

Medical Care Advisory Committee Meeting Minutes

Date: October 21, 2009 **Time:** 1:30 – 4:00 PM **Location:** IDHW Medicaid Office
 3232 Elder St.
Goal: *Update MCAC Members on DHW Issues* **Moderator:** Toni Lawson, MCAC Vice-Chair
 D-East Conference Room
 Boise, ID 83705

Committee Members: Jonathan Krutz (Idaho End-of-Life Coalition-Chair); **Toni Lawson (Idaho Hospital Assoc-Vice Chair.);** Cathy McDougal (AARP); **Deedra Hunt by proxy of Holly Player (Idaho Office on Aging); James (Jim) R. Baugh (Disability Rights Idaho formerly Comprehensive Advocacy – CO-AD); Judith Bailey (Idaho Medical Association);** John Traylor (Ada County); **Denise Chuckovich (Idaho Primary Care Assoc.);** Katherine Hansen (Community Partnership of Idaho); Kristina Jonas (Idaho State Pharmacy Assoc.); Patti Anne Lodge (Idaho State Senate); **Deana Gilchrist (LINC);** Representative Sharon Block (Idaho House of Representatives); **Rep. (Dr.) John Rusche (Board Certified Physician)- by phone;** Robert VandeMerwe (Idaho Health Care Assoc); **Johnna Pokibro (American Indian Tribal Representative); Paula Marcotte (Mental Health Providers Association of Idaho)**

IDHW Staff: Jane Smith (Administrator, IDHW Division of Health); Leslie Clement (Administrator, Division of Medicaid); **Paul Leary (Deputy Administrator, Division of Medicaid);**

Guests: Steve Bellomy (Bureau Chief, Audits and Investigations); Eileen Williams (Welfare Fraud Supervisor, Audits and Investigations); Lori Stiles (Medicaid Program Integrity Supervisor, Audits and Investigations)

Agenda Item	Presenter	Outcome/Action
Introductions – Welcome members	Toni Lawson	Committee Vice-Chair, Toni Lawson, welcomed the committee members and called the meeting to order.
Committee Business Review minutes from July 15, 2009 MCAC meetings Proposed meeting dates for 2010 <ul style="list-style-type: none"> • January 20, 2010 • April 21, 2010 • July 21, 2010 • October 20, 2010 MCAC seats reaching term <ul style="list-style-type: none"> • Two consumer seats representing: <ul style="list-style-type: none"> (1) Ada County vacating 12/09 (2) Medicaid recipient vacated 10/09 • Provider seat representing Pharmacy, vacating 12/09 	Toni Lawson	Committee Business: <ul style="list-style-type: none"> • The Committee reviewed and accepted the minutes from the July 15, 2009, meeting as proposed. Proposed meeting dates for 2010 <ul style="list-style-type: none"> • The Committee accepted the proposed meeting dates for 2010, with one exception. The January 2010 meeting will be held on January 13, 2010 MCAC seats reaching term <ul style="list-style-type: none"> • It was motioned and accepted for Rachel Strutton to work with the Committee Chair in an attempt to find nominations for the two vacating consumer seats by the January 13, 2010 meeting. Rachel is in contact with a potential nominee for the rotating provider seat currently held by Kristina Jonas of the Idaho State Pharmacy Association. • Cathy McDougal volunteered to hold a second term in her rotating consumer seat, there were no objections. Ms. McDougal’s second term will begin January 2010. • Deedra Hunt volunteered to hold a third term in her required permanent consumer seat, representing the aged community, there were no objections. Ms. Hunt’s third term will begin January 2010.

Agenda Item	Presenter	Outcome/Action
Committee Member Updates		<p>Committee Member Updates The Committee members shared some updates.</p> <p>Comprehensive Advocacy (Co-Ad) has changed its name to Disability Rights Idaho.</p>
Personal Assistance Oversight Committee Update	Susan Scheuerer	<p>Personal Assistance Oversight Committee Update:</p> <ul style="list-style-type: none"> • Susan provided a brief overview of both the May 13 and July 15, 2009 meetings. (The MCAC and the PAOC were both held July 15, 2009, not allowing Medicaid staff to give a presentation of updates from the May 13, 2009 meeting during the July MCAC meeting). • A copy of the May 13 and July 15, 2009 meeting minutes were provided in the MCAC meeting packets. • The next Personal Assistance Oversight Committee meeting is scheduled for December 10, 2009.
<p>Project Updates</p> <p>Audits and Investigations</p> <p>MMIS</p>	<p>Steve Bellomy Eileen Williams Lori Stiles</p> <p>Patti Campbell</p>	<p>Project Updates:</p> <p><u>Audits and Investigations</u></p> <ul style="list-style-type: none"> • Steve Bellomy provided a brief overview of the Audits and Investigation Bureau as a whole. • Eileen Williams provided the Committee with an overview of the Welfare Fraud Unit (recipient fraud). • Lori Stiles provided an overview of the Medicaid Program Integrity Unit (provider fraud) and how the complaints are received and investigated. • See attached handouts for Bureau structure, contact information, additional details, the Federal Poverty Guideline report (with income guidelines for different recipient programs) and an example of complaint forms for both recipient and provider fraud. <p><u>MMIS</u></p> <p>Patti provided the Committee with a brief background on the new MMIS project. The new MMIS is comprised of three vendors.</p> <ol style="list-style-type: none"> (1) Unisys, the “Base” system, which will be responsible for the medical claims processing, provider enrollment, web portal for providers and provider services. (2) Thompson Reuter is Medicaid’s decision support system (DSS)/Data Warehouse for reporting and analytics. (3) First Health Systems will handle the new pharmacy benefits management. <ul style="list-style-type: none"> • The first week of November 2009 (11/5/09-11/9/09), providers will receive a letter that will have their case number, user information and a list of all the information needed to update their provider records. This letter will come on green paper with red lettering. • If a provider has more than one provider number, they will receive a letter for each. These letters are not duplicates. An update will be needed for each provider number held. • The provider record updates (PRU) begin November 9, 2009. • Once a provider’s information is transferred from the Aim to the Unisys system, each provider will need to go into the Unisys system to review their records. • Workshop registration began the week of October 12, 2009, and is on going. • Workshops on the PRU will begin on November 16, 2009 through-out the state and will be specific to each provider type. • Large group providers, such as hospitals, will have on-site workshops.

