive Director's Office, Administrative Law Judge Services	$43,449	$21,725	$0	$21,724
(2) Medical Service Premiums (move Clawback)	($61,969,964)	($61,969,964)	$0	$0
(2) Medical Service Premiums (Adjust Prescription Drug Savings)	($27,382,617)	($13,691,309)	$0	($13,691,308)
(5) Other Medical Services, Medicare Modernization Act of 2003 Maintenance of Effort Payment (new line)	$81,411,893	$81,411,893	$0	$0
(6) Department of Human Services Medicaid Funded Programs, MMA County Administration (new line item)	$196,300	$98,150	$0	$98,150
Total FY 07-08 Request	**($7,700,939)**	**$5,870,495**	**$0**	**($13,571,434)**

Administrative Law Judge Services	
A. FY 03-04 Administrative Law Judge Services Hours	5,579
B. FY 03-04 Number of Administrative Law Judge Cases	1,465
C. Average Number of Hours per ALJ Case (= A / B)	3.81
D. Average Cost per Hour for ALJ Services	$114.04
E. Total Number of Low-Income Subsidy Applications Anticipated to be Processed by the State	1,000
F. Percent of Applications Anticipated to be Appealed	10%
G. FY 06-07 and FY 07-08 Request (= C * D * E * F)	**$43,449**

Medical Services Premiums - Update Prescription Drug Estimate	**Total Funds**	**General Fund**	**Federal Funds**
A. FY 05-06 Estimated Savings, Figure Setting March 5, 2005, p. 118	($62,394,408)	($31,197,204)	($31,197,204)
B. FY 06-07 Base Request (row A times 2 to annualize for a full year)*	($124,788,816)	($62,394,408)	($62,394,408)
C. FY 06-07 Estimated Savings, Attachment 2	($144,659,902)	($72,329,950)	($72,329,952)
D. Difference (matches "Summary of Request for FY 06-07" table)	($19,871,086)	($9,935,542)	($9,935,544)
E. FY 07-08 Estimated Savings, Attachment 2	($152,171,433)	($76,085,717)	($76,085,716)
F. Difference from row B (matches "Summary of Request for FY 07-08" table)	($27,382,617)	($13,691,309)	($13,691,308)

* In total, bottom-line adjustments in Medical Services Premiums exhibits EF-2 and EF-3 for "Drug Savings per Medicare Modernization Act" (Volume I of the November 15, 2005 Budget Request) incorporate this full year impact.

Impact on Other Areas of Government: Please see the Schedule 6 for a quantification of how the Department of Human Services and the Department of Personnel and Administration would be affected.

Summary of Impact to the Department of Human Services	**Total Funds**	**General Fund**	**Cash Funds Exempt**	**Federal Funds**
(4) County Administration, Medicare Modernization Act County Administration (new line)	$196,300	$0	$196,300	$0

Assumptions for Calculations:

Administrative Law Judge Services

The Department estimated the amount of increased hearing fees for Part D using FY 03-04 information. Dividing actual number of case hours by the actual number of cases, the Department estimated an average length of time per case in FY 03-04 to be 3.81 hours. Using Common Policy for the average hourly rate for Administrative Law Judge Services, the Department estimated that each case would cost $434.49. Assuming 1,000 clients would request a state determination, and that 10% would appeal, the Department estimated $43,449 would be needed.

MMA County Administration

The number from the Joint Budget Committee's September 20, 2005 decision was used.

Updated Prescription Drug Savings Calculation

All the assumptions are located on attachment 2.

Clawback Calculation

FY 06-07 is the first full year for this federally required contribution. The Department has estimated this cost in Attachment 1 using the actual formula mandated by the Centers for Medicare and Medicaid Services. On October 14, 2005, the Department received notification from the Centers of Medicare and Medicaid Services that the dual eligible per capita for drug expenditures in calendar year 2003 was $2,498.02 (or $208.17 times 12 months). This is the weighted per capita cost of fee-for-service and managed care full-benefit dual eligibles. Once required adjustments are made for inflation, the federal financial participation rate for Colorado, and the phasedown percentage, the net dual eligible per capita for drug expenditures used in the State's Clawback calculation is $1,523.64 and $1,495.35 for the first and second half of FY 06-07, respectively. The above mentioned adjustments include the following:

- The National Health Expenditure prescription drug inflationary increase experienced from 2003 to 2006 is 35.54%;
- The federal financial participation for Colorado is 50%; and
- The phasedown contribution rate for July – December 2006 is 90%, and for January – June 2007 is 88.33%.

These adjusted per capitas for dual eligible drug expenditures are then multiplied by the most recent month's number of full-benefit dual eligibles to determine the monthly Clawback amount.

Due to adjustments being made to the Colorado Benefits Management System in December 2004, a programming fix inadvertently changed historical eligibility spans within the system, and removed the third party liability code within a number of client records. This third party liability code is the code used to determine clients that are dually eligible. While this would not normally cause concerns with the eligibility data because the Department usually has an interface with the Social Security Administration's BENDEX system, this interface was not yet operational at the time the data for this request was pulled. This interface is expected to be operational by the end of November 2005. When this happens, the Department estimates that approximately 2,800 clients that are currently not appearing as dually eligible will automatically be determined to be both Medicaid and Medicare eligible. Therefore, the Department has estimated that in addition to the most current dual eligible caseload of 42,823 (as of October 21, 2005), an additional 2,800 dual eligibles, for a total of 45,623 dual eligibles. This caseload is in line with historical dual eligible counts.

