# Department of Health Care Policy and Financing
# Department Description
# FY 2009-10 Budget Request

**November 3, 2008**

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# I. ORGANIZATIONAL CHART

State of Colorado

June 30, 2008
Health Care Policy & Financing

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

Medical Services Board

EXECUTIVE DIRECTOR'S OFFICE
HENNEBERRY, JOAN*
5.0 FTE $460,255

* INDICATES EXECUTIVE COMMITTEE

MEDICAL & CHP+ PROGRAM ADMINISTRATION OFFICE
WADHWA, SANDEEP*
97.7 FTE $6,552,446

BUDGET & FINANCE OFFICE
BARTHOLOMEW, JOHN*
24.1 FTE $1,775,647

ADMINISTRATION & OPERATIONS OFFICE
EVANS, JENNIFER*
87.5 FTE $6,091,083

PROJECT MANAGEMENT DIRECTOR
WALLACE, LINDY*
3.0 FTE $176,866

CLIENT & COMMUNITY RELATIONS OFFICE
WILLIAMSON, SUE*
49.4 FTE $3,795,046

HUMAN RESOURCES SECTION
SMUDA, JANICE*
6.0 FTE $400,128

| Total: | 272.7 FTE | $19,251,491 | |
|---|---|---|---|
| GF | CF | RF | FF |
| $7,994,379 | $731,501 | $1,557,401 | $8,968,210 |

## II. BACKGROUND INFORMATION

The Department of Health Care Policy and Financing (the Department) receives federal funding as the single state agency responsible for administering the Medicaid program (Title XIX) and the State Child Health Insurance Program (Title XXI), known as the Children's Basic Health Plan. In addition to these programs, the Department administers the Colorado Indigent Care Program, the Old Age Pension State Medical Program, the Comprehensive Primary and Preventive Care Grant Program, the Primary Care Fund as well as the Home and Community Based Services Medicaid Waivers. The Department also provides healthcare policy leadership for the state's Executive Branch. Most of the Department's programs are funded in part by the federal Centers for Medicare and Medicaid Services. The Medicaid program receives approximately 50% of its funding from the federal government and the Children's Basic Health Plan receives approximately 65% of its funding from the federal government.

### Executive Director's Office

Joan Henneberry was appointed executive director of the Department effective January 9, 2007. The Executive Director has organized the Department to allow for greater focus on key program and operational areas. Areas of responsibility for the Executive Director include general governance and financial accountability for the Department, communication with partners within and outside of state government, and research and development for current and future refinement of Department operations and programs.

The State Medical Services Board was created by the Legislature effective July 1, 1994. The Board consists of eleven members appointed by the Governor and confirmed by the Senate. The members are persons who have knowledge of medical assistance programs, experience with the delivery of health care and experience or expertise in caring for medically underserved children. The Board has the authority to adopt rules that govern the Colorado Medicaid program and the Children's Basic Health Plan that are in compliance with state and federal regulations.

### Medical and Child Health Plan Plus Program Administration Office

This office designs, implements and administers Medicaid benefits and the Children's Basic Health Plan. The Acute Care Benefits Section defines the amount, scope and duration of services to be provided in accordance with state and federal law; and coordinates a broad spectrum of programs and services to improve client access and limit duplication and gaps in services. The Managed Care Benefits Section develops, implements, and monitors contracts with managed care organizations, prepaid inpatient health plans and primary care case management plans. This includes behavioral health organizations, physical health plans, other managed care

providers and the enrollment broker. The section's purpose is to assist Medicaid clients' enrollment into physical health managed care programs and to ensure that all managed care contractors provide high quality and cost-efficient health care.
The Long Term Care Benefits Division oversees Medicaid nursing facilities and community based services. Community based services are services provided in clients' homes, as well as in other types of residential care settings such as assisted living facilities. Services for these clients include skilled services available to all Medicaid clients as part of the Medicaid State Plan, such as home health care, private duty nursing, and hospice care. This division also oversees the Medicaid Home and Community Based Services waivers which provide services in addition to the Medicaid State Plan. Through the waivers, the Department is able to provide specialized services to targeted populations.

The Children's Basic Health Plan provides basic health insurance coverage for uninsured children and pregnant women of low-income families. The Children's Basic Health Plan is a non-entitlement, non-Medicaid program that delivers coverage in accordance with the principles of private insurance. The Children's Basic Health Plan benefit package is substantially equivalent to the level of coverage mandated by the State for small, privately insured groups. The Children's Basic Health Plan offers a wide variety of services to children including check-ups, immunizations, doctor visits, hospital services, prescribed medications, mental health services, dental services, hearing aids, and glasses.

The Pharmacy Benefits Section oversees access to medications for Medicaid clients, including the fee-for-service, primary care physician and dual-eligible (Medicare and Medicaid) populations. This section administers the Colorado Cares Rx Program (discount drug card for non-Medicaid clients) and the Rx Review Program (drug therapy counseling sessions for Medicaid clients). The section ensures that medications are used in a clinically appropriate and cost-effective manner through the Preferred Drug List Program and by performing drug utilization analysis, with input from the Drug Utilization Review Board. The section collects federal and supplemental drug rebates from pharmaceutical manufacturers. The section also makes sure that pharmacy benefits are provided in compliance with federal and state statutes and regulations. Finally, the section provides pharmacy benefits information and assistance to clients, pharmacies and prescribers, to facilitate clients' access to their medications.

The Quality Improvement Section is responsible for directing, conducting, and coordinating performance improvement activities for the care and services Medicaid and Children's Basic Health Plan clients receive. Specific functions of the Section include process and outcome measurement and improvement, managing the external quality review of managed care contractors and fee-for-service providers, monitoring managed care plan contract compliance, fee-for-service utilization management, consulting to program managers regarding performance measurement and improvement, and administering the disease management programs.

The Rates Section develops rate-setting methodology and implements managed care rates for health maintenance organizations (HMOs), behavioral health organizations (BHOs), and the Program of All Inclusive Care for the Elderly (PACE) providers. The section monitors and updates rates paid for home and community based services (HCBS). In addition, this section is responsible for rate analysis and operations for hospitals, federally qualified health centers, and rural health clinics. It is the responsibility of the section to make sure that rates comply with all applicable State statutes and federal regulations.

**Human Resources Section**

The Human Resources Section provides the full range of human resource services to all the employees of the Department. This is a decentralized personnel function, which includes recruitment, testing, selection, classification, salary administration, diversity, training, rules interpretation, work force development, employee/manager counseling, corrective and disciplinary actions, separation analysis, dispute resolution and maintaining personnel records within the confines of the State Personnel Rules. This division also provides advice, guidance, counseling and technical assistance to Department managers and staff on the workings of the State personnel system.

The Human Resources Section is responsible for all functions necessary to properly classify Department staff positions and to fill those positions in accordance with the State constitution and the State personnel rules and procedures. This includes proper classification of positions, announcing job openings, reviewing applications, testing candidates, and referring qualified candidates to departmental appointing authorities. Human Resources staff participates in corrective action meetings, disciplinary hearings, and any appeals related to the results of those functions.

**Administration and Operations Office**

The Administration & Operations Office includes the Legal, Controller and Information Technology Divisions and the Audits Section. The Office also provides a staffed reception desk, research tools, and process oversight to ensure the smooth day-to-day operations of the Department.

The legal division handles privacy and HIPAA training and compliance, acts as records custodian and coordinates CORA requests, manages and coordinates external data requests through the Department's data review board, manages the Department's privacy database, manages the Department's state plan and drafts amendments to the state plan, provides assistance in drafting rules, coordinates department rules and department guidance to avoid conflicts of authority, coordinates the Department's relationship with the Attorney General's office and provides analysis and guidance to Department personnel on various regulatory and legal issues.

The mission of the Benefits Coordination section is to extend public purchasing power by pursuing third party payment of medical costs for Medicaid-eligible persons. The Benefits Coordination section pursues responsible payment sources to recover costs for medical care paid for by Medicaid, including trusts, estate recoveries, and recovering any payments to clients who were discovered to be ineligible for Medicaid retroactively.

The Program Integrity section monitors and improves provider accountability for the Medicaid program. Program Integrity staff identify potentially excessive or improper utilization, or improper billing of the Medicaid program by providers. If a situation is identified, staff follow-up to investigate, classify, and recover payments and/or refer the providers to legal authorities for possible prosecution when appropriate. Civil and criminal sanctions may also be pursued by the Department and the Medicaid Fraud Control unit.

The Information Technology Division ensures client access to medical services by assuring timely and accurate reimbursement to Medicaid and Children's Basic Health Plan providers; timely access to medical eligibility data by service providers; and reimbursement compliance with all aspects of state and federal regulations. The Information Technology Division implements the policies governing the administration of Medicaid and the Children's Basic Health Plan dollars within computerized systems, including the Medicaid Management Information System and the Colorado Benefits Management System.

The Controller's Division oversees the accounting and purchasing functions of the Department. The Accounting section ensures the proper recording and reporting of revenues and expenditures in the Department are in compliance with generally accepted accounting principles and state and federal rules and regulations. The Contracts and Purchasing section provides all aspects of procurement for the Department under state and federal procurement laws and regulations.

The Audit Section consolidates many of the auditing functions throughout the Department. Auditing assists the Department to continuously improve the accuracy of expenditures and the quality of services. Auditing activities include: subrecipient monitoring of counties, the Payment Error Rate Measurement Program which monitors the accuracy of eligibility determinations and medical claims payment, the Medicaid Eligibility Quality Control Unit and audit coordination of audits performed on the Department.

**Project Management Office**

The Project Management Office is responsible for ensuring the highest level of success possible on projects throughout the Department. The Office provides assistance in identifying necessary resources, developing work plans, giving any necessary guidance to the project manager and the team, and any other tasks to meet the objectives and goals of a project. The Project Management Office

is also responsible for tracking the Department's implementation of legislation as well as the strategic plan. The Office also supports health care reform issues and works in close contact with the Governor's office. The primary goal for the first year of this office is to ensure that 2008 legislation is successfully implemented and the Department strategic plan is on track.

**Budget and Finance Office**

The Budget and Finance Office consists of the Budget Division and the State Programs and Federal Financing Division. The Budget Division includes the Medical Premiums unit, the Fiscal Note and Policy unit, and the Schedules and Financing unit. The State Programs and Federal Financing Division oversees the Safety Net Programs Section which administers the Colorado Indigent Care Program, the Comprehensive Primary and Preventive Care Grant Program, and the Old Age Pension State Medical Program.

The Budget Division's five key responsibilities are to project, construct, present, monitor, and manage the Department's budget. In addition, the Budget Division presents and defends the Department's budgetary needs to the Executive and Legislative authorities. The Division prepares each phase of the budget request process, including deliverables such as the preparation of statistical forecasting of caseload and premiums. This Division also monitors caseload and expenditures throughout the fiscal year, and ensures expenditures meet legal requirements and are supported by the Department's objectives.

The Colorado Indigent Care Program distributes federal and state funds to partially compensate qualified health care providers for uncompensated costs associated with services rendered to the indigent population. Qualified health care providers who receive this funding render discounted health care services to Colorado citizens, migrant workers, and legal immigrants with limited financial resources. These individuals are uninsured or underinsured, and not eligible for benefits under the Medicaid Program or the Children's Basic Health Plan.

The Comprehensive Primary and Preventive Care Grant Program provides grants to health care providers in order to expand primary and preventive health care services to Colorado's low-income residents. Because primary and preventive care are two of the most cost effective means of keeping people healthy, the Comprehensive Primary and Preventive Care Grant Program is intended to expand these services to Colorado's uninsured or medically indigent populations. However, it is not intended to supplant or expand Medicaid, the Children's Basic Health Plan, or the Colorado Indigent Care Program.

The Old Age Pension State Medical Program provides limited medical care for individuals receiving Old Age Pension grants. Those eligible for this program are over age 60, but may not meet Supplemental Security Income criteria or residence requirements, and are

therefore ineligible for Medicaid. This population could be disabled to some degree, but not sufficiently to qualify for Supplemental Security Income.

**Client and Community Relations Office**

The mission of the Office of Client and Community Relations is to improve communication and accountability with clients, providers, advocates, counties and other partners. The Office strives to streamline business processes and create greater efficiencies to better serve the Department's customers. The Office of Client and Community Relations includes Medicaid eligibility operations and policy, the Early and Periodic, Screening, Diagnosis and Treatment Outreach and Case Management program, the County Liaison, the Americans with Disabilities Act Liaison, as well as oversight of the medical assistance sites and the school-based medical assistance pilot sites. Additionally, the functions of the Department's Public Information Officer, the Customer Service Center, Office of Appeals, Medical Services Board, and the Business Analysis Section reside within this office.

The Eligibility Section exists to ensure access to Medicaid for eligible families, children, the elderly and persons with disabilities. This section defines program eligibility through policy development and training to counties and other agencies. The section also provides policy expertise on Medicaid eligibility for all categories for the rules-based eligibility computer system, the Colorado Benefits Management System.

This office also works closely with the county departments of social/human services and the medical assistance sites to ensure that eligibility determinations are completed accurately and timely. Communication to and from the counties and medical assistance sites is accomplished through a county liaison and medical assistance site coordinator.

The Customer Service Section provides a high level of communication and assistance to all customers who contact the Department. The section acts as a major focal point for callers that require assistance with questions about eligibility and program information and who need help in navigating a complex health care system.

The Early and Periodic Screening, Diagnosis, and Treatment unit is responsible for program outreach and case management services in a manner consistent with federal regulations. These outreach and case management services are aimed at the promotion of health, the prevention of disease, and improved access to health care services for children on Medicaid. This unit also administers the Medical Home program which is currently working to ensure that all children in Medicaid and the Children's Basic Health Plan have a medical home by January 1, 2010.

The Department recognizes the critical need for professional, efficient, consistent, and appropriate analysis of the information, and as such, has a Business Analysis Section. The Business Analysis Section establishes standards for appropriate analytical methodologies for use in making strategic and fiscally responsible decisions. The focus of this section is to address the difficult and complex data analysis needs of both internal and external customers. This section extracts and manipulates data for research, policy formation, report writing, forecasting, and rate setting for Department programs.

The office is committed to providing accurate, understandable and consistent information to the public, clients, providers, legislators, internal staff and advocates. The Public Information Officer ensures that accurate communication is provided timely and in a consistent manner. Communication is conducted through the website, client correspondence, brochures, program newsletters and email blasts. All materials are reviewed to ensure that communication is effective and easy to read. The office works closely with the Governor's and Lieutenant Governor's Office in coordinating messages to the media.

## III. PRIOR YEAR LEGISLATION

The following is a summary of major legislation enacted in 2008.

**HB 08-1072 (Soper, Williams) Medicaid Buy-In for Disabled Persons**
This bill directs the Department to complete an actuarial study of the disabled in Colorado and report to the Joint Budget Committee with a fiscal analysis. If approved, the Department would request federal approval of a state plan amendment for a Medicaid buy-in program for the disabled, which would set premiums and fees according to the results of the actuarial study. This bill also establishes the Medicaid buy-in cash fund to pay for implementation and administration of the program.

**HB 08-1114 (White, Isgar) Reimbursement of Nursing Facilities Under Medicaid**
This bill reforms nursing facility reimbursement rates. It requires facilities to pay a provider fee to the Department, and the Department will request federal matching funds for this fee from the Centers for Medicare and Medicaid Services. The bill also requires the Department to increase nursing facility rates based on a specified formula effective July 1, 2008. The final enacted version of the bill includes alternate appropriation clauses, only one of which will become effective depending on whether federal approval of the waiver is received by April 1, 2009.

**HB 08-1250 (Pommer, Johnson) County Contingency Fund**
This bill creates the county tax base relief fund to supplement county expenditures for public assistance, and allows the Department of Human Services to transfer unexpended funds to offset over-expenditures in either the Department's or the Department of Human Services' County Administration line item. It also allows for the transfer of unexpended funds in the County Administrative line item to be transferred to the new fund, and limits the total amount of moneys transferred to $1 million for any fiscal year.

**HB 08-1374 (Pommer, Johnson) Program of All-inclusive Care for the Elderly – Repeal Cap on Rates**
This bill repeals the requirement that the monthly capitated rate for the Program of All-inclusive Care for the Elderly be based on 95% of the Medicaid fee-for-service costs of an actuarially similar population, and allows the Department to annually renegotiate a monthly capitated rate. The bill does not require the Department to develop a new capitated rate; however, the Department assumes that it would set the new capitated rate at 100% of Medicaid fee-for-service rate or 100% of the Federal upper payment limit, whichever is less.

**HB 08-1407 (Romanoff, Gordon) Insurance Benefit Payments**
This bill requires a person engaged in the business of insurance to not unreasonably delay or deny payment of a claim for benefits owed to or on behalf of any first-party claimant, and increases the penalty for a carrier failing to pay, deny or settle a claim within 90 days. Due to the additional incentives this bill provides for third parties to not unreasonably deny or delay claims, the Department expects to increase its cost avoidance efforts through third party insurance recoveries on behalf of Medicaid eligible clients.

