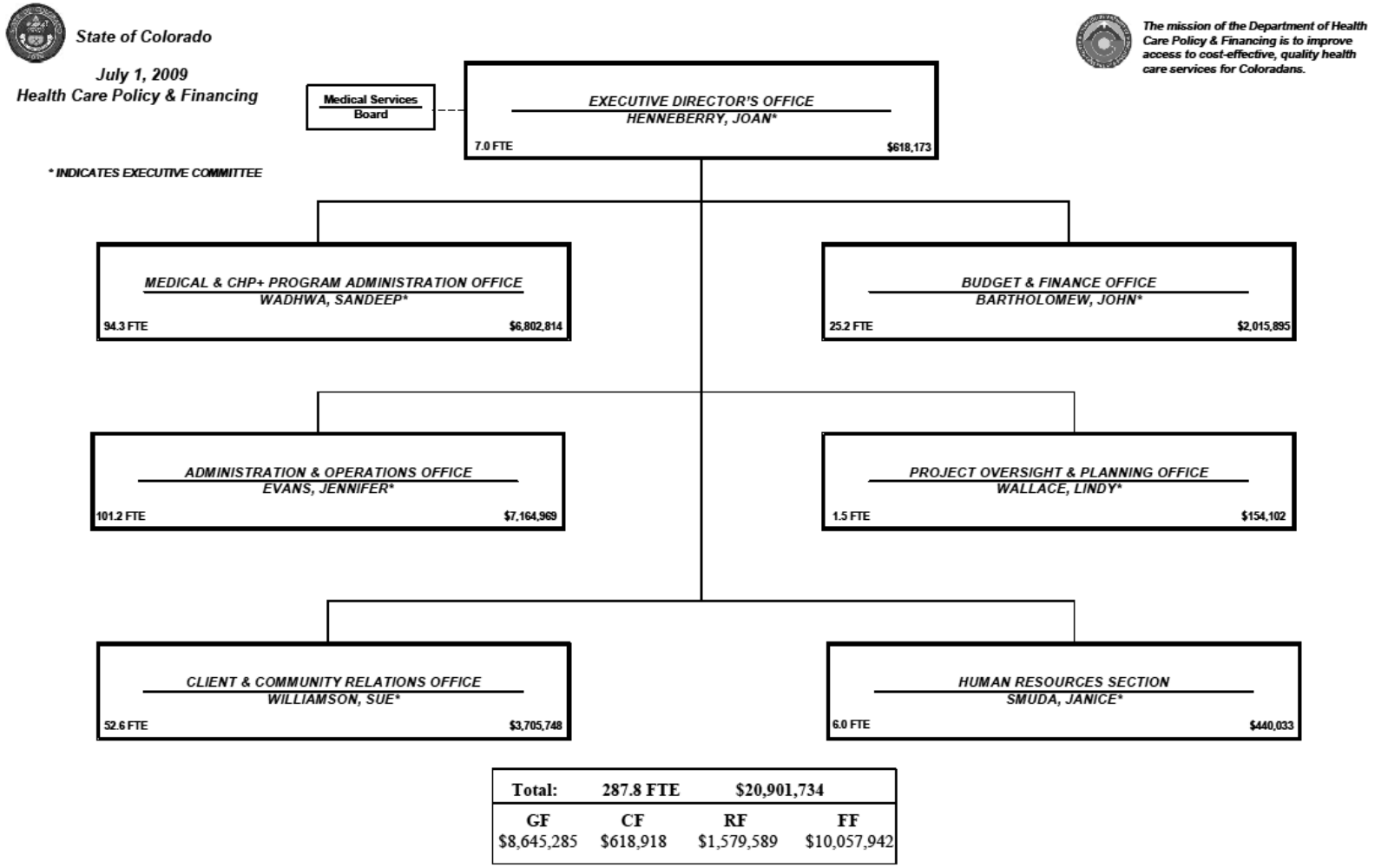
Department of Health Care Policy and Financing
Department Description
FY 2010-11 Budget Request

November 6, 2009

TABLE OF CONTENTS

I. ORGANIZATIONAL CHART



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 health care 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 11 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.

The Department is committed to providing accurate, understandable and consistent information to the public, clients, providers, legislators, internal staff, and advocates. As such, the Department's Public Information Officer resides within the Office of the Executive Director. The Public Information Officer ensures that accurate communication is provided timely and in a consistent manner. Communication is conducted through the Department's Web site, client correspondence, brochures, program newsletters and e-mail blasts. All materials are reviewed to ensure that communication is effective and easy to read. The Public Information Officer works closely with the Governor's and Lieutenant Governor's Office in coordinating messages to the media.

Medical and Child Health Plan *Plus* Program Administration Office

This office designs, implements, and administers Medicaid and the Children's Basic Health Plan. The office aims to improve the health status of all clients and promote effective partnerships with providers and contractors to achieve improved health and functioning of clients. The office recognizes the diversity of geography, age, culture, ethnicity, psychosocial needs, income, and health amongst its clients and aims to deliver high quality, client-centered services.

The Medicaid Program Division is responsible for the administration and performance of Medicaid fee-for-service and managed care services and programs. The Medicaid Program Division seeks to maximize the health, functioning, and self-sufficiency of all Medicaid clients affordably. The services and programs include both physical health and behavioral health benefits. Staff within the division are responsible for provider outreach, policy development, contract management, operations management and overall Medicaid program performance. The division plays an important role in working toward the Department's mission to improve access to cost-effective, quality health care services for Coloradans. The division plays a key role in Medicaid Reform activities.

The Long Term Care Benefits Division oversees Medicaid funded community-based services and nursing facilities. The division has a particular focus on affordably maximizing the health, functioning and self-sufficiency of clients in long-term care institutional or community settings. The clients utilizing these services have complex health care needs requiring coordinated and high quality services. Community-based services are those services provided in clients' homes as an alternative to placement in a nursing facility or other institutional setting. These community-based services provide support for clients to remain at home and in the community, allowing for individual choice. This division oversees all Medicaid home and community-based services waiver programs and skilled services such as home health care, private duty nursing, and hospice care that are available through the Medicaid State Plan. The division is also responsible for managing consumer directed attendant support services which allow qualifying individual clients to direct their own in-home care.

The Children's Basic Health Plan provides basic health insurance coverage for uninsured children and pregnant women of low-income families. The CHP+ Division, which administers The Children's Basic Health Plan, focuses on promoting the health and functioning of children and their mothers affordably. 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 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 Discount Resource Web site (discount drug information 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 aims to simultaneously address underutilization, overutilization, and inappropriate utilization of pharmaceuticals. 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 Health Outcomes and Quality Management Unit is responsible for directing, conducting, and coordinating performance improvement activities for the care and services Medicaid and Children's Basic Health Plan clients receive. The unit works across programs, offices, and divisions to promote effectiveness and efficiency initiatives that support the Department's mission. Specific functions of the unit include:

- process and outcome measurement and improvement;
- managing the external quality review of physical and behavioral managed care contractors and fee-for-service providers;
- monitoring managed care plan contract compliance;
- overseeing external review organization administration of satisfaction surveys to clients enrolled in managed care as well as clients enrolled in the Children's Basic Health Plan;
- development of long-term care quality tools and interagency quality collaborations; and
- development and implementation of quality strategies and consulting to program managers regarding performance measurement and improvement.

The Rates Section develops rate-setting methodology and implements managed care rates for health maintenance organizations, behavioral health organizations, and the Program of All Inclusive Care for the Elderly providers. The section also monitors and updates rates paid for home and community-based services. 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 this 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 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 section 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. Section staff participate in corrective action meetings, disciplinary hearings, and any appeals related to the results of those functions. The Human Resources Section staff is now trained in mediation and provides a full range of resources designed to reduce and resolve disputes within the Department.

The Human Resources Section is also responsible for the development and implementation of internal training for all Department employees. This includes career development, management enhancement, and employee assessment. The Human Resources Section is responsible for training all Department staff on Executive Orders that require training on topics such as sexual harassment, violence in the workplace, and maintaining a respectful workplace. The section provides external tracking of all trainings associated with performance measures and allocates funding for career development seminars.

Administration and Operations Office

The Administration and Operations Office includes the Legal, the Medicaid Management Information Systems, Information Technology, and Controller Divisions. The office also has the following sections: Benefits Coordination, Program Integrity, Contracts and Monitoring, Claims Systems, Accounting, Information Technology Support, Eligibility Systems, Audits, and Contracts and Purchasing. 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 is responsible for handling privacy and Health Insurance Portability and Accountability Act training and compliance. The division also acts as records custodian and coordinates Colorado Open Records Act requests. Other responsibilities of the division include:

- managing and coordinating external data requests through the Department's data review board;
- managing the Department's privacy database;
- managing the Department's State Plan and drafting amendments to the State Plan;
- providing assistance in drafting rules;
- coordinating Department rules and Department guidance to avoid conflicts of authority;
- coordinating the Department's relationship with the Attorney General's office; and
- providing analysis and guidance to Department personnel on various regulatory and legal issues.

The Legal Division includes the Benefits Coordination and Program Integrity Sections. The mission of the Benefits Coordination Section is to ensure Medicaid is the payer of last resort, extending 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. The sources the Benefits Coordination Section pursues include trusts, estate recoveries, and recovery of 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. Section 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 in coordination with the Attorney General's Medicaid Fraud Control Unit.

The Claims Systems and Operations Division (CSO Division) includes the Contracts and Monitoring Section (IT CONMON Section) and the Claims Systems Section. The IT CONMON Section manages the Department's Information Technology (IT) contracts and agreements, monitors IT vendors for contractual compliance, and provides IT vendor operational oversight. The section drafts and negotiates contracts and monitors contract performance as well as federal oversight of IT contracts. The primary IT contracts that the section manages and monitors are the Medicaid Management Information System (MMIS) and the Colorado Benefits Management System (CBMS) contracts, which are multi-year, multi-million-dollar contracts. The section also manages the budgets for both systems. Management of the systems' budgets includes building in changes to the system to reflect changes needed to implement legislation or shifts in policy direction.

Section staff also provide oversight of all operational aspects of the MMIS contract. This includes, but is not limited to, oversight of provider enrollment and claims processing. Claims processing responsibilities include management of claim edits, prior authorizations, claim reconsiderations financial transactions and mass adjustments. The section is also responsible for provider call center functions and provider communication. Responsibilities regarding provider communication include:

- facilitating provider training;
- preparing training materials;
- updating and maintaining billing manuals;
- maintaining provider services Web pages;
- ensuring a secured provider Web portal; and
- preparing the provider bulletin.

In addition, section staff are responsible for addressing escalated billing and provider enrollment issues that require state approval. Section staff also handle provider appeals that are filed with the office of administrative courts. The section works closely with the Claims Systems Section, Department policy staff, programmers, and business analysts at the fiscal agent to ensure the claims systems accurately pay for approved services to eligible clients by enrolled providers. The section provides quality assurance for written transmittals to the MMIS vendor and conducts claims payment audits through claims processing assessment system studies. The section is responsible for ensuring operational compliance and strategic planning to achieve required Health Insurance Portability and Accountability Act transaction standards for covered entities.

The IT CONMON Section manages contracts for the production and issuance of medical identification cards, interagency agreements, the provider-secured Web portal, and data use agreements between the Department and other state and federal organizations. Lastly, the section manages external audit coordination for the CSO Division as well as for the Information Technology Division.

The Claims Systems Section ensures timely and accurate Medicaid and Children's Basic Health Plan claims processing and reporting. Section staff are responsible for directing the systems maintenance and enhancement of the MMIS by working closely with the systems staff of the fiscal agent, ACS Government Solutions. Section staff work with Department policy staff to gather requirements for the maintenance or enhancement of the MMIS by developing requirements documentation, reviewing and approving detail system design approaches, ensuring appropriate testing of changes, and by reviewing and approving all test outputs. Further, they propose IT solutions to program staff and implement those solutions to support Department policies. The division works with policy staff at the

Department and its sister agencies as well as programmers and business analysts at the fiscal agent to ensure the MMIS accurately pays for approved services to eligible clients by enrolled providers.

In addition to supporting the MMIS, the Claims Systems Section directs the claims system programs through maintenance and enhancement efforts on the following systems:

- the decision support system, housed at the fiscal agent site, that provides predefined and ad-hoc reporting capability to Department program managers, contractors, and multiple state agencies; and
- the provider Web portal, operated by a separate vendor, which allows providers to submit claims, search for eligibility verifications, and retrieve files and reports.

The Claims Systems Section also manages several data interfaces, including data communications between CBMS and MMIS. For example, there are daily and monthly interface files with client eligibility and enrollment data sent to the MMIS from CBMS. Another major interface partner is the Colorado Financial Reporting System. In addition, there are weekly interfaces of data for payments (warrants and electronic funds transfers) to providers. This section is also responsible for assuring that medical identification card interfaces are sent to the designated vendor on a daily basis. Finally, this section ensures systems compliance and strategic planning to achieve required Health Insurance Portability and Accountability Act transaction and code set standards for the Department as a covered entity.

The Information Technology Division within the Administrations and Operations Office began reporting to the Governor's Office of Information Technology effective July 1, 2009. Division staff work closely with the CSO Division and Department policy staff to support and advance the Department's Information Technology objectives. Responsibilities of this division include providing Information Technology security and technical support for clients and Department staff. Further, this division ensures the accurate determination of eligibility for medical programs as well as timely interface with downstream applications such as the MMIS. The Information Technology Division implements policies governing the administration of Medicaid and the Children's Basic Health Plan using computerized systems, such as the MMIS and the CBMS in coordination with Department staff and the Department of Human Services and the Governor's Office of Information Technology.

The Controller's Division oversees the accounting functions of the Department. The division ensures the proper recording and reporting of revenues and that expenditures in the Department are in compliance with generally accepted accounting principles and state and federal rules and regulations.

The Audits Section consolidates many of the auditing functions throughout the Department. The Audits Section assists the Department in continuously improving 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.

The Contracts and Purchasing Section provides support for all aspects of procurement for the Department and ensures compliance with state procurement statutes and rules. Staff determine the optimum method of procurement, which may include requests for proposals, invitations for bids, documented quotes, or discretionary purchases. The section also manages the solicitation process, including developing and publishing solicitations, overseeing the evaluation of bids, proposals, or quotes received in response to solicitations. The section issues award notices and acts as a liaison with a variety of external public purchasing entities. The section also reviews departmental contracts for compliance with state rules, regulations, and contracting standards and processes. Section staff are responsible for tracking and maintaining all contracting and purchasing records. The section provides advice and guidance to Department staff on contract management issues by providing the following:

- assistance in the analysis of issues;
- options for issue resolution;
- assistance in the pursuit of contract remedies; and
- training.

Project Oversight and Planning Office

The Project Oversight and Planning Office is responsible for ensuring the highest level of success possible on projects throughout the Department. The office staff facilitate the development of project plans for the effective and timely implementation of each major project for which the Department has responsibility. The office staff also provide assistance in identifying necessary resources, developing work plans, providing guidance to the project manager and the team, and completing any other tasks to meet the objectives and goals of a project. The office is also responsible for facilitating the development of the implementation plan for legislation and then tracking the Department's implementation of that legislation. This office is responsible for facilitating the annual Operational Plan process and working with staff to develop the Department's five-year strategic plan.

The office also supports health care reform projects by conducting research and providing staff support for implementation work groups. The health care reform projects are conducted in close contact with the Governor's office. The office has the responsibility of providing oversight of the bi-annual Colorado Household Survey. This survey is a statewide survey of 10,000 households asking questions about insurance coverage, access to care, and usual sources of care. This information is used by the Department, the Governor's Office, other agencies, partners, providers, and foundations to inform decisions about policy and program development.

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 Notes 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, the Old Age Pension State Medical Program, the School Health Services Program, and the Primary Care Fund.

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 statistical forecasting of caseload and premiums, requests for additional funding, and recommendations for reduced funding. 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 Budget Division also tracks relevant legislation as it moves through the General Assembly and prepares fiscal impact statements for proposed legislation and ballot initiatives that may affect the Department. This division is also responsible for federal reporting as well as coordinating with the Department of Human Services on budgetary issues that affect both departments.

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 are not eligible for benefits under either 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. 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.

The School Health Services Program provides reimbursement to qualified school districts that provide health services to children enrolled in Medicaid. In order to qualify, districts or their corresponding Boards of Cooperative Educational Services (BOCES) must submit a Local Services Plan that outlines the services that the district, the community, and the BOCES would like to provide. Once a plan has been approved, the Department reimburses the district upon receipt of claims for services provided to children enrolled in Medicaid.

The Primary Care Fund, which is funded by taxes on tobacco products, provides an allocation of moneys to health care providers that qualify under a specific set of criteria. These providers must provide basic health care services in an outpatient setting to residents of Colorado who are considered medically indigent. Moneys are allocated based on the number of medically indigent patients served by one health care provider in an amount proportionate to the total number of medically indigent patients served by all health care providers who qualify for moneys from this fund.

The division is also tasked with working closely with the Centers for Medicare and Medicaid Services to ensure that the Department is maximizing federal Medicaid revenue. In addition, the division strives to maximize available federal funding for hospital and clinic providers who participate in Medicaid and the Colorado Indigent Care Program.

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 Unit, 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 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.

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 its statistical 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 the Department's programs.

In coordination with the Department's Public Information Officer, the office provides information to the Department's clients and other stakeholders. The 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.

III. PRIOR YEAR LEGISLATION

The following is a summary of major legislation enacted in 2009.

HB 09-1020 (Acree, Spence) Expedited Reenrollment Processes of Medical Programs
This bill requires the Department to establish a process to allow for reenrollment in Medicaid and the Children's Basic Health Plan via telephone and the Internet. This bill is to augment the Department's current efforts underway to simplify the eligibility determinations process. The bill allows the Department to implement a pilot program that allows a limited number of individuals to apply for reenrollment, but the pilot program is not meant to serve as a replacement for a statewide process. The bill requires the Department not implement the pilot program until spending authority has been received through either the general appropriation act or any supplemental appropriation.

HB 09-1047 (Todd, Williams) Alternative Therapies for Persons with Disabilities
This bill authorizes the Department to implement a pilot program that would allow an eligible person with a spinal cord injury to receive alternative therapies such as chiropractic care, massage therapy, or acupuncture. The bill requires the Department to design the program with input from an advisory committee that shall include individuals with spinal cord injuries receiving alternative therapies. The Department is not required to seek federal approval or implement the program unless sufficient moneys are received from the general fund or gifts, grants, or donations.

HB 09-1073 (Massey, Boyd) Electronic Prescriptions
Contingent upon the receipt of sufficient gifts, grants or donations, this bill requires the Department to contract with a nonprofit for a study on the feasibility of using electronic prescriptions (e-prescriptions) technology for Colorado Medicaid. The study is to conclude before June 30, 2010, and result in a report to be given to the Health and Human Services committees of the Colorado General Assembly. The report will address various items including whether savings could be realized across Medicaid through the use of e-prescriptions; how to ensure that clients' health or access to prescriptions drugs will not be negatively impacted with the use of e-prescriptions; if federal law would permit incentives for the use of e-prescriptions; and if any additional legislation is required for the use of e-prescriptions.

HB 09-1103 (Reisberg, Newell) Presumptive Eligibility for Long-Term Care
This bill allows the Department to seek federal approval to implement a pilot program so that an individual applying for long-term care services may be presumptively eligible for Medicaid. This bill requires that if a person is later determined ineligible, the

Department shall not pursue any recoveries from the county departments of social/human services for the cost of medical services provided or any federal sanctions as a result of the client being determined ineligible.

HB 09-1164 (Primavera, Kester) Breast and Cervical Cancer Prevention and Treatment Program Expansion
This bill adds a $25 surcharge to the cost of new or replacement breast cancer awareness special license plates. The surcharge is to be used to pay for the costs to expand eligibility for the Breast and Cervical Cancer Prevention and Treatment program under Medicaid. Implementation of the eligibility expansion is contingent upon receipt of funds sufficient to sustain the projected number of additional individuals who would become eligible for the program due to this bill.