Concerns or Uncertainties of Alternative: There has never been a new Medicare benefit implemented in this way, and many of the assumptions are based on a lack of experience. It is likely that almost all the estimates will need to be updated in the future.

Alternative B {Status quo; no change in funding; not recommended}:

General Description of Alternative: This alternative would maintain existing levels of funding to the Department. There would be no additional funding in the Department's budget to fund anticipated increases in administrative costs for legal services and county administration would not be budgeted.

Calculations for Alternative's Funding: No change in funding with this alternative.

Concerns or Uncertainties of Alternative: The true implications of not implementing the Federal Medicare Prescription Drug, Improvement, and Modernization Act are not known, but the failure to implement it would put the State in noncompliance with federal law. It is possible that the Department could lose its federal match for the Medicaid program if it does not comply with this law. If administrative funding is not appropriated, there will not be enough funding to support the Department's compliance of the Act.

Supporting Documentation

Analytical Technique: A cost/benefit analysis is used to demonstrate the profitable alternative for the State.

Quantitative Evaluation of Performance - Compare all Alternatives:

	Alternative A (recommendation)	**Alternative B (status quo)**
Admin Costs	$43,449 for Administrative Law Judges and $196,300 for County Administration	$0
Benefit	Aligns Common Policy appropriation with anticipated increase in appeals due to State performing eligibility determinations for federal assistance program.	No benefits. Puts the State's federal matching funds at risk if State is not able to comply with federal regulations. For FY 05-06, this is $1,621,580,650.
Benefit	Provides funding for increased administration costs as a result of higher application volume due to implementing a federal program.	No benefits. County eligibility sites would have to stop processing applications once funding ran out, and all future applicants would have to be directed to other locations.
Benefit	Aligns all State-only funded programs into Other Medical Services Long Bill group, having like funding together.	Contains less consistency in consolidating appropriations with similar aspects together, diminishing the reasoning for Long Bill groups.

Statutory and Federal Authority:

26-4-406.5, C.R.S (2005) Prescription drug benefits - authorization - dual-eligible participation. *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.*

SB 05-162 - Concerning Prescription Drug Benefits Under the Medical Assistance Program for a Person who is Enrolled in a Prescription Drug Benefit Program Under Medicare *Notwithstanding the provisions of subparagraph (i) of this paragraph (a), pursuant to the provisions of section 26-4-406.5, prescribed drugs shall not be a covered benefit under the medical Assistance program for a recipient who is enrolled in 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", p.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.*

Department Objectives Met if Approved:

1.2 To support timely and accurate client eligibility determinations.

1.5 To accurately project, report, and manage budgetary requirements to effect Executive and Legislative intent with program and budget development and operations. To accurately record and monitor expenditures for programs managed by the Department so there may be accurate financial reporting at all times.

