Schedule 13
Change Request for FY 2010-11 Budget Request Cycle

Decision Item FY 2010-11 ✓	Base Reduction Item FY 2010-11	Supplemental FY 2009-10	Budget Amendment FY 2010-11

Request Title: Medicare Modernization Act State Contribution Payment
Department: Health Care Policy and Financing **Dept. Approval by:** John Bartholomew **Date:** November 2, 2009 10/21/09
Priority Number: DI-4 **OSPB Approval:** **Date:** 10-26-09

	Fund	1 Prior-Year Actual FY 2008-09	2 Appropriation FY 2009-10	3 Supplemental Request FY 2009-10	4 Total Revised Request FY 2009-10	5 Base Request FY 2010-11	6 Decision/ Base Reduction FY 2010-11	7 November 1 Request FY 2010-11	8 Budget Amendment FY 2010-11	9 Total Revised Request FY 2010-11	10 Change from Base (Column 5) FY 2011-12
Total of All Line Items	Total	73,720,837	88,808,586	(1,987,584)	86,821,002	88,808,586	1,727,607	90,536,193	0	90,536,193	1,727,607
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	73,720,837	88,808,586	(1,987,584)	86,821,002	88,808,586	1,727,607	90,536,193	0	90,536,193	1,727,607
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	0	0	0	0	0	0	0	0	0	0
(5) Other Medical Services; Medicare Modernization Act of 2003 State Contribution Payment	Total	73,720,837	88,808,586	(1,987,584)	86,821,002	88,808,586	1,727,607	90,536,193	0	90,536,193	1,727,607
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0
	GF	73,720,837	88,808,586	(1,987,584)	86,821,002	88,808,586	1,727,607	90,536,193	0	90,536,193	1,727,607
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	0	0	0	0	0	0	0	0	0	0

Non-Line Item Request: None.
Letternote Revised Text: None.
Cash or Federal Fund Name and COFRS Fund Number: None.
Reappropriated Funds Source, by Department and Line Item Name: None.
Approval by OIT? Yes: No: N/A: ✓
Schedule 13s from Affected Departments: None.

CHANGE REQUEST for FY 2010-11 BUDGET REQUEST CYCLE

Department:	Health Care Policy and Financing
Priority Number:	DI-4
Change Request Title:	Medicare Modernization Act State Contribution Payment

SELECT ONE (click on box):

☒ Decision Item FY 2010-11
☐ Base Reduction Item FY 2010-11
☐ Supplemental Request FY 2009-10
☐ Budget Request Amendment FY 2010-11

SELECT ONE (click on box):

Supplemental or Budget Request Amendment Criterion:
☐ Not a Supplemental or Budget Request Amendment
☐ An emergency
☐ A technical error which has a substantial effect on the operation of the program
☒ New data resulting in substantial changes in funding needs
☐ Unforeseen contingency such as a significant workload change

Short Summary of Request: This Request is for an additional $1,727,607 General Fund in FY 2010-11 for the (5) Other Medical Services; Medicare Modernization Act of 2003 State Contribution Payment line item. The additional funds are needed to keep up with an expected increase in the projected caseload of dual eligible individuals and a projected increase in the per per-client per-month rate paid by the State, per federal regulations. The Department is also requesting a reduction of $1,987,584 in FY 2009-10 as a result of updated caseload and 2010 per-client per-month rate estimates.

Background and Appropriation History: On January 1, 2006, the federal Centers for Medicare and Medicaid Services (CMS) assumed responsibility for the Part D prescription drug benefit replacing the Medicaid prescription drug coverage for dual eligible clients. In lieu of the states' obligation to cover prescription drugs for this population, the federal Centers for Medicare and Medicaid Services began requiring states to pay a portion of what their anticipated dual eligible drug cost would have been had this cost shift not occurred. In January 2006, states began to pay the Centers for Medicare and Medicaid Services these "clawback"

payments. The payments were calculated by taking 90% of the federal portion of each state's average per-client per-month dual eligible drug benefit from calendar year 2003, inflated to 2006 using the average growth rate from the National Health Expenditure per capita drug expenditures. This inflated per-client per-month amount is multiplied by the number of dual eligible clients including retroactive clients back to January 2006. As each calendar year passes, the 90% factor is lowered by 1.67% each year, which is known as the phasedown percentage, until it reaches 75%, where it will remain starting in 2015. In addition, the Centers for Medicare and Medicaid Services inflate each state's per-client per-month rates based on either the National Health Expenditures' growth or actual growth in Part D expenditures.

