Department of Health Care Policy and Financing
Strategic Plan
FY 08-09 Budget Request

NOVEMBER 1, 2007

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DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
FY 08-09 STRATEGIC PLAN

I. INTRODUCTION

In 1993, Governor Roy Romer signed into law House Bill 93-1317 restructuring health and human services delivery systems in Colorado. The goal of this law was to streamline government functions and to make more efficient and effective use of State and local resources. Prior to restructuring, the Department of Social Services performed health and human services functions and administered the Medicaid program. Under the new structure effective July 1, 1994, the Departments of Institutions, the Alcohol and Drug Abuse Division, and most of Social Services were combined into the new Department of Human Services. The Medicaid program was moved from the Department of Social Services to the Department of Health Care Policy and Financing, along with several other non-Medicaid health care programs and health policy functions.

The Department of Health Care Policy and Financing is the federally recognized Single State Agency designated to administer or supervise the administration of the Medicaid program. As such, in order to receive federal financial participation, the Department is responsible for the provision of all health care services to persons who qualify as categorically needy under Title XIX of the Social Security Act. The Department oversees services and distributes administrative costs through interagency agreements with other departments. Because the Department Health Care Policy and Financing is the Single State Agency designated to administer or supervise the administration of the Medicaid program, a number of statewide programs and services are financed through the Department's budget each fiscal year. Included in these programs and services are services for developmentally disabled individuals, mental health institutes, and nurse aide certifications.

In addition to the Medicaid program and the Children's Basic Health Plan, the Department manages:

- The Colorado Indigent Care Program: This is a State designed and operated program, primarily financed by Title XIX and Title XXI of the Social Security Act through the federal disproportionate share and upper payment limit mechanisms. This program provides partial reimbursement to health care providers for providing medical care to eligible uninsured and underinsured residents.

- Old Age Pension State Medical Program: This State-only program provides limited medical care for non-Medicaid individuals receiving Old Age Pension grants. Eligible recipients for program benefits are over the age of sixty, but do not meet the Supplemental Security Income criteria, and are therefore ineligible for Medicaid. This program is funded with $10 million established in the State's constitution and additional funding through statute. HB 05-1262 states that three percent of annual

Tobacco Tax revenue shall be appropriated to the Cash Fund for Health-Related Purposes, and 50% of this fund shall be annually transferred to the Supplemental Old Age Pension Health and Medical Care Fund. This is in addition to the $750,000 appropriated to this fund each year.

- The Comprehensive Primary and Preventive Care Grant Program: This program was established to provide grants to health care providers in order to expand primary and preventive care services to Colorado's low-income, uninsured residents. The program is paid through the Comprehensive Primary and Preventive Care Fund created in Section 25.5-3-207, C.R.S. (2007).

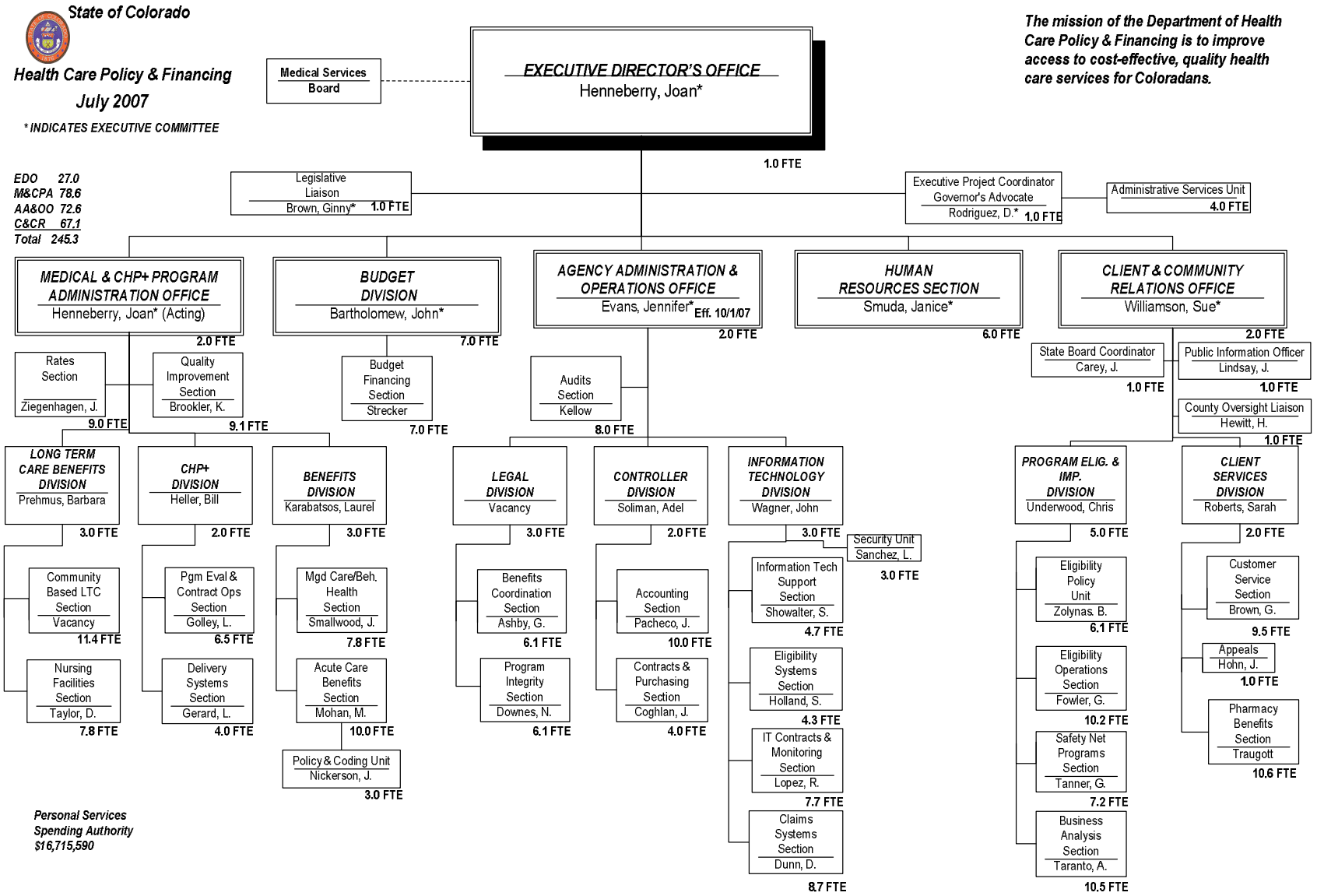
- The Primary Care Fund: This fund was created to provide an allocation of moneys to health care providers that make basic health care services available in an outpatient setting to residents of Colorado who are considered medically indigent. Allocations are based on the number of medically indigent patients that received services from a health care provider in an amount proportionate to the total number of medically indigent patients served by all health care providers who qualify for moneys from this fund. This program is funded through an increase in Colorado's tax on cigarettes and tobacco products which became effective January 1, 2005, in accordance with Section 21 of Article X (Tobacco Taxes for Health Related Purposes) of the State Constitution.

Department Overview

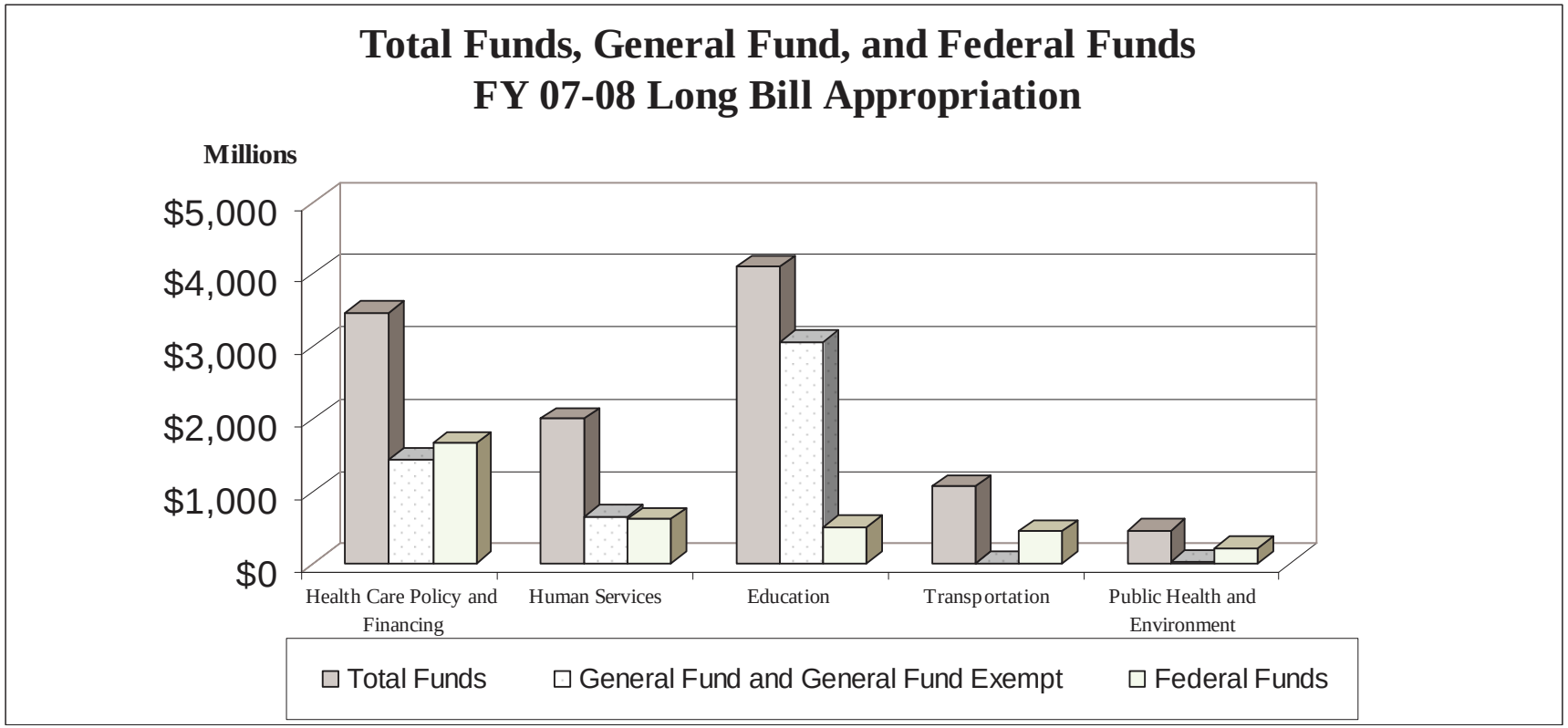
Joan Henneberry serves as the Executive Director. The Department is split into three primary offices, including the Client and Community Relations Office, the Medical and Child Health Plan Plus Program Administration Office, and the Agency Administration and Operations Office. With 245.3 FTEs, Health Care Policy and Financing is the fourth smallest Department in terms of staff size, but, after K-12 Education, Health Care Policy and Financing is the second largest Department budget in State government, second largest consumer of General Fund and General Fund Exempt (23%) based on the FY 07-08 Long Bill (SB 07-239), and first in federal funds drawn.

The Medical Services Board is the entity authorized under statute to adopt rules for the Department's programs, and the Governor appoints its members. Joan Johnson chairs the Medical Services Board.

Departmental Organizational Chart



Comparison of Department's Funds to Other State Departments' Funds



Source: SB 07-239

Comparing Colorado to Other States in Federal Region

For administrative purposes, the Centers for Medicare and Medicaid Services divide the country into ten regions, each home to a regional office. The regional offices are responsible for the administration of the Medicare, Medicaid and the State Children's Health Insurance Program and range in size from two to seven states. Some regional offices have responsibilities for the U.S. Territories in the Caribbean and South Pacific. Colorado is in Region VIII, as are Montana, North Dakota, South Dakota, Utah, and Wyoming.

The following information shows data for the six states comprising Region VIII, to better understand how Colorado compares to its neighboring states. The following information is from the Kaiser Family Foundation's State Facts Online website as of June 2007. *Some components differ from data reported directly by the Department.*

Regional Comparison from Kaiser Family Foundation's State Facts Online										
	FY 06 FMAP	FY 07 FMAP	Estimated Total State Population 2006	Total Medicaid Enrollment in FY 2004	Medicaid Enrollees as % of State Population in FY 2003	Medicaid Expenditures for Benefits and DSH in FY 2005	SCHIP Federal Match in FY 2007	SCHIP Monthly Enrollment June 2006	Income Eligibility as Percent of FPL for SCHIP in FY 2006	SCHIP Total Expenditures in FY 2006
Colorado	50.00%	50.00%	4,753,377	524,600	10%	$2,815,736,074	65.00%	53,894	200%	$92,673,334
Montana	70.54%	69.11%	944,632	112,900	12%	$703,927,288	78.38%	13,165	150%	$21,816,754
North Dakota	65.85%	64.72%	635,867	75,000	12%	$514,888,924	75.30%	4,454	140%	$14,057,263
South Dakota	65.07%	62.92%	781,919	124,000	16%	$614,957,601	74.04%	11,323	200%	$13,991,825
Utah	70.76%	70.14%	2,550,063	295,000	12%	$1,365,765,348	79.10%	35,724	200%	$56,897,188
Wyoming	54.23%	52.91%	515,004	77,600	15%	$410,256,938	67.04%	5,263	200%	$9,352,443

FMAP = Federal Medical Assistance Percentage

FFY = Federal Fiscal Year

FPL = Federal Poverty Level

DSH = Disproportionate Share Hospitals

SCHIP = State Children's Health Insurance Plan (federal term)

Source: Statehealthfacts.org website for all columns excluding population estimates. Estimated total State population is census.gov/popest/states/tables/NST-EST2006-01

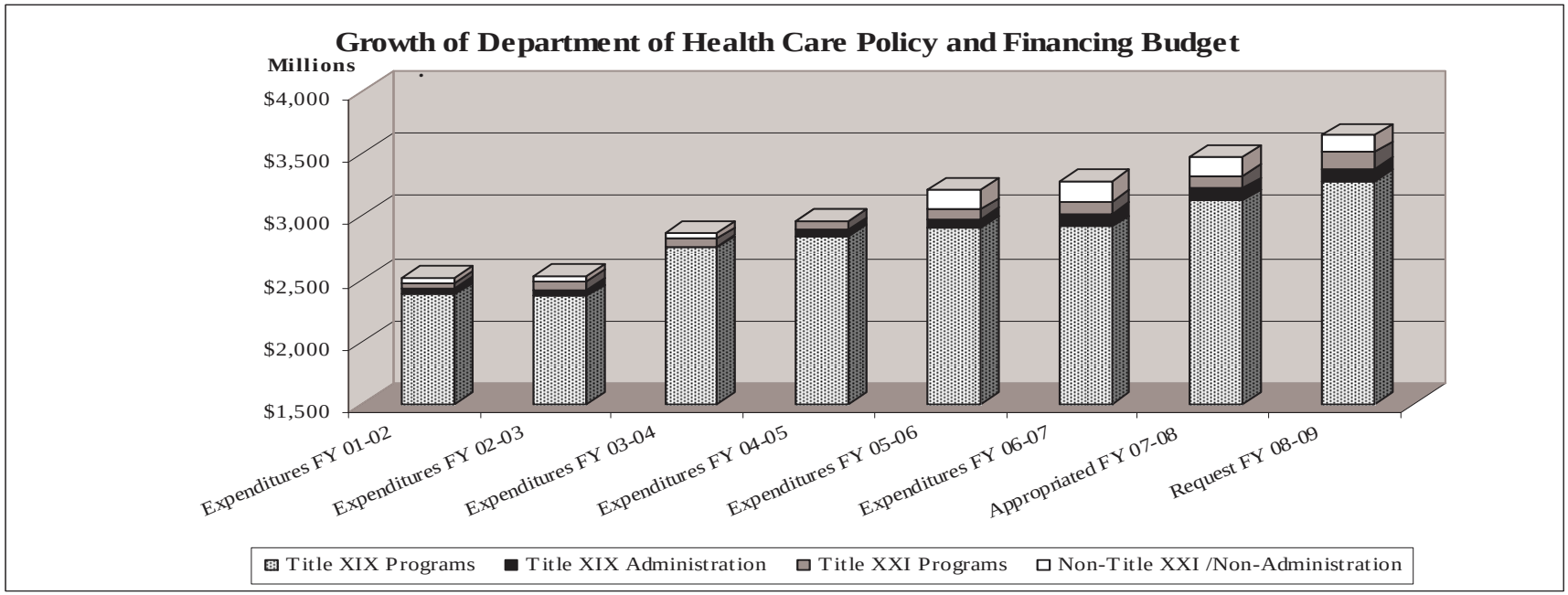
Colorado, Montana, and Utah suspended enrollment in the State Children's Health Insurance Plan between June 2002 and April 2003.

The appropriation for FY 07-08 (including new legislation) exceeds $3.4 billion total funds. The federal match is computed from statewide per capita income using a nationally standardized formula and is reported by the Federal Funds Information Service. The federal match rate available for the Children's Basic Health Plan is 65%; the State's Medicaid match is 50%. Most of the Department's administration costs are privatized or, in some cases, are contracted out to other executive departments. The FY 07-08 Long Bill (SB 07-239) resulted in the following approximate allocation for Department programs:

Total FY 07-08 Long Bill Appropriation (SB 07-239)	**$3,474,770,952**	**100.0%**
Direct Care Services administered by Health Care Policy and Financing	$2,978,670,419	85.7%
Department of Human Services Programs	$401,686,195	11.6%
Contractual Services (including other State departments except Department of Human Services)	$75,231,041	2.2%
Department Administration (Personal Services, Operating, Health, Life and Dental, Short-term Disability, Amortization Equalization Disbursement, Worker's Compensation Performance Based Pay and Salary Survey)	$19,183,297	0.5%

Department Budget Growth and Outlook for FY 07-08 and FY 08-09

Title XXI of the federal Social Security Act is the State Children's Health Insurance Plan (SCHIP), also known in Colorado as Children's Basic Health Plan or Child Health Plan Plus. Title XIX of the Social Security Act is Grants to States for Medical Assistance Programs, better known as the Medicaid program. The following table sets forth the expenditures from FY 01-02 through FY 06-07, the amounts appropriated for FY 07-08 and the budget request for FY 08-09 for Title XIX and Title XXI programs.



Source: November 1, 2007 Budget Request for FY 05-06, FY 06-07, FY 07-08 and FY 08-09

II. STRATEGIC PLAN DIRECTION

Mission

The mission of the Department of Health Care Policy and Financing is to improve access to cost-effective, quality health care services for Coloradans.

Vision

Leadership and staff will partner with stakeholders, providers and clients to achieve the goals of the Department, and to implement the health care initiatives outlined in the Colorado Promise.

Goals

A. The Department will improve health outcomes for all clients and ensure that the health care the Department purchases are medically necessary, appropriate to the population, and cost-effective.

B. The Department will establish and maintain providers, clients, advocacy groups, counties, and other units of government as partners.

C. The Department will build and maintain a high quality, customer-focused team.

D. The Department will continuously improve its business processes, systems, eligibility determinations, payments, and financial projections.

Objectives

A. Assure delivery of appropriate, high quality health care in the most cost-effective manner possible. Design programs that result in improved health status for clients served and improve health outcomes. Expand and preserve health care services through the purchase of services in the most cost-effective manner possible.

B. Improve customer satisfaction with programs, services, and care. Support timely and accurate client eligibility determination.

C. Value Department personnel through effective recruitment, hiring, training, and retention. Allocate its staff and resources in ways that ensure that the Department's priorities are met.

D. Audit expenditures for fraud, abuse, client eligibility, and accuracy in third party payments both internally and with the use of contingency contractors.

E. Provide accurate and consistent information to internal and external customers.

F. Monitor expenditures for programs managed by the Department to ensure accurate financial reporting at all times.

III. PERFORMANCE MEASURES

Performance Measures for the November 1, 2007 Budget Request

Department / Division / Section	Performance Measure	Outcome	FY 05-06	FY 06-07	FY 07-08	FY 08-09
Department	Increase the number of clients served through targeted, integrated care management programs. *Supportive of Goal A.*	*Benchmark*	New Measure / Initiative	New Measure / Initiative	Add 500 clients	Add 500 clients over FY 07-08
		Actual	N/A	N/A	Unknown	Unknown
Department	Increase the number of children served through a dedicated medical home service delivery model. *Supportive of Goal A.*	*Benchmark*	New Measure / Initiative	New Measure / Initiative	Add 15,000 clients	Increase clients by 10% over FY 07- 08
		Actual	N/A	N/A	Unknown	Unknown
Department	Survey customer satisfaction with managed care using the Consumer Assessment of Health Plans Survey (CAHPS). *Supportive of Goals A and B.*	*Benchmark*	N/A	N/A	Increase to at least the NCQA National Medicaid 80th Percentile	Maintain satisfaction at the NCQA National Medicaid 80th Percentile
		Actual		See CAHPS Summary, Section IV	Unknown	Unknown

Department / Division / Section	**Performance Measure**	**Outcome**	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09**
Department	Improve access to and the quality of Medicaid health care as demonstrated through improvements in Medicaid Health plan scores on Health Plan Employer Data Information Set (HEDIS) measures. *Supportive of Goals A and B.*	*Benchmark*	N/A	N/A	HEDIS National Medicaid 75th Percentile	HEDIS National Medicaid 75th Percentile
		Actual		See HEDIS Summary, Section IV	Unknown	Unknown
Department	Increase number of managed care options for clients enrolling in Medicaid. *Supportive of Objective A.*	*Benchmark*	N/A	N/A	Add one new option in the Denver Metro-area	Add one new option within the State
		Actual	Zero	Zero	Unknown	Unknown
Department / Benefits Division	Improve access to health care, increase health outcomes and provide more cost effective services using information technology. *Supportive of Goals A and B*	*Benchmark*	N/A	N/A	Serve 165 clients using telehealth / telemedicine technology	Serve 165 clients telehealth / telemedicine technology
		Actual	Zero	Zero	Unknown	Unknown

Department / Division / Section	**Performance Measure**	**Outcome**	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09**
Client Services Division	Decrease Medicaid pharmaceutical costs for therapeutic classes on the Preferred Drug List. *Supportive of Goal A.*	*Benchmark*	N/A	N/A	Decrease costs by 2%	Decrease costs by 2% over FY 07-08
		Actual	N/A	N/A	Unknown	Unknown
Benefits Division	Increase the number of clients enrolled in viable managed care options. *Supportive of Goals A and B.*	*Benchmark*	N/A	N/A	Increase by 5%	Increase by 5% above FY 07-08
		Actual		77,820 clients enrolled in viable managed care options	Unknown	Unknown
Benefits Division	Survey client satisfaction with the fee-for-service program using the Consumer Assessment of Health Plans Survey (CAHPS). *Supportive of Goals A and B.*	*Benchmark*	N/A	N/A	Increase to at least the NCQA National Medicaid 80th Percentile	Maintain satisfaction at the NCQA National Medicaid 80th Percentile
		Actual		See CAHPS Summary, Section IV	Unknown	Unknown

Department / Division / Section	**Performance Measure**	**Outcome**	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09**
Long Term Care Benefits Division	Conduct nursing facility audits (both change of ownership or risk based audits) to recoup patient payment (third party liabilities) currently used in personal needs accounts. S*upportive of Goal D.*	*Benchmark*	N/A	N/A	Increase by 0.1% over FY 06-07	Increase by 0.1% over FY 07-08
		Actual	Approximate monthly recoupment was $32,470	Approximate monthly recoupment was $82,000	Unknown	Unknown
Budget Division	Maintain or reduce the difference between the Department's spending authority and actual expenditures for Medicaid services. *Supportive of Goal D.*	*Benchmark*	N/A	N/A	1%	0.75%
		Actual	Expenditures were 0.9% below the final spending authority	Expenditures were 1.1% below the final spending authority	Unknown	Unknown

Department / Division / Section	**Performance Measure**	**Outcome**	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09**
Child Health Plan Plus	Expand coverage in the Child Health Plan Plus program. *Supportive of Goals A and B.*	*Benchmark*	N/A	N/A	Add 9,000 clients	Add 6,000 clients
					Increase statewide access to employer sponsored insurance and enrollment in the program.	Increase number of employers participating in the program to 2.
					Increase the number of enrollees to 150.	Increase the number of enrollees to 250.
		Actual		One employer participated in the program and 106 children were enrolled.	Unknown	Unknown
Human Resources	Provide specific job training to each employee. Complete and implement a comprehensive orientation and training curriculum for new staff. *Supportive of Goal C.*	*Benchmark*	N/A	N/A	New orientation training will occur within the first 60 days of employment Job specific training will be provided to at least 90% of all staff.	New orientation training will occur within the first 60 days of employment Job specific training will be provided to at least 90% of all staff.
		Actual	N/A	N/A	Unknown	Unknown

Department / Division / Section	**Performance Measure**	**Outcome**	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09**
Legal Division	Actively audit expenditures to decrease fraud and abuse and increase recoveries. *Supportive of Objective D.*	*Benchmark*			Recover payments made for services to ineligible clients or clients with trusts who are not longer Medicaid eligible.	Recover payments made for services to ineligible clients or clients with trusts who are not longer Medicaid eligible.
					Increase total recoveries in FY 07-08 to $25,000,000.	Increase total recoveries by 2% over FY 07-08.
		Actual	$24,726,808	$25,801,323.82 (which includes a one time payment of approximately $1.6 million from a class action suit)	Unknown	Unknown

Department / Division / Section	**Performance Measure**	**Outcome**	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09**
Legal Division	Conduct provider post payment audits to decrease fraud and abuse and increase recoveries. *Supportive of Objective D.*	*Benchmark*	N/A	N/A	Assess provider compliance with service documentation, medical necessity and payment accuracy	Assess provider compliance with service documentation, medical necessity and payment accuracy
					Increase provider compliance with billing requirements.	Increase provider compliance with billing requirements.
					Increase total recoveries to $10,000,000.	Increase total recoveries to $12,000,000.
		Actual			Unknown	

The FY 06-07 performance measures and the achievements towards those measures can be found in Appendix A.