CALCULATION OF STATE PHASED-DOWN MONTHLY CONTRIBUTION

Uses federal methodology as close as possible

	Item	Colorado Value	Colorado Source
1	(i) Gross per capita Medicaid expenditures for prescription drugs for 2003 for full benefit dual eligibles not receiving drug coverage through a Medicaid managed care plan, excluding drugs not covered by Part D.	$3,031.25	Per Centers of Medicare and Medicaid Services letter received October 14, 2005; Colorado's calendar year 2003 per capita drug expenditures for full-benefit, fee-for-service dual eligibles was $3,031.25 ($127,380,741 in expenditures / 504,270 dual eligible clients).
2	(ii) Aggregate State rebate receipts in calendar year 2003	34,131,984	Per 11-29-04 actual CMS 64. This value is considerably lower than a typical 12 month period. In an average fiscal year, drug rebates typically account for roughly 20% of total drug costs. For this 12-month period, they only account for 14.4%.
3	(iii) Gross State Medicaid expenditures for prescription drugs in calendar year 2003	236,549,670	Per 11-29-04 actual CMS 64. While the 3rd quarter of CY 03 was 20% lower than the average amount reported in the other three quarters, the average rebate in quarter 3 was 96% smaller than the average rebate for other quarters.
4	(iv) Rebate adjustment factor	0.1443	Calculation: (2) ÷ (3)
5	(v) Adjusted 2003 gross per capita Medicaid expenditures for prescription drugs for full-benefit dual eligibles not in managed care plans	$2,593.85	Calculation: (1) * [1–(4)]
6	(vi) Estimated actuarial value of prescription drug benefits under capitated managed care plans for full-benefit dual eligibles for 2003	$1,852.04	Estimated CY 03 pharmacy payments for Part D covered drugs for MCO clients. Does NOT include pharmacy payments for Rocky Mountain ASO claims, which are considered fee-for-service in this analysis.
7	(vii) Average number of full-benefit dual eligibles in 2003 who did not receive covered outpatient drugs through Medicaid managed care plans	42,023	Provided in a letter to the Department by the Centers for Medicare and Medicaid Services on October 14, 2005 (504,270 member months divided by 12).
8	(viii) Average number of full-benefit dual eligibles in 2003 who received covered outpatient drugs through Medicaid managed care plans	6,234	Provided in a letter to the Department by the Centers for Medicare and Medicaid Services on October 14, 2005 (74,806 member months divided by 12).
9	(ix) Base year State Medicaid per capita expenditures for covered Part D drugs for full-benefit dual eligible individuals (weighted average of (5) and (6))	$2,498.02	Calculation: [(7) * (5) + (8) * (6)] ÷ [(7) + (8)]
10	(x) 100 minus Federal Medical Assistance Percentage (FMAP) applicable to month of state contribution (as a proportion)	0.5	Colorado's FMAP percentage is 50%
11	(xi) Applicable growth factor (cumulative increase from 2003 through 2006)	35.54%	This is the National Health Expenditure inflator described in federal law. NHE in 2003 = $605; NHE in 2006 = $820, Growth = 820 / 605 - 1 = 35.54% (Prescription Drugs only)
12	(xii) Number of full-benefit dual eligibles for the month	45,623	BOA query (run 10/22/2005) for any client with a TPL code of 01 - 06 or 21 - 26 with at least one day of eligibility in September 2005, plus 2,800 additional clients assumed to immediately be reported as full-benefit dual eligibles due to the interface with the Social Security Administration's BENDEX system being restored
13	(xiii) Phased-down State reduction factor for the month	0.9	90% as specified in federal statute
14	(xiv) Phased-down State contribution for the month	$5,792,546	Calculation: 1/12 * (9) * (10) * [1+(11)] * (12) * (13)
15	**FY 05-06 Estimated Clawback Payment**	**$34,755,276**	Assume 50% for FY 05-06 due to first payment in January 2006.
16	Growth factor (Increase from CY 2006 to 2007)	9.76%	Inflate the FY 05-06 by NHE again for FY 06-07. NHE in 2006 = $820; NHE in 2007 = $900, Growth = 900 / 820 - 1 = 9.76% (Prescription Drugs only)
17	Phased-down State contribution for the month (calendar year 2006)	$6,357,899	Calculation: (14) * [1+(16)]
18	Phase-down State reduction factor for the second twelve months	88.33%	In 2007, the Phased-down State reduction factor is reduced to 88⅓%, so this percent was used for the second half of the fiscal year.
19	Phased-down State contribution for the month (calendar year 2007)	$6,240,157	Calculation: (17) / (13) * (18)
20	**Total FY 06-07 Estimated Clawback Payment**	**$75,588,335**	Calculation: (17) * 6 months + (19) * 6 months
21	Growth factor (Increase from CY 2007 to 2008)	9.76%	Inflate the FY 05-06 by NHE again for FY 06-07. NHE in 2006 = $820; NHE in 2007 = $900, Growth = 900 / 820 - 1 = 9.76% (Prescription Drugs only)
22	Phased-down State contribution for the month (calendar year 2007)	$6,849,197	Calculation: (19) * [1+(21)]
23	Phase-down State reduction factor for the second twelve months	86.66%	In 2008, the Phased-down State reduction factor is reduced to $86^{2/3}$%, so this percent was used for the second half of the fiscal year.
24	Phased-down State contribution for the month (calendar year 2008)	$6,719,452	Calculation: (22) / (18) * (23)
25	**Total FY 07-08 Estimated Clawback Payment**	**$81,411,893**	Calculation: (22) * 6 months + (24) * 6 months

Clawback Payment

This is a rough preliminary estimate of the clawback calculation for Colorado, using the federal methodology. However, the Department does not have several pieces of the data yet and has tried to use similar information from other sources to approximate the calculation that will be done by the federal government. This is used to calculate the clawback payment only. It has been updated since the Department's Hearing, and is now based on specific fiscal years. The previous estimates were assuming a full first year.

Estimated Actual Savings in the Medical Services Premiums for January - June 2006, FY 06-07 and FY 07-08

	Item	FY 06-07 Request	FY 07-08 Estimate	Colorado Source
1	Estimated Part D Drug Expenditures	$126,790,399	$133,374,048	Actual expenditures from January 2003 through December 2004, trended forward using a linear trend model to estimate drug expenditures for January 1, 2006 forward. A specific drug-rebate percentage of 25.4328% is applied to get post-rebate projected drug costs. Includes Rocky ASO estimated expenditures, after rebate, adjusted for COFRS reconciliation.
2	Average Fee-for-Service Monthly Part D Eligibles	39,729	39,729	Total dual eligibles were estimated from a BOA query (run 10/22/2005) for any client with a TPL code of 01 - 06 or 21 - 26 with at least one day of eligibility in September 2005, plus 2,800 additional clients assumed to immediately be reported as full-benefit dual eligibles due to the interface with the Social Security Administration's BENDEX system being restored. Fee-for-Services dual eligibles were assumed to be 87.1% of all dual eligibles (the CY 2003 actual experience percentage from MSIS data).
3	Per Capita Expenditures for Fee-for-Service	$3,191.38	$3,357.10	[(1) ÷ (2)]
4	Adjustment for MCO Per Capita Expenditures	95%	95%	The managed care per capita cost as a percent of fee-for-service per capita costs changes from CY 2003 (used for federal Clawback analysis) to FY 06-07 due to rebasing which will correct the following things: a) $12 million was missing in
5	MCO Per Capita Expenditures	$3,031.81	$3,189.24	
6	Average MCO Monthly Part D Eligibles	5,894	5,894	Total dual eligibles were estimated from a BOA query (run 10/22/2005) for any client with a TPL code of 01 - 06 or 21 - 26 with at least one day of eligibility in September 2005, plus 2,800 additional clients assumed to immediately be reported as full-benefit dual eligibles due to the interface with the Social Security Administration's BENDEX system being restored. Managed Care dual eligibles were assumed to be 12.9% of all dual eligibles (the CY 2003 actual experience percentage from MSIS data).
7	State Medicaid Per Capita Expenditures for Covered Part D drugs for Full-Benefit Dual Eligible Individuals	$3,170.77	$3,335.41	[(2) * (3) + (5) * (6)] ÷ [(2) + (6)] Weighted average of (5) and (3)
8	Average Number of Full-Benefit Dual Eligibles per Month	45,623	45,623	Sum of average monthly fee-for-service Part D eligibles and average monthly MCO Part D eligibles.
	Estimated Total Funds Savings in Medical Services Premiums	**$144,659,902**	**$152,171,433**	[(7) * (8) * .5 in FY 05-06] FY 05-06 is 6 months (Jan - Jun 2006)
	Estimated General Fund	$72,329,951	$76,085,717	

No inflator is needed because the pharmacy expenditures were already trended above.

