Department of Health Care Policy and Financing
Medical Services Premiums
Medicaid Mental Health Community Programs
FY 07-08 and FY 08-09

Budget Request

FEBRUARY 15, 2008

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(2) MEDICAL SERVICES PREMIUMS

I. BACKGROUND

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

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

1. Adjustments have been made to caseload and per capita costs for estimated impacts due to HB 05-1262, the Tobacco Tax Bill. The costs are calculated through normal Medical Services Premiums per capita cost methodology. Expenditure for the programs included in HB 05-1262 is from Cash Funds Exempts sources other than the General Fund. Adjustments to ensure that funding is requested from the Health Care Expansion Fund are incorporated into Exhibit A, pages EA-2 and EA-3. Pages EA-4 through EA-7 provide detail on the components of the fund splits. Additional information is available in the Department's Tobacco Tax Update in this Budget Request.

2. The implementation of the Medicare Modernization Act on January 1, 2006 impacts prescription drug totals in the FY 05-06 and FY 06-07 actuals. Cost savings estimates for prescription drugs have been accounted for in the per capita estimates.

3. The Department is currently contracting with one managed care plan as a managed care organization and with another health plan to provide services to clients as a prepaid inpatient health plan. A prepaid inpatient health plan receives a monthly administrative fee per client and is not at risk for the cost of services. The Department did not renew its contract with one administrative services organization in May 2006, and one managed care plan did not renew its contract with the Department in September 2006.

4. In February 2007, the Department re-titled the Qualified Medicare Beneficiaries/Special Low-Income Medicare Beneficiaries aid category to "Partial Dual Eligibles." This more accurately reflects the benefit package afforded to these clients, who receive only coinsurance and the Supplemental Medicare Insurance Benefit. The title change does not imply any change to the services provided for these clients.

5. The Department implemented a policy of "Passive Enrollment" in May 2006, which requires most clients in Adams, Arapahoe, Denver, and Jefferson counties to choose between the fee-for-service program, primary care physician program, or managed-care program. Clients who do not make a selection are defaulted into the managed-care program.

6. The elimination of presumptive eligibility for Medicaid pregnant women on September 1, 2004, which was reinstated by HB 05-1262, effective July 1, 2005.

7. FY 98-99 is excluded from expenditure trends because of the unstable nature of the data during the transition from Blue Cross/Blue Shield claims processing system to the current Medicaid Management Information System in December 1998.

8. The Deficit Reduction Act of 2005 and HB 06S-1023 require individuals to provide documentary evidence of citizenship and identity prior to the receipt of public benefits.

The Department's exhibits for Medical Services Premiums remain largely the same as previous Budget Requests. Of note, the following changes have been made since the previous Budget Request:

1. To better identify the type of services being performed, the Department has re-titled several service categories:

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

2. A one-page summary of the Department's Request has been added to Exhibit A, on page EA-1, titled "Calculation of Request". Pages EA-2 and EA-3 now show only the calculation of the fund splits.

3. The Department's year-to-date expenditure exhibits from February have been replaced with a comparison of expenditure for each half of FY 06-07. The Department anticipates the year-to-date expenditure exhibits returning in the November 1, 2007 Budget Request.

4. The Department has substantially revised the methodology used in calculations in numerous places, including: the Breast and Cervical Cancer Treatment Program, the Program of All-Inclusive Care for the Elderly, the Supplemental Medicare Insurance Benefit, and Single Entry Points. Changes are discussed in detail for each program in each program's respective section in this Budget Narrative.

5. The Department has removed the exhibit on the Impact of the Medicare Modernization Act, formerly Exhibit Q.

Details of the changes to individual exhibits are contained in the relevant section for each exhibit in section III.

II. MEDICAID CASELOAD

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

III. BASIC APPROACH TO MEDICAL SERVICES PREMIUMS CALCULATIONS

Once caseload is forecasted, the next step in the process is to forecast per capita costs. Per capita costs contain price, utilization, and Special Bill impacts. Inherent in the per capita cost is the differential "risk" of each eligibility category. The concept of "risk" can be roughly described as follows: due to the differences in health status (age, preexisting condition, etc.), generally healthy clients are less costly to serve (lower "risk") than clients with severe acute or chronic medical needs requiring medical intervention (higher "risk"). For example, on average, a categorically eligible low income child is substantially less costly to serve than a disabled person each year. Because Medicaid caseload is growing and receding at differing rates by individual eligibility categories, it is essential to determine the anticipated cost per capita for all types of eligibility categories that will be served. In very broad terms and for most services, the rate of change that was experienced across actual expenditure reference periods is applied to the future in order to estimate the premiums that will be needed for FY 07-08 and FY 08-09, the Base Request year. To that base, adjustments are made due to policy items or environmental changes (e.g., Change Requests and new legislation).

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

Rationale For Grouping Services For Projection Purposes

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

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

Acute Care:

- Physicians Services and the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT)
- Emergency Transportation
- Non-emergency Medical Transportation
- Dental Services
- Family Planning
- Health Maintenance Organizations
- Inpatient Hospitals
- Outpatient Hospitals
- Lab & X-Ray
- Durable Medical Equipment
- Prescription Drugs
- Drug Rebate
- Rural Health Centers
- Federally Qualified Health Centers
- Co-Insurance (Title XVIII-Medicare)
- Breast and Cervical Cancer Treatment Program
- Prepaid Inpatient Health Plan Services
- Other Medical Services
- Home Health
- Presumptive Eligibility

Community Based Long Term Care:
- Home and Community Based Services: Elderly, Blind and Disabled waiver
- Home and Community Based Services: Mental Illness waiver
- Home and Community Based Services: Disabled Children waiver
- Home and Community Based Services: Persons Living with AIDS waiver
- Home and Community Based Services: Consumer Directed Attendant Support waiver
- Home and Community Based Services: Brain Injury waiver
- Home and Community Based Services: Children with Autism waiver
- Private Duty Nursing
- Hospice

Long Term Care: *(a summary of the totals of individual service calculations, not a grouped calculation):*
- Class I Nursing Facilities
- Class II Nursing Facilities
- Program of All-inclusive Care for the Elderly

Insurance *(a summary of the totals of individual service calculations, not a grouped calculation):*
- Supplemental Medicare Insurance Benefit
- Health Insurance Buy-In

Service Management *(a summary of the totals of individual calculations, not a grouped calculation):*
- Single Entry Points
- Disease Management
- Prepaid Inpatient Health Plan Administration

IV. PROJECTION METHODOLOGY AND DESCRIPTION OF EXHIBITS

EXHIBIT A - CALCULATION OF TOTAL REQUEST AND FUND SPLITS

Summary of Request (Page EA-1)

This page is new, effective with the November 1, 2007 Budget Request, although the information presented on this page was previously contained in other pages in Exhibit A. For the current year, the Department sums total spending authority by fund source, including the Long Bill and any special bills which have appropriations that affect the Department. The total spending authority is

compared to the total projected estimated current year expenditures from page EA-2. The difference between the two figures is the Department's Estimate of Need in the November Budget Request, and the Department's Supplemental Request in the February Supplemental Budget Request.

For the request year, the Department starts with the prior year's appropriation including special bills, and adds in any required annualizations. This total is the Base Amount for the Request year. The total Base Amount is compared to the total projected estimated request year expenditure from page EA-3. The difference between the two figures is the Department's Decision/Base Reduction Item for FY 08-09 in the November Budget Request, and the Department's Budget Amendment in the February Supplemental Budget Request.

Totals on this page correspond with Columns 3, 5, and 8 on the Schedule 13, as appropriate.

Calculation of Fund Splits (pages EA-2 and EA-3)

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

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

- Family Planning: There is 90% federal financial participation available for all documented family planning expenditures. This includes those services that are rendered through health maintenance organizations. Please see Exhibit F, page EF-10.

- Breast and Cervical Cancer Program: This program receives a 65% federal financial participation rate. To determine state funding, the population is separated into two groups: traditional clients, and expansion clients. Traditional clients, who gained eligibility through SB 01S2-012, have funding sources specified in statute, at 25.5-5-308 (9), C.R.S. (2007). For FY 07-08, 75% of total state funding comes from the General Fund, and 25% of state funding comes from the Breast and Cervical Cancer Prevention and Treatment Fund. For FY 08-09, 100% of the state funding comes from the General Fund. Expansion clients, who

gained eligibility through additional screenings funded in HB 05-1262, receive state funding through the Prevention, Early Detection, and Treatment fund. Please see Exhibit F, page 6 for calculations.

- Prenatal Costs: A portion of Acute Care expenditure is for prenatal care for Non-Citizens. Prenatal services are provided as a state-only option and therefore must be funded through 100% General Fund. Delivery costs qualify for the standard 50% federal financial participation rate. For further information, please see Exhibit F, page EF-9.

- Health Care Expansion Fund Programs: Expenditures for clients granted eligibility through HB 05-1262 are funded through the Health Care Expansion Fund. Separate adjustments are made to Acute Care, Community Based Long Term Care, Long Term Care and Insurance, and Service Management. In addition, in instances where the Department cannot isolate certain expenditures, the Department performs a bottom line adjustment to allocate expenditure to the Health Care Expansion Fund. Please see Exhibit A, pages EA-4 through EA-7 for calculation of the fund split for the Health Care Expansion Fund.

- Indian Health Services: The federal financial participation rate for this program is 100%. The total is a rough estimate based on the Department's most recent two years of paid expenditure.

- Supplemental Medicare Insurance Benefit: Medicare premiums are not federally matched for clients who exceed 134% of the federal poverty level. Premiums for clients between 120% and 134% of the federal poverty level receive a 100% federal financial participation rate. In aggregate, the Department estimates that approximately 80% of the total will receive federal financial participation, while 20% will be provided as a state-only option.

- Single Entry Point: A portion of this line item is for clients who do not receive Medicaid coverage (4%) and does not receive federal financial participation. Instead this portion must be funded through 100% General Fund.

- Upper Payment Limit Financing: The Upper Payment Limit financing offset to General Fund is a bottom line adjustment to total expenditures.

- Denver Health Outstationing: Federal funds are drawn to reimburse the Denver Health Medical Center federally qualified health centers for the federal share of their actual expenditures in excess of the current reimbursement methodology. This reimbursement does not require any increase in General Fund. The FY 07-08 and FY 08-09 totals are based on the total amount Denver Health Medical Center was able to certify in FY 06-07.

- HB 03-1292 ICR-MR Fee: This bill permitted the Department of Human Services to collect a service fee for the purposes of maintaining the quality and continuity of services provided by intermediate care facilities for the mentally retarded (ICF-MR).

Fees assessed to public ICFs-MR are transferred to the Department of Health Care Policy and Financing in order to receive a federal match. However, the Department of Human Services has never collected a fee from the Department's only public ICF-MR, and in conversations with Department of Human Services staff, it does not appear that the Department of Human Services will collect this fee in the foreseeable future. Therefore, the Department has removed the fund split adjustment for this fee.

Additionally, all bill annualizations have been relocated from page EA-3 to page EA-1.

Health Care Expansion Fund (page EA-4)

The caseload impacts of the Health Care Expansion Fund from HB 05-1262 are already included in the Medicaid caseload projections. See Exhibit B page EB-1 through EB-3 for additional information. The Medical Services Premiums request is based on these caseload projections and per capita costs, as described in detail below. The overall request for each service category (Acute Care, Community Based Long Term Care, Long Term Care and Insurance, and Service Management) is divided out in the Federal Match Calculation, Exhibit A, pages EA-2 and EA-3 splitting the request by General Fund, Cash Funds Exempt, and federal funds accordingly. To isolate certain expenditures, the Department performs bottom line adjustments to allocate expenditure to the Health Care Expansion Fund. For simplicity, pages EA-4 through EA-7 show the fund split adjustments that need to be made to the General Fund amounts shown in each section of the Calculation of Federal Match exhibits (page EA-2 and EA-3). The following programs are funded via the Health Care Expansion Fund:

a. Expansion Adults
b. Expansion Foster Care (SB 07-002)
c. Presumptive eligibility
d. Legal Immigrants
e. Removal of Medicaid asset test (children expansion)
f. Removal of Medicaid asset test (adult expansion)
g. Children's Home and Community Based Services – State Plan and waiver services
h. Children's Extensive Support – State Plan services

The Department's projections for Expansion Adults and Expansion Foster Care are part of the regular projection methodology for Medical Services Premiums, contained in Exhibits F, G, H, and I.

The Department's projections for presumptive eligibility, Legal Immigrants, the removal of the Medicaid asset test (adult and children expansion), Children's Home and Community Based Services, and Children's Extensive Support are described in detail in the Tobacco Tax Update, Section Q of this Budget Request.

The items above are summed for each fiscal year and a single line adjustment is included in each service category in the Calculation of Match exhibits to correct the funding splits.

EXHIBIT B - MEDICAID CASELOAD PROJECTION AND REQUEST WITHOUT RETROACTIVITY

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

EXHIBIT C - HISTORY AND PROJECTIONS OF PER CAPITA COSTS

Medical Services Premiums per capita costs history (through FY 06-07) and projections are included for historical reference and comparison, and are calculated on a cash-accounting basis.

EXHIBIT D - SUMMARY OF REQUEST BY ELIGIBILITY CATEGORY

The exhibit displays the Medical Services Premiums caseload, per capita costs and expenditure projections for the current year and the request year by eligibility category. Projections include Upper Payment Limit Financing and other financing. Caseload does not include retroactivity.

EXHIBIT E - SUMMARY OF PREMIUM REQUEST BY SERVICE GROUP

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

Pages EE-2 through EE-6 of this exhibit contains a detailed summary of the Department's Budget Request, by service category. In addition, this exhibit directly compares the Department's Budget Request to the Department's Long Bill plus Special Bills appropriation, as determined by the Department's March 8, 2007 Figure Setting and subsequent actions by the Joint Budget Committee, and the General Assembly. This exhibit includes all bottom line impacts and financing, but does not break the request down by eligibility type or funding source. Totals on this portion of the exhibit match the totals on Exhibit A, and the Schedule 13.

EXHIBIT F - ACUTE CARE CALCULATIONS

Calculation of Acute Care Expenditure (Page EF-1)

Acute Care services are calculated in a series of steps. At the top of page EF-1, historical expenditures are provided (yearly change in expenditure and percentage change is provided on page EF-4). Historical per capita costs and their percent changes are provided. The first step of the calculation is to select a historical per capita percent change rate, if possible, to trend the last actual per capita to the next year. Finally, bottom line adjustments for legislation and Change Requests are made. Total expenditures after bottom line adjustments are divided by the projected caseload to obtain a final per capita cost for the current year. To calculate the request year, the same methodology is applied to the projected request year per capita, including a per capita trend factor and bottom line impacts. The total estimated expenditure for Acute Care is added to total estimated expenditure in other service groups and bottom line impacts to generate the total request for Medical Services Premiums. There is no separate request for Acute Care.

In light of the Medicare Modernization Act of 2003, the Department has added a separate page of trends on page EF-2. On this page, expenditures for pharmacy and drug rebate recoveries have been removed from the historical expenditure. This page is particularly relevant, as FY 05-06 and FY 06-07 per capita costs for eligibility categories with significant amounts of dual-eligibles are skewed by the new Part D benefit. In Adults 65 and Older (OAP-A), Disabled Adults 60 to 64 (OAP-B), and Disabled Individuals to 59 (AND/AB), the per capita costs experienced a significant downturn as Medicare has become responsible for most pharmacy. Selecting trends that incorporate FY 05-06 would clearly be erroneous. This new exhibit enables the Department to analyze and select trends without the effect of pharmacy, which has historically been a significant cost driver.

Calculation of Per Capita Percent Change:
The per capita percent change for several different years is computed for each eligibility category on a per capita cost basis. The period of time that was selected for computing the trend or annual rate of change was FY 99-00 through FY 05-06. Prior year information is provided for historical reference. This period was selected for two reasons: first, it is a recent period and second, because Medicaid benefits over this period have remained mostly the same. At the top of page EF-3, the Department has provided a list of historic trends. Included are 2-year, 3-year, 4-year, and 5-year trends, ending in FY 03-04, FY 04-05, FY 05-06, and FY 06-07. Typically, the same percentage selected to modify current year per capita costs were used to modify the request year per capita costs. This method was not utilized in all cases for the FY 08-09 Request.

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

The table below describes the trend selections for FY 07-08 and FY 08-09. In most cases, though not all, the Department has held the trend constant between the two years. On Exhibit F, the selected trend factors have been bolded for clarification. By convention, any trend factor selected based on expenditure without prescription drugs and drug rebate is labeled "Without RX."

There are two overarching concerns when selecting trend factors for the current year, FY 07-08. First, FY 07-08 is scheduled for 53 payment cycles, based on the number of Mondays during the fiscal year. The first half of FY 07-08 had 27 payment cycles, and the second half will have 26. Therefore, year-to-date figures are slightly higher than half the total, and therefore may not provide a completely accurate view of FY 07-08 expenditure. Second, the Department's drug rebate collections were lower than usual (as a percentage of expenditure) in the first half of the fiscal year. Drug rebate collections exhibit large variations because of timing issues involved in receiving funds from manufacturers. The Department anticipates that collections in the second half of the fiscal year will exceed that of the first half, which will reduce current estimated growth rates.

The selected trend factors for FY 07-08 and FY 08-09, with the rationale for selection, are as follows:

Aid Category	**FY 07-08 Acute Care Trend Selection**	**FY 08-09 Acute Care Trend Selection**	**Justification**
Adults 65 and Older (OAP-A)	Year-to-Date Per Capita change -1.18%	3-Year Average of FY 04-05 through FY 06-07 (Without RX) 0.46%	The trend factor for FY 07-08 is based on current year-to-date expenditure. Even with negative base growth, the Department still anticipates that the overall per capita, with bottom line impacts, will grow in FY 07-08. The Department does not anticipate that expenditure in the second half of FY 07-08 will be substantially different from the first half. For FY 08-09, the Department assumes that the base trend will increase, but in the absence of additional rate increases, overall growth will decline.

Aid Category	FY 07-08 Acute Care Trend Selection	FY 08-09 Acute Care Trend Selection	Justification
Disabled Adults 60 to 64 (OAP-B)	2-Year Average of FY 02-03 through FY 03-04 7.22%	5-Year Average of FY 02-03 through FY 06-07 (Without RX) 1.60%	Without prescription drugs, the last four years for this aid category have oscillated between positive and negative trends. In FY 06-07, expenditure and per capita costs (without RX) were virtually flat. Current year-to-date expenditure in this aid category indicates strong growth in FY 07-08; therefore, the FY 07-08 selected trend reflects current growth. History indicates that this aid category does not typically sustain high per capita growth; therefore, the Department anticipates that in the absence of large policy changes, the per capita growth will moderate in FY 08-09.
Disabled Individuals to 59 (AND/AB)	Weighted 3-Year Average of FY 01-02 through FY 03-04 5.99%	5-Year Average of FY 02-03 through FY 06-07 (Without RX) 1.79%	Without prescription drugs, per capita growth has oscillated between positive and negative trends. Negative years have served to keep long- and short-term trend factors low. The overall percent change in per capita from FY 02-03 to FY 06-07 was less than 0.5%. However, prescription drugs are still a part of this category and still show significant growth. In particular, current year-to-date expenditure indicates strong per capita growth. The Department attributes some of the growth to the lack of drug rebate, and the additional payment cycle in the first half of the year. Therefore, the Department estimates that the overall base growth in FY 07-08 will be slightly less than the year-to-date factor. Further, the Department anticipates that growth will continue to abate in FY 08-09, as this aid category generally has not shown a tendency to sustain large growth, particularly when prescription drugs are not included.