HB 09-1191 (McCann, Boyd) Liens Against Claims
This bill brings Colorado statute into compliance with federal law and allows the Department to be consistent in its current recovery practice policy in light of the United States Supreme Court decision for Arkansas Department of Health and Human Services v. Ahlborn ("Ahlborn"). The Ahlborn decision only allows states to have a lien on the medical portion of the judgment, award, or settlement. By making this statute consistent with the federal Ahlborn decision, the Department will minimize the potential for its recovery statute to be challenged as contrary to federal law.

HB 09-1196 (Gerou, Boyd) Nursing Facility Penalty Cash Fund
This bill requires the Department to distribute funds from the Nursing Facility Penalty Cash Fund for measures that will benefit residents of nursing facilities by improving their quality of life by promoting culture change in nursing facilities. The funding would be used for training; consumer education; newsletter production; web site development and maintenance; and other consultation. This bill creates a Nursing Facility Culture Change Accountability Board within the Department to make recommendations regarding the distribution of funds for the use of promoting culture change within nursing facilities. This bill also requires the Department to submit a report detailing the amount of moneys expended for culture change, the recipients of the funds, and the effectiveness of the funds.

HB 09-1293 (Reisberg and Ferrandino, Keller and Boyd) Colorado Health Care Affordability Act
This bill allows the Department to charge a provider fee to hospitals in order to fund the following public program enhancements:

- increasing hospital reimbursement rates for Medicaid inpatient and outpatient care to the upper payment limit;
- increasing hospital reimbursement rates through the Colorado Indigent Care Program to 100% of cost;
- increasing coverage for parents with incomes of up to 100% of the federal poverty level through Medicaid;
- increasing coverage in the Children's Basic Health Plan up to 250% of the federal poverty level;
- initiating coverage for adults without dependent children with incomes up to 100% of the federal poverty level through Medicaid;

- creating a Medicaid buy-in program for individuals with disabilities whose family incomes are too high for Medicaid eligibility but are under 450% of the federal poverty level; and
- implementing continuous eligibility for Medicaid children to reduce administrative burdens on Colorado families and keep eligible kids covered on a continuing basis.

The Department will request federal matching funds for this fee from the Centers for Medicare and Medicaid Services. 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, 2010.

HB 09-1353 (Miklosi, Foster) Eligibility for Pregnant Legal Immigrants
Contingent upon sufficient appropriations and federal financial participation, this bill allows the Department to provide benefits under Medicaid and the Children's Basic Health Plan to pregnant women and children who are qualified legal immigrants prior to the five year waiting period following their entry into the United States.

SB 09-132 (Boyd, Kerr J.) Modify Colorado Cares Rx
This bill modified the Colorado Cares Rx Act and requires the Department to provide information regarding discounted prescription drug programs to the public, including ways to obtain discounted or generic drugs and necessary contact information. Since January 1, 2008, the Department has utilized a mail-order discount prescription program for the Colorado Cares Rx program and provided information about the program through the Colorado Cares Rx Web site, ColoradoCaresRx.com. In addition, the Department promoted the program through press releases in news media, and through outreach to counties, rural health centers, school-based health centers and through various newsletters and bulletins. This bill also requires the Department to continue to research cost-effective programs or mechanisms by which low-income, uninsured individuals may purchase lower-cost prescription drugs.

SB 09-211 (Keller, Ferrandino) Eliminate CHP+ Eligibility Expansion
This bill eliminates the Children's Basic Health Plan eligibility expansion to 225% of the federal poverty level authorized by SB 08-160. Colorado House Bill 09-1293, Colorado Health Care Affordability Act, authorizes an eligibility expansion for the Children's Basic Health Plan up to 250% of the federal poverty level.

SB 09-252 (Boyd, Frangas) Medicaid Mail Order Prescriptions
This bill modifies SB 08-090 which allowed recipients to obtain medications through mail order if their third-party insurance required mail order. This bill changes the requirement to third-party insurers that allow rather than require medications to be obtained through mail order. The Department anticipates there will be a minimal number of new clients utilizing mail order due to this bill.

SB 09-263 (White, Pommer) Payments to Medicaid Nursing Facility Providers
This bill modifies the nursing facility provider fee authorized by HB 08-1114. The bill allows payments to nursing facility providers from the provider fee be paid through supplemental payments rather than increases in per diem rates. The bill also limits increases in the cost of direct and indirect health care services and raw food to a maximum of 8% per year. The bill also establishes the priorities for revenue generated by the provider fee should the fees collected be insufficient to cover all expenses.

IV. HOT ISSUES

FY 2009-10 Budget Reductions

Budgetary, provider, and client impacts

Significant increases in Colorado's unemployment rate led to substantial increases in Medicaid caseload in FY 2008-09. These increases in caseload are projected to continue during FY 2009-10. Coupled with the current economic situation, the Department has had to meet this increased need with resources that are increasingly limited. In response to declining state revenue, the Department proposed and implemented several budget reduction ideas for FY 2009-10 in an attempt to reduce costs while minimizing the impact of the reductions on clients and providers. The reductions authorized in SB 09-259, the FY 2009-10 Long Bill, resulted in a total reduction to the Department's Medical Services Premiums of $54,027,098 for FY 2009-10. A summary of these reductions is shown below.

MEDICAL SERVICES PREMIUMS **Estimated Impact on FY 2009-10 Expenditures**		
JBC Actions: Utilization and Provider Rate Reductions	**Effective Date**	**Total Funds**
Reduce Selected Physician Codes Below 100% of Medicare Rate	July 2009	($5,432,902)
Reduce Pharmacy Reimbursement	January 2010	($4,051,443)
Enroll Eligible Veterans in VA Health Care System	July 2009	($10,826,952)
Add Prior Authorization/PDL Requirements for Anti-Convulsants	July 2009	($960,000)
HCBS Cost Sharing for High Income Families	July 2009	($22,383)
Correct Home Health Billing for Dual Eligibles	July 2009	($500,000)
Restrict Inpatient Hospital Claims for Readmissions within 24 Hours	July 2009	($1,400,000)
2% Provider Rate Reductions	July 2009	($30,833,418)
Total		**($54,027,098)**

The majority of the reductions for FY 2009-10 as authorized by SB 09-259 come in the form of 2% reductions to provider rate reimbursements, which the Department spread over its acute care, community-based long-term care, and other service categories. A breakdown of the estimated savings by service category is shown below.

2% Provider Rate Reductions by Service Category	
ACUTE CARE	
Physician Services & EPSDT	($5,166,634)
Emergency Transportation	($123,310)
Non-emergency Medical Transportation	($176,856)
Dental Services	($1,232,420)
Inpatient Hospitals	($8,695,773)
Outpatient Hospitals	($3,527,966)
Lab & X-Ray	($617,139)
Durable Medical Equipment	($2,054,471)
Home Health	($2,966,267)
COMMUNITY-BASED LONG-TERM CARE	
HCBS - Elderly, Blind, and Disabled	($3,150,190)
HCBS - Mental Illness	($455,245)
HCBS - Disabled Children	($30,198)
HCBS - Persons Living with AIDS	($13,281)
HCBS - Consumer Directed Attendant Support	($314,721)
HCBS - Brain Injury	($240,574)
HCBS - Children with Autism	($15,515)
Private Duty Nursing	($440,509)
OTHER	
Single Entry Points	($505,223)
HMO Impact	($1,107,125)
Total	**($30,833,418)**

The Department received additional authority from the General Assembly to seek appropriate utilization and volume reductions in order to mitigate rate cuts; therefore, the Department has not implemented across-the-board rate cuts. In determining how best to

implement this 2% reduction while minimizing the impact on clients and providers, the Department took a collaborative approach with stakeholders. The Department consulted with external stakeholders in the community, including clients, providers, and policy makers to identify current inefficiencies that could be quickly remedied and would have a significant impact on the budget. Stakeholders shared a number of constructive suggestions and benefits, and policy specialists at the Department reviewed these suggestions for plausibility and impact on clients. As a result of this collaborative process, the Department developed a cost reduction plan which includes targeted reductions to specific provider rates, eliminating redundant or medically unnecessary services and benefits, and investigating potential sources of fraud.

At the time of this update, the Department has not yet evaluated the actual impact these reductions have had on clients. However, the Department strongly believes that the proposed strategies represent the least harmful manner to achieve the required reductions for both clients and providers. Over the past few years the Department has worked hard to increase reimbursement rates for providers. Because the Department was given the flexibility to achieve the budget reduction targets through utilization and volume reductions versus across the board rate cuts, the Department anticipates that the proposal will have a lesser impact on clients, particularly related to access to care. Targeting utilization and volume reductions is anticipated to have minimal negative impact on clients and their quality of care. The Department seeks to encourage efficiency by providing only necessary care and eliminating duplication. This strategy aligns well with the Medicaid Benefit Package Reform initiative in that it allows the Department to evaluate benefits in terms of quality, medical necessity and efficiency. As FY 2009-10 progresses, the Department will continue to communicate with external stakeholders to determine the impact and efficacy of these budget reductions on both clients and providers.

Personal Services Reductions

Governor Bill Ritter signed SB 09-259, the FY 2009-10 Long Bill, into law on Friday May 1, 2009 which authorizes funding for the operation of the Colorado State Government. In addition to the reductions to provider rates and other cuts, this bill mandates a 1.82% personal services, or payroll, reduction for all departments in order to balance the state's budget. As a part of this reduction, the Governor's office is requiring state employees to take four, and possibly six more, furlough days in FY 2009-10. Employees exempt from overtime will be converted to non-exempt employees during all weeks they take furloughs, and their hours will be monitored to ensure that they do not work extra to compensate for the anticipated furlough.

The Department and its staff are committed to fulfilling the Department's mission of providing cost-effective, quality health care services for Coloradans; and to executing the Department's responsibilities in the most effective and efficient manner possible. To accomplish these goals in conjunction with the reduction of its personal services budget, the Department must, and has, taken steps to work internally and with stakeholders in FY 2009-10 to carefully prioritize its responsibilities. Since staff at the Department will not

be able to complete the same amount of work as a result of the furloughs, difficult decisions have been necessary. Of all the groups to be impacted by furlough days, the Department is committed to ensuring that its clients are the least affected. Consequently, the Department anticipates it may be necessary to request extensions of some of its deadlines for various projects and initiatives as staff work to reprioritize tasks.

Department staff spend many hours of their work days generating savings through recoveries, cooperation with providers, cost avoidance activities, and contract management. As a result, there are many intangible effects resulting from the personal services reductions that cannot be quantified or for which the Department can neither plan for nor avoid. Keeping this in mind, below is a list of Department functions at risk due to the personal services reductions:

- decreased recoveries estimated at $184,615 for Program Integrity;
- decreased recoveries and cost avoidance estimated at $218,900 for Benefits Coordination;
- increased statutory violations of state fiscal statutes;
- periodic delays in responding to provider calls;
- delays in scheduling meetings with stakeholders;
- potential delays in contractual payments made via requisitions;
- reduced oversight of staff work by supervisors, resulting in reduced productivity and communication about work responsibilities;
- delays in contract execution;
- delays in budget estimates, forecasts, and fiscal notes;
- delays in responses to legislative requests for information;
- delays in transmittals, transmittal follow-ups, and provider claim submissions; and
- delays in vendor payments.

Legislative Requests for Information

Included in the list of functions at risk due to the personal services reductions are responses to legislative requests for information as a part of the Long Bill Narrative. In addition to the overall effects the personal services reductions will have on staff output, the Department anticipates that the speed with which it responds to legislative requests for information may be reduced. The Department is responsible for responding to 11 legislative requests for information in FY 2009-10. The requests range from monthly Medicaid expenditure and caseload reports to information on implementation on specified legislation. The Department anticipates that it will take a total of 312 staff hours to respond to all of the requests, or an average of 28 staff hours per request. The Department assumes that it won't have enough staff resources to respond in a timely manner to all of the requests. As such, the Department anticipates that

some requests will be submitted late as staff at the Department maintain focus on either their primary job responsibilities or client-related tasks that align closely with the Department's core responsibilities.

American Recovery and Reinvestment Act of 2009

On February 17, 2009 President Obama signed the American Recovery and Reinvestment Act of 2009 (ARRA) into law, an economic stimulus package of $787 billion designed to combat the effects of the global economic downturn. As part of this act, the Department became eligible to receive temporarily enhanced federal funding for Medicaid medical assistance payments and a temporarily increased disproportionate share hospital allotment. The Department also has the opportunity to seek new funding through a variety of new grant opportunities including funding for Health Information Technology, all of which are discussed below.

Enhanced Federal Medical Assistance Payment Rates

As a result of ARRA, the Department is eligible to receive federal medical assistance payment (FMAP) increases. The enhanced FMAP received is dependent upon the unemployment levels within Colorado as identified by the federal Bureau of Labor Statistics. Based on the current unemployment rate, the Department anticipates the following enhanced match rates by quarter from October 1, 2008 through December 31, 2010. If Colorado's average unemployment rate falls below 7.1% for a three-month period, the FMAP percentage may fall, beginning July 1, 2010; however, due to a hold-harmless provision in ARRA, the Department cannot receive a lower FMAP in FY 2009-10.

Quarter	Enhanced FMAP Rate	Unemployment Tier
10/1/2008 - 12/31/2008	58.78%	Tier 1
1/1/2009 - 3/31/2009	58.78%	Tier 1
4/1/2009 - 6/30/2009	61.59%	Tier 3
7/1/2009 - 9/30/2009	61.59%	Tier 3
10/1/2009 - 12/31/2009	61.59%	Tier 3
1/1/2010 - 3/31/2010	61.59%	Tier 3
4/1/2010 - 6/30/2010	61.59%	Tier 3
7/1/2010 - 9/30/2010	61.59%	Tier 3
10/1/2010 - 12/31/2010	61.59%	Tier 3

In order to claim the additional FMAP, the state of Colorado must attest to meeting five requirements. These attestations include:

1) The State is eligible for the increased FMAP because the State is applying Medicaid eligibility standards, methodologies and procedures that are no more restrictive than those in effect under the State Plan (or any waiver or demonstration project) on July 1, 2008. If the State is currently ineligible because it does not meet this condition, the State may be retroactively eligible if it reinstates the former standards, methodologies and procedures prior to July 1, 2009 (Section 5001(f)(1) of ARRA).
2) The State is eligible for the increased FMAP because no amounts attributable (directly or indirectly) to such increased FMAP are deposited or credited to any reserve or rainy day fund of the State (Section 5001(f)(3) of ARRA).
3) The State is eligible for the increased FMAP because it does not require political subdivisions within the State to contribute for quarters beginning October 1, 2008 and ending December 2010, a greater percentage of the non-federal share of such expenditures than the respective percentage that would have been required under the State Medicaid plan on September 30, 2008 (Section 5001(g)(2) of ARRA).
4) The expenditures for which the State draws funds are of a type that would be eligible expenditures. Ineligible expenditures include: expenditures for disproportionate share hospital (DSH) payments; expenditures that are claimed based on the enhanced FMAP (for example, the Children's Basic Health Plan and the Breast and Cervical Cancer Treatment Program); expenditures that are not paid based on the FMAP, such as expenditures for family planning services or administrative expenditures; expenditures for services provided through an Indian Health Service facility; and expenditures for medical assistance provided to individuals made eligible because of increased income eligibility standards that are more restrictive than those in effect on July 1, 2008 (Section 5001(e) of ARRA).
5) The expenditures for which the State draws funds are not payments for health care practitioner claims, or certain nursing home and hospital claims, that were received by the State during periods in which the State is not in compliance with prompt payment standards (Section 5001(f)(2) of ARRA).

Disproportionate Share Hospital Allotments

As a result of ARRA, the Department is eligible for an increased disproportionate share hospital (DSH) allotment of 2.5 percentage points. This increase required a budgetary action to increase the appropriation for (4) Indigent Care Program; Safety Net Provider Payments. The Joint Budget Committee took action to increase this appropriation in SB 09-259, the FY 2009-10 Long Bill and Long Bill Add-ons for FY 2008-09 and FY 2009-10. This action increased the total appropriation by $4,312,816 and $3,179,068 in FY

2008-09 and FY 2009-10, respectively, in cash funds. While ARRA increased the total allotted amount of DSH payments, this funding is not eligible to receive the enhanced FMAP rates.

Although the Joint Budget Committee action taken for SB 09-259 gives the Department spending authority for this increase in funding, the Department must receive and verify uncompensated costs from providers in order to certify public expenditures. The Department is currently working to identify the additional uncompensated costs necessary to draw down additional federal funds. In FY 2008-09 The Department was able to fully certify the public expenditures necessary to draw down the additional DSH funds, and anticipates doing so in FY 2009-10. Based on historical trends, the Department assumes that the providers will have sufficient uncompensated costs to maximize the certified public expenditures needed to draw down all newly available federal funding.

Health Information Technology

The American Recovery and Reinvestment Act also provides funding for Health Information Technology. Title XIII of Division A and Title IV of Division B of ARRA together are known as the "Health Information Technology for Economic and Clinical Health Act" or the "HITECH Act."

The HITECH funding is directed at increasing the speed at which business and clinical technologies across health care are adopted, as well as improving the security of the information technology systems that safeguard protected health information. Standards for use of the funding are still being developed by the Centers for Medicare and Medicaid Services.

On April 3, 2009, Gov. Bill Ritter designated the Colorado Regional Health Information Organization (CORHIO) as the state-level entity to receive HITECH funding. Although the CORHIO was appointed as the state-level entity for HITECH funding, and the funding itself is primarily directed at providers, the Department is in a unique position to act as a resource and a clearinghouse on information regarding the funding that will be made available through HITECH. As such, the Department is working with the Centers for Medicare and Medicaid Services, CORHIO, and other stakeholders to identify how to direct the use of these resources and maximize the available federal dollars.

Colorado plans to use HITECH funds to establish a loan and grant program for providers who are interested in purchasing electronic health records; reimburse Medicaid providers who utilize electronic health records to improve clinical outcomes; and train health care professionals on how to integrate technology into practices that improve health care value. It also hopes to be named as a Health Information Technology Regional Extension Center.

Medicaid Program Efficiencies

One of the 208 Blue Ribbon Commission for Health Care Reform recommendations was that Medicaid program efficiency be improved and enhanced. Further, an integral part of the Department's stated vision is ensuring delivery of appropriate, high quality health care in the most cost-effective manner possible while improving customer satisfaction with programs, services, and care. In light of the Blue Ribbon Commission's recommendation and the challenging economic climate of the last year, the Department has aggressively sought ways to realize this portion of its vision.

Adjustments in funding to the Department's budget in connection with improving Medicaid program efficiency were requested in BRI-2, "Medicaid Program Efficiencies" from the November 3, 2008 FY 2009-10 Budget Request. Authorization for the implementation of this request was provided in SB 09-259, the FY 2009-10 Long Bill. Although cost savings are an important component of this request, the focus of this initiative is achieving improvements to the quality of service provided to Medicaid clients. Further, the initiatives are an important step toward fulfilling the Department's vision, implementing the Blue Ribbon Commission's recommendations, and facilitating client-focused health care reform. A list of the initiatives follows, and a brief description of each is found below.

- Benefits Collaborative
- Health Outcomes Measurement Initiative
- Fluoride Varnish Benefit
- Hospital Back Up Program Enhancements
- Oxygen Durable Medical Equipment Administrator
- Serious Reportable Events[4]

Benefits Collaborative

The Benefits Collaborative process will ensure that benefit coverage decisions are based on clinical standards and that all benefit coverage policies promote the improved health and functioning of Medicaid clients. The amount, scope, and duration of Medicaid benefits will be identified through this process, ensuring that benefit coverage determinations are made in a manner that is transparent to, and inclusive of, all stakeholders. The Benefits Collaborative process has been identified as an opportunity to achieve efficiencies within the Department and lessen the need for reductions in provider rates. The Department anticipates a decrease in the need for

[4] Although funding for serious reportable events was included in this initiative, it is described below in Executive Order D 005 09.

provider rate reductions because the Benefits Collaborative will allow the Department to more closely track and monitor health care utilization and ensure that resources are used efficiently.