**HB 08-1409 (Pommer, Johnson) Medicaid Payment Recovery**
This bill is a requirement of the federal Deficit Reduction Act of 2005. It strengthens the Department's ability to recover from third parties liable for payments made on behalf of Medicaid recipients. This bill requires all third party health insurance companies doing business in Colorado to provide the Department with eligibility records identifying all individuals insured by the third party, and provide other information and cooperation to the Department or its contractor.

**SB 08-003 (Boyd, Riesberg) Family Planning Pilot Program**
This bill extends family planning services to low-income men and women of child bearing age who have no other insurance, and would otherwise not be eligible for Medicaid. It removes the 150% federal poverty level limitation, and allows a new federal poverty level to be established through the waiver process. The Department expects the new eligibility requirement to be between 185% and 200% of the federal poverty level. This bill also requires the Department, in consultation with the Department of Public Health and Environment, to seek approval of a federal waiver that is cost-neutral to the state General Fund over the duration of the waiver.

**SB 08-006 (Boyd, Solano) Suspend Medicaid for Confined Persons**
This bill requires that a confined person remain eligible for Medicaid while confined if the person received Medicaid immediately prior to becoming confined; however, no Medicaid services will be furnished while the person is confined unless federal financial participation is available. Once a person is no longer confined, he or she shall continue to be eligible for Medicaid until determined ineligible.

**SB 08-022 (Sandoval, Ferrandino) Overexpenditure Authority for the Children's Basic Health Plan**
This bill authorizes overexpenditure authority for the Children's Basic Health Plan. It provides needed flexibility for the Department in its budgeting process so that it can address impacts of ongoing fluctuations in caseload. Being granted overexpenditure authority prevents the need by the Department to consider establishing an enrollment cap as an alternative to expenditures exceeding appropriated funds. It also prevents recurring fiscal impacts to future year budgets which must pay for any over-expenditures during the previous fiscal year.

**SB 08-057 (Kester, Marshall) Insurance Coverage for Hearing Aids for Minors**

This bill requires all health benefit plans providing hospital, surgical, or medical expense insurance, except policies covering a specified disease or other limited benefit, to provide coverage for medically necessary hearing aids for children. This bill will increase the coverage offered through the Children's Basic Health Plan since it is based on the basic and standard insurance package. Coverage shall include the initial assessment, fitting, adjustments, and auditory training for covered participants and one set of hearing aids every five years, or more frequently when alterations to the hearing aids fail to meet the needs of covered participants.

**SB 08-090 (Hagedorn, McGihon) Mail Order Rx under Medicaid**

This bill expands the Medicaid population that is eligible to receive maintenance medications through mail order. Although the bill continues the physical hardship requirement for clients to use mail order pharmacy, it allows those with third-party insurance requirements to use it. This bill requires out-of-state mail-order pharmacies doing business in Colorado to provide the pharmacy benefit at a cost of no more than the Medicaid copayment, and allows them to bill the Department for any difference up to the third-party insurance carrier's copayment.

**SB 08-099 (Sandoval, Stafford) Extending Foster Care Eligibility**

This bill adds Medicaid coverage for non-Title IV-E foster care children up to age 21. This extended coverage is for children who were not eligible for Title IV-E federal funds while in foster care, but who received state benefits including subsidized adoption assistance or foster care maintenance payments. Prior to the passage of this bill, Medicaid coverage terminated for these young adults upon turning age 18 or becoming emancipated. Each year, an estimated 750 to 800 foster children and children leaving subsidized adoption will reach the age of 18, age-out of state benefits, and become eligible for Medicaid under this bill. Approximately half of these eligible individuals are expected to enroll under Medicaid. SB 07-002 added Medicaid coverage for Title IV-E foster care children and in conjunction with SB 08-099, these bills will help ensure that children aging out of the foster care system have a medical safety net to help during their transition period.

**SB 08-118 (Keller, Buescher) Money Transfer for Medicaid Programs**

For FY 2008-09 through FY 2012-13, this bill transfers $2 million annually from the Prevention, Early Detection, and Treatment Fund to the Department for Medicaid disease management and treatment programs. This funding will be matched by federal funds to expand programs that address health factors leading to cancer, heart disease, lung disease and associated risk factors.

**SB 08-160 (Hagedorn, McGihon) Improvements to Medicaid and the Children's Basic Health Plan**
This bill expands eligibility for children and pregnant women in the Children's Basic Health Plan to 225% of the federal poverty level, or up to 250% if funding permits. It also requires mental health benefits provided under the Children's Basic Health Plan to be at least as comprehensive as those offered under Medicaid.

**SB 08-161 (Boyd, Merrifield) Income Verification for Medicaid and Children's Basic Health Plan Eligibility**
This bill requires the Department to allow self-declaration of income for individuals applying for Medicaid and the Children's Basic Health Plan, and requires the Department to verify income through records from the Department of Labor and Employment. The provisions of the bill are effective only if the Department receives an amount equal to the cost of implementing it through gifts, grants, or donations by June 15, 2008. The Department received official notice of a grant award dated June 13, 2008. This legislation should ease administrative burdens imposed on families, as they will no longer be required to produce documentation proving their income. In addition, eligibility determinations will be accelerated for those individuals that have a difficult time obtaining such proof of income.

**SB 08-217 (Hagedorn, McGihon) Centennial Care Choices Program**
This bill directs the Department, in coordination with the Division of Insurance and a panel of Governor-appointed experts, to prepare a request for information from health insurance carriers and other interested parties. Carriers are requested to provide information regarding the design of a new health insurance product, known as a value benefit plan, to be offered in the individual market. After information is received, the Department, in collaboration with the Division of Insurance and the panel of experts, must acquire actuarial projections, research potential cost savings, and analyze the information provided by the carriers. The bill requires the Department to provide the House and Senate Health and Human Services Committees with a preliminary report by December 15, 2008, and a final report with legislative recommendations by March 1, 2009. The committees may recommend legislation for the Centennial Care Choices Program including a referendum to the voters for a tax increase if appropriate.

**SB 08-230 (Morse, Buescher) Hospitals to Levy Sales Tax**
This bill grants taxing authority, subject to voter approval, to Denver Health and University Hospital as "unit of government" hospital providers. In addition, it requires the Department to make payments to state university teaching hospitals for providing care to Medicaid clients. This bill addresses a federal rule published by the Centers for Medicare and Medicaid Services that redefined public hospitals as being a unit of government with taxing authority, and made such status a requirement to certify public expenditures as the State match to draw federal funds. The bill also addresses the federal requirement that state teaching hospitals receive direct appropriations from the State.

# IV. HOT ISSUES

## Medicaid Reform

*Eligibility Modernization*

The Blue Ribbon Commission for Health Care Reform (the “208 Commission”) was created to study and establish health care reform models for expanding coverage, especially for the underinsured and uninsured, and to decrease health care costs for Colorado residents. Recommendation 10 in the Fifth Proposal (as released on November 4, 2007) suggested creating a single state-level entity for determining Medicaid and Children’s Basic Health Plan eligibility. This entity would streamline the navigation through the eligibility process of Medicaid and the Children’s Basic Health Plan, create expedited eligibility and improve outreach and enrollment in both programs. These changes would ensure easier, more reliable and timely eligibility and enrollment processes, making the program more efficient and effective and delivering important benefits to clients, providers and enrollment staff. This entity would enhance and complement the current multiple county-level process.

Governor Ritter signed the FY 2008-09 Long Bill, HB 08-1375, into law on April 28, 2008. This bill provided $460,800 in total funds in FY 2007-08 and $153,000 in FY 2008-09 for the purpose of hiring a vendor to gather the requirements and draft the request for proposals for an Eligibility Modernization Vendor. Further, the vendor would be expected to conduct a comprehensive business process analysis, with accompanying cost benefit and return on investment analysis, for the purpose of improving the efficiency and quality of the eligibility and enrollment operations for the Department's health care programs. A request for proposals for this vendor was released on February 25, 2008 contingent on the availability and appropriation of funds to perform the scope of work. An intent to award was issued to Public Knowledge in May 2008 and the contract was awarded in August 2008.

Based on Public Knowledge’s comprehensive business process analysis, Public Knowledge and the Department will develop a request for proposals for a single state-administered contractor to manage the business processes for eligibility and enrollment for the Department’s programs. Public Knowledge will provide a report of its findings to the Department by November 2008.

*Colorado Regional Health Information Organization (CORHIO)*

In 2005, the U.S. 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.

The Colorado Regional Health Information Organization is a not-for-profit, regional health exchange organization with a mission to provide statewide health information exchange for individuals, health care providers, agencies, and organizations. As the development of the Colorado Regional Health Information Organization progresses, the Department wants to be a partner and leader in the development of health information technology and information exchange. This is an integral part of an effort to provide more transparency of quality and cost data, and to exchange information between providers that fosters better integration of heath care.

The Department requested $500,000 in total funds for the Colorado Regional Health Information Organization in its February 15, 2008 Budget Request Amendment, S-1A, BA-A1A, “Building Blocks to Health Care Reform,” page S.1A-3. This funding was appropriated to General Professional Services and Special Projects in the FY 2008-09 Long Bill, HB 08-1375. The Department assumes continuation funding for FY 2009-10, and FY 2010-11. The funding will provide seed money for the development of the Colorado Regional Health Information Organization. In addition, it will allow the Department to participate in developing appropriate policies and procedures for data exchange between the Department as the state Medicaid agency and health care providers that are participating in the Colorado Regional Health Information Organization. As a condition of participation, the funding provided by the Colorado Regional Health Information Organization would require dollar-for-dollar matching by private sector health plans, hospitals, and physician groups.

Governor Ritter signed SB 07-196 into law on May 24, 2007. This bill created the Governor’s Advisory Committee on Health Information Technology, charged with developing a long-range plan for health care information technology. The committee will consider the use of electronic medical records, computerized clinical support systems, and other methods of incorporating information technology in support of greater cost-effectiveness and better patient outcomes in health care. Further, the committee may also pursue an interstate agreement among western states to create internal state health information technology and health information exchange programs with the goal of connecting and exchanging information among the compact states to provide lower-cost, higher-quality, and accessible health care services and benefits.

The Colorado Regional Health Information Organization is represented on the SB 07-196 committee by two members. Recommendations by the committee are expected in January 2009 and the Department anticipates that these recommendations may include a closer collaboration between the Department and the Colorado Regional Health Information Organization as one way of supporting many of the goals being advanced by the committee.

*Medical Homes*

Governor Ritter signed the FY 2008-09 Long Bill, HB 08-1375, into law on April 28, 2008. This bill provided $4,583,667 in total funds in FY 2008-09 to help ensure that all children in Medicaid and the Children's Basic Health Plan have a medical home by January 1, 2010. Providers enrolled as medical homes are responsible for ensuring health maintenance and preventive care; anticipatory guidance and health education; acute and chronic illness care; coordination of medications, specialists, and therapies; provider participation in hospital care; and, 24-hour telephone care for all clients enrolled. Medical home providers who are eligible to do so also participate in the Vaccines for Children Program and utilize the Colorado Immunization Registry.

The Department requested and secured funding for a medical home pilot program for Medicaid in FY 2007-08 (February 15, 2008 FY 2008-09 Budget Request, S.1A "Health Care Reform Building Blocks", page S.1A-1). The Department has met the program's goal of enrolling 124 providers and 15,000 children, and estimates that $7,078,708 will be required in FY 2009-10 to account for increasing enrollment. The Department anticipates an implementation date for medical home for the Children's Basic Health Plan of January 1, 2009.

Medicaid Children

Implementation requires the Department to ensure there is an adequate network of primary care physicians who are willing to participate as medical homes. The Department has increased all rates paid for preventive medicine codes to 90% of the equivalent Medicare rate, or 90% of the national average in the event that an equivalent Medicare rate does not exist, as a step towards achieving this.

Utilization calculations are a critical aspect of program implementation. Currently, eligible children between ages 0 and 4 utilize Early Periodic Screening, Diagnosis, and Treatment services at a rate of 73%, while eligible children between ages 5 and 20 utilize services at a rate of 43%. Part of the funding for the medical home program for FY 2008-09 was for one-time notification of the existence of the program by the Department's enrollment broker. This notification will help the Department achieve its target utilization rates of 80% for children aged 0-4 and 60% for children aged 5-20. The Department anticipates that these targets can be met in FY 2009-10; utilization rates for FY 2008-09 are the midpoint between the current utilization rates and the target rates for FY 2009-10.

Children's Basic Health Plan

The Department is targeting the end of FY 2009-10 as the timeframe for when all children and prenatal women eligible for the Children's Basic Health Plan will have access to a medical home. Similar to the Medicaid program, providers in the Children's Basic Health Plan will be required to train and certify physicians to function as medical homes for enrolled clients.

For FY 2008-09, the Department will make a lump sum payment to each of the five health plans based on the total number of Children's Basic Health Plan clients enrolled in each plan as of January 1, 2009. For FY 2009-10, the Department will increase the capitation rate paid to health plans effective July 1, 2009 for participation in medical home. Because most clients passing through the self-funded network move quickly to a managed care organization, the current utilization of well-child visits is artificially deflated by clients who receive these services when enrolled in a managed care organization. Therefore, the Department is targeting a 20% utilization rate across all clients in the self-funded network.

For clients enrolled in a managed care organization, the Department estimates that utilization targets will be similar to those in the Medicaid population: 80% for children under two years of age, and 60% for children over two years of age.

*Colorado Regional Integrated Care Collaborative (CRICC)*

In FY 2007-08, Medicaid served 391,962 beneficiaries at a total cost of $2,227,037,481 (Exhibits B and M, Nov. 3, 2008 Budget Request, Section E) In the face of an increasingly complex health care delivery system, the Medicaid fee-for-service health care system can be a challenging landscape to navigate for its most vulnerable clients. In an effort to address the complexity and high costs associated with fee-for-service Medicaid, Colorado is one of seven states participating in an initiative entitled, "Rethinking Care Program for America's Highest Need, Highest Cost Populations." This program was started in January 2008 by the Center for Health Care Strategies and is known in Colorado as the Colorado Regional Integrated Care Collaborative. The goal of the program is to better manage the care and costs of subsets of the highest-need, highest cost beneficiaries. The Department is partnering with the Center for Health Care Strategies, local health plans and providers, consumer organizations and other stakeholders to maximize the potential for the Colorado Regional Integrated Care Collaborative to generate sustainable and replicable models that could ultimately reach thousands of Medicaid's most vulnerable patients.

A contract was implemented between the Department and Colorado Access in May 2008 in the following counties: Adams, Arapahoe, Boulder and Broomfield. Denver County was added in October 2008 and there are plans to add Weld County in 2009. Further,

contract negotiations between the Department and Kaiser Permanente are underway to formulate a program from eligible clients in their catchment area.

Both programs are targeting a minimum of 500 clients for enrollment in the intervention. Program effectiveness will be assessed by comparing measures of health care quality, utilization and expenditures between the enrolled group and a control group of 500 comparable clients not enrolled in the program. It is expected that the intervention will be implemented for at least a two-year period. Evaluation of the programs will be conducted by MDRC, formerly the Manpower Demonstration Research Corporation. MRDC is a nonprofit, nonpartisan policy research organization with extensive experience in conducting randomized controlled studies of social policy initiatives targeted at low-income populations.

**Colorado Benefits Management System Project**

This project was initially requested by Budget Amendment BA#A1A, "Building Blocks to Health Care Reform," submitted February 15, 2008. Funding of $5,300,000 was provided by the FY 2008-09 Long Bill (HB 08-1375) for the purpose of working towards a realignment of the Colorado Benefits Management System (CBMS) in order to streamline eligibility determinations for the Department's programs. The goal of this project is to realize of administrative efficiencies that will 1) decrease application processing time, 2) reduce future system change costs, 3) better enable the Department to respond to expansions in eligibility for medical assistance programs and other public health insurance programs that may not have oversight by the federal government, and 4) streamline the application processes for programs administered by the Department of Human Services.

While CBMS will remain the system that determines eligibility Medicaid and the Children's Basic Health Plan within the Department and the financial assistance programs administered by the Department of Human Services, it is in the best interests of both state departments to create an environment that generates simplified client correspondence specific to the financial and medical assistance programs within CBMS and an environment that streamlines the re-determination notices and processes so that there is not a break in a client's eligibility that results in a loss of continuity of care.

The initial goal of the CBMS enhancement process is to understand the options that are available to the Department and Department of Human Services. Further, once both departments make policy decisions on what alternatives are acceptable, a detailed design assessment must be created to provide a final price and budget information. Options need to include the ability to create alternative venues to submitting applications, changes in circumstance information, and re-determinations. Potential options could include the ability for clients to request an application and information online, while the final eligibility determination is made by CBMS.

**Pharmacy**

According to a 2003 study completed by the National Governor's Association, pharmaceuticals are now the fastest growing portion of states' Medicaid program budgets. In an attempt to control these costs, the Department has taken several measures specifically designed to lower the cost of prescription drugs for its clients, thus helping to fulfill one of the Department's guiding principles of purchasing and managing medically necessary and appropriate services to achieve value for the clients and the public. The highlights of these achievements over the last year are listed below.