Agenda Item	Presenter	Outcome/Action
		<ul style="list-style-type: none"> • The next phase of implementation, the pharmacy system (First Health), is scheduled for February 2010, so pharmacists are encouraged to do their provider updates as soon as possible. • The Unisys system, the main implementation, is scheduled for May or June 2010. • Any provider who uses the Provider Electronic Solutions (PES) software, currently provided by EDS, needs to send an e-mail to the MMIS project at IdahoMMIS@dhw.idaho.gov with “PES” in the subject line letting Medicaid know how it is being used so instructions can be given for a new route of claims processing. • The PES software will no longer be compatible once these new systems go live. • For more information on the MMIS project, such as dates and locations of additional trainings, project updates, frequently asked questions and contact information, visit the web site at: www.idahommis.dhw.idaho.gov. <p>Action Item: (1) Patti Campbell to provide a short insert on the MMIS project to Ms. Bailey of the IMA, and Ms. Lawson of the IHA, to add the information to their websites.</p>
<p>Medicaid Status Report</p> <ul style="list-style-type: none"> • Budget Update • Policy Update 	Paul Leary	<p>Medicaid Status Report:</p> <p><u>Budget Update</u> Paul Leary provided a hand out called the <i>Medicaid Presentation</i>, which was the budget report presented to the Joint Finance and Appropriations Committee (J-FAC) October 14, 2009. See attached for details.</p> <p><u>Policy Update</u> Paul Leary reviewed the <i>Division of Medicaid Policy Update October 2009</i> hand out. This hand out provides an update to Administrative Rule, State Plan Amendment and Waiver activity. See attached.</p> <p>The Committee requested to have the <i>Division of Medicaid Policy Update</i> provided prior to each meeting.</p>
Questions and Answers	All	<p>State Hospital South (SHS) and Medicaid Patients: Federal law states an inmate of a public institution can not be on Medicaid. There is a gap of services and medication between the time of release from the institution and eligibility to Medicaid. Apparently Welfare is looking at “holding” a person’s eligibility until the time of release. Can you comment to this?</p> <p>Action Items: (1) Paul Leary to contact Greg Kunz, Administrator for the Division of Welfare and relay the issue.</p>
Adjournment	Toni Lawson	Ms. Lawson adjourned the meeting.

Dates for 2010 MCAC Meetings are (all meetings are located at 3232 Elder, Boise Idaho): January 13, April 21, July 21, and October 20



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Health Care Fraud

Report Medicaid Provider Fraud

Fraud and abuse of public programs affects all of us. Everyone can take responsibility to report fraud and abuse. There are three ways to report fraud and abuse of taxpayer money:

1. **Call** toll free: 1-208-334-5754
2. **E-mail** a fraud complaint to: prvfraud@dhw.idaho.gov
3. **US Mail or Fax**, Complete Provider fraud complaint form and send to:
Fax a complaint form to 1-208-334-2026 or
Mail to: Medicaid Fraud and Program Integrity Unit, P. O. Box 83720, Boise, ID 83720-0036

If you are filling out a form, provide us with as much detail as possible and a contact name, phone number or e-mail address. This will help us if we have additional questions regarding the information you submit.

Together we can ensure taxpayer money is used for people who really need help.

Fraud and abuse significantly impact the Medicaid program by using up valuable dollars necessary to help vulnerable children and adults access health care.

Medicaid fraud and abuse are actively pursued by the Medicaid Program Integrity Unit within Health and Welfare. The unit:

Documents

- Provider Fraud Complaint Form
- Idaho Excluded Providers

- Identifies billing errors made by providers resulting in unnecessary loss of program dollars; and
 - Investigates and prosecutes providers and offenders for filing false or fraudulent claims to the Medicaid program.
 - Investigative units work closely with other state and federal investigative agencies and prosecutors to act against offenders and send a message of a zero tolerance for fraud and abuse within the Medicaid program.
-

What is Health Care Fraud?

Health care fraud is when a provider submits false or fraudulent claims for payment of health care services. Providers may be:

- Hospitals;
 - Mental health or case management providers;
 - Nursing homes;
 - Pharmacies;
 - Physicians;
 - Dentists;
 - Transportation providers; or
 - Any other provider who bills the Medicaid program for services.
-

Common Fraud Schemes

- Altering and/or falsifying records to match services billed;
- Balance billing Medicaid clients for services above the Medicaid payment rate;
- Billing for services not actually performed;
- Billing for services not covered by Medicaid as covered services;
- Billing mid-level services as physician services;

- Billing services for patients who have died;
- Changing the billed dates of service to match client dates of eligibility;
- Deliberately applying for duplicate reimbursement in order to get paid twice;
- Inappropriate billing that results in a loss to the Medicaid program;
- Kickbacks — Providing gifts or incentives for the ability to provide service billed to the Medicaid program;
- Providing service which is not medically necessary;
- Unbundling — Billing related services separately to charge a higher amount than if combined and billed as one service/group of services/panel of services;
- Upcoding — Providing a specific service and billing for a more expensive or detailed service; and
- Violating Medicaid and/or CHIP program policies, procedures, rules, regulations and/or statutes.

Durable Medical Equipment Fraud Schemes

- Billing Medicaid for more expensive equipment than actually supplied;
- Billing used items as new; and
- Continues to send medical supplies when no longer needed.

Hospital/Nursing Home Provider Fraud Schemes

- Billing for more hospital/nursing home days than delivered; and
- False cost reports.

Mental Health Providers

- Billing for services performed by unlicensed or unqualified persons.

Pharmacy Fraud Schemes

- Billing a greater amount of drugs than was actually dispensed;
- Billing for drugs or refills not authorized by a physician; and
- Filling a prescription with a generic drug or over-the-counter drug but billing for a more expensive name-brand drug.

Transportation Fraud Schemes

- Billing for less mileage in an effort to circumvent the need to obtain prior approval;
- Billing for more mileage than incurred; and
- Billing Medicaid for transportation to non-Medicaid services.

Excluded Providers

When a provider or person is found to be involved in fraud or abuse the circumstances may warrant exclusion from participation in the Medicaid program. Once a provider or person is excluded from participation in Idaho Medicaid, they will also be referred to the Office of Inspector General (OIG) for exclusion from any federally funded healthcare program and their name will be published on a national exclusion list.

Providers or persons who have been excluded are prohibited

from treating federal program clients or working for providers or entities who treat federal program clients:

- **Providers excluded by Idaho Medicaid.** Employers also must review the federal sanctioned provider list prior to hiring.
- **National exclusion list** published by the OIG.



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IDAHO DEPARTMENT OF
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PROVIDER FRAUD COMPLAINT FORM

1. Please complete all fields in the form below to the best of your ability.

2. Submit the form by:

- Fax: (208) 334-2026
- Mail: Medicaid Program Integrity Unit
PO Box 83720
Boise, ID 83720-0036

Your Name (optional):

Your contact information (daytime phone/address):

PROVIDER INFORMATION

NAME:

BUSINESS NAME:

BUSINESS ADDRESS:

TELEPHONE NUMBER:

TYPE OF BUSINESS (DENTIST, PHYSICIAN, CLINIC):

COMPLAINT (DESCRIBE IN DETAIL WHAT YOU SUSPECT IS WRONG):

MEDICAID PROGRAM INTEGRITY UNIT HOTLINE # (208) 334-5754

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If you suspect that a participant of any welfare program has received benefits improperly, please report the incident to us.