Aid Category	FY 07-08 Acute Care Trend Selection	FY 08-09 Acute Care Trend Selection	Justification
Categorically Eligible Low-Income Adults (AFDC-A)	2-Year Average of FY 05-06 through FY 06-07 9.10%	5-Year Average of FY 02-03 through FY 06-07 5.03%	Recent history in this aid category is erratic, including a very large per capita increase in FY 06-07, a small increase in FY 05-06 after a large per capita decline, and two other large per capita increases. Of note is that although caseload has experienced a sharp decline in FY 06-07, expenditure did not decrease. This is partially responsible for the large per capita growth in FY 06-07. This growth appears to be continuing in FY 07-08. The Department anticipates that as caseload levels off, per capita growth will also settle to a growth rate more in line with historical trends. Therefore, in FY 08-09, the Department has selected a long-term trend incorporating the most recent history.
Expansion Adults	65.00%	AFDC-A 5-Year Average of FY 02-03 through FY 06-07 5.03%	The selected trend factor is based on current year-to-date expenditure. The growth in this aid category is due to the emerging nature of this population. New populations generally take time before their per capita reaches a natural level. At present, the Department anticipates that as caseload begins to reach a more stable level, per capita growth will also level off. Therefore, the Department assumes that FY 08-09 will more closely resemble the per capita growth rate as the Categorically Eligible Low-Income Adults.
Breast & Cervical Cancer Program	0.04%	0.04%	See the section in this Budget Narrative titled "Breast and Cervical Cancer Program Per Capita Detail and Fund Splits" for a description of this trend factor.

Aid Category	FY 07-08 Acute Care Trend Selection	FY 08-09 Acute Care Trend Selection	Justification
Eligible Children (AFDC-C/ BCKC-C)	2-Year Average of FY 04-05 through FY 05-06 9.12%	4-Year Average of FY 03-04 through FY 06-07 4.33%	The last three years have demonstrated strong positive growth in per capita. Given the level of current year-to-date actual expenditures, the Department anticipates that this trend will continue through FY 07-08. However, the Department believes that per capita growth in the most recent year is more influenced by sharply declining caseload than by actual increases in utilization (although utilization is still a factor). Further, this eligibility category has not demonstrated the propensity for sustained long term growth more than a few years. Therefore, the Department has selected a more moderate trend for FY 08-09.
Foster Care	2-Year Average of FY 05-06 through FY 06-07 5.33%	2-Year Average of FY 05-06 through FY 06-07 5.33%	Per capita costs increased significantly in FY 06-07, which differs from recent history in this category. A comparison of expenditure between the first and second halves of FY 06-07 indicates that growth may be slowing from the FY 06-07 level. Therefore, the Department has selected a short-term growth factor below the FY 06-07 level.
Baby Care Program - Adults (BCKC-A)	Year-to-Date Per Capita change -1.50%	Half of 5-Year Average of FY 00-01 through FY 04-05 2.47%	Year-to-date expenditure indicates that per capita cost for this population will be below the final FY 06-07 per capita cost. This is largely due to the variable timing of presumptive eligibility payments. The implementation of presumptive eligibility added a degree of uncertainty to the timing of payments for these clients. Therefore, the Department anticipates that the year-to-date trend will be the most accurate estimate of final FY 07-08 expenditure. As the presumptive eligibility program is incorporated fully into the Department's claims system, the Department estimates that payment variations will abate, and this aid category will return to moderate per capita growth.

Aid Category	FY 07-08 Acute Care Trend Selection	FY 08-09 Acute Care Trend Selection	Justification
Non-Citizens	30.00%	5.00%	This aid category receives emergency services and prenatal care only. Long term trends in this aid category are affected by policy changes, and may not be indicative of future trends. During the previous fiscal year, caseload has seen a dramatic decrease, while expenditure and the number of utilizers has remained relatively flat. It appears that this is a one-time correction to the caseload in this category. The trend factors for this category are very varied, and are not expected to provide a good indicator for FY 06-07. Therefore, a fixed trend of 30.00% was chosen, based on current year-to-date expenditure, showing a slight decrease in overall expenditure. For FY 08-09, the Department anticipates that per capita growth will return to a more moderate level, as caseload variations level off.
Partial Dual Eligibles	Twice the Year-to-Date Per Capita change 1.46%	FY 07-08 Trend 1.46%	Expenditure in this category is primary for Medicare co-insurance. Prior to FY 06-07, caseload increased sharply without a corresponding increase in expenditure, causing a per capita increase. In FY 06-07, expenditure increased significantly, possibly as a result of clients becoming more familiar with available benefits as a dual-eligible. Expenditure between the second half of FY 06-07 and the first half of FY 07-08 has declined, but year-to-date per capita costs indicate that cost per client has grown. Growth has been modest, but an analysis of expenditure leads the Department to believe that expenditure will continue to increase in the second half of the fiscal year. The Department anticipates that this level of per capita growth will continue in FY 08-09.

Legislative Impacts and Bottom Line Adjustments

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

- SB 04-206 directed the Department to implement a pediatric hospice program. Entry into the program must be approved by single entry point agencies. The Department received approval from the Centers for Medicare and Medicaid Services to add a pediatric hospice effective January 1, 2008. The bottom line impact in FY 07-08 and FY 08-09 reflects the estimated acute care savings of the waiver benefit.
- HB 05-1015 added an outpatient substance abuse benefit, which began July 1, 2006. The bottom-line impact in FY 07-08 reflects the annualization of the expected savings from the program.
- HB 06-1385 provided rate increases to home health providers effective April 1, 2007. The bottom-line impact in FY 07-08 reflects the annualization amount funded in SB 07-239.
- SB 06-165 authorized the Department to implement treatment via telemedicine. Telemedicine services began in October 2007. The bottom-line impact in FY 07-08 reflects only the transmission costs of the program.
- SB 06-165 also added funding for a telemedicine disease management program. The disease management programs began in July 2007. The bottom-line impact in FY 07-08 reflects the savings to Acute Care as a result of the disease management program. Costs for the disease management program are included in Exhibit I. The bottom-line impact in FY 08-09 reflects the annualization amount.
- HB 07-1021 authorized the Department to implement a medication management program. The program is scheduled to start January 1, 2008. The bottom-line impact in FY 07-08 reflects the estimated savings of the program. The bottom-line impact in FY 08-09 reflects the annualization amount.
- SB 07-239 appropriated rate increases to certain provider types, including inpatient hospitals, and select physician and other medical services. The bottom-line impact in FY 07-08 reflects the estimated cost of those rate increases.
- The estimated costs of adjusting of claims paid to certain rural health centers which occurred in FY 06-07. The bottom-line impact for FY 07-08 reflects the annualization of the impact.
- The estimated savings from performing additional audits on hospitals and FQHCs (FY 07-08 Base Reduction Item 1), funded in SB 07-239 and starting July 1, 2007. The bottom-line impact for FY 07-08 reflects the savings from the additional audits.
- The estimated managed care incentive payment funded in SB 07-239. The bottom-line impact for FY 07-08 reflects the estimated payment amount.
- The estimated savings from the implementation of a preferred drug list, established pursuant to Executive Order 004 07 and funded in SB 07-239. The bottom-line impact for FY 07-08 reflects the estimated savings that were assumed during Figure Setting. The bottom-line impact in FY 08-09 reflects the annualization amount.[1]
- The estimated costs associated with administration of the human papillomavirus vaccine. The bottom-line impact in FY 07-08 reflects only the costs of physician visits required to receive the vaccine, as the vaccine is assumed to be covered under the federal Vaccines for Children program.

[1] As described in Section V, this total does *not* reflect the actual savings for the program. See Section V for further details.

- The estimated costs of raising health maintenance organization rates to 100% of fee-for-service costs.

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

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

Per Capita Cost
In the Department's November 1, 2006 Budget Request, the Department observed that the expenditure and per capita costs in FY 05-06 grew at an unexpected rate. The Department has investigated the issues involved, and determined that the total expenditure in FY 05-06 contained a large amount of retroactive transactions, causing the expenditure for FY 05-06 to appear overstated. Further research revealed that these retroactive transactions ceased in June 2006. Additionally, the Department implemented additional system changes to properly record expenditure for clients enrolled in the program in March 2006.

As such, the Department uses only the most recent expenditure history to forecast the per capita for this program. The Department has used monthly program costs from April 2006 through June 2007 to estimate the per capita costs for eligible clients. All monthly costs are as reported in the Department's monthly report to the Joint Budget Committee on the Health Care Policy and Financing Medical Services Premiums Expenditures and Medicaid Caseload (footnote 20 of HB 06-1385), with the exception of June 2006. Because of the last retroactive payment, June 2006 is calculated from data in the Medicaid Management Information System. The Department used the monthly caseload for the program (presented in Exhibit B) to calculate a monthly per capita, and calculated a trend factor by using the average percent change between the rolling 3-month averages. Because this factor is the average increase for each 3-month period, the Department multiplied the factor by 4 to obtain a full-year trend factor. This trend factor is applied to the base per capita on page EF-3. Only the final per capita costs for each year are listed on page EF-6.

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

Per 25.5-5-308 (9) (b) and (c), C.R.S. (2007), some state funding for "traditional" Medicaid Breast and Cervical Program clients comes from the Breast and Cervical Cancer Prevention and Treatment Fund. In FY 07-08, 25% of state funding (8.75% of total funding) comes from the Breast and Cervical Cancer Prevention and Treatment Fund. In FY 08-09, no explicit requirement exists for funding from the Breast and Cervical Cancer Prevention and Treatment Fund; therefore, the Department assumes that all state funding will come from the General Fund. Per 24-22-117 (2) (d) (II), C.R.S. (2007), state funding for clients who have gained eligibility due to the Health Care Expansion Breast and Cervical Cancer Program comes from the Prevention, Early Detection, and Treatment Fund.

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

Antipsychotic Drugs Projection (Page EF-7 through EF-8)

Antipsychotic drugs were moved from the Department's premium line to the Department of Human Services for FY 01-02. For FY 03-04, the General Assembly removed antipsychotic drugs from the Department of Human Services' portion of the budget and located those costs within the Medical Services Premiums line item of the Department. These expenditures are now included in the Acute Care service group, within the Pharmaceutical Drug service category. Exhibit F, page EF-6 through EF-7, is a rough projection of antipsychotic drug expenditures for the current year and the request year. This projection is done only for this service category because it is necessary to establish the informational line item under the Medicaid Mental Health Community Programs Long Bill group. The Department urges much caution in reviewing this exhibit, as trending on service category has proven unstable over time. Also note that technically these dollars are doubled-counted, albeit as Cash Funds Exempt, in the Medicaid Mental Health Community Programs Long Bill group. The most important observation in this area is that the growth in antipsychotics continues to grow well beyond other service categories in Medicaid.

Sharp declines in expenditure were experienced as a result of the implementation of the Medicare Modernization Act of 2003, as antipsychotic drugs are covered under the Medicare Part D benefit. For aid categories affected by the Part D benefit, trend factors in FY 05-06 and FY 06-07 are skewed by the large drop in expenditure. Therefore, for OAP-A, OAP-B, and AND/AB, FY 07-08 Pre-Rebate Expenditures are calculated utilizing FY 06-07 pre-rebate actuals, increased by the average percentage change in pre-rebate expenditures between FY 03-04 and FY 04-05. For other aid categories, FY 06-07 pre-rebate actuals are inflated by the average percentage change in pre-rebate expenditures between FY 05-06 and FY 06-07. The percentage increases are held constant in FY 08-09.

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

Pursuant to 25.5-5-103 (3), C.R.S. (2007), Colorado opted to provide prenatal care at its sole expense for certain non-citizens (legal immigrants not eligible for full Medicaid). SB 03-176 eliminated this service for legal immigrants, however due to legal challenges, there was no interruption in services. HB 05-1086 officially reinstated the services. The Department receives a 50% federal match for any emergency services provided for these clients, in particular, labor and delivery. Effective with the November 1, 2006 Budget Request, the Department has revised its reporting of expenditure. In Budget Requests prior to FY 06-07, the Department's exhibit incorrectly listed the state-only portion of expenditure as the total amount spent on the program.

The FY 07-08 and FY 08-09 estimated expenditures are calculated by trending the FY 06-07 total expenditure by 12.84%. Although the Department experienced sharp declines in expenditure in FY 05-06 and FY 06-07, an analysis of monthly expenditure reveals that total expenditure has been increasing since a low point in April 2006. In order to calculate a trend factor, the Department applied a rolling 6-month average to monthly expenditures and selected a trend factor based on the average percent change in the rolling average over the most recent 6 periods. This incorporates the most recent 12 months of data.

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

Certain services that are family planning in nature are eligible for 90% federal financial participation. However, in order to claim the enhanced match, the State must be able to uniquely identify these services. The services are provided through fee-for-service and beginning in late FY 01-02, the Department was able to identify those family planning services provided by health maintenance organizations. Therefore, the State receives the enhanced match on all family planning services provided to Medicaid clients. A portion of the payments, $2,311,115, were disallowed due to family planning activities that did not qualify for enhanced federal financial participation, resulting in a repayment of federal funds to the federal government in FY 04-05. Totals listed on page EF-10 are taken directly from the Department's requests from the Centers for Medicare and Medicaid Services for enhanced federal funds.

In prior Budget Requests, calculations for fee-for-service and health maintenance organizations were done independently. However, due to changes in the Department's managed care program, the totals have been combined and a single combined estimate has been produced. The total estimate for FY 07-08 and FY 08-09 is based on the average yearly percentage change from FY 04-05 to FY 06-07, 2.00%.

As of FY 05-06, The Department no longer has any contingency-fee based contracts to calculate the managed care portion of the enhanced family planning match rate. This calculation is now done by the Department.

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

As an additional reasonableness check, this section uses fiscal year-to-date actuals through December 31, 2007 to estimate an FY 07-08 per capita. To avoid double counting, year-to-date expenditure is reduced by the estimated amount of bottom-line impacts that have affected the year-to-date expenditure total. Year-to-date average caseload for this exhibit has been taken from Exhibit B of this request. The calculated per capita is a rough estimate; the half-year per capita is calculated and doubled. Expenditure for the full year is estimated by taking the final projected caseload from Exhibit B and multiplying by the estimated full year per capita. The per capita figure calculated in this exhibit is compared to the FY 06-07 per capita, to provide an estimate of how eligibility categories are trending over the course of the year.

The Department urges extreme caution when using the per capita costs calculated in this exhibit. This is a rough projection utilizing year-to-date expenditure patterns as a guide to predict future expenditures. The impact of one-time expenses, or considerations of seasonality are not included. It is not meant to replace the extensive forecasting used in the official Budget Request and is not always a predictor of future expenditures.

EXHIBIT G - COMMUNITY BASED LONG TERM CARE

The increased emphasis on utilizing community based services has served to keep the census in Class I nursing facilities relatively flat. In FY 81-82, with the implementation of the first wave of home and community based service waivers, Class I nursing facility census was over 12,500 clients. Almost immediately, the census dropped to just over 10,000 clients. The census has generally remained in this range despite nearly 1.2% increases in Medicaid caseload for elders since FY 97-98. In response to budget balancing in FY 02-03, rules were passed by the Medical Services Board to improve utilization management, which resulted in a reduction of per capita spending. Among these changes, the Department clarified the requirements necessary to meet the level of care required to qualify for nursing facility care or Home and Community Based Services. In addition, a requirement was added that in order to be eligible for Long Term Home Health, a client 18 years and over had to meet the level of care. Although home health costs are in the Acute Care portion of the Premiums calculation, long term home health costs do correlate to community based long term care costs. High cost clients in the community were reviewed by Single Entry Points and transitioned to less expensive alternatives if their care plans and services did not assure that all services being provided were required. The assessment, which was a functional assessment to determine whether a client meets the long term care level of care, was redone with the help of providers, Single Entry Points, and clients. Responsibilities were shifted to ensure that Single Entry Points are the primary entities through which clients access long term care. Additionally, responsibilities required Single Entry Points to have tools and the authority to act as gatekeepers for long term care benefits. Federal requirements were more completely enforced, ensuring that clients regularly receive Home and Community Based Services waiver services in order to retain eligibility for the waiver.

Calculation of Community Based Long Term Care Expenditure (Page EG-1 through EG-4)

The per capita percent change for several different years is computed for each eligibility category on a per capita cost basis. The period of time that was selected for computing the trend or annual rate of change was FY 00-01 through FY 06-07. Prior year information is provided for historical reference. This period was selected for two reasons: first, it is a recent period and second, because Medicaid benefits over this period have remained mostly the same. At the top of page EG-2, the Department has provided a list of historic trends. Included are 2-year, 3-year, 4-year, and 5-year trends, ending in FY 03-04, FY 04-05, FY 05-06, and FY 06-07. Typically, the same percentage selected to modify current year per capita costs were used to modify the request year per capita costs. This method was not utilized in all cases for the FY 08-09 Request.

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

The table below describes the trend selections for FY 07-08 and FY 08-09. In most cases, though not all, the Department has held the trend constant between the two years. On Exhibit G, the selected trend factors have been bolded for clarification.

The selected trend factors for FY 07-08 and FY 08-09, with the rationale for selection, are as follows:

Aid Category	FY 07-08 Community Based Long Term Care Trend Selection	FY 08-09 Community Based Long Term Care Trend Selection	Justification
Adults 65 and Older (OAP-A)	2-Year Average of FY 04-05 through FY 05-06 2.54%	3-Year Average of FY 03-04 through FY 05-06 5.02%	FY 06-07 experienced a very large per capita growth rate; however, this growth is largely due to the rate increases appropriated by the General Assembly in April and July 2006, and April 2007. The Department has selected a period of relative stability to use as a trend factor in order to avoid double-counting the impact of the recent rate increases. Because enrollment in the Department's Elderly, Blind, and Disabled waiver is increasing, the Department anticipates that base growth in this category will remain strong for the request years.