The Department has been reaching out to clients and other stakeholders to participate in this collaborative process to define the amount, scope, and duration of Medicaid benefits. The process for defining the different benefit groups began in January 2009. The benefits to be defined have been divided into benefit groups such as hospital services, behavioral health, physician services and laboratory/imaging services. All drafted benefit policies will be posted on the Department's Web site for public comment; reviewed by interested boards and committees and the Medical Advisory Committee; and will then be recommended for adoption by the Advisory Group to the Medicaid Director. The Department will implement the new policies by making system edits, sending bulletins, and updating billing manuals. A process for authorization of services for exceptional/individual cases (Exception to the Rule) will also be determined. It is expected that each benefit policy will take three to four months to define. To date, the Department has used the Benefits Collaborative process to define children's dental and reproductive health. The Department is working on Imaging Services and Speech Therapy. The Department is in the process of procuring consultant services to assist in an accelerated process of drafting policies. The Department anticipates that the initial process of defining current benefit coverage will be completed by June 30, 2010 with the assistance of a consultant. All established policies will be reviewed on a regular cycle to stay current with clinical practices.

Health Outcomes Measurement Initiative

Although the Department administers surveys to clients through the Consumer Assessment of Health Plans Survey, it has not performed any systematic evaluation of health outcomes as reported directly by clients. The Health Outcomes Measurement Initiative will allow the Department to survey a portion of Medicaid clients on a monthly basis about their health and ability to function. The information will provide a direct measure to determine if health status is improving among Medicaid clients as well as providing information about whether or not the services rendered result in improved or stable health. By focusing on performance outcomes rather than treatment provided or processes followed, the Department hopes to increase accountability for results.

Implementation requires the preparation of a documented quote in order to award the contract to a vendor that will administer, score, and report survey results. The documented quote has been posted and responses resulted in selection of the survey tool to be used to measure health and functional ability.

The documented quote has been drafted and will be posted shortly to the State's procurement Web site. It is anticipated there will be two to three responses. In an effort to begin a contract as soon as practicable, the contract will be drafted to the extent possible while

the documented quote process proceeds. Once the documented quote response evaluation process is complete, the award announced and the protest period expired, contract negotiations will begin. It is anticipated that the contractor will begin to survey clients by the end of January 2010.

Fluoride Varnish Benefit

The impetus for this initiative was to increase access for children to preventive services and reduce the incidence of early childhood cavities. The consequences of dental cavities may include pain to the child, missed school days, impaired language development, facial cellulitis and possible systemic illness for children with compromised immune systems. Fluoride varnish is a topical agent containing a high concentration of fluoride in a resin or synthetic base and is painted directly onto teeth to combat tooth decay. Flouride varnish has proven to be the safest and most effective form of fluoride provision for young children. Since the rate of early childhood dental cavities is near epidemic proportions in populations with low socioeconomic status, the Department anticipates that this initiative will improve the oral health of many of its childhood clients. Further, increased access to early dental intervention and reduced incidence of dental decay ultimately results in less necessary dental treatment and less cost to the Department.

Separate from the Department's fluoride varnish benefit initiative, the Rose Foundation, Delta Dental Foundation, Colorado Health Foundation, Caring for Colorado Foundation, Kaiser Permanente, and others, have jointly funded Cavity Free at Three, a three-year, statewide effort to prevent oral disease in young children. A technical assistance team comprised of leading dentists, physicians, and dental hygienists who have received in-depth training in the prevention of oral disease in pregnant women and young children are providing free, hands-on education to professionals across the state. This training includes an evidence-based infant and prenatal oral care protocol, oral disease risk assessment tools, clinical guidelines, supporting educational documents, and fluoride varnish kits.

The Department implemented this benefit in July 2009 for children up to the age of six, thus building on the Colorado Health Foundations' Cavity Free at Three educational initiative. Upon implementation, the Department began reimbursing trained medical as well as dental providers, who administer fluoride varnish to young children, conduct oral health risk assessments and examinations, and who provide counseling with the primary caregiver. Included in this group of trained medical providers are family physicians. As 94% of family physicians in the Denver area participate in the Colorado Medicaid program versus 18% of private practice dentists, the Department believes that primary care provider involvement will increase access to preventive oral health care for children who may otherwise not receive care and facilitate earlier referrals to less invasive, painful, and costly dental services.

In FY 2009-10, the Department anticipates that 4,016 clients will access the benefit. As more providers become trained on administering the benefit, the Department anticipates that this number will grow to 16,787 in FY 2010-11. (BRI-2, "Medicaid Program Efficiencies," November 3, 2008 FY 2009-10 Budget Request, Table C.1, page C.1.)

Hospital Back Up Program Enhancements

The Hospital Back Up program was created in 1987. The program admits patients whose conditions require around-the-clock oversight and treatment that can only be rendered by licensed nurses and therapists at a level commensurate to hospital care. Nursing facilities that are Hospital Back Up-certified are equipped and staffed to deliver rehabilitation and nursing care to bedridden patients who require treatment for chronic conditions as well as assistance with the activities of daily living for extended periods of time. Many Medicaid clients (adults and children) who are technologically dependent have remained in acute hospitals for several months after discharge while no longer needing acute care. The delayed hospital discharges have traditionally been caused by limited capacity to provide highly skilled, long-term care in regular nursing facility settings. These medically fragile clients are more susceptible to infections and subsequent complications of prolonged hospitalization.

This initiative enhances the efficiency of the Hospital Back Up program in addition to providing benefits to clients and the provider community. The planned Hospital Back Up program enhancements include: an increase in the cost effectiveness of the program; programmatic changes to provide access to Hospital Back Up services for the pediatric population; and the introduction of operational efficiencies. An example of the improved operations includes the implementation of a Web-based application that allows for the submission and processing of Hospital Back Up applications. As a result of the changes to the program, the Department anticipates that clients will be transferred to Hospital Back Up facilities in a more timely manner, positively impacting the quality of life of clients and their families. Further, since these clients will be in an environment more appropriate to their needs, the Department will avoid costs associated with long and unnecessary hospitalizations.

A changing business environment has delayed the planned implementation of the adult Hospital Back Up program changes. As a result, the Department anticipates that there will be smaller savings than previously projected. The Department initially anticipated that the prospective payment system (PPS) reimbursement methodology, as proposed in BRI-2 "Medicaid Program Efficiencies" from the November 3, 2008 FY 2009-10 Budget Request would simplify the reimbursement methodology, but result in lower reimbursements for participating vendors. The Department assumed that the simplicity of the new rate structure would outweigh the reduction in reimbursement rates for participating Hospital Back Up providers. The proposed methodology change was initially supported by a Colorado-based long-term care association due to the provider community's familiarity with the Medicare reimbursement methodology. An unanticipated sequence of events resulted in postponing the execution of the planned Hospital Back Up expansion.

As of November 2008, three prospective providers had submitted application requests to the Department to open Hospital Back Up units. All three facilities had been informed of the proposed adoption of the PPS reimbursement methodology. However once informed of the planned adoption of the PPS reimbursement policy, the established Hospital Back Up providers stopped accepting new admissions and requested to negotiate a different reimbursement methodology with the Department. All three prospective Hospital Back Up applicants later withdrew their applications pending the outcome of the rates negotiations between the established Hospital Back Up facilities and the Department. Further, Colorado hospitals stopped referring new clients to the Department's Hospital Back Up program until the rates are finalized.

Implementation of the pediatric Hospital Back Up program has also been delayed. These delays are the result of the following issues the Department is working to resolve:

- Licensed facility capacity and reimbursement rates: The prospective provider proposed a rate that represents a third of the hospital rates based on a 90-bed census. The Department's proposal is that the projected census should be reduced given the uncertainty of actual volume of hospitalized clients needing pediatric Hospital Back Up care.
- First year guarantee: The provider requested that the Department provide a 100% guarantee for cost coverage for the first year of implementation of the pediatric Hospital Back Up facility. Currently, the Department is willing to consider only a shared portion of risk for a limited number of beds.
- Location and transportation: The prospective provider has proposed a location outside of the Denver metropolitan area which creates issues about distance from major referral hospitals and families, including transportation concerns.

Once all issues have been resolved, the Department plans to move forward with implementation and will recalculate estimated cost savings at that time.

Oxygen Durable Medical Equipment Administrator

The Department requested and received approval to create and fill a full time equivalent position dedicated to administering the oxygen program. Historically the oxygen benefit had been managed through the durable medical equipment and supplies benefit. Oxygen and oxygen-related services are the highest expenditure category within the durable medical equipment and supplies program. Without a dedicated staff member administering and monitoring the oxygen program, the Department was unable to ensure that the most effective program was being offered and the most efficient oxygen delivery system was promoted. Opportunities to ensure that cost containment strategies were in place were being missed as well.

The Department filled the new position to reform the oxygen program in August 2009. The position is required to assess the current oxygen program regarding coverage, delivery systems, and reimbursement methodologies. Further, this position will compare the program to commercial coverage, Medicare coverage, and best practice guidelines. Implementation of a redesigned oxygen program that achieves cost savings and containment strategies by use of gate keeping provisions such as adding prior authorization components to the program is also required of this position. The position is responsible for monitoring the program performance of the revised oxygen benefit to ensure that cost containment is achieved.

Colorado Accountable Care Collaborative

With the passage of SB 09-259, the FY 2009-10 Long Bill, the Department received an increase of $1,334,222 in total funding for FY 2009-10 and 1.0 FTE in order to provide Medicaid clients, regardless of age or health status, a coordinated delivery system beginning in FY 2010-11. As a result of the 1.87% Personal Services reductions also authorized by SB 09-259, the Department reduced funding for this initiative by $1,966 to a total of $1,332,256 in funding. This initiative, referred to as the Colorado Accountable Care Collaborative, is an extension of the Governor's Building Blocks to Health Care Reform plan and is integral to the Department's statewide Medicaid reform efforts. The Colorado Accountable Care Collaborative will provide a set of enhancements to administrative and program functions and interventions designed to maximize the health, functioning, and self-sufficiency of Medicaid clients and providers. The goal of the Colorado Accountable Care Collaborative is to improve health outcomes for Medicaid clients through a coordinated, client-centered, outcomes-driven system while supporting providers and protecting safety-net providers.

Specifically, the Colorado Accountable Care Collaborative will consist of a statewide data organization and a number of regional care coordination organizations. These regional organizations will be charged with offering care-coordination services and supporting providers and clients that enroll across each region. Payment will be made on a per-member, per-month basis averaging $20.00. In exchange for the additional clinical support provided by the regional care coordination organizations as well as access to state-supplied health information technology, providers will be asked to offer increased access to clients. This increased access may include such things as extended office hours, some same-day appointments, and the provision of a focal point of care for each client.

The Department anticipates that the implementation of the Colorado Accountable Care Collaborative will result in cost savings of $2,231,034 in FY 2010-11.[5] The savings estimate is based on lowered costs resulting from providing coordinated care and eliminating unnecessary tests and therapies. Cost savings generally occur when clients are able to use less costly primary care services instead of

[5] This savings estimate has been built into DI-1, "Request for FY 2010-11 Medical Services Premiums," November 6, 2009 FY 2010-11 Budget Request.

immediately going to an Emergency Department. Further, both the primary care physician and the regional care coordination organizations have financial incentives to encourage clients to engage in advantageous behavior, as performance incentives are tied to outcomes. This incentive structure should reduce the incidence of unnecessary and more costly services.

The Department issued a request for information in July 2009 seeking input from stakeholders on a wide variety of design and delivery considerations. Further, the Department is currently planning on posting a Request for Proposal to solicit competitive bids in February 2010. To ensure that the Department's goals are being achieved, the Department will limit enrollment to 60,000 clients until the efficacy of the program can be demonstrated.

Colorado Health Care Affordability Act

On April 21, 2009, Governor Ritter signed Colorado House Bill 09-1293 "Health Care Affordability Act" into law. Once implemented, the legislation will provide health care coverage for more than 100,000 uninsured Coloradans, reduce uncompensated care costs, and benefit the state as a whole. The Colorado Hospital Association, the Department of Health Care Policy and Financing, and the Governor's Office worked together for nearly a year to develop House Bill 09-1293, which passed both the House and the Senate quickly with more than 40 co-sponsors and bipartisan support.

The bill requires the Department to assess and collect a provider fee from all licensed or certified hospital providers, including providers that do not serve Medicaid clients. The provisions of the legislation bar shifting the payment of the fee to either clients or insurers. With many Colorado businesses and families struggling to secure affordable health insurance, this legislation will help reduce the number of uninsured individuals in Colorado. By partnering with hospitals, the Colorado Health Care Affordability Act will allow Colorado to generate approximately $600 million in additional funding per year through a hospital provider fee, and draw down approximately $600 million in federal Medicaid matching funds for the following:

- increasing hospital reimbursement rates for Medicaid inpatient and outpatient care to the federal upper payment limit;
- increasing hospital reimbursement rates through the Colorado Indigent Care Program up to 100% of cost;
- creation of hospital quality incentive payments for rewarding enhanced quality, health outcomes, and cost effectiveness;
- increasing coverage for parents with incomes of up to 100% of the federal poverty level (FPL) through Medicaid;
- increasing coverage in the Children's Basic Health Plan up to 250% FPL;
- initiating coverage for adults without dependent children with incomes of up to 100% FPL through Medicaid;
- creating a Medicaid buy-in program for individuals with disabilities whose family incomes are too high for Medicaid eligibility but are under 450% FPL;

- implementing continuous eligibility for Medicaid children to reduce administrative burdens on Colorado families and keep eligible kids covered on a continuing basis; and
- covering the Department's administrative costs related to the bill.

The bill also created a 13-member Oversight and Advisory Board to work with the Department to ensure the bill is properly implemented. The Board began meeting in August and approved a fee model for submitted to the Centers for Medicare and Medicaid Services in early September 2009. The Board will also provide ongoing feedback and approval for the expansion populations and the increased reimbursement to hospitals under this bill. The Department has also held public forums to receive community input on the design and implementation of the buy-in program for persons with disabilities and the benefits for adults without dependent children. The Department anticipates implementation to begin by the close of FY 2009-10 with all program enhancements to be implemented by February 2012.

Colorado's Comprehensive Health Access Modernization Program

In June 2009, the Department applied to receive grant funding from the federal Health Resources and Services Administration, State Health Access Program for the Colorado Comprehensive Health Access Modernization Program (CO-CHAMP). The purpose of this additional grant funding is to augment the funding appropriated under House Bill 09-1293 "Colorado Health Care Affordability Act" and ensure its successful and full implementation. In September 2009, the Department received notice that its application was approved to fund seven comprehensive and interrelated projects totaling $42,773,029 over the next five years beginning in FY 2009-10.

The CO-CHAMP grant program reflects the Department's responsibility as leaders to "champion" policies leading to greater access to health care, increased positive health outcomes, and reduced cost-shifting. In the context of the delivery of health care services, the Department's modernization efforts include making investments in prevention; health information technology; infrastructure; and in understanding which treatments work best for any given health condition. In the context of the CO-CHAMP grant, modernization refers to changing the way the Department conducts business to expand access to benefits and improve efficiency by working smarter and more effectively managing limited resources. It includes making investments in infrastructure and technology, and also includes implementing new strategies around benefit design and cost-sharing. In fulfilling the coverage expansions authorized in 2009 under HB 09-1293 "Colorado Health Care Affordability Act," it is essential to ensure that the Department's systems work as well as possible to support the increased caseload. The common thread underlying all of the CO-CHAMP grant projects is making the health care delivery system and access to programs more outcomes-focused and client-centered. The additional funding Colorado will receive for

this project will elevate the health care system and Colorado to a new level, and position the State well for engaging in the national discussion on health reform.

Projects to be funded under the CO-CHAMP grant program include:

- **Maximizing Outreach, Retention, and Enrollment**: The purpose of this project is to design, develop, and implement an enhanced outreach plan for the HB 09-1293 expansion populations that generates awareness of the availability of health care coverage programs and the expanded eligibility, and teaches families how to access health care in appropriate settings.

- **Eligibility Modernization: Streamlining the Application Process:** The purpose of this project is to further streamline the application process by replacing paper documentation with electronic data where possible; develop Web-based services for clients; and create interfaces to other state and federal systems to ease data exchange for the HB 09-1293 expansion populations making it easier for clients to apply for public health insurance programs.

- **Adults without Dependent Children and Buy-in for Individuals with Disabilities Implementation**: The purpose of this project is to develop potential program designs, including models for premium structures and cost-sharing provisions, for adults without dependent children and buy-in for individuals with disabilities expansion populations.

- **Premium Assistance Program:** The purpose of this project is to expand the CHP+ at Work program statewide to expand coverage to children eligible for the Children's Basic Health Plan who have access to employer-sponsored insurance.

- **Health Access Pueblo Community Share Expansion.** The purpose of this project is to design, develop and implement an outreach and marketing plan to new businesses on the availability of Pueblo County's community-share program known as the Health Access Program to expand coverage to the working uninsured.

- **San Luis Valley Three-Share Community Start-Up:** The purpose of this project is to replicate Pueblo County's Health Access Program and create health care coverage for the working uninsured through the San Luis Valley Health Access Program.

- **Weld County Evidence-Based Benefit Design Pilot:** The purpose of this project is to create an innovative benefit design tool that can be implemented easily and administered efficiently for carriers to develop new insurance products targeted at previously uninsured populations.

Executive Order D 005 09

Serious Reportable Events

On March 31st, 2009, Governor Bill Ritter, Jr. signed and issued Executive Order D 005 09, "Medicaid Policy on Serious Reportable Events." The Executive Order directs the Department to propose rules that would either deny or reduce payments under Medicaid and the Children's Basic Health Plan for serious reportable events. Further, the order requires that patients no longer be billed or balance-billed for the cost of services associated with care resulting from serious reportable events. The objective of the order is to ensure patient safety and high quality care.

In keeping with the Executive Order, 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.[6] In addition to this federal rule change, several states have already instituted reporting and non-payment of serious reportable events for their Medicaid programs.

As a result of Governor Ritter's Executive Order, the Department is now a part of this national trend towards non-payment for increased costs associated with care resulting from serious reportable events. The Department's list of serious reportable events is found below.

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;

[6] Source: "CMS improves patient safety for Medicare and Medicaid by addressing Never Events," August 4, 2008, http://www.cms.hhs.gov/apps/media/fact_sheets.asp

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, and;
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.

Pursuant to the Executive Order, the Department proposed rules to the Medical Services Board regarding serious reportable events in September and October of 2009. These rules were adopted in October 2009. The rules require that, 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 during an inpatient hospitalization, 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.

In order to implement the order across the Department's Medicaid fee-for-service program, the Department was appropriated $19,500 in funding to hire a contractor to perform manual review and adjustment of fee-for service claims in SB 09-259, the FY 2009-10 Long Bill. In addition to this funding, the Department modified its Medicaid Management Information System to allow for the accurate tracking of the existence of, and payment for, each of the 15 serious reportable events, and made other changes to its systems to allow for accurate and timely recoupment of overpayments. These changes were made using available programming hours in the Department's information technology pool. The changes were completed in time for an October 1, 2009 implementation date.

Implementation of the order across the Department's Medicaid managed care contractors and the Children's Basic Health Plan required contractual changes. As such, implementation of the order was put into place as of October 1, 2009 for these programs.

The order also encouraged the Department to work with appropriate health care organizations to support the creation of a Patient Safety Organization. The Colorado Hospital Association is taking the lead on the creation of a Patient Safety Organization. The Department is participating in this process, along with other stakeholders. 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 continues to work with the Colorado Hospital Association, private insurers, patient advocacy groups, and other stakeholders in continuing to refine a comprehensive, long-term strategy for addressing serious reportable events.

Electronic State Plan Amendments

In October 2008, the Department learned that the Centers for Medicare and Medicaid Services (CMS) was planning to change the way in which states submit Medicaid State Plan amendments to CMS for federal review and approval.