In FY 2005-06, the Department expended $31,461,626 for 6 months of payments. In FY 2006-07 the Department expended $72,494,301 for a full year of payments. SB 07-133 changed the accounting for the payment from accrual to cash resulting in a one-time savings by shifting the June 2008 payment, which is billed in July 2008, to FY 2008-09. In October 2007, due to a technical change in the system algorithm used to identify dual eligible clients, a significant number of additional dual eligible clients were identified in the October 2007 invoice. As a result of the system change, the Department submitted a supplemental Change Request for $2,548,557 in its FY 2007-08 Supplemental Requests and FY 2008-09 Budget Request Amendments, February 15, 2008 (page S.4-1). Consequently, in FY 2007-08, the Department expended $71,350,801 for 11 months of payments. Due to unexpected under-expenditures in FY 2007-08, the Department submitted an Emergency 1331 Change Request on June 23, 2008 that $744,209 be transferred to the Controlled Maintenance Trust Fund.

As a part of its January 15, 2009 Budget Reduction Proposals the Department recommended that the May payment for each year be paid in the next fiscal year, starting with May, 2009. Federal rules allow the Department to make the May payment as late as July 25 of the same year. SB 09-265 "Medicaid CHP+ Payment Timing" made clear that the Department must make Clawback payments in compliance with the Federal rules but that the Department is not required to make the Clawback payments before they are required by Federal rules. As a result of this, the Department expended a total of

$73,720,837 in FY 2008-09. This amount included payment of the June 2008 through April 2009 invoices from CMS. On June 22, 2009, the JBC approved the Department's 1331 Change Request that requested a transfer of $313,036 General Fund, of an expected $487,997 General Fund reversion, from the (5) Other Medical Services, Medicare Modernization Act of 2003 State Contribution Payment line item to the (1) Executive Director's Office; (B) Transfers to Other Departments, Transfer to Department of Public Health and Environment Facility for Survey and Certification line item to cover an overdraw of federal funds.

As a part of HB 09-1222 "Administration of Appropriated Moneys" the State Controller is authorized to allow overexpenditures by the Department for the State contribution payment pursuant to the Medicare Modernization Act of 2003. This authority expires after FY 2013-14.

The Department is currently appropriated $88,808,586 General Fund for FY 2009-10.

General Description of Request:

The Department currently estimates that the total FY 2010-11 Clawback payment will equal $90,536,193 which is $1,727,607 greater than the FY 2010-11 continuation Base Budget. This information is based on revised projections of the per-client per-month rate, dual eligible caseload, and the anticipated level of retroactivity. The Department currently estimates that the total FY 2009-10 Clawback payment will equal $86,821,002, which is $1,987,584 less than the FY 2009-10 appropriation.

The Department estimates that the total Clawback payment for FY 2009-10 would be $86,061,566 in the absence of the estimated increase in the calendar year 2010 per-client per-month rate to $132.12. The effect of the estimated increase in the 2010 per-client per-month rate is estimated to increase the total FY 2009-10 Clawback payment by $759,436.

The Department estimates that the total Clawback payment for FY 2010-11 would be $87,259,062 in the absence of the estimated increase in the calendar year 2010 and 2011 per-client per-month rate to $132.12 and $136.23, respectively. The increase in both the

2010 and the 2011 per-client per-month rates is estimated to increase the total FY 2011-12 Clawback payment by $3,277,130. The effect of the increases in the per-client per-month rates is greater in FY 2010-11 than in FY 2009-10 since the entire fiscal year is affected by the rate increases in FY 2010-11. Based on this, the increase in the total Clawback payment amount from FY 2009-10 to FY 2010-11 due only to projected caseload increases is $1,197,496.