Aid Category	FY 07-08 Community Based Long Term Care Trend Selection	FY 08-09 Community Based Long Term Care Trend Selection	Justification
Disabled Adults 60 to 64 (OAP-B)	2-Year Average of FY 03-04 through FY 04-05 1.68%	2-Year Average of FY 03-04 through FY 04-05 1.68%	FY 06-07 experienced a very large per capita growth rate; however, this growth is largely due to the rate increases appropriated by the General Assembly in April and July 2006, and April 2007. FY 05-06 is excluded from the trend because of large per capita growth which appears to be a one-time shift in expenditure patterns. The Department anticipates that this category will return to a more stable trend for the request years.
Disabled Individuals to 59 (AND/AB)	3-Year Average of FY 03-04 through FY 04-05 2.60%	3-Year Average of FY 03-04 through FY 04-05 2.60%	FY 06-07 experienced a very large per capita growth rate; however, this growth is largely due to the rate increases appropriated by the General Assembly in April and July 2006, and April 2007. After rate increases, this category in particular experienced sustained monthly expenditure growth, as opposed to a one-time expenditure shift. This will translate into large per capita growth in FY 07-08, even if the growth abates. The low base growth rate still yields a large per capita increase when bottom line impacts are included. The Department anticipates that base growth will remain stable in FY 08-09.
Categorically Eligible Low-Income Adults (AFDC-A)	0.00%	0.00%	Clients in this eligibility category are not generally eligible for community based long term care benefits except hospice care, although there tends to be some expenditure in waiver services. This is due to clients incurring costs before their aid category changes to AND/AB. Because of the uncertain nature of expenditure in this aid category, per capita trends are unreliable. At present, the Department anticipates expenditure to hold constant in this Budget Request.

Aid Category	FY 07-08 Community Based Long Term Care Trend Selection	FY 08-09 Community Based Long Term Care Trend Selection	Justification
Expansion Adults	0.00%	0.00%	Clients in this eligibility category are not generally eligible for community based long term care benefits except hospice care, although there tends to be some expenditure in waiver services. This is due to clients incurring costs before their aid category changes to AND/AB. Because of the uncertain nature of expenditure in this aid category, per capita trends are unreliable. At present, the Department anticipates expenditure to hold constant in this Budget Request.
Breast & Cervical Cancer Program	0.00%	0.00%	Clients in this eligibility category are not eligible for community based long term care benefits.
Eligible Children (AFDC-C/ BCKC-C)	AND/AB 3-Year Average of FY 03-04 through FY 04-05 2.60%	AND/AB 3-Year Average of FY 03-04 through FY 04-05 2.60%	Eligible Children only receive private duty nursing and hospice care. Because a very small number of clients receive services, per capita trends are skewed by changes in caseload, and are unreliable. Eligible children using community based long term case services are similar to children in the disabled population, and so the trend from the Disabled Individuals eligibility category is appropriate.
Foster Care	2-Year Average of FY 05-06 through FY 06-07 1.57%	2-Year Average of FY 05-06 through FY 06-07 1.57%	Foster care children only receive private duty nursing and hospice care. Only a very small number of clients receive services. However, expenditure in this aid category has been relatively constant since FY 05-06. Therefore, the Department has selected a trend factor based on the most recent two years of actuals.

Aid Category	FY 07-08 Community Based Long Term Care Trend Selection	FY 08-09 Community Based Long Term Care Trend Selection	Justification
Baby Care Program - Adults (BCKC-A)	0.00%	0.00%	Clients in this eligibility category are not eligible for community based long term care benefits.
Non-Citizens	0.00%	0.00%	Clients in this eligibility category are not eligible for community based long term care benefits.
Partial Dual Eligibles	150.00%	OAP-A 3-Year Average of FY 03-04 through FY 05-06 5.02%	Clients in this eligibility category are not eligible for community based long term care benefits. In some cases, however, clients who are eligible for these services are incorrectly being assigned to this aid category. This began in January 2007, and appears to be abating. Clients receiving these services are generally eligible for OAP-A. Therefore, the Department assumes a per capita growth factor in line with current year-to-date expenditure for FY 07-08, and the same factor as OAP-A clients in FY 08-09.

Legislative Impacts and Bottom Line Adjustments

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

- SB 04-177 added a waiver benefit for children with autism. Services started in April 2007. The bottom-line impact in FY 07-08 reflects the estimated cost of the waiver benefit.
- SB 04-206 directed the Department to implement a pediatric hospice program. Entry into the program must be approved by single entry point agencies. The Department received approval from the Centers for Medicare and Medicaid Services to add a pediatric hospice effective January 1, 2008. The bottom line impact in FY 07-08 and FY 08-09 reflects the estimated cost of the waiver benefit.

- HB 05-1243 directed the Department to add consumer directed care as a benefit to its Home and Community Based Waiver programs. This option is expected to begin January 1, 2008. The bottom-line impact in FY 07-08 is the estimated savings expected to be generated by the program. The bottom-line impact for FY 08-09 is the annualization amount.
- HB 06-1369 provided rate increases for certain home and community based services. Rate increases for the HCBS – Consumer Directed Attendant Support waiver program was applied in February 2007. The bottom-line impact in FY 07-08 is the annualization amount funded in SB 07-239.
- HB 06-1385 provided rate increases for certain home and community based services. Rate increases were effective April 1, 2007. The bottom-line impact in FY 07-08 is the annualization amount funded in SB 07-239.
- SB 07-239 provided a 1.5% cost of living increase to home and community based services. Rate increases were effective July 1, 2007. The bottom-line impact in FY 07-08 is the amount funded in SB 07-239.

Year-to-Date Expenditure (Page EG-4)

As an additional reasonableness check, this section uses fiscal year-to-date actuals through December 31, 2007 to estimate an FY 07-08 per capita. To avoid double counting, year-to-date expenditure is reduced by the estimated amount of bottom-line impacts that have affected the year-to-date expenditure total. Year-to-date average caseload for this exhibit has been taken from Exhibit B of this request. The calculated per capita is a rough estimate; the half-year per capita is calculated and doubled. Expenditure for the full year is estimated by taking the final projected caseload from Exhibit B and multiplying by the estimated full year per capita. The per capita figure calculated in this exhibit is compared to the FY 06-07 per capita, to provide an estimate of how eligibility categories are trending over the course of the year.

The Department urges extreme caution when using the per capita costs calculated in this exhibit. This is a rough projection utilizing year-to-date expenditure patterns as a guide to predict future expenditures. The impact of one-time expenses, or considerations of seasonality are not included. It is not meant to replace the extensive forecasting used in the official Budget Request and is not always a predictor of future expenditures.

EXHIBIT H - LONG TERM CARE AND INSURANCE SERVICES

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

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

- Health Insurance Buy-In

Summary of Long Term Care and Insurance Request (Page EH-1)
This exhibit summarizes the total requests from the worksheets within Exhibit H.

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

Overall, patient days have declined since FY 99-00, although caseload in the Department's Adults 65 and Older, Disabled Adults 60 to 64, and Disabled Individuals to 59 eligibility categories has increased by approximately 8.3% (through the estimated FY 07-08 total) since that year. This is due to efforts by the Department to place clients in Home and Community Based Services (HCBS), and in the Department's Program for All-Inclusive Care for the Elderly (PACE). Patient days began to increase again in FY 04-05, but the growth apparently ceased in FY 06-07.

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

Because the request for Class I Nursing Facilities is calculated on a date-of-service basis and adjusted to reflect the cash-basis of Medical Services Premiums, reported statistics (such as per diem and patient days) in each Budget Request as estimates of incurred but not reported claims are replaced with actual expenditure. Therefore, totals in this Budget Request will not match totals reported previously for recent periods.

For complete information regarding specific calculations, the footnotes in pages EH-3 through EH-5 describe calculations of individual components. The methodology for the Class I request in Exhibit H is as follows[2]:

[2] For clarity, FY 07-08 figures are used as an example. The estimate for FY 08-09 is based on the estimate for FY 07-08, and follows the same methodology.

- The Department received information from its nursing facility cost-report auditor, Myers and Stauffer, to estimate the FY 07-08 per diem allowable Medicaid rate. This rate is based on a weighted average of nursing facility rates, before the impact of HB 07-1183 is considered. The estimated per diem allowable Medicaid rate is $170.03.
- Using historic claims data from the Medicaid Management Information System (MMIS), the Department calculates the estimated patient payment of $30.20 for claims that will be incurred in FY 07-08. The difference between the estimated per diem rate and the estimated patient payment, $139.83, is an estimate of the amount the Department will reimburse nursing facilities per day in FY 07-08.
- Using the same data from above, the Department calculates the estimated number of patient days for FY 07-08, a total of 3,500,696 days.
- The product of the estimated Medicaid reimbursement per day and the estimated number of patient days yields the estimated total reimbursement for claims incurred in FY 07-08, $489,502,322.
- Of the estimated total reimbursement for claims incurred in FY 07-08, only a portion of those claims will be paid in FY 07-08. The remainder is assumed to be paid in FY 08-09. The Department estimates that 91.94% of claims incurred in FY 07-08 will also be paid during FY 07-08. Footnote 5 of Exhibit H, details the calculation of the percentage of claims that will be incurred and paid in FY 07-08. The total amount estimated to be paid in FY 07-08 for claims incurred in FY 07-08 ("current year claims") is $450,060,950.
- During FY 07-08, the Department will also pay for some claims incurred during FY 06-07 ("prior year claims"). In Footnote 6 of Exhibit H the Department estimates the total amount of outstanding claims to be paid in FY 07-08, $38,576,920.
- The sum of the current year claims and the prior year claims, $488,637,870, is the estimated expenditures in FY 07-08 prior to adjustments ("gross budget estimate").
- Other non-rate factors are then added or subtracted from the gross budget estimate. These include the hospital backup program and out of state placements, estimated estate and income trust recoveries, and recoveries from Department overpayment reviews. Information and calculations regarding these adjustments are contained in the footnotes for the Class I Nursing Facilities request, on pages EH-3 through EH-6.
- Legislative impacts are added as bottom line adjustments. For FY 07-08, this includes HB 07-1183, which established the Nursing Facility Grant Rate Program. For a detailed discussion of bottom-line impacts, see the narrative for the Department's reasonableness projection for Class I Nursing Facilities, located below.
- Once the "non-rate" factors are estimated, the sum of the gross budget estimate and the non-rate adjustments yields the total estimated FY 07-08 expenditure, $486,319,414.

For FY 08-09, the same methodology is applied, taking into account the estimate for FY 07-08.

Legislative Impacts and Bottom Line Adjustments

To account for programmatic changes which are not incorporated in the prior per capitas or trend factors, the Department adds total-dollar bottom-line impacts to the projected expenditure. For complete information on legislative impacts, see section V, Additional Calculation Considerations. The following impact has been included in the Class I Nursing Facilities request:

- HB 07-1183 established the Nursing Facility Grant Rate Program, which increases the rates of providers whose rates decreased as a result of the end of the rate floor provision established in SB 06-131. The total amount appropriated for the Nursing Facility Grant Rate Program is $397,000. No funding exists for FY 08-09.

Summary of FY 07-08 and FY 08-09 Request

FY 07-08 Request	**Amount**
Estimated Expenditures for Claims Paid in Current Year with Current Year Dates of Service	$450,060,950
Estimated Expenditures for FY 06-07 Dates of Service	$38,576,920
Estimated Expenditures in FY 07-08 Prior to Adjustments	**$488,637,870**
Adjustments	($2,318,456)
Total Estimated FY 07-08 Expenditures	**$486,319,414**
FY 08-09 Request	**Amount**
Estimated Expenditures for Claims Paid in Current Year with Current Year Dates of Service	$468,197,808
Estimated Expenditures for FY 07-08 Dates of Service	$39,441,372
Estimated Expenditures in FY 08-09 Prior to Adjustments	**$507,639,180**
Adjustments	($2,120,450)
Total Estimated FY 08-09 Expenditures	**$505,518,730**

Incurred But Not Reported Adjustments

As part of the estimates for the allowable per diem rate, patient payment, and patient days, the Department utilizes the most recent 4 years of incurred claims to calculate estimates for the current year and the request year. However, because not all claims which have been incurred have been reported, the Department must adjust the incurred data for the expected incidence of claims which will be paid in the future for prior dates of service. Without such an adjustment, the claims data would appear to drop off at the end of the year, erroneously introducing a negative trend into the estimate.

The Department uses an extensive model which examines past claims by month of service and month of payment to estimate the amount of claims which will be paid in the future. This is known as an "Incurred But Not Reported" (IBNR) adjustment. The IBNR adjustments analyze the prior pattern of expenditure (specifically, the lag between the time past claims were incurred and when they were paid), and applies that pattern to the data. This enables the Department to use its most recent data, where there is a significant volume of claims which have yet to be paid.

Separate IBNR adjustment factors are calculated for each month, based upon the number of months between the time claims in that month were incurred and the last month in the data set. These adjustments are applied to the collected data, and the Department calculates the estimate of nursing facility expenditure using the methodology described above. This adjustment is most apparent in the Department's estimate of claims paid in the current year for current year dates of service, particularly footnotes 5 and 6 of Exhibit H. In these footnotes, the Department uses the calculated monthly IBNR adjustment factors to estimate the percentage of claims in FY 06-07 which will pay in FY 07-08, and the percentage of claims incurred in FY 07-08 which will be paid in FY 08-09.

The Department has updated its IBNR adjustment calculation from the November 1, 2007 Budget Request, using paid claims data through November 2007.

Nursing Facility Rate Methodology Changes

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

FY 97-98	8% Health Care Cap and 6% Administrative Cap Implemented
FY 98-99	No change
FY 99-00	8% Health Care Cap temporarily removed and Case Mix Cap Implemented
FY 00-01	No change
FY 01-02	8% Health Care Cap permanently removed and Quality of Care Incentive Program / Resident Centered Quality Improvement Program discontinued
FY 02-03	Administrative Incentive Allowance removed for three months then reinstated
FY 04-05	8% Health Care Cap reinstated
FY 05-06	No change
FY 06-07	8% Health Care Cap removed for facilities with an average annual Medicaid resident census that exceeds 64% of the number of actual residents in that facility for that same period. Established a rate floor of 85% of the statewide average rate, or 110% of the facility's current year rate, whichever is lower (SB 06-131). Provisions from SB 06-131 are applicable for FY 06-07 only.

FY 07-08 Established the Nursing Facility Grant Rate Program (HB 07-1183). Providers affected by the end of provisions implemented in SB 06-131 are given additional funding to mitigate the impact of the end of the rate floor.

Class I Nursing Facilities – Cash Based Actuals and Totals by Aid Category (Pages EH-7)

This exhibit has changed since the Department's February 15, 2007 Budget Request. Previously, the Department performed a separate projection of Class I Nursing Facilities expenditure using a per capita-based methodology. However, because that projection was not utilized in the final request, the Department no longer includes it in the official Budget Request. For comparison purposes to other service categories, this exhibit lists prior year expenditure along with the projected expenditure from page EH-2. Estimated totals by aid category are split proportionally to the most recent year of actual expenditure. Additionally, the Department calculates per capita costs for each year.

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

Class II Nursing Facilities (Page EH-9)

This service category is for specialized private nursing facility care for developmentally disabled clients, which was the focus of the Department of Human Services' initiative to deinstitutionalize these clients by placing them in appropriate care settings. The deinstitutionalization strategy was completed in April of FY 97-98. Beginning of FY 98-99, the service category was limited to one facility, Good Shepherd Lutheran. There are no plans to eliminate this facility as it essentially functions more like a group home than an institutional facility.

At the end of FY 05-06, Good Shepherd Lutheran increased its enrollment from 16 clients to 20 clients. During FY 06-07, the census at this facility has remained constant, and there is no expectation that there will be a further change in enrollment at this facility. Additionally, this facility received an annual cost-based rate adjustment, similar to class I nursing facilities. As a result, this service category has experienced expenditure growth that differs sharply from any recent year. Therefore, in order to project expenditure for this category, the Department calculated the projected expenditure for FY 07-08 as the total expenditure in each aid category multiplied by the percent change in total expenditure from FY 04-05 to FY 05-06. Because all clients are paid the same rate regardless of aid category, it is anticipated that change in expenditure per aid category will only change if enrollment varies by aid category. However, total expenditure would still remain the same; therefore, differences between aid categories are less relevant. The Department holds this estimated percent increase constant for FY 08-09.

Program Of All-Inclusive Care For The Elderly (PACE) (Page EH-12)

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

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

To better forecast expenditure, the Department has provided two new metrics on page EH-12: average monthly enrollment, and average cost per enrollee. The average monthly enrollment is based on the number of distinct clients for whom capitations were paid to PACE providers in each fiscal year, as determined by claims information from the Medicaid Management Information System. The average cost per enrollee is the total expenditure divided by the average monthly enrollment for each fiscal year.

The FY 07-08 projection for PACE is computed in several parts: First, the Department estimates the growth in the average cost per enrollee, and applies the selected trend factor to the FY 06-07 average cost per enrollee. Second, the Department estimates the growth in the average enrollment, and applies the selected trend factor to the FY 07-08 average enrollment. The estimated cost per enrollee and estimated enrollment are multiplied to calculate the estimated FY 07-08 base expenditure. Then, the Department adjusts for any bottom line impacts not incorporated in the trend (described below). The sum of the base expenditure and the bottom line adjustments is the estimated FY 07-08 total expenditure. FY 08-09 is calculated in the same fashion.

To estimate the increase in enrollment, the Department selected the average percent increase in enrollment between FY 04-05 through FY 05-06 for Adults 65 and Older, 11.06%, and the percent increase in total Disabled Adults 60 to 64 and Disabled Individuals combined enrollment from FY 03-04 through FY 05-06, 4.81%. The Department selected a combined factor for these groups because of the similarities between the populations.

To estimate the average increase in cost per enrollee, the Department selected the average percent increase in cost per enrollee between FY 03-04 and FY 05-06 for Adults 65 and Older, 6.15%, and the combined average percent increase in cost per enrollee between FY 03-04 and FY 05-06 for Disabled Adults 60 to 64 and Disabled Individuals, 6.57%. There are several factors influencing

the decision to use a more historical period rather than recent periods. First, in FY 05-06, PACE rates were decreased to reflect implementation of the Medicaid Modernization Act. Second, in FY 06-07, due to concerns raised by the Centers for Medicare and Medicaid Services (CMS) late in the PACE rate setting process, PACE rates were not implemented until July 1, 2007, rather than January 1, 2007. Therefore, the Department feels that percent changes from FY 06-07 will not appropriately reflect future changes in cost per enrollee.

Furthermore, implementation of the July 1, 2007 PACE rates have been delayed due to concerns from the Centers of Medicare and Medicaid Services. Therefore, current year-to-date expenditure does not reflect the increase in rates that is anticipated. In preparing this February 2008 Budget Request, the Department has analyzed the probable impact of the rate increase, and believes that the per capita trends selected will adequately reflect the estimated rate increase. It must also be noted that the per capita cost is based on the actual cash-based expenditure; therefore, the per capita increases do not reflect the actual rate increase given to the provider.

The Department has received applications for additional PACE sites, and program staff indicates that two providers are projected to begin accepting clients in April 2008, serving clients in El Paso, Montrose, and Delta counties. The Department anticipates that by the end of FY 07-08, approximately 40 clients will be enrolled in the new programs. For calculation purposes, this reflects an average monthly caseload of 7 clients. In FY 08-09, the Department anticipates that approximately 185 clients will be added to PACE enrollment. Further expansion is anticipated in FY 09-10; as expansion information becomes known, the Department will adjust its Budget Requests accordingly.