The Medicaid State Plan is the Department's contract with the federal government that describes the nature and scope of the Medicaid program in Colorado. The Department is required to adhere to the provisions of the State Plan to receive federal financial participation for the Medicaid program. The Department submits Medicaid State Plan amendments to CMS whenever there is a change in the nature and scope of the program, such as a new payment methodology or a new service is covered.

Currently, the Department submits State Plan amendments to CMS by either hand delivery to the Denver regional office or by e-mail to a central e-mail address. The new system, called e-SPA, replaces these avenues for submission with a Web-based submission system. Once the new e-SPA system is implemented, the Department will be required to resubmit the entire State Plan to CMS over a three-year period to comply with the e-SPA format. In preparation for e-SPA, the Department is reviewing the Medicaid State Plan to determine which provisions will require revisions and updates.

The e-SPA system was originally scheduled for implementation in late FY 2008-09, but has been postponed. The Department has not been provided with a new implementation date for e-SPA but expects that the new system will go online by the end of FY 2009-10.

Colorado Benefits Management System Realignment Efforts: Partnership with Department of Human Services

The Department was appropriated $5,300,000 in HB 08-1375, the FY 2008-09 Long Bill, for the purpose of working towards 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 administrative efficiencies that will:

- decrease application processing time;
- reduce future system changes costs;
- better enable the Department to respond to expansions in eligibility for medical assistance programs and other public health insurance programs; and
- streamline the application processes for programs administered by the Department of Human Services.

While realignment efforts were initially focused on improving access to medical assistance programs, the scope of the realignment effort has been expanded to include financial assistance programs administered by the Department of Human Services (DHS). By partnering with DHS in making these improvements to CBMS, the benefits of realignment are optimized for CBMS users as well as for applicants and clients.

Initial changes to CBMS include the development of a Web-based portal and a redesign of the front end data entry screens and screen flow which will provide improved customer service to CBMS users. The Department anticipates these changes will be implemented by June 2009. The Intelligent Data Entry enhancement to CBMS involves a redesign of data entry screens and screen flow used in the application process for the entry of client data. The Web-based portal will allow individuals to apply for programs or submit redetermination information from any location with internet access. In addition, clients will be able to report changes in information through the Web-based portal and check benefit and application status. The realignment of the user interface and data entry screens into a more user-friendly, work-flow oriented format is expected to reduce application processing time, eliminate redundancies and reduce data entry errors. Making the application process more efficient will result in increased access to benefits and improved workloads for county workers.

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. Such changes would make the program more efficient and effective in delivering important benefits to clients, providers, and enrollment staff. This entity would enhance and complement the current multiple county-level process.

Governor Ritter signed HB 08-1375, the FY 2008-09 Long Bill, 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, and the contract was awarded in August 2008 to Public Knowledge.

Public Knowledge provided a report of its findings to the Department in December 2008. In addition to the report from Public Knowledge, the Department released a request for information regarding ways to modernize its eligibility processes. As more information became available during the project, it became apparent that the practical application of modernizing access to health care would include an array of centralized and decentralized services. Some services might be centralized, and some might best be delivered in decentralized operations, but with modernized tools and processes. Both models for eligibility and enrollment are being considered as part of this analysis, which takes into account the eligibility sites' accessibility to potential and existing clients and to leverage localized expertise for eligibility and enrollment practices.

The Public Knowledge report contained lessons learned from other states as well as best practices for eligibility and enrollment models. The Department and Public Knowledge drafted a request for proposals based on the findings in the report as well as information obtained through the request for information. The Department released the request for proposals for an eligibility and enrollment vendor in September 2009 and anticipates awarding a contract in January 2010. The Department anticipates the eligibility and enrollment vendor will initially implement modernization strategies for Children's Basic Health Plan clients.

Colorado Regional Health Information Organization

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 (CORHIO), 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 CORHIO 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 was appropriated $500,000 in total funds for CORHIO in HB 08-1375, the FY 2008-09 Long Bill. In FY 2008-09, the Department entered into a grant contract with CORHIO for $250,000 in State funds to provide the Department with guidance on the development of policies and procedures for health information exchange. The Department received continuation funding for FY 2009-10. Given the confirmation of continuation funding for FY 2009-10 and CORHIO's compliance with the requirements of the grant contract, it is anticipated that the Department will extend the contract and grant CORHIO an additional $250,000 in State funds in FY 2009-10. The Department assumes continuation funding in FY 2010-11.

In addition to the significant Health Information Technology (HIT) efforts underway in communities and among providers across the state, CORHIO is well established as a statewide public/private non-profit organization dedicated to the promotion of health information exchange. The CORHIO serves as the statewide convener of stakeholders to develop solutions and coordinate implementation of statewide information sharing, to link regional Health Information Exchange (HIE) projects and meet statewide HIT adoption and information sharing needs. The CORHIO reflects stakeholder perspectives from across sectors and interests throughout the state. The CORHIO board is comprised of consumers, providers, health plans, government agencies, and experts in health care quality, value, and information technology. Joan Henneberry became chairperson of the Board as of April 1, 2009.

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. On April 24, 2009, the Governor announced that the Colorado Health Information Technology (HIT) Advisory Committee had released its report identifying how Colorado can significantly reduce costs, improve patient outcomes and make the state's health care system more efficient and effective. The report provides recommendations in each of the following four strategic areas:

- adoption and incorporation of HIT;
- promotion of interoperability and HIE;
- fostering of implementation of Executive branch and other strategies by policymakers; and
- private sector engagement and strategies to expand the use of HIT.

Moving forward, the Department anticipates that it will partner with CORHIO to advance the recommendations contained in the report described above. Further, the Department will continue to work with CORHIO as subsequent grant funding on projects continues to link the IT efforts of the Department with the work done by CORHIO. The Department also plans to collaborate with CORHIO on provider education as funding and additional information about other opportunities becomes more defined under the American Recovery and Reinvestment Act of 2009.

Medical Homes

Governor Ritter signed HB 08-1375, the FY 2008-09 Long Bill 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; providing anticipatory guidance and health education as well as acute and chronic illness care; coordinating medications, specialists, and therapies as well as 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 was appropriated funding for a Medical Home pilot program for Medicaid in FY 2007-08. The Department met the program's goal of enrolling 124 providers and 15,000 children in FY 2008-09, and estimates that $7,078,708 will be required in FY 2009-10 to account for increasing enrollment. The Department implemented medical home for the Children's Basic Health Plan on January 1, 2009.

In FY 2009-10, as a part of the Governor's Building Blocks to Health Care Reform plan, the Department is receiving $145,000 to support ongoing efforts to enroll Medicaid Children into a Medical Home. Toward that end, and building upon the initial notification of the Medical Home Program to all primary medical, oral health, and mental health providers performed in FY 2008-09, the Department will not only be sending out new mailings but also be supplementing mailings with on-going, easily accessible program information. These mailings were designed in conjunction with the 145 member Colorado Medical Home Initiative working group. The information that is mailed out will also be posted on the Colorado Medical Home Web site. The Department will also track returned mail and Web site access to ensure the notification and use of the materials are successful.

Medicaid

Implementation requires the Department to ensure there is an adequate network of primary care physicians who are willing to participate as Medical Homes. Beginning with FY 2008-09, the Department 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 creating an adequate network of providers. As a result of budget reductions, a 2% cut was made to physician services, which included preventive medicine codes. The Department anticipates that this reduction may result in fewer providers participating in the program and a delay in the Department's ability to ensure that every child has a Medical Home by January 1, 2010.

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, utilization rates the Department anticipates it will reach sometime in FY 2009-10.

Providers must be trained and determined as Medical Home providers. Technical Assistance Consultants train and determine both Medicaid and Children's Basic Health Plan providers. If a provider is determined for one program they are automatically determined for both. By the end of FY 2008-09, 357 providers were trained and determined as Medical Home providers. Of this total, 120 providers accept only Medicaid clients and 237 accept clients enrolled in either Medicaid or the Children's Basic Health Plan. In FY 2008-09, 97,537 Medicaid children were enrolled in a Medical Home.

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. Since the January 1, 2009 implementation date across the Children's Basic Health Plan, 237 providers have been trained and determined as Medical Home providers. Further, access to a Medical Home was provided to 64,598 children.

In FY 2008-09, the Department made 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. In FY 2009-10, the Department increased the capitation rate paid to health plans effective July 1, 2009 for participation in Medical Home. This increased capitation rate provides an incentive to increase the number of participating Medical Home providers. 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's target is a 20% utilization rate across all clients in the self-funded network.

For clients enrolled in a managed care organization, the Department's utilization target is 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

In FY 2008-09, Medicaid served 436,812 beneficiaries at a total cost of $2,508,537,655 (Exhibits B and M, November 6, 2009 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 called "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 April 2008 in the following counties: Adams, Arapahoe, Boulder and Broomfield. Denver County was added in October 2008 and Weld County will be added in FY 2009-10. Per internal Department information, the average total monthly enrollment for the CRICC program in FY 2008-09 was 2,018 clients. Further, contract negotiations between the Department and Kaiser Permanente started a second CRICC program in August 2009 in Jefferson County with an estimated year-end enrollment of approximately 1,200 clients for FY 2009-10.

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. MDRC is a nonprofit, nonpartisan policy research organization with extensive experience in conducting randomized controlled studies of social policy initiatives targeted at low-income populations.

Long-Term Care Reform

The Department continues to pursue long-term care reform with input from interested stakeholders. The Department's Long-Term Care Advisory Committee was convened in April 2008 and has already provided input on eligibility reform and the Department's draft request for information on the Colorado Accountable Care Collaborative. The finalized request for information was released in June 2009 and sought input from stakeholders on issues concerning design and delivery. In addition, during the 2009 Legislative Session, the General Assembly enacted House Bill 09-1103, granting the Department authority to pursue long-term care presumptive eligibility. The next steps will focus on achieving federal approval to implement this initiative.

The Department was one of seven states awarded a technical assistance grant from the Center for Health Care Strategies to test innovative care models for people who are dually eligible for Medicare and Medicaid. The Department will work with the grantors and other states to address program design, care models, financing mechanisms and contracting strategies.

During FY 2009-10, the Department plans to engage in public dialogue with stakeholders on opportunities to reform the entry point system into long-term care. Colorado's single entry point system was designed over 15 years ago. The long-term care delivery system has changed in the intervening years, so it is appropriate to revisit the entry point system design to ensure that it meets clients' needs as the Department continues to move forward with its long-term care reform efforts.

Pharmacy

According to a September 2008 report on Prescription Drug Trends published by the Kaiser Family Foundation, the number of prescriptions purchased between 1997 and 2007 grew by 72%, while the U.S. population grew by only 11%. Further, retail prescription prices increased an average of 6.9% a year against an annual inflation rate of 2.6% during the same time period.[7] With these cost increases in mind, coupled with the challenging economic climate of the last year, the Department has taken several steps specifically designed to lower the cost of prescription drugs for its clients. The Department believes these actions are 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 are listed below, beginning with actions resulting from the 2009 legislative session followed by updates on existing programs.

Pharmacy Technical and Pricing Efficiencies

The Department sought adjustments to its base request as a result of BRI-1, "Pharmacy Technical and Pricing Efficiencies," which was submitted in the Department's November 3, 2008 FY 2009-10 Budget Request. Funding for this initiative was authorized by SB 09-259, the FY 2009-10 Long Bill. Specifically, General Fund reductions of $207,348 in FY 2009-10 and $729,443 in FY 2010-11 were authorized. The requested adjustments are the net result of the implementation of an automated prior authorization system as well as changes to the reimbursement rates of drugs using a state maximum allowable cost structure. A description of each is provided below.

[7] Source: Kaiser Family Foundation, "Prescription Drug Trends," Fact Sheet, September 2008, http://www.kff.org/rxdrugs/upload/3057_07.pdf,

Automated Prior Authorizations

Currently, providers are required to submit information to the Department's fiscal agent via either facsimile or telephone call on every prior authorization request for medications. This process is an administrative burden for providers. Further, under the current system, clients can only receive an emergency supply of their prescription while a decision is made on the prior authorization request. As a result, clients must make return visits to the pharmacy to obtain their full prescriptions.

An automated prior authorization functionality screens pharmacy claims against client information from the medical and pharmacy database. It then determines if a client meets the prior authorization approval criteria within a few seconds through the pharmacy point of sale system. If the prior authorization is approved, the submitted claim will pay at the point of sale and no further action is required of the pharmacy or other providers. If the prior authorization is not automatically approved, then the claim is denied and the provider follows the current prior authorization request process. The automated prior authorization functionality will reduce administrative burdens on providers since they will have to submit fewer prior authorization requests. This functionality will also facilitate client access to medications while still allowing the Department to promote utilization of efficacious and cost-effective medications. Further, automating prior authorizations will provide cost savings to the Department's Medical Services Premiums. The savings result from the Department's ability to better manage drug utilization through expansion of the prior authorization criteria across all drug classes.

The Department will require the services of a contractor to provide and support the prior authorization capability. The Department anticipates releasing a request for proposals for the services of a contractor by January 2010, and the Department anticipates that a contractor will be in place by July 2010 for a yearly cost of $732,332.

State Maximum Allowable Cost Methodology

Expanding the number of drugs using a state maximum allowable cost methodology will increase the options available to the Department for the reimbursement of pharmacy claims. The state maximum allowable cost methodology uses the average acquisition cost plus 18%. Pharmacy providers are currently reimbursed at the rate that is the lowest of the four methodologies, (federal upper limit rates, average wholesale price, direct price plus 18%, and the state maximum allowable cost plus 18%). The methodology used determines each pharmacy's provider's final pharmacy reimbursement rate. The state maximum allowable cost methodology will focus on establishing a reimbursement ceiling for drugs without a federal upper limit rate and that could have an inflated average wholesale price.

The Department will contract with a vendor in order to gather acquisition costs monthly from a statistically determined number of pharmacies and to establish a methodology to compare, weigh, and confirm the acquisition costs collected. As a result of using a vendor to obtain acquisition costs for hundreds, possibly thousands, of drugs, the number of drugs with a state maximum allowable cost will increase. Having more drugs with a state maximum allowable cost will cause this methodology to be in effect more frequently when the pharmacy providers' final pharmacy reimbursement rate is being determined.

The Department anticipates releasing a request for proposals for the services of a contractor by January 2010, and anticipates that a contractor will be in place by July 2010 for a yearly cost of $219,700.

HB 09-1073 Electronic Prescription Use for the Medical Assistance Program

On May 20, 2009, Governor Ritter signed HB 09-1073 into law. The legislation requires the Department to contract with a nonprofit organization that facilitates health information exchange to improve the health of all Coloradans for the performance of a study on the feasibility and advisability of using electronic prescriptions (e-prescriptions) technology for Colorado Medicaid. The bill authorizes funding in the amount of $52,500 for the study, subject to the receipt of gifts, grants, and donations. Currently, no donations have been received. The study is to conclude before June 30, 2010, and will result in a report to be given to the Health and Human Services committees of the Colorado General Assembly. The report will address various items including whether savings would be realized across Medicaid through the use of e-prescriptions; how to ensure that clients' health or access to prescriptions drugs will not be negatively impacted with the use of e-prescriptions; if federal law would permit incentives for the use of e-prescriptions; and if any additional legislation is required for the use of e-prescriptions.

The performance and scope of the study as described in the legislation is contingent upon receipt of gifts, grants or donations for funding for the study as well as confirmation from the Centers for Medicare and Medicaid Services that there will be federal financial participation for the performance of the study. Once these issues are resolved, the Department plans to contract with a vendor with the goal of completing the study and producing a report by June 30, 2010.

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 implemented the program on April 1, 2009. As a result, clients with a physical hardship who have difficulties getting to a local pharmacy have been able to receive needed maintenance medications via mail order.

The passage of SB 09-252, "Medicaid Mail Order Prescriptions" expanded the scope of mail order prescriptions authorized under SB 08-090. It broadened the scope of eligible mail-order prescriptions through third-party insurers to include those that allow, rather than require, medications to be obtained through mail order. The Department anticipates there will be a minimal number of new clients utilizing mail order due to this bill.

Executive Order D 004 07 Preferred Drug List

In January 2007, Governor Ritter signed Executive Order D 004 07 establishing a preferred drug list (PDL) for Colorado's Medicaid program. The purpose of this program is to provide needed medications to Medicaid clients while decreasing expenditures for 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 6, 2009, the Department has implemented 21 drug classes on the preferred drug list including: proton pump inhibitors, sedative-hypnotics, statins, antihistamines, antihypertensives, opioids, skeletal muscle relaxants, respiratory inhalants, attention deficit hyperactivity disorder drugs, antiemetics, growth hormones, intranasal corticosteroids, leukotriene modifiers, ophthalmic allergy, triptans, epoetin products, bone resorption agents, meglitinides, hypoglycemic combinations, sulfonylureas and thiazolidinediones. The Department anticipates adding three to four more drug classes by the end of FY 2009-10, and four new drug classes in FY 2010-11. The Department has also pursued supplemental rebates for the preferred agents in each of these classes to provide pharmaceuticals for Medicaid clients at the lowest possible cost.

340B Government Efficiency and Management Performance Review

The Governor's office issued Colorado Government Efficiency and Management Performance Review report (GEMs report) on June 25, 2008. The GEMs report recommended that the most beneficial means for utilizing the 340B drug purchasing program be researched. The 340B drug program was established by the federal government in 1992. Specifically, the GEMs report identified federally qualified health centers as the group of providers who would generate the greatest amount of cost savings through the increased filling of prescriptions.

House Bill 08-1375, the FY 2008-09 Long Bill, created a 340B pricing pilot. The Department spent the first portion of FY 2008-09 researching the 340B program. The Department focused on the best way in which to implement or increase the utilization of the program, taking into consideration the recommendations of the GEMs report. Discussions with representatives from federally qualified health centers resulted in the understanding that increasing the filling of prescriptions for Medicaid clients may not be feasible. Further, it was determined that implementation of the recommendation most likely would not provide the anticipated cost savings as projected in the GEMs report.

Although it was determined that implementing the pilot program was not likely to lead to cost savings, the Department was able to ensure that it had explored all recommendations in the GEMs report. Further, as a result of its analysis and discussions with providers, the Department is reviewing practices of providers that are currently participating in the 340B program and is researching ways that may allow more utilization of the 340B program in the future.

Comprehensive NeuroSciences, Inc.

Starting June 1, 2006, and ending June 30, 2008, the Department engaged in a two-year project with Comprehensive NeuroSciences, Inc. (CNS) to run the behavioral pharmacy education program. Through this program, the Department was able to provide information to prescribers about the psychiatric and opioid medication utilization of their patients. The program was entirely funded by a grant from Eli Lilly and Company and was run at no cost to the Department.

The behavioral pharmacy education program was designed to help ensure that the Department's clients receive the best care possible through more appropriate utilization of pharmaceuticals. Comprehensive NeuroSciences, Inc. has extensive experience in evidence-based and consensus-based standards for psychiatric medication prescribing and has administered several similar projects for a number of other Medicaid programs. Twenty-five other states have also entered into similar agreements with CNS. 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.

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. For example, 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 CNS program had not been implemented and the actual cost since the program's inception in Utah has been a savings of almost $10 million quarterly.

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

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. A few of the highlights of the program are described below.