Schedule 6
Change Request for FY 06-07

Department:	Health Care Policy and Financing				**Dept. Approval by:**	John Bartholomew			**Date:**	November 15, 2005	
Priority Number:	BRI - 4				**OSPB Approval:**				**Date:**		
Program:	Information Technology Contract Monitoring				**Statutory Citation:**	26-4-105, C.R.S. (2005)					
Request Title:	Address Audit Recommendation Related to Prescription Drugs within Medicaid Management Information System										
		1	2	3	4	5	6	7	8	9	10
		Prior-Year Actual	Appropriation	Supplemental Request	Total Revised Request	Base Request	Decision/ Base Reduction	November 15 Request	Budget Amendment	Total Revised Request	Change from Base in Out Year
	Fund	FY 04-05	FY 05-06	FY 05-06	FY 05-06	FY 06-07	FY 06-07	FY 06-07	FY 06-07	FY 06-07	FY 07-08
Total of All Line Items	**Total**	1,955,159,694	2,217,438,594	0	2,217,438,594	2,216,125,856	(1,350,774)	2,214,775,082	0	2,214,775,082	(3,874,744)
	FTE	0.00	213.40	0.00	213.40	212.60	2.00	214.60	0.00	214.60	2.00
	GF	946,011,390	1,054,945,865	0	1,054,945,865	1,050,547,552	(769,136)	1,049,778,416	0	1,049,778,416	(2,012,371)
	GFE	96,464	0	0	0	0	0	0	0	0	0
	CF	0	76,512	0	76,512	76,512	0	76,512	0	76,512	0
	CFE	31,181,005	67,118,062	0	67,118,062	86,171,662	0	86,171,662	0	86,171,662	0
	FF	977,870,835	1,095,298,155	0	1,095,298,155	1,079,330,130	(581,638)	1,078,748,492	0	1,078,748,492	(1,862,373)
(1) Executive Director's Office, Medicaid Management Information System Contract	**Total**	21,076,845	23,261,268	0	23,261,268	23,047,082	375,000	23,422,082	0	23,422,082	300,000
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	5,187,882	5,662,806	0	5,662,806	5,572,025	93,750	5,665,775	0	5,665,775	75,000
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	370,212	568,453	0	568,453	611,540	0	611,540	0	611,540	0
	FF	15,518,751	17,030,009	0	17,030,009	16,863,517	281,250	17,144,767	0	17,144,767	225,000
(1) Executive Director's Office, Personal Services	**Total**	12,795,241	14,850,499	0	14,850,499	14,857,066	112,171	14,969,237	0	14,969,237	112,171
	FTE	0.00	213.40	0.00	213.40	212.60	2.00	214.60	0.00	214.60	2.00
	GF	5,341,465	6,391,700	0	6,391,700	6,340,297	56,086	6,396,383	0	6,396,383	56,086
	GFE	96,464	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	110,984	466,156	0	466,156	409,453	0	409,453	0	409,453	0
	FF	7,246,328	7,992,643	0	7,992,643	8,107,316	56,085	8,163,401	0	8,163,401	56,085
(1) Executive Director's Office, Operating Expenses	**Total**	812,837	1,105,457	0	1,105,457	1,019,560	7,749	1,027,309	0	1,027,309	1,739
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	403,153	528,725	0	528,725	500,470	3,875	504,345	0	504,345	870
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	729	17,850	0	17,850	4,359	0	4,359	0	4,359	0
	FF	408,955	558,882	0	558,882	514,731	3,874	518,605	0	518,605	869
(2) Medical Services Premiums	**Total**	1,920,474,771	2,178,221,370	0	2,178,221,370	2,177,202,148	(1,845,694)	2,175,356,454	0	2,175,356,454	(4,288,654)
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	935,078,890	1,042,362,634	0	1,042,362,634	1,038,134,760	(922,847)	1,037,211,913	0	1,037,211,913	(2,144,327)
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	76,512	0	76,512	76,512	0	76,512	0	76,512	0
	CFE	30,699,080	66,065,603	0	66,065,603	85,146,310	0	85,146,310	0	85,146,310	0
	FF	954,696,801	1,069,716,621	0	1,069,716,621	1,053,844,566	(922,847)	1,052,921,719	0	1,052,921,719	(2,144,327)
Letter Notation:											
Cash Fund name/number, Federal Fund Grant name:				FF: Title XIX, Title XXI, CFE: Children's Basic Health Plan Trust Fund 11G, Old Age Pension Fund from the Department of Human Services, Colorado Autism Treatment Fund 18A, Nurse Home Visitor Fund from the Department of Public Health and Environment, Breast and Cervical Cancer Prevention and Treatment Fund 15D, and Health Care Expansion Fund 18K							
IT Request:	**X Yes**	**No**	(If yes and request includes more than 500 programming hours, attach IT Project Plan)								
Request Affects Other Departments:	**Yes**	**X No**	(If Yes, List Other Departments Here:)								