*SB 08-090 Mail Order Rx under Medicaid*

Governor Ritter signed SB 08-090 into law on May 20, 2008. This bill allows the Department to implement a mail-order prescription drug pharmacy program. The bill restricts the eligible client population to individuals suffering from a physical hardship that prohibits them from obtaining maintenance medications from a local pharmacy. However, it allows Medicaid clients who have third party insurance to receive maintenance medications through a mail-order pharmacy. Furthermore, the bill requires mail-order pharmacies located out of state but that do business in Colorado to provide Medicaid clients the ability to receive medications for the standard Colorado Medicaid copayment amount. For Medicaid clients with third-party insurance, the bill allows the mail-order pharmacy to bill the Department for the difference between the standard Medicaid copayment and the client's third party insurance copayment. The bill also decreased the Department's FY 2008-09 Medical Services Premiums appropriation by $279,272 in total funds.

The Department anticipates an April 1, 2009 start date for the program.

*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 created rules regarding the PDL that became effective on December 1, 2007.

The Pharmacy and Therapeutics Committee was also established pursuant to Executive Order D 004 07 in order to provide clinical recommendations concerning implementation and maintenance of the preferred drug list. The rules regarding the Pharmacy and Therapeutics Committee became effective November 1, 2007. The Executive Director appointed seven physicians, four pharmacists and two consumer representatives to the Pharmacy and Therapeutics Committee. The Pharmacy and Therapeutics Committee first met on December 4, 2007 and has had several subsequent meetings.

As of November 3, 2008 the Department has implemented nine drug classes on the preferred drug list including: proton pump inhibitors, sedative-hypnotics, statins, antihistamines, antihypertensives, opioids, skeletal muscle relaxants, respiratory inhalants, and attention deficit hyperactivity disorder drugs. The Department anticipates adding three to four more drug classes by the end of FY 2008-09, and six to eight new drug classes in FY 2009-10. The Department has also pursued supplemental rebates for the preferred agents in each of these classes to further facilitate providing pharmaceuticals for Medicaid clients at the lowest possible cost.

*340B GEMS project*

In 1992, the Veterans Health Care Act passed by Congress included the 340B provision, giving health care providers that primarily serve low-income patients (“safety-net” providers) access to deep discounts on pharmaceuticals. The 340B program is federally administered, and allows covered entities to provide low-priced outpatient prescription drugs to their patients.

Obtaining 340B pricing is a complex process for state agencies, and requires extra paperwork and other administrative activities for participating pharmacies. The Deficit Reduction Act (DRA) passed by Congress in 2005, however, eased some of that burden on states by making it easier to amend State Medicaid Plans. It also appropriated funds for Medicaid Transformation Grants and for State High Risk Pools that cover individuals who need more coverage than the marketplace offers. All these changes make it easier for states to take advantage of 340B pricing.

Up through FY 2007-08, the Department only paid a small portion of pharmacy claims using 340B pricing. Many of the eligible providers for 340B did not fill prescriptions in-house. As a result, people were taking their prescriptions to retail pharmacies that were not 340B pharmacies.

In an attempt to take advantage of additional 340B pricing options, the Department submitted a February 15, 2008 Budget Request Amendment for FY 2008-09, BA-12 “Efficiencies in Pharmaceuticals through the Expansion of 340B Pricing,” page BA.12-1. The request was for 1.0 FTE and a net reduction in funding of $11,297 in FY 2008-09 and a further decrease of funding for FY 2009-10 of $867,754 for the creation of a pilot program that will increase the number of pharmacy claims paid through this rate structure.

The Governor signed the FY 2008-09 Long Bill, HB 08-1375, into law on April 28, 2008 creating the 340B pricing pilot. The program began on July 1, 2008. Under the bill, the Department will spend the first portion of FY 2008-09 researching how feasible a 340B pricing program is and the best way in which to implement the program. If it is determined to be feasible, the Department will begin the pilot.

*Comprehensive Neurosciences, Inc. (CNS)*

Starting June 1, 2006, the Department engaged in a two-year project with the Centers for Medicare and Medicaid Services to run the Behavioral Pharmacy Education program. Through this program, the Department is able to provide information to prescribers about the psychiatric and opioid medication utilization of their patients. The program is entirely funded by a grant from Eli Lilly and Company and thus results in no cost to the Department.

The Behavioral Pharmacy Education program is designed to help ensure that the Department's clients receive the best care possible through more appropriate utilization of these medications. Comprehensive Neurosciences, Inc. has extensive experience in evidence-based and consensus-based standards for psychiatric medication prescribing and has administrated several similar projects for a number of other Medicaid programs. Twenty-five other states have also entered into similar agreements with Comprehensive Neurosciences, Inc. Missouri, one of the first states, received the 2006 Bronze Achievement Award from the American Psychiatric Association for success in improving the quality of prescribing practices for psychiatric medications and patient outcomes.

During the span of the Behavioral Pharmacy Education program, educational alerts/letters are sent to prescribers to inform them if the medication dosing for their patients is in line with Federal Drug Administration guidelines and, for children, research and consensus-based guidelines. The messages are advisory and intended to be supportive. Prescribers are asked to review each case in the context of the guidelines and decide individually what is best for the patient. The program is also designed to notify prescribers about forgotten refills and when a patient obtains the same class of drug from multiple prescribers. If prescribing patterns do not change, follow-up letters are sent to the prescribers. When deemed necessary, peer consultants meet with prescribers to discuss their prescribing habits and current clinical information regarding the drugs.

While the Behavioral Pharmacy Education program is intended to be educational, many state Medicaid programs that have been engaged in this program for a longer period of time have documented significant cost savings. According to a press release by the Missouri Department of Mental Health dated October 26, 2006[1], Missouri's program has contributed to at least $7.7 million in Medicaid pharmacy cost savings. In addition, the Utah program shows a significant decrease between expected and actual monthly behavioral pharmacy spending, a decrease in monthly behavioral prescriptions per patient for high-risk patients, and no increase in monthly behavioral pharmacy claims despite an increase in the Medicaid membership. The difference between the expected cost of behavioral health drugs if the Comprehensive Neurosciences, Inc. program had not been implemented and the actual cost since the program's inception has been a savings of almost ten million dollars quarterly.

[1] http://www.dmh.mo.gov/2006NewsReleases.htm#pharmproject

**The Centers for Medicare and Medicaid Services Proposed Regulations**

The Centers for Medicare and Medicaid Services has proposed Medicaid regulations affecting financing and federal funding that could severely restrict the ability of state Medicaid operations. The Centers for Medicare and Medicaid Services have stated these regulations are to address what the federal government views as "abuse" of Medicaid federal financial participation and to ensure that states are providing their share for Medicaid expenditures. The proposed regulations by the Centers for Medicare and Medicaid Services have been controversial as they would create large reductions in federal spending that would limit every state's ability to effectively administer Medicaid services at current levels. On February 15, 2008, the Department produced a report entailing the specific impact to Colorado if these regulations were to be passed. The specific regulations and their anticipated impacts are as follows:

<u>Case Management Regulation (CMS-2237-IF)</u>

- Clarifies that Medicaid federal financial participation for case management services is restricted if the services could be offered by a third party or another federal program. This regulation also clarifies that the states cannot restrict freedom of choice of case management providers with the exception of specific target populations.
- This regulation would create heavy burdens and limitations on School Health Services Program providers and would also affect administrative case management provided to child welfare clients and other clients served by the Medicaid program.

<u>Public Provider Cost Limit Regulation (CMS 2258-FC)</u>

- Changes public provider payments and financing arrangements with Medicaid programs. As a result of this regulation, Colorado would experience significant negative impacts as the Department's ability to reimburse publicly owned hospitals for serving low-income individuals would be greatly reduced.
- The Department performed a comprehensive analysis of this regulation and estimates the loss of federal revenue would be approximately $142.2 million per year.

<u>Graduate Medical Education Regulation (CMS 2279-P)</u>

- Eliminates Medicaid federal financial participation for payments for Graduate Medical Education.
- This regulation would result in a loss of supplemental funding to Colorado's teaching hospitals which provide critical physician services to Medicaid and low-income populations.
- The teaching hospitals report that they would not be able to continue their education programs at current levels without the funding received from Medicaid.

Clarification of Outpatient Clinic and Hospital Facility Services Definition and Upper Payment Limit (CMS 2213-P)

- Limits the definition of outpatient hospital services and places restrictions on upper payment limit methodologies for private outpatient hospitals and clinics.
- The proposed regulation overlooks critical services provided to children in hospital-based clinics. The Department has been unable to perform a comprehensive analysis on the impact of this bill due to lack of data and guidance from the Centers for Medicare and Medicaid Services; however, the Department estimates this rule would dramatically change the Medicaid reimbursement models for outpatient hospital services.

School based Administration and Transportation Regulation (CMS-2287-P)

- Eliminates Medicaid federal financial participation for all administrative activities performed by schools and eliminates federal financial participation for transportation services provided to school age children.
- The Department does not currently reimburse schools for administrative activities; therefore, there is no fiscal impact from this new provision.
- Current rules allow reimbursement to schools for transportation, and the Department estimates this regulation would result in a loss of $1.4 million per year and may also result in school districts discontinuing their participation in the School Health Services program due to the loss of transportation revenue.

Provider Taxes Regulation (CMS 2275-P)

- Clarifies language regarding the hold-harmless test for provider taxes.
- The Department does not currently collect any provider taxes and this regulation would have no fiscal impact.

Rehabilitation Services Option (CMS 2261-P)

- Clarifies the broad language of the current regulation to ensure that rehabilitation services are provided in a coordinated manner and are furnished by qualified providers.
- The proposed regulation would increase time and effort in the School Health Services Program to develop rehabilitation plans and maintain case records. In addition, this regulation appears to duplicate documentation required for the Individualized Education Program (IEP) and 504 Rehabilitation plans.
- The Department is not able to estimate a fiscal impact at this time due to lack of data and more specific information from the Centers for Medicare and Medicaid Services.

Due to the heavy costs imposed by these regulations, not only to Colorado, but to every state Medicaid program, Congress has imposed a moratorium on the above federal rules until April 1, 2009. The moratorium would require the Secretary of Health and

Human Services to submit a report on issues the regulations were intended to address, identify strategies in existence to address these problems and assess the impact of each regulation on the states. In addition to these activities at the federal level, Colorado passed a bill, subject to voter approval, to mitigate the impacts of the Public Provider Cost Limitation and Graduate Medical Education regulations (please see the Prior Year Legislation section for a description of SB 08-230).

**The Children's Basic Health Plan**

A key component of the Department's mission of improving access to cost-effective, quality health care services for Coloradans is ensuring that the Children's Basic Health Plan (marketed as Child Health Plan Plus or CHP+) provides affordable health insurance for Colorado children and pregnant women. The Department administers the program through five managed care organizations in a public-private partnership. The Governor's Building Blocks to Health Care Reform initiative advocates improving quality and containing costs. In keeping with these goals, the Department supported several bills during the 2008 legislative session that change or improve eligibility and benefits for the Children's Basic Health Plan. In total, the legislation expands eligibility pursuant to availability of appropriations, and allows for self-declaration of family income (please see the Prior Year Legislation section for more detail regarding this legislation).

In addition to the expansion of eligibility, the Department is taking steps to address two key areas: the uniformity of the methodologies used to track eligible individuals and the validity of the reporting, both of which may be affected by either systems or user errors. The Department is working to improve these methodologies in order to measure the effectiveness of the Children's Basic Health Plan. Areas the Department intends to focus on are penetration rates, contract oversight, and oversight of the counties and eligibility sites.

*Penetration Rates*

Penetration rates can be defined as the number of clients eligible for the program versus the number of clients enrolled in the program. In verifying penetration rates, the Department is seeking the use of outside resources such as the Colorado Health Institute to obtain data on estimated eligible individuals by county. The Department will verify the method used by the Colorado Health Institute to estimate the number of children eligible for the Children's Basic Health Plan. The Department has also received funds from a local foundation to conduct a household survey in 2008 that will provide point-in-time information about the number of uninsured Coloradans and the number of people that might be eligible for public health insurance programs but not yet enrolled.

The Department has also applied for a grant from the Robert Wood Johnson Foundation that will improve the ability to identify and enroll eligible but uninsured children using new technologies and help us define and meet our retention goals.

*Contracts, Counties, and Eligibility Sites*

The Department contracts with outside vendors for a number of administrative services including application processing, eligibility determination, and enrollment services; marketing and outreach; quality review; rate setting; and management of the CHP+ State Managed Care Network. One of these contractors is Affiliated Computer Services (ACS). The Department included several quality control initiatives in its ACS contract amendment for FY 2008-09, such as reconciling enrollment fee transactions, tracking disenrollments, and tracking retention to the extent possible.

Accurate eligibility determination on the part of each participating county is an important part of program effectiveness. The Department completed two eligibility pilot studies and conducted 709 Children's Basic Health Plan eligibility reviews as part of the federally-mandated Payment Error Rate Measurement Program in FY 2006-07. The eligibility pilot studies directly compared case files with information in the Colorado Benefit Management System and focused on identifying and addressing issues with high error rates and recurring problems. The results of the eligibility pilot studies will be shared with the eligibility sites and will allow the eligibility sites the opportunity to analyze information and develop effective and meaningful quality improvement plans as necessary.

The Department and the counties are working to improve data accuracy in the Colorado Benefits Management System by improving employee training on the system. For example, employees are taught how to enter client income prior to granting employees user access. In addition, training on entry of income was conducted at the Social Services Technical and Business Staff conference in April 2008. Knowledge transfer calls have been conducted and ongoing Colorado Benefits Management System training classes are continuously offered to users.

*CHP+ Administrative Service Organization Transition Update*

The Department changed its administrative service organization from Anthem to Colorado Access on July 1, 2008 for the Children’s Basic Health Plan. The administrative service organization provides network administration, claims administration, and professional services for the CHP+ State Managed Care Network. The change is the result of a competitive bid process for the contract and does not affect the other managed care organizations that participate in the Children’s Basic Health Plan.

Network Providers with the State Managed Care Network will continue to be in-network because they contract directly with the State and not with the administrative service organization vendor to provide services related to the Children’s Basic Health Plan. The only anticipated continuity of care issues will be related to behavioral health and pharmacy. Unlike the network providers, behavioral

health providers and pharmacies contract directly with the administrative service organization vendor. The Department is proactively working on remedies to prevent any gaps in coverage.

**Behavioral Health Organizations**

*Reprocurement*

National trends in health care reform as well as policy direction from the Colorado Promise, the Building Blocks for Health Care Reform plan, and the passage of HB 08-1063 have all influenced the Department's evaluation and design of its Medicaid capitated mental health managed care program. Consequently, on June 10, 2008, the Department released a draft request for proposals to administer and operate the Colorado Medicaid Community Mental Health Services Program (the Program). The Department accepted stakeholder comments on the draft request for proposals between June 10, 2008 and July 3, 2008. Completion of the process of posting a final request for proposals and selecting a contractor is anticipated sometime in the first quarter of 2009. The initial term of the contract is scheduled for July 1, 2009 through June 30, 2010, and may be renewed up to four additional one-year periods at the sole discretion of the State. Bidders selected to operate the mental health program in each of the five service areas throughout Colorado will become the behavioral health organizations (BHOs) responsible for delivering, providing or arranging for the provision of all medically necessary mental health services for clients enrolled in the program.

The Department is requesting the addition of new options to be included in the program under the new contract as of July 2009, pending appropriation of funding. The first of these is a plan to move the current limited outpatient substance abuse benefit, added to Colorado Medicaid's fee-for-service benefits in July of 2006, into the Program to be managed by the BHOs. The Department expects that individuals seeking substance abuse treatment may continue to use the same provider network as under the fee-for-service program, and that those individuals without a co-occurring mental health diagnosis would not be required to access the mental health system provider network to obtain substance abuse services. Special Connections, a program for pregnant women on Medicaid who have alcohol and/or drug abuse problems, is excluded from the managed care program at this time. If the Department is able to exercise this option, implementation is anticipated to begin on July 1, 2009.

The Department also seeks to expand and improve care coordination efforts and prevention/early intervention services beyond what is required in the current BHO contract. If exercised, the enhanced care coordination option would require BHOs to coordinate mental health care with any other physical or behavioral health programs providing services to BHO members, as well as other support services such as Medicaid Waivers, wraparound services, and Early, Periodic, Screening, Diagnosis and Treatment Program benefits. BHOs would also be required to assist members in obtaining physical health care and/or identify a primary care provider, as needed.

The option for prevention/early intervention services would require BHOs to engage in activities to reduce the risk of development or emergence of behavioral health disorders, to improve overall behavioral health in targeted populations and communities, and to facilitate referrals for covered behavioral health services for persons with identified needs. A covered diagnosis is not required to receive services in this category. BHOs would submit quarterly reports detailing the type, location, amount and costs of prevention/early intervention services. If exercised, these options are anticipated to become effective on July 1, 2009.