Report Welfare Fraud

Fraud and abuse of public programs affects all of us. Everyone can take responsibility to report fraud and abuse. There are three ways to report fraud and abuse of taxpayer money:

1. **Call** toll-free at 1-866-635-7515
2. **E-mail** a welfare fraud complaint to: welfraud@dhw.idaho.gov
3. **US Mail or Fax** a Welfare Fraud Complaint Form to:
 Fax a complaint form at 1-208-334-5694 or
 Mail to: Welfare Fraud Investigations,
 P. O. Box 83720, Boise, ID 83720-0036

Phone calls are answered by Idaho Careline 2-1-1 operators who are available from 8am to 6pm Monday through Friday Mountain Time. After hours, calls are directed to voice mail.

If you are completing a complaint form or sending an email, provide us with as much detail as possible and a contact name, phone number or e-mail address. This will help us if we have additional questions regarding the information you submit.

Why report Welfare Fraud?

Fraud and abuse significantly impacts the welfare programs by using up valuable dollars necessary to help eligible children and adults.

Fraud and abuse is actively pursued by fraud investigators within Health and Welfare. They investigate allegations of fraud being committed in Idaho Child Care Program (ICCP), Food Stamps, cash, medical, WIC and energy assistance. They initiate administrative, civil and criminal action against persons who abuse or commit fraud in the various welfare programs.

Together we can ensure taxpayer money is used for people who really need help.

What is Welfare Fraud?

Welfare fraud is any intentional action which causes a participant or provider to receive benefits to which they are not entitled.

Common Fraud Schemes

- Providing false or incomplete information to the Department at application or recertification.
- Failing to report changes.
- Submitting a false or fraudulent document to the Department in order to get benefits.
- Transferring, hiding or giving away assets in order to be eligible to receive benefits.
- ICCP providers billing for children not seen.

Welfare Fraud Forms

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WELFARE FRAUD COMPLAINT FORM

1. Please complete all fields in the form below to the best of your ability.
2. Submit the form send by either:
 - Fax: 208-334-5694 or
 - Mail: Welfare Fraud Investigations Unit
P. O. Box 83720
Boise, ID 83720-0036

Your Name (optional):
Your contact information (daytime phone, address):

Your contact information is kept confidential. However, an investigator may contact you for additional information if needed.

Participant's Name:

Participant's Address:

Participant's City & Zip Code:

Participant's Telephone Number:

Participant's Birth Date (or Approximate Age):

Client ID Number:

Gender:

Spouse's Name:

Spouse's Birthdate:

Participant's Social Security Number:

Programs: Cash Assistance Child Care Food Stamps Medical

First and Last Name and Age of Participant's Children and their Client ID Number (if known):

Complaint:

Federal Poverty Guidelines

Effective October 1, 2009

Medicaid for Families and Children Cost Sharing Income Limits for Direct Coverage								
HH Size	TAFI Payment Income Limit MA/MU	Pregnancy-Related Coverage ≤133% PW	QC ≤ 100% Age 0-19 L1-S1	QC >100% ≤133% Age 0-5 L4-S4	QC >100% ≤133% Age 6-19 B1-E1	QC >133% ≤150% Age 0-19 L2-S2	QC >150% ≤185% Age 0-19 L3-S3	QC >133% ≤ 185% Age 0-19 AC
	No Cost Share	\$10/month per child for Basic	\$15/month per child for Basic	Insurance Co-pays and Deductibles				
	DRA Needed May Have Creditable Health Insurance	DRA Needed Must Not Have Creditable Health Insurance	No DRA Needed Must Not Have Creditable Health Insurance	No DRA Needed Must Not Have Creditable Health Insurance	No DRA Needed			
1	205	1,201	903	1,201	1,201	1,354	1,670	1,670
2	251	1,615	1,215	1,615	1,615	1,822	2,247	2,247
3	317	2,030	1,526	2,030	2,030	2,289	2,823	2,823
4	382	2,444	1,838	2,444	2,444	2,757	3,400	3,400
5	448	2,859	2,150	2,859	2,859	3,224	3,976	3,976
6	513	3,273	2,461	3,273	3,273	3,692	4,553	4,553
7	579	3,688	2,773	3,688	3,688	4,159	5,130	5,130
8	645	4,102	3,085	4,102	4,102	4,627	5,706	5,706
ADDL Eff. Date	+65 7/1/06	+415 3/1/09	+312 3/1/09	+415 3/1/09	+415 3/1/09	+468 3/1/09	+577 3/1/09	+577 3/1/09

Note: Pregnant women, Native Americans, and Alaskan Natives are excluded from monthly premium share-of-cost.

Medicaid for Families and Children Federal Poverty Guidelines for Eligibility						
HH Size	Direct Coverage					Children's Access Card
	TAFI Payment Income Limit MA/MU	TAFI Need Income Limit	185% TAFI Need for Initial Eligibility	PW ≤ 133%	QC 0 ≤ 185%	AC >133% ≤ 185%
1	205	643	1,190	1,201	0 - 1,670	1,201 - 1,670
2	251	786	1,454	1,615	0 - 2,247	1,615 - 2,247
3	317	991	1,833	2,030	0 - 2,823	2,030 - 2,823
4	382	1,196	2,213	2,444	0 - 3,400	2,444 - 3,400
5	448	1,401	2,592	2,859	0 - 3,976	2,859 - 3,976
6	513	1,606	2,971	3,273	0 - 4,553	3,273 - 4,553
7	579	1,811	3,350	3,688	0 - 5,130	3,688 - 5,130
8	645	2,016	3,730	4,102	0 - 5,706	4,102 - 5,706
ADDL Eff. Date	+65 7/1/06	+205 7/1/06	+380 7/1/06	+415 3/1/09	See chart above for ADDL persons	

≤ less than or equal to
> greater than

Deductions						
HH Size	Standard Income	SUA	LUA	MUA	Max Shelter	Homeless Shelter
	Amount					
1-3	141	400	190	77	459	143
4	153					
5	179					
6+	205					

Refugee Medical Assistance Income Limits									
HH Size	1	2	3	4	5	6	7	8	ADDL
Amount	1,354	1,822	2,289	2,757	3,224	3,692	4,159	4,627	+468

HH Size	Food Stamps			TAFI	ITSAP	JCCP	At Risk	
	Max FS	Gross Income	Net Income	Work Incentive	133% FPG	135% FPG*	200% FPG	400% FPG
1	200	1,174	903	309	1,201		1,702	3,404
2	307	1,579	1,215	309	1,615	1,540	2,282	4,564
3	526	1,984	1,526	389	2,030	1,932	2,862	5,724
4	668	2,389	1,838	469	2,444	2,323	3,442	6,884
5	793	2,794	2,150	547	2,859	2,715	4,022	8,044
6	952	3,200	2,461	628	3,273	3,106	4,602	9,204
7	1,052	3,605	2,773	708	3,688	3,498	5,182	10,364
8	1,202	4,010	3,085	787	4,102	3,889	5,762	11,524
9	1,352	4,422	3,397	867	4,517	4,281	6,342	12,684
10	1,502	5,228	3,709	947	4,932	4,672	6,922	13,844
Addl	+150	+406	+312	+80	+415		+580	+1,160
Eff. Date	4/1/09	10/1/09	10/1/09	7/1/02	3/1/09	4/2/08	10/01/07	10/01/07

* ICCP Maximum Income is based on 2007 Federal Poverty Limits.
FS updated with changes effective October 1, 2009.