In order to estimate the per-client per-month rate for calendar year 2010, the department followed the procedure outlined by the Office of the Actuary at CMS using the latest available National Health Expenditures estimates of per capita drug expenditures growth for the period 2003 to 2006, combined with the annual percentage increase in the average per capita aggregate Part D expenditures for 2007 and later years as announced on April 6, 2009. In order to estimate the per-client per-month rate for calendar year 2011 and beyond, the Department used the growth factor from the 2008 National Health Expenditure report for drug expenditures. The Department notes that the projection of per-client per-month rates is based on the growth in the National Health Expenditures drug expenditures; however, federal law states the growth factor for 2007 and succeeding years will equal the annual percentage increase in average per capita aggregate expenditures for covered Part D drugs in the United States for Part D eligible individuals during the 12-month period ending in July of the previous year. Since actual expenditure data is not available to the Department for 2011 and beyond at the time of this request, the actual per capita rate growth may differ from the Department's projection. The Department forecasts that the per-client per-month rate will be $132.12 in calendar year 2010 and $136.23 in calendar year 2011 (see Table 3).

The Department estimates that the total dual eligible caseload, including retroactivity, in the invoice for May 2010 will equal 55,912. The Department estimates that by the invoice for April 2011 the same caseload count will equal 57,164. These estimates are based on both the historic growth rate in the billed-month caseload and the level of caseload retroactivity. The dual eligible caseload is comprised of a subset of the Medicaid eligibility categories Adults 65 and Older (OAP-A), Disabled Adults 60 to 64 (OAP-B), and Disabled Individuals to 59 (AND/AB). The caseload data provided to the Centers for

Medicare and Medicaid Services by the Department is obtained through the Medicaid Management Information System.

The Department forecasts that Medicaid caseload will increase in FY 2010-11. In addition, the eligibility categories related to dual eligible clients are projected to increase. The overall Medicaid caseload is projected to increase by 10.96% in FY 2010-11. The Department assumes that during FY 2010-11 the dual eligible clients will continue to increase due to the continuing retirement of the "baby boomers". The Colorado State Demography Office projects the annual growth rates of the Colorado population 65 years and older for 2009 through 2011 will range from 4.50% to 5.06% per year, with an average annual growth rate over that period of 4.82%.

Consequences if Not Funded:

If the Department does not receive an additional appropriation and subsequently cannot make the required payment, the Department is at risk of having the amount due for the Clawback payment, plus interest, deducted from the federal funds received for the Medicaid program. Such a deduction could cause the Department to be under funded to provide medical services in FY 2010-11 and would necessitate a General Fund appropriation to make up the difference.

Calculations for Request:

Summary of Request FY 2009-10	Total Funds	General Fund
Total Request	$86,821,002	$86,821,002
Decision Item Request	($1,987,584)	($1,987,584)
(5) Other Medical Services; Medicare Modernization Act of 2003 State Contribution Payment	$88,808,586	$88,808,586

Summary of Request FY 2010-11	Total Funds	General Fund
Total Request	$90,536,193	$90,536,193
Decision Item Request	$1,727,607	$1,727,607

Summary of Request FY 2010-11	Total Funds	General Fund
(5) Other Medical Services; Medicare Modernization Act of 2003 State Contribution Payment	$88,808,586	$88,808,586

Summary of Request FY 2011-12	Total Funds	General Fund
Total Request	$90,536,193	$90,536,193
Decision Item Request	$1,727,607	$1,727,607
(5) Other Medical Services; Medicare Modernization Act of 2003 State Contribution Payment	$88,808,586	$88,808,586

Table 1: National Health Expenditures 2008 Projections for 2003-2011
Prescription Drug Expenditures

Calendar Year:	Per Capita (in dollars)	Percent Change
2003	$599	
2004	$643	7.35%
2005	$674	4.82%
2006	$725	7.57%
2007	$753	3.86%
2008	$772	2.52%
2009	$796	3.11%
2010	$825	3.64%
2011	$868	5.21%