IV. WORKLOAD INDICATORS

The Department collects data from various sources that provide information on consumer satisfaction, the number of clients served, as well as demographics. This information is provided below.

Consumer Assessment of Health Plans Study (CAHPS)

The Consumer Assessment of Health Plans Study (CAHPS®) [1] is a nationally recognized survey that measures client satisfaction within a given health plan and may be used to compare satisfaction across health plans. The goal of the CAHPS surveys is to effectively and efficiently obtain client information.

The Department requires Medicaid physical health plans to conduct client satisfaction surveys to ascertain whether clients are satisfied with their care, as well as TO ASCERTAIN differences between managed care clients, primary Care Provider Program and fee-for-service clients. As part of a comprehensive quality improvement effort, the Department required physical health plans to conduct the CAHPS 4.0H Survey of Adults and 4.0H Survey of Children with Medicaid clients that had been continuously enrolled in a managed care plan for at least five of the last six months of calendar year 2006. The survey period for this questionnaire was July through December 2006. The data were collected between February and May 2007. National averages for 2006 (the most recent comparative data available) are included.

[1] CAHPS is a registered trademark of the Agency for Health Care Research and Quality.

CAHPS 2007 Summary of Results, Reporting Year 2006

CAHPS Measure	Rocky Mountain Health Plans	Denver Health and Hospital Authority	Primary Care Physician Program	Fee For Service	2006 National Average
Overall Rating of Health Plan *"Using any number from 0 to 10 where 0 is the worst health plan possible, and 10 is the best health plan possible, what number would you use to rate your health plan?"* Percent rating an 8, 9 or 10.					
Adult	78	67	68	62	Unavailable
Child	82	82	78	70	Unavailable
Overall Rating of Health Care *Of those respondents who reported going to a doctor's office or clinic: "Using any number from 0 to 10, where 0 is the worst health care possible, and 10 is the best, what number would you use to rate all your health care in the last 6 months?"* Percent rating an 8, 9 or 10.					
Adult	69	66	73	67	Unavailable
Child	85	82	83	77	Unavailable
Overall Rating of Personal Doctor or Nurse *Of those respondents who saw a primary care provider: "Using any number from 0 to 10, where 0 is the worst personal doctor or nurse possible, and 10 is the best possible, what number would you use to rate your personal doctor or nurse?"* Percent rating an 8, 9 or 10.					
Adult	80	84	79	77	Unavailable
Child	86	89	80	79	Unavailable
Getting Needed Care *Getting needed care is a composite of questions regarding the ease of finding a doctor or nurse, obtaining a referral to a specialist, getting the care the respondent or a doctor believed necessary, and delays in health care while waiting for an approval. Percent rating "not a problem."*					
Adult	90	71	86	83	Unavailable
Child	87	83	81	79	Unavailable
Getting Care Quickly *Getting care quickly is a composite of questions regarding receiving help or advice over the telephone, obtaining routine appointments, obtaining care for an illness or injury, and waiting time in an office or clinic.* Percent rating "always and usually."					
Adult	88	77	84	84	Unavailable
Child	88	66	81	81	Unavailable

CAHPS Measure	Rocky Mountain Health Plans	Denver Health and Hospital Authority	Primary Care Physician Program	Fee For Service	2006 National Average
Doctors Who Communicate Well *How well doctors communicate is a composed of questions regarding how well providers listen to and explain things, whether they show respect and whether they spend enough time with the respondent.* Percent rating "always and usually."					
Adult	91	89	90	89	Unavailable
Child	94	87	89	89	Unavailable
Courteous and Helpful Office Staff *Questions regarding whether office staff at the respondent's doctor's office or clinic treated respondents with courtesy and respect and whether they were as helpful as respondents thought they should be made up the courteous and helpful office staff composite measure.* Percent rating "always and usually."					
Adult	91	N/A	N/A	N/A	Unavailable
Child	95	81	90	92	Unavailable

Health Plan Employer Data Information Set (HEDIS)

The Health Plan Employer Data Information Set (HEDIS®)[2] is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of managed health care plans. The performance measures are related to many significant public health issues such as cancer, heart disease, smoking, asthma, and diabetes that affect Medicaid populations. Each year, different HEDIS measures are selected for measurements that relate to quality improvement efforts outlined in the State Quality Improvement Work Plan.

The Department requires Medicaid health plans to conduct HEDIS measures to ascertain differences between managed care clients, Primary Care Provider Program, and fee-for-service clients. As part of a comprehensive quality improvement effort, the Department required health plans to conduct ten clinical measures on both adults and children. The 2007 data collection period (2006 calendar year) for each of the reported measures was January 1, 2006 through December 31, 2006.

[2] HEDIS is a registered trademark of the National Committee for Quality Assurance.

2007 HEDIS Colorado Medicaid (Calendar Year 2006 Data Collection) **HEDIS Rates for All Medicaid Health Plans** HEDIS is a registered trademarked product of the National Committee for Quality Assurance							
HEDIS Measure	**Denver Health**	**Rocky**	**PCPP**	**FFS**	**Total HMO**	**Colorado Medicaid Weighted Average**	**2006 HEDIS National Medicaid Mean**
Childhood Immunization Status **Percent of Children receiving immunizations by 2 years old**							
4 Diphtheria, Tetanus, Pertussis	84.8%	83.1%	61.7%	45.3%	83.4%	47.6%	76.8%
1 Measles, Mumps, Rubella	95.7%	94.1%	80.7%	60.6%	94.4%	62.8%	89.5%
3 Polio Virus immunizations	92.4%	90.1%	66.6%	57.4%	90.5%	59.3%	84.5%
2 Haemophilus Influenzae Type B	93.5%	90.3%	76.1%	59.1%	90.9%	61.2%	86.7%
3 Hepatitis B immunizations	93.5%	93.3%	62.9%	51.1%	93.3%	53.5%	85.2%
1 Chicken Pox vaccines	95.7%	88.7%	79.1%	59.1%	90.1%	61.2%	86.4%
Pneumococcal Conjugate	87.0%	78.5%	55.5%	36.7%	80.2%	39.4%	46.6%
Combo 2 Rate -- 4 DTP or DTaP, 3 OPV or IPV, 1 MMR, 2 hepatitis B, 1 Hib, and VZV	84.8%	74.5%	49.4%	37.2%	76.5%	39.5%	70.4%
Combo 3 Rate - DTaP, IPV, MMR, HiB, hepatitis B, VZV, pneumococcal conjugate	83.7%	68.0%	41.7%	28.7%	71.1%	31.1%	42.5%
Adolescent Immunizations **Percent of adolescents who received immunizations by 13 years old**							
2 Measles, Mumps, Rubella	95.7%	84.0%	30.4%	27.0%	90.1%	32.5%	70.7%
1 Hepatitis B immunizations	94.6%	81.7%	22.6%	26.5%	88.4%	30.9%	63.6%
1 Chicken Pox vaccines	91.4%	59.8%	18.7%	17.3%	76.2%	22.2%	48.3%
Combo 2 - MMR, Hepatitis B, and VZV	90.3%	53.5%	14.8%	13.9%	72.5%	18.7%	42.3%
Breast Cancer Screening							
Breast Cancer Screening - Age 42-51	34.4%	52.5%	27.3%	17.2%	42.3%	23.4%	N/A
Breast Cancer Screening Age - 52--69	46.4%	56.2%	29.6%	18.7%	50.6%	25.5%	N/A
Breast Cancer Screening Age - Total	42.2%	54.9%	28.8%	18.2%	47.7%	24.8%	53.9%
Comprehensive Diabetes							
Blood Pressure Controlled < 130/80 mm Hg	38.9%	38.4%	24.1%	19.2%	38.7%	22.9%	N/A
Blood Pressure Controlled < 140/90 mm Hg	61.8%	69.3%	32.4%	27.0%	64.7%	33.2%	
N/A	Above	Above	Above	Below	Above		
Eye Exams	46.2%	63.3%	20.4%	18.7%	52.9%	23.6%	48.6%

2007 HEDIS Colorado Medicaid (Calendar Year 2006 Data Collection)
HEDIS Rates for All Medicaid Health Plans
HEDIS is a registered trademarked product of the National Committee for Quality Assurance

HEDIS Measure	Denver Health	Rocky	PCPP	FFS	Total HMO	Colorado Medicaid Weighted Average	2006 HEDIS National Medicaid Mean
HbA1c Testing- Good control (< 7.0%)	27.5%	57.4%	17.0%	9.5%	39.2%	15.1%	N/A
HbA1c Testing - Poor control (> 9.0%)	38.9%	17.8%	74.5%	83.5%	30.7%	74.4%	49.1%
HbA1c Testing	84.2%	91.0%	49.2%	38.7%	86.6%	47.4%	76.2%
LDL-C Level <100 mg/dL	48.4%	42.3%	12.7%	9.5%	46.0%	15.0%	32.6%
LDL-C Screening	71.3%	71.8%	43.8%	36.7%	71.5%	42.9%	80.5%
Medical Attention for Nephropathy	85.2%	81.8%	40.6%	42.6%	83.8%	47.6%	48.8%
Appropriate Medications for People with Asthma							
Ages 5-9	N/A	97.4%	91.3%	92.3%	97.4%	92.4%	88.0%
Ages 10-17	N/A	79.5%	89.5%	89.4%	79.5%	88.9%	85.6%
Ages 18-56	77.9%	85.9%	85.2%	84.8%	82.2%	84.4%	83.4%
All Ages Combined	N/A	87.0%	87.9%	88.7%	84.6%	87.9%	85.7%
Prenatal & Postpartum Care							
Timeliness of Prenatal Care	77.4%	97.1%	54.0%	41.4%	91.9%	44.2%	79.1%
Postpartum Care	33.9%	75.9%	50.6%	35.5%	64.8%	37.4%	57.0%
Well Child Visits in the First 15 Months of Life							
No Visits	0.0%	1.6%	21.2%	20.7%	0.0%	20.3%	5.0%
1 Visit	0.0%	1.1%	9.2%	6.1%	0.0%	6.0%	3.5%
2 Visits	2.8%	3.7%	6.6%	8.3%	0.9%	8.1%	7.1%
3 Visits	5.6%	8.5%	6.6%	8.3%	0.9%	8.1%	7.1%
4 Visits	16.7%	25.5%	10.5%	10.5%	2.7%	10.3%	12.86
5 Visits	13.9%	31.9%	10.5%	18.3%	2.3%	17.9%	18.8%
6 or More Visits	61.1%	27.7%	35.5%	30.2%	10.0%	29.8%	48.6%
Well Child Visits in the 3rd, 4th, 5th & 6th Years of Life							
	68.6%	67.1%	21.1%	26.2%	67.7%	28.7%	63.3%
Adolescent Well-Care Visits							
	35.3%	39.5%	27.5%	23.8%	37.6%	25.2%	40.6%
Appropriate Treatment for Children with Upper Respiratory Infection							
	92.5%	90.0%	85.2%	86.8%	90.7%	86.9%	82.4%

2007 HEDIS Colorado Medicaid (Calendar Year 2006 Data Collection) **HEDIS Rates for All Medicaid Health Plans** HEDIS is a registered trademarked product of the National Committee for Quality Assurance							
HEDIS Measure	**Denver Health**	**Rocky**	**PCPP**	**FFS**	**Total HMO**	**Colorado Medicaid Weighted Average**	**2006 HEDIS National Medicaid Mean**
Appropriate Treatment for Children with Pharyngitis (CWP)							
	84.1%	80.6%	57.9%	56.3%	81.6%	58.2%	52.0%
Controlling High Blood Pressure							
Controlling High Blood Pressure - Total	55.0%	63.8%	51.1%	36.7%	59.9%	45.2%	61.4%
Controlling High Blood Pressure - Age 18-45	52.2%	55.6%	55.6%	40.3%	53.9%	46.4%	N/A
Controlling High Blood Pressure - Age 46 - 85	55.5%	64.8%	50.0%	36.1%	60.8%	45.0%	N/A
Cholesterol Management							
LDL-C Screening	73.0%	72.6%	67.6%	65.6%	72.8%	68.1%	N/A
LDL-C level of <100 mg/dL	54.1%	43.2%	29.8%	18.6%	48.0%	29.7%	N/A

Demographics and Expenditures

Demographic statistics provide valuable insight on the demand for medical care within each region. More populated areas tend to have a greater demand for medical care. Therefore, a region that is more populated is likely to have higher medical expenditures and caseloads. Likewise, as Colorado's population increases, the demand for medical care will also increase. The Department collected 2005 demographic data from the United States Census Report, "2005 American Community Survey" for: 1) population; and 2) percent of total Colorado population. However, this survey does not present data for all geographic areas.

The United States Census Bureau derives its definition of poverty from the Office of Management and Budget's Strategic Policy Directive 14. This definition of poverty accounts for family size, income, and the age of each family member. As the percentage of families living below poverty increases, the demand for medical care provided by the State will increase. Similarly, as the percentage of female-headed households increases, utilization of State provided medical care may increase. Conversely, a higher percent of the population in the labor force should result in a reduction of State provided medical care.

Medicaid

Using the Department's Business Objects of America database, FY 06-07 Medicaid data was collected for the following statistics and reported for the State in the following table, and reported by HIPAA Information Region:

- Medicaid Clients;
- Medicaid Expenditures; and
- Percentage Share of Medicaid Premium Expenditures, Statewide Total

Please note that monthly expenditures reported to the Joint Budget Committee are derived from the Colorado Financial Reporting System. Business Objects of America database extracts data on a different time span and from a different source (i.e., Medicaid Management Information System) than the Colorado Financial Reporting System. Therefore, total expenditures presented in this document will not exactly reconcile with the $2.048 billion for actual medical services reported in Exhibit M, page 1, in the November 1, 2007 FY 08-09 Budget Request.

Children's Basic Health Plan

Using FY 06-07 expenditures and caseload data for the Children's Basic Health Plan, the Department compiled the following data and reported it for the State in the following table.

- Average Number of Children per Month;
- Number of Deliveries for Women; and
- Children's Basic Health Plan Expenditures.

The Children's Basic Health Plan provides medical and dental services to children under age 19, and provides prenatal care and delivery for adult pregnant women who are at or below 200% of the federal poverty level. The total Children's Basic Health Plan expenditures presented in the statewide table below include: State-only Prenatal Program; Children's Basic Health Plan Premium Costs; Children's Basic Health Plan Dental Benefit Costs; and, Children's Basic Health Plan Administration line items.

Colorado's Demographics, Medicaid, and the Child Health Plan Plus Office – A Statewide View

Characteristics	State Totals
Demographic Characteristics	
Population, 2005	4,753,377
Percent of Population in the Labor Force, 2005[3]	70.0%
Percent of Families Below Poverty, 2005[3]	8.4%
Percent of Female Headed Households, 2005[3]	9.8%
Medicaid Characteristics, FY 06-07	
Average Number of Medicaid Clients[4]	393,077
Medical Services Premiums Expenditures	$2,061,396,808
Total Title XIX Service Expenditures[5]	$3,014,416,172
Percent of Total Medicaid Expenditures	68.4%
Child Health Plan Plus Characteristics, FY 06-07	
Average Number of Children per Month[6]	47,047
Number of Member Months for Pregnant Women[6]	1,170
Child Health Plan Plus Expenditures	$101,999,307

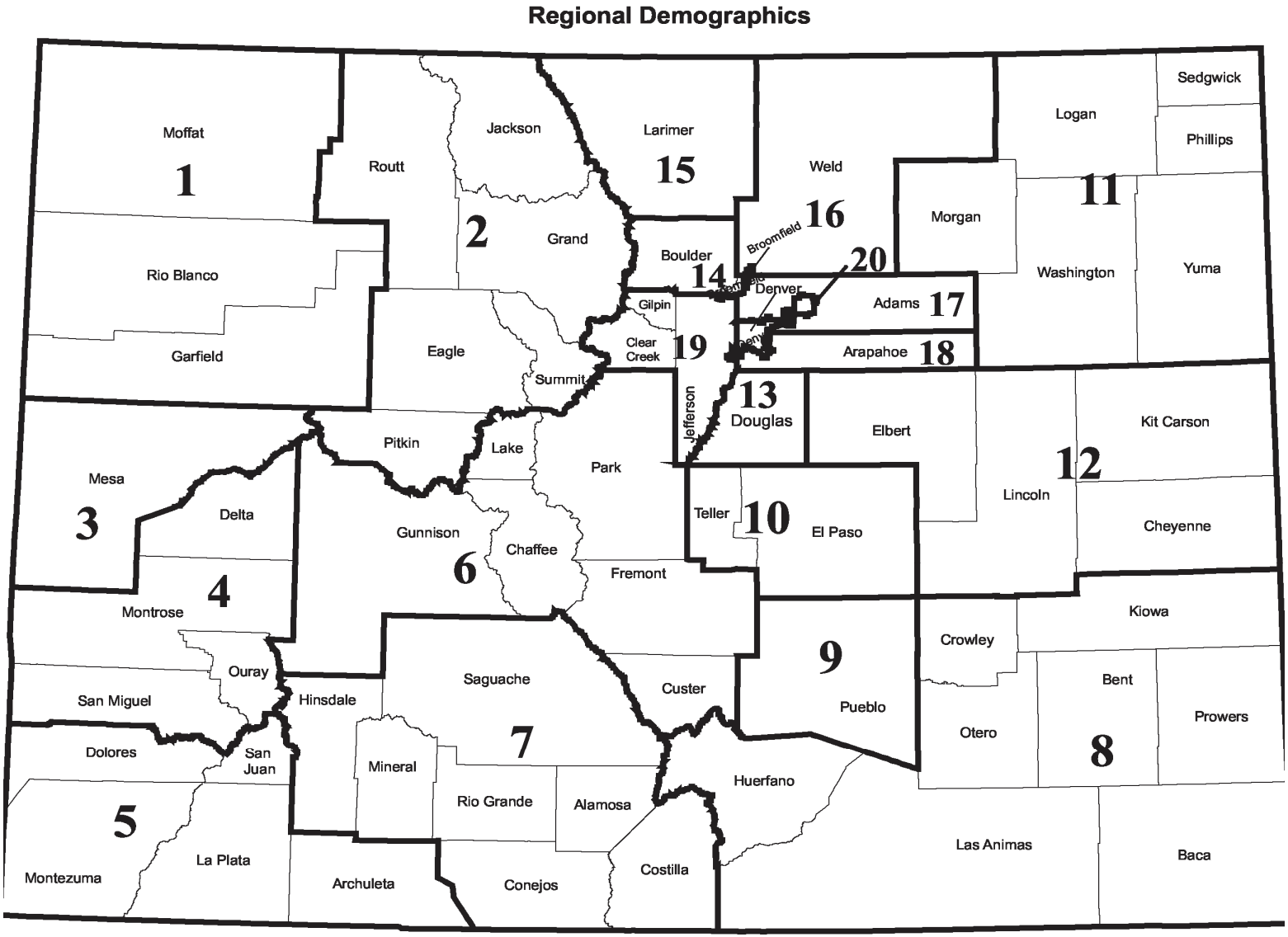
[3] Per '2006 American Community Survey' from the United States Census Bureau. The percents listed are not relative to the total population.
[4] July 16, 2007 Joint Budget Committee Report.
[5] Title XIX Service Expenditures equal $3,014,416,172. Of this $2,061,396,808 is Medical Services Premiums Expenditures, $186,008,435 is Medicaid Mental Health Community Programs, $308,747,280 from Indigent Care Program, $25,477,241 from Other Medical Services and $333,128,748 from the Department of Human Services Medicaid Funded Programs. During June accounting close, several adjustments were made to expenditures in the Medical Services Premiums as appropriate, including: additional drug rebate for unallocated amounts, adjustments to co-insurance, estate recoveries for Class I nursing facilities, and finalizing expired warrants and duplicate payments. All adjustments were for services prior to July 2007.
[6] August 21, 2007 Joint Budget Committee Report.