Federal Reauthorization of the State Children's Health Insurance Program

On February 4, 2009, President Obama signed the Children's Health Insurance Program Reauthorization Act (CHIPRA) into law. This legislation reauthorized the Children's Health Insurance Program (CHIP). The law provides states with $35 billion over the next four and a half years, funded by a $0.61, per-pack increase in the federal tax on cigarettes and other tobacco products. The legislation increases Colorado's federal funding by 36% to $97.5 million in the 2009 federal fiscal year. The federal financial participation rate for the Colorado CHIP program, the Children's Basic Health Plan, is 65%. Currently, there are as many as 31,000 Colorado children

and pregnant women who are eligible for the Children's Basic Health Plan but are not enrolled in the program. The reauthorization allows Colorado to maintain its current program and to continue efforts to enroll eligible but not enrolled children and pregnant women into the Children's Basic Health Plan. The increased federal funding will also allow the expansion of the Children's Basic Health Plan if funding sources are identified for the state's match. A description of what the additional funding supports is listed below:

- Funds CHIP through fiscal year 2013 with approximately $32.8 billion to expand coverage to four million more children. The funding is primarily financed by a $0.61 increase in the federal excise tax on cigarettes;
- Preserves state flexibility to decide income eligibility level for children that need assistance in each state. However, populations above 300% of the federal poverty level will not receive the CHIP enhanced match, and will instead receive the Medicaid match;
- Provides states with the option to lift the current five year waiting period for immigrant children and pregnant women to become eligible for Medicaid or CHIP coverage;
- Dedicates $225 million for a nationwide CHIP quality initiative. The initiative will include the development of new child-specific health quality measures (which will be published by the United States Department of Health and Human Services no later than January 1, 2010), along with a standardized reporting format for States; and
- Extends Medicaid citizenship documentation requirement (as established by the Deficit Reduction Act of 2005) to CHIP. The bill also provides the option for states to use information gathered by the Social Security Administration as a potential way to decrease administrative barriers to coverage.

CHIP Reauthorization Bonus Funding

While CHIPRA offers funding in the form of grants to target the eligible but not enrolled populations, the performance bonuses available through the legislation provide funding to support the additional numbers of enrollees the Children's Basic Health Plan would attract through successful outreach efforts.

The following chart outlines the provisions and Colorado's current status:

8 Enrollment and Retention Provisions

Provision	Description	Medicaid	Children's Basic Health Plan
12-Month Continuous Eligibility under Title XIX and Title XXI *	Establishment of a 12-month continuous eligibility period for children under age 19 in the Medicaid and/or CHIP State Plans.		✓
Elimination of Asset Test under Title XIX and Title XXI*	The State has liberalized asset test requirements for determining eligibility of children for Medicaid or CHIP by either removing asset/resource tests or reducing the documentation requirements for eligibility.	✓	✓
Elimination of In-Person Interview under Title XIX and Title XXI*	The State has eliminated in-person interview requirements for applying for Medicaid or CHIP (with exception for circumstances that justify a face-to-face interview).	✓	✓
Joint Application	The State has established a joint application and verification process for initial enrollment into Medicaid or CHIP and renewals of enrollment.	**	**
Auto Renewal under Title XIX and Title XXI	The State's Medicaid or CHIP program utilizes a renewal form with pre-printed eligibility information that is sent to the parent/caretaker relative of the child with notice that the child's eligibility will be automatically renewed unless other information is provided to the State that affects the child's continued eligibility.		
Presumptive Eligibility under Title XIX and Title XXI*	The State has implemented presumptive eligibility for children under the Medicaid and/or CHIP State Plans.	✓	✓
Express Lane under Title XIX and Title XXI*	The State is implementing the option to utilize express lane agencies under the Medicaid and CHIP State Plans.		
Premium Assistance Subsidy under Title XIX and Title XXI	The State has implemented the option of providing premium assistance subsidies under the Medicaid and/or CHIP State Plans.	**	✓

* Both Medicaid and CHIP must implement these provisions.
** Awaiting CMS guidance on whether or not our current status satisfies these conditions.

Bonus payments are available beginning in federal fiscal year (FFY) 2008-09. For each year, bonuses will be paid by December 31 following the end of the fiscal year (e.g., FFY 2008-09 bonuses will be paid by December 31, 2009, FFY 2009-10 bonuses by December 31, 2010, etc.). Five of the eight policies must be in place for the full federal fiscal year for a state to qualify to receive a bonus.

Once a state has qualified for the performance bonuses through the implementation of five out of the eight specified provisions, the state must exceed an enrollment target. Information about how the target is set and how the bonus is calculated is listed below.

- **How the target is set:** A state's enrollment target will be set each year (beginning in FFY 2008-09) by applying the formula set out in CHIPRA to state enrollment data. Specifically, the Centers for Medicare and Medicaid Services will calculate the target for each state based on the state's child enrollment in Medicaid in 2007, adjusted each year by the state's child population growth and a standard enrollment growth factor that is specified in CHIPRA and that changes over time. The standard enrollment growth factor, which is the same for all states, is based on national projected caseload growth. Because of the recession, it is pegged at a fairly high rate. The rate starts at 4% but drops to 3.5%, 3%, and ultimately to 2%.
- **How the bonus is calculated:** A state's Medicaid bonus is equal to a percentage of the state's share of the average monthly cost per child, applied to the number of children that exceed the enrollment target. The percentage depends on how much enrollment exceeds the enrollment target. A state with enrollment between the target level and 110% of the target level would receive a bonus payment equal to 15% of the state's share of the average cost per child in Medicaid, multiplied by the number of children above the target. The percentage would rise to 62.5% of the state's share of the average cost per child for any enrollment that exceeds 110% of the target.

Reprocurement of the Children's Basic Health Plan Eligibility Vendor

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 Children's Basic Health Plan State Managed Care Network. The eligibility and enrollment contractor is Affiliated Computer Services, which received the contract in August of 2003 through a competitive bid process. The Department issued a request for proposals in March 2008 to reprocure these services. The results of the competitive bidding process were protested, which required the Department to extend the Affiliated Computer Services contract until April 30, 2009. On January 30, 2009, the Department of Personnel and Administration issued their formal response to the protest, cancelling the request for proposals.

Due to the cancellation of the request for proposals and the need to redraft another request for proposals for these services, the contract with Affiliated Computer Services was extended until June 30, 2010, when the eligibility and enrollment operations for the Children's Basic Health Plan will be incorporated into the Department-wide Colorado Eligibility Modernization Project request for proposals. These operations will be in the first year (Phase I) of the request for proposals beginning July 1, 2010.

Behavioral Health Organizations

Reprocurement

The Department's evaluation and design of its Medicaid capitated mental health managed care program have been influenced by national trends in health care reform as well as policy direction from the Colorado Promise, the Governor's Building Blocks to Health Care Reform plan, and the passage of HB 08-1063. The Department contracts with external behavioral health organizations (BHOs) to maintain provider networks and guarantee delivery of services provided through its capitated mental health managed care program. 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. A final request for proposals was released for competitive bids in November of 2008 and contract awards were announced on May 6, 2009. The initial term of the new contract was scheduled for July 1, 2009 through June 30, 2010, with up to four additional one-year periods at the sole discretion of the State. Contract implementation was delayed until September 1, 2009, resulting in an initial contract period of 10 months instead of one year. The five BHOs selected under the procurement operate the program in each of five service areas throughout Colorado and are responsible for delivering, providing, or arranging for the provision of all medically necessary mental health services for enrolled clients.

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 measurement 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. Changes to the program that require additional funding will be subject to the normal budgetary process.

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 (BHOs). 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. (2009) 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. (2009) 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. After intensive and continued review by stakeholders, the Medical Services Board will consider rulemaking that describes the rate setting process, ensures transparency in rate setting, and provides for cost containment mechanisms.

The Department, working in conjunction with the provider community and also the Division of Behavioral Health, Department of Human Services has completed three projects that are important steps in reforming mental health capitation rate setting.

First, a substantial revision to the Accounting and Auditing Guidelines has been completed. These revised guidelines will help the Department ensure that costs used to create the fee schedule used in BHO rate setting are reasonable and consistently reported. Colorado law at 25.5-4-403, C.R.S. (2009) requires that direct reimbursement to community mental health centers and clinics be equal to the actual or reasonable cost of providing services. The preponderance of services authorized by BHOs are provided by community mental health centers, and the Department also uses those costs in the capitation rate setting process.

Second, the departments and the provider community created a system of standardized relative value unit weights for the various mental health services provided by community mental health centers. This system is parallel to the Medicare system for valuing the relative costs of physician services. This system will allow the Department to analyze differences in unit costs between BHOs' subcontracted community mental health centers, and determine if the cost differences are due merely to service mix/acuity, or are due to other factors, like variation in efficiency. These relative value weights will be used in rates effective January 1, 2010.

Third, the Department commissioned a Uniform Service Coding Standards manual. Authored in collaboration with stakeholders, this manual provides consistent coding standards to the BHOs and their community mental health center subcontractors. Certain procedure codes used frequently by the BHOs have broad definitions, and stakeholders told the Department that various providers were interpreting those definitions differently. By providing clarifying guidance around the elements of the medical record necessary to support coding each procedure, the Department will gain consistency in reporting for both rate setting and quality analysis purposes.

The increased quality of data that will result from these three initiatives will allow the Department to continue to work to reform BHO capitation rate setting. While rate reforms have already taken place, in conformance with audit recommendations, data quality will continue to improve as the BHOs and their subcontractors become accustomed to the new or revised guidance provided by the Department. The Department anticipates that further incremental improvements will be made to the BHOs' rate setting process over at least the next two years. As described to stakeholders at the Colorado Behavioral Healthcare Council conference in October 2009, these reforms could well include changes such as removing the implicit penalty provided to the most efficient providers under the current reimbursement mechanism. Behavioral health organizations which contract with community mental health centers which are relatively efficient, and have relatively lower costs, receive a relatively lower capitation rate relative to their peers, all other factors being equal. Changes such as these are likely to be sensitive to the provider community as it is possible that certain reforms could create financial winners and losers. Because of this, the Department has reaffirmed its commitment to an open and transparent process. No rate reforms of this magnitude will be made without further rulemaking by the Medical Services Board. Furthermore, rate reforms having a budget impact will be subject to the normal budgetary process.

Encounter Data Processing

Currently, due to the Department's bandwidth and data transfer technology for the transfer of electronic claims and encounter data, BHOs and other providers with a large number of clients must use dial-up file transfer technology in order to submit data. As a result, users experience dropped connections, incomplete file transfer, and busy signals when performing submission testing and submitting actual claim data. Often, tasks that should take hours can take days. The Department is taking steps to improve its encounter data

processing technology. As such, the Department will be using existing development hours in the Medicaid Management Information System to complete system changes that will allow for batch submission of encounter data using a broadband connection via the Department's Web portal. The Department anticipates these changes will be completed by the end of FY 2009-10.

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 idea by ensuring that providers are billing appropriately and that taxpayer resources are being used efficiently and effectively. Although the vast majority of the health care providers who care for Medicaid clients are honest and dedicated, a small number of providers take advantage of the system by billing for services not rendered or by providing unnecessary services. In actively seeking to reduce the amount of fraud, waste, and abuse the Department's Program Integrity Section and its contractors recovered $7.2 million in FY 2008-09. These recoveries help offset expenditures made by the Department across its Medical Services Premiums line.

As a part of the Department's commitment to achieving value for clients and the public, the Department has purchased Electronic Surveillance Utilization Reporting and Fraud Detection software and is focusing on two initiatives: the Unified Provider Enrollment Process and the Medicare-Medicaid Data Matching Project. The Department is also partnering with the Centers for Medicare and Medicaid Services and its Medicaid Integrity contractors on identifying and preventing provider fraud across the Medicaid Program. A description of each initiative is provided below.

Enterprise Surveillance Utilization Reporting and Fraud Detection

Per the Centers for Medicare and Medicaid Services, surveillance of utilization is a required component of a certified Medicaid Management Information System (MMIS). The Program Integrity Section currently uses a fraud detection tool called the Surveillance Utilization Reporting System, which is run the first weekend of every month. The tool is a sub-system of the Department's current MMIS. The tool allows staff to perform statistical analysis of providers against their peer group to identify which providers prove to be out two or more standard deviations from the norm. The Program Integrity staff uses the Surveillance Utilization Reporting System applications to monitor utilization and target staff resources on cases with the highest probability of aberrant provider billing behavior. The providers that show up with the highest utilization patterns are often those providers actively committing fraud.

The Department was appropriated $778,403 in total funds in FY 2008-09 and $250,000 for maintenance in FY 2009-10 to purchase fraud detection software called the Enterprise Surveillance Utilization Reporting System, or ESURS. This software is an upgrade of

the Surveillance Utilization Reporting System. Program Integrity staff began actively using ESURS in July 2009. The ESURS upgrade allows each Program Integrity employee the opportunity to run utilization reports at any time and get same-day results via Web access. The Department anticipates that the software upgrade will increase fraud referral rates and allow for greater cost avoidance by ensuring that fraudulent providers no longer participate in Medicaid.

Unified Provider Enrollment Process

In FY 2008-09 Colorado began voluntarily participating in the Centers for Medicare and Medicaid Services-sponsored Unified Provider Enrollment Process (UPEP) pilot program. The goal of the UPEP program 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. The UPEP program is a Medicaid-Medicare enrollment system for all fee-for-service providers and for managed care entities. The UPEP program is fully funded by the Centers for Medicare and Medicaid Services with Deficit Reduction Act-allocated funds. The program 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 the Centers for Medicare and Medicaid Services 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.

The UPEP program will contribute to the Governor's Building Blocks to Health Care Reform plan 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 MMIS, provider-submitted information entered into UPEP will be exchanged between the two systems electronically. The online provider enrollment feature of UPEP shifts the enrollment process from a 100% paper process to an electronic transfer process that is approximately 90% online. The amount of staff time at the fiscal agent and the Department 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 program has an anticipated implementation date of May 2010 for the first test group of providers.

During FY 2008-09, significant progress toward final implementation of the UPEP program was made. Memoranda of Understanding were executed between the Centers for Medicare and Medicaid Services and the Department on April 26, 2009. Representatives of the Department's Program Integrity and Contracts and Monitoring Sections, the Centers for Medicare and Medicaid Services, the Contractor hired by the Centers for Medicare and Medicaid Services to implement UPEP, and three other pilot states met in Baltimore the second week of June to further refine the functionality of the UPEP program. As a result of this meeting, attendees finalized state specific requirements for processing provider enrollment data and the system architecture for back-end validation of the submitted information.

Medicare-Medicaid Data Matching Project

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 project is 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.

The Department became a MEDI-MEDI state in FY 2008-09, although the Joint Operating Agreement between the Department and the Centers for Medicare and Medicaid Services wasn't executed until May 2009. Six months of Colorado claims data was sent to the Centers for Medicare and Medicaid Services in May 2009 for preparatory data mapping. The mapping was completed and three years of claims data has also been sent. The first data matching project began October 2009. The Colorado MEDI-MEDI steering committee met in February 2009 and is scheduled to meet again in November 2009 to discuss project status and to determine data mining referrals.

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 Unified Provider Enrollment Process (UPEP) 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 UPEP 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.

The Centers for Medicare and Medicaid Services and Medicaid Integrity Contractors

The Centers for Medicare and Medicaid Services began contracting with three types of Medicaid Integrity contractors in April 2009. One type is a Data Medicaid Integrity contractor, which mines data to identify possible overpayments. The second type is an Audit Medicaid Integrity contractor, which audits providers in their assigned region of states. The third type is called a Provider Education Medicaid Integrity contractor, which uses the issues identified by the previous two Medicaid Integrity contractors and develops education for distribution to providers in their assigned region of states. The Data Medicaid Integrity contractor sends their data results to the Centers for Medicare and Medicaid Services who then authorizes the data reports. These reports are sent to the Audit Medicaid Integrity contractor in the form of a "task order." The Audit Medicaid Integrity contractor takes the list of claims provided in their task order and conducts a review of the providers who submitted the claims in their report. Each of these Medicaid Integrity contractors are assigned a region of states in which to conduct their assigned tasks. The results of the data mining and audit findings are then trended by the Provider Education Medicaid Integrity contractor who will be responsible for developing national level provider education regarding Medicaid fraud, waste and abuse.

The Department's Program Integrity Section has received three separate lists of providers to be audited by the Audit Medicaid Integrity contractor. The Program Integrity Section is in the process of completing the information required on the Medicaid Integrity contractor spreadsheet, which is required by the Joint Operating Agreement between the Department and the Centers for Medicare and Medicaid Services. Once the information is returned to the Medical Integrity contractor, they will add individual claims for their targeted review and return it to the Department's Program Integrity Section for further vetting. If the providers have been, or are currently, under review, Program Integrity will provide that feedback for possible removal from the audit. The Audit Medicaid

Integrity contractor will request records from the provider and conduct their review. Any overpayment findings will be sent to Program Integrity for the return of the federal portion of the overpayment and so the Department can handle the demand for repayment from the providers. The timelines for providers to respond to the Medicaid Integrity contractor will align with Colorado regulations.

The Centers for Medicare and Medicaid Services Proposed Regulations

The Centers for Medicare and Medicaid Services (CMS) proposed Medicaid regulations affecting financing and federal funding that could severely restrict the ability of state Medicaid operations to continue to administer services at the current level. 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 CMS 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.

Due to the heavy costs imposed by these regulations, not only to Colorado, but to every state Medicaid program, Congress imposed a moratorium on the federal rules until April 1, 2009. With the American Recovery and Reinvestment Act of 2009 (ARRA), Congress imposed further restrictions on the proposed regulations. The specific regulations and the actions taken are as follows:

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

- Clarifies the situations in which Medicaid will pay for case management activities and also clarifies when federal financial participation is not available for activities inconsistent with the proper and efficient operation of the Medicaid program.
- ARRA extended the moratorium on this regulation to July 2009. In addition, in May 2009, CMS rescinded parts of this rule – specifically, the sections pertaining to case management for individuals transitioning to community settings and a portion of the section which clarifies the case management activities that qualify for federal financial participation.
- The Department submitted an updated State Plan Amendment for School Health Services that was approved by CMS in July 2008. The current language in the State Plan is in compliance with the remaining portions of this rule and the Department anticipates neither fiscal nor programmatic impact.

Public Provider Cost Limit Regulation (CMS 2258-FC)

- Changes public provider payments and financing arrangements with Medicaid programs. As a result of this regulation, Colorado would experience significant negative fiscal and programmatic 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.
- ARRA instructed CMS to cancel this regulation, however as of October 2009, CMS has taken no further action on this rule.

Graduate Medical Education Regulation (CMS 2279-P)

- 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.
- ARRA instructed CMS to cancel this regulation; however as of October 2009 CMS has taken no further action on this rule.

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.
- ARRA instructed CMS to cancel this regulation and CMS rescinded this rule in its entirety in May 2009.
- 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 CMS; however, the Department estimates this rule would have dramatically changed 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.
- ARRA instructed CMS to cancel this regulation and CMS rescinded this rule in its entirety in May 2009.
- Current rules allow reimbursement to schools for transportation, and the Department estimates this regulation would have resulted 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 currently collects a provider fee from nursing facility providers and anticipates it will begin collecting a provider fee from hospital providers beginning in FY 2009-10. ARRA extended the moratorium on this rule to July 2009 and CMS has further extended the implementation of this rule to July 2010. The Department may have to meet a more strict hold harmless test for its provider fees, but the Department does not anticipate a fiscal impact due to this rule.

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.
- ARRA instructed CMS to cancel this regulation, however as of October 2009, CMS has taken no further action on this rule.

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®) [8] 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 among clients enrolled in Medicaid managed care, the Primary Care Physician Program, and Medicaid fee-for-service. 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 2008. The survey period for this questionnaire was July through December 2008. The data were collected between February and May 2009. National averages for 2008 (the most recent comparative data available) are included.

A minimum of 100 responses to each measure are required in order to report the measure as a CAHPS Survey Result. Measures that do not meet the minimum number of responses are denoted as Not Applicable (N/A). Health Services Advisory Group, the contracted External Quality Review Organization that calculates CAHPS, has advised that plan ratings should not be compared to national averages. Using a national average would not be practicable due its statistical sensitivity in comparison to plan results. It is equally impractical to use a statewide average which is calculated by the National Committee for Quality Assurance because plan results have case mix differences factored into the numbers while the statewide average does not factor case mix differences.