Table 2: Phasedown Percentage from the Medicare Modernization Act of 2003	
Phasedown Percent Per Calendar Year:	**Percentage**
2006	90.00%
2007	88.33%
2008	86.67%
2009	85.00%
2010	83.33%
2011	81.67%
2012	80.00%
2013	78.33%
2014	76.67%
2015 and all future years	75.00%

Table 3: Calculation of Rate Increase Prior to Applying Phasedown			
Row	**Source**	**Amount**	**Description**
From "National Health Expenditure Projections 2007-2017"			
A	Estimated 2003 Per Capita Prescription Drug Expenditures	598	From: Table 11: Prescription Drug Expenditures; Aggregate and per Capita Amounts, Percent Distribution and Annual Percent Change by Source of Funds: Calendar Years 2002-2017
B	Estimated 2006 Per Capita Prescription Drug Expenditures	723	From: Table 11: Prescription Drug Expenditures; Aggregate and per Capita Amounts, Percent Distribution and Annual Percent Change by Source of Funds: Calendar Years 2002-2017
C	Percentage Growth	20.90%	(Row A / Row B) - 1
From "National Health Expenditure Projections 2008-2018"			
D	Estimated 2003 Per Capita Prescription Drug Expenditures	599	From: Table 11: Prescription Drug Expenditures; Aggregate and per Capita Amounts, Percent Distribution and Annual Percent Change by Source of Funds: Calendar Years 2003-2018
E	Estimated 2006 Per Capita Prescription Drug Expenditures	725	From: Table 11: Prescription Drug Expenditures; Aggregate and per Capita Amounts, Percent Distribution and Annual Percent Change by Source of Funds: Calendar Years 2003-2018
F	Percentage Growth	21.04%	(Row D / Row E) - 1
G	Change in the Percentage Growth	0.12%	(1+Row F) / (1+Row C) - 1
H	Annual Percentage increase in average per capita aggregate Part D expenditures for 2009	4.66%	Source: "Announcement of Calendar Year (CY) 2010 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies" from CMS. Appendix IV.
I	Final Percentage Increase in Rate Prior to Applying Phasedown	4.79%	(1+ Row F) * (1+Row H) - 1

Note that numbers may not add due to rounding.

Table 4: Estimates of Calendar Year 2010 and 2011 Per-Client Per-Month Rates	
Actual Calendar Year 2007 Per-Client Per-Month Rate	$120.30
Actual Calendar Year 2008 Per-Client Per-Month Rate	$120.03
Actual Calendar Year 2009 Per-Client Per-Month Rate	$128.62
Calendar Year 2009 Phasedown Percent (from Table 2)	85.00%
Calendar Year 2009 Per-Client Per-Month Rate before Phasedown Percent ($128.62 / 85.00%)	$151.32
Final Percentage Increase in Rate Prior to Applying Phasedown for CY 2010 (from Table 3 Row I)	4.79%
Projected 2010 Per-Client Per-Month Rate before Phasedown Percent ($151.32 * (1 + 4.79%))	$158.56
Calendar Year 2010 Phasedown Percent (from Table 2)	83.33%
Projected Calendar Year 2010 Per-Client Per-Month Rate ($158.56 * 83.33%)	**$132.12**
Prescription Drug Expenditure Growth Rate for CY 2011 (from Table 1)	5.21%
Projected 2011 Per-Client Per-Month Rate before Phasedown Percent ($158.56* (1 + 5.21%))	$166.82
Calendar Year 2011 Phasedown Percent (from Table 2)	81.67%
Projected Calendar Year 2011 Per-Client Per-Month Rate ($166.82 * 81.67%)	**$136.23**

Note: Numbers may not add due to rounding.