CHANGE REQUEST for FY 06-07
EFFICIENCY AND EFFECTIVENESS ANALYSIS

SELECT ONE (click on box):
☑ Decision Item
☐ Base Reduction Item
☐ Supplemental Request Criterion:
☐ Budget Request Amendment Criterion:

Priority Number:	BRI - 4
Change Request Title:	Address Audit Recommendation Related to Prescription Drugs within Medicaid Management Information System
Long Bill Line Item(s)	(1) Executive Director's Office, Medicaid Management Information System Contract; (1) Executive Director's Office, Personal Services; (1) Executive Director's Office, Operating Expenses; (2) Medical Services Premiums
State and Federal Statutory Authority:	26-4-105, C.R.S. (2005); United States Code, Title 42, §1396r-8 (6) (b) (1) (A)

Summary of Request (Alternative A): This request is for additional funding for the Medicaid Management Information System Contract line item to implement a Drug Rebate Analysis and Management System in FY 06-07 to be offset by a savings in the drug rebates credited against prescription drug costs in the Medical Services Premiums line item.

Alternative A {Recommended alternative}:

Problem or Opportunity Description: Rising drug costs are a concern in general for the American public, not just for the state Medicaid programs. To avoid letting drug costs increase beyond the State's resources for paying, Colorado needs to find a way to reduce or offset the rising drug costs.

Since 1991, state Medicaid programs in all states have been able to recover a portion of prescription drug payments by requesting rebates from drug manufacturers. State Medicaid programs reimburse pharmacies for dispensing prescription drugs to Medicaid

recipients and recover a portion of these expenditures by submitting invoices to the drug manufacturers for rebates. The State is responsible for developing an accounting system, subsidiary to the Colorado Financial Reporting System, capable of properly recording and tracking rebate monies paid or owed. Currently Colorado uses a manual system based on receiving a paper report from the drug rebate system in the Medicaid Management Information System. Based on the voluminous paper report, Health Care Policy and Financing manually checks drug payments for correct pricing and prepares a billing for rebates to send to the drug manufacturers on a quarterly basis.

Drug manufacturers can and do dispute rebate amounts claims by states. Disputes delay payment of the rebate until the issue is resolved. Prompt resolution of disputes is critical because the longer the dispute remains outstanding, the more difficult it is to collect the rebate. The Department has had unresolved disputes going back for as long as nine years.

The rebates are not always received in a timely manner. Drug manufacturers calculate and remit interest on aged account receivables. If the rebate is not paid by the manufacturer within 38 days, interest starts accruing on day 39. The Department has no automated or electronic method to assess or to calculate interest. Consequently, all interest is calculated manually. This is problematic because interest rates change daily, necessitating timely updates to existing account information. Due to inefficiencies in the manual process, the Department has no system for verifying the accuracy of the amounts of interest paid by the manufacturers.

In 2004, the State Auditor's Office contracted with the Caley Gordon Group to conduct a performance audit on the Department's Medicaid Prescription Drug Program. The audit work was performed between March 2004 and July 2004. In September 2004, a report was presented to the State Auditor's Office. The Caley Gordon Group contacted other states and found that most states have reassigned or allocated additional staffing resources to improve the rebate process. Unlike many revenues that automatically flow to recipient entities, prescription drug rebates require action on the part of the Department for payment to occur.

The Caley Gordon Group Medicaid Prescription Drug Program Performance Audit of September 2004, page 23 recommends: "The Department of Health Care Policy and Financing should maximize drug rebate collections through the Drug Rebate Program by:

a) Improving the drug rebate accounting system to increase the collection rate and expedite recovery of rebate program revenue…

b) Tracking rebate amounts invoiced, disputed, and collected to establish benchmarks and evaluate trends.

c) Evaluating staffing/workload and assigning staff resources to compute interest on unpaid balances, properly track pricing and rebate per unit changes, research disputed rebates, and resolve all outstanding disputes with manufacturers in a timely manner.

d) Investigating and implementing system edits which will prevent payment claims that could lead to rebates disputes…

e) Using the dispute resolution services of the Centers for Medicare and Medicaid Services when appropriate.

The Department agreed to evaluate staffing levels and to examine system processes to determine the most cost-effective means to improve the drug rebate program. The examination was to include exploration of automated processes used in other states. The Department has complied with the audit recommendation by creating new metrics. Furthermore, the Department believes that the tracking process will continue to evolve, change, and improve, especially upon implementation of a fully automated drug rebate system. The Department is tracking rebate disputes to determine patterns of problems that could be eliminated via a system edit. The Department has also implemented a process to resolve disputes with manufacturers including contacting drug manufacturers via a special mailing with phone follow up, and also by attending a dispute resolution meeting moderated by the Centers for Medicare and Medicaid Services.

General Description of Alternative:

This request is for $491,988 (offset by $1,845,694 savings for higher drug rebates) to add an automated prescription drug rebate analysis and reporting system to the Medicaid Management Information System currently operated by the fiscal agent. The Medicaid Management Information System currently includes a drug rebate subsystem. The functionality of the current subsystem does not include the automated accounting that the auditors recommended. A new rebate subsystem, called Drug Rebate Analysis and Management System (DRAMS), would streamline the drug rebate process by reducing labor and expediting rebate collection. In addition, it would also:

- produce accurate invoices to send to the drug manufacturers
- reduce the likelihood of disputes for rebated amounts
- facilitate rapid reconciliation of payments for both current and prior quarter invoices
- increase cash flow to the Department by expediting rebate billings to the manufacturers
- calculate interest due from drug manufacturers if rebates are late
- improve reporting capacities including drill down on individual invoices and drug manufacturers
- produce Accounts Receivable reports and detailed claims reports for each specified rebate quarter
- provide a mechanized audit trail
- be implemented in five months or less and become active by November 30, 2006

The DRAMS subsystem would improve the drug rebate accounting system, track rebate amounts invoiced, disputed, and collected to establish benchmarks, compute interest on unpaid balances, and properly track pricing and rebate per unit charges. These functions address three of the five audit recommendations mentioned above. Another recommendation for staffing resources is also addressed in this request. The fifth recommendation of using the dispute resolution services of the Centers for Medicare and Medicaid Services (that the Department plans to do, when appropriate) is a policy issue that is outside the scope of system mechanization.