IDAHO DEPARTMENT OF

HEALTH & WELFARE

Bureau of Audits and Investigations Presentation

MEDICAL CARE ADVISORY COMMITTEE

10/21/2009

Presenters:

Steve Bellomy, Bureau Chief, bellomyS@dhw.idaho.gov , 208 334-0609

Eileen Williams, Welfare Fraud (recipient) Supervisor, willia10@dhw.idaho.gov ,208 334-0659

Lori Stiles, Medicaid Program Integrity (provider) Supervisor, StilesL@dhw.idaho.gov ,
208 334-6645



BUREAU OF AUDITS AND INVESTIGATIONS

PERFORMANCE STATISTICS

Fiscal Year To Date

As of September 30, 2009

	YTD September FY 2010	FY 2009	FY 2008	FY 2007	FY 2006
CRIMINAL HISTORY					
Number of Individuals Fingerprinted	5,561	21,311	22,308	N/A	N/A
Designated Crime Denials (Disqualifying Offenses)	19	78	109	142	140
Voluntary Withdraws	45	150	168	238	295
MEDICAID PROGRAM INTEGRITY					
Cases Opened	30	349	151	213	168
Cases Closed	103	309	190	199	139
Ending Open Cases	203	276	N/A	N/A	N/A
Overpayments, Penalties, and Interest	\$496,902	\$3,257,998	\$1,520,260	\$2,020,590	\$1,084,057
Projected Cost Avoidance, Savings	\$25,434	\$2,526,836	\$758,926	\$442,718	\$229,257
Receipts Collected	\$458,686	\$1,821,941	\$841,865	\$1,589,904	\$541,833
WELFARE FRAUD					
Complaints	592	1,898	1,495	933	911
Cases Opened	577	1,824	1,647	495	420
Cases Closed	496	1,602	1,257	498	434
Ending Open Cases	1,070	985	763	373	376
Identified Overpayments	\$220,905	\$1,564,160	\$895,446	\$681,848	\$667,990
Projected Cost Avoidance, Savings	\$584,553	\$1,857,708	\$1,389,997	\$886,276	\$427,886
Receipts Collected	\$76,554	\$389,023	\$269,399	\$326,597	\$185,177

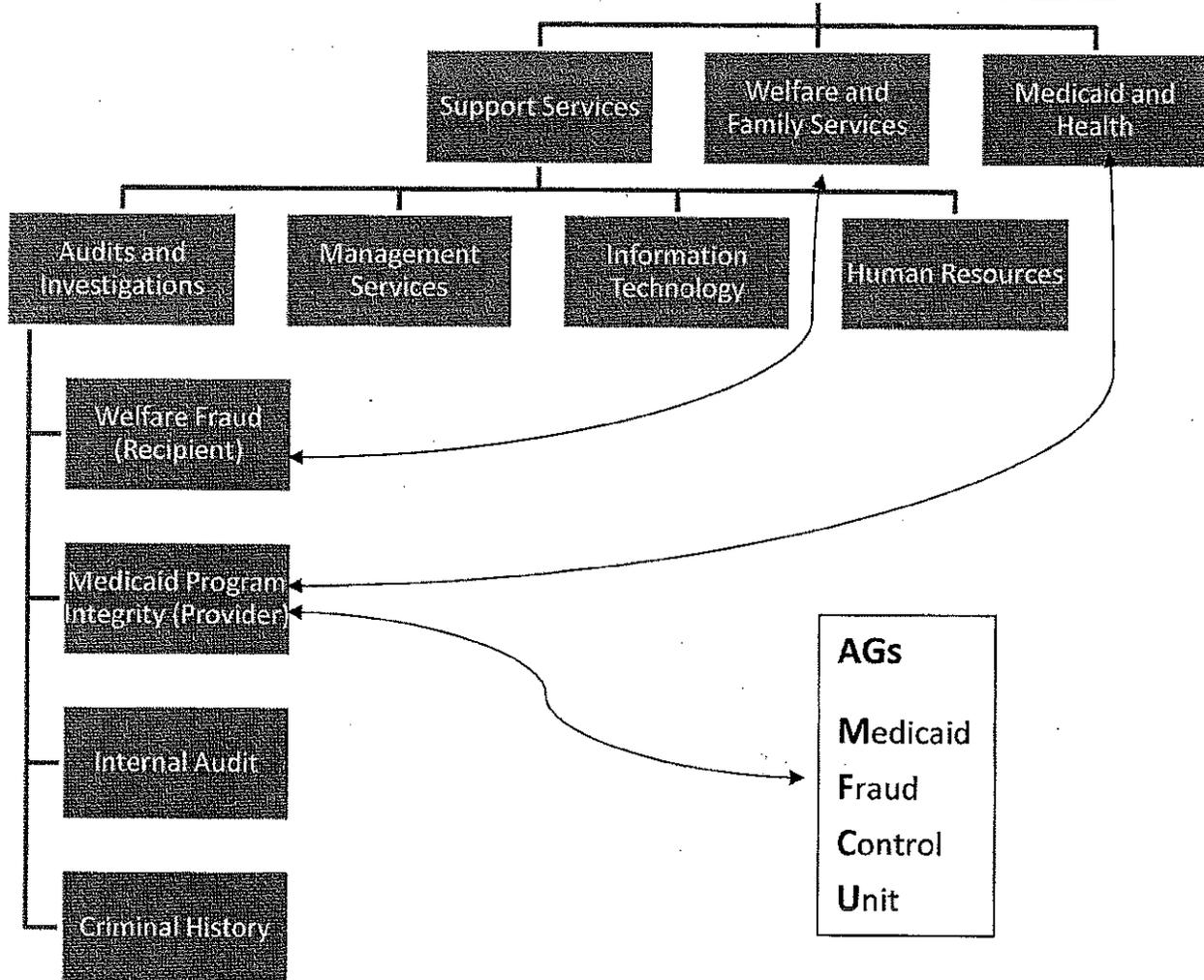
AUDIT SCHEDULE

AUDITS IN PROGRESS	AUDIT STATUS	AUDITS SCHEDULED	START DATE
FY2009 Attestation	Report	BPA Billing Audit	March
Region Four	Response	Idaho State School and Hospital	December
Central Office Cash Receipting	Response	Division of Medicaid	December
Food Stamp Segregation	On Hold	Division of Behavioral Health	October
Division of Management Services	Fieldwork	Region Five Cash Receipting	October
FY2010 Audit Plan	Report		
Region Six	Planning		
Regions Six and Seven Cash Receipting	Planning		
AUDITS COMPLETED (Names are hyperlinks to actual report)			
FY 2010	FY 2009	FY 2008	
FY2008 Sales Tax Audit Report	Target Store Voucher Reconciliation	Bureau of Laboratories	
Region Three	State Hospital South	Regence Blue Shield Payments	
	Emergency Medical Services	State Hospital North	
	P-Card Cancellation	Fixed Assets Audit	
	Region Seven	Division of Information Technology	
	Region One	Region Five	
	Westgate Cash Receipting	Community Hospitalization	
	FY2008 Annual Attestation	Divisions of Management Services and Human Resources	
		Mental Health Authority	
		FY2007 Attestation	