Legislative Impacts and Bottom Line Adjustments
Adjustments to FY 07-08 and FY 08-09 include the following:

- In FY 05-06, the Department reached a settlement agreement with its PACE provider to correct for instances where the incorrect rate was paid for clients. During FY 05-06, the Department recouped $1,462,091. In FY 06-07, the Department recouped the outstanding amount of $350,902. Because of the nature of this recoupment, these are one-time payments to the Department. The Department has adjusted the FY 07-08 estimates as bottom-line adjustments by adding a bottom line adjustment reversing the impact of the estimated FY 06-07 collection.

- In FY 07-08, the PACE rates will be adjusted to include the rate increases provided to Acute Care and Community Based Long Term Care services in HB 06-1369 and HB 06-1385. These rate increases would have been applied on January 1, 2007, however the delay imposed by the Centers for Medicare and Medicaid Services in setting new rates has pushed this impact back to July 1, 2007, effective with new PACE rates. The original estimates for HB 06-1369 and HB 06-1385 did not include an impact for PACE. This is a bottom-line impact for $629,975.

The sum of the bottom line impacts to PACE increases the estimated FY 07-08 projection by $980,877. The revised estimated FY 07-08 PACE total is $50,206,132.

No bottom line impacts have been included for FY 08-09. The estimated FY 08-09 PACE total is $ $59,563,633.

Supplemental Medicare Insurance Benefit (Page EH-16)

The Supplemental Medicare Insurance Benefit (SMIB) consists of two parts: Medicare Part A, the insurance premium for hospital care and Medicare Part B, the insurance premium for Medicare-covered physician and ambulatory care services. Only premiums are paid in this service category; co-payments and deductibles are paid under Acute Care. Medicaid clients who are dual-eligible (clients have both Medicaid and Medicare coverage) or Partial Dual Eligibles receive payment for Medicare Part B, and in some cases, Medicare Part A. The Partial Dual Eligibles aid category has two distinct groups: Qualified Medicare Beneficiaries and Specified Low-Income Medicare Beneficiaries. The Part A premium payments are made for a small subset of the Qualified Medicare Beneficiary eligibility group only.[3] The Supplemental Medicare Insurance Benefit service category includes the estimate of payments for both Part B for all Medicare beneficiary client types, and Part A payments for Qualified Medicare Beneficiary clients. Premiums for Medicare are not federally matchable for clients who do not meet the Supplemental Security income limit.

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

Expenditure in this service category is related to two primary factors: the number of dual-eligible clients, and the increase in the Medicare premiums. For reference, the historical increases in the Medicare premiums are listed in the table below:[4]

[3] Most Medicare beneficiaries do not make a Part A payment, because they have contributed to Medicare for 40 or more quarters during their working life. The Department only subsidizes Part A payments for Qualified Medicare Beneficiaries who do not meet the 40 quarter requirement.
[4] Premium information taken from the Centers for Medicare and Medicaid Services, http://www.medicare.gov/MedicareEligibility/Home.asp?dest=NAV|Home|GeneralEnrollment|PremiumCostInfo#TabTop

Medicare Premiums				
Calendar Year	**Part A**	% Change	**Part B**	% Change
2003	$316.00		$58.70	
2004	$343.00	8.54%	$66.60	13.46%
2005	$375.00	9.33%	$78.20	17.42%
2006	$393.00	4.80%	$88.50	13.17%
2007	$410.00	4.33%	$93.50	5.65%
2008	$423.00	3.17%	$96.40	3.10%

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

The Department has adjusted the methodology to forecast this benefit from prior years. To forecast FY 07-08, the Department inflates the expenditure from the first half of FY 07-08 by the known increase in the Part B premium on January 1, 2008. The Department adjusts current year-to-date expenditure to reflect one monthly payment which has not yet been recorded in FY 07-08. No further adjustment for caseload is made, as it is already incorporated in the first half estimate. The total estimated expenditure for FY 07-08 is the sum of the first half and second half estimates, $89,364,947.

To forecast FY 08-09, the Department first inflates the second half of FY 07-08 by the estimated caseload trend for FY 08-09 from Exhibit B, page EB-1. This figure represents the approximate expenditure for the first half of FY 08-09. Then, the Department inflates the estimated first half expenditure by the estimated increase in the Medicare premium. The total estimated expenditure for FY 08-09 is the sum of the first half and second half estimates, $94,501,821.

Health Insurance Buy-In (Page EH-19)

The Medicaid program purchases the premiums for private health insurance for individuals eligible for Medicaid if it is cost effective. This is known as the Health Insurance Buy-In (HIBI) program, permitted under 25.5-4-210, C.R.S. (2007). In recent years, HIBI expenditure has fluctuated significantly due to numerous policy and administrative changes. In particular, during FY 05-06, due to the implementation of the Medicare Modernization Act, many of the health plans that were previously cost effective became ineffective, since the costs of those health plans included a drug benefit. This caused a significant decrease in HIBI expenditure and enrollment in FY 05-06. Additionally, the Department found that, with rare exception, it was no longer cost effective to purchase commercial

insurance for clients in the Adults 65 and Older (OAP-A) aid category. Instead, the majority of expenditure was shifted to Disabled Individuals to 59 (AND/AB), for clients who do not qualify for the Medicare Part D benefit.

In FY 06-07, the Department experienced significant growth in the program, although the cause appears to be related to administrative changes rather than other factors. For example, a single outside agency has referred approximately 50 new clients to the Department for enrollment in the program. Additionally, during FY 06-07, the Department examined and upgraded the existing process to determine client eligibility for the program. This change enabled the Department to process clients more efficiently, resulting in an increase in caseload.

Because of the dramatic changes in the expenditure patterns in recent years, the Department does not believe that per capita trends are a good indicator for FY 07-08 expenditure. At the same time, the Department believes the most recent growth in expenditure is not likely to continue in the future. Total growth in FY 06-07 was 41.62%; the Department selected 20.81% to trend expenditure to FY 07-08, and 10.41% to trend expenditure to FY 08-09. The Department selected these percentages by reducing the FY 06-07 growth rate by 50% in FY 07-08, and by 50% again in FY 08-09. The Department anticipates that the growth rate will begin to moderate in the absence of additional policy changes.

EXHIBIT I – SERVICE MANAGEMENT

A new category has been set up to account for the administrative-like contract services within the Medical Services Premiums budget. The group is comprised of Single Entry Point agencies, disease management, and administrative fees for prepaid inpatient health plans.

Summary Of Service Management (Page EI-1)

This exhibit summarizes the total requests from the worksheets within Exhibit I on pages EI-2 through EI-8.

Single Entry Points (Page EI-2 through EI-4)

Single Entry Point agencies were authorized by HB 91-1287. Statewide implementation was achieved July 1, 1995. The single entry point system was established for the coordination of access to existing services and service delivery for all long-term care clients in order to provide utilization of more appropriate services by long-term care clients over time and better information on the unmet service needs of clients (25.5-6-105, C.R.S. (2007)). A single entry point agency is an agency in a local community through which persons eighteen years or older, who are in need of long-term care services, can access needed long-term care services (25.5-6-106 (3) (a), C.R.S. (2007)).

The single entry point agency is required to serve clients of publicly funded long-term care programs including nursing facility care, Home and Community Based Services (HCBS) for the elderly, blind and disabled, HCBS for persons living with acquired immune deficiency syndrome, HCBS for persons with brain injury, HCBS for persons with mental illness, long-term home health care, home care allowance, alternative care facilities, adult foster care, and certain in-home services available pursuant to the federal Older Americans Act of 1965 (Section 25.5-6-106 (2) (b), C.R.S. (2007)).

The major functions of single entry point agencies include providing information, screening and referral, assessing clients' needs, developing plans of care, determining payment sources available, authorizing provision of long-term care services, determining eligibility for certain long-term care programs, delivering case management services, targeting outreach efforts to those most at risk of institutionalization, identifying resource gaps, coordinating resource development, recovering overpayment of benefits and maintaining fiscal accountability (25.5-6-106 (2) (c), C.R.S. (2007)). Single entry point agencies also serve as the utilization review coordinator for all community based long term care services.

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

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

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

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

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

Therefore, the Department's request includes an increase to single entry point contracts. The requested increase is based on the expected increase in Home and Community Based Services (HCBS) utilization, as determined by average monthly paid enrollment in the Department's HCBS programs. These figures do not reflect the actual enrollment in HCBS programs; rather, they are based on the number of clients for whom the Department has paid a related claim during each fiscal year. This figure is therefore consistent with the Cash Accounting basis of Medical Services Premiums.

The Department has updated the figures for HCBS paid enrollment in the February 15, 2008 Budget Request. The figures presented in November 2007 erroneously excluded a number of claims.

For FY 07-08, the Department's projection uses the current amount allocated to Single Entry Points in the FY 07-08 Long Bill, and adds two legislative impacts (see below). The Department's estimate does not include any increase for service utilization for this fiscal year, as current projections for single entry point services indicate that the current budget is sufficient.

For FY 08-09, the Department estimates the increase in HCBS utilization based on the average percent change in average monthly paid enrollment from FY 03-04 through FY 06-07 for each aid category. The estimated FY 07-08 total expenditure is inflated by this percentage, and legislative impacts are added to estimate the total FY 08-09 expenditure.

FY 07-08 and FY 08-09 Legislative Impacts and Bottom Line Adjustments

To account for programmatic changes which are not incorporated in the prior per capitas or trend factors, the Department adds total-dollar bottom-line impacts to the projected expenditure. For complete information on legislative impacts, see section V, Additional Calculation Considerations. The following impact has been included in the FY 07-08 and FY 08-09 calculations for Single Entry Points:

- SB 04-206 directed the Department to implement a pediatric hospice program. Entry into the program must be approved by single entry point agencies. The Department received approval from the Centers for Medicare and Medicaid Services to add a pediatric hospice effective January 1, 2008. This is an increase of $26,338 in FY 07-08, and an increase of $79,013 in FY 08-09. These figures are calculated based on the total estimated caseload (25 clients in FY 07-08, and 75 additional clients in FY 08-09) multiplied by the current per client rate. See section V of this narrative for additional details

- HB 05-1243 allowed the Department to add consumer directed care to home and community based waiver services. These services must be approved by single entry point agencies. The Department received approval from the Centers for Medicare and Medicaid Services to add consumer directed care to the Elderly, Blind, and Disabled waiver and the Mental Illness waiver in 2007; the Department expects services to begin January 1, 2008. This is an increase of $504,187 to FY 07-08 and an increase of $504,188 to FY 08-09 (Legislative Council fiscal note for HB 05-1243, March 15, 2005).
- SB 07-239 contained rate increases for Single Entry Points. The Department was appropriated an additional $3,852,887 to the Department for the purpose of increasing the amounts paid to Single Entry Points, effective July 1, 2007 (Figure Setting, March 8, 2007, page 43).

The sum of the bottom line impacts for Single Entry Points in FY 06-07 is an increase of $4,383,412. The revised estimated FY 07-08 Single Entry Points total expenditure is $22,225,122.

The sum of the bottom line impacts for Single Entry Points in FY 08-09 is an increase of $583,201. The revised estimated FY 08-09 Single Entry Points total expenditure is $23,939,186.

Disease Management (Page EI-5)

Beginning in July 2002 the Department of Health Care Policy and Financing implemented several targeted disease management pilot programs, as permitted by HB 02-1003. Specifically, the Department was authorized "to address over- or under-utilization or the inappropriate use of services or prescription drugs, and that may affect the total cost of health care utilization by a particular Medicaid recipient with a particular disease or combination of diseases" (25.5-5-316 C.R.S. (2007)). Initially, pilot programs were funded solely by pharmaceutical companies and began and ended at different times between July 2002 and December 2004.

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

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

As a result of the pilot programs, the Department entered into permanent contracts with two disease management companies for two health conditions: clients with asthma, and clients with diabetes. For clients with asthma, the Department contracts with Alere Medical Incorporated to provide appropriate management to achieve cost-savings, reducing hospitalizations and emergency room visits. For clients with diabetes, the Department contracts with McKesson Health Solutions to provide appropriate management to achieve cost-savings, reducing hospitalizations and emergency room visits.

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

In FY 07-08, the Department replaced its diabetes management program with a congestive heart failure program. FY 07-08 disease management contracts are for a total of $627,778. The Department anticipates that these contracts will continue into FY 08-09.

Legislative Impacts and Bottom Line Adjustments

To account for programmatic changes which are not incorporated in the prior per capitas or trend factors, the Department adds total-dollar bottom-line impacts to the projected expenditure. For complete information on legislative impacts, see section V, Additional Calculation Considerations. The following impact has been included in the FY 07-08 and FY 08-09 calculations for Disease Management:

- SB 06-165 authorized the Department to implement disease management programs via telemedicine. Savings due to the program are realized in the Acute Care section of this Request. This is an increase to Disease Management of $380,928 (Legislative Council fiscal note for SB 06-165, April 24, 2006), effective July 1, 2007. The total is included in the base contracts in FY 08-09.
- HB 05-1262 provided funding for disease management programs "…that address cancer, heart disease, and lung disease" 24-22-117 (2) (d) (IV) (A) C.R.S. (2006). Statutory authority for this funding was set to expire at the end of FY 06-07; however, the Department was granted roll-forward authority for these funding in SB 07-239. This is an estimated increase to Disease Management of $3,940,776 in FY 07-08 (Legislative Council fiscal note for HB 05-1262, April 25, 2005, SB 07-239).

The sum of the bottom line impacts for Disease Management in FY 07-08 increased the estimated FY 07-08 Disease Management projection by $4,321,704. The revised estimated FY 07-08 Disease Management total expenditure is $4,949,482.

Because the bottom line impact for SB 06-165 is incorporated in the base for FY 08-09, there are no bottom line impacts for FY 08-09. The estimated FY 08-09 Disease Management total expenditure is $1,008,706.

Prepaid Inpatient Health Plan Administration (Page EI-7)

Prepaid inpatient health plans (formerly known as Administrative Service Organizations) are an alternative to traditional health maintenance organizations. They offer the case management and care coordination services of a health maintenance organization for a fixed fee. The organizations do this by not taking on the risk traditionally assumed by health maintenance organizations. The Department began using this type of organization to deliver health care to Medicaid clients during FY 03-04. The Department currently contracts with one prepaid inpatient health plan, Rocky Mountain Health Plans. In FY 05-06, the Department ended its contract with Management Team Solutions. Prepaid inpatient health plans receive a fixed amount administrative fee per client. Exhibit EI-6 depicts only the administrative fee expenditures for the Department's current contractor, including estimated cost avoidance payments. The service costs for these organizations are included in Acute Care. Because the administrative fee remains the same in FY 07-08, the Department has used actual enrollment in its current administrative service organization to forecast expenditure in FY 07-08 and FY 08-09.

In addition to an estimate for the amount of administrative fees, the Department has added bottom-line impacts for the estimated contracted cost avoidance payment to Rocky Mountain Health Plans for cost avoidance in both FY 05-06 and FY 06-07. In January 2007, the Department made a contracted payment to Rocky Mountain Health Plans for services rendered in FY 04-05, for $1,058,219. Similarly, in FY 07-08, the Department anticipates making a single contracted payment, for services rendered in FY 05-06. This figure is an estimate based on the percentage enrollment decline of 4.74%. The final payments will differ from the budgeted amount, as the Department will calculate the actual amount of cost avoidance, which may be higher or lower than the FY 04-05 level.

The FY 07-08 estimate for the prepaid inpatient health plan including cost avoidance payments is $4,598,346. The FY 08-09 estimate is $4,600,166.

EXHIBIT J - ESTIMATE OF FY 07-08 EXPENDITURE USING FY 06-07 CASH FLOW PATTERNS

This exhibit displays the FY 07-08 year-to-date expenditures through September 2007 and the cash flow pattern of actual expenditures for the first quarter of FY 06-07 to determine a rough estimate of FY 07-08 expenditures, with certain exceptions. This exhibit is a rough projection utilizing past expenditure patterns as a guide to future expenditures. The Cash Flow Pattern is one forecasting tool used to estimate final expenditures on a monthly basis. It is not meant to replace the extensive forecasting used in the official Budget Request and is not always a predictor of future expenditures.

In places where the Department does not expect the prior year cash flow pattern to be relevant to the current year, the Department has made adjustments based on knowledge of current program trends. Exceptions to the cash flow pattern are noted in footnotes on page EJ-1.

Notably, an exception to the cash flow pattern has not been made for Acute Care services. In October 2006, one of the Departments health maintenance organizations left the program, causing a large number of clients to move from managed care to fee-for-service. Therefore, cash flow patterns for health maintenance organizations are likely skewed. Additionally, because expenditures for fee-for-service categories, such as physician services, are also affected by managed care enrollment, cash flow patterns for fee-for-service categories are also likely skewed. Rather than perform a complex adjustment, for the purpose of this exhibit the Department assumes that cash flow in FY 07-08 will be constant per week.

EXHIBIT K - UPPER PAYMENT LIMIT FINANCING

The Upper Payment Limit financing methodology accomplishes the following:

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

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

Funds received through the Upper Payment Limit for outpatient hospital services are used to offset General Fund expenditures. These offsets started in FY 01-02. Similar methodologies are used for home health and nursing home premiums. While outpatient hospital services and nursing facilities account for a large portion of Upper Payment Limit funding, home health has expenditures that are relatively small by comparison, and will experience little impact relating to changes in reimbursement rates.

In FY 05-06, the Department only certified expenditure for a half year, due to a federal audit requiring the Department to certify expenditure on a calendar year basis. During Figure Setting in March 2006, the Department's FY 06-07 Base Reduction Item #2 (November 15, 2005) was approved; starting in FY 06-07, the Department will record exactly the certified amount as Cash Funds Exempt.

During FY 07-08, the Department was informed by the Centers for Medicare and Medicaid Services that it would no longer be permitted to certify public expenditure for nursing facilities. The Department is appealing this decision, but does not anticipate that a

final decision will be reached before the end of FY 07-08. Therefore, the Department does not include any totals for nursing facilities in its Request. The estimated amount of certification is still presented in Exhibit K, but is shown for information purposes only.

Projections for all provider types are provided in Exhibit K. The FY 07-08 estimate equals $13,100,710. The FY 08-09 estimate equals $13,531,089.

EXHIBIT L - APPROPRIATIONS AND EXPENDITURES

This exhibit displays the FY 06-07 final actual total expenditures for the Medical Services Premiums, including fund splits, the remaining balance of the FY 06-07 appropriation, and the per capita cost per client. The per capita cost in this exhibit includes Upper Payment Limit and financing bills. This exhibit will not match Exhibit C due to these inclusions.

EXHIBIT M – CASH BASED ACTUALS

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

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

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

Effective with the February 15, 2008 Budget Request, the Department has restated actuals for the Prepaid Inpatient Health Plan Services service category for FY 06-07. The Department has adjusted the allocation to exclude categories that did not utilize this service category. The total amount in aggregate remains the same.