In order to improve the upfront accuracy of drug claims processing so DRAMS will not have to deal with pricing errors and other drug claims processing errors, the Department would add two FTEs to monitor production results of the claims processing in the Medicaid Management Information System. Current staff within the Department, and within the Medicaid Management Information System oversight work group in particular, already have heavy workloads and cannot assume any additional job functions without jeopardizing the job functions already performed. Due to insufficient resources, minimal time and effort are currently devoted to monitoring the outcomes of drug claims processing, and the Department is aware that lack of sufficient monitoring may often result in overpayment of drug claims and limited effort to collect drug rebates.

The first position would monitor and research improvements to the Prescription Drug Card System. The position would be a business analyst (General Professional IV classification) with an expertise in pharmacy claims processing and would be responsible for assuring the correct processing of pharmacy claims. Monitoring of the system accuracy would be done through a variety of means, including developing and using key management reports as well as analysis through the main decision support system for the Medicaid Management Information System. Oversight of the installation and enhancement of the Drug Rebate Analysis and Management System would also be the responsibility of this position. Because this position would work closely with the Department's policy makers and would enforce the Department's policies with the fiscal agent, this position needs to reside in the Department's internal staff.

A second position (General Professional IV classification) to monitor and research improvements to the Claims Processing Assessment System (CPAS) is also needed. CPAS currently exists within the Medicaid Management Information System, but due to a shortage of personnel resources, it has seldom been used to analyze drug claims and potential drug rebates for the past three fiscal years. When used properly, the CPAS reviews are comprehensive studies of claims that are paid or denied within the Medicaid Management Information System. The studies include assuring that client, provider, reference, pricing, and other policy edits are applied correctly. This position would also review the operational processes for pharmacy prior authorization reviews. By working

closely with Departmental policy staff, this position would assure that the fiscal agent staff perform their functions as required. This position needs to reside within the Department's internal staff because enforcement of Departmental policy produces better results performed by a position reporting directly to the Department.

The monitoring and reviews are time intensive and require dedicated FTEs to assure that the reviews are timely and thorough. The FTEs must be constant in the positions in order to attain the level of expertise that will achieve the most beneficial results. The General Professional IV classification is appropriate because these two positions must accept the responsibility of oversight and interface with the fiscal agent to guarantee that DRAMS operates constantly and effectively to produce the best results for the Department. Without these two positions, DRAMS would not be fully utilized. DRAMS can produce large volumes of data, but the extra data would be useless if there were no one to supervise the policies leading to the data input and no one to supervise and interpret the data output and to follow up to ensure that drug rebates actually occur.

A full year of Personal Services and Operating Expenses has been calculated for both fiscal years. The two FTEs would go through training on their job duties and learn to use the Medicaid Management Information System, the Prescription Drug Card System, and the Claims Processing Assessment System. They would also review and test data for the Drug Rebate Analysis and Management System to assure that implementation goes smoothly.

These two positions address the audit recommendation and the Department's agreement to evaluate staff resources for efficiently and effectively completing drug rebate processes.

Drug rebates are netted against the cost of prescription drugs within the Medicaid program. Increased drug rebates would produce a larger offset to prescription drug costs than currently occurs. Therefore, there would be additional savings in prescription drug costs that are larger than the costs of implementing and operating DRAMS. Please see the assumptions section for an explanation of the estimated drug cost savings.

Calculations for Alternative's Funding:

Summary of Request FY 06-07 Matches Schedule 6 and Recommended Request	**Total Funds**	**General Fund**	**Federal Funds**
Total Request [Items below total to this]	($1,350,774)	($769,136)	($581,638)
(1)Executive Director's Office, Medicaid Management Information System Contract	$375,000	$93,750	$281,250
(1)Executive Director's Office, Personal Services	$112,171	$56,086	$56,085
(1)Executive Director's Office, Operating Expenses	$7,749	$3,875	$3,874
(2) Medical Services Premiums	($1,845,694)	($922,847)	($922,847)

Summary of Request FY 07-08 Matches Schedule 6 and Recommended Request	**Total Funds**	**General Fund**	**Federal Funds**
Total Request [Items below total to this]	($3,874,744)	($2,012,371)	($1,862,373)
(1) Executive Director's Office, Medicaid Management Information System Contract	$300,000	$75,000	$225,000
(1)Executive Director's Office, Personal Services	$112,171	$56,086	$56,085
(1)Executive Director's Office, Operating Expenses	$1,739	$870	$869
(2) Medical Services Premiums	($4,288,654)	($2,144,327)	($2,144,327)