Looking forward, the Department will be working with other state agencies and task forces to map the future direction of the program, which may include the following: increased integration of services, changes in covered diagnoses, development of electronic cross-system data sharing and common performance measure standards across state systems, coverage of children enrolled in the Children's Basic Health Plan, changes to administration of psychiatric residential treatment facilities and therapeutic residential child care facilities, coverage of psychotropic medications, medical homes, and increasing emphasis on program outcomes. Any of these activities could result in a change to the services described in the request for proposals and/or the statement of work in the contract resulting from this request for proposals. The Department will include the successful offerors in the planning, negotiation and implementation process of any changes to the program.

*Modernizing of Reimbursement (HB 08-1063)*

In November 2006, the Office of the State Auditor released the results of a performance audit of Medicaid mental health rates. The audit was conducted between June and November 2006, and evaluated the Department’s rate setting methodology for its mental health managed care program. The audit identified a need to ensure that the Medicaid mental health payment rates are actuarially sound and equitable. It also revealed wide disparities in rates paid by the Department to participating behavioral health organizations. These disparities were, in part, attributed to a difference between State and federal requirements for calculating capitated mental health rates.

Prior to the passage of HB 08-1063, signed into law April 3, 2008, Colorado statute at 25.5-5-408, C.R.S. (2008) required capitated community mental health services program rates to be based on fee-for-service cost containment mechanisms. This statute was based on a federal requirement that managed care programs cost less than an equivalent fee-for-service program, commonly referred to as the upper payment limit. This federal requirement no longer applies, however, as the Centers for Medicare and Medicaid Services rescinded it in 2003 pursuant to 42 CFR 438.6(c). Because Colorado’s Medicaid statute did not change its capitation rate methodology, the State auditor recommended statutory changes to align Colorado law with the federal regulations concerning Medicaid mental health capitation payments. The auditor’s recommendation was incorporated into statute in 2008 with the passage of HB 08-1063, which amended section 25.5-5-411, C.R.S. (2008) to eliminate the requirement that capitated mental health rates be

based on fee-for-service rates. Alternatively, HB 08-1063 requires capitated mental health rates to be cost-effective, actuarially sound, and include cost-containment mechanisms.

Current capitated community mental health services program rates are approved through December 31, 2008. The Department plans to promulgate rules to define cost containment mechanisms and assure cost-effectiveness for the new capitated rates effective January 1, 2009. In addition, the Department will work with stakeholders to incorporate any needed changes to its rate methodology that are now authorized under 25.5-5-411, C.R.S. (2008).

**Program Integrity**

One of the Department's guiding principles is to "purchase and manage medically necessary and appropriate services to achieve value for clients and the public." The Department's Program Integrity section plays a vital role in the Department's commitment to this principle. Towards this end, the Department is focusing on three initiatives to help advance this ideal: the Provider Enrollment System, the Medicare-Medicaid Data Matching Project, and the serious reportable events initiative. A description of each is below.

*Provider Enrollment System (PES)*

Beginning in FY 2008-09 Colorado will voluntarily begin participating in the Centers for Medicare and Medicaid Services-sponsored Provider Enrollment System (PES) pilot program. PES is a Medicaid Medicare enrollment system for all fee-for-service providers and for managed care entities. The PES program is fully funded by the Centers for Medicare and Medicaid Services with Deficit Reduction Act-allocated funds that will allow the Department to develop an online opportunity for Colorado providers to enroll in Medicare and Medicaid at the same place and at the same time. The system will also be maintained and updated by CMS for ten years with minimal or no cost to the state. The program combats fraud by running the enrollment information across multiple databases and information sources, including national crime information, Secretary of State business information, the Internal Revenue Service, the Fraud Investigations Database, the Social Security Administration, licensing data through the Colorado Department of Regulatory Agencies, and other exclusionary databases. In this manner, ineligible providers will be screened out at the front end, which increases the program's probability of not paying fraudulent or wasteful claims. PES will contribute to the Governor's Building Blocks by creating a streamlined process for new provider enrollment, re-enrollment of existing providers, license verification, as well as performing checks for convictions or exclusions. Since the system will interface with the Department's Medicaid Management Information System, provider-submitted information entered into PES will be exchanged between the two systems electronically. The online provider enrollment feature of PES shifts the enrollment process from a 100% paper one to a fully online, electronic transfer

process. The amount of fiscal agent and Department staff time that is currently devoted to processing paper provider applications will be profoundly reduced, allowing for a shift in staff resources to more urgent or value-added tasks.

The goal of PES at the national level is to build a national repository of Medicaid provider information, just like the existing national repository of Medicare provider information. In this manner, one national repository of all Medicare and Medicaid provider information will be created that will allow program integrity programs nationwide to track trends, monitor migration of fraudulent providers, and increase provider accountability for submitted claims.

*Medicare-Medicaid Data Matching Project (MEDI-MEDI)*

The Medicare-Medicaid Data Matching Project (MEDI-MEDI) is a federal initiative that arose from the Deficit Reduction Act of 2005. The program is a federal-state program integrity partnership. The program seeks to identify fraud by comparing data patterns occurring in Medicaid and Medicare that previously went undetected in either program. Providers submitting aberrant claims in one program are found to be doing the same in the other. Data is shared between the Centers for Medicare and Medicaid Services and the Department by federal contractors assigned to regional groupings of states.

The Department will become a MEDI-MEDI state with scheduled implementation of the project sometime in FY 2008-09. The project will be fully funded by the Centers for Medicare and Medicaid Services with no fiscal impact to the state. Estimates on the effectiveness of the MEDI- MEDI program have not been forecast yet, but performance of the program in the current ten pilot states have identified duplicate billing of claims to Medicare and Medicaid for the same services rendered to the same clients on the same dates of service. The pilot states have reported the recoupment of several million dollars as a direct result of data mining in MEDI-MEDI, with final reports expected during FY 2008-09. In addition to being another tool for detecting fraud, waste, and abuse, the Department anticipates that the data will assist state, local, and federal law enforcement and investigative agencies determine and investigate the combined exposure of identified fraudulent providers and those submitting false claims. Further, the Department anticipates that this information may be used by law enforcement agencies to prosecute fraudulent providers.

Unlike Medicare, state Medicaid programs do not have any centralized mechanism for sharing information. As a result, fraudulent providers can move from state to state, submitting wasteful and fraudulent claims without any way of tracking their location or movement. The Provider Enrollment System (PES) and MEDI-MEDI are parts of a Medicaid Integrity Program effort by the Centers for Medicare and Medicaid Services to combat this kind of fraud. Together, the two programs will create a repository of national provider information through PES and a companion repository of claim information through MEDI-MEDI. Both programs will allow for the national trending and tracking of aberrant billing patterns, provider fraud, and wasteful claim submission practices. It is hoped

that the coordination of these programs will assist program integrity programs and law enforcement in combating provider fraud as well as contain costs for taxpayers.

*Serious Reportable Events Initiative*

The Department defines serious reportable events as avoidable errors that occur during hospitalization. Examples include foreign object inadvertently left in patients after surgery, death/disability associated with incompatible blood, and hospital-acquired injuries: fractures, dislocations, intracranial injury, crushing injury, burn and other unspecified effects of external causes. The Centers for Medicare and Medicaid Services ceased reimbursing hospitals for the added cost of care for 12 conditions on October 1, 2008.[2] In addition to this federal rule change, several states have already instituted reporting and non-payment of serious reportable events for their Medicaid programs.

The Department is working to be a part of this national trend towards non-payment for increased costs associated with care resulting from serious reportable events. As a result, the Department has developed its portion of a statewide program to identify and deny payment for hospital-based Medicaid and Children's Basic Health Plan client care related to serious reportable events. The objective of the policy is to ensure patient safety and high quality care. The Department plans to adjust reimbursement for hospital claims that include the following 15 serious reportable events beginning on July 1, 2009:

1. foreign object inadvertently left in patients after surgery;
2. air embolism – an air bubble that enters the blood stream and can obstruct the flow of blood to the brain and vital organs;
3. transfusion with the wrong type of blood;
4. severe pressure ulcers – deterioration of the skin, due to the patient staying in one position too long, that has progressed to the point that tissue under the skin is affected (Stage III), or that has become so deep that there is damage to the muscle and bone, and sometimes tendons and joints (Stage IV);
5. falls and trauma, including fractures, joint dislocations, head injury, crushing injury, burn and electric shock;
6. catheter-associated urinary tract infection;
7. vascular catheter-associated infection;
8. manifestations of poor glycemic control;
9. surgical site infection following coronary artery bypass graft;
10. surgical site infection following certain orthopedic procedures;
11. surgical site infection following bariatric surgery for obesity;

[2] Source: "Medicare takes new steps to make your hospital stay safer," August 4, 2008, http://www.cms.hhs.gov/apps/media/fact_sheets.asp

12. deep vein thrombosis (a blood clot in a major vein) and pulmonary embolism (blockage in the lungs) following certain orthopedic procedures;
13. surgery performed on the wrong body part;
14. surgery performed on the wrong patient; and
15. wrong surgical procedure on a patient.

Should any of the first 12 serious reportable events listed above happen to clients enrolled in either Medicaid or the Children's Basic Health Plan, the Department will decline reimbursement for any additional costs associated with care resulting from the events. Should one of the remaining three events occur to a client enrolled in either Medicaid or the Children's Basic Health Plan, the Department will deny payment to the hospital for all costs associated with the surgical event. The Department believes a hospital-based serious reportable event non-payment program will increase quality of care, provider accountability, and awareness of quality concerns among providers. The Department is working with the Colorado Hospital Association, private insurers, patient advocacy groups, and other stakeholders to develop a comprehensive, long-term strategy for addressing serious reportable events.

**Long Term Care Reform**

The Department is pursuing long term care reform with input from interested stakeholders. Starting in April 2008 the Department convened a standing Long Term Care Advisory Committee to provide input on identification of policy directions, strategies and timelines for implementation. The Advisory Committee membership is comprised of Medicaid clients, advocates, providers, functional eligibility assessment agencies and policy analysts. As a result of an initial brainstorming session, the Advisory Committee members identified four topic areas for focused monthly workgroups: integrated & coordinated care; building capacity; building infrastructure; and eligibility reform.

Integrated and coordinated care is needed to address long term services and supports, physical health and behavioral health in ways that improve health outcomes, assure quality of care and have sufficient flexibility/incentives to include "hard to serve" clients. The committee has reviewed various models already implemented in Colorado such as the Program of All-Inclusive Care for the Elderly (PACE) and the Colorado Regional Integrated Care Collaborative (CRICC); and begun the dialogue about necessary features and safeguards for enrollment of long term care clients in integrated and coordinated care. It is anticipated that this input will be considered in the managed care strategic plan developed by the Department.

Building capacity focuses on strategies to ensure a sufficiency of community-based providers of long term services and supports, including direct care workforce considerations. Initial work has focused on better understanding where provider system gaps exist and strategies to expand participation in consumer directed care.

Building infrastructure's charge is to work on accurate long term care information to clients, providers and the general public; enhanced accountability of community contractors and strategies to better facilitate transition from institutional settings to community-based long term services and supports. The workgroup has developed training recommendations to enhance the community transition benefit in the Home and Community Based Services waiver for the Elderly, Blind and Disabled (EBD) as well as discussed possibilities for expansion beyond the EBD waiver.

Eligibility reform has looked at issues related to expedited enrollment for long term care clients and formally reviewed and commented on the Department's Request for Information for Eligibility Modernization. Recommendations from the workgroup focused on shared access to information about applicant status and the piloting of medical assistance sites within the Single Entry Point system.

# V. WORKLOAD REPORTS

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®) [3] 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 2007. The survey period for this questionnaire was July through December 2007. The data were collected between February and May 2008. National averages for 2007 (the most recent comparative data available) are included.

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

**CAHPS 2008 Summary of Results, Reporting Year 2007**

| CAHPS Measure | Rocky Mountain Health Plans | Denver Health and Hospital Authority | Primary Care Physician Program | Fee For Service | 2007 National Average |
|---|---|---|---|---|---|
| **Overall Rating of Health Plan**<br>*"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 | 80 | 72 | 48 | 44 | 53 |
| Child | N/A | N/A | 63 | 56 | 64 |
| **Overall Rating of Health Care**<br>*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 | 75 | 67 | 46 | 47 | 47 |
| Child | N/A | N/A | 68 | 64 | 64 |
| **Overall Rating of Personal Doctor or Nurse**<br>*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 | 61 | 63 | 61 |
| Child | N/A | N/A | 66 | 63 | 65 |
| **Getting Needed Care**<br>*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 | 88 | 73 | 50 | 50 | 47 |
| Child | N/A | N/A | 78 | 81 | 80 |

**CAHPS 2008 Summary of Results, Reporting Year 2007 (cont)**

| CAHPS Measure | Rocky Mountain Health Plans | Denver Health and Hospital Authority | Primary Care Physician Program | Fee For Service | 2007 National Average |
|---|---|---|---|---|---|
| **Getting Care Quickly**<br>*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 | 89 | 73 | 56 | 60 | 54 |
| Child | N/A | N/A | 56 | 50 | 51 |
| CAHPS Measure | Rocky Mountain Health Plans | Denver Health and Hospital Authority | Primary Care Physician Program | Fee For Service | 2007 National Average |
| **Doctors Who Communicate Well**<br>*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 | 91 | 63 | 66 | 67 |
| Child | N/A | N/A | 68 | 63 | 66 |
| **Courteous and Helpful Office Staff**<br>*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 | 86 | N/A | N/A | 48 | Unavailable |
| Child | N/A | N/A | 71 | 65 | 68 |

**Health Plan Employer Data Information Set (HEDIS)**

The Health Plan Employer Data Information Set (HEDIS®)[4] 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 that relate to quality improvement efforts outlined in the State Quality Improvement Work Plan. Since different measures are selected annually, variations may occur in data presentation and reported level of detail.

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 clinical measures on both adults and children. The data presented in the following tables show statistics ranging from child immunization rates to cholesterol screenings for clients with cardiovascular conditions. The 2008 data collection period (2007 calendar year) for each of the reported measures was January 1, 2007 through December 31, 2007.

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

**2008 HEDIS Colorado Medicaid (Calendar Year 2007 Data Collection)**
**HEDIS Rates for All Medicaid Health Plans**
**HEDIS is a registered trademark of the National Committee for Quality Assurance.**

| Child under two years old immunization Status | 2006 | 2007 | 2008 | 2008 CO Weighted Avg | 2007 HEDIS 90th Percentile | 2007 HEDIS National Mean |
|---|---|---|---|---|---|---|
| Denver Health | 85.2% | 84.8% | 85.2% | 68.2% | 84.7% | 73.3% |
| Rocky Mountain | 79.2% | 74.5% | 81.5% | 68.2% | 84.7% | 73.3% |
| PCPP | 54.7% | 49.4% | 78.6% | 68.2% | 84.7% | 73.3% |
| Fee-for-Service | 38.4% | 37.2% | 66.4% | 68.2% | 84.7% | 73.3% |
| CO Weighted Average | 41.5% | 39.5% | 68.2% | | | |

| Well child visits in the 1st 15 months of life - 0 visits | 2006 | 2007 | 2008 | 2008 CO Weighted Avg | 2007 High Performance Level * | 2007 HEDIS National Mean |
|---|---|---|---|---|---|---|
| Denver Health | NA | 0 | 1.9% | 20.5% | 0.4% | 3.8% |
| Rocky Mountain | 1.2% | 1.6% | 1.4% | 20.5% | 0.4% | 3.8% |
| PCPP | 31.6% | 21.2% | 18.5% | 20.5% | 0.4% | 3.8% |
| Fee-for-Service | 26.8% | 20.7% | 21.2% | 20.5% | 0.4% | 3.8% |
| CO Weighted Average | 26.3% | 20.3% | 20.5% | | | |

| Well child visits, 1st 15 months of life; 6+ visits | 2006 | 2007 | 2008 | 2008 CO Weighted Avg | 2007 HEDIS 90th Percentile | 2007 HEDIS National Mean |
|---|---|---|---|---|---|---|
| Denver Health | NA | 61.1% | 63.1% | 37.7% | 75.2% | 55.6% |
| Rocky Mountain | 33.7% | 27.7% | 30.6% | 37.7% | 75.2% | 55.6% |
| PCPP | 32.0% | 35.5% | 56.5% | 37.7% | 75.2% | 55.6% |
| Fee-for-Service | 33.3% | 30.2% | 37.5% | 37.7% | 75.2% | 55.6% |
| CO Weighted Average | 33.3% | 29.8% | 37.7% | | | |