For more detail see: Long Version



IDAHO DEPARTMENT OF
HEALTH & WELFARE



**DIVISION OF MEDICAID
POLICY UPDATE
October 2009
ADMINISTRATIVE RULES**

Docket 16-0309-0804 Paul Leary	Tamper Proof Prescription Pads These rules are being amended to meet new federal requirements. This is the second phase of an October 1, 2008 deadline to require handwritten or computer printed Medicaid prescriptions contain at least one industry recognized feature from each of the three categories of tamper resistance. Prescriptions for Medicaid patients that are telephoned, faxed or ePrescribed are exempt from these tamper resistance requirements. House – Passed Senate - Passed	
	Published as Temporary/proposed (10/1/08)	November 5, 2008
	Comment period ends	November 26, 2008
	Changes to rules based on comment submitted to APS	November 28, 2008
	Pending rules publish	October 7, 2009

Docket 16-0309-0901	Reduction of Hospital Floor % Reimbursement (Gov. Holdback) These rules need to be amended in response to the Governor’s Executive Order No. 2008-05, that directed state agencies to hold back 4% of their state general fund budgets in current 2009 fiscal year. Cost savings under these rule changes will be realized through reduction in reimbursement percentages to Medicaid providers of hospital services.	
	Published as temporary/proposed (1/1/09)	July 1, 2009
	Comment period ends	July 22, 2009
	Changes to rules based on comment submitted to APS	July 24, 2009
	Pending rules publish	January 6, 2010

Docket 16-0309-0902	Removal of Disproportionate Share Hospital (DSH) payment to out-of-state hospitals and require private hospitals to pay State’s share of DSH (Gov. Holdback) These rules need to be amended in response to the Governor’s Executive Order 2008-05. Cost savings under these rule changes will be realized through no DSH payments to out-of-state hospitals and reduction in state matching funds for DSH.	
	Published as Temp/proposed (7/1/09)	July 1, 2009
	Comment period ends	July 22, 2009
	Changes to rules based on comment submitted to APS	September 4, 2009
	Pending rules publish	November 4, 2009

Docket 16-0309-0903

School Based Services

A recent court ruling stated that Idaho Medicaid cannot limit the “place of service” where medically necessary services can be delivered. The court decision invalidated Medicaid rules requiring that rehabilitative and habilitative services delivered in the school only be billed by an enrolled school-based services provider.

Existing school based rules include mental health services that were re-defined when mental health rules were reformed and presented to and passed by the 2009 legislature. The school-based rules need to be revised in order to coincide with existing Medicaid mental health rules.

Rules pertaining to paraprofessionals conflict with current occupational therapy, physical therapy, speech language pathology licensure requirements, and the supervision requirements under the developmental disability agencies (DDA) rule.

Published as proposed <small>(Sine Die 2010)</small>	October 7, 2009
Comment period ends	October 28, 2009
Changes to rules based on comment submitted to APS	October 30, 2009
Pending rules publish	January 6, 2010

Docket 16-0309-0904

Preventive Health Assistance

A child who participates in both the Behavioral and Wellness benefits under Preventative Health Assistance (PHA) is currently limited to the cap placed on the Behavioral benefit (\$200/yr) instead of being able to earn maximum points for both the Behavioral and Wellness benefit (total of \$320 per year), if used separately. This limitation complicates PHA benefit administration and is sometimes a source of frustration to families who find their child's Behavioral PHA benefit effectively reduced by \$200 per year to \$80 per year. Additionally, the state will avoid programming costs for Medicaid's new automated system if participants are allowed to earn the maximum points for each type of PHA with out needing to treat those children differently who participate in both benefits.

Published as proposed <small>(Sine Die 2010)</small>	October 7, 2009
Comment period ends	October 28, 2009
Changes to rules based on comment submitted to APS	October 29, 2009
Pending rules publish	January 6, 2010

Docket 16-0310-0902 Paul Leary/David Simmitt	Executive Order 1% Hold back Rule changes are required to meet the Governor's request related to developmental disability agency benefit changes. These changes will reflect a reduction of the maximum amount of service hours available for services provided by Developmental Disability Agencies. House – Passed Senate - Passed	
	Published as temp/proposed (1/1/09)	January 7, 2009
	Comment period ends	January 28, 2009
	Changes to rules based on comment submitted to APS	January 30, 2009
	Pending rules publish	TBD

Docket 16-0310-0903	Limit Daily Reimbursement to Nursing Homes (Gov. Holdback) These rules need to be amended in response to the Governor's Executive Order 2008-05. Cost savings under these rule changes will be realized through reductions in incentive payments to nursing facilities and reductions in percentage increases to the inflation index used to calculate the nursing facility daily reimbursement rate.	
	Published as temp/proposed (7/1/09)	July 1, 2009
	Comment period ends	July 22, 2009
	Changes to rules based on comment submitted to APS	September 4, 2009
	Pending rules publish	November 4, 2009

Docket 16-0310-0904	Freeze ICF/MR daily reimbursement rate for SFY 2010 (Gov. Holdback) These rules need to be amended in response to the Governor's Executive Order 2008-05. Cost savings under these rule changes will be realized through a rate freeze for ICF/MR	
	Published as temp/proposed (7/1/09)	July 1, 2009
	Comment period ends	July 22, 2009
	Changes to rules based on comment submitted to APS	September 4, 2009
	Pending rules publish	November 4, 2009

Docket 16-0310-0905	Children's Personal Care Services (PCS) Rules These rules need to be amended in response to the federal audit conducted by Centers for Medicare and Medicaid Services (CMS) for the period of July 1, 2006 through June 30, 2007, on the PCS program. In order to comply with the recommendations from CMS, Medicaid needs to change the payment methodology for children receiving PCS in a PCS home and establish rules specific to PCS for children.	
	Published as proposed (sine die 2010)	October 7, 2009
	Comment period ends	October 28, 2009
	Changes to rules based on comment submitted to APS	October 29, 2009
	Proposed rules publish	January 6, 2010