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

CAHPS 2009 Summary of Results, Reporting Year 2008

CAHPS Measure	Rocky Mountain Health Plans	Denver Health and Hospital Authority	Primary Care Physician Program	Fee-for-Service	2008 National Average
Overall Rating of Health Plan *"Using any number from 0 to 10 where 0 is the worst health plan possible, and 10 is the best health plan possible, what number would you use to rate your health plan?"* Percent rating an 8, 9, or 10.					
Adult	58.6%	46.8%	51.7%	46.4%	N/A
Child	65.8%	55.6%	63.7%	60.3%	N/A
Overall Rating of Health Care *Of those respondents who reported going to a doctor's office or clinic: "Using any number from 0 to 10, where 0 is the worst health care possible, and 10 is the best, what number would you use to rate all your health care in the last 6 months?"* Percent rating an 8, 9, or 10.					
Adult	50.6%	41.7%	51.0%	42.5%	N/A
Child	56.7%	49.5%	66.1%	56.8%	N/A
Overall Rating of Personal Doctor or Nurse *Of those respondents who saw a primary care provider: "Using any number from 0 to 10, where 0 is the worst personal doctor or nurse possible, and 10 is the best possible, what number would you use to rate your personal doctor or nurse?"* Percent rating an 8, 9, or 10.					
Adult	66.2%	67.8%	62.4%	57.5%	N/A
Child	70.2%	64.2%	73.7%	70.0%	N/A
Getting Needed Care *Getting needed care is a composite of questions regarding the ease of finding a doctor or nurse, obtaining a referral to a specialist, getting the care the respondent or a doctor believed necessary, and delays in health care while waiting for an approval.* Percent rating "not a problem."					
Adult	58.7%	30.0%	52.2%	50.6%	N/A
Child	63.1%	N/A	56.0%	50.9%	N/A

CAHPS 2009 Summary of Results, Reporting Year 2008 (cont.)

CAHPS Measure	Rocky Mountain Health Plans	Denver Health and Hospital Authority	Primary Care Physician Program	Fee-for-Service	2008 National Average
Getting Care Quickly *Getting care quickly is a composite of questions regarding receiving help or advice over the telephone, obtaining routine appointments, obtaining care for an illness or injury, and waiting time in an office or clinic.* Percent rating "always and usually."					
Adult	57.8%	40.4%	55.2%	57.3%	N/A
Child	75.3%	53.6%	74.7%	67.4%	N/A
CAHPS Measure	**Rocky Mountain Health Plans**	**Denver Health and Hospital Authority**	**Primary Care Physician Program**	**Fee-for-Service**	**2008 National Average**
Doctors Who Communicate Well *How well doctors communicate is a composed of questions regarding how well providers listen to and explain things, whether they show respect and whether they spend enough time with the respondent.* Percent rating "always and usually."					
Adult	70.7%	69.6%	63.5%	63.3%	N/A
Child	76.9%	69.2%	77.0%	71.0%	N/A
Courteous and Helpful Office Staff *Questions regarding whether office staff at the respondent's doctor's office or clinic treated respondents with courtesy and respect and whether they were as helpful as respondents thought they should be made up the courteous and helpful office staff composite measure.* Percent rating "always and usually."					
Adult	61.7%	N/A	N/A	39.6%	N/A
Child	N/A	N/A	51.5%	41.0%	N/A

Health Effectiveness Data and Information Set (HEDIS)

The Health Effectiveness Data and Information Set (HEDIS®)[9] 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 health care plans. The performance measures address many significant health care issues such as access to care, effectiveness of care, and use of services. Each year, different HEDIS measures are selected that relate to quality initiatives 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 report HEDIS measure rates each year. The Department uses this information to track the health plans' performance in providing care and services to Medicaid clients and to identify and prioritize improvement efforts. As part of a comprehensive quality initiative, the Department required health plans to report rates on HEDIS measures for adults and children. The data presented in the following tables show performance rates on measures ranging from child immunization rates to cholesterol management. The 2009 rates reflect services provided January 1, 2008 through December 31, 2008.

It was discovered that not all federally qualified health centers (FQHCs) submit the codes needed to accurately calculate some HEDIS measures, although FQHCs clients are included in percentage denominators. This means that some fee-for-service rates are artificially low. The Department is working with the FQHCs to submit the required codes. Where applicable, the measures that may be affected by this data are marked with an asterisk (*).

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

2009 HEDIS Colorado Medicaid (Calendar Year 2008 Data Collection) HEDIS Rates for All Medicaid Health Plans HEDIS is a registered trademarked product of the National Committee for Quality Assurance								
HEDIS Measure	**Denver Health**	**Rocky Mountain Health Plans**	**Primary Care Physician Program**	**Fee-for-Service**	**HMO Weighted Average**	**Primary Care Physician Program & Fee-for-Service Weighted Average**	**Colorado Medicaid Weighted Average**	**2008 HEDIS National Medicaid Mean**
Childhood Immunization Status (H) (Percentage of children with immunization)								
4 Diptheria, Tetanus, Pertussis	88.1%	82.9%	78.8%	74.9%	86.8%	75.1%	76.5%	77.9%
1 Measles, Mumps and Rubella	96.1%	91.9%	92.2%	86.6%	95.1%	86.9%	87.8%	90.5%
3 Polio Virus immunizations	94.9%	94.0%	89.3%	85.4%	94.7%	85.6%	86.7%	87.4%
2 Haemophilus Influenza Type b	98.5%	96.2%	97.1%	92.2%	98.0%	92.4%	93.1%	87.8%
3 Hepatitis B immunizations	96.4%	93.8%	84.4%	84.2%	95.7%	84.2%	85.6%	87.3%
1 Chicken Pox vaccine	96.1%	91.0%	92.2%	86.1%	94.9%	86.4%	87.4%	88.9%
Pneumococcal Conjugate	90.8%	82.1%	80.3%	70.6%	88.6%	71.0%	73.1%	74.0%
Combo Rate 2 – 4 DTP or DTaP, 3OPV or IPV, 1 MMR, 2 hepatitis B, 1 Hib and VZV	87.6%	78.3%	70.1%	70.1%	85.3%	70.1%	71.9%	72.3%
Combo Rate 3 – 4 DTP or DTaP, 3OPV or IPV, 1 MMR, 2 hepatitis B, 1 Hib, VZV and pneumococcal congugate	87.1%	73.7%	65.5%	63.3%	83.8%	63.4%	65.8%	65.6%
Percentage of children with well child visits in the first 15 months of life (H)								
0 visits (lower is better)	2.0%	0.0%	63.8%	31.6%	1.2%	32.0%	30.1%	5.6%
6 or more	56.2%	7730.0%	15.9%	29.7%	64.1%	29.5%	31.6%	53.0%

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HEDIS Measure	**Denver Health**	**Rocky Mountain Health Plans**	**Primary Care Physician Program**	**Fee-for-Service**	**HMO Weighted Average**	**Primary Care Physician Program & Fee-for-Service Weighted Average**	**Colorado Medicaid Weighted Average**	**2008 HEDIS National Medicaid Mean**
Percentage of well child visits in the 3rd, 4th, 5th and 6th years of life (H)	63.0%	63.5%	46.2%	45.5%	63.1%	45.5%	47.7%	65.3%
Percentage of adolescents receiving a well care visit (H)	41.8%	4550.0%	28.0%	27.5%	42.9%	27.5%	29.2%	42.0%
Percentage of Children and adolescents accessing preventive care*								
12-24 months	90.6%	98.3%	14.9%	51.5%	92.4%	50.6%	55.6%	93.4%
25 months – 6 years	77.6%	89.1%	22.8%	40.4%	80.2%	39.5%	44.6%	84.3%
7-11 years	81.9%	92.3%	33.7%	39.3%	85.2%	38.7%	43.2%	85.8%
12-19 years	83.6%	91.9%	38.7%	39.7%	86.5%	39.6%	43.9%	82.6%
Prenatal and Postpartum Care (H)								
Percentage obtaining care within first trimester	86.1%	95.2%	70.2%	64.7%	90.3%	64.8%	67.1%	81.4%
Percentage obtaining care between 21 and 56 days postpartum	59.1%	71.9%	58.2%	53.0%	64.9%	53.1%	54.2%	58.7%
Percentage of Adults accessing preventive care*								
Percentage of clients age 20-44 accessing care	68.9%	86.1%	81.8%	76.6%	74.1%	77.0%	76.7%	76.8%
Percentage of clients age 45-64 accessing care	70.7%	87.6%	86.7%	79.5%	75.4%	80.5%	76.8%	82.4%
Percentage of clients age 65+ accessing care	59.9%	95.2%	81.9%	70.1%	71.3%	71.3%	71.3%	78.8%

2009 HEDIS Colorado Medicaid (Calendar Year 2008 Data Collection) HEDIS Rates for All Medicaid Health Plans HEDIS is a registered trademarked product of the National Committee for Quality Assurance								
HEDIS Measure	**Denver Health**	**Rocky Mountain Health Plans**	**Primary Care Physician Program**	**Fee-for-Service**	**HMO Weighted Average**	**Primary Care Physician Program & Fee-for-Service Weighted Average**	**Colorado Medicaid Weighted Average**	**2008 HEDIS National Medicaid Mean**
Percentage of clients receiving comprehensive diabetic care (H)								
HbA1c Testing	88.3%	85.7%	66.9%	57.7%	87.5%	59.0%	62.3%	77.4%
HbA1c poor control >9.0 (lower is better)	25.8%	25.8%	65.0%	68.9%	25.8%	68.3%	63.4%	47.7%
HbA1c control <8.0	47.8%	64.4%	29.2%	26.5%	53.0%	26.9%	29.9%	31.5%
Eye exam	50.7%	62.0%	38.0%	32.1%	54.3%	33.0%	35.4%	50.1%
LDL-C screening	76.0%	70.1%	57.7%	49.2%	74.1%	50.4%	53.1%	70.9%
LDL-C level <100 mg/dL	52.1%	43.8%	23.6%	20.0%	49.5%	20.5%	23.8%	31.4%
Medical attention for nephropathy	83.1%	76.1%	55.5%	59.6%	80.9%	59.0%	61.5%	74.4%
Blood pressure <130/80	42.2%	47.0%	24.1%	21.9%	43.7%	22.2%	24.7%	29.6%
Blood pressure <140/90	66.8%	79.1%	36.7%	36.5%	70.7%	36.5%	40.4%	55.5%
Percentage of clients with cardiovascular disease receiving cholesterol management* (H)								
LDL screening	85.2%	69.9%	58.6%	57.2%	77.9%	57.4%	59.2%	76.3%
LDL <100	75.9%	45.8%	24.5%	26.0%	61.5%	25.8%	29.0%	38.3%
Percentage of clients on persistent medications receiving annual monitoring*	80.8%	71.4%	82.2%	82.8%	77.8%	82.7%	81.8%	80.1%
ACE inhibitors or ARBs	86.6%	71.4%	89.1%	87.2%	82.0%	87.5%	86.5%	82.6%
Digoxin	N/A	76.7%	90.9%	88.4%	81.6%	88.8%	87.3%	85.0%
Diuretics	83.1%	71.9%	86.2%	86.0%	79.6%	86.0%	84.7%	81.4%
Anticonvulsants	62.2%	69.6%	70.0%	67.3%	64.8%	68.0%	67.5%	65.9%

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HEDIS Measure	**Denver Health**	**Rocky Mountain Health Plans**	**Primary Care Physician Program**	**Fee-for-Service**	**HMO Weighted Average**	**Primary Care Physician Program & Fee-for-Service Weighted Average**	**Colorado Medicaid Weighted Average**	**2008 HEDIS National Medicaid Mean**
Percentage of clients with appropriate asthma medications* (total)	86.4%	89.0%	87.8%	88.7%	87.3%	88.6%	88.4%	86.9%
5-9 years old	97.9%	90.0%	97.0%	93.5%	94.9%	93.9%	94.0%	89.3%
10-17 years old	90.5%	90.3%	86.1%	89.8%	90.4%	89.2%	89.2%	86.9%
18-56 years old	80.4%	88.0%	84.6%	83.6%	83.1%	83.8%	83.7%	84.5%
Percentage of antibiotic utilization for antibiotics of concern*	25.6%	38.8%	41.3%	38.6%	32.0%	38.8%	38.3%	38.5%
Number of ambulatory care visits/1000 member months*								
Outpatient*	220.0	461.3	434.2	364.2	279.1	368.9	358.1	317.8
ED	904.0	59	63.8	63.9	21.6	63.9	58.8	60.9
Ambulatory surgery	16.5	13.6	14.5	11	15.8	11.2	11.7	5.5
Observation stays	0.8	1.25	1.6	2.6	0.9	2.5	2.3	2

Inpatient Utilization								
Number of discharges/1000 mm	5.7	13.9	9	12	7.7	11.8	11.3	8.3
Number of days/1000 mm	21.7	46.5	48.6	45.8	27.8	45.9	43.8	30.6
Average Length of Stay	3.8	3.3	5.4	3.8	3.6	3.9	3.9	3.6

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 2008 demographic data from the United States Census Report, "2008 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 decision support system database, FY 2008-09 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. The decision support system 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 M in the November 6, 2009 FY 2010-11 Budget Request.

Children's Basic Health Plan
Using FY 2008-09 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: 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[10]	5,010,395
Percent of Population in the Labor Force, 2008[11]	70.99%
Percent of Families Below Poverty, 2008	7.80%
Percent of Female Headed Households, 2008	9.65%
Medicaid Characteristics, FY 2008-09	
Total Medicaid Clients[12]	436,812
Medical Services Premiums Expenditures[13]	$2,526,991,443
Total Department Service Expenditures[14]	$3,792,275,247
Medical Services Premiums as a percentage of the total services expenditures	64.96%
Children's Basic Health Plan Characteristics, FY 2008-09	
Average Number of Children per Month[15]	61,582
Average Prenatal Caseload per Month[16]	1,665
Children's Basic Health Plan Expenditures[17]	$130,686,358

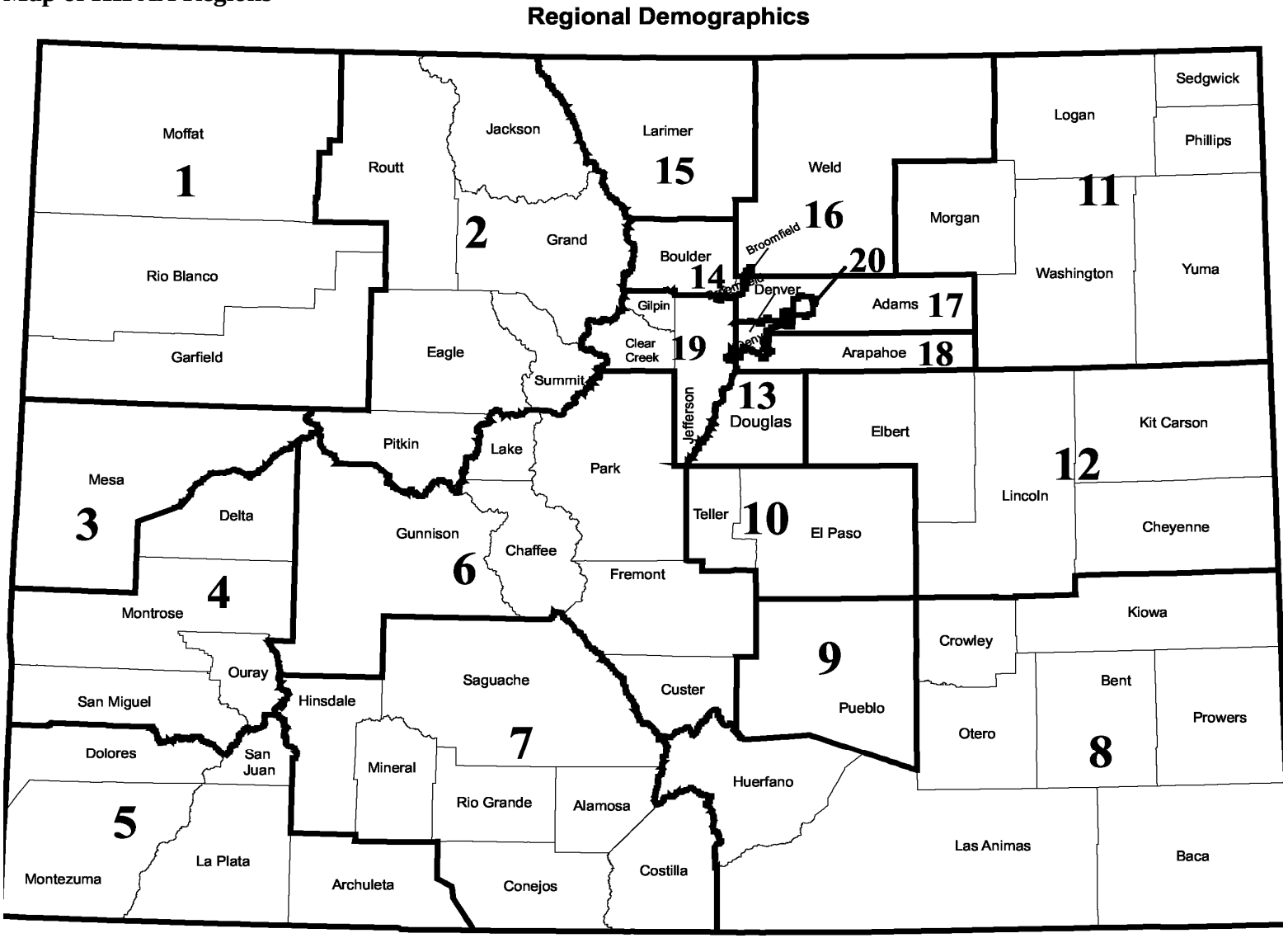
[10] Colorado Division of Local Government, Demography Office, November 2008 - Table 3a. "Preliminary Population Forecasts for Colorado Regions 2000-2010."
[11] Per the "2008 American Community Survey" from the United States Census Bureau. The percents listed are not relative to the total population.
[12] November 6, 2009 FY 2010-11 Budget Request, Exhibit B, "Medicaid Caseload Forecast."
[13] HB 08-1375, the FY 2008-09 Long Bill.
[14] November 6, 2009 FY 2010-11 Budget Request, Schedule 3. Total Department Expenditures equal $3,792,275,247. Of this $2,526,991,443 is Medical Services Premiums Expenditures; $217,637,190 is Medicaid Mental Health Community Programs; $534,553,360 is the Indigent Care Program; $114,703,091 is Other Medical Services; and $398,390,163 is Department of Human Services Medicaid Funded Programs.
[15] July 2009 Joint Budget Committee Report.
[16] July 2009 Joint Budget Committee Report.
[17] November 6, 2009 FY 2010-11 Budget Request, Schedule 3.

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



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 2008-09 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 (MMIS). 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 2009 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 MMIS.