**2008 HEDIS Colorado Medicaid (Calendar Year 2007 Data Collection)**
**HEDIS Rates for All Medicaid Health Plans**
**HEDIS is a registered trademark of the National Committee for Quality Assurance.**

| Well Child Visits in 3rd thru 6th years of life | 2006 | 2007 | 2008 | 2008 CO Weighted Avg | 2007 HEDIS 90th Percentile | 2007 HEDIS National Mean |
|---|---|---|---|---|---|---|
| Denver Health | 55.5% | 68.6% | 56.9% | 48.5% | 79.9% | 66.8% |
| Rocky Mountain | 61.5% | 67.1% | 59.5% | 48.5% | 79.9% | 66.8% |
| PCPP | 21.4% | 21.1% | 42.6% | 48.5% | 79.9% | 66.8% |
| Fee-for-Service | 26.0% | 26.2% | 47.7% | 48.5% | 79.9% | 66.8% |
| CO Weighted Average | 27.9% | 28.7% | 48.5% | | | |

| Adolescent Well Care Visits | 2006 | 2007 | 2008 | 2008 CO Weighted Avg | 2007 HEDIS 90th Percentile | 2007 HEDIS National Mean |
|---|---|---|---|---|---|---|
| Denver Health | 27.4% | 35.3% | 31.9% | 17.4% | 58.9% | 43.7% |
| Rocky Mountain | 35.7% | 39.5% | 40.8% | 17.4% | 58.9% | 43.7% |
| PCPP | 23.1% | 27.5% | 15.2% | 17.4% | 58.9% | 43.7% |
| Fee-for-Service | 20.9% | 23.8% | 15.6% | 17.4% | 58.9% | 43.7% |
| CO Weighted Average | 22.0% | 25.2% | 17.4% | | | |

| Timeliness of Prenatal Care | 2006 | 2007 | 2008 | 2008 CO Weighted Avg | 2007 HEDIS 90th Percentile | 2007 HEDIS National Mean |
|---|---|---|---|---|---|---|
| Denver Health | 71.2% | 77.4% | 82.7% | 55.8% | 91.5% | 81.2% |
| Rocky Mountain | 95.5% | 97.1% | 97.1% | 55.8% | 91.5% | 81.2% |
| PCPP | 58.2% | 54.0% | 63.4% | 55.8% | 91.5% | 81.2% |
| Fee-for-Service | 54.5% | 41.4% | 52.6% | 55.8% | 91.5% | 81.2% |
| CO Weighted Average | 56.0% | 44.2% | 55.8% | | | |

**2008 HEDIS Colorado Medicaid (Calendar Year 2007 Data Collection)**
**HEDIS Rates for All Medicaid Health Plans**
**HEDIS is a registered trademark of the National Committee for Quality Assurance.**

| Postpartum Care | 2006 | 2007 | 2008 | 2008 CO Weighted Avg | 2007 HEDIS 90th Percentile | 2007 HEDIS National Mean |
|---|---|---|---|---|---|---|
| Denver Health | 36.5% | 33.9% | 55.2% | 54.4% | 71.1% | 59.1% |
| Rocky Mountain | 78.0% | 75.9% | 72.8% | 54.4% | 71.1% | 59.1% |
| PCPP | 51.3% | 50.6% | 65.3% | 54.4% | 71.1% | 59.1% |
| Fee-for-Service | 42.8% | 35.5% | 53.3% | 54.4% | 71.1% | 59.1% |
| CO Weighted Average | 44.2% | 37.4% | 54.4% | | | |

| Adults Access to Preventive/Ambulatory Care, ages 20 - 44 | 2006 | 2007 | 2008 | 2008 CO Weighted Avg | 2007 HEDIS 90th Percentile | 2007 HEDIS National Mean |
|---|---|---|---|---|---|---|
| Denver Health | 70.2% | N/A | 66.1% | 66.7% | 88.0% | 78.2% |
| Rocky Mountain | 80.6% | N/A | 83.7% | 66.7% | 88.0% | 78.2% |
| PCPP | 65.3% | N/A | 64.6% | 66.7% | 88.0% | 78.2% |
| Fee-for-Service | 58.1% | N/A | 66.4% | 66.7% | 88.0% | 78.2% |
| CO Weighted Average | 60.3% | N/A | 66.7% | | | |

| Adults Access to Preventive/Ambulatory Care, ages 45 - 64 | 2006 | 2007 | 2008 | 2008 CO Weighted Avg | 2007 HEDIS 90th Percentile | 2007 HEDIS National Mean |
|---|---|---|---|---|---|---|
| Denver Health | 79.6% | N/A | 68.7% | 55.2% | 89.8% | 83.1% |
| Rocky Mountain | 90.4% | N/A | 88.0% | 55.2% | 89.8% | 83.1% |
| PCPP | 65.2% | N/A | 63.7% | 55.2% | 89.8% | 83.1% |
| Fee-for-Service | 43.8% | N/A | 49.9% | 55.2% | 89.8% | 83.1% |
| CO Weighted Average | 52.7% | N/A | 55.2% | | | |

**2008 HEDIS Colorado Medicaid (Calendar Year 2007 Data Collection)**
**HEDIS Rates for All Medicaid Health Plans**
**HEDIS is a registered trademark of the National Committee for Quality Assurance.**

| Adults Access to Preventive/Ambulatory Services, ages 65+ (duals) | 2006 | 2007 | 2008 | 2008 CO Weighted Avg | 2007 HEDIS 90th Percentile | 2007 HEDIS National Mean |
|---|---|---|---|---|---|---|
| Denver Health | 81.0% | N/A | 56.4% | 21.8% | 93.5% | 79.9% |
| Rocky Mountain | 93.0% | N/A | 95.0% | 21.8% | 93.5% | 79.9% |
| PCPP | 28.6% | N/A | 15.1% | 21.8% | 93.5% | 79.9% |
| Fee-for-Service | 18.2% | N/A | 16.5% | 21.8% | 93.5% | 79.9% |
| CO Weighted Average | 24.4% | N/A | 21.8% | | | |

| Cholesterol Management for People with CV conditions, LDL less than 100 | 2006 | 2007 | 2008 | 2008 CO Weighted Avg | 2007 HEDIS 90th Percentile | 2007 HEDIS National Mean |
|---|---|---|---|---|---|---|
| Denver Health | N/A | 54.1% | 51.0% | 30.4% | 51.7% | 35.5% |
| Rocky Mountain | 41.0% | 43.2% | 57.3% | 30.4% | 51.7% | 35.5% |
| PCPP | 18.5% | 29.8% | 24.5% | 30.4% | 51.7% | 35.5% |
| Fee-for-Service | 15.3% | 18.6% | 23.7% | 30.4% | 51.7% | 35.5% |
| CO Weighted Average | 19.1% | 29.7% | 30.4% | | | |

| LDL Cholesterol Screening for People with CV conditions | 2006 | 2007 | 2008 | 2008 CO Weighted Avg | 2007 HEDIS 90th Percentile | 2007 HEDIS National Mean |
|---|---|---|---|---|---|---|
| Denver Health | N/A | 73.0% | 70.6% | 71.7% | 87.4% | 75.5% |
| Rocky Mountain | 65.4% | 72.6% | 74.4% | 71.7% | 87.4% | 75.5% |
| PCPP | 47.2% | 67.6% | 69.2% | 71.7% | 87.4% | 75.5% |
| Fee-for-Service | 47.9% | 65.6% | 72.3% | 71.7% | 87.4% | 75.5% |
| CO Weighted Average | 49.5% | 68.1% | 71.7% | | | |

## 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 2007 demographic data from the United States Census Report, "2007 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 2007-08 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 actual medical services expenditures reported in Exhibit P in the November 3, 2008 FY 2009-10 Budget Request.

**Children's Basic Health Plan**

Using FY 2007-08 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 205% 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 Children's Basic Health Plan – A Statewide View**

| Characteristics | State Totals |
|---|---|
| ***Demographic Characteristics*** | |
| Colorado Population Estimate, 2008[5] | 5,008,259 |
| Percent of Population in the Labor Force, 2007[6] | 69.9% |
| Percent of Families Below Poverty, 2007 | 8.4% |
| Percent of Female Headed Households, 2007 | 9.7% |
| ***Medicaid Characteristics, FY 2007-08*** | |
| Average Number of Medicaid Clients[7] | 388,068 |
| Medical Services Premiums Expenditures | $2,239,961,947 |
| Total Title XIX Service Expenditures[8] | $3,457,770,016 |
| Percent of Total Medicaid Expenditures | 64.78% |
| ***Children's Basic Health Plan Characteristics, FY 2007-08*** [9] | |
| Average Number of Children per Month | 57,795 |
| Average Prenatal Caseload per Month | 1,570 |
| Children's Basic Health Plan Expenditures | $113,400,542 |

[5] Colorado Division of Local Government, Demography Office, November 2007 - Table 3a Preliminary Population Forecasts for Colorado Regions 2000-2010

[6] Per the '2007 American Community Survey' from the United States Census Bureau. The percents listed are not relative to the total population.

[7] July 2008 Joint Budget Committee Report.

[8] Title XIX Service Expenditures equal $3,457,770,016. Of this $2,239,961,947 is Medical Services Premiums Expenditures, $236,784,219 is Medicaid Mental Health Community Programs, $523,919,195 from Indigent Care Program, $105,796,214 from Other Medical Services and $351,308,441 from the Department of Human Services Medicaid Funded Programs.

[9] July 2008 Joint Budget Committee Report.

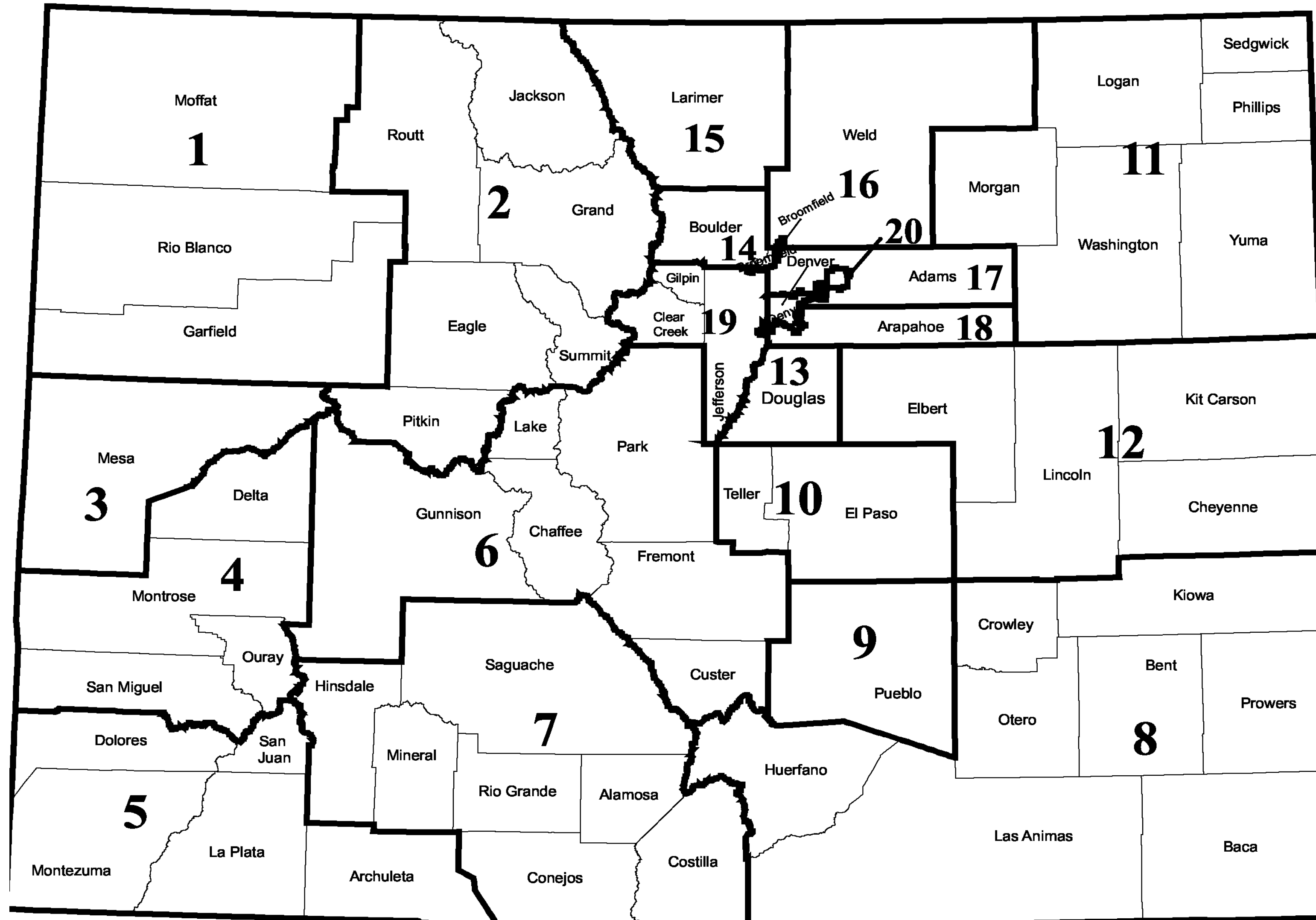
**HIPAA Information Regions**

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

**Regional Demographics**



**Medicaid and the Children's Basic Health Plan**

The following table provides insight on the variations of Medicaid and the Children's Basic Health Plan usage across HIPAA regions. Some important caveats must be mentioned concerning the Medicaid and Children's Basic Health Plan data presented in the region table. Overall, Medicaid and Children's Basic Health Plan expenditure figures by region will not equal the year-to-date FY 2007-08 appropriated or actual amounts. This is due to several factors:

1. The Medicaid and Children's Basic Health Plan 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 Children's Basic Health Plan expenditures presented in the table below will not exactly reconcile with the numbers for actual medical services reported in the June 2008 Expenditure Report to the Joint Budget Committee. Some Medicaid expenditures 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, 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 (2008) | 78,581 | 141,054 | 142,463 | 85,593 |
| Percent of Total Colorado Population (2008) | 1.57% | 2.82% | 2.84% | 1.71% |
| Colorado Population (2000) | 62,961 | 113,788 | 116,255 | 71,602 |
| Percent of Population in the Labor Force (2000) | 70.34% | 81.19% | 64.20% | 61.68% |
| Percent of Homes where Language Other Then English is Spoken (2000) | 13.11% | 15.15% | 7.97% | 10.71% |
| Percent of Families Below Poverty (2000) | 5.31% | 3.73% | 7.03% | 8.42% |
| Percent of Female Headed Households (2000) | 7.87% | 5.31% | 9.78% | 7.91% |
| ***Medicaid Characteristics, FY 2007-08*** | | | | |
| Average Number of Medicaid Clients per Month | 4,682 | 3,919 | 13,407 | 7,947 |
| Percent of Regional Population that are Medicaid Clients | 5.96% | 2.78% | 9.41% | 9.29% |
| Medicaid Expenditures | $27,533,208 | $15,636,638 | $49,060,376 | $29,698,931 |
| Percent of Total Medicaid Expenditures | 1.35% | 0.77% | 2.40% | 1.45% |
| ***Children's Basic Health Plan Characteristics, 2007-08*** | | | | |
| Average Number of Children per Month | 1,022 | 808 | 2,751 | 1,853 |
| Percent of Regional Population that are Children's Basic Health Plan Clients | 1.30% | 0.57% | 1.93% | 2.16% |
| Children's Basic Health Plan Expenditures | $2,279,676 | $1,780,683.55 | $5,738,191.58 | $3,459,741.22 |
| Percent of Total Children's Basic Health Plan Expenditures | 1.97% | 1.54% | 4.96% | 2.99% |
| ***Colorado Indigent Care Program Characteristics, FY 2006-07*** | | | | |
| Number of Colorado Indigent Care Program Providers in Region | 2 | 3 | 3 | 3 |
| Colorado Indigent Care Program Expenditures | $609,375 | $555,772 | $1,459,053 | $1,148,001 |
| Percent of Total Colorado Indigent Care Program Expenditures | 0.4% | 0.3% | 0.8% | 0.7% |

| 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 (2008) | 93,296 | 112,953 | 50,224 | 77,512 |
| Percent of Total Colorado Population (2008) | 1.86% | 2.26% | 1.00% | 1.55% |
| Colorado Population (2000) | 80,071 | 138,310 | 46,980 | 75,518 |
| Percent of Population in the Labor Force (2000) | 66.44% | 56.16% | 60.63% | 54.99% |
| Percent of Homes where Language Other Then English is Spoken (2000) | 10.81% | 8.32% | 33.18% | 19.44% |
| Percent of Families Below Poverty (2000) | 9.13% | 7.21% | 15.45% | 14.23% |
| Percent of Female Headed Households (2000) | 9.15% | 7.27% | 11.32% | 11.02% |
| ***Medicaid Characteristics, FY 2007-08*** | | | | |
| Average Number of Medicaid Clients per Month | 6,926 | 8,289 | 8,846 | 12,027 |
| Percent of Regional Population that are Medicaid Clients | 7.42% | 7.34% | 17.61% | 15.52% |
| Medicaid Expenditures | $32,334,940 | $49,248,919 | $37,772,673 | $69,369,296 |
| Percent of Total Medicaid Expenditures | 1.58% | 2.41% | 1.85% | 3.40% |
| ***Children's Basic Health Plan Characteristics, FY 2007-08*** | | | | |
| Average Number of Children per Month | 1,896 | 1,415 | 1,512 | 1,509 |
| Percent of Regional Population that are Children's Basic Health Plan Clients | 2.03% | 1.25% | 3.01% | 1.95% |
| Children's Basic Health Plan Expenditures | $4,059,849 | $2,813,594 | $2,759,850 | $2,761,905 |
| Percent of Total Children's Basic Health Plan Expenditures | 3.51% | 2.43% | 2.39% | 2.39% |
| ***Colorado Indigent Care Program Characteristics, FY 2006-07*** | | | | |
| Number of Colorado Indigent Care Program Providers in Region | 3 | 4 | 4 | 6 |
| Colorado Indigent Care Program Expenditures | $1,024,832 | $1,276,349 | $2,677,554 | $2,380,571 |
| Percent of Total Colorado Indigent Care Program Expenditures | 0.6% | 0.7% | 1.5% | 1.4% |