Docket 16-0310-0906	School Based Services, Removal of ISSH waiver and revision of IAP A recent court ruling stated that Idaho Medicaid cannot limit the "place of service" where medically necessary services can be delivered. The court decision invalidated Medicaid rules requiring that rehabilitative and habilitative services delivered in the school only be billed by an enrolled school-based services provider. The Idaho State School and Hospital (ISSH) waiver expired June 30, 2009. The rule needs to be revised to reflect this change. As of July 1, 2009 the Independent Assessor Provider (IAP) no longer reviews individual support plans. While the IAP continues to perform assessments, determine eligibility and set individualized budgets; the responsibility for reviewing the service plans shifted from the IAP to department regional care managers.	
	Published as proposed (Sine Die 2010)	October 7, 2009
	Comment period ends	October 28, 2009
	Changes to rules based on comment submitted to APS	October 30, 2009
	Pending rules publish	January 6, 2010

Docket 16-0310-0907	A&D Waiver Self-Directed Services, Remove Fiscal Intermediary Reference The Division of Medicaid is proposing to change these rules to allow for the development of a uniform, state-wide consumer-directed services model for all Medicaid programs. This will allow Medicaid's consumer-directed programs to use the same service model. The rule changes proposed in this chapter regarding the removal of references to the fiscal intermediary services under the A&D waiver will align with changes being proposed under companion docket no. 16-0313-0901.	
	Published as proposed (sine die 2010)	October 7, 2009
	Comment period ends	October 28, 2009
	Changes to rules based on comment submitted to APS	October 29, 2009
	Pending rules publish	January 6, 2010

Docket 16-0313-0901	Waiver Self Direction Program, Fiscal Employer Agent The Division of Medicaid need to change these rules to allow for the development of a uniform, state-wide financial management model for all Medicaid programs. This will allow Medicaid's self-directed programs to use the same service model. Current rules are written only for the Home and Community Based Services (HCBS) Developmental Disabilities (DD) Waiver services. These changes will align with the companion rulemaking being proposed under docket no. 16-0310-0909.	
	Published as proposed (sine die 2010)	October 7, 2009
	Comment period ends	October 28, 2009
	Changes to rules based on comment submitted to APS	October 29, 2009
	Pending rules publish	January 6, 2010

Docket 16-0318-0901	Medicaid Cost Sharing/Katie Beckett Changes/Fees The changes in these rules are to meet legislative intent of the Department's appropriations budget (HB322) that requires the Department to put cost containment measures in place for the SFY 2010. This change will require parents of certain disabled children with family income at or above 133% of the FPG and receiving Medicaid Enhanced Plan benefits to share in the cost of their child's Medicaid benefits.	
	Published as temp/proposed (7/1/09)	July 1, 2009
	Comment period ends	August 21, 2009
	Changes to rules based on comment submitted to APS	August 25, 2009
	Pending rules publish	November 4, 2009

Docket 16-0322-0901	RALF Payment Levels/Statute Changes Section 39-3303, Idaho Code, is being reviewed for amendments by the 2009 Legislature regarding payment levels for non-Department of Health and Welfare clients in a residential care or assisted living facility. The proposed changes to the statute will necessitate corresponding changes and clarification in this chapter of rule. The proposed changes to the statute will modify how private pay residents in a residential care or assisted living facility will be assessed for needs, services, and associated costs for services.	
	Published as proposed (sine die 2010)	September 2, 2009
	Comment period ends	September 23, 2009
	Changes to rules based on comment submitted to APS	September 25, 2009
	Pending rules publish	January 6, 2010

Coming soon: Transportation brokerage

STATE PLAN AMENDMENTS TITLE XIX

- 08-014 **Mental Health (MH) Reimbursement**
Status: Submitted to CMS 9/2/08 - 90 day clock 12/1/08
RAI received 11/25/08 w/response date 2/23/09
Submitted RAI response 2/18/09-new 90 day clock 5-19-09
Submitted request to withdrawal RAI 5/5/09
- 08-015 **Budget reduction Developmental Disability (DD) and Mental Health (MH) service**
Status: Submitted to CMS 11/7/08 - 90 day clock 2/5/09
RAI received 2/3/09 w/response date 5/4/09
Submitted RAI response 3/20/09-new 90 day clock 6/18/09
RAI response 6/12/09-new 90 day clock 9/27/09
Approved 9/1/09
- 08-016 **Mental Health (MH) Rehabilitation Reimbursement**
Status: Submitted to CMS 12/12/08 - 90 day clock 3/12/09
RAI received 3/12/09 w/response date 6/10/09
Submitted RAI response 6/3/09-new 90 day clock 9/1/09
Approved 9/1/09
- 08-017 **Developmental Rehabilitation Reimbursement**
Status: Submitted to CMS 12/12/08 - 90 day clock 3/12/09
RAI received 3/12/09 w/response date 6/10/09
Submitted RAI response 6/3/09-new 90 day clock 9/1/09
Approved 9/1/09
- 09-004 **Never Events**
Status: Submitted to CMS 4/17/09 - 90 day clock 7/16/09
Received RAI 7/15/09 with response date 10/13/09
Submitted RAI response 8/27/09-new 90 clock 11/24/09
Approved 9/24/09
- 09-013 **Nursing Facility (NF) Upper Payment Limit (UPL)**
Status: Submitted to CMS 6/15/09 - 90 day clock 9/13/09
Received RAI 9/11/09 with response date 12/10/09
Submitted RAI response 10/2/09- new 90 day clock 12/31/09
- 09-014 **Re-Write of Attachment 4.19-D**
Status: Submitted to CMS 8/27/09 - 90 day clock 11/25/09

STATE PLAN AMENDMENTS TITLE XXI

#10 Incorporates changes made or pending to the Title XIX State Plan for years 2006-2009
Status: Submitted to CMS 3/17/09 - 90 day clock 6/15/09
Received RAI 3/17/09 with response date 9/13/09
Submitted RAI response 9/10/09 - remainder of 90 day clock 11/9/09

WAIVER ACTIVITY

WVR09-004 FEA as a DD waiver service
Status: Submitted 9/15/09 - 90 day clock 12/14/09