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

EXHIBIT N – EXPENDITURE HISTORY BY SERVICE CATEGORY

Annual rates of change in medical services by service group from FY 95-96 through FY 06-07 final actual expenditures are included in this Budget Request for historical purpose and comparison. This exhibit has been revised to list more recent years first.

EXHIBIT O – COMPARISON OF BUDGET REQUESTS AND APPROPRIATIONS

This exhibit compares the Department's Budget Requests by broad service category to the Department's Long Bill and special bills appropriations, for FY 05-06, FY 06-07, and FY 07-08, in the chronological order of the events. Shaded areas indicate that the Request or appropriation has not yet taken place.

For FY 05-06, this exhibit compares the Department's November 1, 2004; February 15, 2005; November 15, 2005; and February 15, 2006 Budget Requests to the FY 05-06 appropriation and the FY 05-06 actuals. Actions taken by the General Assembly after the Department's February 15, 2006 Budget Request are added to the February total to ensure a comparable comparison to FY 05-06 actuals.

For FY 06-07, this exhibit compares the Department's November 15, 2005; February 15, 2006; November 1, 2006; and February 15, 2007 Budget Requests to the final FY 06-07 appropriation.

For FY 07-08, this exhibit lists the Department's November 1, 2006, February 15, 2007, November 1, 2007, and February 15, 2008 Budget Requests to the FY 07-08 appropriation and the placeholder used by the Joint Budget Committee during the Department's January 23, 2008 Supplemental Briefing.

EXHIBIT P – GLOBAL REASONABLENESS

This exhibit displays several global reasonableness tests as a comparison to the projection in this Budget Request.

EXHIBIT Q – CASELOAD GRAPHS

This exhibit is described in the Caseload Narrative.

V. ADDITIONAL CALCULATION CONSIDERATIONS

Several bills passed during the 2004, 2005, 2006, and 2007 legislative sessions affect the Department's Request for Medical Services Premiums. Additionally, the Department has added several bottom line impacts for factors which are not reflected in historical trends. This section details the adjustments the Department has made to the Request for Medical Services Premiums.

SB 04-177 – Concerning Home and Community-Based Services under the State's Medicaid Program for Children with Autism

Establishes the "Home and Community based Services for Children with Autism Act." The program is for Medicaid children from birth to six years of age with a diagnosis of autism, at-risk of institutionalization in an Intermediate Care Facility for the Mentally Retarded (ICF-MR and not receiving services from any of the alternatives to long-term care waiver programs. The Department was required to seek a federal waiver that meets budget neutrality requirements. Services under this waiver are outlined and limited to $25,000 annually per participant. Community Centered Boards for persons with developmental disabilities are the single entry point agencies for case management services. Administrative costs for the Community Centered Boards are capped at 15%.

The autism waiver application was first submitted on April 19, 2005. Through a series of correspondence, the Department began working with the Centers for Medicare and Medicaid Services in July 2005, and submitted the additional information on October 14, 2005. The Centers for Medicare and Medicaid Services approved the waiver application for Home and Community Based Services for Children with Autism on December 23, 2005. The next steps to implement the waiver were contingent upon receipt of that federal approval.

Upon approval of the waiver application, the Department promulgated rules, including the provider certification process; made necessary systems changes; and developed the contracts with the Community Centered Boards to provide case management services for the Children with Autism waiver clients. All of these processes were interrelated and any delay in one process affected a delay in the others.

The rules were developed with substantial input from stakeholders, including parents of children with autism and medical professionals with expertise treating children with autism. The rules were presented to the Medical Services Board in April 2006 and became effective on July 1, 2006. Provider rates were also developed and finalized at this time.

As a part of the provider certification process, the Department has an agreement with the Department of Public Health and Environment to conduct a review to determine if a provider meets the waiver requirements. Execution of the agreement was delayed, but the Department has been working with the Department of Public Health and Environment to expedite the certification process for providers of the waiver for Children with Autism. The Department expects that surveys will begin in mid-January 2008. In the

interim, the Department has established a provisional certification process for providers to ensure that eligible clients are able to receive services. The Department began to enroll clients in March 2007.

Because of the stringent requirements for certification as a provider in the program, enrollment in the program has been slower than originally anticipated in the fiscal note for SB 04-177. Therefore, the Department's estimates are based on FY 07-08 year-to-date expenditure, and held constant in FY 08-09.

SB 04-177	Total Funds	Cash Funds Exempt*	Federal Funds
FY 07-08 Impact to Community Based Long Term Care			
(2) Medical Services Premiums	$302,586	$151,293	$151,293
(2) Medical Services Premiums – Single Entry Point contract with Community Centered Boards (15%)	$163,500	$81,750	$81,750
Total (included in Community Based Long Term Care – Exhibit G)	**$466,086**	**$233,043**	**$233,043**

*Cash Funds Exempt from the Colorado Autism Treatment Fund.

SB 04-206 -- Concerning Hospice Care for Persons who are Eligible under the "Colorado Medical Assistance Act"

The bill required the Department to seek the appropriate federal authorization to prepare and submit a request for hospice care services for eligible children under the state's Medicaid program. The bill specifies that the hospice care services shall include but need not be limited to: respite care; expressive therapies; palliative care from the time of diagnosis of a potentially life-threatening illness; and continuum of care through the coordination of services, which may include skilled, intermittent, and around-the-clock nursing care. The Centers for Medicare and Medicaid Services granted the Department's waiver request, and services became available to clients effective January 1, 2008.

The fiscal note for SB 04-206 estimated a participation rate and savings based on a small sample of clients who would have qualified, based on diagnosis code, for a similar program for non-Medicaid clients, run by a Denver-area hospital. Because the program requirements have now been finalized, the Department has estimated the impact for the program in the table below. In particular, services are capped at $20,000 per client on the waiver. The Department assumes that, on average, each client will expend only 25% of that cap. Further, the Department estimates costs for Single Entry Points based on the standard rate of $1,053.50 per client, and estimates acute care savings as twice the waiver cost.

SB 04-206	FY 07-08	FY 08-09 (Annualization Amount)
Estimated Caseload	25	75
Average Cost Per Client Per Year	$5,000	$5,000
Estimated Waiver Cost (Community Based Long Term Care)	125,000	375,000
Estimated Single Entry Point Cost	$26,338	$79,013
Estimated Savings (Acute Care)	($250,000)	($750,000)
Total	**($98,662)**	**($295,987)**

HB 05-1015 – Concerning substance abuse treatment under the "Colorado Medical Assistance Act"

This bill adds outpatient substance abuse treatment as an optional service to the state's Medicaid program. The outpatient benefit includes assessment, alcohol/drug screening and counseling, social ambulatory detox, targeted case management, group therapy, and individual therapy adjusted for the average client. Savings are not expected to be realized until six-months after the program starts. The program began on July 1, 2006.

Based on assumptions from the fiscal note for HB 05-1015, the Department assumed that 4,668 clients would utilize substance abuse benefits in the first year of the program at an average cost $1,512.87 per client (November 1, 2006 Budget Request, page M-161). However, caseload for the program to date has been significantly lower than previously estimated. Based on claims reported in the Medicaid Management Information System, average monthly utilization for the program was 203 clients, with total program expenditure of $390,565. However, July and August 2006 saw limited and enrollment and expenditure because of the lag between when claims are incurred and when claims are paid. Therefore, the Department annualizes the total as if the program had only been in effect for 10 months instead of 12.

Based on the revised estimated full year expenditure, the Department recalculated the estimated savings for HB 05-1015. As with prior Budget Requests, the Department assumes that savings will be proportional to the original fiscal note. Because the program is relatively new, the Department does not yet have enough data to accurately determine the actual reduction in costs due to the program.[5] Under the revised assumptions, the Department estimates the impact as follows:

[5] In the fiscal note from HB 05-1015, the savings estimate was based on a 1997 report by the Washington State Department of Social Services, projected forward. This estimate was applied on a per client basis, and therefore it is appropriate to reduce savings proportionally to program caseload.

HB 05-1015	Fiscal Note Estimate	Revised Estimate
Estimated Medicaid Caseload Eligible for Outpatient Substance Abuse Treatment	4,668	243
Annual estimated cost per client	$1,512.87	$1,928.72
Estimated Expenditure (Annual)	$7,062,073	$468,678
Anticipated savings in Medical Services Premiums (6 Months)	($1,218,371)	**($80,858)**

The FY 07-08 impact is the annualization of anticipated savings, $80,858. Program costs are fully annualized in the FY 07-08 base.

HB 05-1243 – Concerning Consumer-Directed Care Under the "Colorado Medical Assistance Act"

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

In 2005, the Centers for Medicare and Medicaid Services completely revised the home and community based services waiver application forms, requiring additional components that needed to be researched and addressed by the Department prior to submission. This caused a substantial extension to the timeframe required for the implementation of this bill. Approval by the Centers for Medicare and Medicaid Services for the implementation of Consumer Directed Care for the Elderly, Blind, and Disabled waiver and the Mental Illness waiver was granted in mid-2007. Services became available to clients in January 2008. Savings estimates are taken from the Legislative Council fiscal note for HB 05-1243, on March 15, 2005, which assumes a savings per client of $373.

Description	FY 07-08	FY 08-09 Annualization Amounts
Service Management (Single Entry Point) (Exhibit I)	$1,008,375	$0
Community Based Long Term Care savings (Exhibit G)	($2,012,790)	($2,415,348)
Fiscal Year Impact	**($1,004,415)**	**($2,415,348)**

HB 05-1262 – Concerning the Implementation of Tobacco Taxes for Health-Related Purposes Pursuant to Section 21 of Article X of the State Constitution

HB 05-1262 requires expansion of existing Medicaid programs to be funded through the Health Care Expansion Fund and the Prevention, Early Detection, and Treatment Fund to provide revenue for the State's General Fund, the Old Age Pension Fund and for municipal and county governments. Appropriations from the Health Care Expansion Fund and the Prevention, Early Detection, and Treatment Fund are made to the Medical Services Premiums Long Bill line item. The following are explanations of the impacts each have to the Department's Request for Medical Services Premiums.

Prevention, Early Detection, and Treatment Fund

This fund is administered by the Department of Public Health and Environment; however, HB 05-1262 provides for a transfer of funds to the Department for two programs: the Breast and Cervical Cancer Program; and Disease Management. In each case, the Department makes a fund-split adjustment on Exhibit A, pages EA-2 and EA-3 to request the appropriate amount from the Prevention, Early Detection, and Treatment Fund. For the Breast and Cervical Cancer Program, the Department calculates the required fund-split on Exhibit F, page EF-6. For Disease Management, the fund-split is made directly on pages EA-2 and EA-3.

Breast and Cervical Cancer Program

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

A description of the calculation for the Breast and Cervical Center Program is contained in the narrative for Exhibit F, on page 17 of this narrative. The following table is a summary of estimated expenditure from the Prevention, Early Detection, and Treatment Fund:

HB 05-1262 - Breast and Cervical Cancer Program	Estimated Clients	Total Funds	Prevention, Early Detection, and Treatment Fund	Federal Funds
Estimated FY 07-08 Health Care Expansion Breast and Cervical Cancer Program	82	$1,997,479	$699,118	$1,298,361
Estimated FY 08-09 Health Care Expansion Breast and Cervical Cancer Program	90	$2,194,280	$767,998	$1,426,282

Disease Management

In HB 05-1262, the Department was given authority to pursue disease management programs for the purpose of assisting in the implementation of the State's strategic plans regarding cancer and cardiovascular disease to provide a cohesive approach to cancer, cardiovascular disease, and chronic pulmonary disease prevention, early detection, and treatment in Colorado. Under HB 05-1262, the program criteria shall address at least one of the following program criteria; 1) translating evidence-based strategies regarding the prevention and early detection of cancer, cardiovascular disease, and chronic pulmonary disease into practical application in healthcare, workplace, and community settings; 2) providing appropriate diagnosis and treatment services for anyone who has abnormalities discovered in screening and early detection programs; 3) implementing education programs for the public and health care providers regarding the prevention, early detection, and treatment of cancer, cardiovascular disease, and chronic pulmonary disease; and 4) providing evidence-based strategies to overcome health disparities in the prevention and early detection of cancer, cardiovascular disease, and chronic pulmonary disease.

Statutory authority for the funding expired at the end of FY 06-07. However, in SB 07-239, the Department was granted roll-forward authority to implement programs in FY 07-08 (Figure Setting, March 8, 2007, page 32). The Department has included the roll-forward, $3,940,777, in its Budget Request in Exhibit I. The Department receives this funding as a transfer from the Department of Public Health and Environment, and not from the Prevention, Early Detection, and Treatment Fund directly.

Health Care Expansion Fund

This fund is administered by the Department of Health Care Policy and Financing. Items funded include 1) the additional Categorically Eligible Low-Income Adults and Eligible Children estimated to become eligible for Medicaid due to the removal of the Medicaid asset test, 2) expansion of child enrollment under the Children's Home and Community Based Services Waiver and the Children's Extensive Support Waiver programs, 3) fund Medicaid to legal immigrants, 4) increase in Eligible Children due to the impact from marketing the Children's Basic Health, and 5) provide presumptive eligibility to pregnant women in Medicaid. The request differs from the analysis in the fiscal note due to updating the per capita costs and caseload estimates to those in the request. The total for each program is listed in the table below. Following the tables are short descriptions for each of the programs. For a complete description of the projections, see Section Q (Tobacco Tax Update) of this Budget Request.

	FY 07-08		FY 08-09	
Health Care Expansion Fund Programs	**Total Funds**	**Health Care Expansion Fund**	**Total Funds**	**Health Care Expansion Fund**
Expansion Adults	$20,548,943	$10,274,472	$25,490,738	$12,745,370
Expansion Foster Care (SB 07-002)	$1,272,491	$636,247	$4,547,756	$2,273,879
Presumptive Eligibility	$6,263,496	$3,131,748	$6,971,916	$3,485,958
Legal Immigrants	$11,596,517	$6,216,752	$11,596,517	$6,216,752
Removal of Medicaid Asset Test	$58,343,755	$29,171,878	$58,426,398	$29,213,199
Children's Home and Community Based Services	$18,443,668	$9,221,834	$19,672,014	$9,836,007
Children's Extensive Support	$2,657,351	$1,328,676	$2,777,198	$1,388,599
Total	**$119,126,221**	**$59,981,607**	**$129,482,537**	**$65,159,764**

Expansion Adults and Expansion Foster Care

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

Presumptive Eligibility

The Department discontinued Medicaid presumptive eligibility on September 1, 2004. Pursuant to HB 05-1262 the Department reinstated the presumptive eligibility process, effective July 1, 2005. Similar to the Children's Basic Health Plan, presumptive

eligibility for Medicaid is handled through the Anthem network. To be eligible for presumptive eligibility, a woman shall have a verified pregnancy, declare that her household's income shall not exceed 133% of federal poverty level and declare that she is a United States citizen or a documented immigrant. Eligibility for Medicaid must be determined by the county within 45 days of application. Once eligibility is determined, the client will be taken off presumptive eligibility and may go to fee-for-service or another Medicaid health maintenance organization. Previously, the Department made payments to Anthem based on the estimated cost per client per month, and checks for duplicates to assure that payments are not also made through the Medicaid Management Information System for these clients. The Department reconciles with Anthem to ensure that the provider has been paid appropriately for services rendered. Effective January 2008, clients who receive presumptive eligibility are being accounted for through the Medicaid Management Information System.

Using the normalized data, the Department has projected caseload for FY 06-07 using the average monthly enrollment in the first half of FY 06-07. Expenditure is projected using the current monthly payment rate of $285.58, plus the amount due to Anthem during the cost settlement, $30.85, multiplied by the monthly caseload. The Department has forecast expenditure based on historical monthly expenditure and caseload. Forecasting methodology is described in the Tobacco Tax Section of this Budget Request.

Medicaid Legal Immigrants

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

Citizenship status is collected to determine which applicants are categorized as legal immigrants versus illegal immigrants in the Colorado Benefits Management System. Illegal immigrants have no documentation and are eligible for emergency services only. Legal immigrants with 5 or more years of residency and 40 or more work quarters are categorized as a mandatory Medicaid population and receive full benefits, provided they meet the eligibility requirements other than citizenship status. Optional Medicaid legal immigrants (those who have 5 years of residency but less than 40 work quarters) also receive full medical benefits. Currently, the Colorado Benefits Management System does not have the capability to discern who is a mandatory legal immigrant and who is optional. This was clearly expressed in the fiscal note for SB 03-176. When SB 03-176 passed, it was intended to eliminate full Medicaid benefits for optional legal immigrants and provide emergency services only. However, SB 03-176 was never implemented and these clients did not lose their full Medicaid benefits. HB 05-1086 reinstated the benefits for these optional legal immigrants. The Department has identified system changes that can be made within the Colorado Benefits Management System that will enable the Department to track this expansion population. The Department is in the process of making systems modifications.

Due to the reinstatement of services to legal immigrants granted by HB 05-1086, $2,638,343 was funded through the Health Care Expansion Fund for FY 04-05. In FY 07-08, the Department was appropriated $11,596,517 for legal immigrants; the amount funded by the Health Care Expansion Fund was $6,216,752 (Figure Setting, March 8, 2007, Appendix B, page 11).

Removal of the Medicaid Asset Test

Effective July 1, 2006, the asset test no longer applies to children and adults. As a result, clients who were previously ineligible for Medicaid became Medicaid eligible. Additionally, clients who were eligible for only the Children's Basic Health Plan now qualify for Medicaid. During FY 06-07, the Department began to receive data on clients who are affected by the removal of the asset test. Currently, however, the Department's reporting only identifies total expenditure and not expenditure by eligibility category. The Department has forecast expenditure based on historical monthly expenditure and known caseload.

Because the Department is no longer able to request asset test information for individuals that are not applying for Medicaid and other financial assistance programs, the asset test removal population has been difficult to track. Changes to the Colorado Benefits Management System allow for all individuals applying for Medicaid benefits to be marked with a flag that reports the following: whether the client would have been eligible for Medicaid regardless of the asset test removal; the client would not qualify for Medicaid if the asset test was still in place; or, it is unknown whether the client's assets are a factor in determining eligibility. Circumstances where this information may not be known include: existing clients who have not gone through a yearly re-determination, or clients who are not required to provide asset information as a result of not applying for other public assistance programs. The Department's fiscal agent has created a report that shows the amount of Medicaid expenditures the State has incurred from clients that have provided asset information. Based on an analysis of Medicaid applicants served by the Colorado Benefits Management System, the Department estimated that 50% of the asset test removal population would be identifiable. Indeed, the asset test removal report states that approximately 48.2% of the total potentially eligible population has been marked with the asset test removal flag.