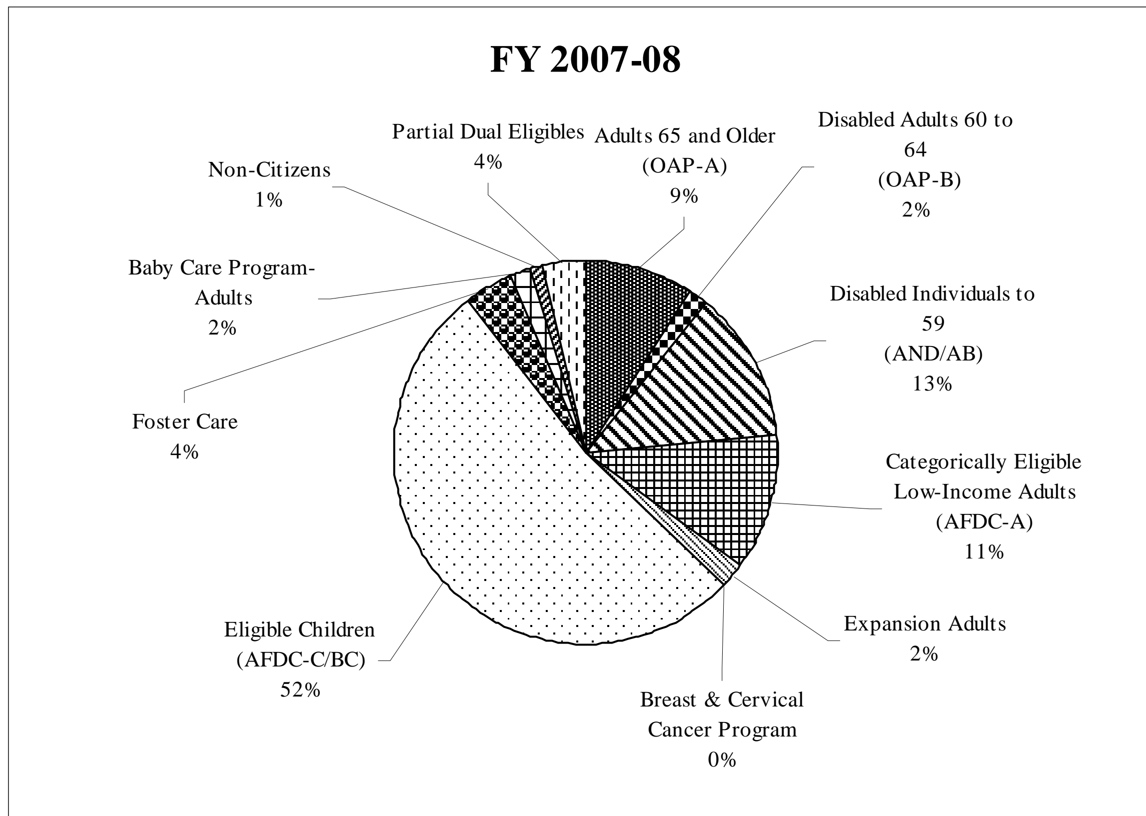
| Regions | Region 9 | Region 10 | Region 11 | Region 12 |
|---|---|---|---|---|
| **Characteristics** | Pueblo | El Paso, Teller | Logan, Morgan, Phillips, Sedgwick, Washington, Yuma | Cheyenne, Elbert, Kit Carson, Lincoln |
| ***Demographic Characteristics*** | | | | |
| Colorado Population Estimate (2008) | 159,204 | 641,075 | 74,754 | 40,108 |
| Percent of Total Colorado Population (2008) | 3.18% | 12.80% | 1.49% | 0.80% |
| Colorado Population (2000) | 141,472 | 537,484 | 69,669 | 36,201 |
| Percent of Population in the Labor Force (2000) | 58.31% | 71.96% | 62.23% | 67.38% |
| Percent of Homes where Language Other Then English is Spoken (2000) | 16.13% | 11.08% | 15.38% | 7.19% |
| Percent of Families Below Poverty (2000) | 11.18% | 5.60% | 8.68% | 5.19% |
| Percent of Female Headed Households (2000) | 13.33% | 10.07% | 7.99% | 6.25% |
| ***Medicaid Characteristics, FY 2007-08*** | | | | |
| Average Number of Medicaid Clients per Month | 26,708 | 47,311 | 7,113 | 2,406 |
| Percent of Regional Population that are Medicaid Clients | 16.78% | 7.38% | 9.52% | 6.00% |
| Medicaid Expenditures | $133,303,470 | $246,447,482 | $38,937,785 | $11,845,654 |
| Percent of Total Medicaid Expenditures | 6.53% | 12.07% | 1.91% | 0.58% |
| ***Children's Basic Health Plan Characteristics, FY 2007-08*** | | | | |
| Average Number of Children per Month | 2,201 | 4,825 | 1,224 | 501 |
| Percent of Regional Population that are Children's Basic Health Plan Clients | 1.38% | 0.75% | 1.64% | 1.25% |
| Children's Basic Health Plan Expenditures | $4,184,120.81 | $11,383,978 | $2,368,531 | $953,716 |
| Percent of Total Children's Basic Health Plan Expenditures | 3.62% | 9.85% | 2.05% | 0.83% |
| ***Colorado Indigent Care Program Characteristics, FY 2006-07*** | | | | |
| Number of Colorado Indigent Care Program Providers in Region | 3 | 3 | 6 | 1 |
| Colorado Indigent Care Program Expenditures | $11,579,642 | $15,205,152 | $1,041,301 | $15,353 |
| Percent of Total Colorado Indigent Care Program Expenditures | 6.7% | 8.7% | 0.6% | <0.1% |

| Regions | Region 13 | Region 14 | Region 15 | Region 16 |
|---|---|---|---|---|
| **Characteristics** | Douglas | Boulder, Broomfield | Larimer | Weld |
| ***Demographic Characteristics*** | | | | |
| Colorado Population Estimate (2008) | 284,144 | 342,918 | 286,872 | 250,835 |
| Percent of Total Colorado Population (2008) | 5.67% | 6.85% | 5.73% | 5.01% |
| Colorado Population (2000) | 175,766 | 291,288 | 251,494 | 180,936 |
| Percent of Population in the Labor Force (2000) | 79.01% | 73.36% | 71.92% | 68.61% |
| Percent of Homes where Language Other Then English is Spoken (2000) | 7.20% | 13.62% | 8.47% | 20.25% |
| Percent of Families Below Poverty (2000) | 1.62% | 4.59% | 4.26% | 8.04% |
| Percent of Female Headed Households (2000) | 5.74% | 7.70% | 7.87% | 9.42% |
| ***Medicaid Characteristics, FY 2007-08*** | | | | |
| Average Number of Medicaid Clients per Month | 4,731 | 15,832 | 17,172 | 20,973 |
| Percent of Regional Population that are Medicaid Clients | 1.67% | 4.62% | 5.99% | 8.36% |
| Medicaid Expenditures | $29,299,620 | $88,223,038 | $89,905,220 | $93,463,406 |
| Percent of Total Medicaid Expenditures | 1.44% | 4.32% | 4.40% | 4.58% |
| ***Children's Basic Health Plan Characteristics, FY 2007-08*** | | | | |
| Average Number of Children per Month | 1,007 | 2,472 | 3,518 | 4,169 |
| Percent of Regional Population that are Children's Basic Health Plan Clients | 0.35% | 0.72% | 1.23% | 1.66% |
| Children's Basic Health Plan Expenditures | $1,940,869 | $4,512,380 | $7,376,779 | $8,191,645 |
| Percent of Total Children's Basic Health Plan Expenditures | 1.68% | 3.90% | 6.38% | 7.09% |
| ***Colorado Indigent Care Program Characteristics, FY 2006-07*** | | | | |
| Number of Colorado Indigent Care Program Providers in Region | 0 | 5 | 3 | 4 |
| Colorado Indigent Care Program Expenditures | 0 | $3,977,615 | $5,587,540 | $9,052,459 |
| Percent of Total Colorado Indigent Care Program Expenditures | 0 | 2.3% | 3.2% | 5.2% |

| Regions | Region 17 | Region 18 | Region 19 | Region 20 |
|---|---|---|---|---|
| **Characteristics** | Adams | Arapahoe | Clear Creek, Gilpin, Jefferson | Denver |
| ***Demographic Characteristics*** | | | | |
| Colorado Population Estimate (2008) | 433,267 | 561,388 | 557,278 | 594,740 |
| Percent of Total Colorado Population (2008) | 8.65% | 11.21% | 11.13% | 11.88% |
| Colorado Population (2000) | 363,857 | 487,967 | 541,135 | 554,636 |
| Percent of Population in the Labor Force (2000) | 70.57% | 73.27% | 73.57% | 67.65% |
| Percent of Homes where Language Other Then English is Spoken (2000) | 21.64% | 15.51% | 9.09% | 26.96% |
| Percent of Families Below Poverty (2000) | 6.46% | 4.18% | 3.32% | 10.63% |
| Percent of Female Headed Households (2000) | 12.11% | 10.64% | 9.06% | 10.84% |
| ***Medicaid Characteristics, FY 2007-08*** | | | | |
| Average Number of Medicaid Clients per Month | 44,358 | 40,707 | 27,716 | 70,897 |
| Percent of Regional Population that are Medicaid Clients | 10.24% | 7.25% | 4.97% | 11.92% |
| Medicaid Expenditures | $213,841,152 | $209,703,527 | $199,884,806 | $376,238,869 |
| Percent of Total Medicaid Expenditures | 10.47% | 10.27% | 9.79% | 18.43% |
| ***Children's Basic Health Plan Characteristics, 2007-08*** | | | | |
| Average Number of Children per Month | 8,048 | 6,140 | 4,128 | 8,192 |
| Percent of Regional Population that are Children's Basic Health Plan Clients | 1.86% | 1.09% | 0.74% | 1.38% |
| Children's Basic Health Plan Expenditures | $14,693,801 | $11,424,548 | $8,392,488 | $14,507,655 |
| Percent of Total Children's Basic Health Plan Expenditures | 12.71% | 9.88% | 7.26% | 12.55% |
| ***Colorado Indigent Care Program Characteristics, FY 2006-07*** | | | | |
| Number of Colorado Indigent Care Program Providers in Region | 1 | 1 | 0 | 6 |
| Colorado Indigent Care Program Expenditures | $1,693,639 | $2,478,436 | 0 | $112,127,238 |
| Percent of Total Colorado Indigent Care Program Expenditures | 1.0% | 1.4% | 0 | 64.5% |

**Medicaid Caseload**

Medicaid caseload trends are influenced by a number of factors including: population trends, in-State migration, age of the population, length of stay, economic conditions, and State and federal policy changes. Projecting annual caseload is complicated by the fact that each of these factors can contribute to categorical changes, some of which may be contradictory. For example, the State may enact legislation that removes clients from a Medicaid category who are aged 65 and older, while the population of adults aged 65 and older is increasing. The chart below shows Medicaid caseload by category as a percentage of the overall caseload for FY 2007-08.




Source: July 2008, Joint Budget Committee Report.

## A. Clients

### A1. 2008 Federal Poverty Levels

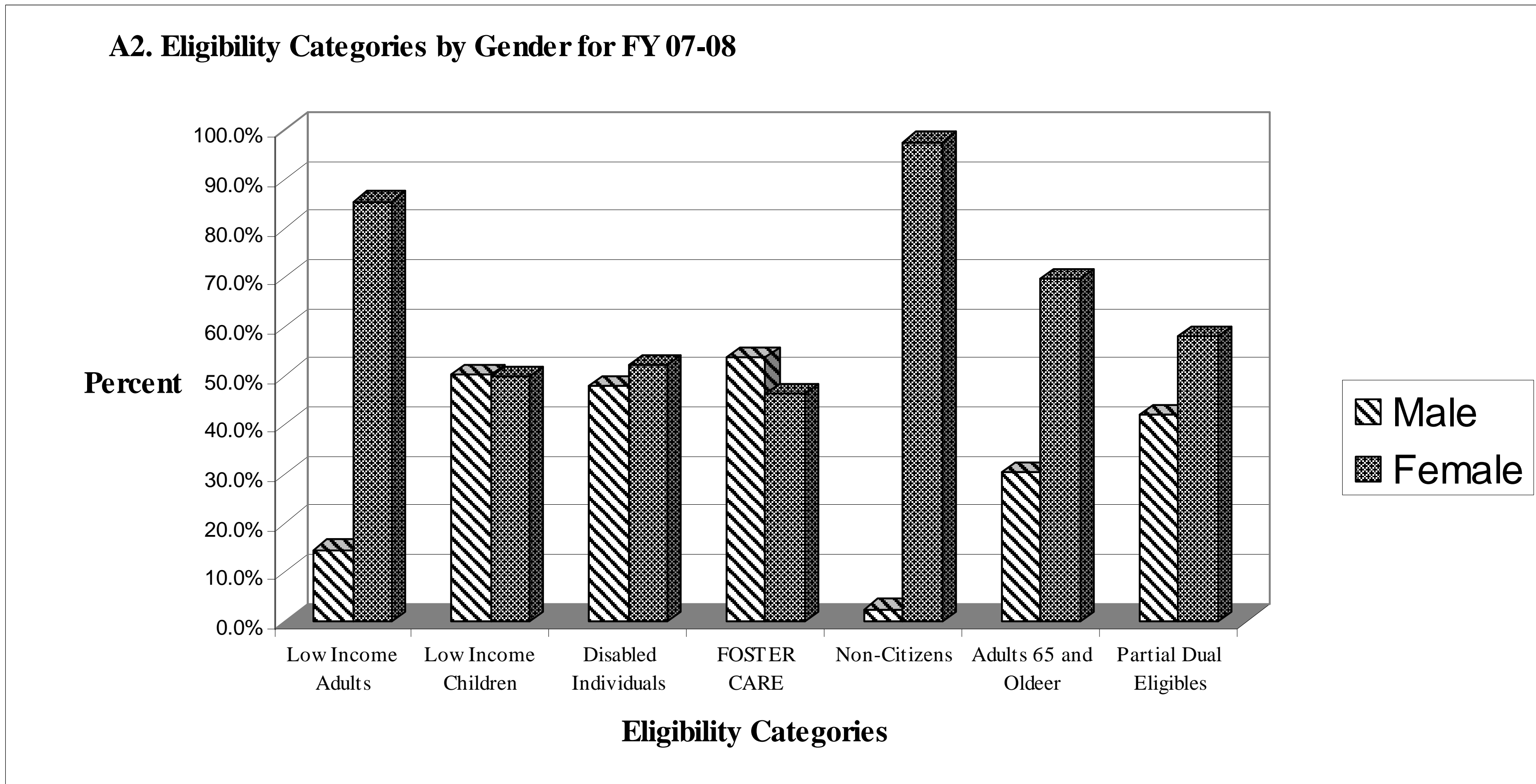
The table below reports the federal poverty levels for all states except Hawaii and Alaska from the Department of Health and Human Services, for federal fiscal year 2008. For family units of more than 8 members, add $3,600 for each additional family member.

**Federal Poverty Levels for Annual Income**

| Family Size | 100% | 120% | 133% | 150% | 170% | 175% | 185% | 190% | 200% | 250% |
|---:|---:|---:|---:|---:|---:|---:|---:|---:|---:|---:|
| 1 | 10,400 | 12,480 | 13,832 | 15,600 | 17,680 | 18,200 | 19,240 | 19,760 | 20,800 | 26,000 |
| 2 | 14,000 | 16,800 | 18,620 | 21,000 | 23,800 | 24,500 | 25,900 | 26,600 | 28,000 | 35,000 |
| 3 | 17,600 | 21,120 | 23,408 | 26,400 | 29,920 | 30,800 | 32,560 | 33,440 | 35,200 | 44,000 |
| 4 | 21,200 | 25,440 | 28,196 | 31,800 | 36,040 | 37,100 | 39,220 | 40,280 | 42,400 | 53,000 |
| 5 | 24,800 | 29,760 | 32,984 | 37,200 | 42,160 | 43,400 | 45,880 | 47,120 | 49,600 | 62,000 |
| 6 | 28,400 | 34,080 | 37,772 | 42,600 | 48,280 | 49,700 | 52,540 | 53,960 | 56,800 | 71,000 |
| 7 | 32,000 | 38,400 | 42,560 | 48,000 | 54,400 | 56,000 | 59,200 | 60,800 | 64,000 | 80,000 |
| 8 | 35,600 | 42,720 | 47,348 | 53,400 | 60,520 | 62,300 | 65,860 | 67,640 | 71,200 | 89,000 |

Source: *Federal Register*, Vol. 73, No. 15, January 23, 2008

**A2. Eligibility Categories by Gender for FY 2007-08**




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 Qualified and Supplemental Low Income Medicare Beneficiaries.
4) Percent based on member months in each category.