WVR09-005 HIFA waiver renewal
Status: Submitted to CMS 8/5/09 - no clock

WVR09-006 HIFA Childless Adults
Status: Submitted to CMS 9/11/09 - no clock

**MEDICAID TRUSTEE & BENEFITS
FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAP) HISTORY**

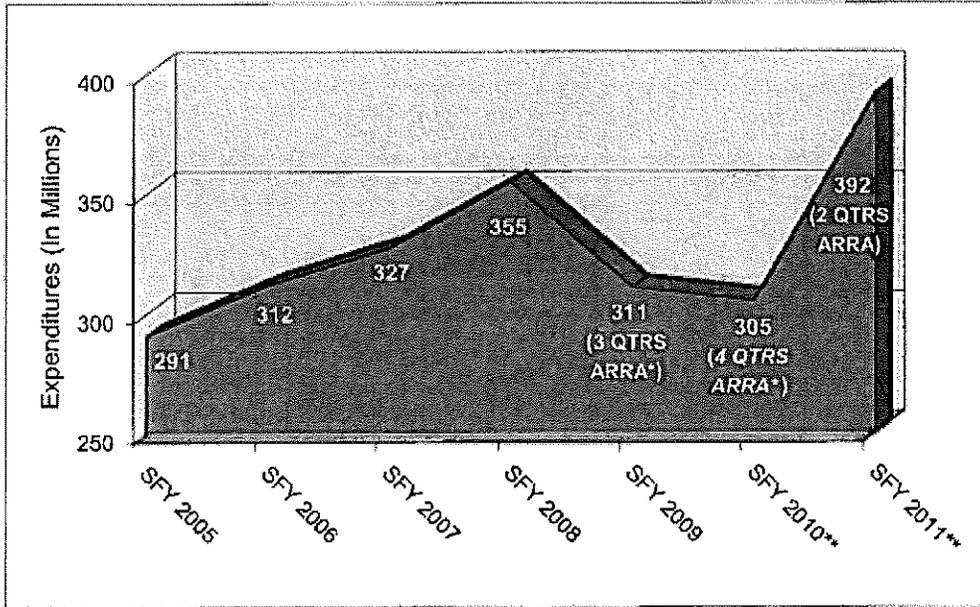
State Fiscal Year	Quarter	FMAP	ARRA Unemployment Tier
2007	Jul - Sep	69.91%	
2007	Oct - Dec	70.36%	
2007	Jan - Mar	70.36%	
2007	Apr - Jun	70.36%	
2008	Jul - Sep	70.36%	
2008	Oct - Dec	69.87%	
2008	Jan - Mar	69.87%	
2008	Apr - Jun	69.87%	
2009	Jul - Sep	69.87%	
2009	Oct - Dec	78.78%	ARRA Tier 2
2009	Jan - Mar	78.78%	ARRA Tier 2
2009	Apr - Jun	79.18%	ARRA Tier 3
2010	Jul - Sep	79.18%	ARRA Tier 3
2010	Oct - Dec	79.18%	ARRA Tier 3
2010	Jan - Mar	79.18%	ARRA Tier 3
2010	Apr - Jun	79.18%	ARRA Tier 3
2011	Jul - Sep	79.18%	ARRA Tier 3
2011	Oct - Dec	79.18%	ARRA Tier 3
2011	Jan - Mar	69.71% ⁽¹⁾	
2011	Apr - Jun	69.71% ⁽¹⁾	

ESTIMATES IN YELLOW⁽²⁾

- (1) FMAP beyond the ARRA is an estimate based upon a formula which compares individual state per capita income to the continental United States per capita income.
(2) FMAP during ARRA subject to final published unemployment data

**MEDICAID TRUSTEE & BENEFITS
GENERAL FUND HISTORY
(IN MILLIONS)**

MEDICAID TRUSTEE & BENEFITS - GENERAL FUND EXPENDITURES



*ARRA: American Recovery & Reinvestment Act of 2009
**SFY 2010 & SFY 2011 reflect the Agency Request

SUMMARY OF STIMULUS FUND REDUCTIONS (IN MILLIONS): General Funds

SFY 2009:	
Rescission - Stimulus Funds (On-Going)	74.2
Caseload Growth	(21.9)
SFY 2009 Rescission - Stimulus Funds, Net of Caseload Growth	52.3
SFY 2010:	
Base Reduction - SFY 2009 Rescission (Reduced On-Going)	52.3
Base Reduction - SFY 2010 Additional Stimulus Funds (Reduced On-Going)	112.1
Caseload Growth	(38.9)
SFY 2010 Base Reduction - Stimulus Funds, Net of Caseload Growth	125.5

**MEDICAID TRUSTEE & BENEFITS
BUDGET REQUEST SUMMARY
(IN MILLIONS)**

	General Funds
SFY 2010:	
Supplemental (2010 Caseload, Pricing & Utilization Increase)	14
Nursing Facility Provider Assessment	(2)
Budget Holdback - Hold 1-2 Weeks of Medicaid Payments ^{(1), (2)}	12
SFY 2010 Shortfall:	24
SFY 2011:	
<u>SFY 2010 On-Going Items:</u>	
Supplemental (2010 Caseload, Pricing & Utilization Increase)	14
Nursing Facility Provider Assessment	(2)
SFY 2011 Caseload Increase	15
SFY 2011 Cost-Based Pricing & Utilization Increase	8
SFY 2011 Mandatory Pricing Increase	2
6 Months of Federal Medical Assistance Percentage (FMAP) Change ⁽³⁾	61
SFY 2011 Shortfall:	99

A \$99 million shortfall in general funds would result in a required cost savings of approximately \$387 million, or about 23% of the Medicaid program.

Based on the composite SFY 2011 FMAP rate of 74.45%.

- (1) Assumes 1-2 Weeks of SFY 2010 Medicaid Payments Held Until SFY 2011
- (2) Includes \$5.6 million of end-of-year payments to the Centers for Medicare & Medicaid Services (CMS), where the federal match is only about 49.5%
- (3) Excludes \$1.8 million of general fund impact related to FMAP change in other programs; State Hospital South, Idaho State School & Hospital, Foster & Assistance Payments, Substance Abuse, and Children's Mental Health

Division of Medicaid Status Report as of October 2009

The Division of Medicaid initiated a number of strategies to reduce spending. The division's 2010 budget was approved, it continued the holdbacks from SFY 2009 and assumed new cost containment initiatives would be implemented to further reduce spending.

The following is a summary of the status of these holdbacks and initiatives in the division's Trustee and Benefits plans to date:

Current Cost Avoidance Initiatives	Status	Target (annual)
Hospitals		
Reduced prices paid for hospital-based ambulatory surgical centers – 2009 ongoing	Implemented	\$6 million
Requirement to pay state share of disproportionate share hospital (DSH) 2010	Implemented	\$5.9 million
5% reduction of hospital interim rates – 2009 ongoing	Implemented	\$4.3 million
Total for Hospitals		\$16.2 million
Long Term Care		
Decrease amount of incentive payments available for nursing homes - 2010	July 1, 2009 – SPA Pending Federal Approval	\$3.5 million
Reduce nursing home rates by 2.7% (for one year) & reduce inflation factors 2010– need to amend statute to add 2 nd year	July 1, 2009 – SPA Pending Federal Approval	\$4.1 million
Adjusted rates to provide incentive to provide companion care - 2009 ongoing	Implemented	\$760,000
Total for Long Term Care		\$8.36 million
Pharmacy		
Added anti-psychotic drugs to preferred drug list; obtain rebates - 2010	Implemented – Drug class reviewed August 2009	\$2.2 million
Expand the use of the State Maximum Allowable Cost pricing approach - 2010	Process developed to expand program	\$8 million
Total for Pharmacy		\$10.2 million
Mental Health		
Reduced the maximum amount of PSR benefits available - 2009 ongoing	Implemented	\$3.9 million
Reduced the maximum amount of partial care benefits available - 2009 ongoing	Implemented	\$8.8 million
Total for Mental Health		\$12.7 million