In FY 06-07, Health Care Expansion Fund expenditures for the asset test removal population were $17,871,753. For clients who have not provided asset test information, the Department transfers funds from the Health Care Expansion Fund under the assumption that a number of clients who have not reported asset information would not have qualified for Medicaid prior to the rule change. In previous years the Department assumed that of the clients who had not reported asset information, the proportion of these clients who would not have qualified prior to the change was the same as the proportion of clients who had reported asset information and would not have qualified. However, based on current year-to-date data, the number of clients who have reported asset information is well below the levels anticipated. Therefore, for FY 07-08, the Department has revised the methodology used to allocate expenditure for clients who have not reported asset information. The Department's preliminary research indicates that clients who gained eligibility because of the removal of the asset test have significantly higher income on average than clients who would have qualified regardless of the change. Further, clients who have not reported asset information have significantly higher income than those clients who have

reported asset information. Based on this information, the Department believes that there is a significant under-reporting bias in the eligibility data, in that clients who have higher income are less likely to provide asset information.

Given the under-reporting bias, for FY 07-08, the Department does not believe that it is appropriate to use the strict ratio of clients who would not have qualified to the total population who have reported asset information. Rather, the Department has used that ratio as a base, and inflated it by 100%. This figure is a rough estimate, based on the average difference in incomes between clients who have reported asset information but would not have previously qualified for Medicaid and those that have not provided asset information. Because the results are preliminary, the Department has made a number of assumptions to ensure that the estimate is conservative and reasonable, and has rounded the figure because of the inherent uncertainty of this projection. The Department continues to research this issue, and anticipates that a more comprehensive and permanent framework will be available in a future Budget Request.

To calculate the FY 08-09 impact, the Department has applied caseload and per capita growth factors to the asset population based on the percent change of the weighted average of caseload and per capita rates.

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

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

Children's Home and Community Based Services (CHCBS) Waiver

Prior to HB 05-1262, 630 clients were actively served by the Children's Home and Community Based Services (CHCBS) waiver program and 478 individuals were on the waiting list. HB 05-1262 provided funding for the Department to take clients from the waitlist and enroll them in the waiver. During Figure Setting, 200 additional expansion waiver slots were added (Figure Setting, March 13, 2006, page 145), increasing the number of available waiver slots funded by the Health Care Expansion Fund to 678. As described in the Medicaid Caseload Assumptions and Calculations, the Department anticipates only 485 of these slots to be filled for FY 06-07, due to the lag between increasing the waiver slots and being able to determine eligibility for the program. By FY 07-08, the Department estimates that 676 of the slots will be full.

Children's Extensive Support (CES) Waiver

Prior to HB 05-1262, the Children's Extensive Support (CES) waiver program had 212 clients that were being served and 148 that were on the waiting list. Of the 148 clients, only 49 were not Medicaid eligible, and were able to be funded with funding from the Health Care Expansion Fund. HB 05-1262 provided funding for the Department to take these clients from the waitlist and enroll them in the waiver. During Figure Setting, 30 additional expansion waiver slots were added (Figure Setting, March 13, 2006, page 145), increasing the number of available waiver slots funded by the Health Care Expansion Fund to 79. As described in Section Q of this Budget Request (Tobacco Tax Update), the Department anticipates that only 59 of these slots will be filled for FY 07-08 and FY 08-09. This figure does not reflect only 59 clients being served; rather, it reflects the fact that some expansion slots are vacated when a traditional waiver slot becomes available and there may be some lag before the expansion slot is filled again.

HB 06-1270 – Concerning the Authority of Public School Personnel to Make Determinations of Eligibility for Certain Public Medical Benefits

This bill creates a demonstration project to make eligibility determinations for Medicaid at the same time that eligibility for free or reduced-cost lunches is determined. The project starts in FY 07-08, and three school districts will be selected to participate. In the Legislative Council fiscal note for HB 06-1270, 306 clients were estimated to be added to the caseload for Eligible Children. The Department's revised caseload estimate, based on current caseload trends, is 230 clients in FY 07-08 and 300 clients in FY 08-09. The Department's forecasting methodology is described in Section II of this section of the Budget Narrative. The Department has incorporated this increase in caseload in Exhibit B, page EB-2. Because this is an increase to caseload, there is no bottom-line impact to the Department's request by service group.

HB 06-1270	FY 07-08	FY 08-09
Estimated Caseload	230	299
Estimated Per Capita	$1,778.29	$1,848.64
Estimated Expenditure	**$409,006**	**$552,743**

HB 06-1385 – Provider Rate Increases

In the FY 06-07 Long Bill, HB 06-1385, footnotes 26, 27, and 28 also provided rate increases for providers. For this Budget Request, rate increases applied effective July 1, 2006 are considered annualized in the base and not expressly considered as bottom line adjustments in this Budget Request.

Footnote 28 of HB 06-1385 was effective April 1, 2007. This footnote provided rate increases for home health and community-based long term care providers. The Department's FY 07-08 Long Bill appropriation in SB 07-239 includes the annualization of these rate

increases. The Long Bill includes $4,097,363 for Home Health rate increases, and $8,318,888 for community-based long term care rate increases (Figure Setting, March 8, 2007, pages 38 and 38a). The Department has incorporated the Long Bill amounts as bottom-line impacts in Exhibit F (Home Health) and Exhibit G (Community Based Long Term Care).

SB 06-165 – Concerning the Use of Telemedicine to Promote Efficiency in the Delivery of Health Care Services, and, in Connection Therewith, Establishing Pilot Programs to Demonstrate Such Efficiency

Beginning July 1, 2006, this bill authorizes the Department to adopt rules implementing telemedicine. As of that date, in-person medical consultations are no longer required under Medicaid, although patients retain the right to choose in-person contact with a health care provider. Telemedicine consultations are also permissible under managed care. Rates for telemedicine services must be at least as great as program rates for comparable in-person services, and the Department is allowed to consider setting the reimbursement rate on a monthly, daily, or per-visit basis. In addition, the Department must establish rates for transmission cost reimbursement, which consider to the extent applicable, reductions in travel costs and access to care.

The Legislative Council fiscal note for SB 06-165 assumes that there will be 80,008 telemedicine consultations in FY 06-07 at $7.50 in transmission costs per consultation. Total expenditure for transmission costs was estimated at $600,060.[6] The program was assumed to start January 1, 2007. Additionally, the fiscal note assumed that there would be a savings in non-emergency transportation services of $277,627. However, in FY 05-06, non-emergency transportation services were moved from Medical Services Premiums to the Department's Executive Director's Office Long Bill group. Therefore, an adjustment was made to Medical Services Premiums in the Long Bill for non-emergency transportation services. The line-item for non-emergency transportation services is adjusted to reflect the estimated savings.

The Department began accepting claims for telemedicine services in late 2007. However, to date, there has been virtually no utilization of the benefit. The Department is investigating the cause of the low utilization, but assumes that as the benefit becomes known to providers, billing will increase. For the purpose of this Budget Request, the Department assumes that expenditure will be 25% of the total assumed in the fiscal note for SB 06-165, $266,693. This would be equal to three full months of claims. The annualization amount in FY 08-09 is $800,077.

Beginning July 1, 2007, the Department entered into an agreement with an outside contractor for a pilot program managing and treating recipients with congestive heart failure and diabetes using telemedicine. The Legislative Council fiscal note for SB 06-165 assumes that this program will treat 512 clients, at an average cost of $62 per client per month. Total expenditure for the disease management program will be $380,928. Because of the new disease management programs, the fiscal note estimates that there will be

[6] The legislative council fiscal note contains a slight rounding error, and lists the total expenditure as $600,058.

savings to Medical Services Premiums of 50% of current emergency room visits and inpatient hospital stays for clients with chronic obstructive pulmonary disease (COPD), estimated at $235,363. This assumes that the pilot program would reach 2% of clients with COPD.

HB 07-1021 - Concerning the Prescription Drug Consumer Information and Technical Assistance Program, and Making an Appropriation Therefor.

HB 07-1021 established the Prescription Drug Consumer Information and Technical Assistance Program to provide advice about prescription drugs to Medicaid clients. The Department of Health Care Policy and Financing is required to administer the program and provide incentive payments to pharmacists and physicians who consult with Medicaid clients about how to avoid dangerous drug interactions and improve outcomes. Pharmacists and physicians participating in the program will receive $75 for each consultation provided to selected Medicaid clients. Each year, 226 clients with high dollar pharmaceutical expense are expected to receive consultations. Payments to pharmacists are included in the Department's Executive Director's Office Long Bill Group.

Based on a similar program in Wyoming, total drug costs for participating clients are expected to be reduced by 33 percent. For FY 07-08, drug expenditures for the 226 clients prior to receiving consultations are anticipated to be $3,786,685. Assuming implementation in January 2008, the savings for the 6 months after the consultations totals $624,803. For FY 08-09, drug expenditures for the 226 clients receiving consultations are currently anticipated to be $4,166,490, and HB 07-1021 is expected to result in full-year savings of $1,374,942. The Department's FY 08-09 calculations reflect the annualization amount of $750,139.

HB 07-1183 - Concerning Reimbursement of Nursing Facilities under the "Colorado Medical Assistance Act", and Making an Appropriation Therefor.

HB 07-1183 established the Nursing Facility Grant Rate Program to provide assistance to certain nursing facilities. Facilities that received a Medicaid rate increase in FY 06-07 as a result of the minimum rate established by SB 06-131, but whose rate for FY 07-08 decreases are eligible for the program. The program is repealed July 1, 2008. HB 07-1183 appropriated a total of $397,000 for the grant program. Per diem rates for affected providers have been adjusted so that total expenditure for the program does not exceed the appropriated amount. This amount is included as a bottom line impact to the Class I Nursing Facilities budget, in Exhibit H, page EH-2.

HB 07-1346 - Concerning Managed Care in the Medical Assistance Program, and Making an Appropriation Therefor.

HB 07-1346, specifies that the Department may enter into prepaid inpatient health plan (PIHP) agreements, which are a type of managed care. These agreements would be with entities that provide medical services on the basis of per capita payments and have

responsibility for inpatient hospital services for enrollees. PIHP agreements may include quality incentive payments of up to 5 percent, so long as incentive payments do not exceed total cost savings. PIHP agreements may also include payment for the costs of collecting and maintaining electronic medical records.

The Department was appropriated funding to initiate a feasibility study for increasing the number of prepaid inpatient health plans participating in the Department's managed care program. When the feasibility study is completed, the Department may submit an additional budget action to change the scope of its current managed care program; however, no such decision has yet been made.

In addition, the bill removes the requirement that managed care capitation rates be no more than 95% of fee-for-service rates for an equivalent group. However, managed care organizations may submit capitation rate proposals of up to 100% of direct health care costs, but the state is not obligated to increase General Fund expenditures. In June 2007, the Department was informed by its only remaining risk-based managed care organization that it would no longer participate in the managed care program unless rates were raised to the 100% level. The Department submitted an Emergency Supplemental request to the Joint Budget Committee on June 20, 2007, requesting funding to raise capitation rates. The Joint Budget Committee denied the request, as it did not sufficiently meet criteria for an emergency supplemental. However, the Joint Budget Committee gave a favorable review to the Department's request and ultimately, the Department raised capitation rates to the 99% level, in accordance with the agreement with its provider.

The Department's FY 07-08 calculation of Acute Care expenditure (Exhibit F) does not include an adjustment to raise rates. These funds were requested in a separate Budget Action. However, it is worth noting that because the Department is already paying the enhanced rates, the impact of this Request is included in year-to-date actuals listed in exhibit F.

SB 07-002 - Concerning Extending Medicaid Eligibility for Persons who are in the Foster Care System Immediately Prior to Emancipation, and Making an Appropriation Therefor.

SB 07-002 expands Medicaid eligibility to young adults, who are under 21 years of age and who were in the foster care system immediately prior to their 18th birthday or emancipation. Currently, most foster children lose Medicaid eligibility on their 18th birthday or when they graduate from high school. Funding for clients who have regaining eligibility as a result of this expansion comes from the Health Care Expansion Fund. The Department's revised caseload estimate, based on current caseload trends, is 1,226 clients in FY 07-08 and 1,678 clients in FY 08-09. The Department's forecasting methodology is described in Section II of this section of the Budget Narrative. The Department has incorporated this increase in caseload in Exhibit B, page EB-2. Because this is an increase to caseload, there is no bottom-line impact to the Department's request by service group.

SB 07-002	FY 07-08	FY 08-09
Estimated Caseload	368	1,259
Estimated Per Capita	$3,457.86	$3,612.20
Estimated Expenditure	**$1,272,491**	**$4,547,755**

Executive Order 004 07 - Establishing a Preferred Drug List

In January 2007, Governor Ritter signed Executive Order D 004 07 establishing a preferred drug list for Colorado's Medicaid program. The purpose of this program is to provide needed medications to Medicaid clients while decreasing expenditures on pharmaceuticals. This Executive Order gives the Department the authority to implement a preferred drug list after evaluating various methods of implementation and determining the best option for Colorado. In addition, the Department will be responsible for forming a Pharmacy and Therapeutics Committee responsible for evaluating clinical data and evidence on all drugs under consideration for inclusion in the preferred drug list. The Department will also evaluate and pursue supplemental rebates to further facilitate providing pharmaceuticals for Medicaid clients at the lowest possible cost.

During Figure Setting in March 2007, the Joint Budget Committee reduced the Medical Services Premiums appropriation by $670,376 in FY 07-08 to reflect expected savings from the implementation of a preferred drug list (Figure Setting, March 8, 2007, page 52). This figure was based on the Legislative Council fiscal note for SB 05-022, despite significant differences in the proposed legislation and the Executive Order.

In this Budget Request, the Department has submitted separate budget actions (Base Reduction Item 2, Supplemental 9, Budget Amendment 3, "Implement Preferred Drug List") to reconcile the differences between the appropriation and the costs and savings associated with implementing the Executive Order. Therefore, to prevent double-counting of the Request, the Request for Medical Services Premiums holds the reduction that was included in the Long Bill constant at $670,376 in both FY 07-08 and FY 08-09 (see Exhibit F, pages EF-3 and EF-4).

Human Papillomavirus (HPV) Vaccines for Children Under 20

During Figure Setting in March 2007, the Joint Budget Committee increased the Medical Services Premiums appropriation by $1,010,084 in FY 07-08 for the costs of dispensing the human papillomavirus (HPV) vaccines to children between the ages of twelve to twenty years old. The Centers for Disease Control has approved the HPV vaccine as a recommend childhood vaccination. The estimate assumed that the cost of the vaccine will be paid by the federal Vaccines for Children program; therefore, the increased costs

are for the office visits that are required in order to receive the vaccine. The Department includes the increased costs as a bottom line adjustment in Acute Care.

Adjustment of Claims Paid to Certain Rural Health Centers

For FY 02-03 and FY 03-04, the Department submitted two Change Requests (Decision Item 7, November 1, 2002, and Supplemental Request 9, January 2, 2003; both titled "Conform to Federal Mandate in Reimbursement Methodology for Rural Health Centers") requesting authorization and funding to implement the per visit methodology. These Change Requests were subsequently approved (Figure Setting, March 13, 2003, page 109), and the Department implemented the new regulations. With the approval of the Centers for Medicare and Medicaid Services, the Department chose to reimburse rural health clinics a per visit rate equal to the higher of the Prospective Payment System rate or their corresponding Medicare rate. Implementing the per visit rate methodology took several years, since these rates could not be set until the Department had the clinics' 1999 and 2000 audited Medicare cost reports. Once the cost reports were available, rates were established retroactive to January 1, 2001 and the Department paid the rural health clinics the difference between what had been reimbursed previously and what was required under the Benefits Improvement and Protection Act.

During FY 06-07, the Department discovered that for three rural health centers the per visit rate methodology was never implemented. Although encounter rates had been calculated for these providers, claims for these providers were paid under the old methodology, wherein the provider was reimbursed a percentage of billed charges. Upon investigation, it was determined that the classification for these providers in the Department's Medicaid Management Information System were not updated to reflect the new methodology; thus, the providers continued to be reimbursed under the old payment system. The Department believes that, by continuing to reimburse these providers under the old methodology, it is out of compliance with both state regulation and the Benefits Improvement and Protection Act of 2000.

In its February 15, 2007 Budget Request, the Department requested a total of $200,318 to adjust claims paid to rural health centers and implement the correct payment methodology going forward. The Joint Budget Committee approved the Department's request, and the annualization amount of $16,982 was included in the Department's Long Bill appropriation (Figure Setting, March 8, 2007, page 38). Accordingly, the Department includes the annualization amount as a bottom line impact to Acute Care (Exhibit F, page EF-3).

(3) MEDICAID MENTAL HEALTH COMMUNITY PROGRAMS

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

History and Background Information

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

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

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

Since the inception of the Medicaid Mental Health Community Programs, the Department has been responsible for oversight and contracting with the managed care organizations. The budget projections, day-to-day operations and administration of the program were the responsibility of the Department of Human Services. In 2004, the administration and programmatic duties were transferred from the Department of Human Services to the Department. These duties include budget projections and accounting for the program, site reviews of the institutions, and contract negotiations. The transfer resulted in a new Long Bill group for the Department in FY 04-05 Long Bill (HB 04-1422). Subsequently, SB 05-112 transferred: (1) the Mental Health Administration appropriation for Personal

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

A historical perspective of the Medicaid Mental Health Community Programs is summarized as follows:

- HB 02-1420 also provided funding for three alternative programs in the Medicaid Mental Health Community Programs: Alternatives to Inpatient Hospitalization at the Mental Health Institute at Pueblo, Alternatives to Inpatient Hospitalization at the Mental Health Institute at Fort Logan, and Alternatives to the Fort Logan Aftercare Program. Each of these programs was the result of reductions in institutional care. Contracting through mental health assessment and service agencies, community mental health centers offered to provide services through managed care at a much lower cost. Initially part of the Mental Health Capitation Payments line, separate appropriations were made in the FY 04-05 Long Bill (HB 04-1422) and the FY 04-05 Long Bill Add-On (SB 05-209). Funding for Alternatives to Inpatient Hospitalization at the Mental Health Institute at Pueblo, Alternatives to Inpatient Hospitalization at the Mental Health Institute at Fort Logan, and Alternatives to the Fort Logan Aftercare Program was incorporated into the capitation base during the request for proposal process for contracts effective January 1, 2005. Due to this new contractual provision with behavioral health organizations, separate appropriations were no longer needed as of FY 05-06.

- In FY 02-03, budget reductions were implemented and Medicaid capitation payments were reduced significantly for FY 02-03 through FY 03-04. This led to a reduction of services provided by the behavioral health organizations. Increasing caseload for Medicaid Mental Health Community Programs and incorporating funding for alternative programs to inpatient hospitalization tempered the effect reductions had on the capitation budget.

- Due to a temporary federal change, the Medicaid federal financial participation match was enhanced for the last quarter of FY 02-03 and the entire FY 03-04 to 52.95% (up from 50%), while the State's share was reduced to 47.05%. The federal financial participation match rate returned to 50% for FY 04-05.