HIPAA Information Regions

The Health Insurance Portability and Accountability Act (HIPAA) requires that the Department release client information in a larger aggregation in order to maintain client confidentiality and anonymity in smaller counties. To do this, twenty "HIPAA Regions" were developed for the provision of Department information. Some individual counties have large enough populations to be stand-alone HIPAA Regions. The map that follows the table identifying the HIPAA regions shows how the State is separated into twenty regions. Information inquiries are responded to either on a statewide basis or by these HIPAA Regions.

HIPAA Regions	
1 = Garfield, Moffat, Rio Blanco	11 = Logan, Morgan, Phillips, Sedgwick, Washington, Yuma
2 = Eagle, Grand, Jackson, Pitkin, Routt, Summit	12 = Cheyenne, Elbert, Kit Carson, Lincoln
3 = Mesa	13 = Douglas
4 = Delta, Montrose, Ouray, San Miguel	14 = Boulder, Broomfield
5 = Archuleta, Dolores, La Plata, Montezuma, San Juan	15 = Larimer
6 = Chaffee, Custer, Fremont, Gunnison, Lake, Park	16 = Weld
7 = Alamosa, Conejos, Costilla, Hinsdale, Mineral, Rio Grande, Saguache	17 = Adams
8 = Baca, Bent, Crowley, Huerfano, Kiowa, Las Animas, Otero, Prowers	18 = Arapahoe
9 = Pueblo	19 = Clear Creek, Gilpin, Jefferson
10 = El Paso, Teller	20 = Denver

Map of HIPAA Regions



Geographical Analysis by HIPAA Region: Comparing Demographics, Medicaid, Child Health Plan Plus and Colorado Indigent Care Program

Medicaid and Child Health Plan Plus

The following table provides insight on the variations of Medicaid/Child Health Plan Plus usage across HIPAA regions. Some important caveats must be mentioned concerning the Medicaid and Child Health Plan Plus data presented in the region table. Overall, Medicaid and Child Health Plan Plus expenditure figures by region will not equal the year-to-date FY 06-07 appropriated or actual amounts. This is due to several factors:

1. The Medicaid and Child Health Plan Plus data were pulled from a different source than the rest of the Budget's exhibits to obtain regional numbers. However, there was an adjustment made to ensure that the average Medicaid caseload, pulled from the Decision Support System would match the official caseload count as reported in the "Exhibit B – Medicaid Caseload Forecast," page EB-1.
2. Regional Medicaid expenditures represent actual fiscal year totals for Medical Services Premiums only.
3. Individuals for whom no county code had been attributed yet were not included in the regional caseload or in the regional expenditures. Typically, this accounts for less than 1% of the average number of the Medicaid client population.
4. Expenditures reported to the Joint Budget Committee are derived from the Colorado Financial Reporting System, whereas the Decision Support System database extracts its data from the Medicaid Management Information System. Therefore, total Medicaid and Child Health Plan Plus expenditures presented in the table below will not exactly reconcile with the numbers for actual medical services reported in the June 2007 Expenditure Report to the Joint Budget Committee. Of all Medicaid expenditures, $12,563,701 are not linked to an eligibility type or to a unique client identification number for the following reasons:
    a. These expenditures are financial transaction payments made to individual providers, health maintenance organizations, service organizations, such as cost settlements or lump sum payments;
    b. Clients had no recorded eligibility type, gender, and/or county code.
5. Expenditures for drug rebates, Consumer Directed Attendant Support, Single Entry Point, and Supplemental Medicare Insurance Beneficiaries are not included in expenditure amounts by region since they are not processed in the Medicaid Management Information System.

Regions	**Region 1**	**Region 2**	**Region 3**	**Region 4**
Characteristics	Garfield, Moffat, Rio Blanco	Eagle, Grand, Jackson, Pitkin, Routt, Summit	Mesa	Delta, Montrose, Ouray, San Miguel
Demographic Characteristics				
Colorado Population Estimate (2007)	74,309	137,533	135,989	83,441
Percent of Total Colorado Population (2007)	1.52%	2.81%	2.77%	1.70%
Colorado Population (2000)	63,429	119,558	117,653	72,113
Percent of Population in the Labor Force (2000)	69.30%	78.50%	64.20%	66.10%
Percent of Homes where Language Other Then English is Spoken (2000)	10.10%	11.10%	8.00%	9.60%
Percent of Families Below Poverty (2000)	6.10%	4.80%	7.00%	7.50%
Percent of Female Headed Households (2000)	7.90%	5.70%	9.80%	7.10%
Medicaid Characteristics, FY 06-07				
Average Number of Medicaid Clients per Month	4,856	3,919	14,047	7,754
Percent of Regional Population that are Medicaid Clients	6.5%	2.8%	10.3%	9.3%
Medicaid Expenditures	$26,253,986	$14,847,271	$47,058,749	$29,874,027
Percent of Total Medicaid Expenditures	1.3%	0.7%	2.3%	1.5%
Children's Basic Health Plan Characteristics, FY 06-07				
Average Number of Children per Month	790	784	2,110	1,551
Percent of Regional Population that are Children's Basic Health Plan Clients	1.1%	0.6%	1.6%	1.9%
Children's Basic Health Plan Expenditures	$1,712,744	$1,699,736	$4,574,543	$3,362,615
Percent of Total Children's Basic Health Plan Expenditures	1.7%	1.7%	4.5%	3.3%
Colorado Indigent Care Program Characteristics, FY 05-06				
Number of Colorado Indigent Care Program Providers in Region	2	3	3	3
Colorado Indigent Care Program Expenditures	$580,202	$437,350	$816,302	$900,752
Percent of Total Colorado Indigent Care Program Expenditures	0.4%	0.3%	0.5%	0.6%

Regions	Region 5	Region 6	Region 7	Region 8
Characteristics	Archuleta, Dolores, La Plata, Montezuma, San Juan	Chafee, Custer, Fremont, Gunnison, Lake, Park	Alamosa, Conejos, Costilla, Hinsdale, Mineral, Rio Grande, Saguache	Baca, Bent, Crowley, Huerfano, Kiowa, Las Animas, Otero, Prowers
Demographic Characteristics				
Colorado Population Estimate (2007)	91,704	112,011	50,619	77,211
Percent of Total Colorado Population (2007)	1.87%	2.28%	1.03%	1.57%
Colorado Population (2000)	80,862	102,833	47,206	75,481
Percent of Population in the Labor Force (2000)	64.60%	61.80%	60.20%	53.30%
Percent of Homes where Language Other Then English is Spoken (2000)	9.90%	9.50%	28.70%	15.80%
Percent of Families Below Poverty (2000)	10.50%	7.40%	14.20%	13.90%
Percent of Female Headed Households (2000)	9.00%	6.60%	9.80%	10.20%
Medicaid Characteristics, FY 06-07				
Average Number of Medicaid Clients per Month	7,144	8,110	9,024	12,183
Percent of Regional Population that are Medicaid Clients	14.4%	5.3%	17.8%	15.8%
Medicaid Expenditures	$31,943,501	$48,445,237	$36,936,955	$66,831,448
Percent of Total Medicaid Expenditures	1.6%	2.4%	1.8%	3.3%
Children's Basic Health Plan Characteristics, FY 06-07				
Average Number of Children per Month	1,648	1,295	1,335	1,338
Percent of Regional Population that are Children's Basic Health Plan Clients	1.8%	1.2%	2.6%	1.7%
Children's Basic Health Plan Expenditures	$3,572,913	$2,807,599	$2,894,320	$2,900,824
Percent of Total Children's Basic Health Plan Expenditures	3.5%	2.8%	2.8%	2.8%
Colorado Indigent Care Program Characteristics, FY 05-06				
Number of Colorado Indigent Care Program Providers in Region	3	4	4	6
Colorado Indigent Care Program Expenditures	$817,093	$878,155	$1,750,240	$2,359,060
Percent of Total Colorado Indigent Care Program Expenditures	0.5%	0.5%	1.1%	1.5%

Regions	**Region 9**	**Region 10**	**Region 11**	**Region 12**
Characteristics	Pueblo	El Paso, Teller	Logan, Morgan, Phillips, Sedgwick, Washington, Yuma	Cheyenne, Elbert, Kit Carson, Lincoln
Demographic Characteristics				
Colorado Population Estimate (2007)	157,346	619,204	74,446	40,723
Percent of Total Colorado Population (2007)	3.21%	12.63%	1.52%	0.83%
Colorado Population (2000)	142,054	541,718	70,139	36,598
Percent of Population in the Labor Force (2000)	58.30%	72.20%	62.10%	63.10%
Percent of Homes where Language Other Then English is Spoken (2000)	16.10%	7.70%	11.80%	8.10%
Percent of Families Below Poverty (2000)	11.20%	4.60%	8.60%	7.20%
Percent of Female Headed Households (2000)	13.33%	8.40%	6.70%	6.50%
Medicaid Characteristics, FY 06-07				
Average Number of Medicaid Clients per Month	26,831	48,199	7,336	2,397
Percent of Regional Population that are Medicaid Clients	17.1%	7.8%	9.9%	5.9%
Medicaid Expenditures	$124,609,984	$225,925,900	$40,111,236	$11,929,380
Percent of Total Medicaid Expenditures	6.2%	11..3%	2.0%	0.6%
Children's Basic Health Plan Characteristics, FY 06-07				
Average Number of Children per Month	1,702	3,628	1,078	408
Percent of Regional Population that are Children's Basic Health Plan Clients	1.1%	0.6%	1.4%	1.0%
Children's Basic Health Plan Expenditures	$3,689,987	$7,865,613	$2,337,136	$884,556
Percent of Total Children's Basic Health Plan Expenditures	3.6%	7.7%	2.3%	0.9%
Colorado Indigent Care Program Characteristics, FY 05-06				
Number of Colorado Indigent Care Program Providers in Region	3	3	6	0
Colorado Indigent Care Program Expenditures	$9,881,469	$13,157,220	$645,710	0
Percent of Total Colorado Indigent Care Program Expenditures	6.1%	8.1%	0.4%	0

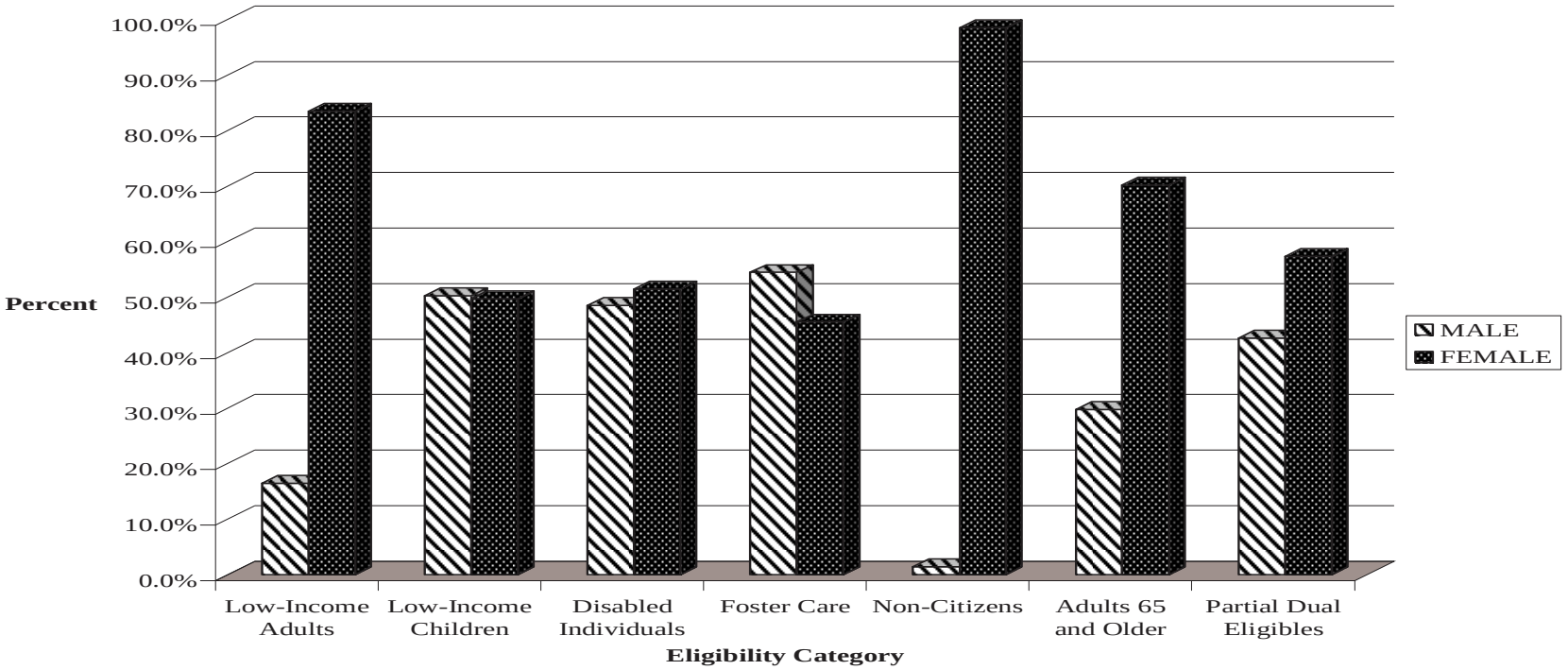
Regions	**Region 13**	**Region 14**	**Region 15**	**Region 16**
Characteristics	Douglas	Boulder, Broomfield	Larimer	Weld
Demographic Characteristics				
Colorado Population Estimate (2007)	274,674	342,941	279,033	241,514
Percent of Total Colorado Population (2007)	5.60%	7.00%	5.69%	4.93%
Colorado Population (2000)	180,689	296,018	253,131	183,560
Percent of Population in the Labor Force (2000)	79.00%	73.40%	71.90%	68.60%
Percent of Homes where Language Other Then English is Spoken (2000)	7.20%	13.60%	8.50%	20.30%
Percent of Families Below Poverty (2000)	1.60%	4.60%	4.30%	8.00%
Percent of Female Headed Households (2000)	5.70%	7.70%	7.90%	9.40%
Medicaid Characteristics, FY 06-07				
Average Number of Medicaid Clients per Month	4,379	15,990	17,697	20,106
Percent of Regional Population that are Medicaid Clients	1.6%	4.7%	6.3%	8.3%
Medicaid Expenditures	$26,444,489	$83,467,086	$85,285,952	$86,543,198
Percent of Total Medicaid Expenditures	1.3%	4.2%	4.3%	4.3%
Children's Basic Health Plan Characteristics, FY 06-07				
Average Number of Children per Month	831	1,860	2,613	3,683
Percent of Regional Population that are Children's Basic Health Plan Clients	0.3%	0.5%	0.9%	1.5%
Children's Basic Health Plan Expenditures	$1,801,633	$4,032,536	$5,665,062	$7,984,854
Percent of Total Children's Basic Health Plan Expenditures	1.8%	4.0%	5.6%	7.8%
Colorado Indigent Care Program Characteristics, FY 05-06				
Number of Colorado Indigent Care Program Providers in Region	0	5	3	4
Colorado Indigent Care Program Expenditures	0	$2,481,586	$3,797,381	$4,731,310
Percent of Total Colorado Indigent Care Program Expenditures	0	1.5%	2.3%	2.9%

Regions	**Region 17**	**Region 18**	**Region 19**	**Region 20**
Characteristics	Adams	Arapahoe	Clear Creek, Gilpin, Jefferson	Denver
Demographic Characteristics				
Colorado Population Estimate (2007)	423,315	550,904	556,229	579,177
Percent of Total Colorado Population (2007)	8.63%	11.24%	11.35%	11.81%
Colorado Population (2000)	366,660	491,134	542,172	555,781
Percent of Population in the Labor Force (2000)	70.60%	73.30%	77.40%	67.70%
Percent of Homes where Language Other Then English is Spoken (2000)	21.60%	15.51%	5.80%	27.00%
Percent of Families Below Poverty (2000)	6.50%	4.20%	2.50%	10.60%
Percent of Female Headed Households (2000)	12.10%	10.60%	7.30%	10.80%
Medicaid Characteristics, FY 06-07				
Average Number of Medicaid Clients per Month	44,036	41,082	29,148	68,840
Percent of Regional Population that are Medicaid Clients	10.4%	7.5%	5.2%	11.9%
Medicaid Expenditures	$201,947,393	$196,086,839	$191,066,814	$360,157,694
Percent of Total Medicaid Expenditures	10.1%	9.8%	9.5%	18.0%
Children's Basic Health Plan Characteristics, FY 06-07				
Average Number of Children per Month	5,851	4,647	3,614	6,282
Percent of Regional Population that are Children's Basic Health Plan Clients	1.4%	0.8%	0.6%	1.1%
Children's Basic Health Plan Expenditures	$12,685,143	$10,074,835	$7,835,260	$13,619,564
Percent of Total Children's Basic Health Plan Expenditures	12.4%	9.9%	7.7%	13.4%
Colorado Indigent Care Program Characteristics, FY 05-06				
Number of Colorado Indigent Care Program Providers in Region	1	1	1	5
Colorado Indigent Care Program Expenditures	$$2,105,606	$764,068	$462,832	$115,572,637
Percent of Total Colorado Indigent Care Program Expenditures	1.3%	0.5%	0.3%	71.3%

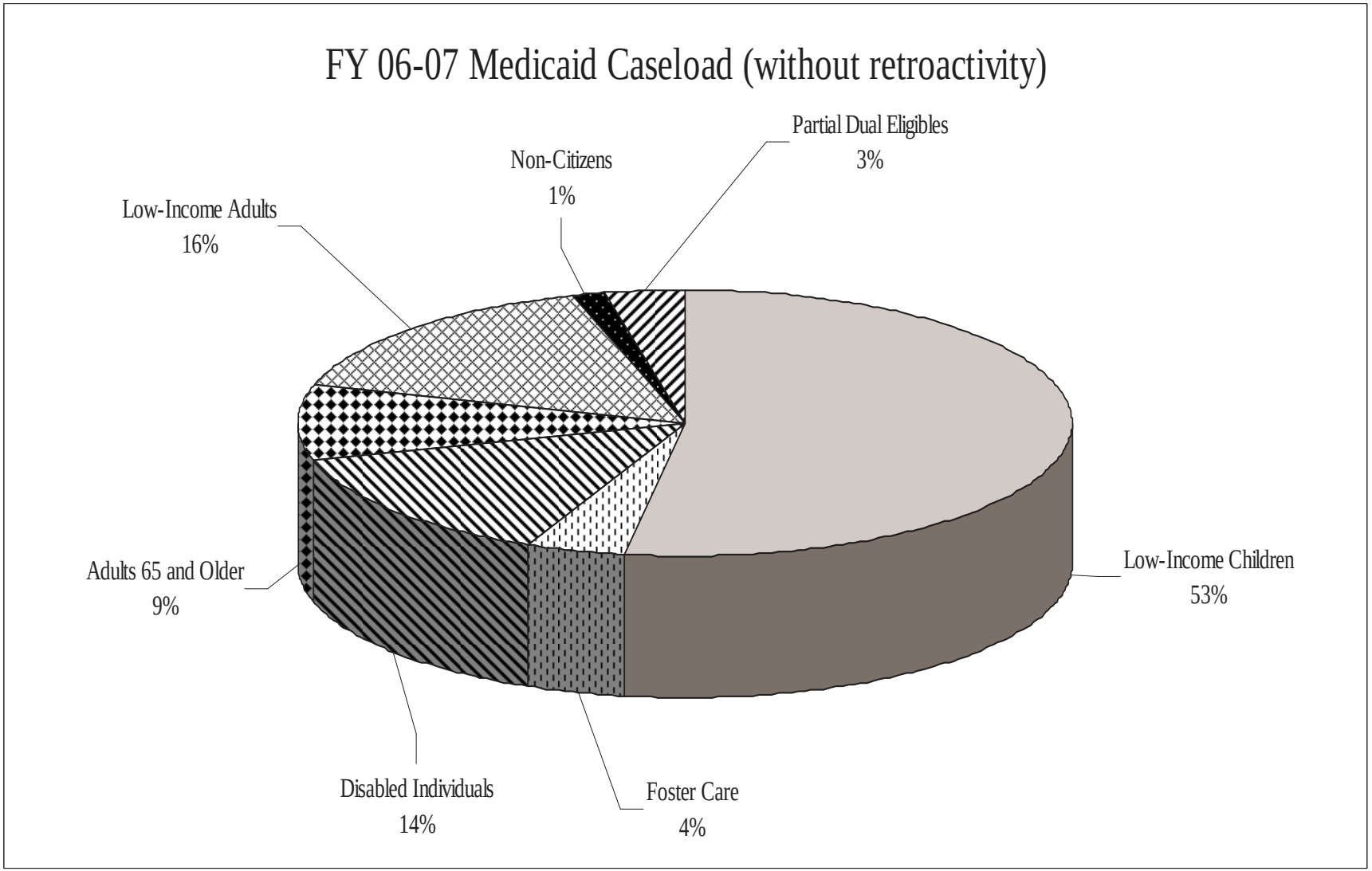
Sources: Business Objects of America queries for caseload and expenditures (last updated July 2007); Colorado State Demography Website for population and demographics numbers. Notes: 1) Average Number of Medicaid/CHILD HEALTH PLAN PLUS Clients per Month is eligibility-based. 2) Expenditures are by region in which the client lived in FY 06-07. 3) Demographic data was updated since the 2000 census for 6 counties (Adams, Arapahoe, Boulder, Denver, El Paso, Jefferson). Data from the 2000 Census was used for all counties for consistency. 4) Number of Colorado Indigent Care Providers (CICP) by Region includes CICP hospitals, clinics and satellite facilities. 5) Medicaid Expenditures include Drug Rebates, Single Entry Point (SEP), Consumer Directed Attendant Services (CDAS), Single Low Income Medicare Beneficiaries (SLIMB), Disease Management, and Other Adjustments.

Medicaid Caseload for FY 02-03 to FY 08-09

The figures presented include caseload information without retroactivity for FY 02-03 to FY 06-07 (FY 07-08 and FY 08-09 are projected). Retroactivity causes historical adjustments to caseload to account for clients who were found to be eligible for Medicaid for past months, thus increasing the count of persons eligible for Medicaid (even after caseload figures are presented to the Joint Budget Committee monthly). This causes much variability in the reporting of caseload, as monthly caseload is adjusted for months after the month has passed. The pie chart (on the following page) shows the percentage of each category as a total of Medicaid population.



Source: Actuals and Projected are derived from the Department's November 1, 2007 Budget Request, "Exhibit B – Medicaid Caseload Forecast," page EB-1. Caseload categories will be updated.
1) Low-income adults include 1931 Adults, Baby Care Program-Adults, Breast and Cervical Cancer Program Clients, and Health Care Expansion Fund Adults.
2) Medicare Beneficiaries include Qualified Medicare and Supplemental Low Income Medicare clients.



Source: July 16, 2007, Joint Budget Committee Report.