Table 5: Estimated Decay Factors Related to Caseload Retroactivity		
Months Prior to the Current Caseload	**FY 2009-10 Estimated Decay Rate (As Percentage of Current Month)**	**FY 2010-11 Estimated Decay Rate (As Percentage of Current Month)**
1st Month	1.829%	1.678%
2nd Month	1.092%	0.959%
3rd Month	0.688%	0.566%
4th Month	0.481%	0.371%
5th Month	0.360%	0.256%
6th Month	0.285%	0.192%
7th Month	0.233%	0.138%
8th Month	0.198%	0.114%
9th Month	0.175%	0.093%
10th Month	0.151%	0.072%
11th Month	0.138%	0.064%
12th Month	0.117%	0.053%
13th Month	0.106%	0.039%
14th Month	0.092%	0.034%
15th Month	0.081%	0.025%
16th Month	0.070%	0.018%
17th Month	0.067%	0.018%
18th Month	0.047%	0.011%
19th Month	0.042%	0.008%
20th Month	0.035%	0.003%
21st Month	0.030%	0.001%
22nd Month	0.001%	(0.006%)
23rd Month	(0.002%)	(0.007%)

	Table6a: Invoices to be Paid in FY 2009-10											
Dual Eligible Attributed to Each Month	**May 2009 Actual**	**Jun 2009 Actual**	**Jul 2009 Estimate**	**Aug 2009 Estimate**	**Sep 2009 Estimate**	**Oct 2009 Estimate**	**Nov 2009 Estimate**	**Dec 2009 Estimate**	**Jan 2010 Estimate**	**Feb 2010 Estimate**	**Mar 2010 Estimate**	**Apr 2010 Estimate**
Jan - Dec 2007 duals	18	(102)	56	34	16	0	(1)	0	0	0	0	0
Jan - Dec 2008 duals	301	97	772	673	589	515	437	364	302	247	198	155
Jan - April 2009 duals	1,575	777	949	712	565	469	399	351	308	271	240	210
May 2009 duals	52,349	675	572	361	253	190	150	123	105	93	80	74
Jun 2009 duals	0	52,232	957	573	362	253	190	151	123	105	93	80
Jul 2009 duals	0	0	52,337	959	574	362	254	190	151	124	105	93
Aug 2009 duals	0	0	0	52,443	961	575	363	254	191	151	124	106
Sep 2009 duals	0	0	0	0	52,548	963	576	364	255	191	152	124
Oct 2009 duals	0	0	0	0	0	52,654	965	577	364	255	191	152
Nov 2009 duals	0	0	0	0	0	0	52,760	967	578	365	256	192
Dec 2009 duals	0	0	0	0	0	0	0	52,866	969	580	366	256
Jan 2010 duals	0	0	0	0	0	0	0	0	52,973	971	581	367
Feb 2010 duals	0	0	0	0	0	0	0	0	0	53,080	973	582
Mar 2010 duals	0	0	0	0	0	0	0	0	0	0	53,187	975
April 2010 duals	0	0	0	0	0	0	0	0	0	0	0	53,294
Total duals from invoice	54,243	53,679	55,643	55,755	55,868	55,981	56,093	56,207	56,319	56,433	56,546	56,660
CY 2007 Rate	$120.30	$120.30	$120.30	$120.30	$120.30	$120.30	$120.30	$120.30	$120.30	$120.30	$120.30	$120.30
CY 2008 Rate	$120.03	$120.03	$120.03	$120.03	$120.03	$120.03	$120.03	$120.03	$120.03	$120.03	$120.03	$120.03
CY 2009 Rate	$128.62	$128.62	$128.62	$128.62	$128.62	$128.62	$128.62	$128.62	$128.62	$128.62	$128.62	$128.62
CY 2010 Rate	$132.12	$132.12	$132.12	$132.12	$132.12	$132.12	$132.12	$132.12	$132.12	$132.12	$132.12	$132.12
Monthly Payment	$6,973,999	$6,904,208	$7,149,733	$7,165,098	$7,180,585	$7,195,869	$7,210,961	$7,226,278	$7,426,556	$7,445,425	$7,462,785	$7,479,505
Total Payment												$86,821,002

Note: To calculate the Monthly Payment, take each calendar year's rate and multiply it by the respective caseload shown for that calendar year. Numbers may not exactly add due to rounding.