### A3. Medicaid Enrollment by Type of Managed Care Provider

The following table shows the breakdown by client count for FY 2002-03 through FY 2006-07 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 2002-03 through FY 2006-07**

| Membership Category | FY 2003-04 Count | FY 04-05 Count | FY 2005-06 Count | FY 2006-07 Count | FY 2007-08 Count |
|---|---|---|---|---|---|
| Health Maintenance Organizations and Prepaid Inpatient Health Plans | 74,439 | 77,354 | 71,799 | 35,985 | 36,701 |
| Primary Care Physician Program | 68,557 | 51,669 | 36,563 | 29,243 | 25,875 |
| Fee-for-Service | 219,535 | 273,779 | 291,343 | 327,849 | 325,492 |
| **TOTALS** | **362,531** | **402,802** | **399,705** | **393,077** | **388,068** |

Source: July 2008 Joint Budget Committee Report. Caseload numbers are an average of the fiscal year's caseload for each month, without retroactivity. Fee-for-service enrollment is derived by the total enrollment minus enrollment in administrative service organizations, health maintenance organizations, and the Primary Care Physician Program.

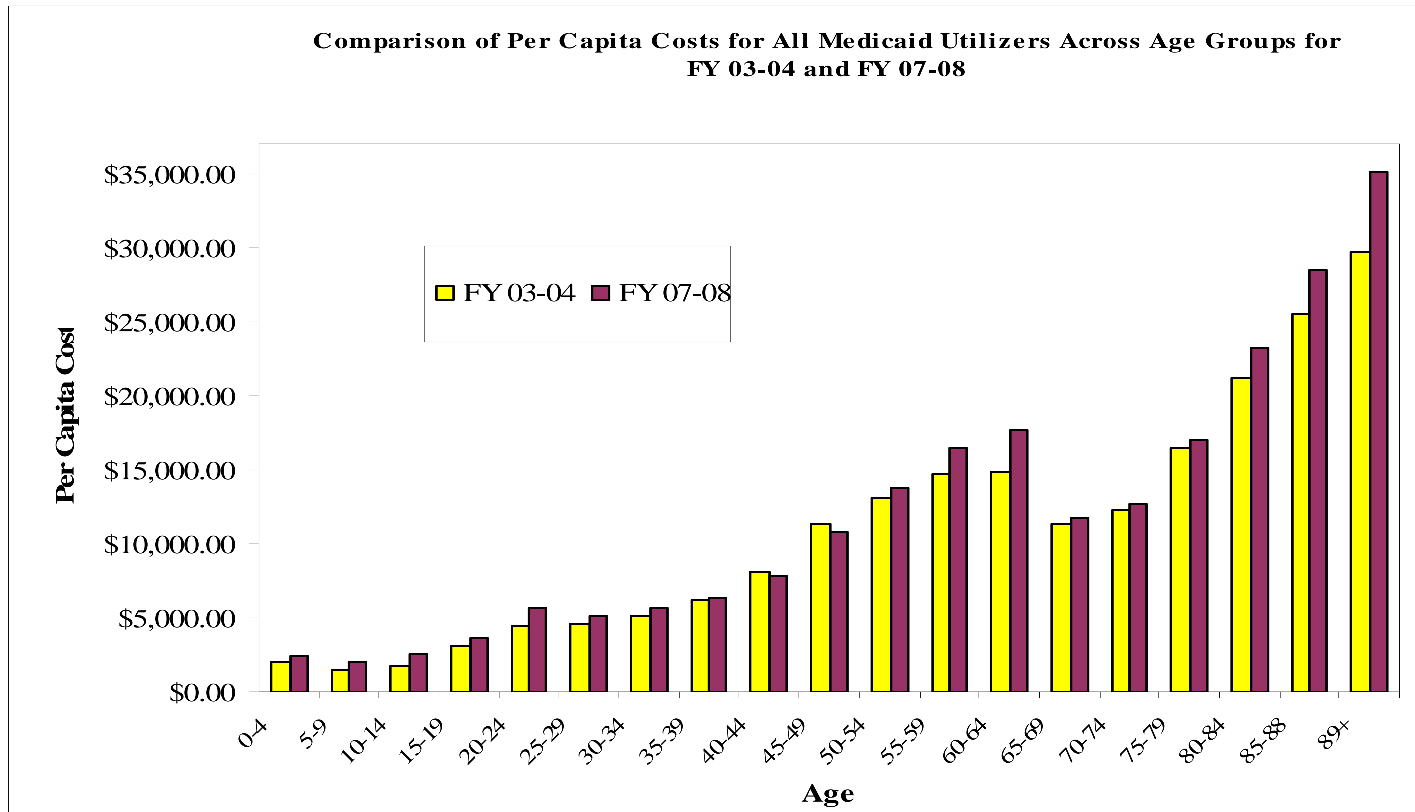
Note: The Department has developed a new caseload report that it believes measures caseload more accurately. Because of the differences between the methodologies used in the original and new caseload reports, the Department restated historical Medicaid caseload through FY 2002-03. The numbers above are based on the old methodologies and will not match restated caseload totals because the Department does not have a methodology for restating caseload by provider type.

## 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 2006-07. 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. Financial transactions and other accounting adjustments are not included in the expenditures by age group.

## B2. FY 2007-08 Services by County

Exhibits B2a - B2b 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 B3a - B3c 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: Elderly, Blind and Disabled; Persons with Mental Illness; Persons Living with AIDS; Persons with Brain Injury; Children's; Children with Autism and Consumer Directed Care for the Elderly.
- 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. The naming of DRG categories was completed through consultation of the ICD-10 (International Classification of Diseases). There is a group called *Non-Specific Symptoms, Disorders or Procedures* which was created to minimize the number of DRG categories. Since the DRG descriptions were sometimes referring to diseases and 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 the first three digits of the ICD-9 codes.
- For the top ten prescription drug tables, the number of prescriptions filled was used instead of the number of prescriptions because it provides better insight on the frequency of pharmacy Medicaid payments. In addition, claims where the payment was zero were excluded from the analysis.
- 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 2007-08 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 | 1,020 | 3,904 | 3,141 | 749 | 2,254 |
| Eagle, Grand, Jackson, Pitkin, Routt, Summit | 141 | 4,094 | 2,582 | 839 | 1,664 |
| Mesa | 25 | 6,484 | 4,585 | 655 | 2,594 |
| Delta, Montrose, Ouray, San Miguel | 120 | 4,120 | 3,079 | 458 | 1,864 |
| Archuleta, Dolores, La Plata, Montezuma, San Juan | 740 | 5,765 | 4,833 | 729 | 3,070 |
| Gunnison, Chaffee, Lake, Fremont, Park, Custer | 446 | 6,495 | 6,191 | 787 | 3,925 |
| Hinsdale, Saguache, Mineral, Conejos, Rio Grande, Alamosa, Costilla | 5,586 | 6,060 | 6,426 | 816 | 3,965 |
| Huerfano, Las Animas, Baca, Otero, Crowley, Bent, Prowers, Kiowa | 4,165 | 9,024 | 8,886 | 1,179 | 6,048 |
| Pueblo | 7,038 | 22,613 | 20,455 | 2,596 | 13,770 |
| El Paso, Teller | 17,517 | 39,146 | 34,281 | 5,178 | 24,484 |
| Washington, Morgan, Logan, Yuma, Phillips, Sedgwick | 1,976 | 5,185 | 5,085 | 795 | 3,349 |
| Elbert, Lincoln, Kit Carson, Cheyenne | 731 | 1,744 | 1,820 | 241 | 1,074 |
| Douglas | 259 | 4,237 | 3,430 | 499 | 2,057 |
| Boulder, Broomfield | 7,184 | 11,755 | 9,947 | 1,901 | 7,419 |
| Larimer | 5,890 | 14,884 | 12,431 | 1,864 | 7,914 |
| Weld | 9,171 | 18,070 | 14,619 | 2,643 | 10,209 |
| Adams | 16,208 | 36,586 | 28,253 | 5,500 | 21,600 |
| Arapahoe | 6,893 | 35,463 | 26,277 | 4,849 | 19,470 |
| Jefferson, Gilpin, Clear Creek | 4,976 | 22,977 | 19,040 | 3,035 | 11,996 |
| Denver | 22,532 | 34,753 | 28,473 | 6,364 | 19,462 |
| **Statewide** | **10,677** | **285,482** | **237,955** | **41,458** | **165,205** |

Source: Medicaid Paid Claims from MMIS-DSS. 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 a sum of the 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 program

## B2b: FY 2007-08 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 | $135.67 | $487.29 | $497.84 | $997.75 | $469.42 |
| Eagle, Grand, Jackson, Pitkin, Routt, Summit | $16.76 | $657.20 | $471.23 | $1,365.83 | $404.42 |
| Mesa | $0.79 | $206.68 | $165.39 | $370.81 | $146.99 |
| Delta, Montrose, Ouray, San Miguel | $6.59 | $205.21 | $199.51 | $346.69 | $155.76 |
| Archuleta, Dolores, La Plata, Montezuma, San Juan | $31.66 | $440.94 | $574.42 | $542.85 | $348.49 |
| Gunnison, Chaffee, Lake, Fremont, Park, Custer | $24.28 | $437.48 | $749.67 | $616.11 | $270.41 |
| Hinsdale, Saguache, Mineral, Conejos, Rio Grande, Alamosa, Costilla | $339.58 | $351.07 | $478.60 | $596.26 | $357.17 |
| Huerfano, Las Animas, Baca, Otero, Crowley, Bent, Prowers, Kiowa | $168.85 | $408.70 | $704.10 | $607.03 | $340.97 |
| Pueblo | $186.70 | $539.60 | $795.41 | $640.87 | $364.29 |
| El Paso, Teller | $226.96 | $565.45 | $663.33 | $662.55 | $428.55 |
| Washington, Morgan, Logan, Yuma, Phillips, Sedgwick | $137.14 | $360.70 | $592.43 | $670.02 | $360.30 |
| Elbert, Lincoln, Kit Carson, Cheyenne | $126.72 | $374.14 | $619.50 | $669.00 | $375.84 |
| Douglas | $18.49 | $627.05 | $736.94 | $717.73 | $445.63 |
| Boulder, Broomfield | $225.15 | $499.96 | $597.18 | $747.43 | $403.89 |
| Larimer | $167.55 | $585.15 | $730.19 | $663.92 | $335.51 |
| Weld | $261.63 | $500.65 | $579.71 | $813.67 | $403.37 |
| Adams | $184.47 | $521.50 | $482.30 | $856.00 | $344.26 |
| Arapahoe | $70.21 | $573.23 | $575.65 | $909.55 | $367.80 |
| Jefferson, Gilpin, Clear Creek | $80.27 | $596.70 | $729.70 | $819.76 | $373.12 |
| Denver | $154.79 | $329.53 | $334.62 | $793.43 | $230.89 |
| **Statewide Average** | **$151.75** | **$475.52** | **$550.09** | **$744.18** | **$336.90** |

Source: Medicaid Paid Claims from MMIS-DSS. 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. 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 of multiple service categories, or may have received the same service in the same service category in one of multiple HIPAA Information Regions. *Early Periodic Screening, Diagnosis and Treatment program.

**B3a: FY 2007-08 Unduplicated Client Count for Home and Community Based Services (HCBS) Waiver Programs, Program of All-inclusive Care for the Elderly (PACE), Home Health and Nursing Facilities**

| HIPAA Information Region | HCBS Waivers Administered by HCPF* | HCBS Waivers Administered by DHS** | Program of All-inclusive Care for the Elderly | Home Health | Nursing Facilities (Class I and Class II) |
|---|---|---|---|---|---|
| Garfield, Moffat, Rio Blanco | 393 | 124 | 0 | 65 | 301 |
| Eagle, Grand, Jackson, Pitkin, Routt, Summit | 134 | 64 | 0 | 104 | 47.0 |
| Mesa | 1,478 | 381 | 0 | 298 | 475.0 |
| Delta, Montrose, Ouray, San Miguel | 767 | 174 | 0 | 321 | 377.0 |
| Archuleta, Dolores, La Plata, Montezuma, San Juan | 613 | 101 | 0 | 225 | 285.0 |
| Gunnison, Chaffee, Lake, Fremont, Park, Custer | 857 | 175 | 0 | 288 | 558.0 |
| Hinsdale, Saguache, Mineral, Conejos, Rio Grande, Alamosa, Costilla | 913 | 94 | 0 | 401 | 275.0 |
| Huerfano, Las Animas, Baca, Otero, Crowley, Bent, Prowers, Kiowa | 1,244 | 272 | 0 | 292 | 778.0 |
| Pueblo | 1,757 | 600 | 0 | 1,074 | 822.0 |
| El Paso, Teller | 2,377 | 809 | 0 | 1,409 | 1,388.0 |
| Washington, Morgan, Logan, Yuma, Phillips, Sedgwick | 672 | 174 | 0 | 156 | 529.0 |
| Elbert, Lincoln, Kit Carson, Cheyenne | 145 | 34 | 0 | 24 | 111.0 |
| Douglas | 351 | 134 | 1 | 136 | 180.0 |
| Boulder, Broomfield | 1,262 | 557 | 1 | 606 | 769.0 |
| Larimer | 1,228 | 495 | 0 | 545 | 775.0 |
| Weld | 936 | 365 | 0 | 580 | 559.0 |
| Adams | 1,548 | 739 | 363 | 853 | 1,375.0 |
| Arapahoe | 1,952 | 905 | 302 | 889 | 1,177.0 |
| Jefferson, Gilpin, Clear Creek | 2,323 | 970 | 409 | 864 | 1,694.0 |
| Denver | 3,811 | 751 | 493 | 1,367 | 1,840.0 |
| **Statewide** | **24,110** | **7,692** | **1,501** | **10,272** | **13,907** |

Source: Medicaid Paid Claims from MMIS-DSS. 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 a sum of the 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).

## B3b: FY 2007-08 Average Cost per Unduplicated Client Count for Home and Community Based Services (HCBS) Waiver Programs, Program of All-inclusive Care for the Elderly (PACE), Home Health and Nursing Facilities

| HIPAA Information Region | HCBS Waivers Administered by HCPF* | HCBS Waivers Administered by DHS** | Program of All-inclusive Care for the Elderly | Home Health | Nursing Facilities (Class I and Class II) |
|---|---|---|---|---|---|
| Garfield, Moffat, Rio Blanco | $4,040 | $45,064 | $0 | $3,227 | $36,946 |
| Eagle, Grand, Jackson, Pitkin, Routt, Summit | $3,104 | $35,502 | $0 | $3,929 | $40,509 |
| Mesa | $10,742 | $57,916 | $0 | $6,847 | $27,626 |
| Delta, Montrose, Ouray, San Miguel | $6,215 | $32,168 | $0 | $7,041 | $31,373 |
| Archuleta, Dolores, La Plata, Montezuma, San Juan | $5,949 | $33,774 | $0 | $12,215 | $30,363 |
| Gunnison, Chaffee, Lake, Fremont, Park, Custer | $8,030 | $32,270 | $0 | $7,119 | $30,862 |
| Hinsdale, Saguache, Mineral, Conejos, Rio Grande, Alamosa, Costilla | $5,166 | $37,173 | $0 | $2,755 | $30,368 |
| Huerfano, Las Animas, Baca, Otero, Crowley, Bent, Prowers, Kiowa | $6,347 | $29,325 | $0 | $6,577 | $31,589 |
| Pueblo | $8,016 | $44,334 | $0 | $11,686 | $30,437 |
| El Paso, Teller | $9,987 | $32,941 | $0 | $19,523 | $36,523 |
| Washington, Morgan, Logan, Yuma, Phillips, Sedgwick | $4,563 | $35,864 | $0 | $5,774 | $29,145 |
| Elbert, Lincoln, Kit Carson, Cheyenne | $6,415 | $19,634 | $0 | $3,408 | $37,954 |
| Douglas | $13,620 | $27,472 | $9,893 | $17,722 | $41,014 |
| Boulder, Broomfield | $7,261 | $38,456 | $23,084 | $10,841 | $33,563 |
| Larimer | $6,604 | $37,499 | $0 | $9,637 | $33,556 |
| Weld | $7,097 | $33,282 | $0 | $9,701 | $31,507 |
| Adams | $9,209 | $33,974 | $11,575,069 | $13,666 | $34,704 |
| Arapahoe | $11,309 | $36,245 | $9,362,281 | $13,673 | $34,915 |
| Jefferson, Gilpin, Clear Creek | $9,606 | $43,652 | $12,408,883 | $16,716 | $35,481 |
| Denver | $11,621 | $28,831 | $15,716,438 | $12,167 | $35,528 |
| **Statewide Average** | **$9,093** | **$38,212** | **$32,709** | **$12,512.62** | **$34,695** |

Source: Medicaid Paid Claims from MMIS-DSS. 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. 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 of multiple service categories, or may have received the same service in the same service category in one of multiple HIPAA Information Regions. *Department of Health Care Policy and Financing (HCPF) **Department of Human Services (DHS).