Final Request												
Official Medicaid Caseload Actuals and Projection without Retroactivity from REX01/COLD (MARS) 464600 Report, including adjustments												
Includes Adjustments on Page EB-2												
Item	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Categorically Eligible Low-Income Adults (AFDC-A)**	**Expansion Adults**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**Baby Care Program-Adults**	**Non-Citizens**	**Partial Dual Eligibles**	**TOTAL**
FY 95-96 Actuals	31,321	4,261	44,736	36,690	-	-	113,439	8,376	7,223	4,100	3,937	254,083
FY 96-97 Actuals	32,080	4,429	46,090	33,250	-	-	110,586	9,261	5,476	4,610	4,316	250,098
FY 97-98 Actuals	32,664	4,496	46,003	27,179	-	-	103,912	10,453	4,295	5,032	4,560	238,594
% Change from FY 96-97	1.82%	1.51%	-0.19%	-18.26%	0.00%	0.00%	-6.04%	12.87%	-21.57%	9.15%	5.65%	-4.60%
FY 98-99 Actuals	33,007	4,909	46,310	22,852	-	-	102,074	11,526	5,017	5,799	6,104	237,598
% Change from FY 97-98	1.05%	9.19%	0.67%	-15.92%	0.00%	0.00%	-1.77%	10.26%	16.81%	15.24%	33.86%	-0.42%
FY 99-00 Actuals	33,135	5,092	46,386	23,515	-	-	109,816	12,474	6,174	9,065	7,597	253,254
% Change from FY 98-99	0.39%	3.73%	0.16%	2.90%	0.00%	0.00%	7.58%	8.22%	23.06%	56.32%	24.46%	6.59%
FY 00-01 Actuals	33,649	5,157	46,046	27,081	-	-	123,221	13,076	6,561	12,451	8,157	275,399
% Change from FY 99-00	1.55%	1.28%	-0.73%	15.16%	0.00%	0.00%	12.21%	4.83%	6.27%	37.35%	7.37%	8.74%
FY 01-02 Actuals	33,916	5,184	46,349	33,347	-	-	143,909	13,121	7,131	4,028	8,428	295,413
% Change from FY 00-01	0.79%	0.52%	0.66%	23.14%	0.00%	0.00%	16.79%	0.34%	8.69%	-67.65%	3.32%	7.27%
FY 02-03 Actuals	34,485	5,456	46,378	40,021	-	46	166,537	13,843	7,579	4,101	8,949	327,395
% Change from FY 01-02	1.68%	5.25%	0.06%	20.01%	0.00%	-	15.72%	5.50%	6.28%	1.81%	6.18%	10.83%
FY 03-04 Actuals	34,149	5,528	46,565	46,754	-	103	192,048	14,790	8,203	4,604	9,787	362,531
% Change from FY 02-03	-0.97%	1.32%	0.40%	16.82%	0.00%	123.91%	15.32%	6.84%	8.23%	12.27%	9.36%	10.73%
FY 04-05 Actuals	35,615	6,103	47,626	56,453	-	86	220,592	15,669	6,110	4,976	9,572	402,802
% Change from FY 03-04	4.29%	10.40%	2.28%	20.74%	0.00%	-16.50%	14.86%	5.94%	-25.52%	8.08%	-2.20%	11.11%
FY 05-06 Actuals	36,219	6,048	47,565	57,754	-	188	213,600	16,311	5,050	5,959	11,012	399,705
% Change from FY 04-05	1.70%	-0.91%	-0.13%	2.30%	0.00%	118.31%	-3.17%	4.10%	-17.35%	19.75%	15.05%	-0.77%
FY 06-07 Actuals	35,977	6,042	48,567	51,361	4,974	230	206,170	16,601	5,123	5,214	12,818	393,077
% Change from FY 05-06	-0.67%	-0.09%	2.11%	-11.07%	0.00%	22.50%	-3.48%	1.78%	1.45%	-12.50%	16.40%	-1.66%
FY 07-08 Projection	35,272	6,050	49,354	45,228	7,886	260	192,834	18,428	5,453	4,762	14,188	379,715
% Change from FY 06-07	-1.96%	0.13%	1.62%	-11.94%	58.54%	13.04%	-6.47%	11.01%	6.44%	-8.67%	10.69%	-3.40%
FY 08-09 Projection	35,498	6,106	49,556	44,183	9,462	278	192,717	19,305	5,649	4,953	15,360	383,067
% Change from FY 06-07	0.64%	0.93%	0.41%	-2.31%	19.98%	6.92%	-0.06%	4.76%	3.59%	4.01%	8.26%	0.88%
FY 09-10 Projection	35,750	6,162	49,606	43,993	10,518	293	192,755	19,715	5,808	5,174	16,590	386,364
% Change from FY 07-08	0.71%	0.92%	0.10%	-0.43%	11.16%	5.40%	0.02%	2.12%	2.81%	4.46%	8.01%	0.86%
FY 07-08 Appropriation	36,703	6,252	48,942	46,708	10,377	277	193,981	17,295	5,264	4,691	13,294	383,784
Difference between the FY 07-08 Projection and the Appropriation	(1,431)	(202)	412	(1,480)	(2,491)	(17)	(1,147)	1,133	189	71	894	(4,069)

Source: November 1, 2007 Budget Request, Exhibits for Medical Services Premiums, Exhibit B, page EB-1.

V. KEY TRENDS

The following are key trends and issues that have been identified by the Department as important to current and future fiscal years. These trends relate to new or recent changes in federal or State legislation, societal and technological changes, and new approaches in serving the Department's clients.

Colorado Benefits Management System Executive Order D 005 07, Reprocurement and Federal Cost Allocation.

On May 27, 2005, then Governor Bill Owens issued an executive order that created the Governor's Office of the Colorado Benefits Management System. On February 15, 2007, Governor Bill Ritter issued Executive Order D 005 07 and rescinded the executive order that created the Governor's Office of the Colorado Benefits Management System. The Governor cited increased efficiency and the ability of the Executive Directors of the Colorado Department of Human Services and the Department of Health Care Policy and Financing to manage the system as reasons for dissolving the Office of the Colorado Benefits Management System.

Executive Order D 005 07 directed the Department of Health Care Policy and Financing and the Colorado Department of Human Services to determine the reassignment of the Governor's Office of the Colorado Benefits Management System staff. Pursuant to that directive, the Department co-authored a 1331 emergency supplemental with the Colorado Department of Human Services that split the 24.0 at-will FTE employed by the Governor's Office of the Colorado Benefits Management System evenly between the departments. The request also reallocated funds from the Governor's Office of the Colorado Benefits Management System to the Department of Health Care Policy and Financing for four contractors that handle help desk ticket analysis, testing, and decision table analysis. The reassignment of the at-will employees brought much of the functionality provided by the Governor's Office of the Colorado Benefits Management System under direct control of the Department. This additional control will allow the Department to more effectively manage the updates and system changes required to provide service to its Medicaid, Children's Basic Health Plan, and Old Age Pension clients.

In addition to changes in staffing at the State level, the Department must re-procure the Colorado Benefits Management System operations contract. Five to ten staff from the Department of Human Services and the Department met as often as weekly to identify a plan for re-procuring the contract. A request for proposals to procure a contractor to assist in re-procuring the Colorado Benefits Management System operations contract was published on April 30, 2007. A contractor was selected on May 30, 2007. Pursuant to the Department's Supplemental request, in March 2007, the Joint Budget Committee approved initial funding in the amount of $512,400, for the development of the request for proposals to re-procure the Colorado Benefits Management System operations contract. The Department of Human Services, the Department and the contractor have drafted an initial scope of work for the request for proposals. The final request for proposals has not been completed as of October 2007.

When the federal government approved the development of the Colorado Benefits Management System, it also approved an allocation method, called the Colorado Benefits Management System calculator, to split the costs among the State and federal programs that need eligibility determinations. However, this allocation methodology was only approved for the development phase of the Colorado Benefits Management System. When the system went online in September 2005, the State was expected to have a new plan approved that allocated operational costs based on each program's portion of eligibility determinations over a fiscal quarter. However, due to the complexity of the Colorado Benefits Management System, this new method, called Random Moment Sampling, was not submitted and retroactively approved for FY 04-05 costs by the U.S. Department of Cost Allocation until June 2007. In keeping with the intent of using the Random Moment Sampling allocation methodology for Colorado Benefits Management System costs, all costs beginning July 1, 2007 have been split using the Random Moment Sampling methodology. As such, all Colorado Benefits Management System costs are split between the Department and the Department of Human Services on a dynamic basis, with the percentage splits updated each quarter.

Pharmacy.

Preferred Drug List (PDL). Executive Order D 004 07.

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. The Department will be responsible for forming a Pharmacy and Therapeutics Committee responsible for evaluating clinical data 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. Although the Executive Order discusses the possibility of joining a purchasing pool, the Department is not currently planning to join such a pool as part of the preferred drug list program.

The legislature assumed that the Department would be able to obtain evidenced-based research from other states at no additional cost. The Department has since determined that there are no free sources of evidence-based research and that a contractor is necessary to provide these services. This contractor will provide support services to the Pharmacy and Therapeutics Committee. The contractor will maintain a database of clinical data, create summary reports, and facilitate committee meetings. The contractor already has a compiled database of clinical information and experts to manage the database. The permanent contractor will be in place beginning March 2008.

To implement the Executive Order in a timely manner, a Documented Quote was necessary to begin the preferred drug list program. This created a pilot program to hire a temporary contractor while allowing the Department time to prepare a request for proposals to hire a permanent contractor. The temporary contractor began work on the preferred drug list in October 2007.

The Pharmacy and Therapeutics Committee rules will become effective on November 1, 2007 and the first committee meeting will occur in December 2007. The preferred drug list rules will become effective on December 1, 2007. The first drug class will be added to the preferred drug list in February 2008. Additional drug classes will be added quarterly and the Department assumes that all ten to twelve drug classes will be added by September 2008.

Colorado Cares. SB 07-001.

Effective September 1, 2007, the Department established the Colorado Cares Rx Program to provide a mechanism for eligible clients to purchase lower-cost generic and non-patented prescription drugs. The Department expects the program to be available to clients on January 1, 2008. Eligible clients must be a resident of Colorado, uninsured, ineligible for Medicaid or the Children's Basic Health Plan, and have family income that does not exceed 300% of the federal poverty level. Participants must apply to participate in the program and pay a fee up to $20 to cover the costs associated with the program. The Medical Services Board will set this fee. The Department may expand eligibility to Coloradans who have coverage with a high deductible health plan as defined by the Department after consultation with health insurance carriers. The bill established a three-member Colorado Cares Rx Pharmacy Advisory Council to provide advice regarding program implementation.

The Department has written and published a request for proposals to procure a contractor. The contractor will be responsible for accepting and processing mail-in applications, collecting fees, determining client eligibility, providing a prescription drug card to eligible clients, and providing all ongoing maintenance for the program, including annual eligibility redeterminations. The Department anticipates that a contract will be executed by January 1, 2008. Clients will be required to use the prescription drug card so that pharmacies can verify participation in the program and access the rate for each of the drugs the client is purchasing. The contractor will provide reports that will allow the Department to track participation, drug utilization, and respond to audits and other oversight measures to ensure the appropriate use of the funds for this program.

Deficit Reduction Act.

Deficit Reduction Act and HB 06S-1023.

HB 06S-1023 was a result of the 2006 special session on immigration issues, and was signed into law on July 31, 2006. It became effective on August 1, 2006. HB 06S-1023 requires the Department to verify the lawful presence in the United States of applicants for medical benefits who are at least 18 years of age. While all children ages 0-18 are exempt from the requirement to provide proof of citizenship under HB 06S-1023, only children receiving benefits under the Children's Basic Health Plan are exempt from the requirement to provide proof of citizenship under the federal Deficit Reduction Act of 2005 (DRA), signed into law February 8, 2006, effective July 1, 2006.

The Medicaid asset test was removed effective July 1, 2006. The expectation was that this would move children from the Children's Basic Health Plan to Medicaid. However, the identification requirements of the DRA may be preventing these asset test children from gaining Medicaid eligibility and leaving them eligible for the Children's Basic Health Plan.

The Department is currently monitoring the status of several bills that were introduced and are progressing through the 2007 U.S. Congress. If passed, the following bills would alter the DRA's citizenship and identity documentation requirements.

H.R. 210--110th Congress (2007) Medicaid Newborn Coverage Act of 2007. This bill would exempt children born to women receiving Medicaid at the time of the child's birth from the documentation requirements during the child's first year of life (this is the current practice in Colorado).

H.R. 1238--110th Congress (2007) This bill would allow states to use their own Medicaid records to serve as proof of citizenship for children in cases where Medicaid paid for the child's birth.

H.R. 1328--110th Congress (2007) Indian Health Care Improvement Act Amendments of 2007. This bill would expand the list of acceptable citizenship and identity documents for federally recognized Indian tribes.

S. 751--110th Congress (2007) Guaranteed Access to Medicaid for Newborns Act of 2007. This bill would exempt newborns from the documentation requirements, and allow states to provide retroactive eligibility to newborns who were denied under the old rules.

H.R. 1535--110th Congress (2007) Children's Health First Act, S. 895--110th Congress (2007) Children's Health First Act, S. 909--110th Congress (2007), H.R. 1878--110th Congress (2007), H.R. 2055--110th Congress (2007) Improving Children's Access to Health Care Act of 2007. These bills would make the DRA citizenship and identity documentation requirements a state option rather than a federal mandate.

S.1893—110th Congress (2007) Children's Health Insurance Program Reauthorization Act of 2007. This bill would give states the option of submitting social security numbers of Medicaid applicants and clients to the Social Security Administration for verification as an alternative to requiring citizenship and identity documents. It also would expand the list of acceptable citizenship and identity documents for federally recognized Indian tribes.

H.R. 3162—110th Congress (2007) Children's Health and Medicare Protection Act of 2007. This bill would make the citizenship and identity documentation requirements a state option for individuals under 21. It also would expand the list of acceptable citizenship and identity documents for federally recognized Indian tribes.

Deficit Reduction Act - Long-Term Care Insurance Partnerships.
Section 6021 of the Deficit Reduction Act of 2005 lifted a moratorium imposed by Congress in 1993 on new states participating in the partnership for long-term care demonstration program. This program was initiated as a model in the 1980s to promote the purchase of private long-term care insurance by consumers. Its purpose is to reduce the financial burden on individuals, and on State and federal Medicaid budgets, for long-term care expenses associated with the aging baby boomer generation. The signing of the Deficit Reduction Act of 2005 thus opened the door for Colorado to pursue its own insurance partnership for long-term care program.

The partnership for long-term care program works by providing consumers with an incentive to purchase private long-term care insurance by ensuring protection of assets if supplemental Medicaid coverage becomes necessary. The program is estimated to save substantial future Medicaid funds as private insurance coverage pays for clients' first years of long-term care expenses, and discourages clients from transferring assets to qualify prematurely for Medicaid.

The Department is currently working with the Division of Insurance and the Department of Human Services to implement Colorado's partnership for long-term care program. In addition, Colorado was chosen in April 2007 as one of 10 states to receive a $50,000 grant and participate in technical training on a national level. The $50,000 will be spent primarily on outreach and provider training in an effort to maximize participation and effectiveness of the program.

Medical Homes for Children SB 07-130.

This bill, coordinated by the Cover all Kids 2010 advocacy group, defines a medical home as a qualified medical specialty, developmental, therapeutic, or mental health care practice that ensures access to and coordination of all medically-related services to a child, and his or her family. The services available to a child through a medical home, include but are not limited to health maintenance and prevention care; anticipatory guidance and health education; acute and chronic illness care; coordination of medications, specialists, and therapies; provider participation in hospital care; and twenty-four hour telephone care. The bill requires the Department to work with the Department of Public Health and Environment to develop systems to maximize the number of Medicaid or Child Health Plan Plus program eligible children who have a medical home. The Department of Public Health and Environment and Colorado Medical Home Initiative have 12 medical providers identified as medical homes. To maximize the number of children who have a medical home, the Department's fiscal agent will send out an updated Provider Enrollment Application to medical providers describing the definitions and requirements of a medical home. After voluntarily electing to become a medical home, the medical provider's Medicaid Management Information System provider profile will be flagged as a medical home. This flag will be used to track and report the progress of maximizing the number of children having a medical home. The report will be submitted annually to the Joint Committee on Health and Human Services.

The Department is currently working with the Department of Public Health and Environment to enroll Medical Home providers and to maximize the number of children participating in the program.

Early Intervention SB 07-004.

As part of Executive Order D 017 05, signed by Governor Owens on December 30, 2005, effective July 1, 2006, the Department of Human Services became the lead State agency associated with Part C of the Individuals with Disabilities Education Act (IDEA). Under Part C, States are required to provide early intervention services to infants and toddlers (children under the age of three) with disabilities. Early intervention services are designed around an Individualized Family Service Plan (IFSP) that is developed by a multidisciplinary team. This team can include the child's physician, therapist, parent or guardian, social worker, psychologists, and nurses. Prior to developing the IFSP, an assessment is performed to identify the child's strengths, needs, and services to meet those needs, as well as the family's resources, wishes, and concerns regarding services for the child.

Pursuant to Part C of the federal "Individuals with Disabilities Education Act", 20 U.S.C. Sec. 1400 et seq., Medicaid currently covers the cost of early intervention services for eligible children; therefore, there were no benefit changes for the Department under Title XIX. However, children enrolled in the Children's Basic Health Plan are not covered for all of the same treatments and services. Pursuant to SB 07-004, the Department has removed the limits on physical, occupational, and speech therapy in the Children's Basic Health Plan benefit package to align these services with Part C requirements, and with Medicaid. The State share is paid out of tobacco settlement moneys.

As part of improving coordination of State funded services to Part C recipients, SB 07-004 requires the Department of Human Services to develop and implement a unified system of payment for developmentally disabled children or children with conditions that may result in developmental delays. The bill directs the Department to work with the Department of Human Services, Department of Education, Department of Public Health and Environment, and the Department of Regulatory Agencies (Division of Insurance) in developing this new system of payment. To assist in this effort, the Department received an additional FTE to ensure that all new providers are certified and able to receive Medicaid reimbursement and that proper expenditures are reflected in the appropriate State departments.

Although the bill became effective on July 1, 2007, mandatory coverage specifications apply to services delivered and health care policies issued on or after January 1, 2008.

Long-Term Care First and Third Party Cost Avoidance and Recovery Reform.

The Department has been working on a comprehensive reform program to help reduce fraud, abuse and misuse in the long term care program and to reposition Medicaid as the payer of last resort. The program addresses issues relating to income, resources, client recoveries, estate recoveries, third party insurance, tort and casualty and other cost avoidance and recovery areas.

Rules are being drafted in the area of misuse and abuse in Medicaid. Additionally, the Department is looking at its client cost avoidance and recovery program and whether there are more effective ways to run the program. Finally, the Department is researching exempt resource issues and how to better control and track exempt resources to avoid not only fraud, abuse and misuse, but mistakes that could hurt clients' eligibility. The Department may seek a federal waiver for this type of program.

Home and Community Based Services for Persons with Developmental Disabilities (HCBS-DD), Supported Living Services (SLS) and Children's Extensive Support (CES) Waivers.

In 2006, the Centers for Medicare and Medicaid Services required the Department to break apart the bundled reimbursement rate for the above referenced waivers into identifiable Medicaid allowable services, and provide a revised reimbursement plan to the Centers for Medicare and Medicaid Services for approval. Because of the complexity of finalizing this task, interim reimbursement rates for each category related to the Home and Community Based Services for Persons with Developmental Disabilities waiver was approved by the Centers for Medicare and Medicaid Services for implementation on July 1, 2006.

Under the guidance of the Centers for Medicare and Medicaid Services, the State has been working on overhauling the Comprehensive, Supported Living Services, and the Children's Extensive Support Developmental Disability waivers. Due to the complexity of these waivers, the State has elected to complete the required changes in phases. The Comprehensive waiver is the first of the three waivers to be overhauled, as this waiver incurs the largest portion of total expenditures. Due to the requirements set forth by the Centers for Medicare and Medicaid Services, the State will complete work on the compliance portion of each of these waivers before proceeding to the renewal and consumer direction phases of the overhaul. The Centers for Medicare and Medicaid Services has expressed its agreement with the State's direction, and has been satisfied with how much the State has done to unbundle the rates and develop a new method of setting the rates based on individual client need by using the Supports Intensity Scale (SIS) Tool.

For the long-term solution, the State selected the Support Intensity Scale as the tool to identify clients' service needs and set a reimbursement rate based on those needs. Since the tool is designed for service planning rather than rate setting, additional work is required to adjust the tool to the proposed rate-setting function. The State has hired a contractor to assist in adjusting the Support Intensity Scale and its application so that the final rates are consistent with the services provided to clients. At the completion of this project, the un-bundled rates will create a system that allows for a clean audit trail that separates Medicaid costs from non-Medicaid costs and administrative payments from benefit payments. Further, the payments made will identify the specific client, specific service, qualified provider and reimbursement amount. The Department anticipates that the new implementation date for the long-term uniform rate methodology will be January 1, 2008.

Along with revising the rate setting methodology for the Developmental Disability waivers, the State is also working on revising the service definitions, pursuant to the Centers for Medicare and Medicaid Services' request. The service definitions provide a written statement of the parameters and services that are allowable under each of the waivers. The State anticipates that refining the

definitions will satisfy the Centers for Medicare and Medicaid Services' objection to the previous definitions that they considered ambiguous and vague.

Finally, services for many of the clients served by the Developmental Disability waiver are offered at Regional Center campuses. The two types of service centers that exist within many Regional Center campuses are Home and Community Based Services (HCBS) facilities and Intermediate Care Facilities for the Mentally Retarded (ICFs/MR). The Intermediate Care Facilities provide care to disabled individuals at the facility and receive additional/enhanced rates to pay for residential and welfare costs above and beyond the typical array of services offered to disabled individuals. The Home and Community Based Services facilities, however, typically provide care to the disabled community at the individual's home or care center. Accordingly, Home and Community Based Services facilities do not receive the additional/enhanced rates that the Intermediate Care Facilities for the Mentally Retarded receive, and believe that they are not being reimbursed for all of the costs they incur. As a solution to this problem, many of the Regional Center campuses would like to have the Home and Community Based Services facilities converted to Intermediate Care Facilities for the Mentally Retarded. In this way, the facilities would qualify for the enhanced/additional rates and therefore receive adequate compensation for the services they provide.

Public Hospital, Unit of Government Status - Senate Joint Memorial 07-004.

In federal fiscal year 05-06, President Bush asked Congress to enact legislation capping Medicaid payments to public providers and restricting the options to states for financing the non-federal share of their Medicaid programs. In President Bush's 2007 budget proposal, the administration proposed that these changes be made administratively rather than legislatively. On January 18, 2007, the federal Centers for Medicare and Medicaid Services published a proposed rule, "Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-state Financial Partnership," that is to take effect on September 1, 2007. The proposed rule would change the current definition of "unit of government"[7] to those local governmental entities that have "generally applicable taxing authority." The effect of the proposed rule would be to deny unit of government status to the public hospitals of Colorado, thereby eliminating the ability of the public hospitals to use certification of public expenditures to draw down federal matching funds. According to the Senate Joint memorial, the proposed rule will reduce federal funding to Colorado's public hospitals by approximately $128 million dollars.