Table A: Costs Added to Medicaid Management Information System Contract				
Fiscal Year	**System Added**	**Total Cost**	**General Fund**	**Federal Funds**
FY 06-07	DRAMS Software Purchase	$75,000	$18,750	$56,250
	DRAMS Installation	$300,000	$75,000	$225,000
	Fiscal Year Total	**$375,000**	**$93,750**	**$281,250**
FY 07-08	DRAMS Ongoing Maintenance	$300,000	$75,000	$225,000
	Fiscal Year Total	**$300,000**	**$75,000**	**$225,000**

Table B: FTE and Operating Expenses			
Fiscal Year(s) of Request		**FY 06-07**	**FY 07-08**
PERSONAL SERVICES	Title:	**General Professional IV**	
Number of PERSONS / class title		**2**	**2**
Calculated FTE per classification		**2.00**	**2.00**
Annual base salary (monthly * 12)		**$50,256**	**$50,256**
Number months working in FY 06-07 and FY 07-08		**12**	**12**
Salary		$100,512	$100,512
PERA	**10.15%**	$10,202	$10,202
FICA	**1.45%**	$1,457	$1,457
Subtotal Personal Services		$112,171	$112,171
OPERATING			
Supplies @ $500/$500	**$500**	$1,000	$1,000
Computer @ $690/$0	**$690**	$1,380	$0
Office Suite Software @ $294/$0	**$294**	$588	$0
Office Equipment @ $2,021 /$0	**$2,021**	$4,042	$0
Telephone Base (Annual)	**$369.60**	$739	$739
Subtotal Operating		$7,749	$1,739
GRAND TOTAL ALL COSTS		**$119,920**	**$113,910**

Table C: Drug Rebate Savings			
Current Estimate	**FY 05-06**	**FY 06-07**	**FY 07-08**
Prescription Drugs (pre-rebate)(1)	$306,323,673	$355,886,843	$253,466,558
Medicare Prescription Drug Benefit Impact(2)	($65,864,527)	($137,719,725)	$0
Revised Prescription Drugs	$240,459,146	$218,167,118	$253,466,558
Drug Rebate(3)	($45,921,591)	($43,895,224)	($50,997,471)
Drug Rebate, due to DRAMS, based on 22%(4)		($47,996,766)	($55,762,643)
Difference/Increased savings(5)		**($4,101,542)**	**($4,765,171)**
Adjustment (reduce by 10%)(6)		**$410,154**	**$476,517**
Annual Savings		**($3,691,388)**	**($4,288,654)**
Six Months of Savings	**N/A**	**($1,845,694)**	**N/A**

Notes for above table:
1) The Department does not project prescription drug costs separately as part of the Medical Services Premiums Budget Request, however for purposes of estimating savings, an estimate of the pre-rebate drug cost for FY 05-06 was taken from page 118 of the March 15, 2005 Figure Setting Document. The Figure was inflated annual by 16.18% (average increase between FY 01-02 through FY 04-05). The impact of the Medicare prescription drug benefit is included in this line for FY 07-08.
2) These estimates were taken from attachment 2 of BRI -3 "Revision to the Medicaid Modernization Act Implementation" submitted November 15, 2005.
3) FY 06-07 and FY 07-08 Drug Rebate is estimated at the FY 03-04 actual rate of 20.12% (per Figure Setting, page 118).
4) Utilize the assumed drug rebate percentage of 22%, an increase of 1.88% above current rate.
5) Difference between Drug Rebate based on actual 20.12% and Drug Rebate based on 22%.
6) The Department reduced the savings by a factor of 10% to adjust for possible variances in the projection.

Impact on Other Areas of Government: No other state agencies are affected by this request.

Assumptions for Calculations: The federal financial participation rate for additional software added to the Medicaid Management Information System is assumed to be 75% and will be confirmed later by an

Advance Planning Document submitted to the federal Centers for Medicare and Medicaid Services.

The federal financial participation rate for Personal Services and Operating Expenses is 50%.

The cost to purchase the Drug Rebate Analysis and Management System (DRAMS) software subsystem was provided by the Medicaid Management Information System fiscal agent, Affiliated Computer Services. $75,000 is the standard price for this particular software. The software is already developed and has been installed in the Medicaid Management Information Systems in other states.

The installation time frame was also provided by Affiliated Computer Services and based on the fiscal agent's experience in installing the same software in the Medicaid Management Information Systems in other states. The estimated installation and annual maintenance cost for DRAMS is $300,000 per fiscal year. The installation covers the information initially supplied for DRAMS to operate. This information changes constantly, so every year there is continual maintenance. Examples of information necessary to be supplied to DRAMS would include:

- Prices paid for particular drugs and every change to the price
- Amount of rebate per unit paid by the manufacturer and every change in amount of rebate
- Daily interest rate changes to charge the manufacturer that pays rebates late
- Whether a drug qualifies for a rebate based on an agreement with the manufacturer (agreement is negotiated by the federal Centers for Medicare and Medicaid Services)
- Retroactive effective dates, if applicable, for drug rebates
- Identification of claims that are likely to be disputed by the manufacturer (based on incorrect billing by a pharmacy or other reason)
- Identification and tracking of payments from the manufacturers for drug rebates

- Crosswalks to medical claim procedure codes to identify rebates due on injectible drugs that would not otherwise receive drug rebates because they are hidden in the procedure codes
- Identification of drugs used in State Only programs (such as Prenatal State Only) for which the full amount of the rebate should be classed as General Fund

From fiscal years 95-96 through 02-03, the percentage of drug rebates collected, as compared to the total prescription drug expenditures, ranged from a high of 20.88% in FY 95-96 to a low of 8.11% in FY 02-03 when Medical Services Premiums converted from accrual accounting to cash accounting and only two quarters of rebates were recorded. During FY 03-04, the rebate percentage returned to a higher amount of 20.12%. The historical rebate percentages mentioned above are actual data from the Final Request for Medical Services Premium submitted February 15, 2005. The Caley Gordon Group, when performing their audit, contacted four states, Missouri, Oklahoma, Tennessee, and Washington, and determined that the Colorado collection rates for drug rebates are similar to the collection rates of these four other states.