	Table 6b: Invoices to be Paid in FY 2010-11											
Dual Eligible Attributed to Each Month	**May 2010 Estimate**	**Jun 2010 Estimate**	**Jul 2010 Estimate**	**Aug 2010 Estimate**	**Sep 2010 Estimate**	**Oct 2010 Estimate**	**Nov 2010 Estimate**	**Dec 2010 Estimate**	**Jan 2011 Estimate**	**Feb 2011 Estimate**	**Mar 2011 Estimate**	**Apr 2011 Estimate**
Jan - Dec 2008 duals	16	6	0	(4)	(6)	(7)	(4)	0	0	0	0	0
Jan - Dec 2009 duals	587	461	364	294	236	188	147	108	79	58	40	26
Jan - April 2010 duals	1,908	1,152	742	514	376	289	226	186	153	124	104	83
May 2010 duals	53,401	898	514	304	200	138	104	75	62	51	39	35
Jun 2010 duals	0	53,509	900	515	305	200	138	104	75	62	51	39
Jul 2010 duals	0	0	53,616	901	516	305	201	139	104	75	62	51
Aug 2010 duals	0	0	0	53,724	903	517	306	201	139	104	75	62
Sep 2010 duals	0	0	0	0	53,833	905	518	307	201	139	105	75
Oct 2010 duals	0	0	0	0	0	53,941	907	519	307	202	139	105
Nov 2010 duals	0	0	0	0	0	0	54,050	909	520	308	202	140
Dec 2010 duals	0	0	0	0	0	0	0	54,159	911	521	308	203
Jan 2011 duals	0	0	0	0	0	0	0	0	54,268	912	523	309
Feb 2011 duals	0	0	0	0	0	0	0	0	0	54,377	914	524
Mar 2011 duals	0	0	0	0	0	0	0	0	0	0	54,487	916
April 2011 duals	0	0	0	0	0	0	0	0	0	0	0	54,596
Total duals from invoice	55,912	56,026	56,136	56,248	56,363	56,476	56,593	56,707	56,819	56,933	57,049	57,164
CY 2008 Rate	$120.03	$120.03	$120.03	$120.03	$120.03	$120.03	$120.03	$120.03	$120.03	$120.03	$120.03	$120.03
CY 2009 Rate	$128.62	$128.62	$128.62	$128.62	$128.62	$128.62	$128.62	$128.62	$128.62	$128.62	$128.62	$128.62
CY 2010 Rate	$132.12	$132.12	$132.12	$132.12	$132.12	$132.12	$132.12	$132.12	$132.12	$132.12	$132.12	$132.12
CY 2011 Rate	$136.23	$136.23	$136.23	$136.23	$136.23	$136.23	$136.23	$136.23	$136.23	$136.23	$136.23	$136.23
Monthly Payment	$7,384,856	$7,400,422	$7,415,471	$7,430,563	$7,445,881	$7,461,048	$7,476,568	$7,491,701	$7,729,653	$7,749,027	$7,766,963	$7,784,039
Total Payment												$90,536,193

Note: To calculate the Monthly Payment, take each calendar year's rate and multiply it by the respective caseload shown for that calendar year. Numbers may not exactly add due to rounding.

Cash Funds Projections: Not Applicable

Assumptions for Calculations: The Department assumes the changes in the per-client per-month rate paid by the Department will be based on the growth in the 2008 National Health Expenditures' prescription drug per capita estimates, as shown in Table 1, and offset by the phasedown percent shown in Table 2. Per 42 CFR 423.902 (4), the growth factor for 2007 and succeeding years will equal the annual percentage increase in average per capita aggregate expenditures for covered Part D drugs in the United States for Part D eligible individuals for the 12-month period ending in July of the previous year. Since the Department does not have the data to project the Part D drug expenditures, the Department has used the 2008 National Health Expenditures forecasts for years past calendar year 2008 as a proxy for the annual growth in the per capita rate.

Tables 1 through 4 provide the relevant information for calculating the per-client per-month rates for calendar year 2010, and 2011. For the entire calendar year 2009, the Department used the per-client per-month rate through September 2009, provided by the Centers for Medicare and Medicaid Services of $128.62. The Department estimates a per-client per-month rate of $132.12 in calendar year 2010. In order to estimate the 2010 per-client per-month rate, the Department followed the procedure outlined by the Office of the Actuary at CMS. The Medicare Modernization Act of 2003 requires CMS to calculate the payment rates for the Clawback payment using the latest available National Health Expenditures estimates of per capita drug expenditures growth for the period 2003 to 2006, combined with the annual percentage increase in the average per capita aggregate Part D expenditures for 2007 and later years. As announced by CMS on April 6, 2009, the annual percentage increase for 2009 is estimated at 4.66%. Table 3 shows the derivation of the per-client per- month rate increase for 2010. The full derivation of the 2010 rate is shown in Table 4.