[7] Currently, a unit of government is a State, a city, a county, a special purpose district, or other governmental unit in the State that: has taxing authority, has direct access to tax revenues, is a State university teaching hospital with direct appropriations from the State treasury, or is an Indian tribe. A health care provider may be considered a unit of government only when it is operated by a unit of government as demonstrated by a showing that the health care provider has generally applicable taxing authority; or the health care provider has direct access to generally applicable tax revenues. This means the health care provider is able to directly access funding as an integral part of a unit of government with taxing authority which is legally obligated to fund the health care provider's expenses, liabilities, and deficits, so that a contractual arrangement with the State or local government is not the primary or sole basis for the health care provider to receive tax revenues; or the health care provider receives appropriated funding as a State university teaching hospital providing supervised teaching experiences to graduate medical school interns and residents enrolled in a State university in the State; or the health care provider is an Indian Tribe or Tribal organization (as those terms are defined in Section 4 of the Indian Self-Determination and Education Assistance Act.) 42 C.F.R. Section 433.50.

On March 14, 2007, the Colorado Senate introduced Senate Joint Memorial 07-004, which urges Congress to enact legislation preventing the federal Centers for Medicare and Medicaid Services from promulgating rules interfering with states' definitions of units of government. The joint memorial was signed on April 12, 2007 by the President of the Senate and Speaker of the House and sent to Colorado's congressional representatives.

The United States Congress introduced three bills (Senate Bill 787 and House Bills 1480 and 1741) that impose a two-year moratorium on implementing the Centers for Medicare and Medicaid Services proposed rule. The congressional bills found that the proposed rule change would significantly change the federal-state financial partnership under Medicaid and the State Children's Health Insurance Program by imposing cost limits on payments, limiting the permissible sources of the non-federal shares and imposing new requirements on providers. Congress determined that more time is needed to study the effects of the proposed rule on states with Medicaid and State Children's Health Insurance Program programs. More recently, the U.S. Senate introduced an amendment to House Bill 2206 ("U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act, 2007") that imposes a one-year moratorium on the Centers for Medicare and Medicaid Services proposed rule. President Bush signed the bill into law on May 25, 2007.

Health Plan Performance Based Incentive Program.

Effective January 1, 2007 the Department implemented a performance based incentive program with the Department's current health maintenance organization contractor. This incentive program was approved by the Joint Budget Committee during Figure Setting and included in the Long Bill, SB 07-239 (Figure Setting, March 8, 2006, page 51). The goal of the incentive payment is to ensure the ongoing participation of providers as risk-based Medicaid managed care organizations. At the same time, the incentive payment will encourage activities that are beneficial to Medicaid clients.

To this end, the Department has developed an incentive payment arrangement that rewards preventive care services. To measure this, the Department has selected 30 measures from the Health Plan Employer Data and Information Set (HEDIS) related to primary and preventive care, and will compare the reported scores from Denver Health Medicaid Choice to the national scores.

Such a program is authorized under Section 25.5-5-408 (5), C.R.S. (2007), which states that the "department may develop quality incentive payments to recognize superior quality of care or service provided by a managed care plan." Further, an incentive program is allowable under federal regulations. 42 C.F.R. Section 438.6 (5) states that excess payments are limited to five percent of capitations paid to the provider, and must be computed on an actuarially sound basis. Additionally, the incentive arrangement must be for a fixed period of time and may not be renewed automatically.

The incentive payment would cover services provided from January through June 2007 with any incentive payment earned being paid in FY 07-08. For each incentive earned, the Department would make an additional payment to the provider based on a percentage of

the total capitations paid during the incentive period. The provider would earn an incentive payment by achieving HEDIS scores higher than national averages on the selected measures, in the following fashion: 1) 0.1666% of total capitations paid would be awarded for each measure at or above the 90th HEDIS percentile; and, 2) 0.1245% of total capitations paid would be awarded for each measure between the 75th and 89th HEDIS percentiles. Under this arrangement, a maximum of five percent of total capitations paid during the incentive period could be paid to the provider.

Improvements to Health Care for Children SB 07-211.

SB 07-211 establishes a 15 member advisory committee on covering all children in Colorado. The committee will be responsible for developing and implementing a plan to ensure that all low-income children have health coverage by the end of 2010, and recommending legislative changes to increase enrollment in the Children's Basic Health Plan and Medicaid. The Department will also begin to report on access to and quality of health care for children to ensure that providers are accepting children eligible for the Department's programs, and that children are receiving continuous, high quality care. The bill also institutes presumptive eligibility for children in the Children's Basic Health Plan and Medicaid. This should decrease barriers for children seeking medical services during the eligibility determination process. Currently, approximately nine states have presumptive eligibility for children.

As written, the legislation institutes presumptive eligibility for Baby and Kid Care children, who have family incomes above the Aid to Families with Dependant Children standard (known as the Section 1931 Medicaid) and below 100% or 133% of the federal poverty level, depending on age. This legislation does not, however, institute presumptive eligibility for the children of families with incomes below the Section 1931 Medicaid standard. The Department does not believe it was the intent of this legislation to exclude these low-income children from presumptive eligibility, and has no way of separating these children populations prior to a complete eligibility determination, so is instituting presumptive eligibility for all children in Medicaid.

In addition, SB 07-097 provides additional Tobacco Litigation Settlement moneys to increase eligibility in the Children's Basic Health Plan from 200% to 205% of the federal poverty level. This increase is anticipated to add 238 children and 32 prenatal women in FY 08-09 (the first full year of implementation). In order to achieve this expansion, the Department is making modifications to the Colorado Benefits Management System and the Health Insurance Flexibility and Accountability (HIFA) section 1115 demonstration waiver under which prenatal women are covered in the Children's Basic Health Plan. These changes are expected to take approximately nine months, and the Department anticipates that the Children's Basic Health Plan will begin providing services to these new clients, both children and prenatal women, beginning March 1, 2008. In addition, the Department will apply an income disregard of up to 1% to achieve the expansion for children under the current Children's Basic Health Plan structure.

These expansion clients are funded from the newly created Supplemental Tobacco Litigation Settlement Moneys Account within the Children's Basic Health Plan Trust Fund. Because the new expansion population is funded from a different source than the two

current populations in the Children's Basic Health Plan (traditional clients up to 185% of the federal poverty level and expansion clients between 186% and 200% of the federal poverty level), the new population will have to be separately tracked and budgeted.

Colorado Regional Health Information Organization (CORHIO).

In 2005, the Secretary of Health and Human Services formed the American Health Information Community to recommend ways to advance health information technology so that most Americans will have access to secure electronic health records by 2014. The Colorado Regional Health Information Organization, under the auspices of the Colorado Health Institute, is part of a nationwide effort to oversee operations for a virtual national health information network and develop a statewide electronic health information exchange.

In conjunction with American Health Information Community's goals of providing electronic accessibility of certain medical information by physicians in emergency treatment facilities, Senate Bill 07-074 created a health care task force. From June to December 2007, the task force will examine and make recommendations concerning issues related to advancing electronic medical records systems and the implementation of an interoperable, statewide electronic health information exchange. The recommendations will include, but not be limited to, privacy and security concerns; the benefits to public medical assistance programs participating in electronic health information exchange; priorities for implementing statewide electronic health information exchange to improve health care safety, quality, and cost-effectiveness; and accessibility of electrocardiogram tracings by emergency treatment facilities. The recommendations will also address how western states can leverage resources and influences to advance regional and national electronic health information exchanges as well as evaluation of the benefits of an electronic health information exchange for Colorado's health care reform efforts.

While developing these recommendations, the task force will solicit information concerning technical development, stakeholder needs and priorities, potential resources, and policy issues from several sources. These sources will, at a minimum, include an independent nonprofit organization established to facilitate the availability of a statewide electronic health information exchange; public and private health care providers from diverse geographic areas of the state; business interests; and consumers.

Member(s) of the Department may be chosen to sit on a subcommittee to assist in advising the task force. However, the Department will have no direct involvement in implementing the recommendations of the task force.

Future Information Technology Projects.

There are at least five projects driven by revisions to the Health Insurance Portability and Accountability Act or its implementing regulations on the horizon. Time frames for implementing each project range from one to five years. These projects include:

Medicaid Information Technology Architecture (MITA)

MITA is a Centers for Medicare and Medicaid Services initiative intended to foster integrated business and information technology transformation across the Medicaid systems to improve the administration of the Medicaid program. It will have common standards with Medicare. The general structure will have interoperability between state Medicaid organizations within and across states and other health care agencies, web-based access and integration, software reusability, use of commercial off-the-shelf software, and integration of public health data.

The objectives of the initiative are to adopt data and industry standards, promote secure data exchange, promote reusable components through modularity, provide a (client) beneficiary-centric focus, support interoperability and integration using open architecture standards, promote good computer programmatic practices, support the integration of clinical and administrative data to enable better decision making, and break down artificial boundaries between systems and funding within the Medicaid program. The initial version of MITA will evolve and grow.

These processes will be integrated into the business and systems that make up Medicaid. The fiscal agent contract is a large service contract designed primarily as a system for paying provider claims accurately and timely. While the Medicaid Management Information System has been considered a single system that handles claims processing, it is actually made up of multiply subsystems to handle third party recoveries, prior authorizations, quality assurance through the claims processing assessment system, Medicaid eligibility quality control, management information reporting through the management and administrative report system, drug rebate processing, and other subsystems. With MITA these subsystems will be tied closer to the business functions that require system capabilities. Through better integration with the business functions, system functionality will be enhanced to allow the systems to grow through the MITA maturity model.

It is possible that there will be an improved return on the information technology investment by providing direction for the future development and evolution of the Medicaid Management Information System through reusable system components, adherence to standards, and improved coordination and alignment with health initiatives. Definite federal rules have not yet been issued.

International Statistical Classification of Diseases and Related Health Problems 10th Revision

The coding of diseases, signs, symptoms, abnormal finding, complaints, social circumstances, and external causes of injury or diseases, as classified by the World Health Organization has reached the tenth revision. This system of codes is often abbreviated as ICD10. The United States is currently using revision nine. However, revision nine needs to be replaced by revision ten because newer developments in medical care cannot be accurately described in either diagnosis or patient procedures of care delivered in current times using revision nine, which was developed 30 years ago.

Implementing ICD10 will increase the number of diagnostic codes from approximately 3,000 to approximately 30,000. Currently, 99 countries in the world are using ICD10. The United States could use a number of European countries as a model, since they have a well-developed health care system. Because of the large increase in the number of codes used, the amount of data storage needed may also increase.

Implementing and using ICD10 would improve the quality of the health care data and maintain clinical data comparability with the rest of the world at a time when global data sharing is critical for public health. Better data provided by ICD10 will lead to improved patient safety, improved quality of care, and improved public health and bio-terrorism monitoring by tracking health codes that arise from different geographic areas.

No HIPAA rules have been issued yet for this project. After rules are issued, the federal Centers for Medicare and Medicaid Services allows two years for implementation of HIPAA related projects. Experience in implementation in Europe indicates that actual implementation could easily take two to three years due to the complexity of the project.

HIPAA 4050 Update

The first HIPAA rule implemented in 2003 was the Transaction Codes. The current transaction codes required by HIPAA rules are the X12 4010 standards. As with any standard, industry needs change, adjustments are necessary, and improvements need to be made. To keep pace with technology and advances in health care, updates would benefit the users. Newer versions of X12 4010 have become available, such as 4020, 4030, 4040, and now 4050. A newer version, X12 5010, is under development by the technology industry. Preliminary rules for the transaction codes standards were published in the Federal Register on September 23, 2005.

Public comments revealed many problems with the preliminary rules. Among the problems were protests from many states about the large costs the states had borne to update the Medicaid Management Information Systems to the HIPAA standard of X12 4010, and objections to bearing large costs again for another update to increasingly higher standards. The nature and content of the public comments caused the final rules on transaction code standards not to be issued in the normal time frame after the close of public comments. As such, the Department is not yet aware of the federal direction for this HIPAA rule, nor the extent of resources the Department would need to implement this rule.

HIPAA National Plan Identifier

National standardized identifiers for managed care plans, behavioral health plans, and similar health plans are expected to become required in the future. In FY 06-07, National Provider Identifiers were implemented according to HIPAA rules. At the current time, the insurance plans that the providers work for do not have standardized identifiers. The multitude of health care policies would not

be considered health plans, rather the entity that bears the risk and administers the policies could be defined as the plan. Examples of entities that may be considered as health plans include:

- Group Health Plans
- Health Insurance Issuer
- Managed Care Organizations
- Medicare Program
- Medicaid Programs
- Medigap Plans
- Long Term Care Plans
- Employee Welfare Benefit Plans offered by two or more employers
- Active Military Plans
- Veteran's Health Care Program Civilian Health and Medical Programs of the Uniformed Services (CHAMPUS)
- Indian Health Service Program
- Federal Employees Health Benefit Plan
- Any other individual or group health insurance plan that pays cost of medical care
- Self-insured Employer Group Health Plans

Currently, there is no comprehensive scheme to enumerate health plans. Existing enumeration systems are incomplete and overlapping. State regulators often use the National Association of Insurance Commissioners' Company Code. The Internal Revenue Service and the federal Department of Labor use a 12-digit identifier consisting of the 9-digit employer number and 3-digit plan designation. Health care providers use codes of alphanumeric listings of plan names and addresses. Medicare fiscal intermediaries and carriers use locally devised codes. A single health plan may have several of the aforementioned types of identifiers, each assigned by different organizations for a specific purpose.

The lack of a standard identifier for health plans costs the health care industry time and money, due to the inability to route transactions in a timely manner. A health care provider may find that its claim has been routed to several locations before arriving at the correct health plan for payment. This misrouting of transactions results in delayed payments to the beneficiary or provider. A unique health plan identifier would simplify and improve the routing of health care transactions and the administration of health care plan benefits. The Medicaid program is the payer of last resort (i.e., pays after any other coverage the patient may have). Use of a single, national numbering system for health plans would assist States in assuring that their health care expenditures are limited to amounts not reimbursable under other plans.

The federal Department of Health and Human Services will develop recommendations for the standards to be adopted. The recommendations will be put in the form of proposed rules and will be published in the Federal Register. A public comment period will follow. Then final rules will be published in the Federal Register.

However, as of November 2007, the HIPAA rules for the National Plan Identifier have not yet been issued. The exact time frame for issuance of rules is not known at this time. After final National Plan Identifier rules are issued, the federal Centers for Medicare and Medicaid Services permits two years to complete the implementation. The Department might only surmise a cost similar to the cost for implementing the National Provider Identifier code which occurred in 2007. However, as the Medicaid Management Information System evolves with considerable demands for changes and additions, this estimate may not be accurate.

HIPAA Attachment Rule Assessment and Implementation

An additional HIPAA rule that would require changes to certain data formulated and received for transmission through the Medicaid Management Information System is also expected sometime in the next two years. The preliminary attachment rule was published in the Federal Register on September 23, 2005. The preliminary rule proposed standards to ask for and receive additional health care information in an electronic attachment. This information request would be used to support submitted health care claims data. A claims attachment is the combination of administrative information and clinical information. Its purpose is to bridge the gap between billing and medical records functions. These standardized attachments are limited to pre-specified questions. In other words, when asking for an electronic claims attachment, each payer or health plan must ask the same clinical questions of all providers.

Initially, six standardized claims attachments are anticipated. Other standardized claims attachments may be required in the future, but it is expected to be many years before the list is expanded. The initial six to be standardized include:

- Ambulance Services
- Emergency Department Services
- Rehabilitative Services
- Laboratory Services
- Clinical Reports with information on operative notes, discharge summaries, and clinical notes
- Medications

Public comments received on the proposed rule were extensive and noted several problems with the proposed rules. The federal Centers for Medicare and Medicaid Services decided to postpone the issuance of final rules until the noted problems can be addressed. In some ways, this proposed rule conflicts with the HIPAA Privacy Rule that requires personal health information to be kept private and secure. Therefore, release of personal health information as an attachment to a claims request causes concern. Considerable

revision to the HIPAA Attachment Rule is needed, and adequate time is needed to finalize the rule. The current estimate for final publication of the rule is sometime in 2009.

Family Planning Waiver

Pursuant to Section 15.5-5-310, C.R.S. (2007), the Department, in consultation with the Department of Public Health and Environment, will submit a family planning waiver to the Centers for Medicare and Medicaid Services. The Department anticipates submitting the wavier during calendar year 2008. The Department will research whether it is feasible to drop the current limit of 150% below the federal poverty level for establishing eligibility, so that non-Medicaid clients will be eligible for the benefit. If the waiver is approved, the benefit would be available to all clients of child bearing age. The benefit will include comprehensive reproductive health services, including contraception, for men and women.

Legislative Summary 2007

The following is a summary of House and Senate Bills that have passed or been adopted in FY 06-07 that are considered important to the Department.

HB 07-1021 (Frangas, Keller) Rx Consumer Assistance Program
This bill creates the prescription drug information and technical assistance program to provide advice on the prudent use of prescription drugs to persons who receive prescription drug benefits under Medicaid. The bill requires the Department to contract with licensed pharmacists for statewide Medicaid pharmacy services and consultations to help pharmacy clients avoid dangerous drug interactions, improve patient outcomes, and save the State money.

HB 07-1183 (White, Isgar) Reimbursement of Nursing Facilities
This bill extends the Department's reporting deadline to November 1, 2007 for submission of its feasibility study of a new nursing facility reimbursement system required under SB 06-131 enacted during the 2006 legislative session. The bill also extends the implementation date for the new reimbursement system to July 1, 2008, establishes the Nursing Facility Rate Grant Program to increase the rates of eligible providers, and specifies a formula for providing grants.

HB 07-1301 (Buescher, Williams) Cervical Cancer Immunizations
This bill creates the Cervical Cancer Immunization Program within the Department of Public Health and Environment and encourages federally qualified health centers to enter into agreements with local public health agencies to vaccinate females entering the sixth grade. Depending upon receipt of gifts, grants or donations, the Department of Public Health and Environment shall conduct a public awareness campaign on cervical cancer immunization and the benefits, disadvantages, and possible side effects of receiving cervical

cancer immunization. The bill adds cervical cancer immunization as a Medicaid service for which federal financial participation is available and which the Department has selected to provide as an optional service for all females under 20 years old.

HB 07-1319 (White, Boyd) Audit Providers under Medical Assistance Program
This bill requires auditors to notify providers of an audit at least 10 business days in advance and allows providers at least 45 days to provide records. The bill requires the Department to notify the provider in writing of its right to an informal reconsideration when an overpayment is detected. Informal reconsiderations will be considered final 30 days after the provider withdraws the request or the Department issues a written decision. In the event a formal appeal is filed, the Department may not implement recovery of the overpayment until the formal appeal has been completed.

HB 07-1346 (Buescher, Tapia) Managed Care in Medical Assistance Program
The bill provides that agreements with Prepaid Inpatient Health Plans may include incentive payments and specifies rules for the payments. The bill allows increases in the management fee paid to Prepaid Inpatient Health Plan to cover costs of electronic medical record keeping, revises the definition of "managed care" to include Prepaid Inpatient Health Plan and removes the requirement that the Department pay no more than 95% of the direct health care cost.

SB 07-001 (Hagedorn, Madden) Colorado Cares Rx Act
This bill establishes the Colorado Cares Rx Program, effective September 1, 2007, to provide generic and non-patented prescription drugs to eligible persons at discounted rates. Persons eligible for this program include uninsured Colorado residents not eligible for Medicaid or Children's Basic Health Plan whose family income does not exceed 300% of the federal poverty level. The bill establishes the Colorado Cares Rx program cash fund for deposit of registration fees.

SB 07-002 (Sandoval, Stafford) Extend Medicaid Eligibility for Foster Care
This bill adds a new optional group to receive coverage under Medicaid subject to the availability of federal funds. The bill extends eligibility until age 21 for foster care children who, prior to turning age 18 or becoming emancipated, are eligible for Medicaid under Title IV-E of the Social Security Act.

SB 07-004 (Shaffer, Todd) Early Intervention Services for Children
This bill requires the Department of Human Services to develop a coordinated payment system for early intervention services for children eligible for benefits under Part C of the Federal "Individuals with Disabilities Education Act," and requires coverage under Medicaid and Children's Basic Health Plan from birth through a child's third birthday. The bill establishes an interagency cooperating agreement and requires certification of early intervention service brokers as billing agents for early intervention services.

SB 07-036 (Keller, Stafford) Mental Health Disorders - Mandatory Coverage
This bill requires group insurance policies to include coverage for mental disorders and defines "mental disorder" as any condition defined as a mental disorder in the international classification of diseases, ninth revision (ICD-9), excluding homosexuality, tobacco use disorder, infantile autism, specific delays in development, mild mental retardation, other specified mental retardation, and unspecified mental retardation.

SB 07-130 (Boyd, Carroll M.) Medical Homes for Children
This bill defines "medical home" as an appropriately qualified medical specialty, developmental, therapeutic, or mental health care practice that verifiably ensures continuous, accessible, and comprehensive access to and coordination of all medically related services to a child and his or her family. The bill requires the Department to work in conjunction with the Colorado medical home initiative in the Department of Public Health and Environment to develop systems and standards to maximize the number of children enrolled in Medicaid or the Children's Basic Health Plan who have a medical home.

SB 07-133 (Tapia, Buescher) Cash Accounting for Department Programs
This bill changes the accounting method for the non-administrative expenditures for the Children's Basic Health Plan; Old Age Pension Health and Medical Care Fund; the Supplemental Old Age Pension Health and Medical Care Fund; and the Medicare Modernization Act of 2003 State Contribution Payment, known as the clawback, from accrual to cash accounting.

SB 07-196 (Hagedorn, Massey) Health Information Technology – Telemedicine
This bill creates the health information technology advisory committee to develop a long-range plan and pursue an interstate compact for health care information technology. On or after July 1, 2007, in-person contact between a home health care or a Home and Community Based Services provider and a patient shall not be required under Medicaid for services delivered through telemedicine. The bill provides that reimbursement rates shall be set by rule of the Medical Services Board after consultation with home health and Home and Community Based Services providers and shall be either budget-neutral or result in cost savings.

SB 07-211 (Hagedorn, McGihon) Improvements to Health Care for Children
This bill establishes the advisory committee on covering all children in Colorado to develop and implement a plan to ensure all low-income children have health coverage by the end of 2010. The bill makes specified low-income Baby and Kid Care children presumptively eligible. The bill excludes eligible pregnant women and individuals over 18 and under 19 from having to prove lawful presence in the United States, allows children with family income exceeding 133% of the federal poverty level to enroll in the plan, and provides that if a child is disenrolled from the Children's Basic Health Plan because the child has become enrolled in Medicaid, the Department will ensure continuous coverage through the transition.

VI. DEPARTMENTAL BACKGROUND

In providing the information in the Departmental Background section of this document, the Department accessed a number of different data sources. Different sources and different methods contain different types of information. Therefore, Medicaid caseload and Medicaid expenditures are represented as different numbers in different places.