An average of the percent of rebates collected for fiscal years in the late 1990s probably is not the best consideration for rebates going forward. Less emphasis was placed on drug rebates during those times. For example, the percentage of rebates in FY 96-97 was 13.58%, in FY 97-98 was 14.31%, and in FY 98-99 was 15.71%. The Department believes that the more recent drug rebate collection rate of 20.12% for FY 03-04 is more indicative of drug rebates for the future. Since rebates for the future are unknown, the Department reduced the calculated savings by 10% to ensure that necessary funding is not removed from the budget.

Per estimates provided by Affiliated Computer Services for drug rebate percentages in other states (District of Columbia, Hawaii, Indiana, Massachusetts, Minnesota, Mississippi, Montana, North Carolina, and Wyoming) that currently use DRAMS, the average drug rebate percentage is 22%. The Department has assumed that drug rebates would increase up to 22% compared to the FY 03-04 actual drug rebate of 20.12% in

Colorado. Due to the uncertainty of this assumption the Department reduced the savings estimate by 10% to allow for variances in the projection.

Although the savings for a full fiscal year in FY 06-07 are estimated to be $3,691,388, DRAMS will take five months to implement and the first month after implementation may be needed to become accustomed to its use, so only six months of savings, $1,845,694, have been used for FY 06-07. Rebates can still be claimed for the first six months of FY 06-07, but there will be some delay in claiming rebates for those months since DRAMS would not yet be operational when the first six months occur. A full year of savings would be expected in FY 07-08.

Personal Services and Operating Expenses are based on Common Policies for these items. Personal Services are calculated for the Job Class Title of General Professional IV. A full year of Personal Services and Operating Expenses has been calculated for both fiscal years.

Children's Basic Health Plan contributes to costs of the fixed price related to claims processing and capitation payments in the Medicaid Management Information System. However, other costs are considered outside the fixed price. Drug rebates are not part of the fixed price at this time, so no contribution from the Children's Basic Health Plan would be applicable to this Request.

The Medicaid Management Information System is currently in the process of reprocurement. It is assumed that the Drug Rebate Analysis and Management System, or a similar system, would continue to be a component of the Medicaid Management Information System after reprocurement is completed and transitional phases occur to continue the operations of the Medicaid Management Information System into future years.

Concerns or Uncertainties of Alternative: The above mentioned savings for drug expenditures is only an estimate. The exact savings can not be known until after the software usage has been in effect for a full fiscal year.

Alternative B {Status quo; no change in funding; not recommended}:

General Description of Alternative: This alternative would not fund the Drug Prescription Analysis and Management System and two additional FTEs. Instead, the status quo would continue.

Calculations for Alternative's Funding: No change in funding with this alternative.

Concerns or Uncertainties of Alternative: The Department would receive no additional relief on the continually rising drug costs and would not be able to increase the monitoring and accuracy of the internal rebate calculations without the necessary additional resources. Therefore, full compliance with the audit recommendations concerning drug rebates likely would be impossible.

Supporting Documentation

Analytical Technique: Analysis by considering return on investment can reveal the profitable alternative for the State. The results of the investment can be expressed in terms of what the State saves, or avoids spending, by completing the investment.

Alternative	Investment During FY 06-07	Cost Avoidance (Return on Investment)
A	$494,920	$1,845,694 saved by increased drug rebates netted against drug expenditures for 6 months. $1,350,774 saved above investment.
B	$0	$0 saved - no increase in drug rebates
Alternative	**Investment During FY 07-08**	**Cost Avoidance (Return on Investment)**
A	$413,910	$4,288,654 saved by increased drug rebates netted against drug expenditures for full year. $3,874,744 saved above investment.
B	$0	$0 saved - no increase in drug rebates

Quantitative Evaluation of Performance -

Compare all Alternatives:

Based on the above analysis, in FY 06-07, a savings of $1,845,694 is generated through Alternative A, with an investment of $494,920 in total funds for a net savings of $1,350,774 in FY 06-07. This is a 270% return on investment (($1,350,774 / $494,920) = 2.7). Alternative B has no extra investment, but also no extra savings. Therefore, Alternative A is the preferred alternative.

Statutory and Federal Authority:

26-4-105, C.R.S. (2005) Federal requirements under Title XIX. *Nothing in this article 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.*

United States Code, Title 42, §1396r-8 (6) (b) (1) (A) *A rebate agreement under this subsection shall require the manufacturer to provide, to each state plan approved under this subchapter, a rate for a rebate period in an amount specified in subsection (c) of this section for covered outpatient drugs of the manufacturer dispensed after December 1, 1990, for which payment was made un the State plan for such period. Such rebate shall be paid by the manufacturer not later than 30 days after the date of receipt of the information described in paragraph (2) for the period involved.*

Department Objectives Met if Approved:

1.3 To assure payments in support of the programs are accurate and timely.

1.5 To accurately project, report, and manage budgetary requirements to effect Executive and Legislative intent with program and budget development and operations. To accurately record and monitor expenditures for programs managed by the Department so there may be accurate financial reporting at all times.

2.2 To improve management of the Department's information systems technology.