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 (2009)	77,639	139,010	145,671	85,394
Percent of Total Colorado Population (2009)	1.55%	2.77%	2.91%	1.70%
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 2008-09				
Average Number of Medicaid Clients per Month	5,660	4,536	14,586	8,798
Percent of Regional Population that are Medicaid Clients	7.29%	3.26%	10.01%	10.30%
Medicaid Expenditures	$40,178,436	$23,160,885	$107,281,793	$46,961,698
Percent of Total Medicaid Expenditures	1.34%	0.77%	3.57%	1.56%
Children's Basic Health Plan Characteristics, FY 2008-09				
Average Number of Children per Month	1,131	1,091	2,500	1,938
Percent of Regional Population that are Children's Basic Health Plan Clients	1.46%	0.78%	1.72%	2.27%
Children's Basic Health Plan Expenditures	$2,527,576	$2,389,872	$5,134,551	$3,718,888
Percent of Total Children's Basic Health Plan Expenditures	2.11%	1.99%	4.28%	3.10%
Colorado Indigent Care Program Characteristics, FY 2007-08				
Number of Colorado Indigent Care Program Providers in Region	2	3	3	3
Colorado Indigent Care Program Expenditures	$732,851	$737,133	$1,635,478	$1,505,579
Percent of Total Colorado Indigent Care Program Expenditures	0.38%	0.38%	0.84%	0.84%

Regions	Region 5	Region 6	Region 7	Region 8
Characteristics	Archuleta, Dolores, La Plata, Montezuma, San Juan	Gunnison, Chaffee, Lake, Fremont, Park, Custer	Hinsdale, Saguache, Mineral, Conejos, Rio Grande, Alamosa, Costilla	Huerfano, Las Animas, Baca, Otero, Crowley, Bent, Prowers, Kiowa
Demographic Characteristics				
Colorado Population Estimate (2009)	91,493	110,060	48,549	75,755
Percent of Total Colorado Population (2009)	1.83%	2.20%	0.97%	1.51%
Colorado Population (2000)	80,071	102,181	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 2008-09				
Average Number of Medicaid Clients per Month	7,769	8,955	9,197	12,671
Percent of Regional Population that are Medicaid Clients	8.49%	8.14%	18.94%	16.73%
Medicaid Expenditures	$47,210,847	$70,962,361	$51,885,894	$91,890,906
Percent of Total Medicaid Expenditures	1.57%	2.36%	1.72%	3.05%
Children's Basic Health Plan Characteristics, FY 2008-09				
Average Number of Children per Month	1,848	1,551	1,613	1,556
Percent of Regional Population that are Children's Basic Health Plan Clients	2.02%	1.41%	3.32%	2.05%
Children's Basic Health Plan Expenditures	$3,916,373	$3,014,814	$2,951,680	$2,861,916
Percent of Total Children's Basic Health Plan Expenditures	3.26%	2.51%	2.46%	2.38%
Colorado Indigent Care Program Characteristics, FY 2007-08				
Number of Colorado Indigent Care Program Providers in Region	3	4	4	6
Colorado Indigent Care Program Expenditures	$1,916,350	$1,591,575	$3,632,100	$2,874,970
Percent of Total Colorado Indigent Care Program Expenditures	0.98%	0.82%	1.87%	1.48%

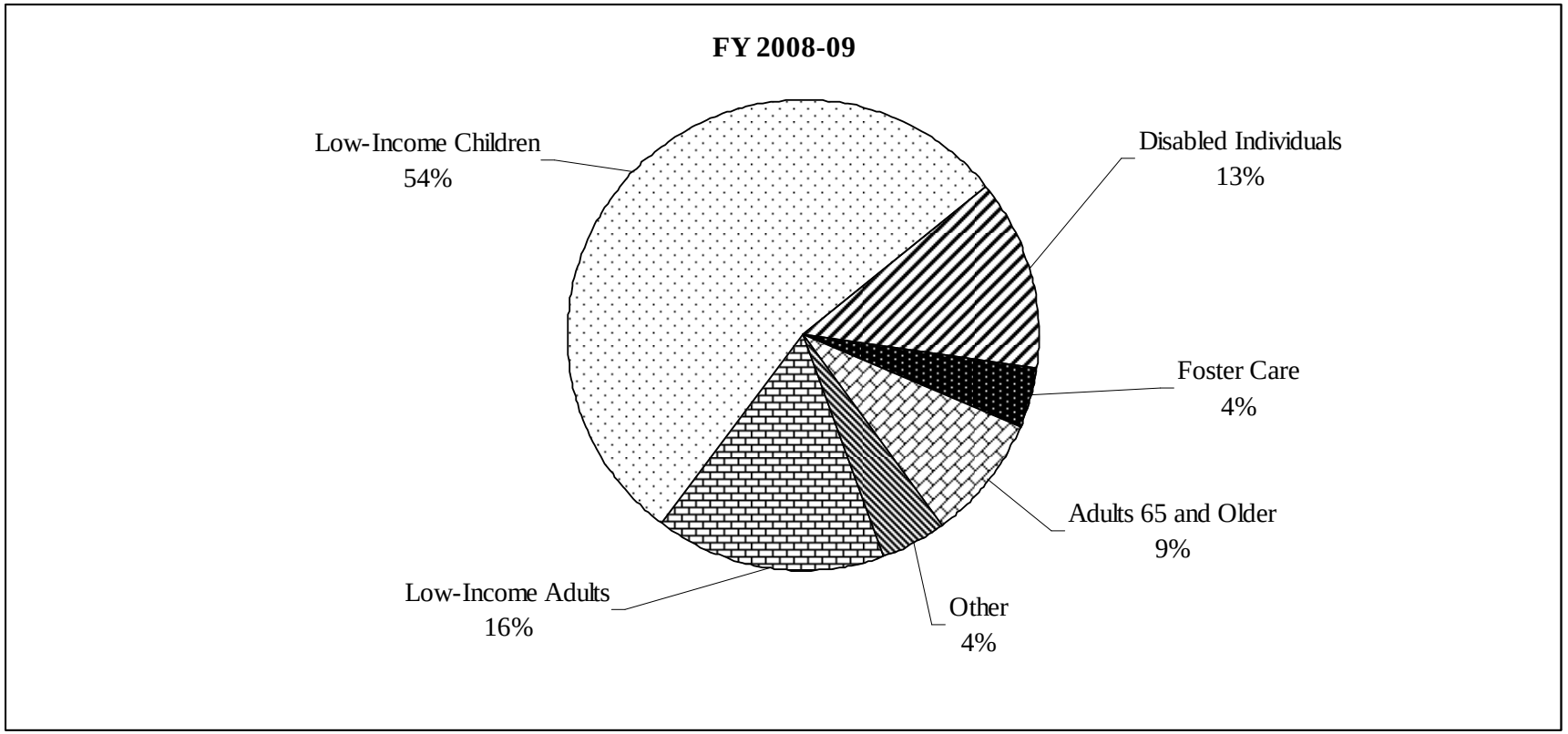
Regions	Region 9	Region 10	Region 11	Region 12
Characteristics	Pueblo	El Paso, Teller	Washington, Morgan, Logan, Yuma, Phillips, Sedgwick	Elbert, Lincoln, Kit Carson, Cheyenne
Demographic Characteristics				
Colorado Population Estimate (2009)	158,966	617,388	71,819	38,452
Percent of Total Colorado Population (2009)	3.17%	12.32%	1.43%	0.77%
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 2008-09				
Average Number of Medicaid Clients per Month	28,048	53,674	7,858	2,653
Percent of Regional Population that are Medicaid Clients	17.64%	8.69%	10.94%	6.90%
Medicaid Expenditures	$201,654,711	$350,814,785	$56,284,678	$16,220,800
Percent of Total Medicaid Expenditures	6.70%	11.66%	1.87%	0.54%
Children's Basic Health Plan Characteristics, FY 2008-09				
Average Number of Children per Month	2,232	6,071	1,262	580
Percent of Regional Population that are Children's Basic Health Plan Clients	1.40%	0.98%	1.76%	1.51%
Children's Basic Health Plan Expenditures	$4,137,914	$12,854,212	$2,328,970	$1,133,418
Percent of Total Children's Basic Health Plan Expenditures	3.45%	10.71%	1.94%	0.94%
Colorado Indigent Care Program Characteristics, FY 2007-08				
Number of Colorado Indigent Care Program Providers in Region	3	3	6	1
Colorado Indigent Care Program Expenditures	$12,264,559	$21,819,965.00	$1,845,976	$39,216
Percent of Total Colorado Indigent Care Program Expenditures	6.30%	11.21%	0.95%	0.02%

Regions	Region 13	Region 14	Region 15	Region 16
Characteristics	Douglas	Boulder, Broomfield	Larimer	Weld
Demographic Characteristics				
Colorado Population Estimate (2009)	287,354	352,736	294,570	252,272
Percent of Total Colorado Population (2009)	5.74%	7.04%	5.88%	5.03%
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 2008-09				
Average Number of Medicaid Clients per Month	5,887	17,850	19,322	24,648
Percent of Regional Population that are Medicaid Clients	2.05%	5.06%	6.56%	9.77%
Medicaid Expenditures	$45,014,972	$142,584,582	$136,184,833	$141,033,136
Percent of Total Medicaid Expenditures	1.50%	4.74%	4.53%	4.69%
Children's Basic Health Plan Characteristics, FY 2008-09				
Average Number of Children per Month	1,132	2,786	3,235	3,972
Percent of Regional Population that are Children's Basic Health Plan Clients	0.39%	0.79%	1.10%	1.57%
Children's Basic Health Plan Expenditures	$2,177,154	$5,004,544	$6,656,418	$7,346,804
Percent of Total Children's Basic Health Plan Expenditures	1.81%	4.17%	5.54%	6.12%
Colorado Indigent Care Program Characteristics, FY 2007-08				
Number of Colorado Indigent Care Program Providers in Region	0	4	4	4
Colorado Indigent Care Program Expenditures	$0	$4,915,451	$10,360,471	$15,251,853
Percent of Total Colorado Indigent Care Program Expenditures	0.00%	2.52%	5.32%	7.83%

Regions	**Region 17**	**Region 18**	**Region 19**	**Region 20**
Characteristics	Adams	Arapahoe	Jefferson, Gilpin, Clear Creek	Denver
Demographic Characteristics				
Colorado Population Estimate (2009)	435,122	563,726	557,770	606,649
Percent of Total Colorado Population (2009)	8.68%	11.25%	11.13%	12.11%
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 2008-09				
Average Number of Medicaid Clients per Month	48,845	45,362	31,142	79,353
Percent of Regional Population that are Medicaid Clients	11.23%	8.05%	5.58%	13.08%
Medicaid Expenditures	$301,794,260	$317,137,334	$311,902,626	$508,595,501
Percent of Total Medicaid Expenditures	10.03%	10.54%	10.37%	16.90%
Children's Basic Health Plan Characteristics, FY 2008-09				
Average Number of Children per Month	8,579	6,714	4,627	8,663
Percent of Regional Population that are Children's Basic Health Plan Clients	1.97%	1.19%	0.83%	1.43%
Children's Basic Health Plan Expenditures	$15,505,495	$12,341,960	$9,001,305	$15,058,127
Percent of Total Children's Basic Health Plan Expenditures	12.91%	10.28%	7.50%	12.54%
Colorado Indigent Care Program Characteristics, FY 2007-08				
Number of Colorado Indigent Care Program Providers in Region	1	1	0	6
Colorado Indigent Care Program Expenditures	$1,806,543	$3,554,604	$0	$108,249,257
Percent of Total Colorado Indigent Care Program Expenditures	0.93%	1.83%	0.00%	55.59%

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 2008-09.[15]



[15] Source: November 6, 2009 FY 2010-11 Budget Request, Exhibit B, "Medicaid Caseload Forecast."

A. Clients

A1. 2009 Federal Poverty Levels

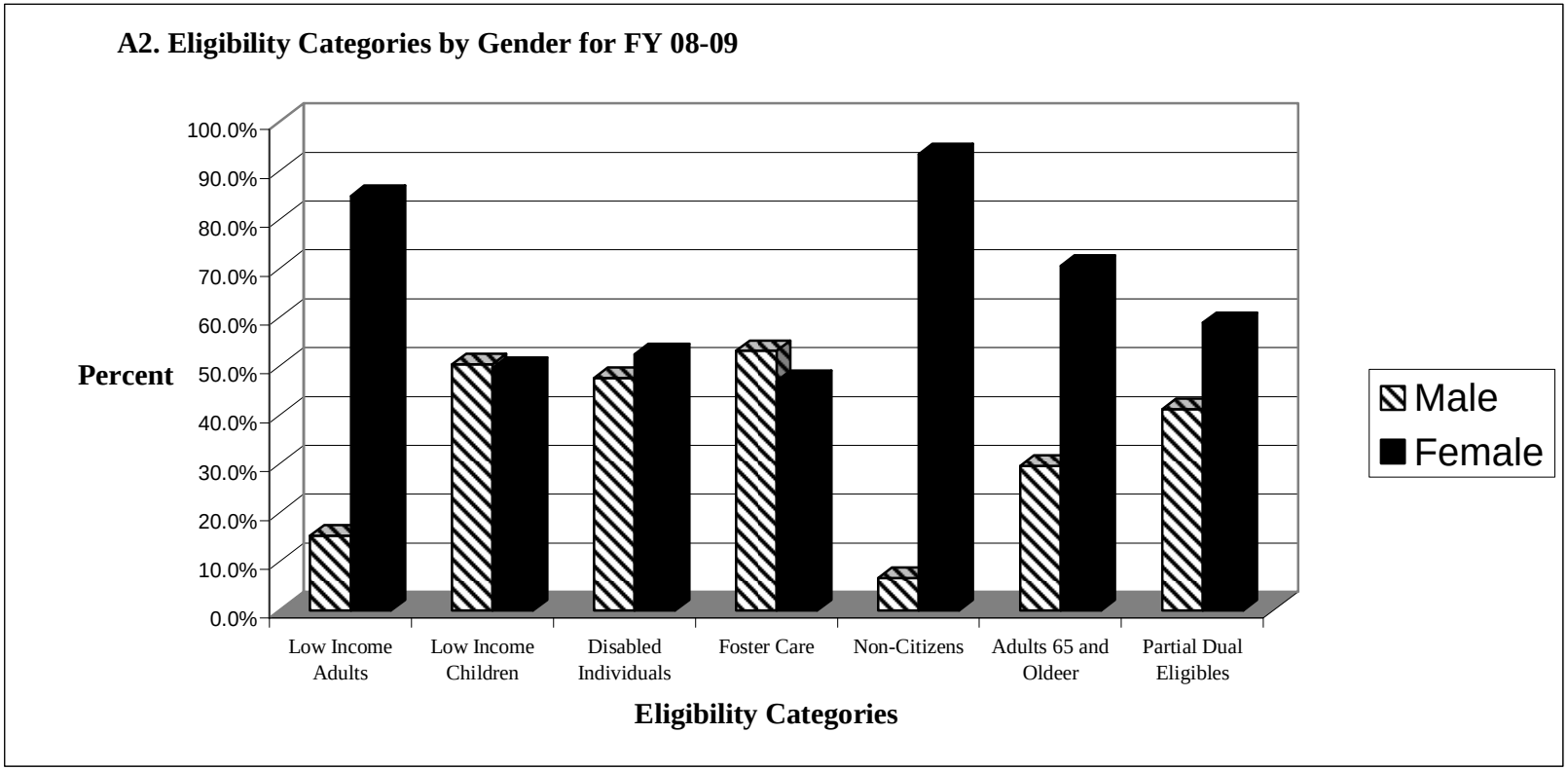
The table below reports the federal poverty levels for all states except Hawaii and Alaska from the Department of Health and Human Services. For family units of more than eight members, add $4,300 for each additional family member[16].

Federal Poverty Guidelines for Annual Income

Family Size	100%	120%	133%	150%	175%	185%	190%	200%	250%
1	$10,830	$12,996	$14,404	$16,245	$18,953	$20,036	$20,577	$21,660	$27,075
2	$14,570	$17,484	$19,378	$21,855	$25,498	$26,955	$27,683	$29,140	$36,425
3	$18,310	$21,972	$24,352	$27,465	$32,043	$33,874	$34,789	$36,620	$45,775
4	$22,050	$26,460	$29,327	$33,075	$38,588	$40,793	$41,895	$44,100	$55,125
5	$25,790	$30,948	$34,301	$38,685	$45,133	$47,712	$49,001	$51,580	$64,475
6	$29,530	$35,436	$39,275	$44,295	$51,678	$54,631	$56,107	$59,060	$73,825
7	$33,270	$39,924	$44,249	$49,905	$58,223	$61,550	$63,213	$66,540	$83,175
8	$37,010	$44,412	$49,223	$55,515	$64,768	$68,469	$70,319	$74,020	$92,525

[16] Source: *Federal Register*, Vol. 74, No. 15, January 23, 2009

A2. Eligibility Categories by Gender for FY 2008-09[17]



[17] 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 2004-05 through FY 2008-09 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[18].

Average Medicaid Enrollment for FY 2004-05 through FY 2008-09

Membership Category	FY 2004-05 Count	FY 2005-06 Count	FY 2006-07 Count	FY 2007-08 Count	FY 2008-09 Count
Health Maintenance Organizations and Prepaid Inpatient Health Plans	77,354	71,799	35,985	36,701	54,510
Primary Care Physician Program	51,669	36,563	29,243	25,875	22,717
Fee-for-Service	273,779	291,343	327,849	325,492	359,585
TOTALS	**402,802**	**399,705**	**393,077**	**388,068**	**436,812**

[18] Source: July 2009 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.

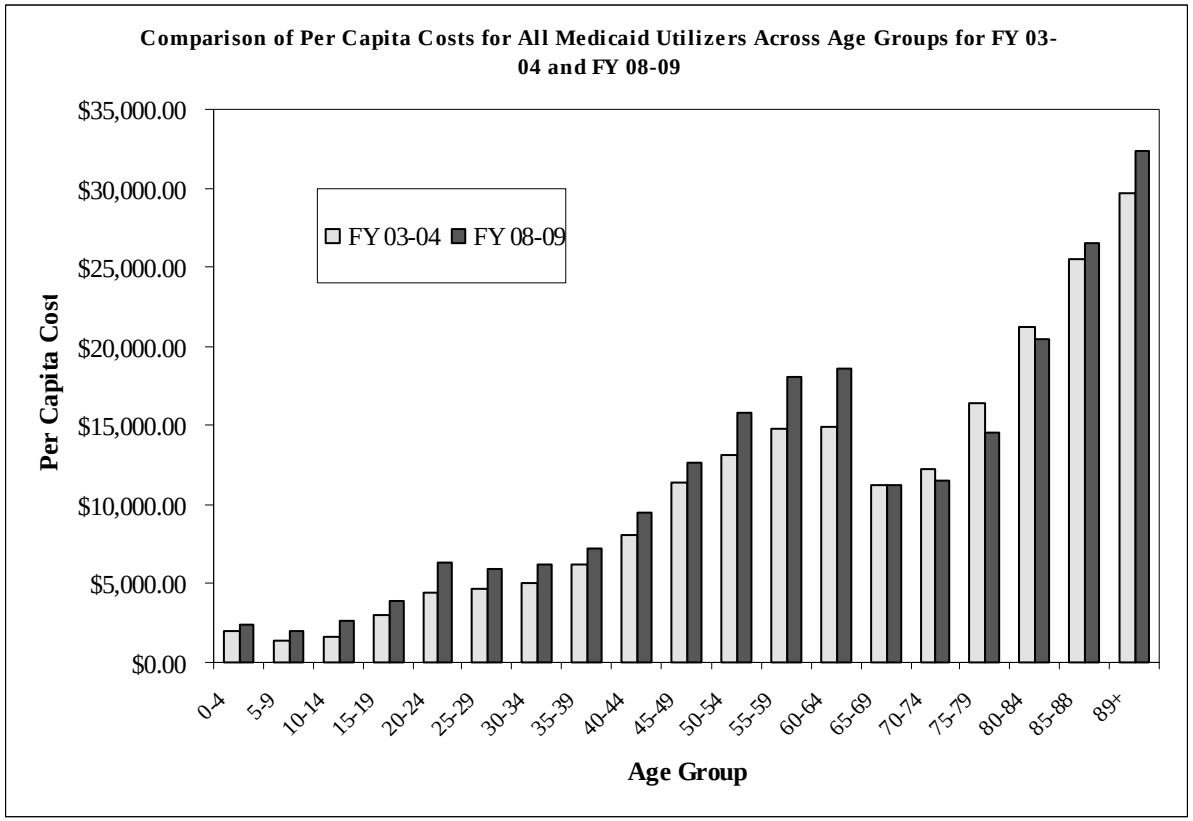
B. Services

B1. Paid Medical Services Per Capita Costs (from all claims) Across Age Groups[19]

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 2008-09. 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

[19] Source: Medicaid paid claims. Financial transactions and other accounting adjustments are not included in the expenditures by age group.