The Department estimates that the 2011 per-client per-month rate will be $136.23. The derivation of this figure is detailed in Table 4. The 2011 estimate is based on the estimates contained in the 2008 National Health Expenditures per capita drug expenditures

published in January 2009 and shown in Table 1. In addition, the projection is also based on the phasedown percentage detailed in 42 CFR 423.908 and shown in Table 2.

The Department assumes that the average growth rate in current month caseload from November 2007 through June 2009 will remain unchanged through FY 2010-11. The Department has excluded the growth rate for October 2007 since the growth rate for that month was unusually high due to the implementation of a systems change, and is thus not a reliable predictor. The Department assumes that the dual eligible caseload will grow at monthly rate of approximately 0.20%, and hence an annual growth rate of approximately 2.44%.

Table 5 shows the Department's estimates for the retroactive caseload adjustments used for the FY 2009-10 and FY 2010-11 caseload estimates. For FY 2009-10, the percentages range from 1.829% for the previous month to (0.002%) for 23 months prior to the current month. The FY 2009-10 retroactivity estimates are based on the average of the rate of decay in the July 2007 through June 2009 Clawback caseload data. Note that for some of the longer lags, fewer historical months are used do to a lack of available history. For FY 2010-11, the percentages range from 1.678% for the previous month to (0.007%) for 23 months prior to the current month. The FY 2010-11 retroactivity estimates are based on the average of the rate of decay in the July 2008 through June 2009 Clawback caseload data. The Department has observed a recent decline in retroactivity adjustments, or the decay rate. This is a relatively new phenomenon the causes of which the Department has not fully identified. For this reason the Department is exercising caution in incorporating the new decay data into its estimates. The decline may be the result of fewer errors and adjustments requiring a retroactive adjustment that will continue or it may the result of random variations in the data that will not persist. Until the Department has a better understanding of the causes as a result of additional data, it will use the new data cautiously in its FY 2009-10 estimate. Since there are more opportunities to address the FY 2010-11 budget request, when more data has been received, the Department is willing to incur greater risks in estimating its need in FY 2010-11.

Table 6a and Table 6b show the projected caseload, level of retroactivity, and expenditures by month for FY 2010-11 and FY 2010-11, respectively. Using the assumptions detailed in Tables 3, 4 and 5, as well as the estimated monthly growth rate of approximately 0.20%, Tables 6a and 6b show the impact of those assumptions on the calculations for the estimated caseload and retroactivity.

Impact on Other Government Agencies: Not Applicable

Cost Benefit Analysis:

FY 2010-11 Cost Benefit Analysis	Costs	Benefits
Request	The cost of this request includes $1,727,607 in General Fund in FY 2010-11 to pay for the increase in the projected caseload of dual eligible individuals and a projected increase in the per-client per-month rate paid by the State, per federal regulations.	This request would allow the Department to meet its obligations to the federal government and ensure the Department would not have the amount of payment plus interest deducted from the federal funds received for the Medicaid program.
Consequences if not Funded	The cost of not funding the request would be the potential deduction in federal funds received by the Medicaid program equal to the amount owed for the payment plus interest. This would equal an amount greater than $1,727,607.	There are no benefits to the Department because the savings of General Fund would be offset by greater loss of federal funds that would need to be backfilled with General Fund for the Medicaid program.