- SB 03-196 mandated the Department to move from accrual-based accounting to cash-based accounting for the Medical Services Premiums and the Medicaid-funded services in the Department of Human Services' budget. This resulted in a one-time savings of approximately $70 million in Medical Services Premiums and $7 million in the Department of Human Services' Medicaid-funded services during FY 02-03. With cash-based accounting, all expenditures became based on the date of payment, regardless of when

the date of service occurred, thus eliminating the six-month accounts payable period maintained under accrual-based accounting. Ideally, all prior expenditure history for mental health services would have been rebuilt on a cash basis for historical comparison purposes, using both the Colorado Financial Reporting System and the Medicaid Management Information System data. However, the Department's current prospective per capita budget methodology did not require the use of historical data prior to FY 02-03.

- SB 03-282 gave the Department and the Department of Human Services' Medicaid-funded programs a one-time appropriation of $1,000,000 in FY 03-04, wherein $500,000 was from the Tobacco Litigation Settlement Cash Fund pursuant to section 24-75-1104, C.R.S. (2005) and the remaining $500,000 was from federal funds for mental health capitation and performance incentive awards.

- Within the appropriation for Medicaid Mental Health Community Programs, the FY 04-05 Long Bill (HB 04-1422) provided funding for the Mental Health Institute Rate Refinance Adjustment. This funding was necessary because in 2001 it was discovered that the capitation-based payment for Medicaid clients did not cover bed costs at mental health institutes. Separate appropriations for the Mental Health Institutional Rate Refinance Adjustment were made in the FY 04-05 Long Bill (HB 04-1422) and the FY 04-05 Long Bill Add-on (SB 05-209). New contracts with behavioral health organizations effective January 1, 2005 began fully covering the negotiated bed cost at the mental health institutes in new capitation rates via payments withheld from behavioral health organizations and made directly to the Mental Health Institute. Therefore, a separate appropriation for the Mental Health Institute Rate Refinance Adjustment was no longer needed as of FY 05-06.

- HB 04-1422 reorganized the Medicaid Mental Health Community Programs Long Bill group into the following sections:

  1. Mental Health Capitation Payments, which included Capitation Base Payments, Mental Health Services for Breast and Cervical Cancer Patients, Mental Health Institute Rate Refinance Adjustment, Alternatives to Inpatient Hospitalization at the Mental Health Institute at Pueblo and the Mental Health Institute at Fort Logan and Alternatives to the Fort Logan Aftercare Program. SB 05-209 consolidated these line items into one Mental Health Capitation Payments line item in FY 05-06.

  2. Other Medicaid Mental Health Payments, which included Medicaid Mental Health Fee-for-Service Payments, Child Placement Agency and Anti-Psychotic Pharmaceuticals. Child Placement Agency and Anti-Psychotic Pharmaceuticals were listed under Other Medicaid Mental Health Payments for informational purposes only. Detailed explanations of the Child Placement Agency and Anti-Psychotic Pharmaceuticals programs and appropriations can be found in the Department of Human Services Child Welfare section and the Department's Medical Services Premiums section, respectively. SB 05-209 did not change these line items. However, in November 2004, the Department received an order from the Centers for Medicare and Medicaid Services to cease making Child Placement Agency payments since they were considered supplemental payments outside the

scope of the existing waiver. Payments were discontinued in December 2004 and the Department began negotiations with the Centers for Medicare and Medicaid Services to reinstate the payments. To date the payments are denied. FY 05-06 Add-ons, HB 06-1385 (FY 06-07 Long Bill) and FY 05-06 Add-ons removed the line from the Department budget until approval is received.

- HB 05-1262, known as the Tobacco Tax bill, established two funds that provide capitated mental health benefits to an increasing population of Medicaid clients. Increased caseload funded by the Health Care Expansion Fund, administered by the Department, and the Prevention, Early Detection and Treatment Fund, administered by the Department of Public Health and Environment, are included in both the FY 07-08 Estimate and the FY 08-09 Budget Request and are elaborated below.

- The federal Medicare Prescription Drug, Improvement and Modernization Act of 2003, commonly known as the Medicare Modernization Act, went into effect January 1, 2006. This legislation provides seniors and individuals with disabilities with a prescription drug benefit.

- On September 20, 2006, the Joint Budget Committee approved a 1331 Emergency Supplemental Request to transfer funding from the Department of Human Services to the Department. This transfer allowed for the inclusion of the Goebel enhanced services in the Medicaid Mental Health Capitation rates and eliminated the need to classify and track them separately.

  The Goebel Lawsuit Settlement line item was created in FY 03-04 to fund specialized and enhanced mental health services for approximately 1,600 Medicaid and non-Medicaid clients with mental illness in northwest Denver. The Goebel lawsuit claimed that residents of northwest Denver with chronic mental illness were being denied services. The FY 03-04 Supplemental Bill (HB 04-1320) established the Goebel Lawsuit Settlement as a separate line item in the Department's Department of Human Services Medicaid-Funded Programs Long Bill group and paid it separately from Medicaid Mental Health Community Programs payments.

  On March 31, 2006, the Goebel lawsuit was dismissed. After consultation with the Department's contracted actuary and review of the Goebel-specific encounter and eligibility data, it was determined that an actuarially certified payment would become part of the Mental Health Capitation Payments line item. An adjustment was made for the inclusion and it began being included in the FY 06-07 capitations.

- SB 07-002 expanded Medicaid eligibility for certain foster care children up to age 21.

Program Administration

In FY 05-06, SB 05-112 transferred all of Medicaid Mental Health Community Programs - Program Administration expenditures into the Executive Director's Office Long Bill group, and is reflected in the lines for Personal Services, Operating Expenses, and Mental

Health External Quality Review Organization. The FY 07-08 Estimate and the FY 08-09 Budget Request for Program Administration are included in the Executive Director's Office Long Bill group.

Medicaid Anti-Psychotic Pharmaceuticals

As part of the Long Bill, estimated expenditures for anti-psychotic pharmaceuticals are appropriated to this Long Bill group as Cash Funds Exempt. This is an informational-only line item: the costs for these drugs are paid in the Department's Medical Services Premiums Long Bill group, and no actual transfer takes place. Because there is no corresponding decrease to the Medical Services Premiums Long Bill group, this double counts the funding for these drugs. In previous Budget Requests, the Department has recommended the removal of this informational line item. However, no action has been taken.

In this Budget Request, the Department is officially requesting the removal of the Medicaid Anti-Psychotic Pharmaceuticals line item. This will not impact the Department's ability to pay for these drugs, as they are still part of the Medicaid physical health benefit (as are all other pharmaceuticals related to the treatment of mental health conditions, such as anti-depressants). The Department will continue to report expenditure for anti-psychotics in its Budget Request in future years (such as in Exhibit F of the exhibits for Medical Services Premiums, and/or the Strategic Plan), and so no information will be lost from the Budget Request.

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

(A) MENTAL HEALTH CAPITATION PAYMENTS

The Mental Health Capitation Payments line item reflects the appropriation that funds Medicaid mental health services throughout Colorado through managed care providers contracted by the Department. As a result of competitive procurement, five behavioral health organizations were awarded contracts with updated capitation rates and services effective January 1, 2005. Payments for Mental Health Institute Rate Refinance Adjustment, Alternatives to Inpatient Hospitalization at the Mental Health Institute at Pueblo, Alternatives to Inpatient Hospitalization at the Mental Health Institute at Fort Logan, and Alternatives to the Fort Logan Aftercare Program were separate payments prior to FY 05-06, and incorporated into the Mental Health Capitation Payments line item in FY 05-06.

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

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

Eligible Medicaid Mental Health Populations

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

Analysis of Historical Expenditure Allocations across Eligibility Categories:

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

Description of Transition to New Methodology:

Member month methodology was used prior to 2005 when the administration of Medicaid Mental Health Community Programs was transferred from the Department of Human Services to the Department. Historical expenditures were divided by the capitation rates for the region served by each mental health assessment and service agency (now known as behavioral health organizations) to estimate the number of member months for which capitation payments were made. Mental health caseload growth rates were applied to these member months to calculate projected member months. Member months were multiplied by the capitation rates for the upcoming year to determine the projected capitation base payments. The problem with this system was that member months, which reflected the

impact of retroactive payments, were not equivalent to the Medicaid caseloads used in Medical Services Premiums, which did not include retroactivity. This methodology was used until February 15, 2005.

The FY 04-05 Supplemental Request and FY 05-06 Budget Request Amendment presented to the Joint Budget Committee on February 15, 2005, began moving towards the current per capita methodology. The FY 04-05 Supplemental Request relied upon a regional analysis of actual expenditures for the first half of the year and regionally projected member months multiplied by capitation rates for the second half of the year. The FY 05-06 Budget Request Amendment was based on an analysis of statewide per capita costs with forecast factors by eligibility type, leading to the per capita costs selected to estimate FY 05-06 expenditures, which were multiplied by the mental health caseload.

Similarly, the FY 06-07 Budget Request presented to the Joint Budget Committee on November 15, 2005 was developed from trended statewide per capita costs to estimate FY 05-06 per capita. The per capita was multiplied by the mental health caseload to arrive at projected expenditures by eligibility category. After an adjustment for recoupments planned for FY 05-06, the final requested per capita was determined by dividing projected net expenditures by the projected average mental health caseload.

The FY 05-06 Supplemental Request and FY 06-07 Budget Request Amendment presented to the Joint Budget Committee on February 15, 2006 combined the annualized per capita from the second half of FY 04-05 actual expenditures and first half of FY 05-06 actual expenditures using average monthly caseload for the two periods. Annualized per capita was then determined for each half year and the one most closely reflecting trended data was used to develop the FY 05-06 Supplemental Request. Following the FY 05-06 Budget Request, the FY 06-07 Budget Request Amendment was then developed, using an estimated rate increase of 2.71%, based on various forecast factors, including the Department's trended cost analysis, the Medicare Economic Index from the Centers for Medicare and Medicaid Services, and the U.S. Department of Labor's Bureau of Labor Statistics consumer price index for local medical costs, for each eligibility category. While the data was from two different fiscal years, this was the first use of actual per capita to develop projected expenditures.

The FY 07-08 Budget Request was the first to fully implement the process using previous year actual amounts trended forward by applying a 3.85% increase (from the actuarial certification letter) to the FY 05-06 actual per capita by eligibility category to reflect a comparable change in rates to develop the FY 06-07 estimate per capita. The FY 06-07 Estimate per capita base was also increased due the inclusion of $12,343,420 for Goebel enhanced services. A transfer of $12,275,081 was approved by the Joint Budget Committee, through the 1331 Emergency Supplemental request of September 20, 2006. The remaining $68,339 was due to rate increases that were implemented July 1, 2006. This was necessary because the Centers for Medicare and Medicaid Services denied the Department to continue “pass-through” payments for Goebel enhanced services and required actuarially certified rates be used.

The Department determined that the best way to achieve actuarial certification of these services was by including Goebel enhanced service costs in the per capita. Mental health caseload projections were also updated to reflect the most recent data. The updated mental health caseload multiplied by the estimated per capita result in the FY 06-07 Estimate. The same process, using a 3.76% actuarially certified increase, was then used to develop the FY 07-08 Budget Request using the FY 06-07 Estimate as the base. The FY 08-09 Budget Request was calculated using the same methodology, adjusting for current expenditure as appropriate.

The following narrative describes in greater detail the assumptions and calculations used in developing the FY 08-09 Budget Request for Medicaid Mental Health Community Programs. It should be noted that the data and values in many of the exhibits are contained and/or calculated in one or more other exhibits which may come before or after the exhibit being described. When this occurs, the source exhibit will be noted. The exhibits being referenced can be found in the Department's November 1, 2007 Budget Request, Volume 1, Section F.

Medicaid Mental Health Community Programs Historical and Future Projection Overview (Exhibit AA):

Exhibit AA demonstrates the changes in spending and caseload for Medicaid Mental Health Community Programs. The expenditures are those reported in the Colorado Financial Reporting System for completed fiscal years, plus the FY 07-08 Estimate and the FY 08-09 Base Budget Request. All of the years prior to FY 06-07 have been adjusted to include Goebel enhanced service costs for each particular year (see page DD-5 for the calculations) and therefore vary from previous submissions. One of the strengths of per capita budget methodology is using the mental health caseload shown in Exhibit DD by eligibility category. Certain Medicaid Medical Services Premiums eligibility categories shown in Exhibit B are excluded from the mental health eligibility categories, namely Partial Dual Eligibles and Non-Citizens.

The mental health caseload excludes the caseload for Partial Dual Eligibles and Non-Citizens and ties to the Medicaid Medical Services Premiums Exhibit B. Please see the Medicaid Caseload section of the Medical Services Premiums narrative for further discussion of Medicaid Caseload projections. The chart in Exhibit AA illustrates a comparison in the change of the mental health caseload compared to the change in capitated expenditures.

General Fund, Cash Funds Exempt, and Federal Funds Match Calculations, FY 08-09 (Exhibit BB):

Exhibit BB details funds splits for all Mental Health Community Programs budget lines for the FY 07-08 Estimate and the FY 08-09 Budget Request. For all of the capitation payments except the Breast and Cervical Cancer Program, the funding is 50% state funds and 50% federal funds. Payments for clients in the Breast and Cervical Cancer Program receive a 65% federal match rate and are described separately below. Capitation expenditures have been split between traditional clients and expansion clients funded from Tobacco Tax Funds.

In both the FY 07-08 Estimate and the FY 08-09 Budget Request capitation base, traditional clients receive 50% General Fund and 50% federal funds, while capitation base expansion clients receive 50% Cash Funds Exempt from the Health Care Expansion Fund, created by the Tobacco Tax Bill, and 50% federal funds, except for the Breast and Cervical Cancer Prevention and Treatment Program which receives 35% State funds and 65% federal funds. In the FY 07-08 Estimate, funding for Breast and Cervical Cancer Program traditional clients is 8.75% Cash Funds Exempt from the Breast and Cervical Cancer Prevention and Treatment Fund (administered by the Department), 26.25% General Fund and 65% federal funds. Funding for expansion clients is 35% Cash Funds Exempt from the Prevention, Early Detection and Treatment Fund (administered by the Department of Public Health and Environment) and 65% federal funds. In the FY 08-09 Budget Request, Breast and Cervical Cancer Program funding for traditional clients is 35% General Fund and 65% federal funds. Funding for expansion clients is 35% Cash Funds Exempt from the Prevention, Early Detection and Treatment Fund and 65% federal funds. A separate exhibit was not necessary for the Breast and Cervical Cancer Program. Hence, a description of the Breast and Cervical Cancer Program immediately follows this section.

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

Anti-Psychotic Pharmaceuticals are reported for information purposes only as Cash Funds Exempt to avoid double counting an appropriation that is included in the Department's Medical Services Premiums line item. As described above, the Department is officially recommending removal of this double count, as the amount can be found in the Medical Services Premiums section. A brief summary of the Anti-Psychotic Pharmaceuticals line follows the Mental Health Fee-For-Service Payments (Exhibit HH) section.

The Department's current year estimate (FY 07-08) is no longer inflated due to the over-expenditure restriction imposed as a result of the Department's FY 06-07 over-expenditure. This differs from prior year Budget Requests. This line item has over-expenditure authority pursuant to Section 24-75-109 (1) (a), C.R.S. (2007). The Department will require a supplemental appropriation for the total restriction pursuant to Section 24-75-109 (4) (a), C.R.S. (2007), but this is not reflected in the Department's Request. The total supplemental appropriation required to lift the restriction is described in Exhibit FF.

Mental Health Services for Breast and Cervical Cancer Program Adults:

SB 01S2-12 created the Breast and Cervical Cancer Prevention and Treatment Program. SB 05-209 incorporated funding for the Breast and Cervical Cancer Patients into the appropriation for Medicaid Mental Health Community Programs Capitation Payments effective with the FY 05-06 budget. Mental health care for clients in the Breast and Cervical Cancer Program is managed through the capitation contracts with the behavioral health organizations. Therefore, the budget is based on the mental health caseload that includes the Breast and Cervical Cancer Program Adults eligibility category. In addition to different fund splits, a separate per capita is paid for Breast and Cervical Cancer Treatment Program Adults than the one paid for Eligible Adults, Health Care Expansion Fund

Low-Income Adults, and Baby Care Program – Adults. For this reason, they are shown as a separate eligibility category throughout the budget request.

Annual designations of General Fund contributions to program costs are specified in Section 25.5-5-308 (9) (b) and (c), C.R.S. (2007). Exhibit BB details funds splits for Mental Health Community Programs Capitations lines. In addition to clients already enrolled in the program, also called "traditional clients", the Department received funding from the Tobacco Tax Bill (HB 05-1262) to enroll more clients in the Breast and Cervical Cancer Program. These clients, called the "expansion clients", are funded by the Prevention, Early Detection and Treatment Fund administered by the Department of Public Health and Environment and the Tobacco Tax Bill (see the explanation below and Exhibit GG, which shows all Tobacco Tax impacts, for a full explanation). The funding for the expansion clients is 35% Cash Funds Exempt and 65% federal funds. For traditional clients, the source for Cash Funds Exempt is the Breast and Cervical Cancer Prevention and Treatment Fund; for expansion clients, the Department receives a transfer from the Department of Public Health and Environment from the Prevention, Early Detection and Treatment Fund.

Medicaid Mental Health Community Programs Summary (Exhibit CC):

Exhibit CC presents a summary of mental health caseload and capitation expenditures itemized by eligibility category as well as a summary of the rest of the Mental Health Community Programs. The summary reflects the overall change in capitation expenditures from $184,640,568 during FY 06-07 to an estimated $206,859,423 for the FY 08-09 Budget Request. At the same time, total Medicaid Mental Health Community Programs expenditures increased from $220,303,363 (including the $1.5 million overexpenditure) in FY 06-07 to an estimated $250,600,083 for FY 08-09. During that time frame, capitation expenditures decreased from 83.8% to 82.2% of total Medicaid Mental Health Community Program expenditures. These calculations include an increase of $9,445,931 in Medicaid Anti-Psychotic Pharmaceuticals.

The net capitation payments include recurring events, such as net recoupment of payment for clients later deemed ineligible for Medicaid (explained in detail on page F.FF-2), but not one-time events, such as the impact of a prior year overexpenditure restriction. In this manner, recurring events become part of the capitation base. One-time events are separately identified and are not folded into trended analyses by eligibility category. One-time adjustments not incorporated into trended capitation expenditures are listed in Exhibit EE.

Mental Health Caseload and Per Capita History and Projections, Expenditure History, and Calculations for Goebel Adjustments, for FY 08-09 Request (Exhibit DD):

Exhibit DD has been completely revised for the FY 08-09 Budget Request. Per capita history and projections, formerly in Exhibit EE, have been significantly expanded to provide information on each of the nine eligibility categories. The same is true for per capita projections and historical expenditures. The calculations, including the Goebel lawsuit expenditures into the expenditure history, are included for FY 03-04 through FY 05-06. Each of the tables that comprise Exhibit DD is described below.