Current Cost Avoidance Initiatives	Status	Target (annual)
Medical		
Reduced the rates paid for incontinence supplies- 2009 ongoing	Implemented	\$390,000
Freeze physician and dentist rates (one year) 2010 – need to amend statute to add 2 nd year	Implemented	\$4.3 million
Freeze related medical services rates (one year) - 2010– need to amend statute to add 2 nd year	Implemented	\$1.1 million
Implement utilization management approach (diagnostic imaging) - 2010	RFP - currently posted vendor selection October 2009	\$1 million
Total for Medical		\$6.79 million
Medicaid Managed Care Contracts		
Re-negotiated premium payments and re-bid outsourced dental plan - 2010	Implement in SFY 2009 - On track Dental RFP October 2009.	\$2.2 million
Development Disabilities		
Change pricing methodology for certified family home payments - 2010	In Development	\$2.8 million
Change the pricing method for affiliated agencies	Lawsuit pending – – Loss of \$1.4 million savings	\$0
Freeze intermediate care facility (ICF) prices - 2010	July 1, 2009 – SPA Pending Federal Approval	\$314,000
Reduced the maximum amount of DDA benefits available - 2009 ongoing	Implemented	\$6 million
Reduced Independent Assessment Contract - 2009 ongoing	Implemented	\$1 million
Total for Development Disabilities		\$10.114 million
Non-Emergency Medical Transportation		
Removed benefit for Basic Plan participants	CMS reversed; federal regulations changed – SPA Disapproved - Loss of \$1 million	\$0
Outsource to transportation broker – 2010	RFP being resubmitted – September 2009	\$6.8 million
Total for Non-Emergency Medical Transportation		\$6.8 million
Cost Sharing		
Implement cost sharing (premiums) for Katie Beckett families – 2010	February 1, 2010 Rules revised based on public comment	\$1 million
Impact of Current Cost Containment Initiatives		
State General Funds	Federal Funds	Total Funds
\$15.831 million	\$58.803 million	\$74.364 million

Initiatives under Development		
Hospital Short Term Pricing Reductions	In negotiations	\$6.5 million
Nursing Home Reimbursement Reductions	Under analysis	\$5.3 million
Medical Supply Pricing Reduction	Under analysis	\$500,000
Personal Care Services Rate Freeze	Under analysis	\$1.6 million
Deputy Attorney General for Estate Recovery	Beginning discussions with AG	\$2.5 million
Drug Utilization Review Contract Reduction	Completed; will terminate in April	\$325,000
Optional Benefits and Pricing Strategies under Analysis	Under analysis	TBD
State General Funds	Federal Funds	Total Funds
\$3.482 million	\$13.243 million	\$16.725 million

**MEDICAL ASSISTANCE PROGRAM
EXPENDITURE BY SERVICE CATEGORY
(IN MILLIONS OF DOLLARS)**

The numbers below
reflect the Department's
September 1st Budget Submission

Service Required	Rate Set	Row Number	Service Category	2009 Actual	2010 Estimate	2011 Estimate
federal	rule	1	Hospital	\$ 256.2	\$ 274.6	\$ 298.9
rule	rule		Upper Payment Limit	24.7	24.7	24.7
rule	rule		Disproportionate Share Hospital Payments	22.2	22.7	23.3
federal	state	2	Nursing Facility	151.7	164.9	168.5
federal	state	3	Physician Services	73.4	84.1	94.3
federal	federal	4	Medicare Parts A & B	36.0	43.9	50.3
federal	federal	5	Part D Clawback (100% General Funds)	19.5	24.0	25.4
federal	rule	6	Medical Transportation	20.5	22.3	22.6
federal	rule	7	Laboratory/Radiology Services	14.3	17.9	21.3
federal	federal	8	Federally Qualified Health Center	10.6	14.1	15.8
federal	federal	9	Home Health Services	8.8	11.9	14.6
federal	rule	10	EPSDT Services	11.7	13.5	14.3
federal	federal	11	Rural Health Clinic Services	8.5	9.9	10.6
federal	federal	12	Hospice Benefits	6.3	7.7	8.3
federal	rule	13	Family Planning	3.7	4.5	4.9
federal	federal	14	Indian Health Services	2.0	2.0	2.0
state	rule	15	Prescribed Drugs	104.9	113.6	130.0
state	state	16	Mental Health (Task 1000 & COS 704)	87.6	95.7	101.1
state	rule	17	Aged/Disabled-Walver (TBI Included)	86.6	94.6	95.7
state	rule	18	ISSH/DD Waiver	74.9	75.7	81.4
state	Coverage Group	19	School District Services	30.5	48.7	65.8
state	Coverage Group	20	Child Health Program (Title XXI)	46.0	54.4	62.5
state	state	21	Development Disability Center	58.1	61.7	61.5
state	state	22	ICF/MR Care	37.2	39.4	40.8
state	rule	23	Medicaid Prepaid Health Plans	28.8	25.7	31.7
state	rule	24	Durable Medical Equipment & Med Supplies	21.1	25.4	26.4
state	state	25	Personal Care Svs Plan	22.7	24.3	25.2
state	rule	26	Ambulatory Surgical Centers	20.4	21.5	22.8
state	rule	27	Other Practitioners	17.4	19.5	20.8
state	state	28	Inpatient Mental Health < 21 (COS 701 & 705)	14.3	17.1	20.2
state	state	29	Targeted Case Management	14.0	15.6	18.2
state	rule	30	Dental Services	9.2	11.5	14.8
state	rule	31	Physical Therapy	9.6	11.7	12.0
state	Coverage Group	32	Breast & Cervical Cancer Program	6.3	7.1	8.5
state	rule	33	Healthy Connections	6.8	7.1	7.5
state	rule	34	Outpatient Rehab	3.4	4.1	4.2
state	rule	35	Nurse's Aide Training	3.6	3.1	3.1
state	rule	36	Group Health Plan Payments	2.4	2.4	2.6
state	rule	37	District Health	0.4	0.5	0.5
state	rule	38	Preventive Health Accounts	0.2	0.2	0.2
state	state	39	Personal Care Services	-	-	-
TOTAL EXPENDITURES				\$ 1,376.5	\$ 1,523.6	\$ 1,659.6
PERCENT CHANGE				9.29%	10.69%	8.93%

Note: Medicaid eligibility cannot be modified until FMAP reverts to the pre-ARRA levels on Jan 1, '11
All State plan changes must be approved by CMS

<u>Breakdown by Funding Source:</u>				
General Funds	\$	311.1	\$ 305.3	\$ 392.1
Dedicated Funds		90.7	95.3	107.1
Federal Funds		974.7	1,123.0	1,160.4
TOTAL EXPENDITURES	\$	1,376.5	\$ 1,523.6	\$ 1,659.6