Comparison of Per Capita Costs for All Medicaid Utilizers Across Age Groups for FY 03-04 and FY 08-09
$35,000.00
$30,000.00
$25,000.00
$20,000.00
$15,000.00
$10,000.00
$5,000.00
$0.00
FY 03-04
FY 08-09
Per Capita Cost
0-4
5-9
10-14
15-19
20-24
25-29
30-34
35-39
40-44
45-49
50-54
55-59
60-64
65-69
70-74
75-79
80-84
85-88
89+
Age Group

B2. FY 2008-09 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., the MMIS) 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 2008-09 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	1,465	4,671	3,691	854	2,846
Eagle, Grand, Jackson, Pitkin, Routt, Summit	235	4,964	2,900	953	1,983
Mesa	54	7,323	5,106	637	3,119
Delta, Montrose, Ouray, San Miguel	150	4,671	3,321	411	2,029
Archuleta, Dolores, La Plata, Montezuma, San Juan	914	6,467	5,287	720	3,573
Gunnison, Chaffee, Lake, Fremont, Park, Custer	436	7,200	6,566	851	4,187
Hinsdale, Saguache, Mineral, Conejos, Rio Grande, Alamosa, Costilla	6,036	6,320	6,373	864	3,895
Huerfano, Las Animas, Baca, Otero, Crowley, Bent, Prowers, Kiowa	4,415	9,731	8,962	1,135	6,341
Pueblo	7,110	23,669	20,656	2,599	14,282
El Paso, Teller	21,211	44,151	37,664	5,420	26,681
Washington, Morgan, Logan, Yuma, Phillips, Sedgwick	2,221	5,789	5,499	836	3,841
Elbert, Lincoln, Kit Carson, Cheyenne	714	1,904	1,931	257	1,191
Douglas	255	5,573	4,286	613	2,577
Boulder, Broomfield	7,997	13,339	11,057	1,983	8,131
Larimer	6,659	17,031	13,556	2,151	9,185
Weld	11,462	20,901	16,786	2,893	12,091
Adams	17,554	41,126	30,863	5,697	24,137
Arapahoe	7,419	39,313	28,285	5,101	21,641
Jefferson, Gilpin, Clear Creek	5,482	26,221	20,957	3,094	13,742
Denver	24,673	40,352	31,964	6,886	23,100
Statewide	**123,961**	**321,176**	**258,894**	**43,736**	**184,933**

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 2008-09 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	$149.98	$532.03	$441.77	$923.66	$427.46
Eagle, Grand, Jackson, Pitkin, Routt, Summit	$26.20	$715.42	$498.44	$1,331.32	$392.81
Mesa	$1.19	$212.85	$149.93	$340.05	$169.70
Delta, Montrose, Ouray, San Miguel	$8.55	$227.08	$187.15	$310.14	$168.21
Archuleta, Dolores, La Plata, Montezuma, San Juan	$36.56	$472.53	$547.34	$523.86	$390.32
Gunnison, Chaffee, Lake, Fremont, Park, Custer	$25.92	$505.80	$817.54	$637.44	$364.58
Hinsdale, Saguache, Mineral, Conejos, Rio Grande, Alamosa, Costilla	$407.91	$387.20	$505.11	$640.22	$345.38
Huerfano, Las Animas, Baca, Otero, Crowley, Bent, Prowers, Kiowa	$190.23	$456.64	$682.65	$574.49	$365.31
Pueblo	$182.19	$576.97	$808.73	$662.41	$423.81
El Paso, Teller	$252.23	$603.02	$665.73	$707.92	$408.18
Washington, Morgan, Logan, Yuma, Phillips, Sedgwick	$149.44	$379.71	$599.29	$636.92	$426.36
Elbert, Lincoln, Kit Carson, Cheyenne	$137.03	$426.03	$616.60	$615.92	$434.51
Douglas	$17.75	$731.84	$706.71	$794.45	$442.86
Boulder, Broomfield	$229.47	$566.07	$535.75	$767.64	$410.77
Larimer	$166.96	$609.52	$745.11	$655.09	$358.14
Weld	$284.36	$558.47	$579.22	$837.34	$431.92
Adams	$187.02	$576.17	$453.17	$803.90	$412.65
Arapahoe	$74.82	$626.18	$517.03	$879.13	$428.27
Jefferson, Gilpin, Clear Creek	$87.46	$696.48	$797.84	$829.21	$446.46
Denver	$154.70	$376.64	$333.91	$829.11	$276.31
Statewide	**$160.00**	**$525.74**	**$543.83**	**$749.87**	**$374.25**

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 2008-09 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	374	142	-	64	265
Eagle, Grand, Jackson, Pitkin, Routt, Summit	132	72	-	87	51
Mesa	1,592	388	-	267	466
Delta, Montrose, Ouray, San Miguel	850	179	137	281	364
Archuleta, Dolores, La Plata, Montezuma, San Juan	679	108	-	211	310
Gunnison, Chaffee, Lake, Fremont, Park, Custer	892	186	-	314	572
Hinsdale, Saguache, Mineral, Conejos, Rio Grande, Alamosa, Costilla	940	96	-	426	295
Huerfano, Las Animas, Baca, Otero, Crowley, Bent, Prowers, Kiowa	1,297	279	1	292	707
Pueblo	1,866	622	1	1,169	804
El Paso, Teller	2,511	909	31	1,508	1,438
Washington, Morgan, Logan, Yuma, Phillips, Sedgwick	694	173	-	146	506
Elbert, Lincoln, Kit Carson, Cheyenne	160	35	-	22	109
Douglas	408	161	1	151	190
Boulder, Broomfield	1,367	589	1	610	816
Larimer	1,326	508	-	572	789
Weld	1,066	389	-	679	572
Adams	1,705	771	360	907	1,325
Arapahoe	2,256	1,024	341	963	1,207
Jefferson, Gilpin, Clear Creek	2,504	1,091	450	989	1,567
Denver	4,172	760	566	1,502	1,861
Statewide	**22,756**	**8,053**	**1,794**	**10,902**	**13,836**

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 2008-09 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	$3,716	$42,939	$0	$4,264	$44,215
Eagle, Grand, Jackson, Pitkin, Routt, Summit	$3,499	$34,070	$0	$3,197	$45,463
Mesa	$10,753	$68,790	$0	$7,689	$32,458
Delta, Montrose, Ouray, San Miguel	$5,979	$35,424	$19,800	$7,692	$36,053
Archuleta, Dolores, La Plata, Montezuma, San Juan	$5,905	$31,335	$0	$12,548	$32,050
Gunnison, Chaffee, Lake, Fremont, Park, Custer	$8,049	$36,189	$0	$7,589	$35,192
Hinsdale, Saguache, Mineral, Conejos, Rio Grande, Alamosa, Costilla	$5,122	$40,087	$0	$2,801	$33,252
Huerfano, Las Animas, Baca, Otero, Crowley, Bent, Prowers, Kiowa	$6,503	$32,111	$3,634	$7,943	$36,909
Pueblo	$8,222	$50,448	$14,534	$13,248	$34,776
El Paso, Teller	$10,758	$32,532	$14,534	$21,959	$38,234
Washington, Morgan, Logan, Yuma, Phillips, Sedgwick	$4,535	$39,743	$0	$6,096	$35,426
Elbert, Lincoln, Kit Carson, Cheyenne	$6,831	$28,140	$0	$14,373	$38,099
Douglas	$12,462	$23,671	$10,901	$20,424	$42,587
Boulder, Broomfield	$7,360	$38,369	$10,901	$11,941	$35,847
Larimer	$6,941	$38,018	$0	$10,314	$39,285
Weld	$7,046	$36,223	$0	$9,678	$35,507
Adams	$9,275	$35,853	$35,061	$13,634	$39,895
Arapahoe	$11,636	$36,401	$33,879	$14,975	$36,582
Jefferson, Gilpin, Clear Creek	$10,150	$44,921	$33,957	$15,875	$39,383
Denver	$12,014	$29,089	$33,440	$12,027	$40,241
Statewide	**$10,002**	**$8,053**	**$34,371**	**$13,439**	**$38,706**

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 2004-05 through FY 2008-09 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 the Department of Health Care Policy and Financing (HCPF)

Fiscal Year	Elderly Blind and Disabled; and Consumer Directed Care for the Elderly*	Children's Home and Community-Based Services	Persons with Brain Injury	Persons with Mental Illness	Persons Living with AIDS	Children with Autism	Pediatric Hospice	Total HCPF
FY 2004-05	14,833	618	322	1,844	66	0	0	**17,407**
FY 2005-06	16,415	1,049	297	1,948	58	0	0	**19,534**
FY 2006-07	17,019	1,254	306	2,160	62	17	0	**20,553**
FY 2007-08	17,627	1,360	264	2,312	71	73	0	**21,522**
FY 2008-09	18,618	1,334	264	2,489	71	89	42	**22,756**

*The Consumer Directed Care for the Elderly waiver ended in December 2007, coinciding with the implementation of the Consumer Directed Attendant Support Services benefit in the Elderly, Blind and Disabled waiver.

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 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**	**29,157**
FY 2008-09	156	3,285	4,379	423	**8,053**	**30,738**

B3c: FY 2004-05 through FY 2008-09 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 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**
FY 2008-09	10,902	1,794	13,614	22	**13,636**

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 2003-06) one and one-half months (FY 2006-07) 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 2008-09 Top 10 Major Diagnostic Categories (Inpatient) Ranked by Expenditures

Rank	MDC Code	Description	Expenditures	Unduplicated Client Count
1	14	Pregnancy, childbirth and the puerperium	$99,182,841	24,045
2	4	Respiratory system	$28,999,663	4,272
3	15	Conditions of newborns	$28,437,816	3,446
4		Pre-MDC Other	$25,393,507	253
5	5	Circulatory system	$22,209,764	1,577
6	6	Digestive system	$18,154,161	2,509
7	8	Musculoskeletal system and connective tissue	$16,497,515	1,664
8	1	Nervous System	$15,003,504	1,678
9	11	Kidney and urinary tract	$13,037,399	1,105
10	18	Infectious & parasitic diseases	$9,417,610	993
		Top Ten Total	**$276,333,779**	**41,542**

Source: Medicaid paid claims from MMIS-DSS. Notes: 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 2008-09 Top 10 Inpatient Hospital Diagnosis Related Groups Ranked by Expenditures

Rank	DRG	Description	Expenditures	Unduplicated Client Count
1	373	Vaginal Delivery without Complicating Diagnoses	$42,506,722	14,476
2	370	Cesarean Section with Complicating Diagnoses	$17,360,219	2,319
3	371	Cesarean Section without Complicating Diagnoses	$16,835,691	2,985
4	541	Tracheostomy with Mechanical Ventilator with Major Operating Room Procedure	$15,634,685	140
5	372	Vaginal Delivery with Complicating Diagnoses	$11,783,062	2,900
6	801	Neonates < 1,000 Grams	$7,754,137	107
7	898	Bronchitis and Asthma, Age < 17 with Complicating Diagnoses	$4,913,759	1,292
8	802	Neonates, 1,000 - 1,499 Grams	$4,714,074	157
9	317	Admit for Renal Dialysis	$4,660,453	34
10	803	Neonates, 1500 - 1,999 Grams	$4,513,097	357
		Top Ten Total	**$130,675,898**	**24,767**

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 2008-09 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	$8,401,874	12,690
2	521	Diseases of Hard Tissues of Teeth	$5,739,045	3,191
3	786	Symptoms Involving Respiratory System and Other Chest Symptoms	$5,343,130	12,358
4	780	General Symptoms	$4,809,783	13,540
5	585	Chronic Renal Failure	$3,887,018	269
6	V58	Other and Unspecified Aftercare	$2,883,790	2,345
7	784	Symptoms Involving Head and Neck	$2,751,943	5,866
8	493	Asthma	$2,692,842	5,164
9	474	Chronic Disease of Tonsils and Adenoids	$2,651,397	2,090
10	787	Symptoms Involving Digestive System	$2,540,524	9,528
		Top Ten Total	**$41,701,346**	**67,041**

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 2008-09 Top 10 Outpatient Surgical Procedures Ranked by Expenditures

Rank	Surgical Procedure Code	Description	Expenditures	Unduplicated Client Count
1	23.41	Application of crown	$2,352,575	864
2	28.3	Tonsillectomy with adenoidectomy	$1,310,817	491
3	23.09	Extraction of other tooth	$924,525	330
4	99.29	Injection or infusion of other therapeutic or prophylactic substance	$819,515	1,003
5	89.17	Polysomnogram	$648,355	450
6	20.01	Myringotomy with insertion of tube	$586,504	322
7	66.29	Other bilateral endoscopic destruction or occlusion of fallopian tubes	$575,420	368
8	93.54	Application of splint	$556,777	1,849
9	23.2	Restoration of tooth by filling	$472,921	192
10	51.23	Laparoscopic cholecystectomy	$450,802	138
		Top Ten Total	**$8,698,212**	**6,007**

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 2008-09 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	$13,687,670	50,770
2	V72	Special Investigations and Examinations[20]	$9,103,977	29,617
3	V22	Normal Pregnancy	$6,067,648	7,209
4	465	Acute Upper Respiratory Infections of Multiple or Unspecified Sites	$2,972,156	14,267
5	382	Suppurative and Unspecified Otitis Media	$1,526,414	6,873
6	V04	Need For Prophylactic Vaccination and Inoculation Against Certain Viral Diseases	$1,092,894	7,300
7	V70	General Medical Examination	$1,036,788	4,985
8	780	General Symptoms	$962,412	4,799
9	V25	Encounter For Contraceptive Management	$951,515	3,470
10	250	Diabetes Mellitus	$898,565	2,293
		Top Ten Total	**$38,300,037**	**131,583**

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.

[20] Principal Diagnosis Group Number V72, "Special Investigations and Examinations" may include a substantial amount of dental claims.

B4f: FY 2008-09 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	$704,940	3,858
2	465	Acute Upper Respiratory Infections of Multiple or Unspecified Sites	$357,592	2,074
3	V22	Normal Pregnancy	$326,370	574
4	382	Suppurative and Unspecified Otitis Media	$287,534	1,552
5	V72	Special Investigations and Examinations[21]	$215,864	701
6	462	Acute Pharyngitis	$146,155	1,179
7	780	General Symptoms	$141,635	1,068
8	724	Other and Unspecified Disorders of Back	$122,846	643
9	461	Acute Sinusitis	$120,612	963
10	789	Other Symptoms Involving Abdomen and Pelvis	$118,142	796
		Top Ten Total	**$2,541,690**	**13,408**

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.

[21] Principal Diagnosis Group Number V72, "Special Investigations and Examinations" may include a substantial amount of dental claims.

B4g: FY 2008-09 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	$13,826,117	86,893
2	650	Normal Delivery	$8,878,072	12,445
3	367	Disorders of Refraction and Accommodation	$5,600,724	39,269
4	789	Other Symptoms Involving Abdomen and Pelvis	$5,353,392	27,940
5	786	Symptoms Involving Respiratory System and Other Chest Symptoms	$5,117,255	41,995
6	V25	Encounter For Contraceptive Management	$5,097,077	16,789
7	780	General Symptoms	$5,082,011	36,611
8	315	Specific Delays in Development	$4,061,164	3,352
9	783	Symptoms Concerning Nutrition, Metabolism, and Development	$3,985,678	8,167
10	770	Other Respiratory Conditions of Fetus and Newborn	$3,648,566	2,534
		Top 10 Totals	**$60,650,056**	**275,995**

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.

B4h: FY 2008-09 Top 10 Dental Procedures
Ranked by Expenditures

Rank	Procedure Code	Procedure Description	Total Expenditures	Unduplicated Client Count
1	D8090	Comprehen Ortho Adult Dentition	$5,846,199	1,889
2	D2930	Prefab Stainless Steel Crown Primary	$5,367,848	17,023
3	D2391	Resin Based Comp One Surface Posterior	$4,033,769	22,674
4	D1120	Prophylaxis Child	$3,702,842	96,992
5	D1330	Oral Hygiene Instructions	$3,483,635	116,011
6	D2392	Resin Based Comp Two Surfaces Posterior	$3,017,759	15,860
7	D7140	Extraction Erupted Tooth/Exposed Root	$3,012,258	21,488
8	D2150	Amalgam Two Surfaces Permanent	$2,300,371	16,205
9	D3220	Therapeutic Pulpotomy	$2,291,863	12,554
10	D2140	Amalgam One Surface Permanent	$2,277,858	18,650
		Top Ten Total	**$35,334,403**	**339,346**

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 2008-09 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	$1,781,934	29,496
2	87591	Neisseria Gonorrhea, DNA, Amplified Probe Technique	$1,757,703	29,293
3	80101	Drug Screen, Single	$1,745,282	7,371
4	85025	Complete Blood Count with Automated White Blood Cells Differentials	$1,183,802	66,933
5	80053	Comprehensive Metabolic Panel	$950,678	41,188
6	84443	Thyroid Stimulus Hormone	$885,157	31,223
7	87086	Urine Culture / Colony Count	$557,353	36,450
8	80050	General Health Panel	$532,700	10,416
9	80061	Lipid Panel	$528,201	23,534
10	88305	Tissue Exam by Pathologist	$525,681	7,995
		Top 10 Totals	**$10,448,492**	**283,899**

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 2008-09 Top 10 Durable Medical Equipment and Supplies Procedures Ranked by Expenditures

Rank	Principal Diagnosis Group Number	Description	Expenditures	Unduplicated Client Count
1	E1390	Oxygen Concentrator	$9,356,286	9,791
2	S8121	Oxygen Contents Liquid, per Pound	$9,078,864	5,632
3	B4160	Enteral Formula for Pediatrics, Calorie Dense	$3,773,407	1,350
4	T4527	Adult Sized Disposable Incontinence Product	$1,959,374	2,693
5	E0434	Portable Liquid Oxygen	$1,745,607	4,862
6	B4161	EF pediatric hydrolyzed/amino acid	$1,725,145	346
7	B4035	Enteral feed supp pump per d	$1,587,164	875
8	T4535	Disposable liner/shield/pad	$1,533,257	4,454
9	A4253	Blood Glucose Test or Reagent Strips, per 50 Strips	$1,486,584	5,519
10	T4526	Adult size pull-on medium	$1,332,235	2,575
		Top 10 Totals	**$33,577,922**	**38,097**

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 2008-09 Top 10 Prescription Drugs Ranked by Expenditures

Rank	Drug Name	Therapeutic Class	Expenditures	Unduplicated Client Count
1	Synagis	Monoclonal Antibody (prevention/treatment of respiratory virus in infants)	$14,423,672	1,194
2	Abilify	Antipsychotic	$12,099,828	4,447
3	Seroquel	Antipsychotic	$11,014,912	4,981
4	Zyprexa	Antipsychotic	$6,739,843	1,826
5	Prevacid	Proton-Pump Inhibitor	$6,168,966	10,909
6	Topamax	Anti-Convulsant	$3,896,033	2,401
7	Lipitor	Anti-Hyperlipidemic	$3,892,695	5,470
8	Risperidone	Antipsychotic	$3,650,068	3,976
9	Advair	Bronchodilator and Corticosteroid	$3,495,715	5,609
10	Oxycodone	Analgesic	$3,376,597	24,781
		Top Ten Total	**$68,758,331**	**65,594**

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 2008-09 Top 10 Prescription Drugs Ranked by Number of Prescriptions Filled

Rank	Drug Name	Therapeutic Class	Total Prescriptions Filled	Expenditures
1	Hydrocodone	Analgesic	108,837	$1,569,107
2	Amoxicillin	Antibiotic	87,104	$752,824
3	Oxycodone	Analgesic	76,747	$3,376,597
4	Lorazepam	Anti-Anxiety Drug	48,019	$721,656
5	Azithromycin	Macrolide	47,292	$1,286,332
6	Proair	Beta-Adrenergic Agent	46,625	$1,985,481
7	Lisinopril	ACE Inhibitor	40,576	$454,568
8	Clonazepam	Anti-Convulsant	38,819	$544,174
9	Levothyroxine	Thyroid Hormone	37,855	$310,790
10	Ibuprofen	NSAID	36,407	$215,678
		Top Ten Total	**568,281**	**$11,217,208**

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.