Medicaid Mental Health Community Programs Caseload for FY 08-09 Request

Medicaid Mental Health Community Programs caseload is displayed in two tables. Table 1 is the same format as previous years showing total caseload for the combined disabled categories as well as the combined Adult categories. Table 2 displays caseload by all Mental Health eligibility categories. Figures for FY 03-04 through FY 06-07 are actual caseloads, while FY 07-08 and FY 08-09 caseloads are trended current estimates. The caseload numbers and percentage changes are used in numerous exhibits throughout the Medicaid Mental Health Community Programs Exhibits and narrative.

Medicaid Mental Health Community Programs Per Capita Historical Summary

As with caseload, Medicaid Mental Health Community Programs per capita is displayed in two tables. Table 1 sets forth total per capita for the combined disabled categories as well as the combined Adult categories. Table 2 displays per capita by all Mental Health eligibility categories. However, since the actual per capita from Table 1 is the same for both disabled categories, and the three Adult categories have a single per capita, the true per capita is shown in those categories and will not mathematically be the same as dividing each individual category expenditure by the caseload. Figures for FY 03-04 through FY 06-07 are actual caseloads, while FY 07-08 and FY 08-09 caseloads are trended current estimates. The per capita numbers are used in numerous exhibits throughout the Medicaid Mental Health Community Programs Exhibits and Narrative.

Medicaid Mental Health Community Programs Expenditures Historical Summary

The history of expenditures covers FY 04-05 through FY 06-07, includes combined category and expanded category tables, as well as total expenditures for both capitations and fee-for-service expenditures. For fee-for-service expenditure, service categories are listed separately. Expanded service category information for fee-for-service expenditure is not available prior to FY 04-05.

As described briefly in "Analysis of Historical Expenditure Allocations across Eligibility Categories" above, actual expenditures are only available from the Colorado Financial Reporting System. Expenditures by eligibility category, other than the Breast and Cervical Cancer Treatment Program, are not available from the Colorado Financial Reporting System. The Medicaid Management Information System does provide expenditures by eligibility category, but does not include offline transactions and accounting adjustments. Since the two systems are within 0.3% of each other, data from the Medicaid Management Information System can be used to distribute total expenditures from the Colorado Financial Reporting System across eligibility categories.

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

eligibility category are determined, they may be divided by the actual average monthly caseload for each eligibility category to determine the actual per capita for each eligibility category. This is the base year information necessary to develop estimate and request year figures. The per capita are then labeled on page F.DD-2 as FY 06-07.

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

For comparative purposes, expenditures for all years must contain the same primary components. However, expenditures for Goebel enhanced services were not included in the capitation payments for the years shown prior to FY 06-07. Therefore, an adjustment was made for those years. The table sets forth actual expenditures including the Goebel expenditures. Actual expenditures were distributed by an average percentage from available years since actual percentages were not available for every year. These are the capitation expenditures used in the previous sections of this exhibit.

Medicaid Mental Health Community Programs FY 07-08 Estimate and FY 08-09 Budget Request (Exhibit EE):

Exhibit EE provides calculations for exhibits that use FY 06-07 Actuals, FY 07-08 Estimate year, and/or FY 08-09 data. The calculations for eligibility category expenses and per capita in the FY 06-07 base year, as well as development of the FY 07-08 Estimate year and the FY 08-09 Budget Request year are presented in this exhibit. It is from this exhibit that data in other exhibits regarding these years was derived.

The Department has adopted a per capita budget methodology that incorporates the mental health caseload shown in Exhibit DD by eligibility category and Medicaid Mental Health Capitation Program expenditures using combined disabled categories as well as combined Adult categories. Per capita methodology has been used to calculate the FY 07-08 Estimate and to develop the FY 08-09 Budget Request. Per capita budget methodology is a zero-based budget tool that examines the cost per eligible Medicaid client and multiplies that unit cost by the number of clients expected. Historical data shown in detail in Exhibit DD began in FY 03-04 because the transfer of Medicaid Mental Health Services to the Department began in the last quarter of that year. Prior data not only had a different accounting basis, but reflected different rates, services, and provider groupings.

The per capita budget methodology is straightforward. In FY 06-07, the base year, per capita costs were calculated by dividing total actual expenditures for each eligibility category by the actual average monthly mental health caseload shown in Exhibit DD to determine a per capita cost for the base year by eligibility category. This represents an average amount spent per client by eligibility category in the base year. This calculation is important since the base year is the most recent year for which actual expenditures and caseload are available. Once the base year amounts were determined, the FY 07-08 Estimate and FY 08-09 Budget Request per capita were developed.

To develop the FY 07-08 estimate, the Department starts with total year-to-date expenditure and the year-to-date per capita cost. This per capita cost is not final; because of the cash-based accounting system, per capita costs reflect payments from prior years as well as the current years. Therefore, the Department adjusts the current half-year per capita to account for the estimated change in the per capita cost from the first half of the year to the second half. The adjusted per capita is multiplied by the estimated average monthly caseload for the second half of FY 07-08, and the sum of the expenditure from the first and second halves of the fiscal year constitute the estimated FY 07-08 base expenditure. The Department then subtracts the estimated value of recoupments expected to be performed during FY 07-08. This is the estimated FY 07-08 total expenditure.

To develop the FY 08-09 estimate, the Department beings with the FY 07-08 Base Per Capita Cost. This figure does not include expected recoupments in FY 07-08. The base per capita is trended forward using the average percentage increase in the actuarially certified rates between FY 05-06 and FY 07-08. The Department's rationale for this trend factor is described below. This per capita is then multiplied by the FY 08-09 projected caseload to determine the expenditures before adjustments (the "Base Expenditure"). The Department then subtracts the estimated value of recoupments expected to be performed during FY 08-09. This is the estimated FY 08-09 total expenditure.

Beginning in January 2009, the Department will implement calendar year rates instead of fiscal year rates. Since the actuarially certified percentage increase is accepted as the most reliable predictor of mental health capitation expenditure growth, the Department has adjusted the FY 08-09 per capitas by 3.70%. This percent is based on the actuarially sound inflation factor that all plans will be given for the period of July 1, 2008 – December 31, 2008. This rate increase is constant across all aid categories. It is unknown at this time whether growth will be substantially different after the end of the current contracts. Therefore, the Department assumes that while payments between plans and regions may change, overall growth, as measured in the Budget Request, will hold to the predicted 3.70%.

It is important to note that the Department does not adjust projected expenditure for either estimated costs due to the Goebel lawsuit, or SB 07-002 (Expansion of Foster Care). Goebel payments were included in the FY 06-07 capitation base and are included as part of the total estimate. The Department accounts for SB 07-002 by increasing total caseload by the estimated number of clients. This adjustment is described in detail in the Medicaid Caseload portion of this Budget Narrative. Because these clients are paid at the same capitation rate as other foster care children, no additional adjustment needs to be made.

Actuarially Certified Rates

The determination of capitated rates with the behavioral health organizations needs to be actuarially certified and approved by the Centers for Medicare and Medicaid Services, thus actuarially certified rate increases could reasonably be expected to be good predictors of future costs. The trended cost analysis by the Department's contracted actuary began by reviewing encounter data and financial reports from each behavioral health organization and regions, and annual average rate increases for various service areas.

Then, the analysis was used to develop estimates of cost increases or cost factors for each service area through FY 07-08 and an average trend for each was calculated.

For the FY 07-08 Supplemental Request, the Department has replaced the trend factor based on the actuarially sound rate increase with actual expenditure data. For FY 08-09, the Department uses the actual increase, 3.70%, which will be applied to each provider and aid category.

Reconciliation of Spending Authority to Actual Expenditures (Exhibit FF):

This exhibit has been revised for the February 15, 2008 Budget Request, and is now a similar format to the Medical Services Premiums Exhibit L. This exhibit displays the FY 06-07 final actual total expenditures for the Medicaid Mental Health Community Program, including fund splits, and the remaining balance of the FY 06-07 appropriation (if applicable).

Explanation of FY 06-07 Overexpenditure:

In FY 06-07, there was a total funds overexpenditure of $1,499,555. While the actual caseload was 0.05% under the appropriation, a change in mix between high and low cost eligibility categories, and a change in the mix of various behavioral health organizations' rates, contributed to the overexpenditure. The overexpenditure was the net of: greater than anticipated caseload in Children/Foster Care and Adults, with capitation payments $2.1 million and $0.1 million over the projected amounts, respectively, and lower than anticipated caseload in the disabled category, which had capitation payments $0.7 million under the appropriated amount.

Of the Department's overexpenditure, $1,474,141 was General Fund and $750,906 was federal funds. Total overexpenditure was partially offset by an underexpenditure of $725,492 in Cash Funds Exempt. Underexpenditure, however, does not cause any restrictions to the Department's appropriation. Pursuant to Section 24-75-109 (4) (a), C.R.S. (2007), the Department will require a supplemental appropriation to lift the restriction.

Mental Health Recoupment of Payments Made for Clients Found to be Ineligible for Medicaid (Exhibit FF):

Capitation payments are made on a monthly basis throughout the year in the Medicaid Management Information System. When clients are determined to be eligible for benefits retroactively, retroactive capitation payments are made to the behavioral health organizations through the Medicaid Management Information System. When clients are determined to be ineligible for Medicaid benefits retroactively, a recoupment of the capitation payments is completed separately. Because this recoupment is a recurring process, it is regarded as part of the capitation base for analytical purposes. Page F.FF-2 summarizes the expected fiscal impacts.

The Department has worked to reduce the payments to the behavioral health organizations for clients later deemed ineligible for Medicaid. Historically, monthly capitation payments were made on a prospective basis. In February 2004, the Department converted to concurrent capitation payments. FY 04-05 was the first full year for monthly capitation payments on a concurrent basis.

Prior to FY 05-06, the recoupment process was done once a year, with a two-year lag. Implementation of biannual recoupments with a one-year lag will shorten the time to recoup capitation payments made for retroactively ineligible clients. No recoupments were made during FY 05-06 due to a computer programming change, which was completely implemented in early 2007. The estimated FY 07-08 and FY 08-09 recoupments have been decreased as a result of more timely eligibility processing due to the implementation of the Colorado Benefits Management System and a systems change made in FY 06-07 to pop-up a warning message to Colorado Benefits Management System users when the potential for cancellations or retroactive terminations arises. The warning is intended to minimize the number of retroactive terminations or benefits cancellations. Since payments should be minimized during months where a client was terminated, no recoupments will be necessary for them. As the implementation was begun before any recoupments were made, the Department chose not to process any recoupments in FY 05-06. There was time for only one year's recoupments to be made for FY 03-04 ineligibles in FY 06-07. It is planned that recoupments for FY 04-05 and FY 05-06 ineligibles will be made in FY 07-08 which will bring the Department to a one year lag beginning in FY 08-09. The Department's estimate of FY 07-08 recoupments of payments made during FY 04-05 and FY 05-06, when concurrent capitation payments were made throughout the year, reflects the effect of the change to concurrent recoupments. Changes due to the change in termination procedures mentioned above will be reflected in future years. Due to these two changes, the amount of funds the Department recoups is expected to drop significantly from the past.

Tobacco Tax Impacts on General Fund, Cash Funds Exempt, and Federal Funds Match Calculations (Exhibit GG):

Exhibit GG is a stand-alone exhibit designed to show the effect of the Tobacco Tax Bill (HB 05-1262) to the Medicaid Mental Health Community Programs. This exhibit presents projected caseload and costs itemized by eligibility category for the FY 07-08 Estimate and the FY 08-09 Budget Request. Note that the caseloads shown are the average monthly number over each year and will fluctuate monthly through the year.

HB 05-1262 established a number of funds, two of which provide funding to the Medicaid Mental Health Community Programs line: the Health Care Expansion Fund administered by the Department, and the Prevention, Early Detection, and Treatment Fund administered by the Department of Public Health and Environment. The Health Care Expansion Fund provides capitated mental health funding for expansion adults, individuals eligible as a result of the removal of the Medicaid asset test, as well as the Children's Extensive Support and Children's Home and Community Based Services waiver programs. The Prevention, Early Detection, and Treatment Fund provides funding for cancer treatment through its Breast and Cervical Cancer Treatment program. The caseload attributable to these clients is included in the mental health caseload in Exhibit DD and therefore is included in all exhibits that include caseload.

With the passage of HB 05-1262, the Department received funding to provide services to the 478 individuals on the Children's Home and Community Based Services waiver program waiting list. In addition, the Joint Budget Committee decided to add an additional 200 expansion slots during FY 06-07 Figure Setting (see the March 13, 2006 Figure Setting Document, page 145). In total, there are 678 expansion slots in the Children's Home and Community Based Services waiver program that will be served in FY 07-08 and subsequent fiscal years. Please see Exhibit GG for the Department's projected Health Care Expansion Fund expenditures for the Children's Home and Community Based Services.

HB 05-1262 also provided additional funding to pay for 148 individuals on the Children's Extensive Support wait list. However, since 99 of these clients were already Medicaid eligible, expenditures associated with these clients cannot be billed to the Health Care Expansion Fund. Therefore, only 49 of the original 148 expansion slots are funded with Health Care Expansion Fund money. During FY 06-07 figure setting, the Joint Budget Committee approved an additional 30 expansion slots (March 13, 2006 Figure Setting Document, page 145), of which 10 will be paid for through the Health Care Expansion Fund. In total, the Department expects to pay for 59 Children's Extensive Support expansion slots in FY 07-08 and subsequent fiscal years. Exhibit GG provides additional detail regarding the Department's FY 07-08 and FY 08-09 estimate of expenditures for the Children's Extensive Support expansion population.

The Health Care Expansion Fund also provides capitated mental health services to expansion adults. This population consists of individuals that meet the following requirements: 1) they are parents of children that are eligible for either Medicaid or the Children's Basic Health Plan, 2) their income is less than 60% of the federal poverty level, and 3) they are not otherwise eligible for Medicaid. The estimated caseloads of 8,151 in FY 07-08 and 9,629 in FY 08-09 were taken from the Department's caseload projections provided in this November 1, 2007 Budget Request (see Exhibit EB – 1). Per capita costs for each expansion population are assumed to be the same as for the traditional populations. This is because the vast majority of mental health services payments are made via the capitation, and do not change based on client utilization.

Finally, the Health Care Expansion Fund pays for individuals that are eligible for Medicaid as a result of the removal of the asset test, as required by HB 05-1262. Due to the fact that many Medicaid recipients are no longer required to submit information for the asset test, the Department has found it difficult to track expenditures for this population. Currently, approximately 50% of the total asset test removal population has an asset test flag that allows the Department to discern whether or not they are eligible as a result of the removal of the asset test. To project expenditures in the Medicaid Mental Health Community Programs line for the asset test removal population from FY 07-08 and forward, the Department has applied its estimated caseload and per capita growth rates from FY 06-07 to FY 07-08 to actual FY 06-07 expenditures. As a result, the Department estimates that the asset test removal population will require $5,323,236 and $5,364,751 in total funds for FY 07-08 and FY 08-09, respectively.

(B) OTHER MEDICAID MENTAL HEALTH PAYMENTS

All Medicaid Mental Health Community Programs payments which are not part of the capitation payments are under this Long Bill group. Of the two appropriations in this group, only Mental Health Fee-For-Service Payments are actual expenditures while Mental Health Anti-Psychotic Pharmaceuticals, which are paid from Medical Services Premiums, are included for information only.

Medicaid Mental Health Fee-for-Service Payments (Exhibit HH):

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

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

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

History and Background Information

The nature of Medicaid Mental Health Fee-for-Service Payments has changed in recent years. Prior to FY 02-03, Fee-for-Service Payments were included in the Medicaid Mental Health Capitation base appropriation. During FY 02-03, case management services provided by community mental health centers were included in the Mental Health Fee-for-Service Payments appropriation. During FY 03-04, case management services were provided by Single Entry Point agencies and were still part of the Mental Health Fee-for-Service Payments appropriation, but they were moved to the Medical Services Premiums appropriation in FY 04-05. Also during FY 04-05, fee-for-service mental health care for developmentally disabled clients living in Regional Centers was transferred from the Department of Human Services to the Department's Mental Health Fee-for-Service Payments appropriation. The changes to case management services and mental health care for developmentally disabled clients are discussed below.

Historically, community mental health centers provided case management services to the Children's Home and Community Based Services for the Mentally Ill waiver clients on a fee-for-service basis. Effective July 1, 2003, the Department began utilizing contracted Single Entry Point agencies for these services instead of the community mental health centers. Funding for these case

management services remained in the fee-for-service payments appropriation for FY 03-04. However, since Single Entry Point contracts are customarily paid from the Medical Services Premiums, the Department requested that these services be transferred to the Medical Services Premiums Long Bill group. The supplemental appropriation to the Department (SB 05-112) moved Single Entry Point case management from the Mental Health Fee-for-Service Payments line item to the Medical Services Premiums line item in FY 04-05 and was effective July 1, 2004.

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

In FY 05-06 there was a one-time recoupment of $303,492 in the inpatient services area for disallowed payments going back to FY 01-02. The recoupment was added back to get an accurate base for trending forward. The recoupment was then deducted to arrive at a bottom line expenditure which matches data from the Colorado Financial Reporting System. The expenditures in Exhibit HH are broken out into the three major categories which make up Medicaid Mental Health Fee-for-Service: inpatient services, outpatient services, and physician services.

Current Calculations

The FY 07-08 Estimate is based on current year-to-date expenditure, adjusted to reflect the full year, to $1,435,786. The FY 07-08 Estimate is trended forward by the change in the mental health caseload to the FY 08-09 Budget Request. The requested amount is $10,550 less than FY 07-08 Estimate. The Department's request incrementally decreases $63,767 from the FY 07-08. No rate or utilization increases are forecast. Please see the Medicaid Mental Health Fee-for-Service Payments table that reconciles to the Department's FY 07-08 Estimate and FY 08-09 Budget Request.

Mental Health Anti-Psychotic Pharmaceuticals:

This line is included in the Other Medicaid Mental Health Payments appropriation section within the Long Bill for informational purposes only. Original funding is in the Medical Services Premiums Long Bill group of the Department's budget. For calculations of the requested amount, see Calculation of Anti-psychotic Drugs under the Medical Services Premiums section, Exhibit F. Through implementation of the Medicare Modernization Act, the costs to the State for providing prescription drugs, including anti-psychotic medications, were expected to decline. However, the rate of increase for anti-psychotic medications has been approximately the same, and is projected to continue.

In this Budget Request, the Department is officially requesting the removal of the Medicaid Anti-Psychotic Pharmaceuticals line item. This will not impact the Department's ability to pay for these drugs, as they are still part of the Medicaid physical health benefit (as are all other pharmaceuticals related to the treatment of mental health conditions, such as anti-depressants). The Department will continue to report expenditure for anti-psychotics in its Budget Request in future years (such as in Exhibit F of the exhibits for Medical Services Premiums, and/or the Strategic Plan), and so no information will be lost from the Budget Request.

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

Global Reasonableness Test for Mental Health Capitation Payments (Exhibit II):

This exhibit displays several global reasonableness tests as a comparison to the projection in this Budget Request.