For budget purposes and monthly reporting to the Joint Budget Committee, the Department reports Medicaid expenditures as the amount of the Medical Services Premiums Long Bill group. Medicaid expenditures are reported with or without federal financing, depending on the purpose of the report. For instance, federal financing can easily skew the perception of Medicaid services. Also, in some of the descriptive information provided in this document, the Department has queried the system and reported on *all* Medicaid expenditures, even those in other Long Bill groups such as "Other Medical Services" and "Department of Human Services Medicaid-Funded Programs." As long as taken in context, this information is provided to educate the General Assembly and the public regarding various aspects of Medicaid. Some information will not correlate directly with the official Budget Request.

A. CLIENTS

A1. 2007 Federal Poverty Levels

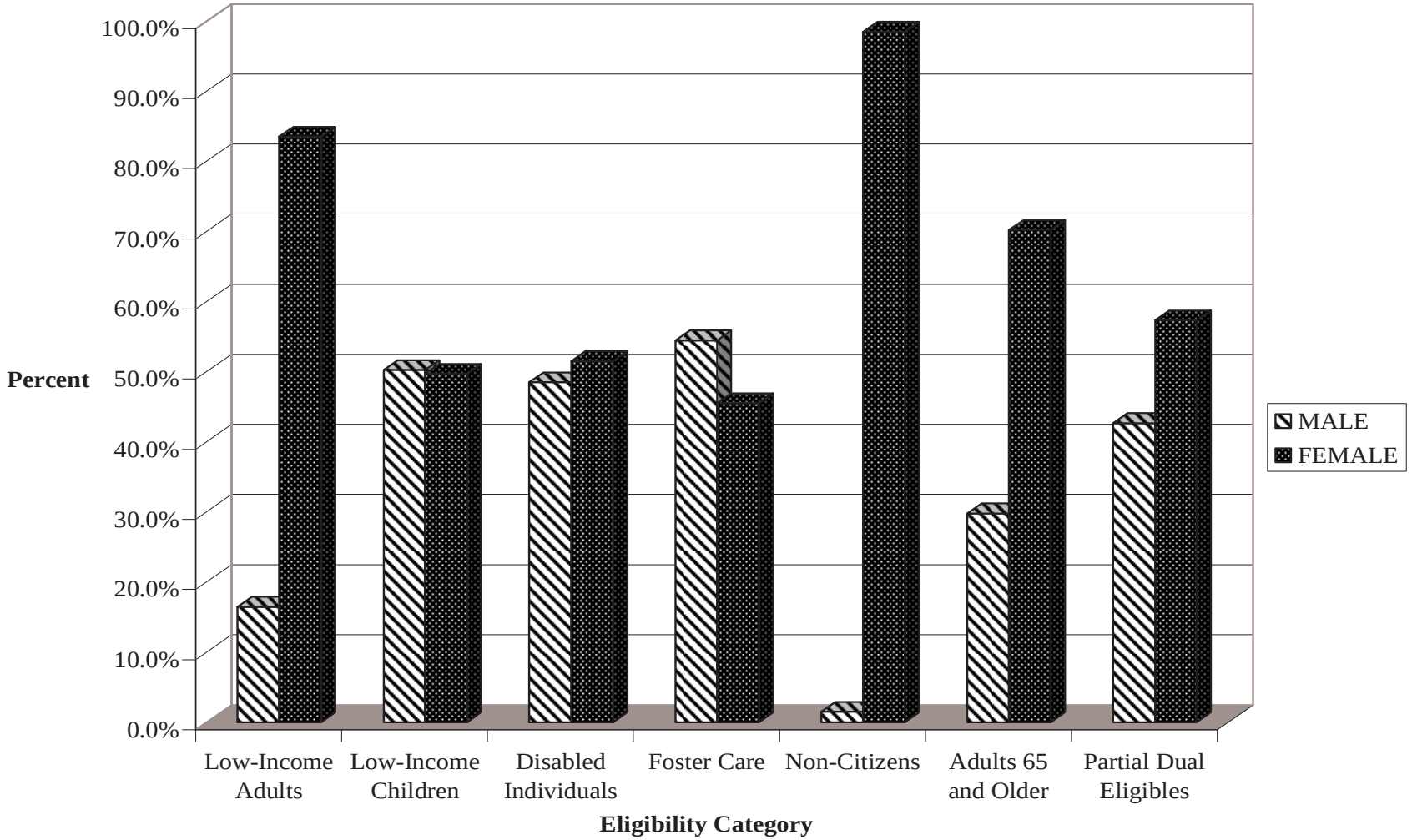
The table below reports the federal poverty levels for all states except Hawaii and Alaska from the Department of Health and Human Services, for federal fiscal year 2007. For family units of more than 8 members, add 3,480 for each additional family member.

Federal Poverty Levels for Annual Income

Family Size	100%	120%	133%	135%	150%	175%	185%	200%	250%
1	$10,210	$12,252	$13,579	$13,784	$15,315	$17,868	$18,889	$20,420	$25,525
2	$13,690	$16,428	$18,208	$18,482	$20,535	$23,958	$25,327	$27,380	$34,225
3	$17,170	$20,604	$22,836	$23,180	$25,755	$30,048	$31,765	$34,340	$42,925
4	$20,650	$24,780	$27,465	$27,878	$30,975	$36,138	$38,203	$41,300	$51,625
5	$24,130	$28,956	$32,093	$32,576	$36,195	$42,228	$44,641	$48,260	$60,325
6	$27,610	$33,132	$36,721	$37,274	$41,415	$48,318	$51,079	$55,220	$69,025
7	$31,090	$37,308	$41,350	$41,972	$46,635	$54,408	$57,517	$62,180	$77,725
8	$34,570	$41,484	$45,978	$46,670	$51,855	$60,498	$63,955	$69,140	$86,425

Source: 72 FR 3147, January 24, 2007

A2. Eligibility Categories by Gender for FY 06-07



Source: Business Objects of America query.
1) Low-Income Adults also includes Baby Care Program-Adults and Breast and Cervical Cancer Program Clients.
2) Disabled Individuals includes Disabled Adults 60 to 64 and Disabled Individuals to 59.
3) Partial Dual Eligibles includes include Qualified and Supplemental Low Income Medicare Beneficiaries.

A3. Medicaid Enrollment by Type of Managed Care Provider

The following table shows the breakdown by client count for FY 02-03 through FY 06-07 for clients enrolled in health maintenance organizations, prepaid inpatient health plan, Primary Care Physician Program, and unassigned fee-for-service. Health maintenance organizations, prepaid inpatient health plan and Primary Care Physician Program enrollment figures were subtracted from total caseload numbers (without retroactivity) to calculate the fee-for-service enrollment figures, and as a result may cause the fee-for-service counts to be underrepresented.

Average Medicaid Enrollment for FY 02-03 through FY 06-07

Membership Category	FY 02-03 Count	FY 03-04 Count	FY 04-05 Count	FY 05-06 Count	FY 06-07 Count
Health Maintenance Organizations and Prepaid Inpatient Health Plans	126,669	74,439	77,354	71,799	35,985
Primary Care Physician Program	65,475	68,557	51,669	36,563	29,243
Fee-for-Service	135,251	219,535	273,779	291,343	327,849
TOTALS	**327,395**	**362,531**	**402,802**	**399,705**	**393,077**

Sources: Prepaid inpatient health plans (that is, Rocky Mountain Health Plan), health maintenance organization, Primary Care Physician Program enrollment numbers are from the Managed Care Report. FY 06-07 total Medicaid count comes from the averages for twelve months of this fiscal year. Caseload numbers are an average of the fiscal year's caseload for each month, without retroactivity.
Note: Fee-for-service enrollment is derived by the total enrollment minus enrollment in administrative service organizations, health maintenance organization, and the Primary Care Physician Program.

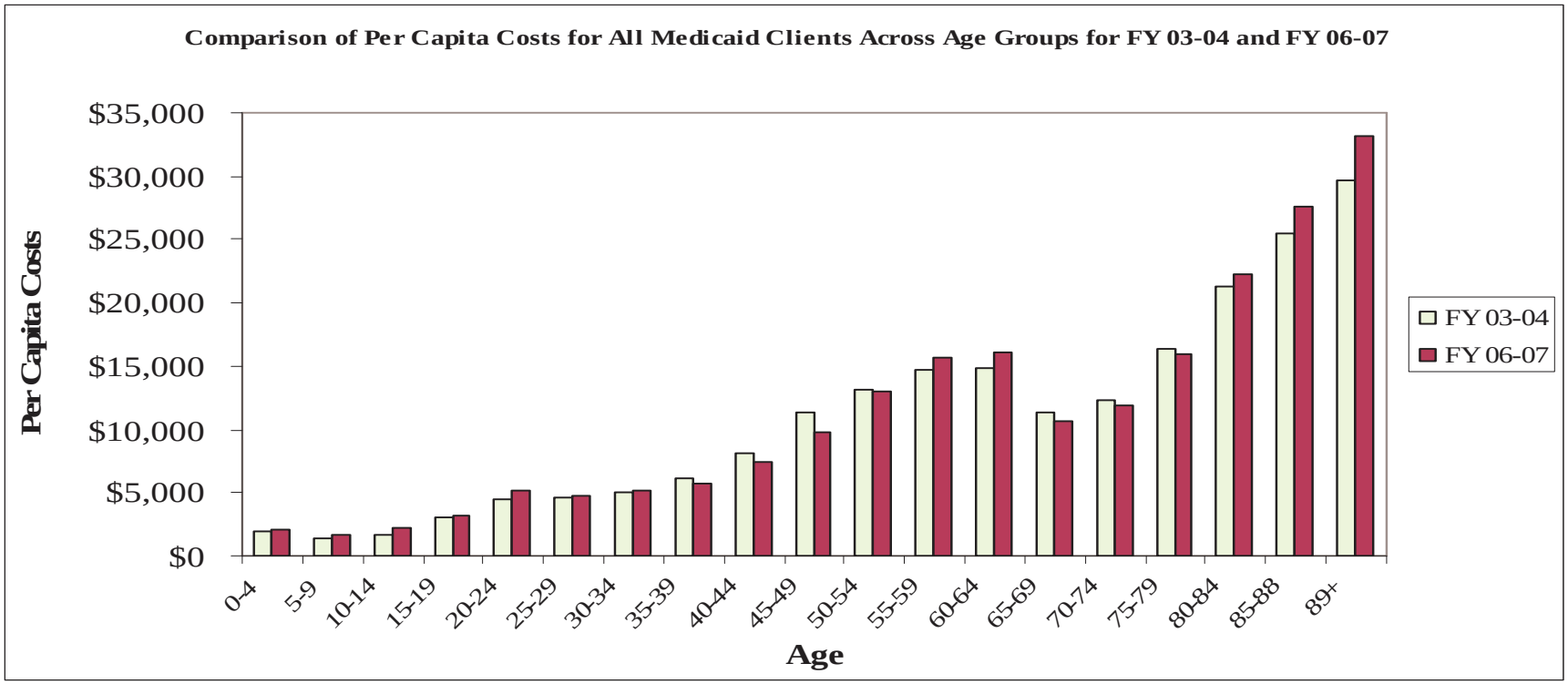
B. SERVICES

B1. Paid Medical Services Per Capita Costs (from all claims) Across Age Groups

The graph below represents Medicaid per capita costs by client age as of first date of service as reported on his or her most recent claim in FY 06-07. The graph also contains all clients in the following caseload categories:

- Adults 65 and Older (OAP-A): This includes persons with Supplemental Security Income for persons 65 years of age or older (Old Age Pension-A).
- Disabled Adults 60 to 64 (OAP-B): This includes Supplemental Security Income for disabled persons 60-64 years of age (Old Age Pension-B).

- Disabled Individuals to 59 (AND/AB): This includes Supplemental Security Income for disabled individuals up to the age of 59 (Aid to the Needy Disabled/Aid to the Blind).
- CE Low Income Adults: Categorically Eligible Low Income Adults (Aid to Families with Dependent Children - Adults)
- BCCP: Breast and Cervical Cancer Program
- Health Care Expansion Fund: Low-Income Adults
- Eligible Children: Eligible Children (Aid to Families with Dependent Children - Children/Baby Care Children)
- Foster Children: Foster care (Aid to Families with Dependent Children - Foster Care)
- Baby Care Adults: A Medicaid eligibility category appropriated in the Long Bill that deals only with pregnant women
- Non Citizens: Adults and/or children who have not established legal residency in the US and certain qualifications of legal immigrants who meet certain eligibility requirements
- Partial Dual Eligibles (QMBs/SLMBa): Qualified Medicare Beneficiaries and Special Low Income Medicare Beneficiaries



Source: Medicaid paid claims and eligibility spans from MMIS-DSS. Note: Financial transactions and other accounting adjustments are not included in the expenditures by age group.

B2. FY 06-07 Services by County

Exhibits B2a - B2d show utilization of the following medical services by HIPAA Information Region by unique client count and average cost per full time equivalent client.

Acute Care, including:

- Federal Qualified Health Centers
- Physician and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services
- Prescription Drugs
- Inpatient Hospital
- Outpatient Hospital

B3. Client Counts for Long Term Care and Home and Community Based Services

Exhibit B3 shows client counts for Long Term Care and Home Health and Long Term Care Services, including:

- Home and Community Based Services (HCBS)
- Program for All-Inclusive Care for the Elderly (PACE)
- Home Health
- Nursing Facilities

B4. Top Tens

Exhibits B4a – B4j shows expenditure and utilization for the top ten diagnoses and procedures for the following:

- Inpatient Hospital
- Outpatient Hospital
- Federal Qualified Health Centers
- Rural Health Centers
- Physician and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services
- Dental
- Laboratory
- Durable Medical Equipment and Supplies

Exhibits B4k and B4l show the top 10 prescription drug expenditures and the top ten prescription drugs by number of prescriptions filled, in total and pre and post implementation of Medicare Part D.

The following should be noted:

- Clients with no HIPAA Information Region designation are not included.
- The Department's decision support system (MMIS-DSS), extracts data on a different time span and from a different source (i.e., Medicaid Management Information System) than the Colorado Financial Reporting System. This decision support system contains a full extract of all county level data in the MMIS.
- The Department administers the following Home and Community Based Services waivers: Client Services, Mental Illness, Children's, Persons Living with AIDS, and Brain Injury.
- The Department of Human Services administers the following Home and Community Based Services waivers: Developmentally Disabled, Supported Living Services, Children's Extensive Support, and Children's Habilitation Residential Program.
- The inpatient diagnosis related groups (DRGs) were categorized to improve the interpretation and evaluation of services (tables B4a and B4b). Research and reasonableness were used to determine the DRG categories As far as the naming of categories through the consultation of the ICD-10 (International Classification of Diseases). The logic was to create specific DRG categories without creating too many groupings, and that is partly why there is a group called *Non-Specific Symptoms, Disorders or Procedures.* Since the DRG descriptions were sometimes referring to diseases, sometimes to procedures, the term 'Disorders or Procedures' was often included in the names of categories, or groups.
- The tables exhibit the top 10 client counts, top 10 service utilizations, and top 10 expenditures by types of commonly used medical services. It should be noted that sometimes the ranking of top client counts and service utilizations are the same, but the expenditures rankings differ.
- The outpatient diagnosis groupings are based on ICD-9's three-digit categories.
- For the top ten prescription drug tables, the number of prescriptions filled was preferred to the number of prescriptions because it provides better insight on the frequency of pharmacy Medicaid payments. Excluded from the analysis were claims where the payment was zero.
- It is important to mention that the totals at the bottom of each of the top ten tables reflect the sum of unique client count/count of services/expenditures for the top ten groupings only. These sums should not be mistaken for the totals of clients, services and expenditures for a type of medical service.

B2a: FY 06-07 Unduplicated Client Count for Selected Acute Care Service Categories by HIPAA Information Region

HIPAA Information Region	Federally Qualified Health Centers	Physician and EPSDT*	Pharmacy Prescriptions	Inpatient Hospital	Outpatient Hospital
Garfield, Moffat, Rio Blanco	938	3,982	3,328	711	2,346
Eagle, Grand, Jackson, Pitkin, Routt, Summit	140	4,081	2,513	806	1,647
Mesa	44	7,146	4,723	661	2,832
Delta, Montrose, Ouray, San Miguel	109	4,254	2,995	486	1,902
Archuleta, Dolores, La Plata, Montezuma, San Juan	1,628	5,678	4,969	757	3,086
Gunnison, Chaffee, Lake, Fremont, Park, Custer	504	6,145	6,054	875	3,862
Hinsdale, Saguache, Mineral, Conejos, Rio Grande, Alamosa, Costilla	5,811	6,097	6,521	807	3,907
Huerfano, Las Animas, Baca, Otero, Crowley, Bent, Prowers, Kiowa	3,978	9,153	8,791	1,161	5,835
Pueblo	6,249	22,594	20,233	2,561	13,632
El Paso, Teller	15,792	37,940	33,472	5,202	22,993
Washington, Morgan, Logan, Yuma, Phillips, Sedgwick	2,056	5,256	5,230	805	3,357
Elbert, Lincoln, Kit Carson, Cheyenne	758	1,781	1,762	226	1,027
Douglas	301	3,752	2,955	459	1,772
Boulder, Broomfield	7,371	11,396	9,842	1,839	7,234
Larimer	5,932	14,704	12,507	1,979	7,724
Weld	8,029	16,088	13,437	2,596	8,950
Adams	15,390	34,263	26,254	5,341	20,189
Arapahoe	7,641	33,721	25,020	4,838	17,873
Jefferson, Gilpin, Clear Creek	5,339	22,484	18,594	2,958	12,171
Denver	23,061	34,733	27,059	6,626	19,526
Statewide	**109,161**	**278,009**	**230,792**	**41,509**	**159,059**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to one and one-half months after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category in that specific HIPAA Information Region only. Statewide totals represent an unduplicated client count for the entire State. Statewide totals are not the sum of all HIPAA Information Regions as a specific client may receive a service in one or multiple service categories, or may have received the same service in the same service category in one or multiple HIPAA Information Regions. *Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program.

B2b: FY 06-07 Average Cost per Full Time Equivalent Client for Selected Acute Care Service Categories by HIPAA Information Region

HIPAA Information Region	Federally Qualified Health Centers	Physician and EPSDT*	Pharmacy Prescriptions	Inpatient Hospital	Outpatient Hospital
Garfield, Moffat, Rio Blanco	$120.96	$446.33	$482.67	$907.31	$426.46
Eagle, Grand, Jackson, Pitkin, Routt, Summit	$17.79	$609.26	$430.14	$1,349.41	$324.76
Mesa	$1.08	$199.44	$161.20	$269.34	$159.74
Delta, Montrose, Ouray, San Miguel	$5.08	$230.80	$202.32	$335.22	$169.44
Archuleta, Dolores, La Plata, Montezuma, San Juan	$79.18	$411.84	$502.58	$640.45	$295.92
Gunnison, Chaffee, Lake, Fremont, Park, Custer	$24.30	$446.58	$708.73	$675.86	$295.34
Hinsdale, Saguache, Mineral, Conejos, Rio Grande, Alamosa, Costilla	$336.68	$310.70	$427.03	$517.04	$324.03
Huerfano, Las Animas, Baca, Otero, Crowley, Bent, Prowers, Kiowa	$149.55	$402.64	$635.45	$597.50	$299.91
Pueblo	$152.26	$509.81	$699.01	$606.05	$318.83
El Paso, Teller	$200.76	$506.04	$592.30	$620.49	$353.96
Washington, Morgan, Logan, Yuma, Phillips, Sedgwick	$144.93	$369.41	$553.83	$730.40	$327.01
Elbert, Lincoln, Kit Carson, Cheyenne	$145.67	$340.23	$627.08	$690.67	$359.08
Douglas	$27.12	$576.69	$641.40	$703.41	$386.82
Boulder, Broomfield	$237.71	$447.37	$514.11	$745.46	$367.07
Larimer	$156.73	$527.77	$664.08	$647.91	$303.48
Weld	$228.58	$459.35	$519.95	$882.64	$324.19
Adams	$170.29	$436.82	$429.16	$818.96	$312.62
Arapahoe	$76.95	$499.01	$476.28	$845.28	$316.63
Jefferson, Gilpin, Clear Creek	$86.00	$501.06	$597.40	$754.00	$318.06
Denver	$157.98	$305.23	$315.61	$867.21	$220.53
Statewide	**$144.60**	**$428.98**	**$489.74**	**$732.52**	**$299.03**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent unduplicated average cost per full time equivalent client information presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to one and one-half months after the end of the fiscal year have been included. Average cost per full time equivalent client is total payments divided by a calculated full time eligible as determined by client eligibility months for that specific HIPAA Information Region only. Statewide averages represent the average for the entire State. Statewide averages are not an average of all HIPAA Information Regions as a specific client may receive a service in one or multiple service categories, or may have received the same service in the same service category in one or multiple HIPAA Information Regions. *Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program.

B2c: FY 06-07 Unduplicated Client Count for Home and Community Based Services (HCBS) Waiver Programs, Program for All-Inclusive Care for the Elderly (PACE), and Long Term Care Service Categories by HIPAA Information Region

HIPAA Information Region	HCBS Waiver Programs Administered by HCPF*	HCBS Waiver Programs Administered by DHS**	Program for All-Inclusive Care for the Elderly	Home Health	Nursing Facilities (Class I and Class II)
Garfield, Moffat, Rio Blanco	401	121	0	75	282
Eagle, Grand, Jackson, Pitkin, Routt, Summit	137	54	0	131	52
Mesa	1,449	382	0	301	453
Delta, Montrose, Ouray, San Miguel	757	176	0	317	425
Archuleta, Dolores, La Plata, Montezuma, San Juan	636	99	0	210	308
Gunnison, Chaffee, Lake, Fremont, Park, Custer	842	169	0	299	558
Hinsdale, Saguache, Mineral, Conejos, Rio Grande, Alamosa, Costilla	977	96	0	431	305
Huerfano, Las Animas, Baca, Otero, Crowley, Bent, Prowers, Kiowa	1,215	294	0	291	770
Pueblo	1,707	590	0	935	852
El Paso, Teller	2,295	786	0	1,308	1,440
Washington, Morgan, Logan, Yuma, Phillips, Sedgwick	654	184	0	156	555
Elbert, Lincoln, Kit Carson, Cheyenne	139	32	0	32	134
Douglas	316	123	0	143	188
Boulder, Broomfield	1,150	540	0	558	749
Larimer	1,179	484	0	548	789
Weld	874	363	0	525	606
Adams	1,477	717	325	883	1,331
Arapahoe	1,749	832	257	903	1,174
Jefferson, Gilpin, Clear Creek	2,127	944	366	881	1,739
Denver	3,651	769	476	1,485	1,829
Statewide	**23,732**	**7,755**	**1,424**	**10,412**	**14,539**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to one and one-half months after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category in that specific HIPAA Information Region only. Statewide totals represent an unduplicated client count for the entire State. Statewide totals are not the sum of all HIPAA Information Regions as a specific client may receive a service in one or multiple service categories, or may have received the same service in the same service category in one or multiple HIPAA Information Regions. *Department of Health Care Policy and Financing (HCPF), **Department of Human Services (DHS).