## B3c: FY 2003-04 FY 2007-08 Unduplicated Client Count By Dates of Service for Home and Community Based Services (HCBS) Waiver Programs, Home Health, Program of 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 | Children with Autism | Total HCPF |
|---|---|---|---|---|---|---|---|
| FY 2003-04 | 15,734 | 631 | 376 | 2,065 | 98 | 0 | **18,559** |
| FY 2004-05 | 14,833 | 618 | 322 | 1,844 | 66 | 0 | **17,407** |
| FY 2005-06 | 16,415 | 1,049 | 297 | 1,948 | 58 | 0 | **19,534** |
| FY 2006-07 | 17,019 | 1,254 | 306 | 2,160 | 62 | 17 | **20,553** |
| FY 2007-08 | 17,627 | 1,360 | 264 | 2,312 | 71 | 73 | **21,522** |

### 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 2003-04 | 214 | 3,113 | 3,958 | 226 | **7,364** | **25,923** |
| FY 2004-05 | 204 | 2,935 | 3,688 | 220 | **6,927** | **24,334** |
| FY 2005-06 | 191 | 3,092 | 3,690 | 375 | **7,212** | **26,746** |
| FY 2006-07 | 165 | 2,982 | 4,112 | 381 | **7,521** | **28,057** |
| FY 2007-08 | 149 | 3,057 | 4,207 | 430 | **7,692** | **31,683** |

## B3c: FY 2003-04 FY 2007-08 Unduplicated Client Count By Dates of Service for Home and Community Based Services (HCBS) Waiver Programs, Home Health, Program of All-inclusive Care for the Elderly (PACE), and Nursing Facilities (cont)

**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 2003-04 | 8,275 | 1,046 | 14,196 | 16 | **14,212** |
| FY 2004-05 | 8,687 | 1,187 | 13,919 | 17 | **13,936** |
| FY 2005-06 | 9,430 | 1,271 | 14,287 | 20 | **14,299** |
| FY 2006-07 | 10,161 | 1,376 | 14,045 | 21 | **14,066** |
| FY 2007-08 | 10,272 | 1,501 | 13,886 | 21 | **13,907** |

Source: Medicaid paid claims from MMIS-DSS. 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 2007-08 Top 10 Major Diagnostic Categories (Inpatient)
## Ranked by Expenditures

| Rank | MDC Code | Description | Expenditures | Unduplicated Client Count |
|---|---|---|---|---|
| 1 | 14 | Pregnancy, Childbirth and the Puerperium | $94,666,271 | 23,067 |
| 2 | 4 | Respiratory System | $27,235,360 | 4,316 |
| 3 | 15 | Conditions of Newborns | $24,860,403 | 2,899 |
| 4 | | Pre-MDC Other | $19,150,681 | 209 |
| 5 | 5 | Circulatory System | $18,777,480 | 1,409 |
| 6 | 6 | Digestive System | $16,295,494 | 2,146 |
| 7 | 8 | Musculoskeletal System and Connective Tissue | $15,898,841 | 1,487 |
| 8 | 1 | Nervous System | $13,335,188 | 1,401 |
| 9 | 11 | Kidney and Urinary Tract | $9,467,180 | 1,015 |
| 10 | 18 | Infectious & Parasitic Diseases | $7,865,031 | 807 |
| | | **Top Ten Total** | **$247,551,929** | **38,756** |

Source: Medicaid paid claims from MMIS-DSS. Notes: The diagnostic categories have changed compared to last year's. These diagnostic categories group the DRGs according to the major diagnostic categories (MDC), a recognized etyological classification in the public health field based on the ICD-9. 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 three 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 2007-08 Top 10 Inpatient Hospital Diagnosis Related Groups Ranked by Expenditures

| Rank | DRG | Description | Expenditures | Unduplicated Client Count |
|---|---|---|---|---|
| 1 | 373 | Vaginal Delivery without Complicating Diagnoses | $41,494,220 | 13,996 |
| 2 | 371 | Cesarean Section without Complicating Diagnoses | $17,580,230 | 3,045 |
| 3 | 370 | Cesarean Section with Complicating Diagnoses | $15,185,794 | 2,006 |
| 4 | 372 | Vaginal Delivery with Complicating Diagnoses | $10,500,711 | 2,717 |
| 5 | 541 | Tracheostomy with Mechanical Ventilator with Major Operating Room Procedure | $9,905,316 | 97 |
| 6 | 801 | Neonates < 1,000 Grams | $6,684,676 | 84 |
| 7 | 898 | Bronchitis and Asthma, Age < 17 with Complicating Diagnoses | $5,218,821 | 1,409 |
| 8 | 802 | Neonates, 1,000 - 1,499 Grams | $4,258,586 | 141 |
| 9 | 542 | Tracheostomy with Mechanical Ventilator without Major Operating Room Procedure | $4,052,197 | 66 |
| 10 | 803 | Neonates, 1500 - 1,999 Grams | $3,982,973 | 318 |
| | | **Top Ten Total** | **$118,863,523** | **23,879** |

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 three 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 2007-08 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 | $6,440,547 | 10,194 |
| 2 | 786 | Symptoms Involving Respiratory System and Other Chest Symptoms | $4,371,717 | 10,971 |
| 3 | 521 | Diseases of Hard Tissues of Teeth | $4,364,120 | 2,599 |
| 4 | 780 | General Symptoms | $3,843,225 | 11,548 |
| 5 | 585 | Chronic Renal Failure | $3,768,378 | 248 |
| 6 | 784 | Symptoms Involving Head and Neck | $2,170,975 | 4,708 |
| 7 | 787 | Symptoms Involving Digestive System | $2,098,188 | 8,499 |
| 8 | 648 | Other Current Conditions in the Mother Complicating Pregnancy, Childbirth, and the Puerperium | $2,089,978 | 6,385 |
| 9 | 474 | Chronic Disease of Tonsils and Adenoids | $1,893,970 | 1,681 |
| 10 | 724 | Other and Unspecified Disorders of Back | $1,824,141 | 4,785 |
| | | **Top Ten Total** | **$32,865,239** | **61,618** |

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 three 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 2007-08 Top 10 Outpatient Surgical Procedures Ranked by Expenditures

| Rank | Surgical Procedure Code | Description | Expenditures | Unduplicated Client Count |
|---|---|---|---|---|
| 1 | 23.41 | Application of crown | $1,914,915 | 781 |
| 2 | 23.2 | Restoration of tooth by filling | $836,054 | 335 |
| 3 | 28.3 | Tonsillectomy with adenoidectomy | $789,441 | 338 |
| 4 | 99.29 | Injection or infusion of other therapeutic or prophylactic substance | $710,713 | 926 |
| 5 | 66.29 | Other bilateral endoscopic destruction or occlusion of fallopian tubes | $522,783 | 373 |
| 6 | 89.17 | Polysomnogram | $521,272 | 335 |
| 7 | 20.01 | Myringotomy with insertion of tube | $448,158 | 278 |
| 8 | 93.54 | Application of splint | $396,017 | 1,444 |
| 9 | 51.23 | Laparoscopic cholecystectomy | $383,926 | 129 |
| 10 | 37.23 | Combined right and left heart cardiac catheterization | $373,972 | 45 |
| | | **Top Ten Total** | **$6,897,251** | **4,984** |

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 three 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 2007-08 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 | $12,006,874 | 46,216 |
| 2 | V72 | Special Investigations and Examinations | $7,350,927 | 25,118 |
| 3 | V22 | Normal Pregnancy | $5,018,277 | 6,527 |
| 4 | 465 | Acute Upper Respiratory Infections of Multiple or Unspecified Sites | $2,786,565 | 13,941 |
| 5 | 382 | Suppurative and Unspecified Otitis Media | $1,360,042 | 6,592 |
| 6 | 250 | Diabetes Mellitus | $826,624 | 2,156 |
| 7 | 780 | General Symptoms | $809,762 | 4,197 |
| 8 | 650 | Normal Delivery | $798,498 | 1,090 |
| 9 | V70 | General Medical Examination | $787,422 | 3,726 |
| 10 | 462 | Acute Pharyngitis | $759,368 | 4,467 |
| | | **Top Ten Total** | **$32,504,360** | **114,030** |

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 three 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 2007-08 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 | $603,359 | 3,395 |
| 2 | 465 | Acute Upper Respiratory Infections of Multiple or Unspecified Sites | $297,920 | 1,856 |
| 3 | 382 | Suppurative and Unspecified Otitis Media | $294,895 | 1,552 |
| 4 | V72 | Special Investigations and Examinations | $211,304 | 622 |
| 5 | V22 | Normal Pregnancy | $180,143 | 395 |
| 6 | 462 | Acute Pharyngitis | $119,016 | 1,015 |
| 7 | 466 | Acute Bronchitis and Bronchiolitis | $109,823 | 731 |
| 8 | 780 | General Symptoms | $105,098 | 802 |
| 9 | 034 | Streptococcal Sore Throat and Scarlet Fever | $104,202 | 578 |
| 10 | 461 | Acute Sinusitis | $103,583 | 856 |
| | | **Top Ten Total** | **$2,129,345** | **11,802** |

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 three 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 2007-08 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 | $10,146,172 | 75,408 |
| 2 | 650 | Normal Delivery | $7,793,890 | 11,868 |
| 3 | 780 | General Symptoms | $4,179,544 | 35,086 |
| 4 | 789 | Other Symptoms Involving Abdomen and Pelvis | $3,944,922 | 24,004 |
| 5 | 786 | Symptoms Involving Respiratory System and Other Chest Symptoms | $3,911,590 | 38,982 |
| 6 | V25 | Encounter For Contraceptive Management | $3,829,557 | 14,352 |
| 7 | 367 | Disorders of Refraction and Accommodation | $3,823,733 | 31,235 |
| 8 | V22 | Normal Pregnancy | $3,479,803 | 15,165 |
| 9 | 765 | Disorders Relating to Short Gestation and Unspecified Low Birthweight | $3,445,251 | 2,217 |
| 10 | 654 | Abnormality of Organs and Soft Tissues of Pelvis | $2,963,767 | 3,407 |
| | | **Top 10 Totals** | **$47,518,231** | **251,724** |

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 three 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.

## FY 2007-08 Top 10 Dental Procedures
## Ranked by Expenditures

| Rank | Procedure Code | Description | Expenditures | Unduplicated Client Count |
|---|---|---|---|---|
| 1 | D2930 | Prefab Stainless Steel Crown Primary | $4,365,214.77 | 16,104 |
| 2 | D8090 | Comprehen Ortho Adult Dentition | $3,693,886.25 | 1,195 |
| 3 | D1120 | Prophylaxis Child | $2,874,149.42 | 80,687 |
| 4 | D2391 | Resin Based Comp One Surface Posterior | $2,729,221.52 | 20,099 |
| 5 | D2140 | Amalgam One Surface Permanent | $2,131,794.82 | 19,751 |
| 6 | D7140 | Extraction Erupted Tooth/Exposed Root | $2,114,745.28 | 19,375 |
| 7 | D3220 | Therapeutic Pulpotomy | $1,897,790.31 | 12,539 |
| 8 | D2392 | Resin Based Comp Two Surfaces Posterior | $1,848,554.34 | 13,364 |
| 9 | D2150 | Amalgam Two Surfaces Permanent | $1,805,301.12 | 16,026 |
| 10 | D0120 | Periodic oral evaluation | $1,608,146.68 | 68,295 |
| | | **Top Ten Total** | **$25,068,804.51** | **267,435** |

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. Clients receiving dental services at a FQHC are not included in this analysis.

## B4i: FY 2007-08 Top 10 Laboratory Procedures Ranked by Expenditures

| Rank | Principal Diagnosis Group Number | Description | Expenditures | Unduplicated Client Count |
|---|---|---|---|---|
| 1 | 87491 | Chlamydia Tracholmatis, DNA, Amplified Probe Technique | $1,430,268 | 24,164 |
| 2 | 87591 | Neisseria Gonorrhea, DNA, Amplified Probe Technique | $1,375,182 | 23,422 |
| 3 | 80101 | Drug Screen, Single | $1,205,393 | 5,400 |
| 4 | 85025 | Complete Blood Count with Automated White Blood Cells Differentials | $1,024,400 | 58,105 |
| 5 | 80053 | Comprehensive Metabolic Panel | $788,600 | 34,486 |
| 6 | 84443 | Thyroid Stimulus Hormone | $739,776 | 26,132 |
| 7 | 87086 | Urine Culture / Colony Count | $449,928 | 29,668 |
| 8 | 80050 | General Health Panel | $444,323 | 8,572 |
| 9 | 80061 | Lipid Panel | $443,337 | 19,412 |
| 10 | 88305 | Tissue Exam by Pathologist | $437,258 | 6,925 |
| | | **Top 10 Totals** | **$8,338,465** | **236,286** |

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 three 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 2007-08 Top 10 Durable Medical Equipment and Supplies Procedures Ranked by Expenditures

| Rank | Principal Diagnosis Group Number | Description | Expenditures | Unduplicated Client Count |
|---|---|---|---|---|
| 1 | S8121 | Oxygen Contents Liquid, per Pound | $9,211,608 | 5,745 |
| 2 | E1390 | Oxygen Concentrator | $8,498,293 | 9,389 |
| 3 | B4160 | Enteral Formula for Pediatrics, Calorie Dense | $3,380,521 | 1,239 |
| 4 | E0434 | Portable Liquid Oxygen | $1,715,947 | 5,149 |
| 5 | T4527 | Adult Sized Disposable Incontinence Product | $1,541,503 | 2,226 |
| 6 | T4535 | Disposable Line / Shield / Pad for Incontinence | $1,402,485 | 3,880 |
| 7 | B4035 | Neteral Feeding Supply Pump per Day | $1,399,900 | 784 |
| 8 | A4253 | Blood Glucose Test or Reagent Strips, per 50 Strips | $1,309,209 | 5,202 |
| 9 | E0445 | Oximeter Non-Invasive | $1,276,193 | 1,254 |
| 10 | B4161 | Enteral Formula for Pediatrics, Hydrolyzed / Amino Acid | $1,272,949 | 288 |
| | | **Top 10 Totals** | **$31,008,608** | **35,156** |

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 three 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 2007-08 Top 10 Prescription Drugs
## Ranked by Expenditures

| Rank | Drug Name | Therapeutic Class | Expenditures | Unduplicated Client Count |
|---|---|---|---|---|
| 1 | Seroquel | Antipsychotic | $10,097,265 | 4,896 |
| 2 | Abilify | Antipsychotic | $9,301,054 | 3,494 |
| 3 | Synagis | Monoclonal Antibody (prevention/treatment of respiratory virus in infants) | $9,200,292 | 830 |
| 4 | Risperdal | Antipsychotic | $7,514,525 | 4,104 |
| 5 | Zyprexa | Antipsychotic | $5,931,861 | 1,687 |
| 6 | Lamictal | Anti-Convulsant | $4,737,403 | 2,488 |
| 7 | Depakote | Anti-Convulsant | $4,188,172 | 3,565 |
| 8 | Topamax | Anti-Convulsant | $4,002,509 | 2,493 |
| 9 | Advair | Bronchodilator and Corticosteroid | $3,680,523 | 6,153 |
| 10 | Oxycodone | Analgesic | $3,578,185 | 20,845 |
| | | **Top Ten Total** | **$62,231,790** | **50,555** |

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 three 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 2007-08 Top 10 Prescription Drugs Ranked by Number of Prescriptions Filled

| Rank | Drug Name | Therapeutic Class | Total Prescriptions Filled | Expenditures |
|---|---|---|---|---|
| 1 | Hydrocodone | Analgesic | 99,270 | $1,168,731 |
| 2 | Amoxicillin | Antibiotic | 84,396 | $788,216 |
| 3 | Oxycodone | Analgesic | 72,974 | $3,578,185 |
| 4 | Azithromycin | Antibiotic | 45,974 | $1,468,426 |
| 5 | Lorazepam | Anti-Anxiety Drug (benzodiazepine) | 44,536 | $1,154,163 |
| 6 | Albuterol | Bronchodilator | 40,243 | $818,956 |
| 7 | Lisinopril | Hypotensive (angiotensin converting enzyme inhibitor) | 37,710 | $714,348 |
| 8 | Proair | Bronchodilator | 36,286 | $1,212,405 |
| 9 | Clonazepam | Anti-Convulsant | 36,065 | $706,729 |
| 10 | Levothyroxine | Thyroid Hormone (to treat hypothyroidism) | 34,575 | $312,866 |
| | | **Top Ten Total** | **532,029** | **$11,923,024** |

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and prescriptions filled 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 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.