Implementation Schedule: Not Applicable

Statutory and Federal Authority:

42 C.F.R. §423.908 (2009) *Phased-down State contribution to drug benefit costs assumed by Medicare. This subpart sets forth the requirements for State contributions for Part D drug benefits based on full-benefit dual eligible individual drug expenditures.*

42 C.F.R. §423.910 (a) (2009) General rule: *Each of the 50 States and the District of Columbia is required to provide for payment to CMS a phased-down contribution to defray a portion of the Medicare drug expenditures for individuals whose projected Medicaid drug coverage is assumed by Medicare Part D.*

42 C.F.R. §423.910 (b) (2) (2009) Method of payment*: Payments for the phased down State contribution begins in January 2006, and are made on a monthly basis for each subsequent month. State payment must be made in a manner specified by CMS that is similar to the manner in which State payments are made under the State Buy-in Program except that all payments must be deposited into the Medicare Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund. The policy on collection of the Phased-down State contribution payment is the same as the policy that governs collection of Part A and Part B Medicare premiums for State Buy-in.*

42 C.F.R. §423.910 (g) (2009) Annual per capita drug expenditures. *CMS notifies each State no later than October 15 before each calendar year, beginning October 15, 2005, of their annual per capita drug payment expenditure amount for the next year.*

24-75-109, C.R.S. (2009). Controller may allow expenditures in excess of appropriations - limitations - appropriations for subsequent fiscal year restricted - repeal. *(1) For the purpose of closing the state's books, and subject to the provisions of this section, the controller may, on or after May 1 of any fiscal year and before the forty-fifth day after the close thereof, upon approval of the governor, allow any department, institution, or agency of the state, including any institution of higher education, to make an expenditure in excess of the amount authorized by an item of appropriation for such fiscal year if:*

(a.6) The overexpenditure is by the department of health care policy and financing for the required state contribution payment pursuant to the federal "medicare modernization act of 2003", pub.l. 108-173;

(6) The controller may allow overexpenditures pursuant to this section only for the fiscal years beginning July 1, 1998, July 1, 1999, July 1, 2000, July 1, 2001, July 1, 2002, July 1, 2003, July 1, 2004, July 1, 2005, July 1, 2006, July 1, 2007, and July 1, 2008, July 1, 2009, July 1, 2010, July 1, 2011, July 1, 2012, and July 1, 2013, and this section is repealed, effective September 1, 2014.

25.5-4-105, C.R.S. (2009) *Nothing in this article or articles 5 and 6 of this title shall prevent the state department from complying with federal requirements for a program of medical assistance in order for the state of Colorado to qualify for federal funds under Title XIX of the social security act and to maintain a program within the limits of available appropriations.*

25.5-4-201, C.R.S. (2009) Cash system of accounting - financial administration of medical services premiums - medical programs administered by department of human services - federal contributions - rules. *(1.5) (a) The state department shall utilize the cash system of accounting, as enunciated by the governmental accounting standards board, for the contributions required by 42 U.S.C. sec. 1396u-5 (c).*

(b) The contributions required by 42 U.S.C. sec. 1396u-5 (c) shall be made in the manner required by the federal centers for medicare and medicaid services, or any successor agency. Nothing in this paragraph (b) shall require the state department to make the contribution before the contribution is due.

25.5-5-503, C.R.S. (2009) *(1) The state department is authorized to ensure the participation of Colorado medical assistance recipients, who are also eligible for medicare, in any federal prescription drug benefit enacted for medicare recipients. (2) Prescribed drugs shall not be a covered benefit under the medical assistance program for*

a recipient who is eligible for a prescription drug benefit program under medicare; except that, if a prescribed drug is not a covered Part D drug as defined in the "Medicare Prescription Drug, Improvement, and Modernization Act of 2003", Pub.L. 108-173, the prescribed drug may be a covered benefit if it is otherwise covered under the medical assistance program and federal financial participation is available.

Performance Measures:

If the Department does not receive an additional appropriation, and subsequently cannot make the required payment, the Department is at risk of having the amount due for the Clawback payment plus interest deducted from the federal funds received for the Medicaid program. This deduction would hinder the Department's ability to achieve all performance measures requiring State and matching federal funding. Funding this request would assist the Department in achieving many of its performance measures, including the following:

- Increase the number of clients served through targeted, integrated care management programs.
- Increase the number of children served through a dedicated medical home service delivery model.
- Maintain or reduce the difference between the Department's spending authority and actual expenditures for Medicaid services.