B2d: FY 06-07 Average Cost per Unduplicated Client Home and Community Based Services (HCBS) Waiver Programs, Program for All-Inclusive Care for the Elderly (PACE), and Long Term Care Service Categories by HIPAA Information Region

HIPAA Information Region	HCBS Waiver Programs Administered by HCPF*	HCBS Waiver Programs Administered by DHS**	Program for All-Inclusive Care for the Elderly	Home Health	Nursing Facilities (Class I and Class II)
Garfield, Moffat, Rio Blanco	$3,973.68	$44,669.20	$0.00	$1,979.72	$37,223.36
Eagle, Grand, Jackson, Pitkin, Routt, Summit	$3,863.91	$32,856.35	$0.00	$3,112.89	$36,048.59
Mesa	$10,155.96	$55,202.52	$0.00	$6,914.51	$29,676.02
Delta, Montrose, Ouray, San Miguel	$6,533.31	$30,736.40	$0.00	$5,924.74	$29,768.58
Archuleta, Dolores, La Plata, Montezuma, San Juan	$5,988.60	$29,330.88	$0.00	$10,847.97	$27,721.24
Gunnison, Chaffee, Lake, Fremont, Park, Custer	$7,293.44	$31,950.63	$0.00	$5,760.40	$31,248.68
Hinsdale, Saguache, Mineral, Conejos, Rio Grande, Alamosa, Costilla	$5,239.87	$33,473.74	$0.00	$2,459.84	$28,525.97
Huerfano, Las Animas, Baca, Otero, Crowley, Bent, Prowers, Kiowa	$5,735.37	$27,393.80	$0.00	$6,349.07	$32,193.29
Pueblo	$8,181.55	$43,143.14	$0.00	$9,852.19	$29,951.51
El Paso, Teller	$8,621.91	$29,773.94	$0.00	$18,035.24	$35,069.77
Washington, Morgan, Logan, Yuma, Phillips, Sedgwick	$4,616.14	$32,332.75	$0.00	$4,504.15	$29,773.05
Elbert, Lincoln, Kit Carson, Cheyenne	$6,129.28	$19,697.06	$0.00	$2,651.15	$32,859.91
Douglas	$12,248.49	$25,427.52	$0.00	$15,161.57	$40,551.55
Boulder, Broomfield	$6,780.20	$35,595.32	$0.00	$11,044.77	$33,292.74
Larimer	$5,824.78	$34,809.03	$0.00	$8,494.06	$31,439.97
Weld	$6,898.40	$30,944.14	$0.00	$9,640.97	$29,658.90
Adams	$9,073.34	$33,107.82	$32,537.06	$11,783.15	$35,072.02
Arapahoe	$11,213.98	$34,997.66	$32,104.31	$11,451.30	$33,070.30
Jefferson, Gilpin, Clear Creek	$9,649.14	$42,152.88	$30,966.48	$13,364.77	$34,830.41
Denver	$11,240.68	$26,736.86	$30,999.13	$10,407.83	$35,340.34
Statewide	**$7,463.10**	**$33,716.58**	**$31,651.75**	**$8,487.01**	**$32,665.81**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent unduplicated average cost per full time equivalent client information presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to one and one-half months after the end of the fiscal year have been included. Average cost per full time equivalent client is total payments divided by the unduplicated client count that specific HIPAA Information Region only. Statewide averages represent the average for the entire State. Statewide averages are not an average of all HIPAA Information Regions as a specific client may receive a service in one or multiple service categories, or may have received the same service in the same service category in one or multiple HIPAA Information Regions. *Department of Health Care Policy and Financing (HCPF), **Department of Human Services (DHS).

B3: FY 02-03 to FY 06-07 Unduplicated Client Count by Dates of Service for Home and Community Based Services (HCBS) Waiver Programs, Home Health, Program for All-Inclusive Care for the Elderly (PACE), and Nursing Facilities

HCBS Waiver Programs Administered by Department of Health Care Policy and Financing (HCPF)

Fiscal Year	Elderly Blind and Disabled and Consumer Directed Care to the Elderly	Children's Home and Community Based Services	Persons with Brain Injury	Persons with Mental Illness	Persons Living with AIDS	Total HCPF
FY 02-03	15,702	638	407	2,062	106	**18,841**
FY 03-04	15,734	631	376	2,065	98	**18,559**
FY 04-05	14,833	618	322	1,844	66	**17,407**
FY 05-06	16,415	1,049	297	1,948	58	**19,534**
FY 06-07	17,019	1,254	306	2,160	62	**23,732**

HCBS Waiver Programs Administered by Department of Human Services (DHS)

Fiscal Year	Children's Habilitation Residential Program	Supported Living Services	Developmentally Disabled	Children's Extensive Support	Total DHS	Total HCPF and DHS HCBS Waiver Programs
FY 02-03	240	3,056	3,884	235	**7,243**	**26,084**
FY 03-04	214	3,113	3,958	226	**7,364**	**25,923**
FY 04-05	204	2,935	3,688	220	**6,927**	**24,334**
FY 05-06	191	3,092	3,690	375	**7,212**	**26,746**
FY 06-07	165	2,982	4,112	381	**7,755**	**31,487**

Long Term Care Programs Administered by Department of Health Care Policy and Financing

Fiscal Year	Home Health	Program for All-Inclusive Care for the Elderly	Class I Nursing Facilities	Class II Nursing Facilities	Total Nursing Facilities (Class I and II)
FY 02-03	7,326	688	14,645	17	**14,661**
FY 03-04	8,275	1,046	14,196	16	**14,212**
FY 04-05	8,687	1,187	13,919	17	**13,936**
FY 05-06	9,430	1,271	14,287	20	**14,299**
FY 06-07	10,161	1,376	14,045	21	**14,539**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to three months (FY 03-06) one and one-half months (FY 07) after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only. Totals are not the sum of categories.

B4a: FY 06-07 Top 10 Inpatient Hospital Diagnosis Categories Ranked by Expenditures

Rank	Description	Expenditures	Unduplicated Client Count
1	Childbirth	$91,392,125	23,046
2	Circulatory System Disorders or Procedures (heart and cerebrovascular diseases)	$33,931,198	1,669
3	Neonate Related Complications or Procedures	$26,020,505	2,936
4	Pulmonary and/or Respiratory Related Disorders or Procedures	$24,860,777	3,663
5	Digestive System Related Disorders or Procedures	$21,277,513	2,634
6	Bone, Muscle, Joint or Connective Tissue Related Disorders or Procedures	$16,988,805	1,554
7	Renal and/or Urinary System Related Disorders or Procedures	$8,369,692	890
8	Hematology (Blood) Related Disorders or Procedures	$7,625,287	532
9	Brain Injuries, Brain Disorders and/or Brain Related Procedures	$6,459,029	684
10	Pregnancy Related Complications or Procedures	$6,435,790	1,823
	Top Ten Total	**$243,360,722**	**39,431**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to one and one-half months after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only.

B4b: FY 06-07 Top 10 Inpatient Hospital Diagnosis Related Groups (DRG) Ranked by Expenditures

Rank	DRG Number	Description	Expenditures	Unduplicated Client Count
1	373	Vaginal Delivery without Complicating Diagnoses	$40,806,509	14,159
2	371	Cesarean Section without Complicating Diagnoses	$18,266,665	3,180
3	370	Cesarean Section with Complicating Diagnoses	$15,915,324	2,104
4	541	Tracheostomy with Mechanical Ventilator	$11,022,478	111
5	372	Vaginal Delivery with Complicating Diagnoses	$10,988,487	2,878
6	801	Neonates Less Than 1,000 Grams	$7,567,336	97
7	898	Bronchitis and Asthma, Under Age 17 with Complicating Diagnoses	$4,919,701	1,283
8	802	Neonates, 1,000 - 1,499 Grams	$4,777,162	163
9	803	Neonates, 1500 - 1,999 Grams	$4,086,381	312
10	383	Other Antepartum Diagnoses with Medical Complications	$3,339,279	984
		Top Ten Total	**$121,689,321**	**25,271**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to one and one-half months after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only.

B4c: FY 06-07 Top 10 Outpatient Hospital Principal Diagnosis Categories Ranked by Expenditures

Rank	Principal Diagnosis Group Number	Description	Expenditures	Unduplicated Client Count
1	789	Other Symptoms Involving Abdomen and Pelvis	$5,710,306	9,798
2	786	Symptoms Involving Respiratory System and Other Chest Symptoms	$3,975,840	10,119
3	585	Chronic Renal Failure	$3,911,389	238
4	780	General Symptoms	$3,667,582	10,704
5	521	Diseases of Hard Tissues of Teeth	$3,294,752	2,338
6	784	Symptoms Involving Head and Neck	$1,888,611	4,447
7	648	Other Current Conditions in the Mother Classifiable Elsewhere But Complicating Pregnancy, Childbirth, and the Puerperium	$1,858,654	6,121
8	V58	Other and Unspecified Aftercare	$1,777,663	1,702
9	787	Symptoms Involving Digestive System	$1,691,212	7,127
10	724	Other and Unspecified Disorders of Back	$1,630,379	4,533
		Top Ten Total	**$29,406,387**	**57,127**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to one and one-half months after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only.

B4d: FY 06-07 Top 10 Outpatient Surgical Procedures Ranked by Expenditures

Rank	Surgical Procedure Code	Description	Expenditures	Unduplicated Client Count
1	23.41	Application of Crown	$1,056,655	544
2	99.29	Injection or Infusion of Other Therapeutic or Prophylactic Substance	$904,044	1,170
3	28.3	Tonsillectomy with Adenoidectomy	$664,370	356
4	23.2	Restoration of Tooth by Filling	$517,071	236
5	66.29	Other Bilateral Endoscopic Destruction or Occlusion of Fallopian Tubes	$507,556	376
6	89.17	Polysomnogram	$491,837	266
7	23.70	Root Canal, Not Otherwise Specified	$456,928	238
8	20.01	Myringotomy with Insertion of Tube	$375,690	295
9	96.54	Dental Scaling, Polishing, and Debridement	$311,048	158
10	93.54	Application of Splint	$308,579	1,190
		Top Ten Total	**$5,593,777**	**4,829**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to one and one-half months after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only.

B4e: FY 06-07 Top 10 Federally Qualified Health Center (FQHC) Principal Diagnosis Categories Ranked by Expenditures

Rank	Principal Diagnosis Group Number	Description	Expenditures	Unduplicated Client Count
1	V20	Health Supervision of Infant or Child	$11,545,673	44,331
2	V72	Special Investigations and Examinations	$7,118,854	25,028
3	V22	Normal Pregnancy	$4,830,767	6,232
4	465	Acute Upper Respiratory Infections of Multiple or Unspecified Sites	$2,752,439	14,254
5	382	Suppurative and Unspecified Otitis Media	$1,413,573	7,027
6	462	Acute Pharyngitis	$783,976	4,746
7	650	Normal Delivery	$757,318	1,075
8	V70	General Medical Examination	$750,062	3,902
9	250	Diabetes Mellitus	$737,241	2,124
10	780	General Symptoms	$711,586	3,912
		Top Ten Total	**$31,401,487**	**112,631**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to one and one-half months after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only.

B4f: FY 06-07 Top 10 Rural Health Center (RHC) Principal Diagnosis Categories Ranked by Expenditures

Rank	Principal Diagnosis Group Number	Description	Expenditures	Unduplicated Client Count
1	V20	Health Supervision of Infant or Child	$557,455	3,283
2	382	Suppurative and Unspecified Otitis Media	$301,582	1,709
3	465	Acute Upper Respiratory Infections of Multiple or Unspecified Sites	$286,182	1,787
4	V22	Normal Pregnancy	$152,579	334
5	V72	Special Investigations and Examinations	$138,407	488
6	462	Acute Pharyngitis	$124,985	1,046
7	461	Acute Sinusitis	$117,973	996
8	780	General Symptoms	$112,633	838
9	466	Acute Bronchitis and Bronchiolitis	$104,948	799
10	493	Asthma	$90,428	551
		Top Ten Total	**$1,987,171**	**11,831**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to one and one-half months after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only.

B4g: FY 06-07 Top 10 Physician and Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program Principal Diagnosis Categories Ranked by Expenditures

Rank	Principal Diagnosis Group Number	Description	Expenditures	Unduplicated Client Count
1	V20	Health Supervision of Infant or Child	$9,592,140	69,838
2	650	Normal Delivery	$6,437,215	11,071
3	780	General Symptoms	$3,797,662	30,920
4	789	Other Symptoms Involving Abdomen and Pelvis	$3,751,570	22,011
5	V22	Normal Pregnancy	$3,713,214	14,049
6	786	Symptoms Involving Respiratory System and Other Chest Symptoms	$3,595,979	33,944
7	367	Disorders of Refraction and Accommodation	$3,195,811	28,576
8	V25	Encounter For Contraceptive Management	$2,910,614	13,069
9	765	Disorders Relating to Short Gestation and Unspecified Low Birthweight	$2,787,500	2,090
10	770	Other Respiratory Conditions of Fetus and Newborn	$2,778,983	2,166
		Top Ten Total	**$42,560,688**	**227,734**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to one and one-half months after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only.

B4h: FY 06-07 Top 10 Dental Procedures Ranked by Expenditures

Rank	Procedure Code	Description	Expenditures	Unduplicated Client Count
1	D2930	Prefabricated Stainless Steel Crown - Primary Tooth	$4,182,647	15,704
2	D2391	Resin-Based Composite - One Surface, Posterior	$2,951,106	20,410
3	D8090	Orthodontic Treatment of the Adult Dentition	$2,531,343	834
4	D2140	Amalgam - One Surface, Primary or Permanent	$2,192,130	19,923
5	D7140	Extraction, Erupted Tooth or Exposed Root	$2,036,629	18,830
6	D3220	Therapeutic Pulpotomy	$1,977,535	12,868
7	D1120	Prophylaxis - Child	$1,762,083	58,742
8	D2392	Resin-Based Composite - Two Surfaces, Posterior	$1,706,386	12,431
9	D2150	Amalgam - Two Surfaces, Primary or Permanent	$1,640,394	15,251
10	D0120	Periodic Oral Evaluation	$1,527,949	65,214
		Top Ten Total	**$22,508,202**	**240,207**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to one and one-half months after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only.

B4i: FY 06-07 Top 10 Laboratory Procedures Ranked by Expenditures

Rank	Procedure Code	Description	Expenditures	Unduplicated Client Count
1	87491	Chlamydia Tracholmatis, DNA, Amplified Probe Technique	$1,320,997	21,913
2	87591	Neisseria Gonorrhea, DNA, Amplified Probe Technique	$1,121,028	19,209
3	85025	Complete Blood Count with Automated White Blood Cells Differential	$967,116	56,265
4	80101	Drug Screen, Single	$752,998	5,185
5	80053	Comprehensive Metabolic Panel	$708,685	32,465
6	84443	Thyroid Stimulus Hormone	$702,478	25,111
7	88305	Tissue Exam by Pathologist	$431,115	6,828
8	80061	Lipid Panel	$429,615	18,992
9	80050	General Health Panel	$426,134	8,436
10	80048	Basic Metabolic Panel	$412,171	24,634
		Top Ten Total	**$7,272,337**	**219,038**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to one and one-half months after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only.

B4j: FY 06-07 Top 10 Durable Medicaid Equipment and Supplies Procedures Ranked by Expenditures

Rank	Procedure Code	Description	Expenditures	Unduplicated Client Count
1	S8121	Oxygen Contents Liquid, Per Pound	$8,897,051	5,711
2	E1390	Oxygen Concentrator	$7,783,393	8,663
3	B4160	Enteral Formula for Pediatrics, Calorically Dense	$2,639,931	1,067
4	E0445	Oximeter Non-Invasive	$2,094,868	1,205
5	E0434	Portable Liquid Oxygen	$1,471,865	4,797
6	B4035	Enteral Feeding Supply Pump per Day	$1,288,297	736
7	A4253	Blood Glucose Test or Reagent Strips, per 50 Strips	$1,248,753	4,851
8	T4535	Disposable Liner / Shield / Pad for Incontinence	$1,139,393	3,268
9	T4527	Adult Sized Disposable Incontinence Product	$1,136,908	1,956
10	B4150	Enteral Formula Complete with Intact Nutrient	$1,136,008	1,546
		Top Ten Total	**$28,836,466**	**33,800**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to one and one-half months after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only.

B4k: FY 06-07 Top 10 Prescription Drugs Ranked by Expenditures

Rank	Drug Name	Therapeutic Class	Expenditures	Unduplicated Client Count
1	Seroquel	Antipsychotic	$9,120,167	4,957
2	Risperdal	Antipsychotic	$7,563,768	4,356
3	Abilify	Antipsychotic	$7,413,641	2,988
4	Synagis	Monoclonal Antibody (prevention/treatment of respiratory virus in infants)	$6,225,852	676
5	Zyprexa	Antipsychotic	$5,878,122	1,867
6	Lamictal	Anti-Convulsant	$3,824,026	2,177
7	Depakote	Anti-Convulsant	$3,793,782	3,721
8	Advair	Bronchodilator and Corticosteroid	$3,371,627	6,268
9	Topamax	Anti-Convulsant	$3,243,756	2,325
10	Oxycodone	Analgesic	$3,241,797	18,935
		Top Ten Total	**$53,676,537**	**48,270**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to one and a half months after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only.

B4l: FY 06-07 Top 10 Prescription Drugs
Ranked by Number of Prescriptions Filled

Rank	Drug Name	Therapeutic Class	Total Prescriptions	Expenditures
1	Hydrocodone	Analgesic	95,971	$1,059,494
2	Amoxicillin	Antibiotic	77,644	$729,406
3	Oxycodone	Analgesic	65,513	$3,241,797
4	Albuterol	Bronchodilator	62,172	$1,171,948
5	Azithromycin	Antibiotic	43,716	$1,391,776
6	Lorazepam	Anti-Anxiety Drug (benzodiazepine)	41,343	$1,074,281
7	Zyrtec	Antihistamine	38,352	$2,290,106
8	Lisinopril	Hypotensive (angiotensin converting enzyme inhibitor)	33,939	$732,855
9	Seroquel	Antipsychotic	33,430	$9,120,167
10	Clonazepam	Anti-Convulsant	32,697	$646,281
		Top Ten Total	**524,777**	**$21,458,113**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to one and a half months after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only.

APPENDIX A

FY 06-07 ACHIEVEMENTS TOWARDS PERFORMANCE MEASURES

FY 06-07 OBJECTIVE: **1.1 To maximize the opportunity to maintain health care services through the purchase of services in the most cost-effective manner possible.**		
Division / Section	**FY 06-07 Performance Measure**	**Achievements towards FY 06-07 Performance Measures**
Client Services Division. Pharmacy Section	The Pharmacy Section will effectively utilize the Drug Utilization Review Board to identify opportunities for cost savings. The Board will meet on a quarterly basis.	The Drug Utilization Review Board held quarterly meetings on July 18, 2006, November 8, 2006, January 23, 2007 and April 24, 2007. The Drug Utilization Review Board recommended that Provigil, Advair, attention deficit hyperactivity disorder drugs, narcotics containing acetaminophen, and injectables be prior authorized as a cost savings measure.
Client Services Division. Pharmacy Section	Based on identifying opportunities with the pharmacy program and utilizing the Drug Utilization Review Board recommendations, the Finance Division will provide recommendations for prior authorizations, limits, and controls to effectively manage the prescription drug expenditures on a quarterly basis.	The Department implemented prior authorizations on eight drugs and drug classes effective March 1, 2007. The Department will report the outcome in its annual report to the Joint Health and Human Services Committee on December 1, 2007.

FY 06-07 OBJECTIVE: **1.1 To maximize the opportunity to maintain health care services through the purchase of services in the most cost-effective manner possible.**		
Division / Section	**FY 06-07 Performance Measure**	**Achievements towards FY 06-07 Performance Measures**
Child Health Plan Plus Division. Program Evaluation and Contract Operations Section	The Child Health Plan Office will promote private sector insurance in Colorado by implementing a pilot program for employer sponsored insurance with two large employers by January 2007.	The pilot program began on October 1, 2006 to solicit applications from interested employees. Only one employer, Denver Health, agreed to participate in the program. The program began to cover ninety-nine children on January 1, 2007, at the start of the employer's benefit year. As of April 1, 2007, 106 children have been enrolled in the program.
Long Term Benefits Division. Community Based Long Term Care Section	The Community Based Long Term Care Section will ensure a 90% accuracy rate in the submission and payment of claims that are for services delivered as benefits of the Home and Community Based Services (HCBS) Persons with Brain Injury Waiver program by December 31, 2006.	The Community Based Long Term Care Section has not been able to measure the accuracy rate of claims payments.
Health Benefits and Finance Divisions	The Health Benefits and Finance Divisions will monitor the cost-effectiveness of disease management, physical health pre-paid inpatient health plans and enhanced primary case management programs on at least an annual basis, holding costs for diabetics to less than or equal to $681,735 and $317,500 for asthmatics. These amounts are estimated for 300 diabetic clients and 500 asthmatic clients respectively.	The Department anticipated that the diabetes disease management program savings would at least equal program costs. Because program costs exceeded program savings, the program was canceled effective June 30, 2007. The asthma disease management program costs were $151,353 in FY 06-07.

FY 06-07 OBJECTIVE: **1.2 To support timely and accurate client eligibility determination.**		
Division / Section	**FY 06-07 Performance Measure**	**Achievements towards FY 06-07 Performance Measures**
Eligibility Operations Section	The Eligibility Operations Section will research inaccurate eligibility determinations and recommend Colorado Benefits Management System Changes that will reduce the number of "trouble tickets" reported in FY 05-06 by counties and Medical assistance sites by at least 10%.	In February 2006, the medical programs' help desk tickets numbered 777. In February 2007, the number of help desk tickets increased to 944. Adult medical assistance trouble tickets decreased by 22% (from 45 to 35 tickets). Child Health Plan Plus trouble tickets increased by 10% (from 89 to 99 tickets). Family medical assistance trouble tickets increased by 19% (from 566 to 674 tickets.) The Medicare savings program increased by 86% (from 20 to 37). Presumptive eligibility increased by 100% (from 1 to 2 tickets.)
Eligibility Operations Section	Monitor counties and medical assistance sites to determine the number of pending cases that are exceeding processing guidelines. Ensure that medical assistance sites continue to work the pending reports by sending out reports as they are received from the Colorado Benefits Management Report System Project. Follow up with counties that are having difficulties keeping their pending cases that are exceeding processing guidelines, to a minimum.	Counties and medical assistance sites were monitored for cases that exceeded processing guidelines on a daily basis. Section staff provided data entry error training to counties and medical assistance sites that had difficulties keeping pending cases exceeding guidelines to a minimum.
Eligibility Operations Section	The Eligibility Operations Section will conduct Colorado Benefits Management System procedural training for counties and Medical assistance sites. At least one internal training session will be provided for Department staff, and at least two county medical assistance site training sessions will be held.	The Section conducted statewide Colorado Benefits Management System training on October 2006 at the Social Services Technical and Business Staffs training, and monthly conference call training sessions for the counties and medical assistance sites. Internal staff attended the counties and medical assistance site training sessions.

FY 06-07 OBJECTIVE: **1.2 To support timely and accurate client eligibility determination.**		
Division / Section	**FY 06-07 Performance Measure**	**Achievements towards FY 06-07 Performance Measures**
Audit Section	The Medicaid Eligibility Quality Control Unit will conduct needs assessment for critical eligibility issues and implement at least two pilot proposals for FY 06-07.	The Department preferred to conduct a more comprehensive needs assessment of eligibility issues than originally planned. Therefore, on October 1, 2006, the Medicaid Eligibility Quality Control Unit implemented an extensive 18 month pilot program. The 18 month pilot program will be broken down into three identical studies in six month increments. The first report was completed on October 1, 2007. The study reviewed all individuals or families determined eligible for Medicaid and Child Health Plan Plus during the audit period and for all individuals and families that were determined not to be eligible or terminated from Medicaid or Child Health Plan Plus during the audit period. The second and third reports are anticipated to be completed on January 1, 2008 and July 1, 2008.
Client Services Division. Eligibility Policy Unit	The Eligibility Policy Unit will conduct at least six Health Care Policy and Financing informational meetings, holding one meeting every other month throughout the fiscal year. At least one internal training session will be provided for Health Care Policy and Financing staff.	The Eligibility Policy Unit conducted nine informational meetings and included outlying counties by offering the opportunity to participate by telephone. The Eligibility Policy Unit also conducted one internal training session covering basic Medicaid eligibility in October 2007.
Information Technology Division. Claims Systems Section	The interface between the Colorado Benefits Management System and the Medicaid Management Information System will be reviewed at least twice during the fiscal year to verify that clients are within an accuracy rate of 0.1% between systems.	The interface between the Colorado Benefits Management System and the Medicaid Management Information System was reviewed weekly. At the end of FY 06-07, there was an average error rate of 0.011% for clients in the Colorado Benefit Management System. The average error rate for clients in the Medicaid Management Information System was 0.169%.

FY 06-07 OBJECTIVE:
1.3 To assure payments in support of the programs are accurate and timely.

Division / Section	**FY 06-07 Performance Measure**	**Achievements towards FY 06-07 Performance Measures**
Finance Division. Safety Net Financing Section	Quarterly payments to Colorado Indigent Care Program providers will be made according to a published schedule.	The FY 06-07 quarterly payments for the Colorado Indigent Care Program were made to qualified providers based on rate letters sent pursuant to contract.
Long Term Benefits Division. Community-Based Long Term Care Section	Long Term Benefits will implement a process to have 90% of the prior authorization requests electronically submitted directly to the fiscal agent from providers and/or contracted utilization review agencies by December 31, 2006. This is a continuation of FY 05-06 Performance Measure 1.3.	This performance measure has not been met.
Finance Division. Data Section	The Division will respond to requests for ad hoc reports within ten business days, 90% of the time.	The Data Section provided data analysis and ad hoc analysis by the due date, 94% of the time, implemented an electronic tracking system to assist in managing workload, and responded to all customers within 48 hours.
Finance Division. Rates Section	The Division will conduct a validation assessment on the accuracy and timeliness of all managed care program payments compared to the rates identified in the various contracts throughout the fiscal year.	The Rates Section performed reconciliations that validate actual capitation payments. Reconciliations result in settlements or recoveries. The Department entered into a settlement agreement with Total Long-Term Care for the Program of the All-Inclusive Care for the Elderly effective November 27, 2006. Recovery demand letters were sent to Behavioral Health Organizations on April 16, 2007. The settlement for Denver Health Medicaid Choice's managed care plan will be completed prior to December 31, 2007.

FY 06-07 OBJECTIVE:
1.3 To assure payments in support of the programs are accurate and timely.

Division / Section	FY 06-07 Performance Measure	Achievements towards FY 06-07 Performance Measures
Finance Division. Rates Section	Rates will be calculated in a timely manner for managed care, programs of all inclusive care to the elderly and administrative service organizations, and will meet all required actuarial standards.	The FY 06-07 rates for four of the five behavioral health organizations were finalized in May 2006, and were included in FY 06-07 contract amendments. Rate setting for the fifth behavioral health organization required meeting with the Centers for Medicare and Medicaid, which delayed calculation of the rates. While the rates were completed after July 1, 2006, they were applied retroactively pursuant to a contract amendment effective July 1, 2006. Managed care organization rates were completed and distributed on May 22, 2006 and included in the FY 06-07 contract amendments. All behavioral health organization and manage care organization rates were certified by a qualified actuary. Rates for the program of all-inclusive care for the elderly have been calculated on a calendar year for the past three years. The calendar year 2006 rates were extended pursuant to a contract amendment through June 30, 2007.
Information Technology Division. Claims Systems Section	The Division will review each Medicaid Management Information System subsystem during FY 06-07 to assure that the payments made are accurate and timely.	Both the pharmacy claim system and the electronic submission of claims (both interactive and batch methods) have been reviewed for accuracy. The pharmacy claim system was upgraded to a new version in May 2007 to assure ongoing accuracy. The electronic claims processing was upgraded in May 2007 to comply with the National Provider Identifier rule. During the upgrades, all systems were tested and verified for accuracy.

FY 06-07 OBJECTIVE:
1.3 To assure payments in support of the programs are accurate and timely.

Division / Section	**FY 06-07 Performance Measure**	**Achievements towards FY 06-07 Performance Measures**
Information Technology Division. Information Technology Contracts and Monitoring Section	The Department will increase internal audits of the claims processing system.	An internal processing audit was completed in September 2006. The fiscal agent completed twelve processing audits in FY 06-07, compared to the ten processing audits that were completed in FY 05-06.
Controller Division. Accounting Section	The Accounting Section of the Controller Division, with the assistance of the Department's Information Technology Division, will work to ensure that the interface between the Medicaid Management Information System and the Statewide accounting system operates effectively and efficiently, through two specific systems interface fixes to be completed prior to December 2006.	The Accounting Section worked consistently with the Information Technology Division and the Department's fiscal agent to resolve issues that exist in the interaction between the Medicaid Management Information System and the Colorado Financial Reporting System. The intra-governmental interface was successfully completed prior to December 2006. On May 1, 2007, work on the automated update/interface between the Medicaid Management Information System and the Colorado Financial Reporting System for provider records (CSR 1970) was completed.

FY 06-07 OBJECTIVE: **1.4 To assure delivery of appropriate, high quality care. To design programs that result in improved health status for clients served and to improve the health outcomes. To ensure that he Department's programs are responsive to the service needs of enrolled clients in a cost-effective manner.**		
Division / Section	**FY 06-07 Performance Measure**	**Achievements towards FY 06-07 Performance Measures**
Long Term Benefits Division. Community-Based Long Term Care Section	The Community Based Long Term Care Section will fully implement the Children's Autism waiver with enrollment equal to 100% of capacity by December 21, 2006.	Case Management contracts between the Department and the Community Centered Boards were executed in December 2006. Provider rates were loaded into the Medicaid Management Information System by December 9, 2006. Providers began enrolling clients in February 2007 and children began receiving waiver services in March 2007. The date on which the maximum enrollment capacity will be met cannot be projected because there are not a sufficient number of providers to serve the clients.
Health Benefits Division. Acute Care Benefits Section	Pending the Centers for Medicare and Medicaid Services approval of two waivers in FY 05-06, the Division will provide substance abuse treatment for at least 42 Native Americans and expand the substance abuse treatment for pregnant women in the Special Connections program to at least 67 clients.	The Department amended the Community Mental Health Service Program waiver to increase postpartum services to twelve months for women with substance-related disorders. The increased services became effective January 1, 2007. The Department has provided substance abuse treatment for 82 women. The Centers for Medicare and Medicaid Services excluded Native Americans from the waiver because they are eligible to receive services through the federal Indian Health services.
Child Health Plan Plus Division. Health Care Delivery Section	The Department will implement performance based contracting with managed care plans using the Health Employer Data and Information Set and Consumer Assessment of Health Care Study measures, to begin July 1, 2006.	The managed care organization submitted Health Employer Data and Information Set measures to the Department's external quality review contractor in March 2007. The report from the quality review contractor was received in September 2007. Child Health Plan Plus is evaluating the results to assist in implementing an appropriate policy change that assures the delivery of high quality care.

FY 06-07 OBJECTIVE: **1.5 To accurately project, report, and manage budgetary requirements to effect executive and legislative intent with program and budget development and operations. To accurately record and monitor expenditures for programs managed by the Department so there may be accurate financial reporting at all times.**		
Division / Section	**FY 06-07 Performance Measure**	**Achievements towards FY 06-07 Performance Measures**
Finance Section. Safety Net Financing Section	Safety Net Financing Section staff will track monthly expenditures under the Colorado Indigent Care Program to ensure that the program expenditures remain within available appropriations.	The FY 06-07 quarterly payments for the Colorado Indigent Care Program were made to qualified providers based on the rate letters sent to the qualified providers according to the contractual agreement. Quarterly reconciliations were performed to ensure that payments were made appropriately and within the available appropriation.
Controller Division. Accounting Section	The Accounting Section of the Controller Division will continue its projects to improve the accounting and reporting of provider recoveries by documenting all sources of recoveries and the processes associated with those recoveries. Based on that understanding, the section will develop routine reporting mechanisms for provider recoveries. This reporting will assist in the effort to properly account for recoveries in the Department's Budget process.	The Accounting Section has begun reviewing all provider recovery processes and has made changes/improvements to some reporting methods such as the drug rebate and Medicaid Management Information System reconciliations. Two meetings have taken place since July 1, 2006 between program and accounting staff to discuss new routine reporting mechanisms that need to be implemented for provider recoveries. Final implementation is scheduled for December 2007.
Budget Division	The Division will provide the Office of State Planning and Budget with all budget requests (Supplementals, Budget Amendments, Decision Items, FY 07-08 Budget Request) by the requested due dates.	The Division provided the Office of State Planning and Budgeting with the Strategic Plan, Program Crosswalks, Executive Budget Request for FY 07-08 and Schedules 2, 3, 4, 5, and 11 by October 31, 2006. FY 06-07 Supplementals were provided one day following the requested due date to the Office of State Planning and Budgeting. Budget Amendments were provided by the requested due dates.

FY 06-07 OBJECTIVE: **1.6 To work toward systemic improvement in the Department's operations to expand efficiencies, minimize waste, ensure coordination, and eliminate discrepancies.**		
Division / Section	**FY 06-07 Performance Measure**	**Achievements towards FY 06-07 Performance Measures**
Long Term Benefits Division. Nursing Facilities Section	The Nursing Facilities Section will work with providers on the development of a new nursing facility reimbursement methodology to propose during the 2006 Legislative session. The intent of the proposal will be to combine price based reimbursement with quality indicators, resulting in fewer nursing facility rate appeals. If the legislature approves this proposed reimbursement methodology, the Department will work with providers to develop new Volume 8 rules before the end of the fiscal year.	On November 1, 2006, the work group established to develop the new nursing facility reimbursement methodology requested that the Joint Budget Committee extend the feasibility study deadline due to the complexity of developing the new reimbursement methodology. The work group met monthly from August 2006 through April 2007 and weekly during May and June 2007. A Quality Subcommittee and a Behaviors Subcommittee met monthly through April 2007. The work group is building the reimbursement model and incorporating the subcommittees' work into the structure of the new methodology. The work group will have a feasibility study and report ready for the Joint Budget Committee on November 1, 2007.

FY 06-07 OBJECTIVE: **2.1 To expand areas of potential financial recovery such as third party insurance (that should be a primary payer) and cases of fraud and abuse.**		
Division / Section	**FY 06-07 Performance Measure**	**Achievements towards FY 06-07 Performance Measures**
Client Services Division. Benefits Coordination Section	Benefits Coordination Section will maintain or increase recoveries from third party insurance over the prior year's level and strive to identify other cost-avoidance practices.	FY 05-06 overall recoveries totaled $24,726,808. As of June 30, 2007, total recoveries for FY 06-07 were $25,801,323.82. The Benefits Coordination Section has identified additional cost avoidance and recovery opportunities such as noncustodial parent medical support payments.

FY 06-07 OBJECTIVE: **2.1 To expand areas of potential financial recovery such as third party insurance (that should be a primary payer) and cases of fraud and abuse.**		
Division / Section	**FY 06-07 Performance Measure**	**Achievements towards FY 06-07 Performance Measures**
Client Services Division. Program Integrity Section	A comprehensive post payment of at least three of the following provider types will be conducted in FY 06-07 to assess provider compliance regarding service documentation, medical necessity and payment accuracy. The provider types include home health, emergency transportation, Home and Community Based and School Based waivered services, Durable Medical Equipment providers, Federally Qualified Health Clinics and school based services.	The Program Integrity Section has audited home health agencies, transportation providers, Home and Community Based Services providers, durable medical equipment and supply providers, Federally Qualified Health Clinics and school based services. The audits resulted in the recovery of nearly $10,000,000 from overpayment to providers. The Program Integrity Section referred ten cases to the Medicaid Fraud Control Unit, five cases to the United States Attorney and six to the Office of the Inspector General for civil and criminal fraud investigation.

FY 06-07 OBJECTIVE: **2.2 To improve management of the Department's information systems technology.**		
Division / Section	**FY 06-07 Performance Measure**	**Achievements towards FY 06-07 Performance**
Information Technology Division. Claims Systems Section	The Division will focus ongoing efforts to centralize the information systems used by the agency, to improve both security and management of vast amounts of client data used by the Department.	The Department has eliminated a free-standing SQL Server and has relocated needed data to the Rates Data Warehouse, a special feature of the Medicaid Management Information System's Decision Support System. This system has specific security protocols and professional database management.

FY 06-07 OBJECTIVE: **2.3 To hold accountable the Department's administrative contractors, including state and local agencies, by more outcome-based contracting and more sophisticated contract management.**		
Division / Section	**FY 06-07 Performance Measure**	**Achievements towards FY 06-07 Performance Measures**
Budget Division. Budget and Financing Section	The Budget and Financing Section will hold structured monthly meetings with budget staff from the Department of Human Services and the Department of Public Health and Environment to create greater accuracy and consistency within expenditure tracking, projections, and Budget Requests.	The Budget and Financing Section held structured monthly meetings with budget and accounting staff from the Department of Human Services and the Department of Public Health and Environment, creating greater accuracy and consistency within expenditure tracking, projections, and Budget Requests. In addition, the Department of Human Services and Department budget and program staff held monthly (and sometimes bi-weekly) meetings during FY 06-07 to attempt to resolve issues with the developmental disability waivers.
Controller Division. Contracts and Purchasing Section	The Contracts and Purchasing Section of the Controller Division will develop and hold at least one contract management training session for the Department's program staff responsible for managing contracts.	There were no contract management training sessions in FY 06-07. However, the Contracts and Purchasing Section developed the contract management training program and presented it to all Department managers on July 2, 2007.

FY 06-07 OBJECTIVE: **2.4 To ensure program safeguards and controls.**		
Division / Section	**FY 06-07 Performance Measure**	**Achievements towards FY 06-07 Performance Measures**
Budget Division-Budget and Financing Section	The Budget and Financing Section will create and distribute monthly expenditure tracking report by appropriation. This document will be used to assist program staff in awareness of program trends and to create more awareness regarding provider billing habits. This report will be distributed to all program staff within two weeks after each period close.	The Budget and Financing Section created and distributed a monthly expenditure tracking report by appropriation for the months of July 2006 through June 2007. The report is used to assist program staff in awareness of program trends and to create more awareness regarding vendor billing habits. This report has been distributed to all program managers and office directors.
Finance Division. Safety Net Financing Section	The Section will establish additional procedures to maximize federal revenue to sustain or increase payments to providers that conform to federal guidelines by January 1, 2007.	The Safety Net Financing Section submitted a State Plan Amendment to the Centers for Medicare and Medicaid Services on September 29, 2006. The State Plan Amendment included a protocol for the certification of public expenditures. This is a financing mechanism utilized by the Colorado Indigent Care Program that provides the State share for a federal match for qualified public providers without the use of additional General Funds. The Centers for Medicare and Medicaid Services has not approved or denied the Amendment as of June 30, 2007.

FY 06-07 OBJECTIVE: **3.1 To improve customer satisfaction with programs, services, and care.**		
Division / Section	**FY 06-07 Performance Measure**	**Achievements towards FY 06-07 Performance Measures**
Long Term Benefits Division. Nursing Facilities Section	The Nursing Facilities Section will obtain at least three internal trainings from other sections and divisions within the Department to broaden staff's knowledge base and improve customer service.	The Nursing Facilities Section completed three section cross training sessions during FY 06-07, covering Post Eligibility Treatment of Income, Pre-Admission Screen and Annual Resident Review, and Patient Payment auditing.

FY 06-07 OBJECTIVE: **3.1 To improve customer satisfaction with programs, services, and care.**		
Division / Section	**FY 06-07 Performance Measure**	**Achievements towards FY 06-07 Performance Measures**
Health Benefits Division. Managed Care Section	The Division will monitor customer satisfaction with Mental Health Community Services program through the use of annual adult and child satisfaction surveys, quarterly grievance appeal reporting, and feedback received in open forums with consumers.	Adult consumer satisfaction results in six areas ranged from 58.4% to 71.6% in FY 05-06. Child consumer satisfaction results in six areas, as reported by parents, ranged from 53.7% to 75.3% in FY 05-06. Feedback from stakeholder meetings indicated overall satisfaction with the program.

FY 06-07 OBJECTIVE: **3.2 To enhance customer service, provider and eligibility personnel's understanding of program requirements, benefits, and responsibilities. To improve the usefulness of communications with clients, constituents, partners and stakeholders.**		
Division / Section	**FY 06-07 Performance Measure**	**Achievements towards FY 06-07 Performance Measures**
Budget Division	The Budget Division will conduct training sessions during FY 06-07 for Department staff to educate on budget-related activities and responsibilities. At least two sessions in each of the following areas will be conducted: the budget cycle, change requests, fiscal notes, and operating budgets. As appropriate or timely, new legislation affecting the Department will be presented.	Two fiscal note training sessions were completed by December 15, 2006, prior to the start of the legislative session. The Budget and Financing Section completed the Operating Budget training conducted by the Personal Services and Operating Budget Analyst by May 2007 for all program managers. Budget cycle training was provided to new budget staff throughout the fiscal year.

FY 06-07 OBJECTIVE: **3.2 To enhance customer service, provider and eligibility personnel's understanding of program requirements, benefits, and responsibilities. To improve the usefulness of communications with clients, constituents, partners and stakeholders.**		
Division / Section	**FY 06-07 Performance Measure**	**Achievements towards FY 06-07 Performance Measures**
Long Term Benefits Division. Systems Change Section	By December 31, 2006, the Department will have an outreach and awareness campaign underway to inform clients and collateral supporters about the opportunities and advantages of consumer direction. This campaign will achieve a 75% success rate, as measured by follow-up surveys.	Focus groups, key informant interviews, and background research were conducted as part of the statewide outreach and marketing campaign. Based on the information received, brochures, informational packets and comprehensive training materials were created and disseminated to various stakeholders. The training protocol and training tools for consumer directed initiatives were enhanced through a comprehensive revision of the Consumer Directed Attendant Support Training Reference Manual, which is now available on CD in regular and tutorial format. A consumer directed training DVD was created utilizing the voices and images of clients leading their peers through the training process. Evaluation of the marketing and outreach campaign identified a marked increase in the number of inquiries made to the Department and community agencies with regard to consumer directed options, a 50% increase in the submission of Consumer Directed Attendant Support applications to the Department, and positive feedback from clients regarding the training materials indicating that a 75% success rate was achieved.
Privacy and Public Policy Division	The Division will continue to enhance external communications with Health Care Policy and Financing clients and providers.	All privacy forms for clients have been made available in English and Spanish, privacy calls have been returned within 24 hours, and requests for privacy forms have been distributed within three days. The Medical Services Board webpage has been enhanced to offer easier accessibility to rule changes and information pertaining to rules.

FY 06-07 OBJECTIVE: **3.2 To enhance customer service, provider and eligibility personnel's understanding of program requirements, benefits, and responsibilities. To improve the usefulness of communications with clients, constituents, partners and stakeholders.**		
Division / Section	**FY 06-07 Performance Measure**	**Achievements towards FY 06-07 Performance Measures**
Privacy and Public Policy Division. Customer Service Section	The Customer Service Section will decrease the call abandonment rate by 5% from the FY 05-06 level.	The average abandonment rate for the period of July 1, 2006 to June 30, 2007 was 38.95%.
Information Technology Division. Information Technology Contracts and Monitoring Section	The Information Technology Contracts and Monitoring Section will explore new mediums for provider communication to facilitate timely communication of changes, issues and impacts to providers.	In FY 06-07, the fiscal agent started sending provider bulletins electronically. During FY 06-07, URL links to the bulletin were emailed to 11,000 providers, reducing the number of bulletins sent via postal mail by 34%. Bulletin links were emailed to 118 provider associations and State personnel. Urgent information was posted on the Department's Provider Services website and on the web portal. Email broadcast messages were also sent to appropriate trade associations and to approximately 150 non-provider recipients to disseminate information quickly.
Child Health Plan Plus Division. Program Evaluation and Contract Operations Section	The Child Health Plan Office will evaluate the effectiveness of the marketing plan implemented in FY 05-06, and will use the results to refine the marketing plan by January 2007.	The Child Health Plan Plus Division, Contract Operations Section evaluated the marketing strategies through the use of the eligibility and enrollment contractor reports. The contractor submitted a new marketing and outreach plan to the Department in January 2007.

FY 06-07 OBJECTIVE: **4.1 To build and maintain a high quality, customer-focused team.**		
Division / Section	**FY 06-07 Performance Measure**	**Achievements towards FY 06-07 Performance Measures**
Privacy and Public Policy Division-Customer Service Section	The Customer Services Section will conduct informative staff meetings on a weekly basis during the fiscal year, and will also have at least one team building meeting each month.	The Customer Service Section has conducted weekly staff meetings and held one team building meeting every quarter.

FY 06-07 OBJECTIVE: **4.2 To develop enhanced training and retention strategies for departmental staff.**		
Division / Section	**FY 06-07 Performance Measure**	**Achievements towards FY 06-07 Performance Measures**
Human Resources Section	The Human Resources Section will fully implement its training program for Department managers on State Personnel Rules and processes, including hiring, reclassification, employee performance management, and employee discipline.	The Human Resources Section provided six Personnel Description Questionnaire's and employment performance training sessions, three family and medical leave act training sessions, fourteen respectful workplace training sessions, two workplace violence training sessions, two sexual harassment training sessions, and six performance management performance plan training sessions.